

A qualitative study exploring British Muslim
women's experiences of motherhood while
engaging with NHS maternity services

Shaima Mohamed Hassan

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Abstract

Women in the UK have access to NHS maternity services and most will attend hospital to give birth in the NHS. Much effort has been undertaken over several decades to improve childbirth and to enhance the experiences of those using NHS maternity services. However, while most women report positive experiences of maternity care, existing evidence suggests that women from ethnic minority groups in the UK have poorer pregnancy outcomes, experience poorer maternity care, are at higher risk of adverse perinatal outcomes and have significantly higher severe maternal morbidity than the resident white women (Puthussery, 2016; Henderson et al, 2013; Puthussery et al., 2010; Straus et al., 2009). Muslim women of child-bearing age make up a significant part of UK society, yet their health needs and their experiences of health services have not been extensively researched. The term ‘Muslim’ is often combined with ethnic group identity, rather than used to refer to people distinguished by beliefs, practices or affiliations. Muslim women commonly observe certain religious and cultural practices during their maternity journey and the little research there is in this area suggests that more could be done from a service provision perspective to support Muslim women through this, spiritually and culturally significant life event (McFadden et al., 2013; Alshawish et al., 2013). This study explores Muslim women’s perceived needs and the factors that influence their health seeking decisions during their transition to motherhood. Using a generic qualitative approach, seven English-speaking first time pregnant Muslim women and a Muslim mother who is second time pregnant but experiencing motherhood as a Muslim for the first time, were interviewed at different stages of their maternity journey (antenatal, post-labour and postnatal); five focus groups were conducted with Muslim mothers; and 12 semi-structured interviews were conducted with healthcare professionals. Thematic analysis of the transcripts revealed that Muslim women: 1) had a unique perspective on motherhood based on Islamic teaching; 2) sourced information from a number of sources, additional to midwives; 3) experienced difficulty expressing their religious requirements when preparing a birth plan; 4) assumed that healthcare professionals would have a negative view of Islam and Islamic birthing practices. While one-to-one interviews revealed that healthcare professionals: 1) varied in their perceptions of Muslim women; 2) had a general awareness of Muslim women’s Islamic practices but not specific to motherhood; 3) sourced cultural and religious information to enhance their understanding of women’s needs and their specific practices; 4) had some challenges when addressing women’s specific religious practices such as fasting; 5) would benefit from cultural/religious competency training that incorporates lived experience and group discussion.

The implications for institutions, midwifery practice and further research are outlined. The study concludes that transcultural knowledge and specifically Muslim women’s worldview incorporated into healthcare professional training would enhance the competency and quality of healthcare services.

Key Words: Cultural Competency, Maternity, Midwifery, Motherhood, Muslim.

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Chapter One: Introduction

In the United Kingdom (UK) having a child for the majority of women is a joyous, thankful and natural life event. Women in the UK have access to NHS maternity services and most will attend hospital to give birth in the NHS. Overall most women are healthy when giving birth and stay that way (Tingle, 2016). However, while most women report positive experiences of maternity care in the NHS, existing evidence suggests that women from ethnic minority groups in the UK have poorer pregnancy outcomes, experience poorer maternity care, are at higher risk of adverse perinatal outcomes and have significantly higher severe maternal morbidity than the resident white women (Puthussery, 2016; Henderson et al., 2013; Puthussery et al., 2010; Straus et al., 2009; Pollock, 2005; Maternity Alliance, 2004; Bulman and McCourt, 2002; Ellis, 2000). Approximately a quarter of women giving birth in England and Wales are from minority ethnic groups (Office for National Statistics (ONS) (2011) and striking inequalities persist in neonatal and infant outcomes between white and ethnic minority groups in the UK with some groups being particularly disadvantaged (Puthussery, 2016).

Although UK policies explicitly urge a woman-centred approach that is accessible, efficient and responsive to changing needs, ensuring choice, access and continuity of care, evidence of the impact of such policies in addressing inequalities in maternal health outcomes is relatively thin (Puthussery, 2016). Following a number of national policy documents and local initiatives (Henderson et al., 2013) there is a body of research that highlights this as a cause for concern and indicates that the maternity services in the UK are still struggling to provide appropriate care that meets the needs of women from diverse populations (Henderson et al., 2013; Puthussery et al., 2010; Straus et al., 2009; Pollock, 2005; Maternity Alliance, 2004). Katbamna (2000), Laird et al. (2007) and Puthussery et al. (2008) argue that this is mostly due to a lack of awareness of ethnic minority groups and their needs, due to limited research.

In general, there are a range of individual, contextual, structural, organisational and social factors for unfavourable maternal and infant outcomes, whereby ethnic minority status is regarded as one of the important factors in determining maternity experience (Puthussery, 2016). Ethnicity is commonly linked to migration from abroad, although some ethnic groups have significant numbers of migrant mothers, women born in the UK account for a significant proportion of mothers in some ethnic groups (Jayaweera et al., 2007). Ethnic groups in the UK are generally differentiated by a combination of factors including racial origin, skin colour, cultural and religious affiliation, national and regional origins and language (Puthussery, 2016). Religion has been recognized as a key element of the UK's BME population identity in contrast to the UK white population (Sunak and Rajeswaran, 2014), with the Muslim population making up the second largest religious group in the UK (ONS, 2011). British Muslims' religious identity is an essential attribute that is more important than ethnicity (Sheikh, 2007).

However, despite evidence on health outcomes, including maternal outcomes, ethnicity has been the defining attribute for the British Muslim (Puthussery, 2016). The term 'Muslim' in particular is ambiguous in the health literature and is often combined with ethnic group identity, rather than used to refer to people distinguished by beliefs, practices or affiliations (Laird, et al. 2007). What little research there is suggests that many Muslim women received poor and inappropriate maternity care, which put them and their babies at risk (Pollock, 2005; Maternity Alliance, 2004). Research shows that Muslim women encounter poor communication, stereotyping, racism, inaccurate cultural assumptions held by some practitioners, and a general lack of research and sensitivity concerning the cultural and linguistic needs of women from diverse populations (McFadden et al., 2013; Reitmanova and Gustafson, 2008; Maternity Alliance, 2004).

Sheikh (2007) regards this as a general failure among academics, policymakers, and clinicians to understand the particular needs of religious and ethnic communities, as without an understanding of these needs they are in no position to address them. Pollock (2005, p55) highlights that maternity services must be informed and shaped by the diverse needs of the communities they serve, and suggests that increasing accessibility and quality of maternity care will improve health outcomes in the UK's black and minority ethnic communities, including Muslim communities. This emphasizes the need for significant research to provide data that will help in addressing the needs of a growing and diverse Muslim population in healthcare settings (Laird et al, 2007).

This study focused on the motherhood experiences of Muslim women engaging in NHS maternity services. Using qualitative research methods, the study explored Muslim women's perceived needs and the factors that influenced their health seeking decisions during their transition to motherhood, with a view to creating insight and understanding to help promote the development of effective maternity services with the best possible health outcome for Muslim women. This chapter give an overview of the researcher's interest in the experiences of Muslim women with consideration given to the rationale and aim of this study, the researcher's standpoint and finally an outline of the organisation of the complete thesis.

1.1 Rationale for this study

It is important to acknowledge aspects that arrived with and makes up UK's ethnically diverse populations. People from different ethnic groups have different cultures, religions and beliefs that influence the way they see, behave and react to the world (Eckersley, 2006). These factors are powerful filters through which the individual receives information (such as belief systems, religion and cultural values) (Thomas et al., 2004). Understanding such attributes can help in the development of culturally sensitive maternity services.

There has been a Muslim presence in Britain since at least the 8th century, but it has only been quantitatively and socially significant since the Second World War (Field, 2010). Muslim communities in the UK are historically, culturally, ethnically and linguistically diverse, including immigrants and native-born (Rassool, 2014). In 2001, the Muslim population in the UK was 68% South Asian (Pakistanis 42%, Indians 9%, and Bangladeshis 17%), with smaller percentages of White British, other White Non-British 12% (includes Turks, Arabs and East Europeans) and Black African accounting for 6% Muslim population (Peach and Gale, 2003). This underpins that British Muslims do not constitute a homogeneous entity, but a community of communities. The religious identity for British Muslims is recognized to be more important than culture and ethnicity. Field's (2010) Harvard-Manchester survey of face-to-face interviews with 480 British Muslims, highlighted that 7 in 8 reported that religion is extremely or very important in their daily life, and 82% reported that religion is very important to their sense of identity. This study focused on exploring Muslim women as a unique group, because for most Muslims Islamic beliefs and practice dominate aspects of their individual life and behaviour; it represents the prism through which Muslims view and interpret their world (Rassool, 2014; Shaikh, 2007). Rassool (2014, p12) indicates that the behaviours of Muslims are shaped by religious values and practices rather than cultural practices; the belief system of religion shapes the culture in relation to habits, customs, traditions, superstitions, tribal or ethnic codes of conduct, hopes and fears of the group or community. He concludes that to Muslims, Islam is a religion and a way of life, and the cultural practices of Muslim communities are strongly linked to their religious beliefs.

Islamic beliefs not only provide guidance in spiritual matters but also place considerable emphasis on health and there are a number of Islamic beliefs that will affect the attitudes and behaviours of Muslim patients in hospitals and community settings, such as beliefs about modesty, privacy, dietary restrictions, and fasting (Rassool, 2014). Rassool (2014) suggests that it is important that healthcare providers have an understanding of these attitudes and beliefs so that more culturally appropriate care may be provided. There is a shortage of literature describing the overall health profile of Muslims in the UK. For the first time in over a century, the 2001 National Census collected data on religious groups within Britain, which indicated that Muslims in the UK have the highest age-standardised rate of reported ill health (13% for males, 16% females) and disability (24% of females, 21% of males) in comparison to other religious groups (Laird et al., 2007). What little research there is mainly focuses on specific health-related subject areas, such as epilepsy, cancer detection, organ transplantation or mental illness (Rassool, 2014). Rassool, (2014) reported that surveys into the utilisation of hospitals services by Muslim patients in the UK have consistently demonstrated levels of dissatisfaction with care in relation to meeting religious and cultural needs.

There are only a handful of studies which focus specifically on Muslim women's experiences, including maternity services, or culturally appropriate and patient-centred care. Muslim beliefs and practices have implications for a wide range of health conditions including but not limited to sexual norms, maternal

and child health issues, such as prenatal care, labour and delivery, post-delivery consultation, care of new-borns and breastfeeding (Hasnain, 2006). Muslim women's culture is based on Islam, which permeates their thinking patterns, their interactions with themselves and others, and all activities of their daily lives (Carter and Rashidi, 2004). Hasnain (2006) reports that the lack of service providers' attention to these needs may seriously compromise care, providers' lack of knowledge about Muslim women's beliefs and practices include the failure of breast and cervical cancer screening programs to accommodate for Muslim women's needs to be covered in line with Islamic modesty. A report from the Maternity Alliance, based on interviews with Muslim women from around the UK, says that many pregnant Muslim women's needs are not being met by UK maternity services and some are insensitive to their needs (Pollock, 2005). The biggest complaint concerns staff failing to respect Muslim women's privacy, resulting in acute discomfort and embarrassment during pregnancy and childbirth; for example, some Muslim women do not want to be treated by male staff, but their wishes are overlooked or not accommodated because of a lack of female staff (Pollock, 2005). Other concerns include poor communication between healthcare professionals and Muslim parents, a severe shortage of interpreters and a lack of appropriate, easy-to-understand information about pregnancy, childbirth and the postnatal period (Pollock, 2005). Exploring such issues in health services is essential to the development of effective strategies to decrease health inequalities among diverse groups of women.

Hasnain (2006) reports that due to their particular religious and cultural beliefs, Muslim women face barriers in accessing and utilizing healthcare and many providers also feel challenged in meeting the needs of Muslim patients, especially female Muslim patients. For a woman, motherhood is not only a time of major life changes but also one of the most moving times in her life - it is also a time when she feels exposed, vulnerable and alone because of what she is experiencing (Mitchell, 2001). Mitchell (2001) reported that for Muslim women giving birth in a cross-cultural setting is stressful, whereby women had to adjust to an environment, which challenged their beliefs and values. Muslims are heavily criticised for failing to integrate and yet little effort is made to bridge the gulf between the Muslim and majority communities (Field, 2010). Sheikh (2007) regards this as a general failure among academics, policymakers, and clinicians to understand the particular needs of religious and ethnic communities, as without an understanding of these needs they are in no position to address them. Katbamna (2000) points out that this lack of research, literature and sensitivity concerning the cultural and linguistic needs of patients means that women from minority groups have little alternative but to accept the form of care provided by the maternity services of the NHS. Carter and Rashidi (2004) suggest for healthcare professionals seeking to achieve positive health outcomes with Muslims living in Western society, knowledge of their cultural and spiritual values is critical. Knowledge of Islam/Muslims has improved somewhat but is still limited, mostly deriving from media coverage which is often negative (Field, 2010). Therefore, much work is needed and research is lacking concerning the understanding and integrating the health beliefs of this population into the healthcare model. Seybold and Hill (2001)

suggested healthcare providers should try to understand the fundamental contributory role of religion to women's health. Understanding a Muslim as an individual with special needs, implementing sensitive and culturally appropriate care will enhance positive health outcome (Rassool, 2014).

Hasnain et al. (2011) suggest that improving care would require a flexible and collaborative care model that respects and accommodates the needs of Muslim women, provides opportunities for training providers and educating women, and makes necessary adjustments in the healthcare system. The maternity services in the UK have witnessed development over the years and are in contentious development today. There has been a call for women-centred care to improve the quality of services, safety, outcomes and satisfaction for all women through promoting choice in the type of care available and ensuring continuity of care and support (Department of Health, 2007). However, maternity care remains a challenged policy arena - health reform in England continues to call for the development of maternity services that provide high quality care, both women-focused and family-centred. Promoting a maternity service that is accessible, designed and competent to take full account of all women's individual needs, including language, cultural, religious, and social needs or specific needs related to disability (Department of Health, 2007).

Overall, the quality and outcome of maternity services have improved significantly over the last decade (National Maternity review, 2015). However, there is still a considerable variation across the country in the quality, safety and effectiveness of maternity care, which indicates scope for improvement (National Maternity review, 2015). Bourke (2013) indicated that the statements preserved in maternity care policies do not always translate into practice; almost 2,000 women will give birth and many will not receive the quality care recommended by the NHS women-centred care. Choice is advocated but some women will be denied the opportunity to make choices, and left out of decisions about their care, and others will find themselves without the emotional care, physical support, information and advice they need during the early weeks of the postnatal period (Bourke, 2013). This is concerning when considering the growing UK's multi-diverse population; where there are different groups that have specific needs, one fits all type of care regardless of its high standards is not appropriate in meeting the needs of a multicultural society (McFadden et al., 2013). McFadden et al. (2013) indicated that improving the healthcare experiences of populations from disadvantaged minority ethnic groups requires policymakers and health practitioners to understand when cultural context makes a difference and when it does not. This will also depend on the education and professional confidence and competence of midwives, obstetricians and general practitioners in providing care that understands and acknowledges the needs of a multi-diverse population (McIntosh & Hunter, 2014).

The maternity services within the UK still show significant ethnic inequalities in maternity outcomes, both qualitative and quantitative research has shown that Black and Minority Ethnic (BME) women, which include Muslim women, experience worse maternity outcomes compared to the White British

population (Garcia et al., 2015; Raleigh et al., 2010; Redshaw & Heikkila, 2010; Bharj and Salway, 2008). Bharj and Salway (2008) suggest that unless more is done to bridge the gap between policy and practice, women from BME communities will continue to have poorer maternity experiences and outcomes than the White majority. Garcia et al. (2015) suggest that creating research evidence on current specific maternity interventions for BME women in the UK will enable policy makers to modify services and develop services, which can reduce inequalities and improve maternal and birth outcomes.

This thesis will therefore explore Muslim women's motherhood experiences, consider their access to and experiences of the NHS maternity services, and the religious factors that influence their health seeking decisions. Addressing and understanding the perceived influence of religion on Muslim women's maternity experience will help to promote the development of more effective maternity services and the best possible health outcomes for Muslim women. Greater understanding of this phenomenon will provide an opportunity for maternity services to deliver the best possible care for this client group and endeavour to meet their cultural and spiritual needs. The findings of this study may also inform future research aimed at ensuring high quality, culturally appropriate, women-centred healthcare for Muslim women in the UK and other western societies.

1.2 Philosophical framework

This study took a generic qualitative approach. As qualitative research evolved, researchers in the field have struggled with a persistent tension between a need for both methodological flexibility and structure. Generic qualitative research is a research approach that falls under the broad category of traditional methodologies (phenomenology, ethnography, and grounded theory) (Kahlke, 2014). This approach allowed flexibility in the use of elements of one or more than one established methodology, which allowed the researcher to avoid adhering to any single methodological framework. Such an approach helps in exploring individuals' accounts of their personal opinions, attitudes, beliefs, or reflections on their experiences of particular things in the outer world (Merriam, 1998). Use of side-by-side methods helps in complementarily and mutually enriching the perspectives (Padgett, 2012). This allowed the researcher to use methods side-by-side without being caught up in the intricacies of grounded theory or phenomenology.

However, this study could have claimed and used mixed established methods such as phenomenology and grounded theory, but the researcher decided against this when considering the fact that each method can influence the overall design of this study and to avoid complications during the analyses. The aim of this study is not to create theory, as it would have done had it taken a grounded theory approach, but insight that may in the future help in developing a model of care for Muslim women. In addition, the focus of this study was not the content of the experiences as in phenomenology, rather the focus was on what are the experiences of Muslim mothers.

Therefore, a multi-qualitative research design guided this generic study (Percy et al. 2015; Kahlke, 2014; Merriam, 1998) so this study can tap different dimensions of these complex research phenomena. The three phases of data generation started with in-depth longitudinal interviews with seven first time pregnant Muslim women and a Muslim mother who is second time pregnant but experiencing motherhood as a Muslim for the first time, and its analysis. Followed by five focus groups with Muslim mothers. The in-depth longitudinal interviews were necessary to elicit good data on how the motherhood journey unfolds for Muslim women and the focus group discussions produced good data on common shared norms and experiences. These two phases captured Muslim women's accounts of their personal opinions, attitudes, beliefs, and reflections on their motherhood experiences. The results from the two methods helped in increasing the credibility of the findings; dissimilar results from one method do not necessarily invalidate the results of another, rather they reveal a variety of perspectives, and the different way that Muslim women conceptualize and evaluate the same situation (Ulin et al, 2005).

The final phase, one-to-one semi-structured interviews with 12 healthcare professionals and their analysis, helped further understanding of Muslim women's motherhood experiences and elicited insight into healthcare professionals' perspectives on providing competent care. Over the years, healthcare professionals have improved at identifying, assessing spiritual needs using verbal and non-verbal clues and their willingness to regard provide spiritual care as part of their role (Lovering, 2008).

1.3 Researcher's standpoint

This thesis explores what motherhood is to a Muslim woman and what is it like to be a Muslim woman experiencing motherhood in the UK. My curiosity arose from my own experience as a Muslim woman living in the UK. My religion is the foundation of my identity and the prism through which I interpret the world. Often the choices I make, for example health decisions, are influenced by my religion, often subconsciously. My Master's programme in Public Health raised my interest in how factors such as religion can have a significant influence on an individual's health behaviours and choices. As a student, I wondered if Islam had an impact on other Muslim students' health decisions; that I was a Muslim and a student put me in a unique position to explore this. Therefore, my Master's thesis explored the perceived influence of Islam on health-related beliefs and practices amongst Muslim university students in Liverpool. The study revealed that Muslim students were conscious of Islamic teachings in relation to health and sought to implement such teachings. Often their health behaviours adhered with their Islamic teachings subconsciously, and students were more likely to receive health promotion messages positively from Islamic teachings than from general health promotional messages. Muslim students highlighted specific needs that institutions need to acknowledge, such as facilitating their dietary

requirements, prayer and activities that do not clash with their religious practice, such as social activities in bars.

My interest in how religion influences health behaviours continued to develop from my own experience as an interpreter within Merseyside maternity services. Though I have not experienced childbirth, joining non-English speaking women, who were often Muslim, on their motherhood journey and working alongside healthcare professionals who deliver care to this group of women, gave me insight into what it is like to experience childbirth within NHS maternity services. I often reflected on the quality of care delivered and the competency of healthcare professionals in acknowledging the specific needs of the Muslim women they care for. The NHS acknowledged the women language barrier well, yet I witnessed that Muslim women I interpreted for did not share their intention of fasting while pregnant with their midwives or express their preference to be seen by a female healthcare professional. I wondered why and whether their language barrier had an impact; I was curious if this would also be the case with English-speaking Muslim women experiencing childbirth in UK maternity services.

I commenced my doctoral studies with an interest in exploring the motherhood experience of Muslim women in the UK. The intention behind this study was to create insight into Muslim women's motherhood experiences of care and the factors that influence their health-seeking decisions when engaging in NHS maternity services. Greater understanding of this phenomenon will hopefully enable maternity providers and maternity services understand and deliver the best possible care for this group of women. I was influenced by researchers such as Ann Oakley, whose seminal work (1979-1980) entitled '*Transition to Motherhood*' gives value to exploring women's actual experiences of motherhood using qualitative methods; Bowes and Domokos work (1996- 2003) whose work focused on Pakistani women who are predominately Muslim women highlights the importance of empowering research strategy to raise the muted voices; and Ellis (2000) whose work explored the maternity experience that gave specific attention to women who I personally can relate to in some ways - second generation British, English-speaking, UK educated Muslim women (South Asian).

My position as a Muslim woman in the Merseyside community, an active member within the local Mosque, an interpreter within local maternity services and a member of the Merseyside Muslim mailing group known as 'Barakah¹' has been an advantage. I was not foreign to Muslim culture nor to the Muslim community. I was able to relate to the Muslim women participating in this study and they were able to relate to me. My reputation as an academic Muslim researcher also supported this study. The

¹ This is a mailing group that has a collection of members used by and created by local Muslim women. They use this group for sharing information on different topics, whether it is Islamic information, general information, sales, announcements of upcoming events, which also include announcements of women giving birth, death and new comers to the community. This is an active group that has many Muslim women subscribers and it is also open for more Muslim women to subscribe.

Muslim community holds education in high regard and I was widely perceived as a potential advocate who might provide better outcomes.

I did not anticipate that such would be the case. I was keen on living up to such expectations and to champion high quality healthcare for Muslim women; however, this was sometimes challenging considering the climate in which I carried out my research. I was aware of the stereotypes surrounding Muslims and in particular Muslim women within the Western world. Often Islam is not projected in a positive manner within Western society and media, this became more apparent to me during my search within the literature; where topics in the spotlight such as Islamophobia, terrorism, extremism/radicalisation, stereotypical attitudes towards Muslim population in the UK, women's rights and dress code, and topics focusing on Muslims as individuals and their needs were not given much attention. Being exposed to such negative expression was challenging for me as a Muslim researcher, as it provoked mixed emotions but I had to remain optimistic that this research would help to bring about a positive change. However, we cannot deny the fact that we live within a political arena and the impact that it has on the world we live in. At times during the process of this research events such as the Charlie Hebdo², Brussels airport bombings³, Nice terror attack⁴, the refugee crisis in Europe and Brexit⁵. This was a time when billboards, newspapers and politicians sent messages that are unwelcoming to migrants and refugees, and often pointed blame to non-British people for 'British problems', such as claiming that migration puts huge pressure on public services, including the NHS.

I often wondered if my study would find a platform or have a positive impact at the time of such events and would I fulfil the responsibility that the Muslim women have anticipated of me. I cannot deny that such climate created anxiety on how this research will be received but in the real world, it has been received really well within the healthcare arena and others. The research received huge enthusiasm when presented at different conference and during academic discussions. The climate in which I carried out this research made me realize the importance and the need of this research.

Being surrounded by a team of excellent supervisors constantly reminded me of my important role as a researcher in promoting critical thinking, knowledge and understanding. Listening to the likes of Professor Laura Serrant⁶ present her talk entitled '*Lifting as you climb: Enabling others and celebrating self*' and listening to Muslim women's stories has reminded me that the journey to change is challenging and not easy but for sure possible. This was a push that helped me build my momentum, continue being

² Two masked gunmen carried out a terror attack on the French satirical weekly newspaper Charlie Hebdo in Paris on the 7/1/2015 in which 12 people died.

³ On 22/3/2016 Brussels terror bombings killed 32 people and wounded many.

⁴ On 14/7/2016 a terrorist in a lorry killed 84 people and injured many on the promenade in the seaside town of Nice.

⁵ Brexit is an abbreviation for "British exit," which refers to the June 23, 2016, referendum whereby British citizens voted to exit the European Union.

⁶ Professor of Nursing in the Faculty of Education Health and Wellbeing at Sheffield Hallam University.

optimistic and further my passion for this research. My interest in this phenomenon led me to understanding myself and my perception of my life as a Muslim woman in the UK. This study's journey has given me a drive to be active in promoting cultural and religious awareness and knowledge within the field of health and amongst other fields. The outcome of this research creates further knowledge for the broad understanding of Muslim women and a stepping-stone in designing teaching and training materials that enhance and advance the competency and the quality of care for Muslim and other women from different groups.

1.4 Organization of the Thesis

While each participant's motherhood experience was unique, shared experiences soon emerged, and these produced major themes that allowed the researcher to develop knowledge of the experience of care and factors that influence health outcomes. This thesis was divided into eight chapters, starting with this introductory chapter giving an overview of the rationale of this study and the researcher's standpoint. This provides the reader with a foundation from which to understand Muslim women's experiences of motherhood in the UK and the importance of religion in Muslim women's identity.

Chapter Two reviews the literature that explores the understanding of motherhood; it commences with an overview of motherhood within research and its understanding over time, highlighting the diverse UK population, in particular the UK Muslim population, and finally introduces the Islamic teachings of motherhood.

Chapter Three further reviews the literature exploring the development of the UK maternity services, with a specific focus on the development of Midwifery-Led care. The chapter explores the UK's diverse populations' outcomes of care in general due to the limited number of studies exploring Muslim women's experience of care. Finally, the chapter explores competent care for a multi-cultural society.

Chapter Four provides an overview of the various philosophical frameworks of qualitative research and explains the decision to choose a generic approach. The chapter then discusses the steps used in conducting this study, starting with the obtaining of ethical approval, followed by a detailed lay out of the study's three phases. The criteria by which participants were included, the procedure used to recruit, and the data collection methods of each phase, are discussed, whereby detailed descriptions of setting is included, the reasons why each method is particularly suited to this study and the steps used to analyse each data set. The role of the researcher in the research process is discussed, including the steps used to achieve reflexivity and validity.

Chapter Five, the first findings chapter, introduces the eight Muslim women participating in phase one-longitude interviews. This is followed by four detailed accounts of individual motherhood journeys, of

each of those I have called (pseudonyms) Noor, Hanan, Samah and Khadija. The accounts reflect on the main themes presented in the following chapter.

Chapter Six discusses the shared experiences of both phase one and two through thematic analysis. Four main themes emerged from the data; perceptions of motherhood, information needs and service awareness, religious practice, and Muslim women's perceptions of healthcare professionals and seeking support. Each of these themes includes extensive quotations from the women's narratives to support the interpretation of the data.

Chapter Seven, the final findings chapter, presents the experiences and perspectives of 12 healthcare providers through thematic analysis. Five main themes emerged from the data:

- 1) Perceptions of Muslim women,
- 2) Understanding and awareness of religious practices,
- 3) Sources of cultural and religious knowledge and awareness,
- 4) Addressing the needs of Muslim women,
- 5) Training culturally competent healthcare professionals

Chapter Eight discusses the overall findings of this study and relates them to the relevant literature by comparing and contrasting the participants' experience with previous work on this area of study. Finally, it articulates the study's original contributions to the body of literature in this field. The chapter presents the implications of the finding and suggestions for further research, finishing with presenting the limitations of this study.

Chapter Two: The Motherhood journey

2.1 Exploring the Motherhood journey

Motherhood is a profound life journey; it is considered a developmental life event that involves the transition from a current known reality to an unknown new reality (Mercer, 2004), a transition that unfolds differently for all women and can bring about many challenges as they go through a process of significant personal, interpersonal and biological changes (Squire, 2009). The physiological and psychosocial changes that occur throughout the pregnancy, labour and birth are not just the side-effects of hormone levels or an enlarged uterus, rather they are changes that play a vital role in guiding a woman as she makes the journey of becoming a mother. Speier (2001, p16) highlights that one aspect that remains constant for humanity at all times is the fact that 'when a woman gives birth to a child she gives birth to herself as a mother'.

For many years researchers have been interested in exploring motherhood in various aspects; in the 1940s and 50s researchers mainly focused almost exclusively on the child's wellbeing and since women were considered as the producers of the next generation, a woman's motherhood experiences were coincidentally considered because they impacted the child's wellbeing (McCourt, 2006). However, the medical and psychiatric model tended to dominate the research even though the actual physiological process of childbirth has not changed much over the period of human existence (Smith, 1999; Simkin, 1996). This period witnessed the foundation of the NHS in 1948, which was a doctor-dominated service. This marked a turning point in the history of maternity services and sparked renewed interest in maternal health (increased public and political attention upon the health of mothers and babies) (Greenlees and Bryder, 2013). There was a dramatic shift in the location of childbirth (from home to hospital); focus on maternal mortality that had risen in England and Wales between 1900 and 1937, and post-war, delivery at consultant-led obstetric units became the norm and medical intervention in pregnancy and childbirth (Greenlees and Bryder, 2013). Quirke and Gaudilliere (2008, p448) highlighted that within this period the NHS in some form or another, in matters of health policy strategy politicians were prepared to cede power to the medical profession; the public health sector and the local authorities experienced a significant loss of power. This resulted in a system that emphasised curative medicine (medical model) at the expense of the interrelated and overlapping fields of preventive medicine (social model).

The status of pregnancy was unclear; Teijlingen (2005) reported that pregnancy in Western societies linked the boundary between illness and health, whereby pregnancy and birth are biological and physiological events that are very much embedded in a social and cultural setting. In the industrialised

world, pregnancy was considered as potentially pathological, yet midwifery practice emphasized normality. Researchers such as Bowlby and Winnicott in the 1940s and 50s believed that motherhood is naturally part of womanhood, they considered it as instinctive to all women (Winnicott, 1953; Bowlby, 1951). Research exploring the motherhood transition shifted with the social, cultural and demographic changes that took place between the 1970s and the 1980s. The 1970s witnessed a growth of feminist activism, which encouraged a reconsideration of the role of the woman within society and recognition of the cultural pressure in becoming a mother. This started to revolutionize the way in which motherhood was socially perceived and practised; motherhood and reproduction became the centre of feminist discourse, whereby feminists insisted on the distinction between biological and social motherhood (Neyer & Bernardi, 2011). Feminist researchers placed women's lives at the centre of social inquiry, creating rich new meanings that challenged the traditional ways of knowing (Hesse-Biber, 2013).

Feminist scholars in the 1970s and 80s regarded social factors as having a profound influence on the overall motherhood transition - there were major concerns about the way care was being delivered and the impact on women, and the role of medical professionals. Simkin (1996) highlighted that childbirth is ever changing not because of the physiological factors but because of other social factors such as family, economic and attitudes toward women. Feminist researchers such as Chodorow (1978) and Oakley (1979) stressed that motherhood is formed and influenced by both the social expectations and practices mixed with the biological responsibilities of childbirth and childhood.

Quantitative research methods had been largely used for decades to explore women's experiences of motherhood/childbirth. This method was not particularly embraced by feminist researchers nor disregarded, yet concern was expressed on the sole use of this method, which might lead to what is called 'bad science'. Feminist researchers urged scholars to be critical when assessing quantitative researchers' generalized claims. They urged scholars across different disciplines to become mindful of who is left out or lost within these claims (Hesse-Biber, 2013). Rather than including women from other marginalized groups into the quantitative sample to 'correct' biases of mainstream studies; feminist researchers used qualitative methods focusing on women's unique lives and experiences to build on the general knowledge (Hesse-Biber, 2013). Feminist researchers embarked on new research approaches that focused on women and other marginalized groups, drawing attention to their experiences and perceptions of the world.

Sheila Kitzinger pushed back against the medicalization of birth and advocated for listening to and learning from women. She was one of the first women in the 20th century to write and publish about her own experience of childbirth in *The Experiences of Childbirth* (1962). She stressed the importance of women's stories in the understanding and development of childbirth, even though the medical view insisted that listening to women's experiences was neither 'modern' nor scientific. It would be more

than a decade before Oakley's (1979-1980) major research entitled '*Transition to Motherhood*' sought to create a comprehensive picture of the women's journey to motherhood; she placed women at the centre of her research and was keen to explore this transition through the women's own words. She used longitudinal interviews with women experiencing motherhood for the first time. Oakley interviewed each woman on four different occasions - weeks 14 and 34 during pregnancy, and weeks 5 and 20 weeks during the postnatal period. Following women as they made their transition, Oakley was able to highlight the social and psychological changes women encountered during the transition to motherhood, and revealed how women in Britain experienced motherhood within a medically controlled setting. Her work gave attention and value to the richness of women's accounts of their own experiences and increased knowledge of this complex life event.

Being mindful of the work of Bowes and Domokos (1996) who emphasized the importance of listening as much as the role of speaking throughout the research process; highlighting that appropriate research approach can enable women from muted groups to speak and raise their own concerns. Phase one of this study adopts Oakley's longitudinal approach to explore the motherhood transition for Muslim women. While Oakley focused on exploring the experiences of white women who were mostly from managerial and skilled non-manual classes, the current study focused on exploring the first-time experiences of motherhood from a Muslim woman's perspective. Following Oakley's (1979; 1980) work in the late 1970s and the 1980s, sociologists and social anthropologists started to give value to exploring the motherhood experiences from the woman's perspectives in different ways (Darvill et al., 2008; Butler, 2007; Speier, 2001). Nicolson's (1986) work had stressed the importance of a 'women-centred' approach to research, taking a woman's own accounts as 'central' rather than considering the motherhood transition as intrinsically pathological. The use of women's own perspectives in understanding how they identified motherhood and how they engaged with their social environment during this transition helped in developing recognition of the complexity of this major life transition (Richardson, 1993).

A shift in the 1970s and 1980s contributed to the deconstruction of traditional research (quantitative) and marked a number of contributions of qualitative research that focused on exploring the motherhood experiences from the women's perspectives (Hesse-Biber, 2013; Smith, 1999). A research synthesis by Brunton et al. (2011) reviewed how the motherhood transition was explored since the 1970s in both social and healthcare research, highlighting the increased amount of research exploring women's perceptions of their motherhood experiences over the past three decades. In terms of the quality of maternity care Brunton et al. (2011) suggest that women's views in relation to the quality of care they received appears to remain fairly consistent. What has changed in the past ten years is women's clear description of their particular needs in connection to their healthcare providers and the place in which the care is provided. For example, Brunton et al. (2011) mention that women wanted to give birth based on their own terms but this was often muted as they progressed through their motherhood journey; they

suggested this is due to healthcare providers not carefully paying attention to the women's needs and preferences. Women's increased expectations and the morale of midwives working in busy maternity units in the UK may also have a negative impact on their competency to provide high-quality care (McAreel et al., 2010).

The review highlighted that over the course of thirty years, women participants that contributed to research published in the UK were predominantly of middle class white women living with partners. Even though there was a dramatic growth in the number of ethnic minority women due to the mass immigration that came about in the midst of the 20th century, only in recent years have women from more diverse background started to gain research attention. Many studies published in the UK focused in exploring diversity in terms of social class and motherhood than ethnicity (Tyler, 2008; Duncan et al., 2003), this focus caused a gap in the exiting evidence base research on the phenomenon of motherhood. The UK is a relatively homogenous country dominated by a white British majority, but the mass migration has made the UK into a multiracial and multicultural society (Platt, 2009). The relative similarity in research samples is problematic since the UK population continues to become more diverse and this diversity remains persistently linked with patterns of social disadvantages (Brunton et al., 2011). Additionally, national surveys of maternity care have highlighted ethnicity as a marker of poorer experiences. Jomeen and Redshaw (2012) indicated that this is significant when we consider the context of motherhood as socially and culturally constructed and influenced by the values of the societies from which women come and in which care is delivered. Therefore, exploring and understanding BME women's own perspectives should be the first step in improving service quality.

2.2 Diverse populations and Motherhood

Globalisation and other forces worldwide have also been responsible for mass population movement resulting in diversity in various societies (Benza and Liamputtong, 2014). The BME now make up 14% of the UK population (Sunak and Rajeswaran, 2014). The ONS (2014) reported there were 507,587 live births to UK born mothers compared with 187,610 to non-UK born mothers, that is over a quarter of all live births (27.0%) in 2014 were to mothers born outside the UK. This indicates the increase in the number of women of childbearing age (15 to 44); between 2013 and 2014, the total number of UK born women of childbearing age living in England and Wales decreased by 1.3%, to 8.77 million. Conversely, the number of non-UK born women of childbearing age was 3.4% higher than in 2013, increasing to 2.35 million in 2014 (ONS, 2014). In England and Wales in 2014, births to mothers born in the European Union (EU), excluding the UK, represented 9.2% of all live births. Mothers born in the Middle East and Asia contributed 9.5% of all live births, while mothers born in Africa contributed 5.0%. Platt (2009) said that these indicators suggest that groups that are considered as minorities in the future will make up a large proportion of the UK population.

Despite this increase in the UK's diverse population, research knowledge and understanding of communities that make up this diverse population has not kept up with their increasing importance. Sunak and Rajeswaran (2014) highlighted that attempts made by politicians to appropriately understand Britain's minority populations have been low and often the media tends to assume that all BME populations can be treated as a single political entity. This perspective is based on an assumption that all the ethnic populations in Britain have similar perspectives and practices in the way they live their lives.

The ethnic communities in the UK are so significantly diverse that in London's playgrounds alone over 100 different languages are spoken. Single ethnic communities are themselves becoming more complex due to the growth of the mixed population and generational changes. For example, the Indian community are the most religiously diverse community, spread across Islam (14%), Hinduism (45%) and Sikhism (22%). Sunak and Rajeswaran (2014) highlight that there are clear differences between UK BME communities and since these communities continue to become a significant part of the UK they suggest that policymakers and politicians should understand these differences.

The differences between BME communities are not just simple markers that help to differentiate between the communities; they are the group's identity that resemble an umbrella of many powerful attributes that influence the way in which an individual interprets, behaves and reacts to the world they live in (Eckersley, 2006). These attributes are the representation of an individual's unique personal experience, memory, ethnicity, culture, religion, gender, occupational roles, social status, family and various others (Yamin, 2008). Culture for example, acts as a set of lenses through which an individual sees their everyday world, defining their perceptions, behaviours, judgements, interpretation and decisions (Henley and Schott, 1999). Attributes such as culture and religion persist across generations, but the traits important to one's identity may become more pronounced at certain points in a person's life, depending on particular stages and experiences in one's life cycle (Yamin, 2008).

Choices that are made by women from all ethnic groups, such as whether and when to have children, or how many children to bear, do not occur in isolation but may be influenced by strongly held views about women's roles within their community (Connolly and White, 2006). This role of a mother, maternal behaviours and rituals are greatly determined by the women's response to their cultural environment (Koniak-Griffin et al., 2006). As the UK becomes more diverse, the effect of diversity on various life aspects is becoming recognizable; women's definition and experiences of motherhood take its form within a web of cultural values and social influences that are expressed through the role and structure of family and also through beliefs and customs about childcare and rearing (Koniak-Griffin et al., 2006). These cultural values vary amongst cultural groups and are critical to the motherhood journey.

Thus, providing a common model of maternity care may not meet the needs of all the different groups that are present in a multicultural society (Henley and Schott, 1999). The pictures that women have of themselves as mothers are highly influenced by their culture of origin. A study by Sawyer (1999) interviewing 17 first-time mothers with a Black ethnic origin in the US, found that the mothers are engaged in a mothering process that is embedded within their context of family, history and life experiences. Koniak-Griffin et al. (2006) highlight that cultural displacement also impacts this mothering process; Tummala-Narra (2004) explains that mothers in the West with a non-Western ethnic origin are expected to transmit their cultural values and the languages of their country of origin to their children and to support their children in adjusting to the expectations of both cultures (Western and non-Western), which can often be challenging.

Judging people from 'other cultures' on the basis of what is 'normal' or 'appropriate' to 'us' can lead to misunderstandings, serious misjudgements and failures of healthcare services in addressing the need of its community. Henley and Schott (1999) agree that assumptions and generalisations can sometimes seem useful short cuts or an easy option, but they block the ability to understand and communicate to meet an individual specific need. Therefore, needs relating to motherhood cannot be acknowledged or addressed unless viewed within the context of a variety of other factors that influence motherhood experiences. It is important to explore and understand significant attributes that are part of women's identity such as culture or religion and treat them as a lifelong process inextricably linked to women's status and their role in their home and society (McFadden et al., 2013; Koniak-Griffin et al., 2006). The researcher was interested in exploring an attribute that specifically defines and unifies the study's ethnically diverse group of women, their religion, Islam.

It is important to acknowledge that both culture and religion consist of systemic patterns of beliefs, values and behaviours that are acquired by individuals that are members of their society. Culture is dynamic and shapes an individual's worldview. Religion, as Rassool (2014) explains, is a component under the umbrella of culture because it is often the religious beliefs that are the sources of moral strength and a basis for the cohesion of the cultural group. The belief system of religion shapes the culture in relation to the habits, customs, traditions, superstitions, tribal or ethnic codes of conduct, hope and fears of the community. Islam in particular can be regarded as a religio-cultural phenomenon (Rassool, 2014), whereby the behaviours of a believer are shaped by religious practice rather than cultural practice – Islamic teachings encompass all aspects of life and ethics, hence God-consciousness is encouraged in all believers' affairs. This is also highlighted by Ibrahim (2009) who argues that cultural practice amongst Muslim communities is closely linked to religious beliefs. There are certain practices that Muslims do subconsciously as taught from a young age and they are actually mandated, or encouraged, and rooted in the Quran and the *Hadith*. For example, saying *Bismillah* (in the name of Allah) before doing just about anything, *Inshallah* (if Allah wills) when speaking of future events,

saying *Alhamdulillah* (praise is entirely and only to Allah) in all situations, and eating with the right hand.

Ibrahim (2009) highlights that the term ‘Islamic culture’ is often used to describe all cultural practices common to Muslims around the world. This common ‘Islamic culture’ is recognized as connecting Muslim communities, giving them some homogeneity with regards to health beliefs and practice; health risks; family dynamics and decision-making processes (Rassool, 2015). Therefore, separating Islam and culture can prove difficult, if not impossible - hence, this study focuses on Muslim women, accepting Islam as a unifying set of beliefs and practices which will influence their experiences of motherhood. This study does not attempt to compare their journey with that of Western women, it lets Muslim women speak for themselves.

2.3 Religion and wellbeing

Science and religion can sometimes be at the opposite ends of the spectrum of thought; science holds the thought of a material world and religion argues that the material world is simply the manifestation of much deeper non-material realities (Fontana, 2003). In recent decades, this topic has been the subject of research encompassing a broad range of disciplines; including sociology, psychology, health behaviour and health education, psychiatry, gerontology and social epidemiology (Omoto et al., 2008; Clarke, 2006; Stuckey, 2001; Ellison and Jeffrey, 1998). Many researchers have highlighted the correlation between religion and health and its positive influence on the overall well-being of individuals within specific communities (Puchalski and O'Donnell, 2005; Fontana, 2003; Stuckey, 2001). A study by Ellison (1991), for example highlights how strong religious beliefs enhance both cognitive and affective perceptions of life, whilst church attendance and private devotion contribute to well-being indirectly. It is suggested therefore that religious faith ‘buffers’ some of the negative effects of trauma and enhances life satisfaction. Epidemiological, clinical and medical studies/research have supported the influence of religious association and involvement on a range of mental and physical health indicators and disease states and have highlighted the beneficial influence of religion on a range of health outcomes, such as depression, drug and alcohol use, suicide, psychological distress and certain functional psychiatric diagnoses (Chatter, 2000).

Stuckey (2001) identified two key reasons why religion can play an important role in overall well-being: 1) a religious beliefs system can give a rationale for why pain and suffering exist, 2) the belief in life after death which transports followers to a perfect existence after they die, allows them to manage difficulties of life as temporary burdens before an eternal reward. According to Basu (2011) there are four interpretations of how religion influences the pathways of wellbeing: 1) Health behaviours: religions can protect and promote a healthy lifestyle by prescribing a certain diet and/or discourage/forbid the abuse/use of certain substances such as alcohol, drugs, tobacco, etc. 2) Social

support: religion provides support and protection by providing social contact with co-religionists and a web of social relations; 3) Psychological states: religion provides a positive state of mind, hope and optimism that leads to less stress which leads to better mental and physical state and; 4) 'Psi' influences: religion may have supernatural laws that govern energies (not yet understood by science).

Amongst this potential to profoundly influence many aspects of an individual's life, there is relatively little research exploring the influence of religion on women's reproductive health (Gaydos et al., 2010; Schenker, 2005). Among what research there is, it has been suggested that religion influences issues relating to reproductive health on two branches; first the timing of the marriage, beliefs about sexual contact and childbearing outside of marriage, and desired family size. This influences the person's or couple's decision-making on many health decisions faced on a daily basis such as contraceptives, when and how to have a family, fertility treatments and other reproductive health issues. The second branch is at a community level, where it is suggested that religious institutions such as churches, temples, mosques or synagogues have the potential to play a key role in community norms and directly influence reproductive health (Gaydos et al., 2010). Whether through a pulpit or in spoken and unspoken values shared among a religious community, religion is thought to have an influence on service provision, as in having categorical rules about provision of reproductive healthcare services, political action aimed at the services and the forming of public policies in line with moral teaching (Gaydos et al., 2010).

Moreover, whether it is intentional or not, religious perceptions are instrumental in the establishment of community values (Gaydos et al., 2010). This is because faith communities are often the only place where intergenerational groups of the community members meet on a regular basis to address and provide support on a variety of issues that are important to the community. Hence, the researcher was keen on approaching Muslim women within their regular and familiar environment, such as the local mosque and Muslim community centres. Gaydos et al. (2010) explain that these places are a centre of strength for the community and when health issues and other concerns arise, it is not surprising that people of faith will seek answers from their religious communities. Even though religion and reproductive health may not be clear partners, they both have a key focus on family and both look to better the holistic wellbeing of the people they serve. Schenker (2005) suggests that it is important for professionals and policy advocates to understand the attitudes towards reproduction that derive from different religions and to work with them rather than fighting the tensions that often result between religion and health policy advocates around issues this topic.

2.4 Religion in the UK

The UK is a multi-faith society whose population has become more culturally and religiously diverse in recent years. Religion has been recognized as a key element of the UK's BME groups' cultural identity; in contrast to the UK white population, BME groups are more likely to follow a particular

religion, are more likely to be in regular practice of their religion and are more likely (70%) to feel that religion plays a key role in their life (Sunak and Rajeswaran, 2014). There is a recognizable difference in the size of religious communities in the UK. Schenker (2005) explains that there are three factors that determine the religious influence on a community, 1) size of community, 2) authority of current perspective and 3) the harmony and diversity of opinions present.

Islam is one of the fastest growing religions across the European region and the Muslim community in the UK is growing ten times faster than the rest of society. According to the ONS (2011) Muslims have the youngest age profile of all the religious groups in Great Britain increasing from 3.0 per cent in 2001 to 4.8 per cent in 2011. Muslims are one of the religious groups who are least likely to have been born in the UK, with just under half of Muslims living in Great Britain in 2001 born in the UK (ONS, 2011). The number of children for Pakistani and Bangladeshi (dominantly Muslim) women was 3.4 and 3.6 compared with 2.1 for white women of childbearing age (ONS, 2014). This growth indicates that midwives who have not yet cared for Muslim women are more likely to do so in the future and might require training around religious and cultural issues.

Despite the large number of Muslims in the UK, data relating health specifically to this group is rare, particularly when seeking to explore Muslim women's experiences of maternity care. It should be noted that the term Muslim is ambiguous in the health literature and is often combined with ethnic group identity rather than used to refer to people distinguished by beliefs, practices or affiliations (Laird et al., 2007). Sheikh (2007) explains that religious identity to British Muslims is an essential characteristic, it represents the prism through which Muslims see and interpret the world. This emphasizes the importance of exploring Muslim women's motherhood experiences.

2.5 Islam and Motherhood

In general terms Islam is an Arabic term meaning 'submission', therefore a Muslim is a person who submits to the will of God or a person who is a follower of Islam; Muslims follow a strict monotheism with one creator, Allah, and that is the fundamental belief of Islam (Rassool, 2014). The religion has a moral code as well as a civil law with a unifying ethical framework; the aim is for one to create peace in one's self, family, and society by actively submitting to and implementing the will of Allah (Gordon, 2002). Islamic practices are not only related to divine revelations; the Islamic teachings are based on the Quran the central religious text of Islam that deals with subjects such as wisdom, doctrine, worship and law providing guidelines for a just society, proper human conduct and an equitable economic system (Rassool, 2014). Another sacred source is the *Hadith* a reliably transmitted report of what the Prophet Muhammad said, did, or approved of; this is the second authority for Muslims and central to Islamic faith. For Muslims, Islamic practices dominate every aspect of their life and behaviour and God-consciousness is encouraged in all human affairs (Master et al., 2007). Master et al. (2007) highlight

that there are injunctions and commandments which concern virtually all facets of one's self, one's family and civil society. This includes such matters as diet, clothing, personal hygiene, interpersonal relations, business ethics, responsibilities towards parents, spouse and children, marriage, divorce, inheritance, civil and criminal law, fighting in defence of Islam, and relations with non-Muslims.

In terms of Islam and motherhood, Islamic texts describe mothers as objects of veneration. The teaching based on the Quran and *Hadith* contains numerous references to mothers; stories of exemplary women found in the Quran emphasize the importance of childbearing as a central part of a Muslim woman's identity (Oh, 2010). A child for a mother possesses a unique status of being, objects of great social worth with the symbolic power to transform women's identities (Oh, 2010). Islam explicitly states that children are to respect their mothers. Prophet Muhammad has said: "Paradise is under the feet of the mother", and, in another narration, mothers are deserving of the kindest of companionship, even before the fathers. The Quran and the *Hadith* show recognition of the physical and moral tasks of mothering.

In Islam, pregnancy is viewed as natural, ordained by Allah, and not requiring immediate care (Bawadi, 2009). The Quran introduces pregnancy by giving detailed explanation of embryology and explains every stage of the process. For example: *"Then He made his progeny from a quintessence of despised liquid"* (32:8) and *"Then We made the sperm-drop into a clinging clot, and We made the clot into a lump [of flesh], and We made [from] the lump, bones, and We covered the bones with flesh; then We developed him into another creation. So blessed is Allah, the best of creators"* (23:14). In the Quran a pregnant woman is literally referred to as one with a burden, *"And for those who have a burden (pregnant) their term is when they bring forth their burden"* (65:4). The mother's pain in labour is viewed as an occasion for immense gratitude and verses in the Quran indicate that a Muslim must respect one's mother since *"His mother carried him through weakness upon weakness"* (31:14). The Quran also acknowledges the uncertainty that mothers may feel given the hardship associated with childbearing - one's *"mother carried him with reluctance and bore him forth with reluctance"* (31:15).

The Quran also highlights the story of Mary, the mother of Jesus, as an example of the pain or struggle that mothers may go through during labour; *"The pains of labour drove her to the trunk of a date-palm. She exclaimed: 'Oh, if only I had died before this time and was something discarded and forgotten!'"* A voice called out to her from under her: *"Do not grieve. Your Lord has placed a small stream at your feet. Shake the trunk of the palm toward you, and fresh, ripe dates will drop down to you. Eat and drink, and delight your eyes"*. There are many Prophetic *Hadiths* about the significance of pregnant and mothers in labour; for example, *"the reward of a woman, from the time of pregnancy until birth and breastfeeding, is the same as the reward of one on the path of Allah, and if a woman leaves this world during that time because of the hardship and pains of birth, she has the reward of a martyr"*⁷. In another

⁷ Makarim al-Akhlaq, pg. 238

narration “Every time a woman becomes pregnant, during the whole period of pregnancy she has the status of one who fasts, one who worships during the night, and one who fights for Allah with her life and possessions. And when she is giving birth, Allah grants her so much reward that nobody knows its limit because of its greatness”⁸.

Islam also acknowledges and appreciates when mothers nurse their children; a nursing mother is considered as one performing a moral deed that is worthy of reward (Shams, 2011). Within the narration of the Prophet Muhammad ‘*She receives for every mouthful [of milk] and for every suck, the reward of one good deed. And if she is kept awake by her child a night, she receives the reward of one who frees seventy slaves for the sake of Allah*’. Islamic teachings encourage mothers to breastfeed, but the physical and moral challenge of this task for a mother is recognized and it emphasizes the father’s position in supporting the mother during this period; ‘*the mothers shall suckle their children for two years completely for those who desire to complete the term of suckling, but the father of the child shall bear the cost of the mother’s food and clothing on a reasonable basis... if they both decide on weaning by mutual consent there is no sin on them. And if you decide on a foster mother to suckle your children there is no sin on you provided you pay what you agreed on a reasonable basis*’ (2:233).

Alongside this unique elevated status and reward that Islam specifies for mothers, there are Islamic customs in relation to motherhood that are common practices amongst the majority of British Muslims and other Muslim across the world. From the literature, the researcher highlights the common customs in the table below:

2.5 Table 1: Common Islamic practice (table created by researcher)

Religious practice	Description	Time of practice
Quran recitation	The Quran is the word of Allah; it is a guide for life, death and the hereafter. Reflecting on Allah’s verses is a form of worship that will draw one close to Allah Most High. The recitation of the Quran is a common practice amongst Muslims; verses or chapters of the Quran are recited on a daily basis during prayer. Muslim women are encouraged to recite the Quran throughout their motherhood journey.	There are certain chapters that are recommended to be recited during certain stages of the journey, such as; - Chapter of <i>Inshiqaq</i> (The Splitting Asunder) (84) – to be recited on a daily basis throughout Pregnancy - Chapter of <i>Luqman</i> (31) – to be recited in the 1st trimester - Chapter of <i>Yusuf</i> (12) – to be recited in the 2nd trimester

⁸ al-Kāfi, vol. 5, pg. 496

https://www.al-islam.org/from-marriage-to-parenthood-heavenly-path-abbas-and-shaheen-merali/chapter-6-pregnancy#fref_bfb60ae9_11

		- Chapter of <i>Maryam</i> (19) - to be recited in the 3rd trimester as labour approaches
Salah (Prayer)	<p><i>Salah</i> is one of the five pillars of Islam. Muslims are to perform five daily prayers; <i>Fajr</i>, <i>Zuhr</i>, <i>Asr</i>, <i>Maghrib</i> and <i>Isha</i>. They are at dawn, immediately after noon, in the mid-afternoon, at sunset, and at night, respectively.</p> <p>Muslims have to perform <i>Wudu</i>, which is a ritual washing to be performed in preparation for prayer.</p>	Muslim women are to perform these daily prayers within the set times. Women are exempt from performing these daily prayer during their menstrual cycle and postpartum bleeding.
Dua'a (Supplications)	<p><i>Dua'a</i> "invocation" is an act of supplication. The term is derived from an Arabic word meaning to 'call out' or to 'summon'. Muslims regard this as a profound act of worship. <i>Dua'a</i> is key for a person to communicate to his Lord directly.</p> <p>Muslims call out to Allah at every point of their lives, whether in joy or sadness, ease or hardship. Through <i>Dua'a</i> they show gratitude for blessing, seek refuge, blessing and mercy from Allah.</p>	<p>Muslim women are encouraged to make <i>Dua'a</i> throughout the motherhood journey. There are certain recommended <i>Dua'a</i> and calling on Allah's attributes or names, such as <i>Ya Latif</i> (One Who is Gentle) (daily) or</p> <p>During Labour "O One Who is gentle with His creation, O One who has complete knowledge of His creation, O One who has complete awareness of His creation! Treat us with gentleness O Gentle, O All-Knowing, O All-Aware!"</p>
Modesty	<p>Islamic ethics considers modesty as more than just a question of how a person dresses, and more than just modesty in front of people; rather it is reflected in a Muslim's speech, dress, and conduct: in public in regards to people, and in private in regards to God. Allah commands both men and women to maintain their modesty in the Quran (24:31).</p> <p>In Islam, screening most of your body off from the gaze of a stranger, especially of the opposite sex, is actually mandated. <i>Hijab</i>, the head-covering worn by Muslim women, is an outer manifestation of an inner commitment to worship God. When God revealed the verses of modesty, the female companions of the Prophet Muhammad promptly adopted these guidelines. In a similar spirit of obedience, Muslim women have maintained modest covering (<i>hijab</i>) ever since</p>	<p>Muslim women cover certain parts of the body in the presence of a <i>Maharim</i> (male relatives through lineage or marriage with whom marriage is prohibited) (except the husband) and other Muslim women. They are to cover the area between the navel and the knees in their presence.</p> <p>In terms of the extent of the body to be covered by a Muslim woman in the presence of a 'stranger' (any male apart from the mahram), she is to cover her whole body except the face and hands (up to the wrists).</p> <p>In certain situations, such as for medical treatment it is not unlawful to be bare without necessity.</p>
Fasting	<i>Ramadhan</i> is the ninth month of the Islamic lunar calendar. Every day during	Women are exempt from observing the fast during their menstrual

	<p>this month, Muslims around the world spend the daylight hours in a complete fast. Muslims all over the world abstain from food, drink, and sexual relations during the daylight hours. As a time to purify the soul, refocus attention on God, and practice self-sacrifice.</p>	<p>cycle, postpartum bleeding, and they also have an exception not to fast during their pregnancy or breastfeeding period.</p> <p>Note that women have to make up the fasting days at other times.</p>
Lawful (<i>Halal</i>) food, medicine and vaccine	<p>Muslims are to consume and accept what is considered lawful and disregard anything that is prohibited (with the exception of an emergency situation such as there is no availability of a lawful option for one to survive.</p> <p>Muslims are only allowed to eat foods not expressly forbidden in the Quran and animals slaughtered "in the name of Allah" are considered halal, or lawful, to eat. The Quran says only animals which chew the cud and have cloven hooves can be eaten, and as pigs do not chew the cud they are considered or forbidden. The consumption of any alcohol is generally forbidden in the Quran.</p>	<p>Any products containing unlawful substance are considered as impure. Muslim are to refrain from unlawful products as much as they can.</p> <p>Some scholars say for example, there is no prohibition to using medicines currently in production containing a very small measure of alcohol for the purpose of preservation or dissolving, until an alternative is available. Treatment of diabetes patients with insulin obtained from a pig source is permissible because of 'necessity' given that the relevant rules and principles of Islamic law are observed.</p>
Eating dates during initial stages of labour	<p>In a number of Quranic verses, dates are honoured as one of the blessings of Paradise. (Quran, 55:68) The features of the date are noted in the chapter of Maryam (19:23-26). Maryam was encouraged by Allah to eat dates during the initial stages of her labour.</p>	<p>Muslim women are recommended to eat fresh dates at the initial stages of labour and also after the birth of their child.</p>
<i>Adhan</i> and <i>Iqamah</i>	<p><i>Adhan</i> is the first call for prayer and the second call for prayer is known as <i>Iqamah</i>. In the right ear of the new-born baby, the <i>Adhan</i> may be whispered, and in the left ear, the <i>Iqamah</i>. These words include the name of Allah the Creator and are followed by the Declaration of Faith: "<i>There is no deity but Allah; Muhammad is the Messenger of Allah.</i>"</p>	<p>Ideally, <i>Adhan</i> should be performed as soon as possible after birth. It is customary for it to be done by the father, or a respected member of the local community; the entire ceremony takes only a few minutes.</p>
<i>Tahneek</i>	<p><i>Tahneek</i> is the practice of a small piece of softened date being gently rubbed into the child's upper palate. Where dates are not available, substitutes such as honey may be used.</p>	<p>It is preferably soon after birth and before the infant is fed.</p>
Burial of the placenta	<p>It is believed that Allah has bestowed honour on the human beings over other creation. Therefore, the human body and</p>	<p>It is preferable for Muslim women to bury their placenta soon after birth.</p>

	its parts must be respected; as a dead body must be buried according to the Islamic law (<i>Shari'ah</i>), any separated limb or organ from one's body is recommended to be buried as well.	
Breastfeeding	Breast feeding is positively encouraged by religious teachings, with the recommendation that it should ideally continue for a period of two years.	Muslim women are encouraged to initiate breastfeeding soon after birth.
Male Circumcision	<p>Circumcision is the surgical removal of the foreskin, the tissue covering the head (glans) of the penis.</p> <p>Muslims consider male circumcision important mainly for hygienic purposes, so that when the child matures and begins to offer prayers, there is no danger of his clothes becoming soiled from small amounts of urine held up in the foreskin—an important consideration because soiled clothes nullify prayer.</p>	It is an obligation for all male infants to be circumcised. It is recommended to be performed on the seventh day of infancy.
Shaving new-born hair	It is traditional, but not required, for parents to shave the hair of their new-born child. The hair is weighed, and an equivalent amount in silver or gold is donated to the poor	Preferably on the seventh day after birth.
Aqiqah	A sheep is offered in sacrifice for every new-born child as a sign of gratitude to Allah.	This is usually performed on the seventh day, and the meat is distributed among family members and the poor. Many will arrange for the sacrifice to be performed in their countries of origin, thus allowing the meat to be distributed where there is greater need, simultaneously enabling disparate family members to partake in the celebrations.
Community visiting mother after childbirth	New mothers traditionally get many happy visitors. Among Muslims, visiting and assisting the indisposed is a basic form of worship to bring one closer to God. For this reason, the new Muslim mother will often have many female visitors.	It is common for close family members to visit right away, and for other visitors to wait until a week or more after birth in order to protect the child from exposure to illnesses. Depending on culture practice, some new mother are in convalescence for a period of 40 days, during which friends and relatives will often provide the family with meals.

2.6 Summary

Motherhood is a profound journey that unfolds differently for all women. The way in which this profound transition has been explored changed over the years. Feminist researchers such as Oakley (1979) placed women's lives at the centre of social inquiry, creating rich new meaning that challenged the traditional ways of knowing (Hesse-Biber, 2013). Qualitative research has helped in developing recognition of the complexity of this major life transition (Richardson, 1993).

However, only in recent years have women from more diverse backgrounds started to gain research attentions. The literature suggestions that research knowledge and understanding of communities that make up this diverse population has not kept up with their increasing importance. Muslim in the UK have a religious identity and make up the second largest religious group in the UK [4.8%] (ONS, 2011). Despite the large number of Muslims in the UK, data relating health specifically to this group is rare, particularly when seeking to explore Muslim women's experiences of maternity care.

This chapter briefly discussed motherhood and diverse populations, specifically highlighting the Islamic teachings and customs that are common practices amongst the majority of British Muslims and other Muslim across the world. The next chapter will discuss the development of maternity services in the UK and competent care for a multi-cultural society.

Chapter Three: The Development of maternity services in the NHS

3.1 Introduction

The provision of maternity care has witnessed significant changes throughout the process of its development and it still continues to develop today. The word ‘midwife’ can be traced back to Anglo-Saxon times; however, the legal recognition and regulation of midwifery began in 1902 (RCM, 2002). The 1902 Midwives Act introduced training and supervision for midwives in England and Wales; prior to the Act, they were untrained, unqualified and uncertified, and any woman or any man could practice midwifery (Reid, 2011; RCM, 2002). The Act outlawed uncertified and untrained midwives, and those who were certified but untrained. The Midwives Act of 1902 was part of a series of governmental measures relating to public health, and more specifically infant and maternal health. Reid (2011) highlights that the maternal and child health movement was fuelled by a blend of stubbornly high infant mortality rates and declining fertility, and poor standards of education and hygiene among the working classes were blamed. The 1902 Midwives Act was the result of a struggle between those who wanted midwives to only focus on normal births, and those who wanted independent midwives with responsibility for all births (both normal and abnormal) (Reid, 2011).

Reid (2011) reported that the number of births attended by qualified midwives increased steadily over the early years of the 1900’s and by the 1930s almost all practising midwives had received training. Likewise, the number of babies delivered by doctors decreased, partly due to the growth in trained midwives and the absence of doctors in the First World War. The Midwives Act 1902 was amended and added to by later Midwives Acts in 1918, 1926 and 1936. However, the 1902 Act survived into the NHS era and the National Health Service Act 1946 (section 23) retained it, but made local health authorities the supervising authorities in place of the local councils (RCM, 2002).

The Ministry of Health made the development facilities for institutional birth an official policy after the First World War; they started to fund the development of what were known as ‘Maternity homes’-which had some similarities to what is now known as a Midwifery-Led Unit (MLU) (Campbell & Macfarlane, 1994).

After the Second World War the National Health Service (NHS) was established; even though the work of the ‘maternity homes’ continued after the war, the government were not interested in evaluating the advantages and disadvantages of such birth settings, rather they focused on responded to the hospital

care demands. The Cranbrook report in 1959 set a target for 70 percent of all births to take place within a hospital and the remaining 30 percent of women were judged safe to have a home birth (Davis, 2013). However, the concept of risk and managing women became essential to the new obstetric knowledge and methods, this classed more pregnancies as high-risk leading the medical community to debate the idea of home births managed by midwives and sometime GPs with little involvement of obstetricians. The government funded the involvement of GPs in the maternity services and promoted hospital births; by the end of 1950s the 'Maternity homes' become isolated GP units (Campbell & Macfarlane, 1994).

The 1970s became a significant decade for maternity care development and influencing women's expectations and experiences of childbirth.

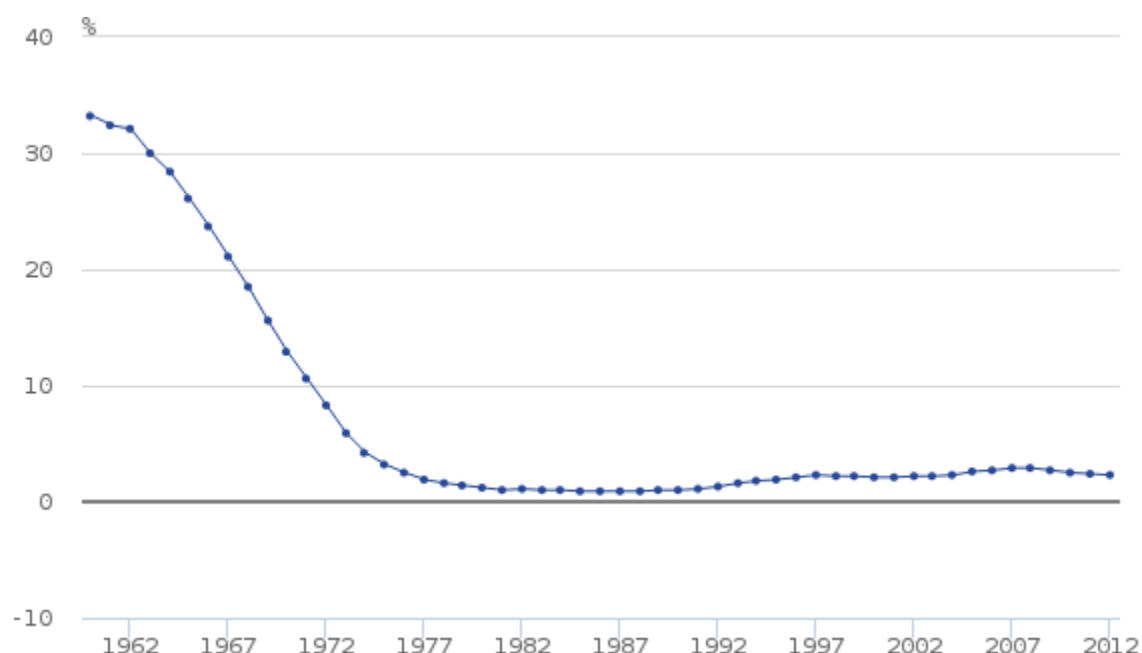
The Peel Report in the 1970s called for 100 percent hospital births with medical and midwifery care provided by consultants, GPs and midwives working as a team. Even though this report was criticised for the lack of evidence to support its claim that hospital birth is the safest for women, the country still witnessed a dramatic increase in hospital births from around 65 percent in the late 1940s up to 87 percent in the 1970s (Davis, 2013; Campbell & Macfarlane, 1994). This shift to a medicalised setting as the 'natural' and 'safe' place of birth led women and families, obstetricians and midwives in the UK to regard pregnancy and birth as a medicalised process that needed professional assessment and management. The introduction of new technologies during the 1970s such as new antenatal testing and the use of ultrasound contributed to increased hospital births, thus intervention quickly became a routine feature of pregnancy and childbirth (Davis, 2013). The National Birthday Trust Fund national study in 1970 of all deliveries that took place during one week, revealed an increase in the use of caesarean sections, oxytocic drugs to induce labour and episiotomy⁹, indicating that such procedures were becoming routine in many consultant units. By 1975, the number of home births dropped to less than 5 percent and ever since, hospitals births have remained very much at 95 percent (Davis, 2013).

This strong notion of medicalised childbirth continued pretty much until the present day; reports such as *Reducing the Risk - Safer pregnancy and childbirth* in 1977 put emphasis on hospitals being the safest place for childbirth. The report stressed that one cannot predict a normal birth even if a woman is considered as low risk, one cannot be sure it is a normal childbirth until it is complete. The notion of hospitals being better able to deal with emergencies and facilitate special care that some babies need continued in the 1980s (Davis, 2013). However, the continued criticism that maternity care faced from service users and feminist groups pushed the government to set up the Maternity Services Advisory Committee to the Secretary of State for Social Services in 1982. This committee recognised that there were problems, yet it continued to claim that hospitals are the safest places for childbirth, because it

⁹ Episiotomy is a surgical incision to enlarge the vaginal opening (Davis, 2013)

believed that all births carried medical risk. Between the years 1985 and 1988 England and Wales witnessed the lowest ever record rate of home births (0.9 percent) (Davis, 2013; ONS, 2013).

3.1 Figure 1: Maternities taking place at home, 1960–2012 England and Wales (ONS, 2013).



Traditionally, women paid careful attention to and were mindful of their physical and emotional state, thus encouraging them to be the experts and the guides in their motherhood journey (Lothian, 2008). Their awareness of these changes allowed them to make their own judgments; for example, they were able to recognise their pregnancies as soon as they noticed physical changes such as missing a menstrual cycle, nausea, fatigue, aversion to certain food and sore breasts. However, the notion of medicalising pregnancy and childbirth that accrued in time, stripped women from being the experts, making the healthcare providers the experts of their motherhood journey.

Lothian (2008) explains that this makes a woman affirm that the healthcare professionals are the experts that need be consulted to gain details that will reassure and help guide her motherhood transition. Women find themselves in a setting that brands their motherhood experiences as an illness that requires medical intervention.

The 1990s witnessed a significant change in the policy rhetoric, although there was still a conservative medical attitude towards motherhood. The Changing Childbirth report (1993) called for choice, control and continuity of maternity care, the report claimed that these are the most important tenants of maternity care. The report moved back towards empowering women and made the case for choice as a vital element for good quality maternity care. The report criticised unsympathetic healthcare professionals who used ‘safety’ to impose unwanted interventions on mothers. The report highlighted

the physical as well as the psychological impact of childbearing on women and through this the report was widely heralded for enshrining the concept of woman-centred care.

“The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.” (The Changing Childbirth Report - The Department of Health, 1993)

This notion of choice continued to be promoted to recent years by the Department of Health through Maternity Matters. The government underlined the importance of providing high quality, safe and accessible maternity care for all women through prompting choice in type and place of care. Aiming to guarantee all women will have choice of how to access care, type of antenatal care, place of birth and place of postnatal care by the end of 2009 (Department of Health, 2007). The National Childbirth Trust (NCT) report in 2009 highlighted that women’s choices remain severely limited, with only 4.2% who had a full range of choice - especially on the choice of the place of birth. Only a small minority of births taking place in MLUs or at home despite these options being both safe and cost-effective than births in consultant-run units. Nevertheless, the *Changing Childbirth* report calling for radical practical and philosophical changes in the maternity services was certainly a positive call to action, but also a milestone because it was a very short term challenging target and any failure would be and was clear and noticeable (McIntosh & Hunter, 2014). The influence of the *Changing Childbirth* report went beyond the field of childbirth and helped to set the agenda for other areas of patient care, promoting the acknowledgment that patient have the right to be involved in their treatment and have a choice as to whether or not to have a particular procedure.

Recently the most common reason for women being admitted into a hospital in England is because they are having a baby. Up to 700,000 babies were born in 2012 and this number continues to grow at round 2 percent each year (House of Commons Report, 2014). Maternity care remains a challenged policy arena - the health reform policy in England continue to call for the development of maternity services that provide high quality care, both women-focused and family-centred, promoting a maternity service that is accessible, designed and competent to take full account of all women’s individual needs (including language, cultural, religious, and social needs or specific needs related to disability) (Department of Health, 2007).

The National Maternity review (2015) highlights that quality services must be personalised. The review set out recommendations for how maternity services should be developed to meet the changing needs of women and babies, highlighting a framework that includes seven key priorities; 1- *Personalised care* (centred on the woman, her baby and her family), 2- *Continuity of carer* (based on a relationship of mutual trust and respect in line with the woman’s decisions), 3 - *Better postnatal and perinatal mental health care*, 4- *A payment system* (that fairly compensates providers for delivering different types of

care to all women, while supporting commissioners to commission for personalisation, safety and choice), 5 - *Safer care* (professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place), 6 - *Multi-professional working* (breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care), and finally 7 - *Working across boundaries* (providing and commissioning maternity services to support personalisation, safety and choice, with access to specialist care whenever needed).

Overall, despite the increase in the number of births and the increased complexity of cases in women giving birth later, the quality and outcomes of maternity services have improved significantly over the last decade (National Maternity review, 2015). However, there is still a considerable variation across the country in the quality, safety and effectiveness of maternity care, which indicates the scope for improvement (National Maternity review, 2015). The many debates on maternity care throughout time often led to a separation between those who celebrate modern interventions and the ‘safe’ hospital setting for birth (conservative medical attitude) and those who call for minimal interventions and home-birth environments. Professional culture matters considerably and where it is dysfunctional it has a direct impact on the quality of services; the National Maternity review (2015) suggests that the establishment of the right culture, needs good leadership and commitment from all healthcare professionals.

Baroness Julia Cumberlege (Chair of the Maternity Review) said: *‘To be among the best in the world, we need to put women, babies and their families at the centre of their care. It is so important that they are supported through what can be a wonderful and life-changing experience. Women have told us they want to be given genuine choices and have the same person looking after them throughout their care. We must ensure that all care is as safe as the best and we need to break down boundaries and work together to reduce the variation in the quality of services and provide a good experience for all women’*¹⁰.

3.2 Midwifery-Led model of care

Throughout time, midwives have been key healthcare professionals engaged in the provision of maternity care even before midwifery became an established profession in 1902. The care they provide to women, babies and families is of the utmost importance to society. They are key in ensuring a safe and emotionally satisfying motherhood journey. The coming decade presents new challenges and opportunities for midwives to develop further their role as practitioners, partners and leaders in the delivering and shaping maternity services (Midwifery 2020, 2010; McIntosh & Hunter, 2014).

¹⁰ <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-review/>

There is a social and medical dimension to care and both are essential in maternity provision. The care for women is sometimes led by midwives or obstetricians and sometimes the responsibility is shared by both. There are several ways to look after the health and well-being of women and babies during the motherhood journey – these ways are called ‘models of care’. One of these models is called the Midwifery-led model of care; this is where the midwife is the lead professional starting from the initial booking appointment, up to and including the early days of parenting. This model is shaped by the philosophy that motherhood is ‘normal’ and it is a profound life event that carries significant meaning to the woman, her family, and the community (International Confederation of Midwives, 2011). It is a woman-centred approach, which includes the physical, psychological, spiritual and social well-being of the woman and family throughout the motherhood cycle. The midwifery-led model of care reflects a more holistic approach that acknowledges the psycho-social factors such as the woman’s relationship with her family and her care-giver that are considered as essential components for the mother’s and baby’s physical and clinical health (Sandall et al., 2009).

There is an increasing amount of evidence that demonstrates the benefits of this model (Sandall et al., 2013; Hatem et al., 2008); it is associated with reduction in the use of epidural anaesthesia, fewer episiotomies and instrumental births, increased spontaneous vaginal births, higher perception of control, attendance at birth by a known midwife and an increase in initiating breastfeeding (Hatem et al., 2008). The International Confederation of Midwives (2011) highlights that access to midwifery-led care is the single most important factor in achieving improved outcomes in maternal and new-born health. Zander and Chamberlain (1999) acknowledged that 75 percent of pregnant women care was delivered by midwives and suggested that the midwifery model of care could possibly become the dominant future model of care. As they perceived consultant input to be changing and moving towards that of other consultants working in the NHS — midwives supervise medical staff and are becoming a referral point of contact for all women who require specialist input.

The midwife-led model is unlike the obstetric-led model of care, which arguably bends towards objectifying and fragmenting women by concentrating on specific biological components of motherhood and gives less interest to all the possible physical, psychosocial and emotional interactions (Page, 2009). Not only does the midwifery-led model of care prioritise relationships and social interactions, but it is also provided within a multi-disciplinary network of other care providers - which makes the care for women a shared responsibility between different healthcare professionals, with the midwife playing a central role in the co-ordination of this care (Sandall et al., 2013). Hatem et al., (2008) suggest that this model of care should be offered to most women, encouraging women to ask for this option of care, although caution should be exercised in applying this advice to women with substantial medical or obstetric complications. However, according to the National Institute for Health and Clinical Excellence NICE (2014), evidence now shows midwife-led units to be safer than hospital for women having a straightforward (low risk) pregnancy and home-birth is equally as safe as a midwife-led unit.

Therefore, their recommendation is that women should be given this information to help them think about where they would most like to give birth, but the final decision should be made by them and supported by healthcare professionals.

Regardless of the model of care a woman receives, the priority for modern maternity services throughout the UK is to focus on individual needs and encouraging greater choices within a high quality model of care. This resulted in a broad consensus in the development of maternity services that focused on ways to achieve high quality maternity care. Major studies such as Sandall et al. (2013) looked into the advantages of midwifery-led settings and guidelines in terms of midwifery practice, produced by the likes of NICE (2014; 2012), Royal College of Obstetricians and Gynaecologists and Royal College of Midwives (RCM) (2008) helped in shaping the UK's maternity policy. Across the UK policies aimed to achieve this by promoting care that is women-centred, safe, continuous and has choice - also care that reduces the use of unnecessary interventions and specifically reduce inequalities (DoH, 2007). The vision for high quality maternity care resonates with the NHS Constitution in England, which includes core values of respect, compassion, everyone counts, commitment and working together for patients (DoH, 2013). Also within the vision of the five year forward plan for maternity care in improving the outcome of maternity services in England (National Maternity review, 2015); *“Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries”* p8.

The many examples of excellent practice of midwifery-led care in the UK have been robust evidence in highlighting the quality and effectiveness of this model (Sandall et al., 2013). Most women in the general population are satisfied with the care they received and the outcome, however as mentioned earlier there are still variations in the level of quality care across the country. Bourke (2013) indicated that the statements preserved in maternity care policies do not always translate into practice; almost 2,000 women will give birth today and many will not receive the quality care recommended by the NHS women-centred care. Yes, choice is advocated but some women will be denied the opportunity to make choices; left out of decisions about their care; and others will find themselves without the emotional care, physical support, information and advice they need during the early weeks of the postnatal period (Bourke, 2013).

Further improvement within the UK maternity care services is important; the Midwifery 2020 report *Delivering expectations (year needed)* was commissioned with a vision of how midwives across the UK can respond to the challenges and opportunities of meeting the needs of women, babies and their

families in the future. The expectations for Midwife 2020 is seen and remains in professional documents, although hospital maternity care still needs to have greater emphasis on planning community based provision of maternity services that take into account the needs of the local population. The needs of the UK's multi-diverse population bring about challenges to this vision; within a multi-diverse population there are different cultures that have specific needs, one-size fits all type of care regardless of its high standards is not appropriate in meeting the needs of multicultural society. McFadden et al. (2013) specifies that maternity services still struggle to provide culturally appropriate care that meets the needs of women from diverse populations due to problems such as lack of understanding of the role of culture in women's lives and stereotypes held by health practitioners. Therefore, future change will also depend on the education and professional confidence and competence of midwives, obstetricians and general practitioners in providing care that understands and acknowledges the needs of a multi-diverse population of today (McIntosh & Hunter, 2014).

3.3 BME and Maternity services - with a focus on Muslim women

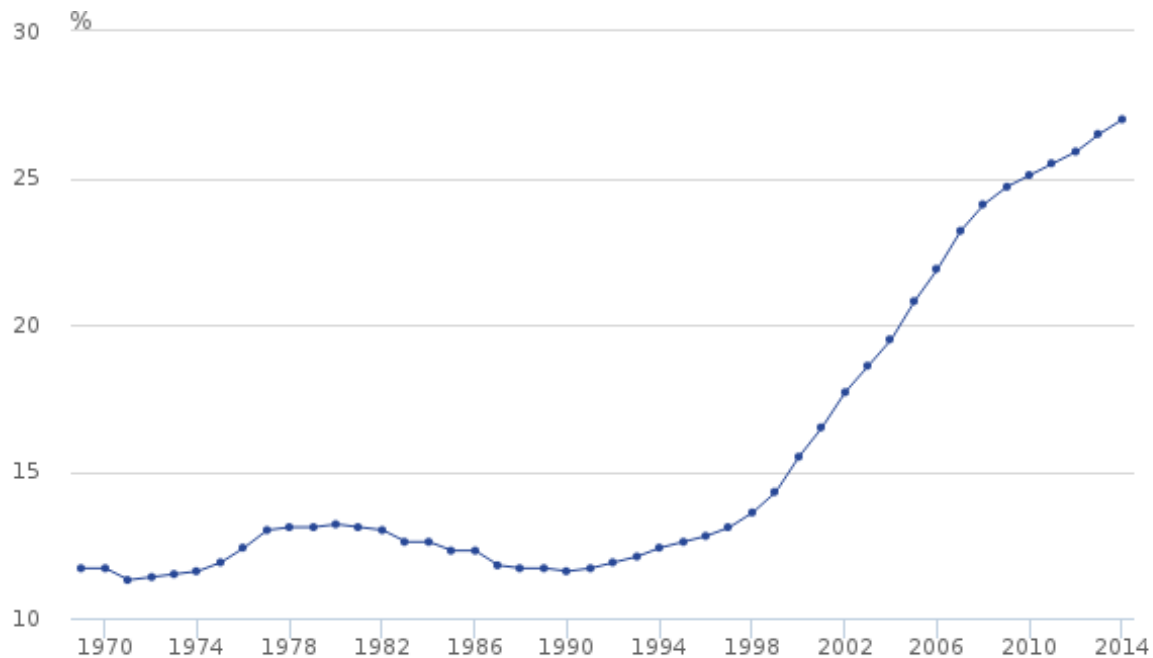
Research has indicated that women from ethnic minority groups have experienced poorer maternity care and maternity outcomes than the resident white population (Garcia et al., 2015; Puthussery et al., 2010; Straus et al., 2009; Maternity Alliance, 2004; Bulman and McCourt, 2002; Ellis, 2000). This body of research indicates that the maternity services in the UK are still struggling to provide culturally appropriate care that meets the needs of women from diverse populations.

Several factors have been identified: poor communication between practitioners and patients, stereotyping and inaccurate cultural assumptions held by some practitioners, and a general lack of research and sensitivity concerning the cultural and linguistic needs of patients from minority groups (McFadden et al., 2013; Reitmanova and Gustafson, 2008; Maternity Alliance, 2004). Other contributory risk factors, such as socioeconomic status, including education status and income, and living in areas of high deprivation are frequently cited as distal determinants of poorer health outcomes (Garcia et al., 2015). The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK] (2016) and the Centre for Maternal and Child Enquiries (2011) have reported that such issues have an impact on morbidity and mortality rates for women and babies. Garcia et al., (2015) highlight that in the UK, there are inequalities in maternal mortality rates; the estimated White British maternal death rate is 8 per 100,000 maternities, compared to 12.24 for Asians (Indian, Pakistani and Bangladeshi's), 28.05 for the Black ethnic group (combined), 31.89 for Black Caribbean's and 32.82 for Black Africans. There are similar discrepant trends evident in the statistics of infant birth outcomes including stillbirth, pre-term delivery and perinatal mortality from BME women in UK.

Communication barriers have been identified as one of the obstacles to providing high quality health care for many BME women (Bharj and Salway, 2008). A study by Ellis (2000) exploring the birth experience of South Asian Muslim women highlights that communication problems often exist between midwives and Muslim women even without major language problems. The Maternity Alliance report (2004) also identified poor communication between Muslim women and health professionals and a lack of appropriate information provided during pregnancy, childbirth and postnatal periods, especially for women for whom English is a second language. Other studies indicate that poor communication may result in women not receiving important information which can lead to nutritional problems and inadequate access to maternity service for regular antenatal check-ups (Balaam, et al., 2013; Lundberg and Gerezgiher, 2008; Berggren et al., 2006; Wiklund et al., 2000). The CMACE report (2011) emphasized that poor communication is one of the risk factors associated with increased morbidity and mortality among black and ethnic minority women.

Stereotyping and inaccurate assumptions by healthcare professionals were also identified as other issues that Muslim women experience. The Maternity Alliance Report (2004) reported that Muslim women experienced stereotypical comments during their maternity care. Women from minority ethnic groups are also more likely to be labelled as 'high risk', even in the absence of specific risk factors (McFadden et al., 2013). Balaam et al. (2013) highlighted that ethnic minority women tend to avoid using health services if they are unfamiliar with the health system as certain attitudes on the part of healthcare professionals may be seen as disrespectful. McFadden et al. (2013) emphasised that stereotyping and inaccurate assumptions expressed by healthcare practitioners are barriers to women making informed decisions about their own care and having their individual needs met. Other studies indicate that migrant women may lack the confidence to discuss their concerns and are sometimes reluctant to ask midwives questions (Berggren et al, 2006; McLeish, 2005). Specific behavioural expectations and unconscious stereotypical views held by health professionals also have the potential to affect their clinical decision-making and practice. These attitudes may also reduce client satisfaction, adherence to compliance levels, and can cause disparities in access to services (Puthussery et al., 2008).

3.3 Figure 1: Percentage of live births to mothers born outside of the UK, 1969 to 2014 in England and Wales (ONS, 2014)



As Laird et al. (2007) pointed out, despite Muslims forming the second largest religious group in the country (2,4 million in 2005), and having the youngest age profile of all the religious groups in Great Britain (ONS, 2014), more attention is often given to the appearance of Muslim women than their health needs. Even the term ‘Muslim’ is ambiguous in the health literature and is often combined with ethnic group identity, rather than used to refer to people distinguished by beliefs, practices or affiliations (Laird et al., 2007).

Katbamna (2000) points out that this lack of research, literature and sensitivity concerning the cultural and linguistic needs of patients means that women from minority groups have little alternative but to accept the form of care provided by the maternity services of the NHS. This is problematic, as according to Henley and Schott (1999), the British NHS is organised and run by white middle-class English values, which can even pose problems for women born and brought up in the UK, let alone for women who are used to a different care system. Sheikh (2007) regards this as a general failure among academics, policymakers, and clinicians to understand the particular needs of religious and ethnic communities, as without an understanding of these needs they are in no position to address them. Therefore, significant research is needed to provide data that will help in addressing the needs of a growing and diverse Muslim population in healthcare settings (Laird et al., 2007).

The little research there is, suggests that more could be done from a service provision's perspective to support Muslim women, as they make the life changing transition to motherhood. Therefore, it is important to have competent healthcare services and professionals for the future development of maternity services.

3.4 Competent care for a multi-cultural society

The term competence has multiple definitions in the healthcare literature; however, using Bazron et al.'s (1989) definition, competence is having the capacity to function effectively as an individual and an organisation within the context of the cultural behaviours, and needs presented by people and their communities. Therefore, it is used to describe behaviours that reflect appropriate application of knowledge and attitudes. Having competence within a healthcare setting that serves a multi-cultural society is known as cultural competence in the health literature. The term consists of two words 'Culture' and 'competence'; it is essential to understand the concept of culture first to understand cultural competence. Culture is dynamic, people do not biologically inherit a culture - they learn it, they share cultural tendencies and pass them to the following generations. There are many factors that have a profound impact on an individual's way of life, such as ethnic identity, religion, socioeconomic status, gender and migration history - based on these factors people may be members of subcultures that units within a larger culture (Leavitt, 2002).

The term cultural competence has become a fashionable term within the health literature, yet there is no single definition that can define this term precisely enough to operationalise it in clinical training and best practice (Kleinman & Benson, 2006). There are various definitions such as 'the ability of providers and organisation to effectively deliver healthcare services that meets the social, cultural and linguistic needs of patients (Betancourt et al., 2002) or more simply 'care that includes knowledge, attitudes and skills that support caring for individuals across different cultures' (Seeleman, 2014). However, within various definitions for cultural competence there are key phrases that are often referred to: Awareness, Knowledge, Skills and Attitude (Leavitt, 2010).

However, the development of cultural competence is not as simple as leaning lists of 'facts' about 'other' cultures, it is a process of understanding and working with different individuals from diverse cultural and social backgrounds that use the health services. This is highlighted by Kleinman & Benson (2006), who claim that cultural competence suggests that culture can be reduced to a technical skill which clinicians can be trained to develop, and this can pose a major problem.

Both qualitative and quantitative research has shown that BME women experience worse maternity outcomes compared to the White British population. (Garcia et al, 2015; Raleigh et al, 2010; Redshaw & Heikkila, 2010; Bharj and Salway, 2008). Even though the NHS has reflected its commitment to

equality in maternity services in a wealth of policy initiatives striving to redress the persistent ethnic inequalities in experiences and outcomes (Bharj, 2007). Garcia et al. (2015) report that there are still inequalities that exist in maternal and infant birth outcomes of BME women giving birth in the UK compared to the majority. They also report that very few BME women had access to specific maternity interventions; highlighting the need for local maternity services in the UK to be modified to better accommodate the needs of high risk BME women, through specific and culturally competent interventions, whilst meeting the needs of the wider population and other vulnerable groups, such as recent migrants or asylum seekers.

The NHS is increasingly being called to account for its failures to mitigate inequalities in maternity outcomes for BME women. Bharj and Salway, (2008) suggest that this failure reflect a number of factors:

- The pattern of service provisions and delivery has not kept up with the changing population profiles
- Maternity provision is inflexible and based on the assumption of homogeneity
- Providers of maternity services have not been adequately prepared in terms of attitudes and generic skills, as well as cultural knowledge. to sensitively meet the needs of a multi-ethnic population
- Innovative initiatives have tended to be small-scale and short-term and their learning has often not been mainstreamed
- Necessary data to monitor and address ethnic inequalities in maternity services receipt and outcomes have not been collected and acted upon
- Addressing the needs of diverse communities has not been consistently identified as a priority so that responding to other directives has impeded progress and change.

Redshaw & Heikkila (2010) suggest that even though most women were positive about their maternity care, there are differences between phases of care, regions and populations, between women with varying clinical needs and between women with different individual needs. They emphasise the need to both respond to women's individual needs and to provide a service that meets the needs of the whole population of childbearing women and their families. Bharj and Salway (2008) also suggest that unless more is done to bridge the gap between policy and practice, women from BME communities will continue to have poorer maternity experiences and outcomes than the white majority.

There are several models for cultural competent care, such as Giger and Davidhizar's model of transcultural nursing (2008); Papadopoulos et al. Model (1998) that consists of four concepts - cultural awareness, cultural knowledge, cultural sensitivity and cultural competence, and the Campinha-Bacte Model. The Campinha-Bacte Model was first presented in 1991 and then modified on different

occasions up to 2010; five main concepts within the framework - cultural awareness, a process of self-examination of one's own biases towards other cultures and exploration of one's cultural and professional background; cultural knowledge, a process in which the healthcare professionals seek and obtain sound knowledge about culturally diverse groups that include health-related values and practices, cultural values, and disease incidence and prevalence; cultural skills, the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment; cultural encounter, a process that encourages the healthcare professionals to directly engage in the face-to-face cultural and other interactions with culturally diverse groups to help modify existing beliefs about cultures and prevent possible stereotyping; and finally cultural desire, the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters (Campinha-Bacte, 2010). This concept of cultural desire is perhaps the most crucial in the process of developing cultural competence. Nevertheless, whilst each model provokes considerable debate there are similarities in the conceptualisations and processes that lead to the development of cultural competence.

It is suggested that cultural knowledge is the most important construct of cultural competence for healthcare professionals, it is crucial for the accurate appreciation of the service user's world view (Okrentowich, 2007). Esegbona-Adeigbe (2011) indicates that cultural knowledge is vital in today's healthcare services; acquiring cultural knowledge will not only equip healthcare professionals with important skills but will create a stepping-stone to cross the gap between healthcare professionals and women. However, while healthcare professionals may be aware of the importance of cultural awareness and competency, they may not necessarily have access to cultural knowledge which they can utilize in practice. Usually healthcare professionals get the opportunity to gain first-hand knowledge of women's culture through regular contact with women from different ethnic backgrounds, exploring specific cultural needs. Student midwives are also now being educated about specific cultures and cultural practices that are relevant to pregnancy and childbirth (Esegbona-Adeigbe, 2011). Yet there is recognition that certain cultures are still overlooked within the provision of healthcare services, some ethnic groups appear higher on the agenda of healthcare commissioners than other groups (just because they represent a larger portion of the ethnic minority population) and some ethnic minority groups may be categorized together despite their numerous cultural differences (such as African people) (Adebajo et al., 2004).

3.4 Figure 1: How cultural knowledge can improve women's contact with healthcare services (Esegbona-Adeigbe, 2011)



Lehman et al. (2007) reported that healthcare providers who received cultural competence training, demonstrated greater understanding of the central role of culture in healthcare; recognized common barriers to cultural understanding among providers, staff and service users. They also identified characteristics of cultural competence in healthcare settings and interpreted and responded effectively to diverse older adults' verbal and non-verbal communications cues. Moreover, they assessed and responded to differences in values, beliefs, and health behaviours among diverse populations; demonstrated commitment to culturally and linguistically appropriate services; worked more effectively with diverse healthcare staff; and acted as leaders, mentors, and role models for other health care providers. This demonstrates the importance of cultural awareness in helping healthcare professionals understand and recognize individual cultural difference and remove any barriers that are unconsciously created due to unawareness of the importance of culture for a childbearing woman (Esegbona-Adeigbe, 2011). Understanding cultural difference extends far beyond language needs, it includes beliefs regarding health, illness, healing and health systems; cultural behaviour in seeking healthcare and attitudes toward healthcare providers; and views and values of those delivering the care (Szczepura, 2005). Esegbona-Adeigbe (2011) suggests that midwives should use culture as a first point of assessment for women when planning care; allowing for consideration and acknowledgment of cultural

norms and respect for any taboos, while facilitating women's needs by removing barriers that may compromise their culture.

3.5 Summary

The provision of maternity care has witnessed significant changes throughout the process of its development and it is still continuing to develop today. The 1902 Midwives Act introduced training and supervision for midwives in England and Wales survived into the NHS era (RCM, 2002). Throughout time, midwives have been key healthcare professionals engaged in the provision of maternity care, ensuring a safe and emotionally satisfying motherhood journey.

Most women in the general population are satisfied with the care they received and the outcome, however, there is still a considerable variation across the country in the quality, safety and effectiveness of maternity care, which indicates the scope for improvement (National Maternity review, 2015). Women from ethnic minority groups have experienced poorer maternity care and maternity outcomes than the resident white population (Garcia et al., 2015). Maternity services in the UK are still struggling to provide culturally appropriate care that meets the needs of women from diverse populations (Sheikh, 2007). However, the development of cultural competence is not as simple as leaning lists of 'facts' about 'other' cultures, it is a process in understanding and working with different individuals from diverse cultural and social backgrounds in the use the health services.

Chapter Four Methodology

4.1 Introduction

The overall aim of the thesis is to investigate Muslim women's motherhood journey and explore the factors that influence their health needs and health-seeking-decisions when engaging with maternity services located in the North West of England, with a view to improving services for Muslim women. In order to identify appropriate means to carry out the necessary investigations, an exploration of the research philosophy and methodology was undertaken.

This study's three phased research design is described and an explanation for this design is highlighted. Each phase of the research is identified together with the particular issues which arose during the fieldwork. The ethical issues involved in this study are also considered.

4.1.1 Rationale for Research method

In the processes of identifying appropriate research methods both quantitative and qualitative research methods were explored. For decades, there has been a so called 'paradigm war' between quantitative and qualitative researchers, each group of researchers claiming superiority over the other (Boutellier et al., 2013). Neither one of these research methods is better than the other, they are different in the way they approach and address a research question. Both have their strengths and weaknesses, yet the navigator that determines the research method used in a study is the research question (Everest, 2014).

4.1.1.2 Quantitative Research

The fundamental worldview of quantitative research is that it is described as being 'realist' or 'positivist', whereby objective research methods are used to uncover an existing reality (Muijs, 2011). By assuming that social reality is objective and external to the individual, it attempts to answer certain questions under controlled conditions by removing the simultaneous influences of many variables to provide definite answers (Burns, 2000). Standardised methods such as questionnaires are used to maximise objectivity and minimise subjectivity. Quantitative researchers believe that humans behave in accordance with numerous social laws (Bilton et al., 2002) whereas qualitative researches believe that humans cannot be explained by inflexible social laws, because some parts of reality are at least constructed by us and by our observations. Unlike quantitative researchers, qualitative researchers believe that all reality can only be relative and not definitive (Muijs, 2011).

Generally quantitative research methods generate statistics through the use of large-scale survey research, using methods such as questionnaires. A definition given by Aliaga and Gunderson (2000) states that surveys explain phenomena by collecting numerical data that are analysed using mathematically based methods. Quantitative research most often answers questions such as ‘how many’, ‘what is the numerical change’, ‘what are the factors relating to the change’ and test hypotheses. Numerical data is essential to this type of research, however, since knowledge and understanding surrounding this study’s research phenomenon are lacking, analysing such a phenomenon in terms of trends and frequencies may not be enough to create in-depth understanding of the phenomenon. Quantitative researchers may often fail to develop concepts which aid in the understanding of phenomena with emphasis on the meaning, experiences and views of individuals. Often the research question determines the methodology used in research, therefore, a crucial question is not ‘what is the best research method?’ but ‘what is the best research method for answering this question most effectively and efficiently?’ (Al-Busaidi, 2008). Therefore, understanding this study’s new phenomenon requires in-depth description, which creates knowledge beyond measure of the outcome of care but understanding the experiences that influence the maternity care outcome for Muslim women.

4.1.1.3: Qualitative research

Over the years, qualitative research has generally gained recognition in the fields of social science, natural science research and other areas such as public health, healthcare, education, sociology, culture studies (Everest, 2014). Although the disciplines of social sciences have their own methodological traditions, what they have in common is a focus on human behaviour in context, whether social, cultural or historical. It is not therefore surprising that healthcare practitioners, managers and policy-makers have increasingly turned to qualitative methods of social inquiry to enhance our understanding of health, health behaviour and healthcare services, and improve the management and provision of health services (Green & Thorogood, 2004).

This kind of research is described as ‘subjectivist’, which means that it explores a phenomenon in its natural settings, and the way people interpret and make sense the worlds in which they live (Cresswell, 2003). Unlike the questions answered by quantitative research such as ‘how much’ or ‘how many’; qualitative research is able to answer important questions such as ‘how’, ‘why’ and ‘in what way’.

Qualitative researchers employ methods such as interviews to explore experiences, attitudes and behaviours of individuals. Unlike quantitative research, this research does not depend on numeric information but rather depends on transforming information from observations, reports and recordings into words (Boutellier, 2013). Qualitative research is an interactive process in which the individual studied teaches the researcher about their life, which makes it a method that accords with the aim of this study. This approach does not start with a hypothesis or have dependent or independent variables

nor does it try to give a definitive account of a pre-existing reality, as a quantitative approach might. Such research takes a subjectivist stance, whereby everything in reality is relative and not definitive (Muijs, 2011).

This study aims to explore what motherhood is like for Muslim women living in the UK. Qualitative research is adept at exploring phenomena that are under investigated or have not been explored before, through generating in-depth data and a thorough understanding (Bowling, 2002). It was important to create a picture of the participants' world and qualitative research was considered most appropriate in understanding the motherhood experience as told from Muslim women's own perspectives. The knowledge created by this research approach can be limited in its inability to generalise on a broad scale like quantitative research, however it is able to build a low-generalisation based on created localised accounts.

4.1.2 Research approach

The term qualitative research is actually an umbrella term that encompasses a wide range of research approaches, such as grounded theory, ethnography, phenomenology, to name a few. A qualitative approach is basically a general way of thinking about conducting qualitative research, whereby each approach differs in how it describes the purpose of the research, role of the researcher, phases of research and methods of data analysis (Muijs, 2011). This family of approaches brings about numerous benefits, such as the ability to collect and interpret data through individuals' own meanings, studying a small number of cases in-depth, conducting and analysing cross-case comparisons, generating understanding and a description of individuals' subjective experiences of phenomena, and responsiveness to the needs of stakeholders and local situations (Everest, 2014). The researcher considered several approaches when choosing the research specific approach and these are summarised below:

4.1 Table 1: Qualitative research approaches (*table created by researcher*)

Qualitative research approach	Approach description	Approach's relevance to research topic.	Approach's irrelevance to research topic.
Grounded Theory	<p><i>'To generate or discover a theory'</i> This approach is based on developing a theory 'grounded in data systematically gathered and analysed' (Strauss & Corbin, 1994). It develops low level of generalisations that might possibly be applied elsewhere.</p> <p>Data collection methods: commonly uses in-depth interviews. Observational methods and focus groups can also be used.</p>	This approach is ideal for exploring the contextual factors that affect women's lives; exploring factors beyond assumptions and preconceptions to understand Muslim women motherhood experience.	This study intends to create low level of generalizations, but not theory. That will help service providers deliver more culturally appropriate care for Muslim women.
Ethnography	<p>Ethnography mainly comes from the field of anthropology; it is an approach that explores cultures' social interactions, behaviours and perceptions (Reeves, et al., 2008). Through direct interaction and involvement with a discrete cultural group in their natural setting, insight is created. This approach helps in documenting the culture, perspectives and practices of groups. The aim is to 'get inside' the way each group of people sees the world.</p> <p>Data collection methods: commonly uses observation and interviews.</p>	This approach is ideal for creating a rich holistic insight into the nature of the maternity care environment that Muslim women access.	<p>This approach is unsuitable for this study as Muslim women are not a discrete ethnic or cultural group. The women share a religion, but they come from different ethnic and cultural backgrounds.</p> <p>The main feature of this approach is observation, which involves observing the women throughout their motherhood journey. The observation element will be very difficult to carry out with pregnant women (for whom experiences unfold differently) in a busy hospital.</p>

<p>Phenomenology</p>	<p>Phenomenology is sometimes regarded as a philosophical perspective in the social sciences (Groenewald, 2004). This approach aims to generate an insight and awareness of people's 'lived' experiences and interpretation of their world.</p> <p>The aim is to present an accurate description of the individual's world view, whether it is through descriptive phenomenology or interpretative phenomenology.</p> <p>Each approach differs slightly; descriptive phenomenologists refrain from making preconceptions about the studied phenomenon through a process of 'bracketing' (the method to ease the potentially deleterious effects of preconceptions that may taint the research process). Interpretative phenomenologists believe that it is difficult for the researcher to completely refrain from making preconceptions about the phenomenon, so the researcher uses their own experiences to interpret those of others (Balls, 2009).</p> <p>It can be difficult to maintain both of these approaches, as neither can be guaranteed.</p>	<p>This approach is ideal in understanding what was the motherhood experiences like for Muslim women when engaging with Maternity services in the UK.</p>	<p>Even though this approach might have been suitable it was not used as it focuses on the content of experiences rather than what are the experiences. For example, if a woman was to report that 'sadness' was part of her experience, phenomenology would be interested in exploring the 'lived' experiences, so what is the experience of being 'sad' and what did it mean for the woman? However, this study is interested in what was experienced, that is the fact that the woman was 'sad' and not the meaning.</p> <p>Also often phenomenologists explore a phenomenon in an unstructured way and this study needed a more structured approach, as it focused on improving services and finding ways to increase the literacy of healthcare professionals, by feeding back to the staff the findings of the interviews for implications.</p>
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	Data collection method: commonly use interviews. Diaries and observation can also be used.		
Action Research	<p>Action research is commonly used for improving conditions and practices in a range of healthcare environments.</p> <p>The aim of action research is to identify specific problems relevant to a group of individuals and collect data on possible solutions to these problems (Koshy, et al., 2010). The strength of this research approach is its focus on generating solutions to identified problems through the involvement of participants.</p> <p>Data collection method: can use qualitative or quantitative research methods or both.</p>	<p>This approach would be appropriate for finding solutions to problems that Muslim women may be facing while engaging in UK maternity services, to bring about change.</p>	<p>This approach could be possible but do we have enough knowledge about Muslim women and their motherhood experiences to do action research?</p> <p>There is little research within the health literature that explores the experiences of Muslim women during the motherhood journey, it is important to generate more knowledge and understanding of the experiences of these women before trying to create solutions to issues that are not clearly identified.</p> <p>The feedback to staff bring this together and finds implications to what to do next; Action research can be the next step.</p>

The aim of this study is to describe, record issues and explores approaches for improving the delivery of maternity services and possible change. The researcher concluded that generic research was the most suitable for this study.

4.1.2.1 Generic research

In many applied fields such as education and healthcare, the popularity of generic research has increased over recent years (Percy et al., 2015). Not all qualitative studies are about culture, as in the ethnographic approach, or improving practice, as in action research, or a thorough study of a small group of individuals' lived experiences, as in phenomenological research, nor are they about the development of theory, as in the grounded approach. In those cases, generic research is considered by many researchers in the field of education and health-related research to be an appropriate alternative (Merriam, 1998). Terms such as 'non-categorical qualitative research' (Thorne et al., 1997), 'fundamental qualitative

research' (Sandelowski, 2000), and 'generic qualitative research' are sometimes used (Merriam, 1998), but to avoid any confusion the study will use the term given by Merriam of 'generic research'.

Generic research does not follow a set of philosophical foundations like those of an established qualitative research approach. Rather this approach exhibits some or all of the characteristics of other established qualitative research approaches without making claim to any particular approach. Merriam (1998) states it is an approach that '*simply seeks to discover and understand a phenomenon, a process or the perspectives and worldviews of the people involved*' (p11). In other words, it aims to explore individuals' accounts of their personal opinions, attitudes, beliefs, or reflections on their experiences of particular things in the outer world.

Generic research uses data collection methods and analytical methods that best suit the study's questions, instead of fitting the study's questions to a certain philosophical viewpoint (Smith, et al., 2008). It uses methodologies that provoke participants to report on their thoughts about their real life experiences (Percy et al., 2015). For example, generic research will use semi- or full structured interviews, instead of unstructured data collection methods such as the ones used in phenomenology (open-ended interviews) or ethnography (participant and/or researcher's observation).

Generic research was appropriate for this study as it enabled the researcher to explore Muslim women's thoughts, attitudes and beliefs regarding their motherhood experiences. This approach gave room for the study to use a wider variety of Muslim women to enable a wider represent of this group of women. Generic research also allows for combined methods and thus study employed both interviews and focus groups. Semi-structured interviews were used as this gave the researcher the opportunity to ask questions such as 'can you tell me more' when wanting to explore further (Percy et al., 2015). Smith et al. (2008) state that generic research is essential if healthcare policy is to be met in relation to valuing and understanding users' and carers' perspectives of their healthcare.

Sometimes generic research may appear as a loose method or a less demanding approach for not having a set of philosophical foundations like other research approaches (Caelli et al., 2003). However, that does not mean that it is less rigorous than the other research approaches. Caelli et al., (2003) argue that a researcher applying a generic approach needs to make their theoretical position clear, clearly identifying the reason for the research question and the preconceptions the researcher may have about the topic of interest. They also need congruence between methodology and methods; this means that the methods used in this approach should be sufficiently described to distinguish between them and other methods in other approaches. Finally, they need to have a clear approach to establish rigour and the analytic approach that the researcher uses to engage with the data needs to be identified (Caelli et al., 2003).

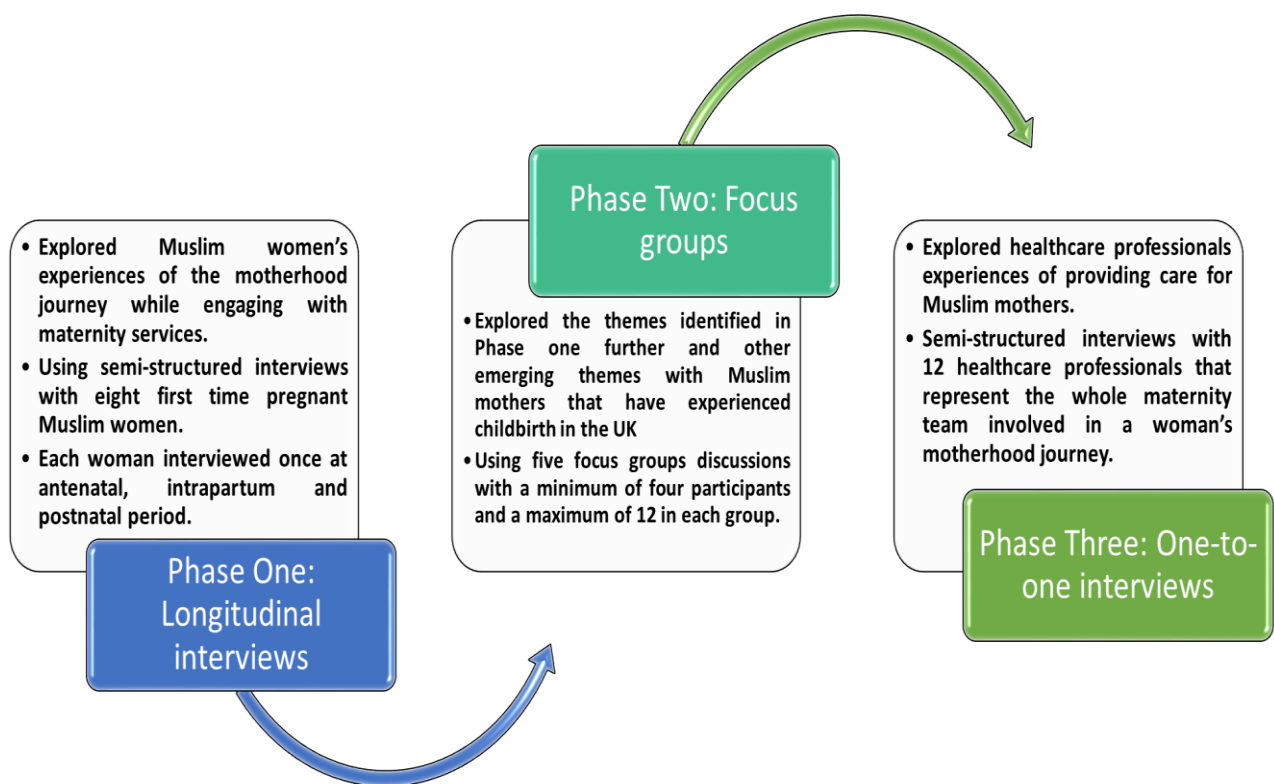
4.2 Research design

The overall aim of the study was to investigate Muslim women's motherhood journey and explore the factors that influenced their health needs and health seeking-decisions when engaging with services at a provider of maternity services located in the North West, with a view to improving services for Muslim women. The specific objectives were:

- To explore Muslim women's experiences of motherhood
- To explore Muslims women's perceived maternity health needs
- To identify the factors influencing Muslim women's health behaviours and health-related decisions during and after pregnancy
- To explore healthcare professionals' experiences of providing maternity care for Muslim women

This study was in three phases, Phase one used longitudinal semi-structured interviews with seven first-time pregnant Muslim women and a Muslim mother who is second time pregnant but experiencing motherhood as a Muslim for the first time, Phase two used focus groups with Muslim mothers and Phase three used semi-structured one-to-one interviews with healthcare professionals. These are the common methods of data collections used in qualitative research and each method is unique in its ability to generate data (Gill et al., 2008).

4.2 Figure 1: Research design (*figure created by researcher*)



This approach is called triangulation, which is the use of several research methods to explore a research question in order to enhance confidence in the ensuing findings (Bryman, 2001). Triangulation is sometimes used for validating findings, as researchers assume that using several methods will strengthen the study, as the weaknesses of one method will be compensated by the others. Other researchers regard this approach as controversial and triangulate different methods simply to ensure that the study is rich, robust, comprehensive and well-developed (Bryman, 2001; Angen, 2000; Patton, 1999). This is the approach taken here; this study triangulates methods, which helped facilitate a deeper understanding of Muslim women's experiences in the transition to motherhood.

Longitudinal interviews in phase one allowed the researcher to explore Muslim women's perspectives at different stages of their motherhood journey. This first phase created insight into each woman's motherhood experiences, which generated four themes. These themes were explored further in the focus groups of phase two, adding validity to the findings of phase one but also adding another layer of information. The final phase of interviews with healthcare professionals added another layer of information to the findings of the earlier two phases from a different dimension.

4.2.1 Ethical consideration

Even though developing knowledge is important in qualitative research, maintaining research ethics is also essential throughout the research process. Like any research method that involve face-to-face interactions with participants, this research needed to undergo ethical consideration. The main purpose of research ethics is ensuring that the research does good and avoids harm. Orb et al. (2000) highlight that the application of appropriate ethical principles helps to prevent or reduce harm. Therefore, it was the researcher's responsibility to take into account and address all the possible ethical issues that might accrue in the process of this research. This includes confidentiality, data protection, potential harm and relations between researcher and participants. Ethical approval for the study was obtained from the NHS Research Ethics Committee (through the Integrated Research Application System (IRAS)) prior to commencing data collection (refer to appendix 1).

All interviews and focus groups were conducted in English; similar to Ellis (2000) work this study focused in exploring the motherhood experiences where language was not an obstacle to communication. This is because the language barrier is a significant factor that has a great impact on an individual's experiences and can be the barrier to effective and equitable healthcare (Meuter et al., 2015). Women's experiences with language barriers may have a different dimension to the experiences of women with no language barriers. Meuter et al. (2015) highlight that language differences may result in increased psychological stress and medically significant communication errors for already anxious patients, to which the patients' encounters that share similar language with healthcare professionals are less vulnerable. This study's insight into the motherhood experiences of English speaking Muslim women in the UK will support future exploring of the motherhood experiences of non-English speaking Muslim women.

In terms of informed consent, each phase of this study had a specific research information sheet (refer to appendix 3) and consent form that were presented to participants before they took part in the research (refer to appendix 4). Before obtaining informed consent, the researcher ensured that all participants were fully aware of the purpose of the study and clearly understood their role in this study. Participant information sheets highlighted the overall aim of the study, the specific objectives of that particular research phase, the role of the participants, the data collection methods, and how the data would be used. It also highlighted the importance of the participants' rights, explaining that all participants had the right to withdraw at any point without repercussions. Each participant was given the chance to read the information sheet and discuss further with the researcher.

Once participants were confident that they understood the aim of the research and what it involves, a consent form stating the following was presented:

- Participant's right to withdraw and terminate their participation at any point without repercussions.
- How data would be obtained (audio recording)
- Confidentiality and anonymity

No data collection began without participants' verbal and signed consent. Informed 'process consent' was considered throughout this study. In phase one participants were interviewed at three stages of their motherhood journey: to ensure that participants were still interested in participating in this longitudinal study, following each interview, participants were asked if they were still happy to later be contacted regarding the next interview. In addition, at the start of subsequent interviews participants were reminded of the overall aim of the study and the researcher obtained verbal consent again, emphasising their right to withdraw from the study at any point. No participant chose to withdraw from the study.

In terms of confidentiality and data protection, the researcher used several methods to maintain participants' confidentiality during the data collection and presentation of findings. The researcher asked for participants' contact details only to schedule initial interview or focus group and arrange follow up interviews.

The researcher used an audio recorder for each interview and focus group, all participants were informed of this and consent was obtained. Audio recordings were transcribed by the researcher; participants remained anonymised throughout this process, pseudonyms and numbers were used throughout to protect all participants' identities; other than the researcher, it is not possible for other individuals to link the pseudonyms and numbers to the participants. However, during phase two the study maintained confidentiality and anonymity of participants; for example, during the focus group sitting, the participant's anonymity was not possible, because participants were familiar with each other and some were friends. Bowling (2002) also notes that confidentiality is not obtained in group settings and in research related to health within local groups, the anonymity of the participants is not necessarily aimed for. It was also impossible to maintain confidentiality if participants talked about the focus group discussion outside the focus group. This was mitigated by laying down ground rules that everything that was mentioned in the focus group stayed within the room.

All the research documents were stored in a secure locker in the research office of the university that only the researcher had access to. All transcripts were anonymised before being subjected to analysis; and all documents (audio files and anonymised transcripts) were stored on a password protected secure server.

In terms of potential harm, it is the obligation of the researcher to anticipate the possible outcomes of the research and weigh the benefits against the potential harm (Houghton et al., 2010). Therefore, if the participants exhibited any signs of emotional distress during the interview or the focus group it was the

researcher's responsibility to end the interview or focus group and provide support. The researcher provided participants with details of counselling, self-help and healthcare services from which they might wish to obtain support (e.g. Patient Advice & Liaison Services). Also considering the nature of longitudinal interviews and the level of involvement between the researcher and the participants, there was potential risk of disclosure of matters of a distinctly personal nature (Farrall, 2006). At the start of each interview the researcher reminded the participants of the study's aim and briefed the participants on what would be discussed and picked up on issues they referred to in the earlier interview(s).

4.3 Phase One

This phase explored Muslim women's experiences of the motherhood journey while engaging with maternity services during the antenatal, intrapartum and postnatal periods. To explore all aspects of this journey, longitudinal semi-structured interviews were carried out with seven first time pregnant Muslim women and a Muslim mother who is second time pregnant but experiencing motherhood as a Muslim for the first time. Each woman was involved in three interviews. A longitudinal approach is particularly useful when studying a phenomenon that involves a developmental process (Farrall, 2006). It involves returning to interviewees over a time period and collecting data on specified conditions of change and the processes associated with these changes (Hermanowicz, 2013; Farrall, 2006). Rather than providing a snapshot of the women's motherhood journey, longitudinal interviews provided an insight to how motherhood unfolded over time for each participant.

The first interview was during the final trimester of the woman's pregnancy (29 to 40 weeks of pregnancy), the second interview was within the first two months after the birth, and the final interview was carried out two to four months later. Interviewing women at these significant periods of their motherhood journey allowed them to express their experiences and events clearly and accurately. Farrall (2006) highlights that this approach makes the study prospective rather than retrospective; retrospective studies can be influenced by participants' failure to recall events or the correct ordering of events, which leaves them open to deliberate biases as they attempt to imbue their actions with a rationality that they did not have at the time or non-deliberate biases due to subconscious suppressions of painful memories, whereas in prospective studies, they get a chance to recall events earlier.

In keeping with the semi-structured approach, an interview guide was followed rather than a specific list of questions. This facilitated exploration of pertinent issues identified prior to data collection whilst also facilitating identification of other issues that participants felt were relevant. The first interview asked general questions around the experiences of pregnancy, access to services, services' ability in meeting needs, religious practices, specific needs during pregnancy, and religious needs that are specific to birth. The second interview asked questions around the experiences of labour, service access, after labour care, if they had been able to implement their specific religious practice at birth and how they

had been addressed. Finally, the last interview asked question about the overall experience of pregnancy and birth, service provision and implications of service provision. The researcher reflected on events and explored specific topics discussed in previous interviews such as birth plans.

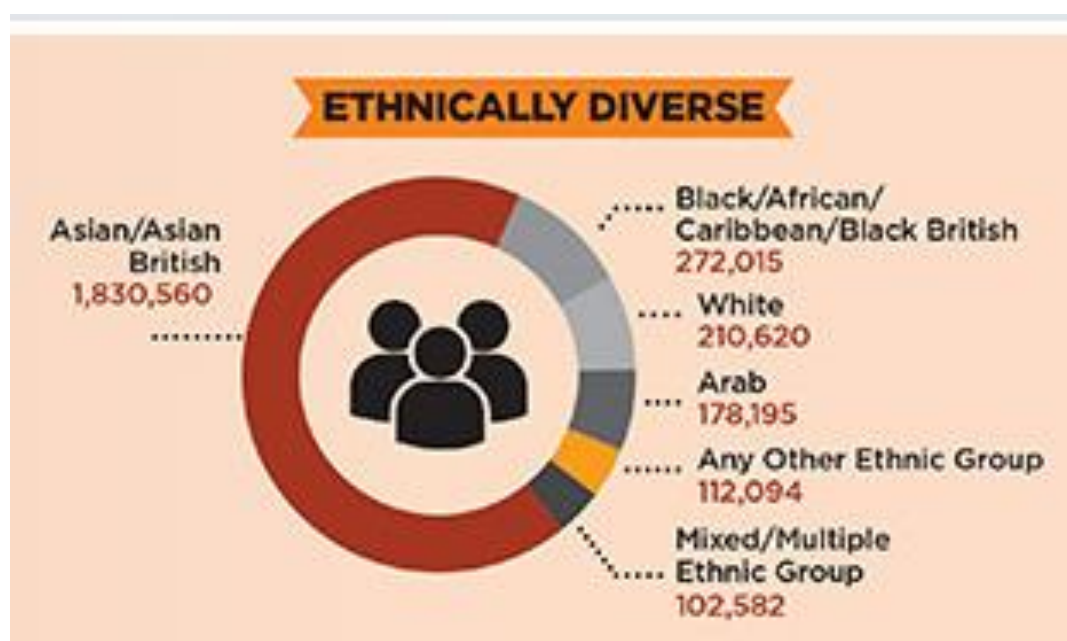
4.3.1 Sampling

Generally, sampling refers to the selection of individuals, units, and/or settings to be studied. Unlike quantitative research that seeks for a random statistical sample representative of whole populations, sampling in qualitative research is about choosing a population that has the characteristics relevant to the research questions (Koerber and McMichael, 2008).

The population for this phase of the study was first time pregnant Muslim women living and receiving maternity care in the Merseyside region of England. The study defined Muslim women as those women that consider themselves followers of the Islamic religion. They were included if they were above age of 18 years old and spoke English. Individuals were excluded if they did not meet these criteria; with one exception, a woman who was not experiencing childbirth for the first time was still included because it was her first experience of childbirth as a Muslim woman. The researcher acknowledged that this woman in comparison to the first-time mothers of this study might differ in term of needs, experience and schedule of care provided. However, the research was keen in including her as she shares common religious values with the other women, her experience of motherhood as both a non-Muslim and a Muslim woman will help in giving a deeper insight into how religion may influence the overall experience, needs, health seeking decisions and meanings of motherhood when reflecting on both of her experiences.

With purposeful sampling, there is a danger that the sample selected is not diverse enough to represent the variation recognised to exist in the population being researched. It is essential for the researcher to strive to include individuals who represent the broadest variety of perspectives possible within the range specified by the research aim (Koerber and McMichael, 2008). Even though this study selected women living in one geographical range for convenient access, the researcher strove to select Muslim women who will reflect variation (ethnicity, age, education, marital statues) in the sample of this study. The researcher sought to select eight Muslim women who would represent the variety of the Muslim population living in the UK. The Muslim Council of Britain [MCB] (2011) Census highlighted that 20% of Muslims in the UK are economically active, 29% of Muslim women age between 16-24 are in employment, 18% aged between 16-74 year olds women look after home or family, 24% of the Muslim population aged 16 and above have a degree level and above qualifications, and 43% of Muslims full-time students are females.

4.3.1 Figure 1: MCB 2011 Census highlighting UK Muslim population ethnically diversity.



Longitudinal interviews generate very large data sets even with a small sample (Farrall, 2006). The researcher carried out 24 interviews, which generated an in-depth and rich data set. Theoretical saturation is reached when there is enough information to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible (Fusch and Ness, 2015). A sample size of eight women was sufficient for this phase, the aim of this phase is to generate insight into the motherhood experience and the factors that influence this experiences. The researcher was not obtaining additional new information, the thick and rich data generated by 24 interviews were enough for this study's initial stage to reach theoretical saturation.

4.3 Table 1: Phase one participant demographics (*table created by researcher*)

Name (= Pseudonym)	Age	Birthplace	Age at migration	Ethnicity	Education	Job states	Marital statues
Noor	25	UK	N/A	Indian	BSc from university in UK	Self employed	Married (living with husband)
Hanan	24	Yemen	9	Yemeni	BSc from university in UK	House wife	Married (husband out of the country)
Khadija	33	Somalia	16	Somali	College	House wife	Married (living with husband)
Samah	32	UK	N/A	White British	College	House wife	Married (living with husband)
Sahar	27	UK	N/A	White British	BSc from university in UK	employed	Married (living with husband)

Eman	20	UK	N/A	Yemeni	College	House wife	Married (living with husband)
Nesreen	21	UK	N/A	White British	College	Employed	Married (living with husband)
Fatimah	28	Yemen	28	Yemeni	BSc from university in Yemen	House wife	Married (husband out of the country)

4.3.2 Recruitment

The researcher had good access to the population for several reasons. Firstly, the researcher is a Muslim woman from within the Merseyside community, an active member within the local Muslim mosque, an interpreter within the local maternity services and a member of the Merseyside Muslim mailing group known as ‘Barakah’. The researcher’s position gave her a great advantage in recruiting Muslim women to this study.

Initially Muslim women were directly approached at local Muslim religious institutions such as the mosque and Muslim community groups such as Islamic study classes for women. Within such forums, the researcher already had a rapport, as she was a regular attender at both the local mosque and at Islamic study classes. The researcher directly approached several women who were recognizably pregnant and other women that might have contact with other pregnant women. Through conversation, the researcher was able to inquire if it was their first time experiencing childbirth and/or if they knew of other women who were first time pregnant. The researcher recognized that approaching participants at the local mosque and Muslim community groups might limit the study to participants that attend such centres or classes. Therefore, when approaching participants at the mosque and Islamic classes, the researcher provided potential participants and also women who had contact with other mothers her number and email with the participant information sheet. Giving them the opportunity to contact her if they had any further enquiries regarding the study and asking that they contact her within a week if they were interested in taking part in the study.

The research also sent a formal email via the ‘Barakah¹¹’ mailing group, which many local Muslim women in Merseyside have access to, informing and inviting Muslim women to take part in the study (refer to Appendix). Many women showed an interest, however many of the women who responded to the invitation did not fit the study’s criteria, as they were not experiencing childbirth for the first time.

¹¹ This is a mailing group that has a collection of members used by and created by local Muslim women. They use this group for sharing information on different topics, whether it is Islamic information, general information, sales, announcements of upcoming events, which also include announcements of women giving birth, death and new comers to the community. This is an active group that has many Muslim women subscribers and it is also open for more Muslim women to subscribe.

The researcher personally and/or via email thanked the women for their interest and informed them they could take part in phase two of this study and would be contacted near to the time.

This outreach through the Barakah email helped the research to reach other Muslim women that are not within the mosque or attendees of the Local Islamic classes. Muslim women, who did not fit the researcher's criteria but were interested in the study, contacted the researcher and introduced her to Muslim women who did fit the study's criteria. Two participants were recruited this way.

In total, the study recruited eight Muslim women and no one withdrew from the study. One participant had to postpone her final interview because she had travelled overseas after the birth of her child. Since she still wished to take part, she was interviewed when she returned 6 months after the birth.

4.3.3 Data collection

A longitudinal qualitative approach has an established role in social science disciplines, over the recent decades it has been employed by many studies, particularly within healthcare research (Carduff et al., 2014; Calman et al., 2013; Hermanowicz, 2013). 'Time' is the unique feature of this approach, which distinguishes it from other qualitative approaches (Carduff et al, 2014). Qualitative research methods are able to answer questions such as 'why' and 'how' individuals are experiencing a certain aspect of their life, however the longitudinal approach takes this a step further and focuses on 'why' and 'how' these experiences change over time (Calman et al., 2013). Longitudinal interviews enable the researcher to identify and understand the meaning of temporal change across individuals' lived experiences and how individuals interpret and respond to such changes (Hermanowicz, 2013).

Motherhood is a complex transitional process, in order to generate further understanding it is essential to explore the women's experiences during the three stages that make up the motherhood transition (pregnancy/labour/parenthood) and how these experiences shape the overall experience of motherhood (Calman et al, 2013; Modh et al, 2011).

Farrall (2006) mentions that usually studies that use qualitative research explore individuals' experiences of certain life events but rarely return to these individuals to explore 'how' and 'why' their lives, emotions and beliefs have changed over time. Farrall (2006) argues that many qualitative studies are limited to what he describes as contextualised snapshots of process and people. He points out that if these studies were to return to their participants, we would gain a greater understanding of matters such as the impact of certain interventions on participants' lives or how and why participants feel about an issue over time. The great advantage of a longitudinal qualitative approach is that it is iterative, which means it tells a story that draws on what has been previously learned to develop an understanding of change over time (Carduff et al., 2014; Calman et al., 2013).

It was particularly important for this research to tell the full story of how and why the transition to motherhood unfolded for Muslim women. Modh et al. (2011) highlight that understanding women's overall experiences of childbirth is key in understanding the outcome of labour and how it unfolded. The use of longitudinal interviews helped elicit a vivid image of the individual's perspective and interpretation of motherhood. They are particularly useful in exploring an under-studied phenomenon that need more insight, and sensitive topics that some individuals may not feel confident sharing in a group setting (Gill et al., 2008).

Eight Muslim women experiencing the transition of motherhood were involved in this phase of the research. This journey is a process that involves the shifting from a known current reality to an unknown new reality (Mercer, 2004), it was therefore important for this study to explore this major life transition as it unfolds for Muslim women who are yet to experience the new reality of this transition. This provided the study with reported experiences of motherhood that are not based on previous experiences, with the exception of one participants who had experienced motherhood as both a non-Muslim and a Muslim provided a reflection of both experiences with religion being key in this reflection. All participants reported experiences based on recent accounts that are still vivid of major events in the motherhood journey (pregnancy/labour/being a mother) (Hermanowicz, 2013).

The wider literature helped guide the development of an interview guide; such as beliefs about motherhood, the overview of maternity care in the UK, availability and access to maternity services, Islamic practice and the health issues and needs of BME groups in relation to maternity. The interview guide included open-ended questions to allow for the expression of more details (refer to appendix 6).

The researcher was also aware of the risk that the interviews can become repetitive; the researcher reduced this risk by exploring new accrued events by revisiting topics discussed in the previous interview. For example, during the first interview the participants were asked about their birth plan, participants mentioned specific practices that they were planning to do during their labour. During the follow up interview the researcher revisited this topic and explored further whether participants were able to carry out the birth plan; if yes 'how' and if not 'why'. This allowed participants to revisit topics which were important to them, reflect and comment on whether anything had changed, and introduce new topics. This helped participants get to the point more quickly and made the data less overwhelming for the researcher (Calman et al., 2013).

Mack et al. (2005) highlighted that ideally the place in which interviews are conducted should be private and where individuals feel that their confidentiality is maintained. The researcher offered participants to have the interviews in their own homes or wherever they would like the interview to take place. All participants were happy for the interviews to take place in the comfort of their own homes. Interviewing the participants at home allowed them to feel confident and in control of the environment that they were

in. It also avoided troubling participants with the hassle of traveling while they were at a late stage of their pregnancy, early after their labour or with a young child.

As mentioned earlier, participants were familiar with the researcher, which made them feel content in welcoming her into their homes. The researcher acknowledged the hospitality nature of the women's culture, for example, the researcher is aware that one is not to be empty handed on arriving at the homes they are visiting, one is to present a small token of appreciation on entering their homes, this can include things such as biscuits, cakes, drinks or fruits. The researcher ensured that at every visit she presented the women with such tokens, which the women appreciated. The researcher also acknowledged that women would express hospitality culture by offering a hot drink and something to eat (biscuits, sweets or cakes) and they would start by asking about the visitor's overall wellbeing. The researcher embraced such cultural values by giving each woman enough time to relax and talk before starting the interview. This helped build the women's confidence in the researcher, whereby they treated the interviews as times to socialize and an informal discussion of topics that mattered to them. The participants looked forward to the follow up interviews and contacted the researcher to inform her when they had delivered the baby. The participants told the researcher that they had enjoyed the interviews and found them therapeutic. This was highlighted by Carduff et al. (2014), who mentioned that there is evidence to suggest that qualitative longitudinal research has a therapeutic potential for participants. The interviews gave women time to reflect and discuss their experiences of this significant life event, which may have helped them to articulate thoughts and emotions on particular events. However, the researcher was aware that the long contact with the participants could lead the participants to disclose personal information, such as issues within their marriage life. The researcher helped in reducing this by giving the participants room to express themselves but at the same time trying to maintain the focus of the research. Meanwhile, the researcher had information available to signpost women if they were in need of any support.

Once the interview time and date were confirmed, most participants stuck to it, each interview was about 60 to 75 minutes. However, there were participants that had to cancel and rearrange. The researcher allowed for flexibility on interview times, some of the interviews took place during daytime hours and some were late in the evening. The new born children were present in the second and third interviews. Their presence did not cause major interruptions to the interviews, some mothers would feed their child and continue with the interview discussion, and some would ask to be excused while they fed their child. The researcher encouraged participants to do what they would like and not feel restricted; some mothers answered phone calls or the door, made themselves something to eat or the baby a bottle. There were times when some women had to answer to their husband; the researcher acknowledged the element of segregation within Islamic culture, whereby it is not common for some, for a man to be present in women's sitting. Therefore, the researcher tried to arrange the interview for a time when the husband was not present, to respect their space within their own homes. There were

two occasions when the husband arrived home near the end of the interview, the researcher paused the audio recorder and gave space for the women to see to their husbands. Once they returned, the researcher checked if they were happy to continue the interview, and they were. The researcher would not continue for long and she would quickly bring the interview to a close.

4.4 Phase Two

This phase highlights the triangulation approach of this study; after the completion of phase one the research explored the identified themes further in phase two and explored other emerging themes with Muslim mothers that have experienced childbirth in the UK in the last three years. This approach was key in developing a comprehensive understanding of the study's phenomenon (Bekhet and Zauszniewski, 2012), it was particularly useful as it broadened the researcher's insight into the common aspects and the possible different aspects underlying the motherhood experiences of Muslim women. The advantage of this approach is that it also provides confirmation of findings (Bekhet and Zauszniewski, 2012); this enabled the researcher to explore the motherhood experience through the collective experiences of Muslim mothers. Five focus group discussions were held in this phase with a minimum of four participants and a maximum of 12 in each. Focus groups make use of group dynamics for discussions that involve open-ended questions, to gain ideas and an insight to look at research topics in greater depth and using the terms used by participants (Bowling, 2002). This dynamic group interaction enables the researcher to generate rich information on collective perspectives and the meanings that accompany these perspectives (Gill et al., 2008). This is a method that is very flexible, which enabled the researcher to initially present the four main themes identified in phase one; perceptions of motherhood, information needs and service awareness, religious practices, and perceptions of healthcare professionals and seeking support, to gain insight into the mother's shared understanding of the motherhood. Focus groups are particularly beneficial as they produce greater understanding of the experiences and beliefs of a group of individuals, as well as illuminating the differences in perspective between groups of individuals (Rabiee, 2004).

For each theme, the researcher asked open-ended questions such as 'what are your thoughts on the information provided in antenatal care?' This gave room for the mothers to comment and share their opinions with each other more openly. Blackburn and Stokes (2000) highlighted that individuals are more likely to be more open with their views, feelings, and experiences in a group of peers rather than on a one-to-one basis with an interviewer because soon they realize that the things they say are not necessarily being identified with them. Moreover, this approach allowed the researcher to test out how widely these themes were shared and the collective experiences of Muslim mothers.

4.4.1 Sampling

The population for this phase of the study was Muslim mothers who had experienced childbirth in the last three years, accessed UK maternity services, were above the age of 18 years old, and could speak English. Individuals were excluded if they did not meet these criteria. The researcher decided on networking through existing groups and certain gatekeepers as a sampling approach. The researcher had awareness of and had easy access to the local Muslim women's groups such as social circles, mother and toddler and breastfeeding groups. The researcher contacted the individuals that run these groups, to help the researcher gain full access to the group of interest.

The ONS (2001) highlights that 69% of working-age Muslim women are economically inactive, the study's participants closely reflects this, whereby 13 participants out of 24 were economically inactive. The average age of Muslims in the UK is 28 years old; participants in this study do not quite reflect the general population as the majority were above average. In terms of education, the percentage of Muslims (over 16) with 'Degree level and above' qualifications is similar to the general population (24% and 27% respectively), whereby 43% of Muslims full-time students are females (MCB, 2011). The majority of participants in this study are highly educated this may have also a relation to some participants being born in the UK (90.1% of Liverpool residents were born in the UK). Where Muslims who were born in the UK are twice more likely than Muslims born elsewhere to have a degree or equivalent qualification at any age (ONS, 2001).

4.4 Table 1: Overview of the Muslim mothers who participated in the focus groups (table created by researcher).

Age	Ethnicity	Birth place	Time lived in the UK	Education level	Marital status	Number of children	Were all births in UK	Occupation
47	Pakistani	Bangladesh	45yrs	University	Divorced	3	Yes	Teacher
33	British	UK	N/A	University	Married	3	Yes	Housewife
29	Black African	Saudi Arabia	23yrs	University	Married	2	No	Housewife
30	Mixed Iranian/English	UK	N/A	University	Married	4	Yes	Housewife
30	Pakistani	Pakistan	5yrs	University	Married	1	Yes	Doctor
28	Pakistani	UK	N/A	University	Married	2	Yes	Pharmacist

32	Nigerian	Nigeria	9yrs	College	Married	4	No	Housewife
32	Somali	Somalia	25yrs	University	Married	4	Yes	Nurse
33	Somali	UK	N/A	College	Married	5	Yes	Public health
35	Somali	Somalia	25yrs	University	Married	5	Yes	Housewife
34	Somali	Somalia	19yrs	College	Married	7	Yes	Housewife
42	British	UK	N/A	University	Married	2	Yes	Self employed
24	Yemeni	UK	N/A	College	Married	1	Yes	Medical receptionist
43	Asian	UK	N/A	University	Divorced	3	Yes	Solicitor
31	British	UK	N/A	University	Divorced	1	Yes	Self employed
30	Somali	UK	N/A	University	Divorced	1	Yes	Healthcare
27	Somali	UK	N/A	University	Married	2	Yes	Legal co-ordinate
27	Somali	UK	N/A	University	Married	1	Yes	Housewife
19	Pakistani	UK	N/A	College	Married	1	Yes	Housewife
23	Yemeni	UK	N/A	University	Married	1	Yes	Housewife
42	Pakistani	UK	N/A	College	Married	4	Yes	Housewife
34	Pakistani	Pakistan	20yrs		Married	4	Yes	Housewife
48	British	UK	N/A	University	Married	5	No	Housewife
34	Yemeni	UK	N/A	College	Married	4	Yes	Housewife

The study conducted five focus groups with a total of 24 participants. The researcher gave room for each focus group to include a minimum of 4 participants and a maximum 12; a typical focus group is six to eight participants (Gill et al., 2008; Mack et al. 2005). There is a fear that over-recruiting can be difficult to manage and can cause some participants to feel that they have had insufficient opportunities to share their opinions with the rest of the group, and under-recruiting can also lead to limited discussions. However, this is not always the case, even though the group size is important to focus group research, interaction is essential for a successful focus group. Successful interaction between participants can make focus groups with as few as three and as many as 14 participants' successful (Gill et al., 2008).

4.4.2 Recruitment

Via an email to the Barakah group, the research invited Muslim mothers to attend a scheduled focus group that the research facilitated to take place within a local community centre. The researcher also approached mothers within the local mosque with an invitation to attend the focus groups discussion. Even though the mothers responded positively and agreed to attend the scheduled focus group, unfortunately, they did not attend. The researcher made a second attempt using the same approach to invite mothers to attend another scheduled focus group discussion, and likewise the outcome was the same. Therefore, the researcher sought to reach Muslim mothers through different avenues such as Muslim women social circles, Muslim mother and toddler groups and a Muslim Sisters breastfeeding group. These were groups lead by local Muslim mothers in their own homes, with an aim of providing social events, advice and support for each other over motherhood and other issues.

The researcher first approached the key organizers for each group and introduced the study. The researcher attended the Muslim mother and toddler groups and the Muslim Sisters breastfeeding group twice; the first visit was to introduce herself and the study, this gave mothers an opportunity to ask and express their interest in the study. The mothers were happy for the researcher to carry out the focus group discussion in the following group meeting, which is normally every fortnight. Seven mothers from the mother and toddler group attended the focus group and no women were excluded as they all met the research criteria. As for the Muslim Sisters breastfeeding group, the expected number to attend the focus group was six, but only four women attended.

Another avenue that the research sought to approach Muslim mothers were through social circles; three other focus groups were organized through Muslim mothers' social circles; these circles are normally made up of a group of mothers who are close friends. The researcher contacted certain mothers from three separate groups; the researcher asked the mothers if she could join them in their gatherings to introduce the research. The researcher join the mothers and introduce herself and the research, giving women the opportunity to ask questions and express their interest. The researcher got the chance to return and carry out three separate focus groups; five mothers attended the first group and four mothers in each of the other two groups.

No focus groups were carried out prior to receiving informed written consent from all mothers. Miles & Huberman (1994) highlights that the data collected needs to occur from a natural setting to give a strong insight as to what 'real life' is to be. The participants attended their gathering as normal, at their regular place and time.

4.4.3 Data collection

Focus groups are more than a method that collects similar data from a number of participants at the same time. Focus groups were first used in the 1940s in the field of marketing and their success in this field helped them to gain interest from other research fields (Dilshad & Latif, 2013; Gill et al., 2008). Especially in the field of health research, Rabiee (2004) highlighted that focus groups have been a popular tool that helped in involving health services users in the process of the development of effective health services, such as care management and strategy development, needs assessment, participatory planning and evaluation of health promotion. Moreover, the ability of focus groups to explore what individuals believe and why they behave in such a manner, gives them the ability to explore sensitive topics within certain groups (Green and Thorogood, 2004). Focus groups are commonly used with marginalized segments of the society such as minorities to give them the opportunity to express their specific needs (Dilshad & Latif, 2013). Denzin & Lincoln (2000) used focus groups to give a voice to women of colour who had been silent for cultural reasons. This was also important for this research, the experiences of Muslim women are under researched within the health literature, this study gives Muslim women a voice to express their experiences and needs to bring about knowledge and understanding through their own accounts.

A distinguishing feature of focus groups is their ability to bring together a group of individuals with similar characteristics to discuss a given topic presented by the researcher in a more natural setting. Casey and Krueger (2000) explain that in real life, individuals usually influence others and are influenced by others, and focus group are more useful in facilitating this than one-to-one interviews. This group interaction is more valuable than gathering individuals' views (Dilshad & Latif, 2013). The nature of focus groups helped this research bring together Muslim mothers to explore their attitudes and perceptions toward motherhood.

On more of a specific note, this research method was particularly useful in clarifying, extending and challenging data collected in Phase one of the research (Gill et al., 2008). Focus groups are used as an individual method in research but they also can be an essential part of a more complex research design to aid in enhancing the findings of other methods, whereby they are used in developing research hypotheses, challenging research approaches and understanding findings obtained by other methods (Dilshad & Latif, 2013). The researcher presented the interview findings in the focus groups and this generated more discussion and new insights.

Each focus group varied in size, the smallest group had four participants and the largest group had seven participants. To generate rich data from group interactions, participants within a focus group have to be willing to engage fully in the discussion. The level of participants' engagement within a group discussion may depend on whether it is a homogeneous (same societal and cultural background) or

heterogeneous (stranger group) group. There is a difference in opinion in regards to this, some advocate for the use of heterogeneous groups as they believe that participants who are strangers to each other will find themselves able to express themselves freely without fear of repercussion (Gill et al., 2008). Others argue that homogeneous groups ensure open and honest discussion amongst participants in the group, the familiarity amongst the participants gives them the ability to challenge each other comfortably (Gill et al., 2008; Bowling, 2002; Krueger, 1998; Morgan, 1997). This study followed the latter argument that homogenous groups ensure open and honest discussion amongst participants and used pre-existing groups from within the local Muslim community.

The four themes recognized in Phase one were used to guide the focus group discussions; 1) perceptions of motherhood, 2) information needs and service awareness, 3) religious practices, 4) Muslim women perceptions of healthcare professionals and seeking support. The researcher used focus questions to explore each theme further, for example 'Can you tell me about the religious practices that you do during pregnancy/labour/after birth?', and 'Can you tell me where you sought the information you needed?' The researcher then followed the focus questions with probe questions such as 'Can you explain more about this practice? What do you mean by...? Was that the same to your previous pregnancy/labour/child?' These questions encouraged the mothers to explain and express their perceptions more openly.

The focus groups were semi-structured and did not all follow the same sequence. The researcher did not want to force the discussion but rather allowed the discussions to take on a life of their own while maintaining the focus to the research topic; the participants determined the order in which the themes were explored. At the start of some focus groups, some mothers did not wait for the questions to be asked by the researcher, rather they started to talk to each other about their maternity experience; for example, they started saying 'You know when I had my first child...', 'You know being a mother has changed me.' The researcher allowed for this as this was positive interaction between the participants, and the mothers were confident with each other, which made them ask each other questions like 'why did you not do ...?', 'how did you come about doing it?', 'the midwife I had was the same throughout, what about you?' The researcher allowed the discussion to take its natural flow with some control to keep the discussion focused. The researcher would listen to the mothers discuss a certain topic and take the opportunity to probe the topic further, by asking questions without expressing her own view on the topic. This was to avoid giving the participants prompts as to what to say, and allowing the mothers to be open and honest about their own experiences (Gill et al., 2008). To maintain this the researcher was in constant reflection to understand her own preconceptions, attitudes and religious and social background. This helped the researcher acknowledge how she might influence the collection of the data, particularly as the researcher shared the religious background as the mothers. Sharing the religious background of the participants made it easy for them to talk to the researcher and reduced the risk of

misunderstanding; the researcher was familiar with the Islamic and cultural terms used by the participants (Dilshad & Latif, 2013). The researcher was aware that sharing the same background as the participants may create some blind spots, where the researcher may not see perspectives other than the ones she is familiar with. However, the researcher believes she did not experience any, the researcher shared the same religion but did not share the experiences of motherhood or religious practices related to motherhood, this helped the researcher be open-minded throughout this learning process.

The main drawback with focus groups is that the data cannot be generalized amongst an entire population. A group can be dominated by one person or by participants and moderator (Denzin and Lincoln, 2000). The researcher tried to overcome this limitation by involving all the mothers in the group discussion and encouraging them to share their views on the topics discussed. For example, the researcher gave sufficient time for a participant to speak their views, then redirected the question to other participants by asking questions such as ‘Was this the same for you?’ or ‘What do you think?’ or ‘What about your experience, how was it?’ This gave each mother the opportunity to share her own views with the rest of the group and did not allow any one participant to dominate.

Each focus group discussion was audio-recorded, with each discussion lasting approximately 90 minutes. Green and Thorogood (2004) noted that a typical focus group lasts between one to two hours. The focus groups took place in the homes of the mothers, where, in some cases, young children were present. This posed a challenge, as it was difficult maintaining participants’ full concentration at all times, as some mothers had to respond to their children. The researcher was tolerant and happy of interruptions and welcoming mothers back into the group. She was tolerant to interruptions by the young children and allowed the mothers to not feel restricted and see to their children, the researcher continued listening to the mothers as they responded to their children. This helped the mother to stay engaged and settled her child quickly to be able to get back into following the conversation. Most interruptions made by the children were not enormous, the child would say something such as ‘mummy look at me’ the mother would quickly acknowledge the child and continue with the group discussion.

However, there were a few times when mothers had to leave the group to see to their child. The researcher maintained the flow of the conversation by directing the questions to other participants while the mother was away; the researcher said things such as ‘you know like (name) was saying ..., what do you think of that?’ which helped in allowing them to relate to and pick up on points made by other mothers. Once back, the researcher integrated mother back into the group, using phrases such as ‘The ladies were just saying... what is your take on that?’ and this helped the mother feel confident that she had not missed out on the group discussion. Following every focus group except the last, the researcher took time to reflect on the data collected and how it was collected, which helped the researcher think further on topics that might need to be explored or addressed in the following focus group (Mark et al., 2005).

4.5 Phase Three

Finally, phase of the triangulation approach used one-to-one semi-structured interviews to explore healthcare professionals' experiences of providing care for Muslim women. The researcher interviewed 12 healthcare professionals with a wide range of experiences from a large maternity service provider located in Merseyside. This was essential for the development of the research, it helped decrease the weakness of individual method and strengthen the outcome of the study (Bekhet and Zauszniewski, 2012). Taken into account the experiences of healthcare professionals when providing care for Muslim women enhanced the understanding of the study's phenomenon, where it brought about different perspectives and minimizing researcher's bias to a particular cohort.

Healthcare professionals can play a major role in the overall motherhood experience. McFadden et al. (2013) indicate that women making informed decisions about their care and having their individual needs met are restricted by the stereotyping and assumptions expressed by the practitioners. Judging people of other cultures on the basis of what is 'normal' or 'appropriate' to us can lead to misunderstandings, serious misjudgements and failures of healthcare services in addressing the needs of the community. Therefore, semi-structured interviews helped to capture the ways in which healthcare professionals interpreted events, experiences and relationships with Muslim women. In this study, semi-structured interviews were used to stimulate conversation about healthcare professionals' experiences of providing care for Muslim women.

It was important to include Muslim healthcare professionals in this study since they are likely to act as cultural brokers for Muslim women while using the maternity services. Cultural brokers act as a go-between and advocate on behalf of another individual or group of differing cultural backgrounds for the purpose of reducing conflict or producing change (MacLachlan, 2006; Jezewski & Sotnik, 2001). Five of the twelve health professionals interviewed were Muslims.

4.5.1 Sampling

In this phase, the researcher used both purposeful sampling and snowball sampling. The researcher sought to involve different healthcare professionals to help produce a vivid picture of maternity care for Muslim women. Muslim women mentioned several practitioners that they commonly encountered, such as midwives, nurse-gynaecologists, breastfeeding infant support team, sonographers, general practitioners and health visitors. The researcher initially aimed to interview 10 healthcare professionals, however as snowball sampling continued she decided to approach individuals until a saturation point had been reached (Dawson, 2009). After the 10th interview, the researcher was not obtaining additional new information, so the researcher decided to stop at 12 interviews.

4.5 Table 1: Overview of the healthcare professionals who participated in the semi-structured interviews
(table created by researcher).

Healthcare Professional- No	Healthcare professional current role	Provided care outside of the UK	Years of providing care; more (<) or less (>) than 10 years	Muslim healthcare professional
HP-1	Community and Link clinic midwife	Yes	>10	No
HP-2	Community and Link clinic midwife	Yes	>10	No
HP-3	Community and Link clinic midwife	No	>10	Yes
HP-4	Link clinic midwife	No	>10	No
HP-5	Sonographer	No	>10	No
HP-6	Community midwife	No	>10	Yes
HP-7	Nurse - gynaecology unit for emergencies	No	<10	Yes
HP-8	Nurse - gynaecology unit for emergencies	No	<10	Yes
HP-9	Midwife - labour unit	No	>10	Yes
HP-10	Midwife and breastfeeding infant support	No	>10	No
HP-11	Breastfeeding peer support worker	No	<10	No
HP-12	Breastfeeding peer support worker	No	<10	No

4.5.2 Recruitment

The researcher is employed as an interpreter within the maternity services, working alongside healthcare professionals within this service for eight years. However, the nature of snowball sampling is that the researcher recognise key contact that will help in identifying potential participants. The researcher was aware of five potential participants with whom she worked with; these five potential participants were key contacts for the researcher to identify other potential participants. The five participants were approach directly and through informal chats, the study was introduced and information sheet were provided with contact details with the request to contact the researcher within one week if they were interested in taking part in the research. All five healthcare professionals showed interest in taking part in the study and all five were interviewed.

Mack et al., (2005) suggest that the consultation of local active people within the population of the study's interest would help in giving the researcher ideas in how to access and approach the group of interest. On completing each interview with the five initial participants, the researcher enquired whether

any of the participants were aware of any other healthcare professional who might be interested in participating in this study. The five participants responded to this request really well and personally introduced the researcher to other potential participants whom she has not had contact or worked with before. Seven more participants were recruited this way. The researcher strove to include a range of the healthcare professionals; however, some were difficult to reach without further key contacts, such as GPs.

4.5.3 Data collection

One-to-one qualitative semi-structured interviews were used to explore the experiences of the care providers. Prior to the interviews the researcher prepared an interview guide taking into account the wider literature and the initial analysis from Phases one and two. The researcher took into account topics such as awareness of other cultures and religious beliefs, recognition of Muslim women and their specific needs, cultural competency, overview of good practice and training availability regarding care for Muslim women. A significant theme that was common in both previous phases was religious practices; both women from phase one and two mentioned the different religious practices that they practiced during their maternity journey. The researcher was interested to explore healthcare professionals' awareness of these practices and how they deal with them. Therefore, the researcher used open-ended questions to elicit open responses; questions such as 'what do you know of Muslim women's religious practices?' and 'what do you think of women fasting during their maternity journey?' However, before asking such questions it was important to make participants feel at ease and build up their confidence. The interview guide included simple questions such as 'How long have you been working as a midwife?' and 'Have you had any experience working outside of the UK?' to develop the interview further (Gill et al., 2008) (refer to appendix 6).

The researcher familiarised herself with the interview guide before every interview to make the process of the interview appear more natural and less rehearsed. This was also supported by the rapport the researcher already had with the participants prior to the interviews – her role as an interpreter working alongside healthcare professionals helped in making the participants feel confident when sharing their experiences. The researcher gave the participants the freedom to choose the time and the location that best suited them, with a request that the place chosen did not have much in the way of distraction bearing in mind that the interview would be audio recorded. The researcher appreciated the demanding nature of the participants' role within the service and avoided making the participants feel uncomfortable in having to make extra time to travel to an unfamiliar place.

Three participants choose for the interview to take place during their lunch hour, one interview took place in a quiet area in the staff lunch area and the other two took place in the staff room while it was free. Seven participants arranged for their interviews to take place once their work shift was complete

or during the free time they had between their work duties. These interviews took place in private offices or in meeting rooms. The final two interviews took place in a local café shop chosen by the participants. The researcher did not have much control over the environment in which the interviews took place, however they were environments that participants were familiar with, which helped in making them feel relaxed leading to a more productive interviews (Gill et al., 2008). Every interview was audio recorded and lasted approximately 60 minutes.

At the end of each interview, the researcher thanked participants for their time and asked if there was anything they would like to add. This gave them the opportunity to raise issues that they saw as important but which had not been adequately covered during the interview. Gill et al. (2008) highlight that doing this often leads to the discovery of new and unexpected information; this did not happen here rather women restressed on points discussed previously that they believed were significant to their motherhood experience. The researcher took time at the end of each interview to reflect on the data collected, and then compared this data set with the others from Phases one and two.

Researcher's additional notes: The initial plan for the study's methodology that received ethical approval was to include a phase four, which is a feedback focus group with healthcare professionals who participated in the study's phase three. Phase four was an opportunity for healthcare professionals to receive feedback of the findings and discuss further implication. However, the researcher recognized the challenge in bringing together a multidisciplinary team of healthcare professionals with a busy and various work schedule for an hour's group discussion. The researcher recognized this challenge during the data collection of phase three, were contacting, arranging and rearranging suitable interview times for the healthcare professionals was time consuming and a long widened process. The researcher had to be very flexible with times, which required researcher to schedule interviews during healthcare professionals work hours, lunch break, after work hours/evenings in work place or cafe and weekends. Some interview took more than four weeks to arranging. Therefore, the research decided to take a different approach that still gives the health care professionals the opportunity to feedback on the findings. During phase three, the researcher used the interviews to explore healthcare professionals' experiences when caring for Muslim women and followed by a brief discussion on the four main themes that emerged from phase one & two. The healthcare professionals were able to discuss and give their thoughts on the main themes, for example, they discussed the religious practice highlighted in phase one & two. Discussing whether they have encountered such practices and how they managed to deal with them. This did not require any changes to the study's ethical approval.

The researcher also saw the importance of feedback for learning and increasing awareness amongst healthcare professionals, the researcher presented in conferences such as the 7th Annual University

of Worcester Birth Conference and Perceptions of pregnancy Conference at University of Hertfordshire to disseminate the findings of this study.

4.6 Data analysis methodology

Qualitative data consists of mainly words, not numbers, which will have order and understanding once analysed. This is why it is important that the researcher approaches the data using a systematic process that will help in generating an understanding of the participants' experiences. There are many data analysis approaches but the overall aim of any approach is always to provide an understanding through the researcher's interpretation of the data. This study used an approach known as thematic analysis in all three phases; Braun & Clark (2006) describe this approach as a process that aids the researcher to identify, analyse and report patterns (themes) within data sets. The fact that thematic analysis is not specific in representing a research design makes it an approach that is compatible with many research designs and theoretically flexible in the process of analysing qualitative research (Percy et al., 2015; Cooper and Endacott, 2007). The compatibility and flexibility in this approach enabled the research to go beyond counting of words or phrases and focus on recognizing and describing both hidden and explicit themes within the data set. Percy et al. (2015) consider thematic analysis as a generic approach that is able to both reflect reality and unravel the surface of reality as reported by participants and create the basis for various qualitative interpretations. An attractive feature of this approach is that it enabled the researcher to extract information to define the relationship between variables and to compare different sets of data that relate to different situations in the same study (Alhojailan, 2012). This approach was specifically appropriate for the study's triangulation method, it facilitated the identification and use of emerging themes which were needed to ensure that Muslim women's experiences, meanings and attitudes of the transition to motherhood were explored.

Thematic analysis is commonly used within qualitative research, yet there is no clear agreement in how this approach is applied. In terms of the actual process for coding the themes, thematic analysis is very similar to grounded theory. Yet there are distinguished features that gives each approach its uniqueness; grounded theory is unique in that it starts the process of data collection and data analysis at the same time, which means that any further data collected is grounded in what has been previously analysed (Alhojailan, 2012). This was unsuitable for this research design, the researcher sought to compare the data collected in the early phase of the research with the data collected in the later phases of the research. In addition, the researcher used pre-determined cohorts for each phase, which is not suitable for the grounded theory approach as it depends on theoretical sampling for its analysis, which is determined during data collection.

The researcher used Braun & Clark (2006) and Percy et al. (2015) as a guide to forming a systematic approach to handling the raw data and then used their own approach to analysing the data. The analysis of the data started at the initial phases of the research.

4.6.1 Method of managing and analysing data

Following each interview and focus group, the researcher transcribed the audio recordings into written words, the transcription of the data from verbal sounds to written words may appear as a simple mechanical act, but in fact it is an important interpretive act that helps to generate meanings (Braun & Clark, 2006). The researcher used this transcription process to help inform the early analysis of the data; the researcher started to read through the transcript highlighting any sentences, phases or paragraphs that appeared to be meaningful and relevant to the research question.

The researcher used a manual method (using Excel and Word processes) to manage and analyse all the study's data. Both traditional methods and software are used in qualitative analysis, depending on the preference of the research either can be used (Alhojailan, 2012). NVivo is a software package that this research might have found a useful tool to use, it is a tool that aids in organizing and grouping the data into specific themes. This tool is recommended for use by qualitative researchers as it is suggested that it helps to reduce a great number of manual tasks and gives the researcher more time to discover tendencies, recognize themes and derive conclusions (Hilal and Alabri, 2013).

Initially, after attending day courses on data analysis, based on the volume of the data the researcher decided to use NVivo and see if it was appropriately user-friendly. The researcher organized the audio files and transcripts onto this software, and started to code and organize the data into themes (nodes). The software search facility is seen as one of NVivo's main assets for facilitating interrogation of the data. This search is reliable when searching for attributes, for example, 'how many women identified a child as a gift from God?' This is good in gaining an overall impression of the data. However, in interrogating content that is more detailed it is more difficult, this is because multiple synonyms would lead to partial retrieval of information. For example, although it is possible to search for particular terms, the way in which participants expressed similar thoughts in completely different ways make it difficult to recover all responses using the search facility on NVivo. An example is a researcher search (within the node 'Antenatal-perceptions' which was about women's views of their antenatal care) for women who have expressed negative reports about the way in which the care was delivered. For example, the researcher searched for the words "unhappy" or "negative" which only returned as two women, but when the researcher carried out a manual search she (or they) found more examples of this attitude, expressed in terms such as "clinical care", "routine", "not enough time", "going through the notions", "regular checks", "not about the woman" "lack of empathy". The search facility is good to help a

researcher carry out quick searches of a particular type but the researcher felt that she had to do a manual searches so that the data is thoroughly interrogated.

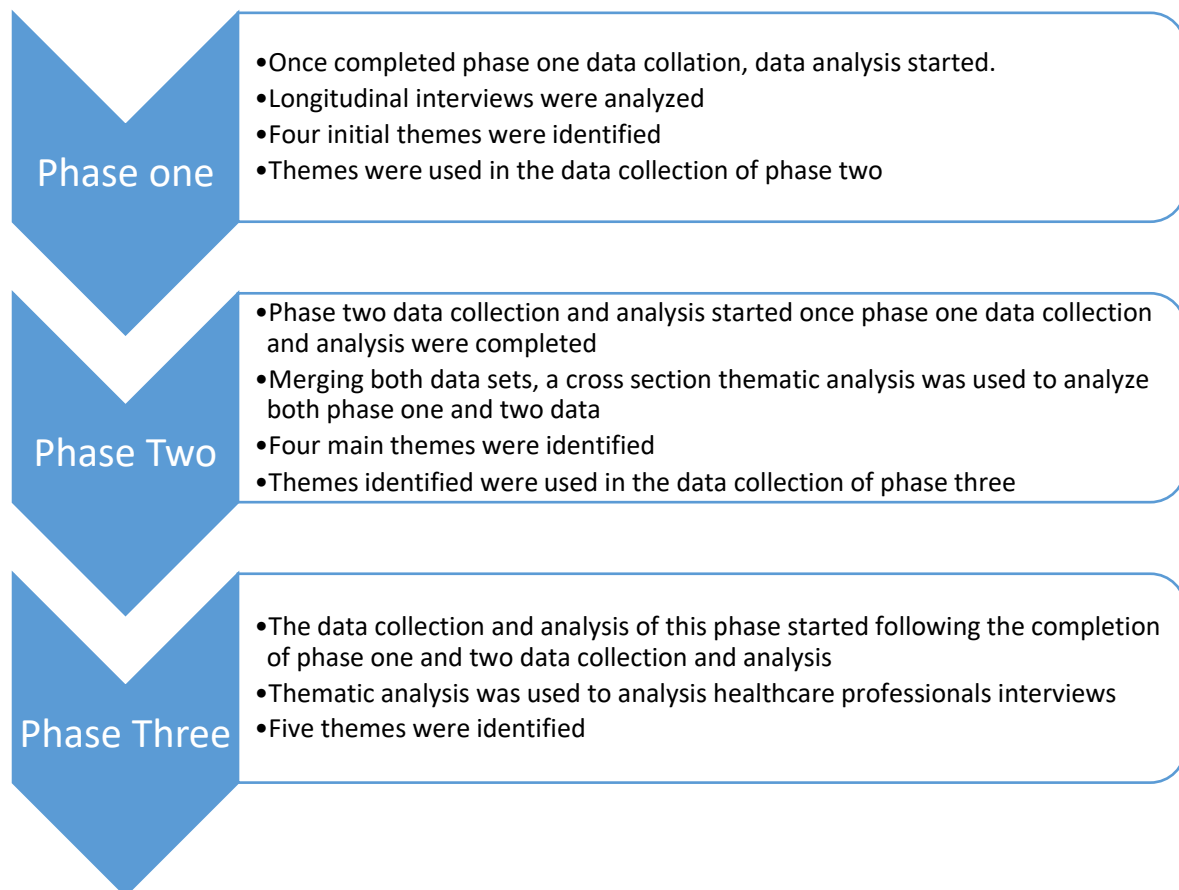
The researcher's manual search would not be added to the nodes automatically; the researcher would have to add the data individually to the node. Therefore, in terms of searching through the thematic ideas themselves to gain a deep understanding of the data, NVivo is less useful because of the type of search it is capable of. Moreover, NVivo is a software program that is often updated, (it is now on version 11) and like any other software it is prone to systematic failures. The researcher experienced the software crashing on two different occasions, which led to the loss of a great amount of data that could not be recovered. This was time consuming for the researcher and doubled the size of the task the researcher had to do, she had to start the entire process all over again. It is suggested that in order to achieve the best results it is important that the researchers do not reify either electronic or manual methods and instead combine the best features of each (Welsh, 2002). NVivo is a data management software package and not data analysis software, such software may do little to enhance the quality and value of the findings produced. It is unlike software packages for quantitative analysis that use methods of aggregation, quantification and categorisation to arrive at a scientific truth; this is useful for quantitative research because there is a congruence between the underlying philosophies of the research and its analysis and the computer technology employed to assist with (Roberts & Wilson, 2002).

Qualitative research looks for uncovering meaning as they are apparent to each participant; the data is derived from language and allows for the detailed exploration of feelings, attitudes and the subjective understanding a participant had of a certain social situation at a particular point in time (Roberts & Wilson, 2002). Therefore, the data can be fuzzy with slippery boundaries between meanings, the researcher needs to have a good understanding of the social world and this can be achieved by understanding the social phenomena by accessing the meaning as it existed for the participants (Roberts & Wilson, 2002). Roberts & Wilson (2002) highlight that computers do not and cannot analyse data, but only the analyst, and no tool should replace the researcher's capacity to think through the data and develop his or her emergent conclusions (Baugh et al., 2010). The researcher found the use of a manual method using computer technology, Excel and Word processes was sufficient for this research to manage the data and aid the process of the data analysis. The Word process was used to read through, code, highlight and pull out what was meaningful in the raw data and the Excel program was used to organize the list of possible ideas (copy paste), themes and sub-themes, which reflected nodes used in NVivo (refer to appendix 7). The researcher kept memos that captured thoughts and perceptions in a field diary, making notes of participants' behavioural characteristics and non-verbal communications, which were then linked to the appropriate transcript to enrich the data and place data into context. Baugh et al., (2010) highlight that as concepts, patterns, and themes begin to emerge from the data analysis and interpretation, memos allow the researcher to capture these thoughts as well and link them to appropriate encoding levels.

4.6.2 Identifying themes

This manual process requires the researcher to manage and analysis the data early to avoid missing critical evidence and provide trustworthiness in the process (Baugh et al., 2010). The researcher did this as the study's triangulation process of data collection required it.

4.6.2 Figure 1: Process of data analysis



The researcher read and reread through the transcripts thoroughly before generating initial ideas and interpretations. This gave the researcher the opportunity to immerse and familiarize herself with the data, which helped the researcher to reflect on the participants' experiences. For each interview and focus group the researcher made notes of certain points that needed to be explored further, highlighting what was meaningful and relevant to the research. Braun & Clark (2006) said that rereading the data at least once would help in shaping the ideas and the identification of possible themes; revisiting data and exploring the initial ideas helped in identifying clear possible patterns that are relevant to the research question. It also gave the researcher time to give full and equal attention to each data set, which prevented the researcher making hasty conclusions. The advantage of this initial data analysis helped the researcher live the experiences with the women as they went through their journey, giving the researcher deeper understanding about how the journey unfolded for these women.

On the completion of all the data collection of each phase, the highlighted data extracts were reviewed to assure that they related to the research question because some data may be interesting but not relevant to the research question, any unrelated highlighted data was eliminated (Percy et al., 2015). The researcher started to organise the data into potential themes, by starting to group similar sets of data that are connected to each theme (Percy et al., 2015; Braun & Clark, 2006). The researcher organized the data into themes, through this the researcher was able to place data that corresponds within a specific recognized theme. She placed all the patterns that did not relate to the themes under a separate category called 'unrelated patterns' to allow for investigation later.

Specifically, for phase one, the initial themes that emerged were explored further in phase two. The researcher analysed phase two, exploring patterns with an open mind and exploring emerging new themes relevant to the research question. The initial themes from both data sets were then revisited as a whole. The researcher then started to think about the relationships between the themes, to identify the main overarching themes and sub-themes within them. Throughout this process the themes of all data sets shifted and changed, whereby some data moved to form main themes, some main themes became sub-themes and some data did not seem to fit. By reviewing the themes, the researcher managed to identify main themes that are rich and well supported by powerful extracts of data.

The researcher will present selected individual cases to tell the story of the motherhood journey, it was important to give the reader the chance to know the women more closely and have a complete picture of their unique journey unfolded as reported by them (chapter 5). The researcher will then present a detailed analysis for each individual theme that has been identified across the data set of phase one and two to present a contextual background to the essence of the study phenomenon (chapter 6). Finally, five main themes were identified in phase three, each theme is presented in detail with the use of direct quotes to elucidate each theme (chapter 7).

4.7 Reflexivity

An essential aspect in qualitative research is reflection on how the researcher's position influences the way in which the data is approached. This is commonly known as reflexivity, it is considered as a process whereby the researcher is in continuous reflection into how their own values, behaviours and perception shape the collection of data and analysis (Lambert et al., 2010). It is argued that reflexivity is important to the quality of the research, as it is a strategy that can be used to help the researcher understand and be sensitive to their own assumptions and biases that could influence the understanding of the research phenomena and the accurate descriptions of the meanings made by participants (Morrow, 2006). This strategy is particularly significant for this study's generic approach, since this approach

does not follow a set of theoretical foundations like those of an established qualitative research approach, Caelli et al., (2003) highlight that it is important for the researcher to describe their 'theoretical position'. This is the researcher's own motives and assumptions that brought them to the research topic. The researcher's theoretical position was highlighted within the literature review, emphasizing the importance of creating a deeper insight into Muslim women experiences, which will help in promoting the development of high quality competence care.

In this study, the researcher had both an insider and an outside role; which has its advantages. The researcher is a Muslim woman and part of the local Muslim community in Merseyside, giving her an insider position. The researcher is a practising Muslim, this gave her a deep awareness and understanding of the Islamic beliefs and practices. This helped the women feel that they were being understood and they could speak freely using Islamic terminology without causing any confusion, and be more open in giving great detail when reporting their religious practices. Yet if the researcher did not have this position, the participants might have been less open in discussing practices that to some might be considered as taboo. The women knew the researcher and took the research topic seriously, this was a topic that they were passionate to talk about and they saw the researcher as a means to promote and advocate better understanding of Muslim women.

The researcher was also an outsider because they had not experienced motherhood, yet this was still an advantage, as the women felt empowered by them being the experts in this motherhood journey and they had the opportunity to educate the researcher on this matter. This also helped build the researcher's curiosity in finding out more about the women's journeys, which often led to the expression of more detailed and in-depth information. The researcher being a student and not a healthcare professional allowed the Muslim women to express their attitudes and feelings toward the maternity care they experienced.

This was also the case with the healthcare professionals, that the researcher did not have a healthcare profession background gave room for the participants to express their experiences and attitudes in-depth. The researcher was also partially considering as an insider by healthcare professionals because of her role as an interpreter within the maternity services. Participants felt that the researcher understood some of the challenges mentioned when providing care, such as the work load, the nature of their job and barriers such as language barriers.

The researcher tried to avoid bias and imposing her own meanings onto the data during the data analysis by documenting the data collation journey as it proceeded. The researcher kept a research diary in which she used to express how she felt after the interviews and her initial interpretation of the data collected, this helped in maintaining reflectivity (McGhee et al., 2007). The researcher was in continuous reflection on the research process; by herself and with her supervisory team. The researcher read through literature such as '*The spirit catches you and you fall down*' (Fadiman, 1997) and '*Whose side*

are we on?’ (Becker, 1967) which helped develop researcher self-awareness and their own initial reactions to the research question. (McGhee et al., 2007).

4.7.1 Credibility

The generic qualitative research approach helped to ensure that the data collection and analysis approaches used best fitted the research question, which helped to enhance the credibility of the research findings. The fact that this research approach did not try to fit the research question to a particular philosophical position meant that the researcher stayed close to the data to ensure accuracy when describing Muslim women’s experiences and ensured that the interpretation of the data is transparent. As illustrated earlier the researcher took special consideration when obtaining the research sample, applying data collection and data analysis that these were consistent with the purpose of the study to assure research credibility (Smith et al., 2008).

4.7.2 Validity

The research triangulation method is now recognized as a research approach that helps to ensure the validity and reliability of the research findings (Everest, 2014). The use of a combination of data collection methods helped to create a better and deeper understanding of Muslim women’s motherhood experiences. This approach produces rich and fruitful data that helped the researcher answer many questions, which enhanced the exploration of the overall research questions beyond the surface features. Golafshani (2003) said that the engagement of multiple methods in qualitative research would lead to more valid, reliable and diverse construction of realities. The researcher searched for convergence among the data generated from the three research phases to form themes, this is accepted as a procedure of validity.

4.8: Summary

This chapter has shown the relevance of qualitative research in studying experiences, attitudes and behaviours of individuals. In addition, different approaches were discussed, as was the approach of generic research. It also showed that generic research was the most appropriate approach with which to create insight and understanding of the motherhood experiences of English speaking Muslim women in the UK.

Finally, this chapter addressed the methods used in each phase of the study, including sampling, recruitment of participants, interview technique, data analysis and ethical issues. The following three chapters will discuss the findings of the study.

Chapter Five: The Motherhood Journey of Muslim Women

5.1 Introduction

Motherhood is a complex event that unfolds differently for every woman (Redshaw et al., 2007). This study explored how this phenomenon unfolded with seven first time pregnant English-speaking Muslim women living in the North West of England: Noor, Hanan, Khadija, Sahar, Eman, Nesreen and Fatimah; and Samah who was in her second pregnancy but was experiencing pregnancy as a Muslim woman for the first time. Each women provided a unique narrative of how motherhood unfolded, creating deeper insight and understanding of the overall experiences, and specifically onto how religion influenced this journey. Even though Samah as a second time pregnancy mother may have experienced a different clinical care plan in comparison to first-time mothers, her narrative provided a deeper understanding into the unique role that religion has on this motherhood journey.

This chapter presents the motherhood journeys of four women that best exemplify the themes contained within all eight. The topics discussed in these four themes were also experienced by the other women, but to the individuals chosen here, demonstrate the issue most vividly.

5.1 Table 1: Brief overview of the eight Muslim women (table created by researcher)

Name: (Pseudonyms)	Access of Maternity services				
	Booking appointment (weeks of pregnancy)	Attended antenatal educational classes	Place of Labour	Breastfeeding Or Bottle feeding using formula milk	Support
Noor	8 weeks	Yes	MLU	Breast fed	Bambis ¹²
Hanan	15 weeks	No	MLU	Breast fed	Health care assistant
Samah	8 weeks	No	MLU	Breast fed	Friends, Bambis
Khadija	7 weeks	No	MLU	Both	Bambis

¹² Liverpool BAMBIS (Babies & Mums Breastfeeding Information and Support) are a team of peer supporters who offer breastfeeding support and information to pregnant women, breastfeeding mums & their families.

Sahar	7 weeks	Yes	MLU	Breast fed	Bambis
Eman	8 weeks	No	MLU	Both	Bambis
Nesreen	7 weeks	Yes	Delivery suite	Both	Bambis
Fatimah	27 weeks	No	MLU	Both	Midwife, Bambis

5.2 Noor's Motherhood Journey

Noor is a second generation British Indian, who recently moved to Liverpool with her husband. She was first interviewed at the 34th week of her pregnancy.

Attending local Islamic classes within local Muslim community centres, Noor managed to form her circle of friends that were her main support network throughout her pregnancy journey. Noor found that she was not alone during her pregnancy, the local Muslim community was prosperous Muslim women who were first time pregnant and mothers who have had multiple pregnancies.

'When I fell pregnant it was a boom in Liverpool, everyone was pregnant Alhamdulillah (praise be to Allah); you never felt alone. Every time you went to see someone, you can just talk about pregnancy, there was always someone that was pregnant there. So it was nice not just be on your own, you have someone else that is going through the same thing as you and like I said we have the 'WhatsApp'¹³ group with all the pregnant ladies in it so you can discuss all your aches and pains together - I can't imagine if you didn't have that it would be so isolating; you would feel like you are on your own, if you didn't have someone that you can turn to and say 'did you get this or get that' - so I think it added to my positive experience.'

At first Noor did not really understand what healthcare services were being provided to women who were pregnant. She was not registered with a local GP. Through Rufaidah's¹⁴ advice, Noor managed to register with a GP. At 8 weeks of her pregnancy, she had her first appointment¹⁵ with the community midwife at her local GP practice and continued to receive her care at the same place.

¹³ WhatsApp Messenger is a proprietary, cross-platform instant messaging subscription service for smartphones and selected feature phones that uses the internet for communication. In addition to text messaging, users can send each other images, video, and audio media messages, etc... Local Muslim Mothers in Liverpool created a WhatsApp group to help them stay in contact with each other and share information.

¹⁴ Rufaidah is a local Muslim midwife who is a very wellknown healthcare professional within the local Muslim community- often approached by many Muslim women for advice and sign posting.

¹⁵ The booking appointment is one of the most important appointments women have when they are pregnant, as it is an opportunity for the midwife to find out all about the woman and her family, whilst at the same time giving her the most up to date advice regarding staying healthy whilst pregnant.

Noor did not always see the same midwife at her antenatal appointments, her first midwife went on maternity leave and was replaced by two other midwives. This was not an issue for Noor, she reported that her antenatal care had a clinical approach which she believed was good in giving her comfort during her pregnancy. In terms of emotional support, Noor felt that was lacking, which led Noor to seek other avenues for emotional support.

'I think because you have other avenues not everyone does, but I didn't feel like I needed any emotional support from them (the midwives). To me it was like a quick ten-minute appointment to see that everything was okay and then go home. So I never relied on them (midwives) for my whole pregnancy. Maybe if I didn't have a support system then I would have needed more from my midwife.'

Family and friends were key in terms of emotional support and other support, such as housekeeping, providing information on maternal health and religious practice, and advice on services available. It was common for local Muslim mothers to share their recent or current pregnancy experiences with each other, which Noor found as a great advantage.

Noor also noted that Rufaidah was more informative and had a greater influence on her in terms of decision making than her own community midwife. She felt that there were certain topics that her community midwife did not mention or discuss in detail, only if asked; such as deferred cord clamping, the content of vitamin K injections, and details of antenatal workshops or discussing birth plan in details.

'I think if I am being totally honest it is not something that they (midwives) would really bring up because some of them are quite controversial topics. So in fairness, I understand they only talk about it if you bring it up. So I don't have an issue at all, I am glad that they were open about it when I brought it up, but you can't really expect someone to go out of their professional circle and start talking about these things, only your friends would do that.'

Noor was not aware that there was a page in her hand held notes¹⁶ specified for her to write a birth plan¹⁷. Noor thought of religious practice that she would like to uphold during her labour, yet was not confident enough and somehow unsure if it was acceptable to discuss such practices with her midwife. She explained that her midwife vaguely discussed a birth plan, highlighting things such as type of pain relief and birthing pool. Women were generally encouraged to write a birth plan, yet Noor was not confident enough that midwives would acknowledge her birth plan at the time of her labour. She was anxious at first, but with Rufaidah's encouragement, she considered writing a birth plan.

¹⁶ Hand held notes: A record of the woman's pregnancy that contains all test results, scans and details of any problems they have had. Pregnant women are to keep them and advised to take them to any appointments they have so health professionals have quick access to medical notes and specific details for each woman.

¹⁷ Birth plan: A birth plan is a record of what the pregnant woman would like to happen during labour and after the birth. NHS Foundation Trust try to see all pregnant woman at around 36weeks of pregnancy to talk through their birth plan, covering topics such as place of birth, pain relief.

'Rufaidah being a midwife, she brought light to certain things that I wouldn't probably come across if it hadn't been for her.'

Noor was not enthusiastic and unsure about attending antenatal classes, but attended as she was keen for more information. She found that the classes were informative and covered important details that the midwife could not go through in short appointments.

'Before the workshop, I did not know much on what to expect from labour and the midwives in the appointments do not have the time to tell you everything because they have other things to do. I did not know what to expect, so I went to the birth class and after 2 hours, I came out and I knew exactly what I was going to do. That for me was the best and most successful session out of all the workshops.'

Rufaidah played a key role during Noor's labour, she made sure that Noor's birth plan was acknowledged and that she could perform the religious practices that she wished for, such as birth position, silence at birth, deferred cord clamping and modesty. There were certain religious practices that Noor did not mention in the birth plan and depended on her husband to do, such as the recitation of the Quran and supplications during labour, giving her dates to eat, and doing the *Adhan*¹⁸ and *Tahneek*¹⁹. Noor explained that her midwife would have acknowledged her needs if Rufaidah was not around. However, Rufaidah was a bonus during her birth, she focused on details of faith that the non-Muslim midwife would not have done.

'I think with Rufaidah being around helped a lot, she knew exactly what I wanted, I think if she was not there the midwife would have still respected what I wanted because she kept asking me throughout if there is anything I need. Rudaidah came a little later because she was not on duty that day. The midwives were really nice and respected my needs. But obviously because Rufaidah was there she was doing the little things- she had an audio player to put on Nasheeds²⁰ and things like that. I do not think another midwife would have done the spiritual side. So certain things like the position of labour other midwives would have been fine with but the finer details such as the religious stuff such as calling and chanting - I do not think they could have helped with.'

Noor stayed in hospital for an extra two days after having the baby, she was well enough to be discharged but she wished to stay longer to build her confidence that she and baby were well enough to go home. Her husband was able to attend a workshop on her behalf that covered different aspects of care for new-born babies, such as bathing, cot death and baby's temperature. The first week of the postnatal period Noor physically struggled, she felt that adapting to the changes was physically

¹⁸ *Adhan* is the first call for prayer and the second call for prayer is known as *Iqamah*. In the right ear of the new-born baby, the *Adhan* may be whispered, and in the left ear, the *Iqamah*.

¹⁹ *Tahneek* is the practice of small piece of softened date is gently rubbed into the child's upper palate.

²⁰ Nasheed "chants"; is Islamic vocal music that is either sung a cappella or accompanied by percussion instruments such as the daf (drum).

challenging. While at the hospital, Noor contacted Rufaidah first with her health concerns before directly approaching midwives at the hospital. Only through the encouragement of Rufaidah did she then approach the midwives at the hospital. Noor explained that she anticipated that following the birth everything would all be well, and did not anticipate that she might face any health issues.

'I was feeling light headed and one of the nurses said that I am feeling that because of my uterus contracting which was giving me the feeling like I was in labour. I asked 'can I have some pain killers' because the thought of going through labour at that moment was not good. I think everyone needs to be informed of that; once you have the baby you will not feel 100% right and you may feel like you have a ball in your stomach and you can't sit up straight and the bleeding is so heavy and you have that to deal with.'

Noor planned to breastfeed her child because it is religiously recommended and has health benefits for both mother and child. The first attempt of breastfeeding was difficult, although she had attended the breastfeeding workshop while pregnant. She felt that the workshop was helpful in terms of understanding the benefits of breastfeeding but not practical enough. She found it difficult to implement what she had learnt but not practised, this is why it was a great advantage to have the breastfeeding support group at the hospital. They gave her a lot of support, they supported her in her home and stayed in contact with her through telephone, sending her regular reminders through text messages.

'To be honest, the workshop was good in terms of providing information about breastfeeding, like the benefits of it all which does encourage you to breastfeed in that sense. But for me in terms of practice, when you are not yet going through it, you are not going to absorb it. However, they have the BAMBIS group coming in to show you at the time you need someone to show you again, because you do forget and you will not be able to recall what you learnt in a class that you did two months ago.'

Overall, Noor reported her motherhood experience was good and if there is one thing that she was not pleased about- it was one encounter that she had with the midwife. In this encounter, Noor felt that the midwife did not respect her choices and felt she was being forced to do something that she did not wish to do. Noor explained:

'If I was to mention a negative, it was the night when he was a little bit cold and they put him in the incubator just to warm him up. I remember one of the midwives that was on call that night saying that because he was in the incubator for a while, maybe we should give him some formula milk to warm him up a bit. I did not feel happy about this because I am breastfeeding and I would like to keep it exclusively breastfeeding, giving the fact that his temperature was going up and it was not declining. I felt it was like bullying tactics and she was really trying to force the formula milk on me to give my baby and she even brought a readymade bottle with her and she was saying 'no give him some formula you do not want him to end up in A&E'. I thought there is no need for that because his temperature was not declining and it was going up steadily, so I reached a part when I thought I was going to give in but

luckily my husband was there and he was sort of standing his ground. So I think that there was no need for that really and if the parents are happy to breastfeed, then you have to respect it and don't try to force formula milk on them.'

In the first ten days of Noor arriving home, she was visited by a midwife and health visitor at different stages of her postnatal period, then moved to a different city to stay at a family home.

Islamically it is an obligation for a baby boy to be circumcised; Noor found this challenging at first, she wanted her child to be circumcised in a place that is safe. She searched for NHS approved private circumcision clinics and depended on family recommendations. Noor did not feel confident enough to speak to any healthcare professional about this, she felt that it is a practice that attracts a lot of controversy in the Western world and they might not understand.

'I think we checked online because there are a few NHS approved clinics that do it, but not all of them are NHS approved. So we searched online and we didn't speak to any medical staff or midwives because I know there is a lot of controversy about it and it's something that you sort out yourself. I would have spoken to my GP but even then, I don't think I would have mentioned it; I would have just spoken to someone that is a Muslim and has possibly gone through it with their children.'

It was important for her to obey her religious obligation and to make sure that her child was safe. Noor believed that the NHS was the safe environment for her child, she felt that it would have been really helpful if Muslim women were to be given a leaflet that gives information about male circumcision on the NHS and a list of NHS accredited private clinics. This would have helped her feel at ease during her search and direct her to a safe environment for her child. She also believed that staff should be trained to acknowledge such religious practices.

'The NHS accredited circumcision clinics have certain policies like if anything would go wrong with the procedure then it would be their responsibility. We trust the NHS - they have guidelines, so I would rather do it like that. I actually did not know that there were NHS accredited private clinics until my husband mentioned it because he must have come across them online. It is a good idea to let the women know about the availability of NHS accredited circumcision clinics, through training the staff about Muslims who have baby boys that will go through circumcision, so you can recommend certain clinics.'

5.3 Hanan's Motherhood Journey

A first generation Yemeni, who migrated to the UK at the age of four with parents, Hanan considers the UK to be her second home, but she also keeps ties with her Yemeni heritage. Hanan recently got married in Yemen and became pregnant three months after her marriage. Hanan was not dramatically excited about her pregnancy at first because she was not yet established in her married life to have children. Yet she believed that she should not stop a blessing and gift from God.

'It was a shock, but then again I was not using contraception so I was not 100% surprised. So if [I] was to become pregnant, then thank God. It's a blessing and we are blessed and if I was to become pregnant after a year or two it would have been even better because we could settle our lives, organize work and do the things we need to do. So we were good either way, but as soon as I found out I was pregnant we were both overwhelmed and very happy and blessed.'

Hanan was a late booker²¹, she was in Yemen when she found out about her pregnancy and was there during the first trimester (12 weeks) of her pregnancy. She found out about her pregnancy when she was going to see a doctor at the hospital complaining of abdominal pain. The scan indicated that she was five weeks pregnant and had a 5cm cyst. This caused her many concerns; she was worried about her pregnancy but what made her more anxious was her lack of confidence with the healthcare she was receiving. She believed that the healthcare system in Yemen was not to a high standard in comparison to the NHS.

'I went to the hospital and they found out that I had a 5cm cyst which was quite big in the uterus, at this stage of pregnancy and that was giving me a lot of pressure and pain. I was just not ensured enough and comfortable with what the medics were saying over there, people say different things. So I had to spend three months on bed-rest, it was very hard. It is nice to have a healthcare system that you can trust because the healthcare over there is like a shop, you go in, you pay and you are out and people tell you different things and different prices. I wasn't assured in that way.'

Although Hanan had not experienced UK's maternity services, she built her expectations of the services through her university education and the experiences of family members who had used the services. She believed that the UK maternity services are well regulated. Throughout her stay in Yemen, she was not seen by a midwife - only doctors at hospitals and had no other checks or blood tests.

'I wanted to be reassured about everything, they do not do blood tests like they do here and they do not even check your blood pressure. So you just go in and say you want a pregnancy test and you are on the scan and that's it.'

Hanan was given the green light by doctors to travel when her cyst disappeared. On arriving to the UK, Hanan went directly to the A&E with a minor bleed. She wanted to make sure that her baby was well and she then contacted her GP to arrange for her first antenatal appointment.

'I went to A&E, and they checked everything and said that everything was fine with the baby and the bleeding was just the walls of your inside. I was reassured and I had a scan and then I had my midwife appointment. My doctor referred me to the antenatal care where I had my first midwife appointment in

²¹ Pregnant women are normally booked for the first midwife appointment before 12 weeks + 6 days of pregnancy. Late bookers are women who present for the first time after 12 weeks pregnancy.

the GP. I just went there to make sure that everything was ok with the bleeding, it was minor bleeding but I wanted to be reassured, just after I had that, I felt better.'

She then received regular antenatal checks and she was looked after by her community midwife who saw her every month. Hanan was pleased that she was able to contact her midwife by phone if needed and felt the attitude of the midwife was very positive in comparison to doctors' abroad. Hanan explained that if it had not been for the support of her family while she was abroad, she would have really struggled.

'I think the attitude of the midwife plays a good part in how you feel, she was always very positive and she would say that "you have a happy baby there and very active".'

Hanan was pleased with the antenatal care she received in the UK; yet she believed that the care provided had a more of a clinical approach. This is why she still relied on her family for support.

'The NHS will give you the facts and what is going on, like if there is something wrong with my blood pressure then NHS will give me that information, but how I feel - is what my family will help me with. The family will support me emotionally and the NHS will deliver with the medical facts.'

After this long journey of worry, Hanan was finally able to celebrate her pregnancy. She felt that she was blessed with a personal gift from God; to her, becoming a mother is one of the greatest gifts that anyone can be blessed with. She explained that her Islamic faith gives a very high status to a mother, which was uplifting and miraculous.

'I know everyone gets pregnant naturally but when it is you; I just felt that I was chosen, God just sent something to me, something amazing. I am feeling it now although I have not gone through the miraculous stage of holding my baby yet. Becoming a mother makes heaven under your feet, it's just too good. The honour, respect and the unconditional love that you will get and everything, it is a big thing in Islam. I think without my Islamic point of view, I must have thought this is too early and I wouldn't have been as happy as I am about my pregnancy, even with the complications that I had, it has always been like "wow", every day is amazing.'

Hanan went through other health challenges such as Carpal tunnel syndrome²², she found that her faith had strengthened during her pregnancy and if it had not been for her Islamic beliefs she would have struggled mentally.

'I think without my faith I would probably lose a lot of confidence; I would probably go through depression or something because of the things I went through. I experienced a lot of things in my pregnancy. I have talked about the first 3 months of my pregnancy and how I had that cyst issue and

²² Carpal tunnel syndrome is a relatively common condition that causes a tingling sensation, numbness and sometimes pain in the hand and fingers.

then I came here and I bleed during my travel. So I have been through a lot of ups and downs. Then I had that sciatic nerve pain nerve pain, which caused me not walk properly so I had to grab my leg, that was in the middle stage of pregnancy. Then Carpal tunnel syndrome, which makes your hands numb and you cannot sleep because of the extra fluid in your body. So I have had it all really but Alhamdulillah it is all good. I think if you have that belief that it is a miracle and it is amazing, you would just forget the pain. Like women in general we do just forget pain, once you feel a kick off the child, you just forget the pain because of the mother connection. My faith definitely plays a part in what I think. When I was younger I was not into my faith as much as I am now, I was always negative about life and about everything. So strengthening my faith made my mentality more positive towards any problems that I face and as you grow, you face more problems.'

Faith was also one of the main reasons for Hanan's breastfeeding, she felt that her Islamic knowledge of breastfeeding was sufficient and encouraging enough for her, and did not feel the need for breastfeeding workshops.

'They have breastfeeding classes but I think from my Islamic knowledge of breastfeeding, the Sunnah²³ and what is recommended, I think it is enough for me. From what I know, you are not just feeding your child, you are feeding your child love, mercy and you are feeding them the best of the best. If you do it for two years, it is the Sunnah and it is what the prophet recommended. So whatever is recommended in Islam is only good for me. It is good for my health and I know it reduces the risk of breast cancer if you breastfeed and you are feeding your baby the best. Also it is a form of contraception.'

The breastfeeding workshop was not the only workshop that Hanan did not attend; she did not find the need for her to attend any other antenatal educational workshops.

'I did not go to them because my partner is not here, there are a lot of workshops where you and your partner can attend and discuss your birth plan. I have family that have a lot of experience of birth, my sister who is like a midwife, she has attended so many births and she is very strong. I am very confident in her, so she is my birth partner. So I did not feel the need for more information, I think if my partner was here I would bring him with me so he is more alert, I would go for his sake.'

Hanan's water broke two days before her estimated delivery date, she had no sign of contractions but was still happy that things were progressing and labour would be soon. However, when she was seen at the hospital, she was told that her water loss can put the baby at risk of infection. She was given 24 hours' wait to allow labour to come about naturally or the next step would be an induced birth. At this point Hanan felt that she lost control of her labour.

²³ *Sunnah* is the verbally transmitted record of the teachings, deeds and sayings, silent permissions (or disapprovals) of the Islamic prophet Muhammad, as well as various reports about Muhammad's companions.

'So then the 24 hours passed and I went to get induced (12 hours on the gel) and then the whole thing started. They started the drip, then the midwife said to me 'be aware that the contraction with the drip would be a lot harder' and I was like 'Oh thank you', by her saying, it just did not help. My stress levels were so high and that could have played a part in the whole thing. I was in labour for almost two days; I read a lot about active labor, in which gravity plays a part, so I tried everything and then I got through it all - from 4-6 cm to 10cm. They said: now that you are 10 cm - push. I still did not get the urge to push because it was not natural. My mum said 'wait until it comes naturally from God and you will get the urge to push' but I did not get that, so I was forcing my body to push, when it did not want that. Just went through the dictating of the midwife for 1 hour and a half, like people push for 20 minutes max and I was very dehydrated and tired. So I was pushing but no progress. The doctor came in to examine me and said "the baby is too high, so we will take you to the theatre room". I was in the worst state ever, they gave me a needle to attempt forceps, but it was not doable and I was like "what the hell". I just wanted to die at that moment, it was really hard and then they just said emergency caesarean section, the baby was too far up and he was a big baby.'

Although Hanan was not too pleased with how her labour unfolded, she overcame it through the support of her family. On a positive note, Hanan felt proud of herself for breastfeeding her child after going through with a caesarean section. Like Noor, Hanan found breastfeeding challenging at first, she was struggling with the positioning and the baby latching onto the breasts. Hanan did not seek help from the healthcare professionals but continued trying on her own. She explained that if it was not for the healthcare assistant volunteering to give her support without her requesting it, she would have failed to breastfeed.

'She came to me and she was like "how are you feeding him?" and I said "I do not know", I was a first time mum and I was like - I want to breastfeed. That was my plan, even though I was so tired after the labour. She said: "I will put him on you" and she kind of forced it through, which was amazing and I am so thankful for that, she really helped me. I think if it was not for her, I would have seen my baby go through the stress of hunger and I would have ended up giving him a bottle and once the baby tastes the bottle they would only want the bottle.'

Hanan had family support and community support, but still felt that being a mother is a lot harder than what she had anticipated and the responsibility is far greater than what she had expected. It was very common for the majority of women to experience mood change after birth - commonly known as baby blues²⁴. Hanan mentioned that the recitation of the Quran, praying and reminding her of the rewards gained through this motherhood journey was an effective practice that helped to uplift her mood.

²⁴ Postnatal depression, commonly known as baby blues is thought to be linked to hormonal changes that happen during the week after giving birth. Symptoms can include: feeling emotional and irrational, bursting into tears for no apparent reason, feeling irritable or touchy and/or feeling depressed or anxious. It is thought to affect around

'I could not wait to be able to pray physically because I had the postnatal bleeding²⁵, I felt like I was being unthankful "why am I sad when I have this blessing in my hand?" So I read a lot of Quran and I played a recording of it while sleeping with my baby and just got through it that way, I think it helped me calm down and I think baby blues are physical and I used spirituality to help me out.'

Like Noor, Hanan wanted her boy to be circumcised early as it is religiously recommended, she relied on friends' recommendations to find a safe private circumcision clinic. She felt that if she never had her friends to signpost her to a clinic, it would have been very difficult and felt that NHS health services should provide more information.

'A friend of mine recommended a clinic in Manchester and we just took him there. I think healthcare professionals should acknowledge that you follow a certain religion and should provide you with more information on the matter. I had to put my trust on friends' recommendations, what if I did not have my friends and my family? I would not have known and I would have had to google it but there is positives and negatives about the internet.'

5.4 Khadija's Motherhood Journey

Khadija came to the UK as a teenager and learnt to adapt to the new ways of living. She attended college and university, which helped her learn English fluently as a third language. The majority of Khadija's family live outside the UK.

Khadija allowed things to take their natural processes and she believed that if she was to become pregnant she would notice. Khadija had been anaemic for a few years and suffered with symptoms such as dizziness, tiredness and irregular period cycle. So when she became pregnant she did not recognize her pregnancy like she planned, she related her feelings of dizziness, tiredness and nausea with her anaemia. Only after she had missed two periods and continued to feel nausea she decided to do a home pregnancy test, she was about 7 week pregnant.

'I did not know where to go from here, I have no experience, so I called my GP and they told me to go to the hospital's A&E department. So I went, they took some details from me and then tested a urine sample that confirmed that I was pregnant. They told me to go back home and then two days later I had an appointment for an internal scan to see the heartbeat of the baby. They told me that everything is fine and then they booked a midwife appointment for me, which was a few weeks later. I went in to see

one in 10 women (and up to 4 in 10 teenage mothers). Many women suffer in silence. Postnatal depression usually occurs two to eight weeks after the birth, though sometimes it can happen up to a year after the baby is born.

²⁵ During the postnatal bleeding Muslim women are excused from 'Salat', performing the Islamic prayer and fasting.

a midwife, she asked me some questions, took blood samples and a urine sample to check for all kinds and make sure that you are healthy.'

The older women of the Muslim community were of benefit to Khadija, she enjoyed referring to them for maternal advice. She believed that they had more experience and they knew more, so being around them gave her some guidance. Khadija asked them question that she felt were inappropriate to ask her midwife. Khadija asked her midwife questions that she considered as serious and medically related. However, she mentioned that healthcare professionals would generally understand her religious needs and practice if she clearly explained its purpose. Khadija explained that her midwife was relaxed and easy to talk to and if she should have asked anything the midwife would have been happy to answer. She mentioned that if she was able to fast the month of *Ramadhan* during pregnancy than she would inform her midwife and clearly explain to her why she is doing it.

'I feel relaxed with her and she is fine and she makes you feel relaxed. Well you have to ask questions and she answers because she knows when something is wrong that is her job. I would tell her if I was going to fast Ramadhan, if I knew that I could do it- then I would tell her. I would explain to her the reason why I need to fast.'

Khadija developed a good relationship with her midwife, she was seen by the same midwife throughout her pregnancy which made her feel more comfortable. She noted that she had many people around giving her different opinions from a traditional perspective on what to do and what not to do during her pregnancy. Khadija explained that she would take into account some of the traditional advice only if it did not contradict her midwife's advice. She gave an example of a common tradition that she used to do but stopped as advised by the midwife.

'My midwife once said to me you are not allowed to eat liver, but back home the women eat it all the time and they are fine. Here they tell you that it may harm the baby, so once the midwife told me this I stopped eat[ing] it. I used to eat it because of my anaemia, I used to eat it for breakfast, and it is not that I liked it, but the women used to always tell me to eat it.'

The Down's syndrome²⁶ (DS) screening was not something that Khadija would have considered or would have taken any notice of, if it had not been for her midwife's advice. She explained that even if she was high risk, abortion was not something that she would religiously consider.

²⁶ All pregnant women are offered screening for Down's syndrome. A screening test for Down's syndrome is available between 11 and 14 weeks of pregnancy. The screening test will not tell the woman if her baby has Down's syndrome or not. It will tell the woman if she has a higher or lower risk of having a baby with Down's syndrome. If the screening test shows a higher risk, women will be offered an appointment to discuss the test results and the further options. A small number of women who have a diagnostic test will find out their baby has Down's syndrome. They then have two options. Some women decide to continue with the pregnancy and prepare for their child with Down's syndrome; others decide to terminate the pregnancy.

'You have gratitude to Allah as it is in his hands, regardless of whether your baby is well or not, but in the other hand it is good to know and prepare for it. When I was asked if I want the screening it made me think do I really need to know that because it is like obvious you do not want anything to happen to your child and you can refuse to have the screening. The midwife explained to me and said "I would rather you have it than not to have it, then you know if there is anything wrong with you or the baby". So I did it, at first I was like 50-50 and then she said that I have to tell her so she can book it with the scan. I had the scan, the baby was not in a good position to carry out the screening then they decided to take blood. They sent the results and they said it was fine Alhamdulillah.'

Khadija decided not to attend any antenatal workshops because her midwife did not explain what the workshops involved and did not indicate the benefits of attending.

'She gave me a leaflet, I looked, it was about first time mothers, how to breastfeed and how to care for a new-born. Probably she thinks that because I am a Muslim and Muslim girls know this any way or we have an idea of how to look after babies. She did not give me much information about them.'

At the time of labour, Khadija felt that she was disadvantaged in making some of her own decisions about the events that took place leading up to her labour. Similar to Hanan, Khadija was not expecting other than her labour progressing naturally without any medical interventions but things took a turn. Ten days over her estimated date of delivery, her midwife told her that she would have to be induced.

'I was not expecting that at all, I thought I would give birth normally and I would have contractions and my water will break as normal but it was a surprise to me and at the time you don't think about yourself but the baby and all you want is the baby to be fine.'

This decision of being induced by the midwife came as a surprise for Khadija, she had no idea of what was the procedure or what it involved. Khadija explained that at no stage of her antenatal check-ups did her midwife mention that induced labour was a possible option. Fourteen days before Khadija was induced the midwife still did not mention anything about the induction of labour or the possibility of it happening. Only one day before she was induced Khadija was informed.

'I was a bit annoyed because I was thinking should I go (to the hospital to be induced) or should I not? Which made me think do they just want to induce me so it is easy for them, I had doubts and then I thought to myself if I do not go for the induction then I will end up regretting it. So I just went for the sake of the baby because you put your baby first, then yourself.'

At the arrival of the new born, Khadija had some religious practices. The main one was the whispering of the *Adhan* which she insisted that her husband was to do. She felt that the midwives were aware of this practice because as her husband was doing it, they did not question it. The *Tahneek* and taking the placenta home for burial were practices that she was not able to adopt, as she had forgotten to bring

dates with her to the hospital and since she had no garden, she was not sure where it would be suitable to bury her placenta. Khadija also mentioned that it was difficult for her to breastfeed while in hospital.

'I breast fed at first, it was difficult because when you are on the ward and it was visiting time, I you had to draw the curtains and if someone comes in I had to cover myself with a scarf. It is different when you are in your own home and when you are in the hospital you do not really get much of a privacy I would say.'

When arriving home after birth, the health visitor came to see Khadija on different occasions. She felt that the health visitor only came along to weigh the baby and give leaflets but did not really answer some of her questions and only referred her to the GP or the children's centre.

5.5 Samah's Motherhood Journey

Samah was a White British Muslim. She chose Islam as a religion three years ago and was experiencing motherhood as a Muslim woman for the first time. She expressed joy and excitement about this pregnancy that she long tried for without the aid of clinical intervention or advice. To Samah, her first pregnancy was an event that was part of a natural process that was going to happen - influenced by her upbringing in a big family. As for her recent pregnancy, she explained that it was an event that she had aspired for religiously.

'I now understand the reasons for having families; for procreating, it is something that Allah has put man and wife together for. Obviously it is a gift (children) from Allah and He does not grant it to everyone, but it is something if gifted with, then that's what marriage is for and what families are for. Even the Prophet had children. This is something that we aspire to do as well.'

She believed that this pregnancy made her more conscious of her religious beliefs and practices, especially in matters relating to motherhood. Samah used Muslim teachers, religious studies classes, Islamic books and friends as a point of reference for seeking knowledge and understanding of her role as a Muslim mother to-be. With pregnancy being believed to be a blessing from God, Samah felt that this motivated her to have a positive state of mind and what she described as being a better person. To her, this was a noticeable change, in comparison to her first pregnancy:

When Samah found out about her pregnancy, she contacted her GP to make an appointment with the community midwife. Following this appointment, she had two regular scans and a third scan at the A&E following a car accident she had. A midwife did not see her again until she was 27 weeks pregnant because her community midwife was fully booked. She was disappointed with the level of contact she had with her midwife and felt that it was a huge gap that deprived her from developing a mutual relationship with her midwife. There were also other events which impacted her relationship with the

midwife. Samah explained that when she attended her first appointment, she was asked her ethnicity and when she said 'White British', the midwife was in doubt and asked her for the ethnicity of her parents. She felt that her midwife associated Islamic dress with BME people and not white British.

Samah believed that there was a lack of understanding of religious beliefs amongst healthcare professionals and what minor understanding they may have; they may have gained it through the media. She believed that people would not really understand Muslim people because they do not truly understand the value of religion to a Muslim person.

'Many people are uneducated about who a Muslim woman is, but they will still see you as a Muslim woman regardless of how practising you are. It is something that they cannot get away from (referring to dress code) visually. I think sometimes I felt a barrier between me and people because I am a Muslim woman.'

Samah mentioned an encounter that she once had with her midwife, where the response that she received from the midwife formed a barrier for her expressing or communicating her needs.

'I asked the midwife about fasting during Ramadhan: "what would you advise women, now that the fasting month of Ramadhan is approaching?" She was like, "well, you do not have to fast, you are pregnant, you don't have to fast. So what is the problem?" But I want to fast. I feel like they do not want me to fast but I feel they would say that to any one even if a non-Muslim woman was asking. Unless you become a Muslim you don't or you will never understand the spiritual side of it and you wouldn't understand why someone would want to do it. So I do not necessarily see it as them being prejudiced against me doing it, I just see it as if they do not understand why I would want to do it. Religion is so much more than a physical aspect that people can see, it is something that comes from within our hearts, so that love and that spiritual feeling is something and unless you are a Muslim you will never understand it.'

Even though Samah did not receive a response that she had hoped for when questioning the midwife in regards to fasting for *Ramadhan*, she fasted the month of *Ramadhan* without informing her midwife. An appointment for Anti-D injection²⁷ was made for Samah during the first week of the month of *Ramadhan*. She decided to call her midwife and tell her that she would be traveling during the time of the appointment as her reason for wanting to rearrange the appointment. Samah felt that she was forced to hold back the true reason for her rearranging her appointment, she believed if she had told her that she was fasting, her midwife would not have considered it as a good enough excuse.

²⁷ Rhesus disease (RhD) can largely be prevented by having an injection of a medication called anti-D immunoglobulin. This can help avoid a process known as sensitisation, which is when a woman with RhD negative blood is exposed to RhD positive blood and develops an immune response to it.

Samah felt that if she had to express any religious belief she would always have to back it up with an explanation or justification- out of concern at being misunderstood in a negative way. She explained that Muslim people are taken at face value because of the many false assumptions believed about Islam, which makes it their responsibility as Muslims to negate these false assumptions.

'I feel that I have to quickly back it up (religious practice) with some kind of quick explanation. Like I spoke to another person about fasting and I felt that I had to explain myself not because they didn't accept the fact that I wanted to fast, but I felt that I had to explain myself like "no, we don't have to fast but we can try it" and I felt like I was pressured to explain myself. Most probably I was more open before, not that I have something to hide now. I think due to the way Muslims are portrayed in the media, it makes me feel that we have to or forced to hide or maybe again that is from a very stereotypical view that we assume that people will think certain things of us. So we feel that maybe to conceal is easier rather than allowing people to think that the religion is too demanding. Before, I never had that worry over my religion - being who I was, it was just that I was a pregnant woman and that was it, whereas now, I am a Muslim pregnant woman. Every movement or what kind of decision I make; I feel as though my religion is put on the line because of this. I feel that I have to be careful in front of non-Muslims in order to make a decision that they will be happy with. So I feel like I have to justify who I am in order for them to accept me because I always think: how would they perceive it rather than just "I am just going to midwife's appointment"- which was the case when I was non-Muslim. I feel like Muslims are judged so much that for me I will never want to portray something that they would find negative. I think when living here, it is really important to always give the best impression and I think this also plays with your mind as well.'

Samah believed that a Muslim midwife would have understood her needs, and she would have expressed herself more freely. Samah had a large circle of friends that she depended on for support, within her circle of friends there was Rufaidah, like Noor, Samah referred to her for advice rather than her own community midwife.

Samah was induced two weeks after her estimated delivery date, there were certain religious practices that she wanted to practice during her labour, such as being covered and not being too exposed, reciting the Quran, remembrance of God, having dates during the early stages of labour, silence at birth, *Adhan* and *Iqamah*, and *Tahneek*. She did not feel that it was necessary to discussing these practices with her midwife and was not keen on writing a birth plan. Yet Samah was convinced by Rufaidah to write out a birth plan, but was still in doubt whether the birthing plan would be acknowledged by the midwives.

'I just wanted to go with the flow because I did not know what will happen on the day. So I was just like, if the pool is available, I will have the birthing pool if not then what ever. My husband knew that we were going to do (referring to some of the Islamic practice mentioned earlier) and I did not feel like there was something that we had to plan or anything of that sort. I wrote a rough birth plan to take in

with me which simply said if the pool is available I would like to use it and we were going to take the placenta home, we like quiet after the baby is born and if possible all female staff and that was it really.'

After the baby was born, Samah's child was offered a vitamin-K injection²⁸, which she rejected. She mentioned that the injection had animal substances that she believed were not religiously suitable²⁹. She had already spoken to her GP about this and they were happy to arrange for her child to be prescribed with an animal free option, which was not available at the hospital.

Samah also rejected the BCG vaccine³⁰ that was offered at the hospital, this time it was not for religious purposes but more of her own choice that was made by her disbelief in the importance of vaccinations- although she fully vaccinated her first child. Samah felt that she was being pressurised by the healthcare professional to change her mind.

'There was this other woman, she must have been a Pediatric, she came in and she was talking about the vaccines. I felt that I was being pressurised by her, like she even wanted the baby to get this vaccine because she's obviously got family who don't necessary live in this country. I did feel under pressure, she was like "well you know" and she even asked me about the future vaccines- whether I was going to get her vaccinated or not. I kind of felt under pressure and even though I said to her I will think about it she kept on returning. She came in again an hour later to try to persuade me to get them done. It was a bit uncomfortable because you do not really want to turn around be like 'well I'm not getting them done, that is it and it's the end of it' kind of thing, but I was like you know I am just weighing out my options. I know about the research and I have looked at it and I am still a bit unsure and I am just going to look into bit more because obviously I have had my first baby completely vaccinated but now I think people are a lot more aware of the side effects and this and that, so I don't know I just felt a bit uncomfortable.'

Samah was happy with the visits by the midwife and health visitor after her birth, she did not find them necessarily beneficial, but it was nice that they checked the baby's growth every time. Samah did not attend any baby and mother workshops that were offered by children's centres.

²⁸ Vitamin-K helps regulates normal blood clotting, and is an essential nutrient necessary for responding to injuries. Some new-born babies have too little Vitamin-K, which can result in a rare bleeding disorder called haemorrhagic disease of the new-born that can cause dangerous bleeding into the brain. New-borns are offered an injection of Vitamin-K to prevent this. The Vitamin-K injection is not an animal free product as it contains a substance that is from animal/cattle gall bladder. However, if parents prefer that the baby doesn't have an injection, oral doses of vitamin K are available that is an animal free product.

²⁹ Cattle animals such as cows, sheep, goat etc... are considered as lawful animals but they become sinful or prohibited if the animal is not properly slaughtered in an Islamic fashion. Certain animals are deemed *haram* such as pork; everything of this animal is considered as sinful. It can only be considered lawful in emergencies when a person is facing starvation and his life has to be saved through the consumption of this animal.

³⁰ The BCG (Bacillus Calmette-Guérin) vaccine protects against TB (Tuberculosis). It is not given as part of the routine NHS childhood vaccination schedule unless a baby is thought to have an increased risk of coming into contact with TB.

'It was not necessarily beneficial, it was general things that they have to do for the baby, such as making sure the baby is ok in the first few weeks. So it was not necessarily beneficial for me. I do not think it brought me anything. Personally I just thought one or two visits would be fine just to weigh the baby, but I think because a lot of people get postnatal depression, it's nice for them to have that support and reassurance. But obviously if you don't suffer from anything, then it's ok.'

5.6 Summary

This chapter presented detailed accounts of the women's motherhood journeys, giving an insight of how each journey unfolded and glimpses into the experiences common to all four women. Many of the women spoke of their religious values and practices, and described how healthcare professionals approached their needs. The women clearly articulated both the positive and negative aspects of care given by the maternity services. The following chapter discusses the shared experiences common to all women, four main themes are presented.

Chapter Six: The Motherhood journey of Muslim women: Overall Themes

6.1 Introduction

This chapter will explore the main themes that emerged from the analysis of all narratives, this includes the eight participants longitudinal interview from phase one and phase two five focus groups with participation of 24 Muslim mothers who have experienced one or multiple births in the UK. Due to the nature of this study's triangulation approach, the researcher integrated both data sets of phase one and two highlighting the collective experiences between Muslim mothers, the common factors that influenced their overall experience and the impact of these factors on women experiencing motherhood for the first time and mothers.

The motherhood journeys of Muslim women will be presented using the emerging themes rather than the questions identified in the research design, since the questions were now woven into the conversation, providing a more natural way of guiding the conversation.

Four main themes emerged from the eight cases:

1. Perceptions of motherhood
2. Information needs and service awareness
3. Religious practices
4. Muslim women perceptions of healthcare professionals and seeking support.

The four main themes identified were explored further in five focus groups, revealing more about the shared meaning of being a Muslim mother and collective experiences of childbirth in the UK. Quotations from the longitudinal interviews and focus groups will be interspersed throughout the descriptions of each theme in order to support the interpretation. While some of the quotations are lengthy, reducing them further would have lost the essence of the points the women were making.

6.2 Perceptions of Motherhood

This study, like many other studies (Rizvi, 2007; Gopin, 2000; Henley & Schott, 1999; Warner & Mochel, 1998) highlights that religion is embedded in the inner life and social behaviour of many individuals, which gives individuals meaning in their lives and validates their lifestyle in a society. This was illustrated when participants were asked about their thoughts of motherhood - all Muslim women associated most aspects of the motherhood journey with their religious beliefs. Religion was not the

primary reason for them becoming pregnant but it still had a great influence in them aspiring to become mothers. All women expressed their knowledge of various Islamic teachings regarding Motherhood i.e. the 'high status of a mother in Islam', 'rewards', 'a gift and blessing from Allah', 'recommended practice', 'obligatory practice' and 'responsibility of becoming a mother'. Becoming pregnant was the key motive for them becoming curious in exploring the Islamic teachings regarding motherhood. This curiosity is not just a phase that happens during the first experience of pregnancy but it continues in every pregnancy.

This curiosity to seek and explore Islamic opinions on motherhood gave women something to reflect on with their own experiences, which made the journey more meaningful. All women described motherhood as spiritual, whereby they indicated that one does not have to be actively practising religion for the motherhood journey to be spiritual, the motherhood journey itself made the mother more spiritual.

'It is such a spiritual journey; one thing that you can relate to in pregnancy, labour, post labour and even looking after your child, is religion. Even if you were not religious before, what happens in motherhood journey would make you gain some Iman (Faith) and Islamic knowledge. Because you are so fearful of what is going on, you have that anxiety, you just need that hope and patience, and you are so grateful for what Allah has given you. Once you have given birth, you have this child that is your responsibility to raise as an ideal Muslim. So regardless of how you were and what your status was in terms of religion at the beginning of that journey, by the end of it- you would have gained more belief and become more spiritual.' (**Gp4; P1**³¹)

All mothers said that the Islamic teachings were encouraging and supportive at different stages of their motherhood journey. For instance, Hanan, Eman and Fatimah had a non-planned pregnancy, which at first made them doubt whether they are ready for their pregnancy. However, they said that their Islamic beliefs helped them to accept their non-planned pregnancy.

'When I found out I was pregnant I was feeling so bad, Astaghfirullah (May Allah forgive me) I wanted the baby out. I had so many plans and I was recently married - which was the main reason for me not wanting the child. Then I became happy because I was told that it is from Allah. Islam has honoured the woman in pregnancy and made heaven under her feet for the struggle that she goes through and Islam supported the woman and there are a lot of the Prophet's narrations about al-wadod al-walod (warm-hearted and the fertile).' (**Fatimah**)

Meanwhile, Sahar was trying for a baby but found a delay in conceiving just like Khadija and Samah. They explained that they did not find the need to rush in seeking medical opinion or intervention since a child is Allah's given gift that only He grants whom he wishes with. Regarding a child as a gift from

³¹ **Gp (No.)** - refers to focus group. **P (No)** – refers to the person in the focus group.

Allah was a common belief amongst all participants, which they found created hope and patience. This was also recognized among mothers from the focus group; for some mothers this helped them deal with situations, such as loss of a child, and when medically they have been told that they would not be able to conceive.

'[Name of baby] was a miracle, I felt like Mary, her pregnancy was also a miracle. I had a procedure post-40 and they said "You would not be able to have any more children". When I got married, I remember praying in Al-Azhar mosque in Cairo, asking for a son. I remember praying when I did Umrah³² in 2010, asking for a son. And at that time, I thought I was fertile. I had a procedure in 2011 and they said, "after this you would not be able to have any more children". Then I got pregnant. So it was a miracle.' (Gp3; P2)

The religious belief of a child being a God given gift by all participants made the majority feel very strongly toward DS screening. They all mentioned their midwives offering them the DS screening, most women from the interviewees disregarded the screening, except for Nesreen who had a family history of DS, Khadija whose midwife encouraged her to do it, and some mothers in the focus groups considered the DS screening as a routine screening that they do. Either way, all participants indicated that they would not terminate the pregnancy and it was not an option that they would consider, for religious reasons. The majority of participants explained that a gift from Allah was to be accepted in the way that it is gifted. Therefore, for some, doing the screening would just cause unnecessary worry that would interrupt the harmony of their pregnancy.

'I rejected the screening this time, I do not think that I would have rejected it for my first child but now I just think you know as a Muslim, we would never terminate our children regardless of what stage we are at. So why put myself in worry for my pregnancy when whatever will be will be with the baby that is Allah's choice for me to have that kind of child or whatever. So why make myself worry or cause concern in my pregnancy? I would rather just enjoy my pregnancy and just let it be the way it is.' (Samah)

All participants mentioned many religious teachings and the religious rewards that accompany motherhood; they explained that there are rewards given by Allah for every struggle a woman faces during her motherhood. As mentioned in Hanan's journey; motherhood is believed to be a form of worship, they found that this spiritual reward helped them stay positive throughout their journey and helped them in coping with certain struggles during pregnancy.

'For every pain you feel you are rewarded, so you do not think of the pain or the struggle, but you keep saying that this is a reward and this is a challenge from the Lord of the universe. In every struggle I go

³² Umrah is a pilgrimage to Mecca, Saudi Arabia, performed by Muslims that can be undertaken at any time of the year, in contrast to the Hajj.

through I get good deeds written for me and bad deeds are dropped, so yeah it is a great support.”
(**Fatimah**)

‘I was in a lot of pain and I was in and out of the hospital when I was 16 weeks because I have had miscarriages at this stage before. I try to think about how Heaven is under the feet of a mother and my husband will talk to me about the rewards of the pain and it does help to lift me up and it gets me out of it straight away.’ (**Nesreen**)

All women were briefed regarding postnatal depression, commonly known as baby blues, by their midwives or during home-visits. Some women mentioned that they managed to overcome the low mood by being spiritually connected. Hanan and Samah said that the recitation of the Quran and being involved in prayer was what helped them get through their low mood. Sahar also said:

‘I was feeling low after birth and it was like I was feeling sorry for myself. My husband supported me so much in the first week after birth and then left for work. I felt low and I needed support and I was thinking my family are in this country and they are not here for me. So I started telling myself that I have God and I do not need people and do not need to feel sorry for myself.’ (**Sahar**)

Furthermore, all women explained that motherhood does not only carry great religious ‘reward’, but also carries great religious responsibilities. All women mentioned that there are religious duties which encourage parents to ensure the welfare of the child. Samah said that ‘*as parents they should strive to up bring their children in a way that is pleasing to Allah*’; the majority of women said that they felt the need to better themselves and change some life habits for the greater good of their child’s welfare:

‘I think now it is looking after the welfare of the child and making sure that you have to help them learn when they grow older. I advise every woman to make sure that what the child hears is only Islamic. Even when I bath him I do the Sunnah bath³³ with him and if that is what he thinks the bath is then he will always do it like that. You know to do ‘wudu’³⁴, even if he does not need it because he’s a baby but it does not matter because it is ritual that will be for him when he is older.’ (**Noor**)

For some women living in a Western society challenges this responsibility, which caused concern. This was particularly challenging for Fatimah, Nesreen and some (less than half) of the mothers in the focus groups.

‘Living in this society is very worrying because it’s very open and has no restrictions, little children know so much that we never used to know when we were children. I do not think I want her to be here

³³ Washing the body in accordance to the Prophetic teaching, i.e. washing the head first then the body and completing with Wudu.

³⁴ Wudu is the Islamic procedure for washing parts of the body using water, typically in preparation for formal prayers (salat), maybe before handling and reading the Quran. This washing involves the washing of the face, washing both the arms including the elbows, wiping the head and washing both the feet up to and including the ankles.

when she is older because there is no limitation to things they should not know at a little age. I feel also that children are not well behaved and may not respect elders here and everyone should have their respect like the parents, the teachers and the community. It does cause a worry for me and I do not think I will stay her when she is older.’ (Fatimah)

In conclusion this theme highlights that the motherhood journey for Muslim women was linked to a spiritual meaning driven by their religious beliefs. Muslim women believed that a child was Allah’s giving gift, and one does not have to be actively practising religion for the motherhood journey to be spiritual, the motherhood journey itself made the mother more spiritual.

6.3 Information needs and Service awareness

A study by Singh et al. (2002) highlighted that 70% of first-time mothers seek more information regarding pregnancy and birth. The need for information was commonly discussed among all participants, however the first-time mothers in this study were more keen and wanted to be more informed. Mothers from the focus groups explained that they were as keen to seek information during their first pregnancy but became less keen during their following pregnancies. The majority felt they could relate to their previous childbirth experience and were confident that they had the understanding of what to expect.

‘In the first one, you read a lot and you follow the advice, and I went mad in everything, but then when I had my second one, I did not follow anything and I even give my kids food that I never did for the first one. That is because you know now and you have done it before and then you get use to your sickness and all that.’ (Gp1; P6)

The antenatal appointments were said to be one of the information sources that were not very satisfying for some of the participations. Khadija explained earlier that she felt lost at the early stages of pregnancy. Like Khadija, the majority of participants said that they needed the community midwives to give them more detail regarding the physiological changes that were to happen during the progression of their pregnancy. They noted that midwives would only provide them with detailed information if they were to ask a question, yet some participants wanted to be educated by the midwife without them having to ask questions.

‘The community midwife did not just tell me things like ‘do this’ and ‘do that’ or ‘you are in this stage’ or ‘this week’ or ‘check if you feel like that’. As long as you ask she will answer or tell you; she only says ‘is there any problems?’ and that is it. She does not tell you like ‘you are at this trimester now and this will happen or that or whatever’. I wanted the midwife to be more aware of the communication with a woman and tell her more and just advise her and inform her with things especially for a first-time mum.’ (Fatimah)

Meanwhile, all participants mentioned that the short antenatal appointments made it difficult for the midwives to provide detailed answers to questions they asked. They noted that they were provided with their community midwife's contact number to provide direct access if they had any questions or issues. The majority of participants said that this was useful and they would have contacted their midwife if they had needed their advice. However, Nesreen and Eman had contact with two midwives during their antenatal care, they were confident to contact one midwife and not the other. As for Sahar, she said that she would not contact her midwife to avoid being trouble.

'My midwife gave me a contact number to call if I need anything but it was when she made the comment about texting. She said "if you just text me first do not call, because some of these women call me and I am with clients" So that stuck with me because I thought I do not want to be that woman that calls when she is with patients. That is what put me off and then again yes she never rushed me but I was always aware of how little time she had. So that definitely had an impact, I do not want to feel like I was bothering her and where ever I gave the impression that I was fine.' (**Sahar**)

Some women explained that at a certain stage of their journey they lacked detailed information, which impacted their decision making and control of the event. Labour was a stage that all participants wanted to progress naturally without any medical intervention. Hanan and Khadija were induced and this was something they had not expected or prepared for. They said that their midwives had not discussed the possible actions that would be taken by the service if they were to exceed their estimated date of delivery. They said that they were informed of labour induction at short notice. Both Hanan and Khadija said that their acceptance of labour induction was not an informed decision. As for Nesreen, for health reasons she had a planned induction which was discussed a few weeks before the planned date of her induction, yet she said that she was not given enough information. Eman was also informed on very short notice.

'I just wanted everything natural and not pain reliefs. I had an appointment at 9 am but at 5:30am I started getting mild contractions; I was 11 days over my estimated date of delivery. I went for the appointment, they monitored me and the midwife wanted to induce me there and then but I said 'no'. I do not want to be induced and she said "I do not think you have enough fluid around the baby" so I said to her "are these contractions?" and she said "we do not know they look like contractions/some other thing". I did not expect to be induced and so I did not accept it. They did not end up inducing me, they said ok go home we will give you 4 days. My labour then came about naturally later that evening.' (**Eman**)

All participants found alternative sources of information, which made them less dependent on information provided by their midwives. The major information source for all participants was through people they knew and had confidence in, such as family members, friends, local Muslim community and Muslim healthcare professionals within the local community.

'Especially first time because you always think what is this? Why is it happening? So you get confused. Now my sister calls me for information and I am like it is fine. For me I was so scared and I am not a worried person but I was worried in my first, but luckily I had my auntie who works at a children centre and she was my point of reference.' (Gp4; P2)

Some women preferred to seek the local Muslim community; like in Sahar's case, who explained that family members do not share the same religious beliefs as her, and would not have been able to meet her information needs. This was also the case for Samah, Nesreen and some mothers from the focus groups; nevertheless, all participants had a strong community network and said that the local Muslim community was a key source of information. As mentioned by Noor earlier, there were many first-time mothers and other mothers within the local Muslim community. The majority of participants said that this was a great advantage for them in terms of information sharing. Muslim healthcare professionals such as Rufaidah who was mentioned earlier are said to be well known within the community and approached for information by the majority of participants. Local Muslim midwives are said to be an advantage to the local Muslim community, most participants felt more confident to approach local Muslim midwives with their inquiries than their community midwives.

Participants also spoke about literature provided during their first antenatal appointment; hand held notes, breastfeeding leaflet, antenatal educational classes timetable, children centre leaflet and DS screening leaflets were provided to all participants. Some of the participants said that the literature provided was standard but others said that it was not necessarily beneficial. All participants suggested that the service needs to provide information that they can relate to especially from the religious aspect. For example, leaflets on fasting and pregnancy, NHS and male circumcision, women only groups.

'What was amazing about the hospital was when I lost the baby they gave me a booklet by a Muslim organisation based in Manchester and it was called Children of Jannah (children of paradise), and they are bereavement counsellors and it helped a lot. They gave me something that I can relate to and that was nice of them.' (Gp1; P2)

All participants gained access to information they needed through use of different internet sites such as NHS website, Google, motherhood related Facebook groups and online forums. The majority of participants said that online forums were very useful as they can interact with other mothers and learn from each other's experiences. Women said that they do not only search for general information for a clinical understanding but also sought information on Islamic teachings and the experiences of other women that they can relate to.

'I used things like online forums that are really good. I could search for anything and you can type it in to a forum; there is one that is really good called the 'pregnant Muslimah' just for Muslim women - that one is really good.' (Noor)

Also all participants were aware of the availability of antenatal workshops³⁵. However, all participants said that they were not clear on what the workshops covered, the midwives provided the workshops timetable but did not explain what the workshop will cover and how they will benefit from it. The majority of participants did not attend the antenatal workshops, mothers from the focus groups explained that they felt that the focus of the workshops were not of their interest and that the workshops focused on the physical management of labour pains, pain reliefs and breathing techniques or breastfeeding. For all participants these physical aspects had spiritual aspects linked to them and they felt that they would have been interested if there was a spiritual aspect to it.

Participants also felt uncomfortable about attending workshops that were attended by couples, the present of men in the workshops felt inappropriate for them. Other mother felt unwelcomed in the workshops because there was not much diversity within the group, they felt that it was targeted at a certain 'class' of mothers. Others said that they did not find the need to attend because they had family and friends whom they can learn from. However, Noor explained earlier that she found the active birth workshop beneficial and suggested that midwives should stress the benefits of attending the workshops. As for Sahar, she suggested that a group question and answer session will be more beneficial.

'The classes are passed on a piece of paper and it's like every last Tuesday of the month and you still have to check if they are running on the today. The information of the classes were not even on the Trust's website which is disappointing. I attended the active birth class, it was good but I kind of got the impression that there would be a series of classes but it was not. It was nice and I felt welcomed and it felt really nice to have a professional telling you what contraction is, as opposed to all the literature that is out there. There were other classes but I could not be bothered to be honest and there was breastfeeding which if I had more time I would have made the effort to go. I was confident that the support will be there once the baby is here, that I would be shown how to do it by the midwives. I think what would be good is a question and answer session in a group, someone may be thinking of a question but may not feel comfortable to ask, but another person will ask making it easier for women express their concerns.' (Sahar)

The children's centres³⁶ were another information source for the women, all participants mentioned that midwives and health visitors encouraged them to register with a nearby centre. Children's centres

³⁵ Antenatal workshops (sometimes called parent craft classes) can help women prepare for their baby's birth and learn to look after and feed their babies. They can help women stay healthy during pregnancy, and give them confidence and information. They can learn about the different arrangements for labour and birth, and the choices available for them. Most antenatal classes start around 8-10 weeks before the baby's estimated date of delivery. Classes are normally held once a week, either during the day or in the evening, for around two hours. Some classes are for pregnant women only. Others welcome partners or friends to some or all of the sessions.

³⁶ Children's centres are linked to maternity services. They provide health and family support services, integrated early learning, and full-day or temporary care for children from birth to five years. They also provide advice and information for parents on a range of issues, from effective parenting to training and employment opportunities. Some have specific services for young parents.

provide different workshops or activities for the mother and infant to engage in; such as baby massage, fun/messy play and they also have a baby weighing clinic³⁷ that was most popular among participants. Not all participants use children's centres; as for those that did attend children's centres they said they got advice, met other mums and baby weighing made them feel reassured that their babies were developing well.

'I always go to the children centre; we take part in most of the activities, today he has messy play and he loves it; the baby singing and baby massage. They are really good, I would be a mess if I did not have the children centre. I like to be out of the house every day and if I stay home I will be depressed, so if I did not have the children centres, I will just be walking to the local markets everyday just to go out. So I meet new mums and we talk about everything and we are all at the same level. I contacted the centre for advice on the baby food when I wanted to start him on solid food and they said that they will send someone around to help me get him on solid food. That helped.' (Nesreen)

In conclusion this theme highlights the importance of being informed for all women. First-time mothers were more keen on information and expected their midwives to be the source of this information. Most women sought information from family, friends, Muslim healthcare professionals from within the Muslim community, internet, and books. Most women were not keen on attending antenatal workshops for various reasons, this includes not having details on what the workshop covered.

6.4 Religious Practice

Henley and Schott (1999) suggest that exploring people's religious beliefs and practices is a starting point for a good foundation for identifying possible health needs. This study recognises certain practices associated with participants' religious beliefs and the possible health needs relating to each practice. Participants discussed different practices recommended by religion, the practices that they planned to implement, and the practices that they were unable to implement.

³⁷ Children Centres provide a drop in baby weighing clinic once a week for health and development review; the reviews will usually be done by a member of the health visitor team. Mothers are able to drop in at their registered children centre for their baby to be weighed, this review is to make sure that the baby stays healthy and is developing normally. The reviews are also an opportunity for to ask questions and discuss any concerns they may have.

6.4 Table 1: Religious practices mentioned by participants (*table created by researcher*)

Religious Practice	During Pregnancy	During Labour	During Post-labour
Recitation of Quran and Supplications	√	√	√
Maintaining modesty	√	√	√
Absences of male health professionals	√	√	√
Fasting	√		√
Eating dates		√	
Silence at birth		√	
Burying of placenta			√
<i>Adhan and Iqamah</i>			√
<i>Tahneek</i>			√
Animal-based product in pharmaceuticals	√	√	√
Breastfeeding			√
Male Circumcision			√
Shaving the hair of a new born			√
<i>Aqiqah</i>			√
Community visiting mother after childbirth			√

Recitation of Quran and Supplications

The Quran is of a high importance to all participants; this was obvious as the recitation of the Quran is the first and most constant religious practice carried out by participants throughout the stages of childbirth. All participants said that there is a great benefit in the recitation of the Quran for the mother and child. It is believed that the recitation and the reflection on *Allah's* words is a form of worship that draws the individual closer to *Allah*; women recited the Quran during pregnancy - reflecting on the words of *Allah* and exposing their unborn child to hearing the word of *Allah*.

All participants had plans for the Quran recitation to be played using an audio device during the early stages of their labour. When arriving at the hospital Noor, Samah and Fatima requested a CD player from their midwives to play their CD of the Quran recitation in the room. Sahar mentioned that she did not get this opportunity, the midwife bought a radio into the room for the sake of her mother who was a non-Muslim and not really for her sake. She explained that her husband tried to play the recitation of the Quran using his mobile phone but her mother questioned the midwife about a TV in the room so the midwife offered a radio. Sahar felt that the midwife was more concerned with her mother's needs than hers. One of the mothers in the focus group had a similar situation to Sahar, she strove to find Muslim

doulas³⁸ to attend her birth rather than family members who are non-Muslim to assure that the religious practices are fulfilled.

'I wanted the bed to be backward in the room because I wanted it to face the direction of prayer (Qibla)³⁹ [laugh] they must think we are mad. I wanted the recitation to be played and someone reciting certain supplications next to me. I wanted, dates and water, and for the first words to be the name of Allah. That is why I really wanted Muslim sisters to be there and not my non-Muslim family, because if my non-Muslim family were at the birth, just like the doctors and the midwives, they'll be like, what is going on? Whereas I had two Muslim sisters with me, they took over the room and organised it. I think the midwives feel like they were sort of, okay, like they feel they knew what they are doing. Whereas if I had gone in with my non-Muslim family and friends and like I say "I want this", I would have been too weak and I would have just been overpowered and none of it would have happened.' (Gp3; P3)

The majority of participants did not request an audio player from the midwives, they used their own audio devices like mobile phones and headphones to listen to the recitations privately, and had their birth partners recite while they were waiting for labour to progress. Some mothers said that it was obvious that the midwives did not understand what they were calling out but did not feel discouraged by them and were confident to continue their recitation.

'There are things that we had to recite and I remember my sister making me call it out and the midwives were watching me. I had to do it and my midwife was there and they said it was amazing. I was doing it and they were telling me to do it between pushes.' (Gp4; P2)

Maintaining Modesty

Modesty is one of the main elements of faith for Muslim women; in Islamic ethics modesty is considered as more than just a question of how a person dresses, rather it is reflected in a Muslim's speech, dress and conduct. In this study modesty was discussed by all participants; for the majority of participants the main concern was to maintain their modesty during labour and during examinations. It was important for them not to be too exposed during labour; for some, this concern was causing them anxiety as to whether they would be able to maintain it at all times, and whether their midwives would acknowledge this concern.

'I think definitely you get caught up in what the media presents about labour such as all the screaming and so on. I think you have the power over yourself, you know what needs to be shown and what does

³⁸ A woman who gives support, help, and advice to another woman during pregnancy and during and after the birth.

³⁹ The Qibla is the direction that should be faced when a Muslim prays; it is fixed as the direction of the Kaaba in Mecca.

not. So for me I think modesty definitely ties in with my religion, you are not just going to let it go because you are having a baby, so you have to hold on to your belief.’ (Noor)

However, the majority of participants said that their modesty was acknowledged during their labour and those present tried their best to keep them covered. Sahar explains how her midwife recognised this need and acted to deliver it.

‘Modesty played on my mind a lot and it is quite frustrating because I asked ladies whether they were able to maintain modesty during labour. They are like “Oh do not worry about that when it happens”, but for me it was a real fear I wanted to preserve my modesty. Just because I will be in labour- that does not mean I will throw it all. So when I was in labour I do not think that my midwife recognised that I was a Muslim and just treated me as white British woman. When they put me on the wheelchair to go and get my stitches, I never had a head scarf and they were going to take me out of the room. I said to my husband can you please pass me my head scarf and I think that was the first time my midwife actually realized I am a Muslim. Then she said “get the sheet and cover her (my) legs”. It is then that she made more of an effort.’ (Sahar)

Absences of Male Healthcare Professionals

The attendance of male healthcare professionals is another concern discussed by participants; all participants preferred not be seen by male healthcare professionals during scan appointments, examinations or attending during their labour. Participants explained that they are aware of their religious teachings regarding this situation. They explained that religion gives them an exception during the unavailability of a healthcare professional of the same gender, based on that it is then permissible to be attended to by a healthcare professional of the opposite gender.

The participants had different opinions on how they would approach this situation; Hanan and Nesreen said they would enquire if it is possible to be seen by a female professional first, if a female is not available then they would take the religious exception and accept the attendance of a male professional. As for Fatimah and Khadija they felt very strongly about this, they said that they would ask for a female professional, if this is not possible then they would request for their appointment to be rescheduled with a female. Both of these opinions were recognized amongst mothers from the focus groups. Meanwhile Samah, Noor, Eman and Sahar did not feel confident enough to ask about whether a female healthcare professional was available to attend to their care. They felt that the healthcare professionals would not acknowledge this need, and they might be considered as a burden through what they believed - that their need is an extra demand on the services.

‘I had a car crash and I had to go for an anti D injection at 20 weeks and I was seen by a man, I actually felt very uncomfortable but I felt I like I was in a situation where I could not even say to him “can I

have a woman". I felt I was kind of pushed to a corner, like I could not say I wanted a female, maybe that is my stereotypical view of the fact that I felt that I could not voice my concern or ask him. I feel like he may think "Oh here we go, a Muslim woman complaining" or like he may think that "Oh she is making more work on us" or whatever, so I felt like I could not ask for a female.' (Samah)

However, during labour some participants were in a situation where male healthcare professionals had to be involved for medical reasons. Fatimah asked for a female if possible but with the female being unavailable she was attended to by a male professional. As for Eman and Hanan's situation, they had to be taken into a medical theatre with the attendance of male professionals. They both felt that they could not voice their need in such situation. Some mothers in the other hand felt very strongly about this and would only accept to be seen by a male professional once they were in a critical situation and they had insisted on being attended to by a female professional.

'I had complications, the midwife tried but it was not working and at that time I was still alert and there was some male doctor that came in and I just said "get out", he just walked out again. The midwife told me there is only so much she can do but she needs to get the doctor in, and I said "he can assess me but he will not do anything like in terms of helping me give birth", so they said to me that we have to try forceps or you will end up having a caesarean section, then I said ok, can I not have a man. They went back and tried; there was a female doctor that just about come out of her shift then she just stayed and helped me through labour. I knew I can have a male from the religious perspective but it was like intrusive in my mind that it was like haram (religiously unlawful).' (Gp4; P3)

Fasting the month of *Ramadhan*

The month of *Ramadhan* is a significant month in the Islamic calendar for being the month of fasting; participants discussed their opinions and practices during this month. There was a difference in opinion amongst participants in whether they would observe the fast while they were pregnant or while breastfeeding. Participants highlighted that religion exempts them from observing the fast while they are pregnant or breastfeeding. However; most participants do not take the religious exception before they attempt the fast first, once they felt that they were physically unable to tolerate the fast, they would then consider the exception. Khadija, Eman, Hanan, Fatimah and most mothers from the focus groups made an attempt to fast while they were pregnant and found it difficult to observe, as for Noor and a few mothers they managed to fast the majority of the month. When breastfeeding Sahar and Khadija decided not to fast; this was also recognized amongst mothers from the focus group. More than half of the participants said that *Ramadhan* is a spiritual month that all the community engages in seeking Allah's rewards and blessings, therefore it is difficult for one to make a choice to not engage in this community spirit. One of the mothers mentioned how the midwife acknowledged this and respected her choice in fasting.

'I remember when I was pregnant it was Ramadhan and I was feeling a bit weak what with it being my first pregnancy and I was doing one day on and one day off, and the midwife said to me are you sure you want to do this? And my mum was like "no, do not do it". But that was my way of getting closer to Allah, if I do a good deed then it will benefit me and my un-born baby and will give me strength. The midwife said to me "you know yourself and listen to your body" and "you can do what you want to do" and she respected that. It made me feel good that she respected.' (Gp2; P4)

When participants were asked if they had informed or sought information from their midwives regarding the fast of *Ramadhan*, the majority of participants said that they would not mention the fast to their midwives. They explained that midwives would not promote the fast and would advise against fasting during pregnancy. Most of the mothers approached their family, friends and some approached Muslim healthcare professionals within the community.

'They see it from a medical point of view, but they do not understand that people all around the world, not only Muslims, fast and they have babies, and nothing ever happens to them. Yes, if you have diabetes or other illnesses, it can affect you, but the way they see it, it's almost a danger. They do not understand that if you are happy to do it and if you have been doing it for a long time and it is not affecting you, then you should be okay with it. They just see it as no, you know, it is just like a religious thing. I feel like they see it as kind of a backward thing, rather than trying to understand it from a spiritual side. Obviously, in the medical field, they do not have spirituality, they just have knowledge of biology, chemistry, physics, and their opinion would be based on that. In fact, on the NHS⁴⁰ it states that fasting is good for you. I remember a colleague at work asked me why I am fasting and I said "because I just enjoy fasting and it is supposed to be good for you" and she was like, "but it is not good for you though" I was just, like, "you work for the NHS and it is on the NHS website", but some people are just so ignorant.' (Gp4; P1)

Samah, Noor and Fatimah said that it is not easy to accept their midwives telling them not to fast but they would have benefited if the midwife had provided information regarding fasting and pregnancy. All participants suggested that it would be beneficial if they were provided with a health leaflet covering fasting and pregnancy, given the option about how to keep a healthy pregnancy if they decided to fast. Mothers highlighted a similar opinion - that midwives should not discourage fasting but rather give mothers information that will help them make their own decisions.

'If only they have leaflets on fasting while pregnant or breastfeeding because it is not easy just to tell someone to not fast. So it is nice to have something that is fixable and just informs the mother on what

⁴⁰ <http://www.nhs.uk/livewell/healthylramadan/pages/fastingandhealth.aspx>

she can do and eat to make sure that she is still healthy while fasting, like what food and drinks to have when breaking the fast.’ (Fatimah)

Eating dates during initial stages of labour

Eating dates during the early stages of labour is common amongst the majority of participants. They highlighted the eating of dates during the early stages of labour is religiously recommended, as it is considered as a form of pain relief and an energy source. The majority of participants started to eat dates while still at home as soon as labour pains came about, they also continued to have the dates during the early stages of labour in hospital. Mothers explained that this practice can be difficult to maintain during their following pregnancy, labour can often be very spontaneous and fast giving no time to have dates.

Silence at Birth

This practice was mentioned by some participants; Samah, Noor, Fatimah and Sahar explained that they preferred to have silence in the labour room when the when their child is born. This is because they believed that the first words that their child should hear are the words of Allah. Samah and Noor’s midwives acknowledged this when they mentioned it on arriving at the hospital. Like most mothers, Sahar and Fatimah did not feel confident enough to mention this practice to their midwife; Sahar was not about to practice this but Fatimah tried to compromise. When the baby was about to be born Fatimah started calling out the name of Allah in a slightly higher voice than the voices in the room in order for her baby to hear the word of God first.

‘The silence in the room at birth is so the first word the child hears is Allah. I would like that a lot because we know that a person’s end in life is like their beginning. So if your first word is Allah then inshallah (God willing) your last will be Allah. That was something that I made sure of and that the midwives do not speak, and the first word to be Allah. I know in Muslim countries they practise this; some midwives are very spiritual and they will do it without you worrying but here you have to take it in to your own hands. Rufaidah also told the midwife caring for me that I want silence at birth and that worked well but even if Rufaidah did not mention it, I think my husband would have vocalised that and said that to the midwives “can we please have silence” and I think they would have completely respected it and they were really good like that. I know even leaving Islam aside even people that follow scientology they ask for silence in birth and I think that is alright and midwives would not have an issue with it.’ (Noor)

Burying the Placenta

The burial of the placenta was mentioned by all the participants as an Islamic recommended practice; they explained that as it is an obligation to bury the dead human body and it is encouraged to bury any separate part of the human body if possible out of respect. All the participants wished to do this practice but the majority found it difficult to practise without have the facilities. They explained that a common

practice is that the placenta is buried in the garden of one's home but because they do not have a garden and were not sure of any other option they have decided not to engage in this practice. Only Noor and Samah managed to do this practice and as for mothers only a few managed to bury their placenta.

'I put down that I want the placenta because of religious beliefs that we do not incinerate any human parts and I think in the hospitals they incinerate the placentas. I think if you ask for it you can bury it, which is the way to deal with human parts and it is sanctified in our religion.' (Noor)

Adhan and Iqamah

This practice was considered as one of the most important practices carried out by mostly the birth partners; religiously it is recommended to whisper the *Adhan* into the baby's right ear and the *Iqamah* into the left ear. What was interesting about these practices is that they are considered as a significant religious ceremony that is highly recommended to take place first thing when the child is born. Yet the majority of participants and their birth partners were confident to implement this ceremony with the presence of the midwives in the room, but not confident enough to fully inform or explain to the midwives what they were doing or intended to do. The majority of participants said that midwives or the staff that were in the room were busy completing what they had to do and did not notice the practice. Generally, all participants said that they would have appreciated less talking in the room while this was practised. Samah's and Noor's midwives acknowledged this and remained quiet while the partner completed the practice; meanwhile similar to some mothers from the focus groups, Sahar and Nesreen had to delay this practice until the midwives had left the room.

'Labour is an important part of her coming in to the world, there is certain things that I wanted to practice, I wanted her to hear the Adhan for me and my husband that is so important. The baby was passed to my husband; he is a bit shy so he was not able to say to the two midwives "can you all be quiet". Then he asked me to tell them to please be quiet while he recites the Adhan, as the midwife and the student midwife were talking and examining me. So I said "we need to read something for the baby, can you please be quiet while we do that" they just said "ok" and they just continued talking and whispering. It was clear that they did not understand what we were doing, so he started to do it again but he then stopped and just said "I will do it later". So when they both left the room he was able to read it into both of her ears. So that was a lack of understanding on their part because they would if they knew- they would have said "they want to do their practice now, so be quiet", but they were not aware.' (Sahar)

'We could not do it, we hid away. When my husband took the baby and went to one side, the midwife was like "where is he?" "What has he done with the baby?" And she kept on asking and she was like "we really need to clean him now" and she was trying to take the baby. But maybe it was because we did not explain to her what we were doing, but at that stage you're just so tired and you do not want to sit there explaining.' (Gp4; P1)

Tahneek

This practice was another reason why the participants prepared dates to bring into hospital for labour. It is recommended that soon after the birth before the baby's first feed, for the mother or the birth partner to take a small piece of softened date and gently rub it into the baby's mouth. Some participants practised this as recommended, they had dates with them in the hospital and others practised once they arrived home after the baby's first feed. Meanwhile all participants avoided doing this practice while midwives or staff were still present in the room; they explained that staff may consider this as taboo and would discourage it. So to avoid being discouraged, all participants delayed this practice until no healthcare professional was present.

'I did not want them to think that I am not a good mother and say "look she is putting solids in his mouth". I did not want them to take it to that extreme. So that was quite a personal time for me, I just wanted them to leave, so I can do it while they were busy.' (Gp2; P3)

Some participants mentioned that they read an article referring to scientific research that highlights the possible benefits of given a new-born sugar gel by rubbing it in the inside cheek of premature babies to protect against brain damage (BBC Sept 2013⁴¹). Samah, Fatimah, Noor and some mothers said they find it more beneficial when science backs up their religious practice, as it helps in removing the taboo of the practice.

'My husband did the Tahneek when the midwife left the room because she would not understand. There is research that has just come out about giving a new-born child sugar can help protect them from brain issues. So it is nice for health staff because obviously they do not believe in the revelations but the revelations are enough proof for us, but for the health professionals it is nice to have evidence to back up our practice.' (Samah)

Animal-based products in pharmaceuticals

There are a large number of animal products in pharmaceuticals that can possibly present Muslims with a serious dilemma; weighing their health against their religious principles. There are certain materials that the Islamic religion makes forbidden upon Muslims; such as any material that is from cattle that are non-Islamic slaughtered⁴² or from pigs. This teaching makes Muslims careful and on the lookout for any animal derivatives in medicine that do not comply with the religious teaching. This concern was raised by a few participants in this study when the Vitamin-K injections was discussed. As was

⁴¹ 'Sugar gel' helps premature babies <http://www.bbc.co.uk/news/health-24224206>

⁴² In Islamic law, the prescribed method of ritual slaughter of all animals excluding locusts, fish, and most sea-life. This method of slaughtering animals consists of a swift, deep incision with a sharp knife on the throat, cutting the jugular veins and carotid arteries of both sides but leaving the spinal cord intact. The precise details of the slaughtering method arise from Islamic tradition taught by Muhammad, himself. It is used to comply with the conditions stated in the Qur'an.

mentioned by Samah earlier, Noor and Fatimah were informed by friends that the Vitamin-K injection given to the child at birth has some animal derivatives that are unlawful for Muslims. Noor tried to find another alternative for the Vitamin-K that is free from any animal derivatives. Unlike Samah, Noor did not approach her GP to discuss other possible options, she felt that healthcare professionals do not take much notice of the details of what is within the injection, but the benefits of it. Noor found another alternative for the Vitamin-K injection free from animal derivatives in the form of tablets online. Noor decided to refuse the Vitamin-K injection offered at the hospital but did not give her child the Vitamin-K alternative, she did not receive the online order on time for the birth of her child.

'I mentioned that I did not want the Vitamin-K injection which was a big decision for me; Vitamin-K is what they normally give the child straight after birth in case they have bleeding. But I found out that the Vitamin-K actually has pig's ingredients, which is completely prohibited in religion. For me it was an informed decision to not give it to my child because there are actually other options available that are vegetarian based. A lot of doctors and nurses do not tell about the injection, I think little details like that need to be told especially to Muslims because pig is such a big thing for them and to have it injected into their child who has just come into the world, is just so wrong! I think if I had not come across this information of the injection and I found out later after given it to my child, it would have been quite heart breaking.' (Noor)

Fatimah agreed to give her child the Vitamin-K injection provided at the hospital even though she was aware of the animal derivatives within the injection. She explained that she was not aware of alternative options, which then had to weigh the benefits versus the risks of the injection for the wellbeing of her child. Some mothers from the focus groups were also in a similar situation as Fatimah. Samah, Noor and Fatimah suggested that the maternity services should have a product free from animal derivatives available in the hospital.

The majority of participants were not aware that the Vitamin-K injection may not comply with their religious beliefs and presumed that they would have been informed of animal-based pharmaceuticals because they believed that healthcare professionals would be aware of their dietary needs.

'I think they should know if there are animal-based products that are forbidden for us to have. I think the health professionals are well educated and I trust that. If there was something that is forbidden in other people's religious or dietary needs, I think they are smart enough to tell us and it would be silly if they do not. I know that the products are given for the benefit of the child but if there was something I knew of that is unlawful then I would not give it to my child. I believe that God will protect my child more than the vaccination; I have never really thought that deep about it because everyone is doing it and I know a lot of people who have accepted the injection or vaccinated their kids. If there was something wrong someone would have told me.' (Hanan)

Breastfeeding

Over the recent years, the UK has moved toward the promotion of breastfeeding; all participants in this study committed to breastfeeding. Participants were aware of the breastfeeding health benefits, however their commitment to breastfeed is mainly inspired through their religious teachings. Participants showed great understanding of the religious teachings regarding breastfeeding, they highlighted that in the Islamic traditions breastfeeding is a highly rewarded act, encouraging mothers to breastfeed her child for a maximum period of two years. All participants explained that the reward that is gained from breastfeeding their children is something that they all pursued. Samah, Sahar and Nesreen explained that they considered the uptake of breastfeeding even though breastfeeding was not a common norm witnessed amongst their families.

'In terms of breastfeeding, the Quran speaks about the blessing and rewards of this act and even how long you should breastfeed for. The breast milk is pure and she is born a Muslim, where I was not. I want to give her the best start as much as Islamic influence as possible. I was concerned that I probably would not succeed in breastfeeding but I persevered because of the Islamic element. I understood that there is a reward and blessing in this act and that mainly pushed me to do it.' (Sahar)

There are many challenges in breastfeeding; the mothers explained that if a mother was to struggle with breastfeeding then she is not obliged to continue while struggling and she should not feel guilty about it. All participants explained that they found the first few attempts at establishing breastfeeding challenging, and required staff assistance or support. What was interesting is that mothers who have established breastfeeding with their first child also found breastfeeding challenging with their following children. Most mothers mentioned that they sought support from midwives, breastfeeding support team and family and friends while trying to establish breastfeeding with all their children. All participants explained that support during the early stages of breastfeeding is key in helping them persevere.

'A member of the Bambis team came and she tried so hard to get my baby latching, but the baby would not take my breast so she left it. She sent another one to help me try to get the baby to latch on, she was good- we got the baby to latch on to the breast.' (Eman)

'I know a lot of girls see breastfeeding as a natural thing but the reality of it is that it is hard and the struggle of it is hard. Unless you have someone around you guiding and supporting you, I can imagine a lot of girls just quit. I remember my first 3 weeks I was in pain all the time and I was so sore. So if I did not have someone to say listen 'this is how you have him on your breast' which I needed someone to show me, then I would have probably quit as well.' (Gp1; P1)

Participants found breastfeeding challenging in the presence of others or in public. The majority of participants said that they would stay home most of the time to avoid breastfeeding in public. Even in front of other women, some participants did not feel confident enough to breastfeed because they felt a

bit exposed. Noor, Samah and Sahar explained that they found this very challenging at first but were then advised by friends to use a breastfeeding apron/cover which helped them to gain the needed amount of privacy with their baby while breastfeeding. This was also recognized amongst mothers from the focus groups.

'I would like to breastfeed my own child indoors and I would not feel comfortable to go and breastfeed somewhere else. Even at the hospital ward I had to make sure that the curtain was always closed, I would inform the midwife or nurse that I will breastfeed the baby because they just come in and open the curtain, leave them open and then you have men and women visitors. So obviously we are Muslims, we have to cover ourselves.' (**Khadija**)

'The first month of breastfeeding I rarely left the house, I was worried that she would get hungry while we are out. I know I can cover up but I did not really master the art of that at first, even in front of other Muslim ladies it felt so strange, they all saw it a natural thing to do but I would be mortified. So I did not go out very much at all; my sister gave me this lovely cover and that gave me so much confidence knowing everywhere I went I had it, so eventually my confidence did grow. Breastfeeding stopped me socialising at first, friends would tell me to go the park and I would be horrified - but a simple piece of material that covers me with a ring/opening where I can see my baby while she is breastfeeding worked wonders.' (**Sahar**)

Participants said that the discouragement they got from some family members and friends posed a challenge for them continuing breastfeeding. Some participants explained that their mothers were not so keen on them breastfeeding because they believed that bottle milk is a better option for both mother and child. All participants said that breastfeeding is challenging enough and not having close people supporting them can often leave them vulnerable.

'Research shows that women that have support from mothers and husbands are more likely to continue breastfeeding because you cannot do it on your own. If I did not have my friends, there were times when I wanted to give up and I was ill when I had my fourth child. I was very ill and my mum and mother-in-law did not want me to breastfeed, but the only person that said no was my friend and she was telling them to let me breastfeed and that was healing for me and I know if I did not breastfeed I would not have healed.' (**Gp2; P2**)

'I told my mother that I was going to breastfeed and she said "you have money, you do not need to worry about that and bother with breast feeding". I will do it anyway, but she also thinks that because my husband is foreign she thinks that is why I want to breastfeed. She said "he is influencing you" and I said "no, he is not bothered" so it was like she was trying to give an excuse for me not to do it. I tried to breastfeed at first but I ended up giving up because I lost a lot of blood in labour, I had no energy to breastfeed.' (**Nesreen**)

Other challenges that women faced during breastfeeding was that it was not as practical as bottle milk. Having to return to work and the demand of other children made some mothers introduce bottle milk to their children at a very early stage. Mothers explained that they felt that they had no other option but to do that even though they wanted to continue breastfeeding.

Male Circumcision

It is an Islamic obligation for every male child to be circumcised; this practice was discussed by three women from the interviews and many mothers from the focus groups who have had male children. The participants explained that this practice was an important religious requirement that has no religious exceptions and one cannot be laidback about. It is recommended for the child to be circumcised as early as seven days after birth; all participants aimed for their children to be circumcised early as it is recommended but most found it difficult. All participants explained that they lacked information regarding how and where circumcision can be done. They were keen on seeking a safe and reliable circumcision clinic. Before making a decision on how or where to do the circumcision, mothers tried to source information from NHS services, family and friends, and Muslim healthcare professionals within the local community.

The majority said that the NHS was the first place they sought, however, undergoing circumcision with the NHS can be a lengthy process and certain NHS trusts only allow for children above the age of one to have the surgical procedure. Difficulties in obtaining circumcision on the NHS mean some participants had to find other alternatives, some were in two minds whether to wait on the NHS or consider private circumcision clinics, which often made them feel anxious. Noor explained that she was not confident with any private clinics, she believed that NHS accredited clinics are trustworthy. Meanwhile, Hanan found it really difficult to search for private clinics; she decided to put her trust on the recommendation of other people who have used the private clinic for their children. This was also the case for many mothers, the majority preferred to do it early following the religious recommendation and for the better wellbeing of the child.

'There are sisters that did not know that there are private clinics and they would wait for the NHS until their children are so much older, they are going to be in so much pain. My son did not even cry or flinch, it was healed in two or three days, it was nothing. But when they are older it is like a week until it heals. Where I took my child it was so professional, the doctor was amazing and it was a GP surgery, you had 24-hour access, you could go back into the GP in the normal hours when he was there in his clinic.' (Gp3: P3)

Other participants such as Nesreen preferred to wait on the NHS list because they were not confident with private clinics and only trusted NHS services. However, there were mothers that chose to take a different route the second time they had to go through circumcision. Some mothers had their first child circumcised in the NHS, but chose to take their second child to a private clinic. They explained that

they realized that the earlier the child is circumcised the better and the quicker the healing process is. Other mothers had their first child circumcised in a private clinic and then decided to have their second child circumcised on the NHS. Some said that the circumcision of their first was not done appropriately, which then caused them to end up in the NHS, so they decided to not make the same mistake and just waited for the NHS for their second child.

'My first boy was circumcised on the NHS and that was awful. I wish I did it when he was younger, all my sisters did it when their boys were 40 days and I wish did not wait until my child was a year. For my second one I am certainly going private and doing it within the first 40 days.' (Gp2; P1)

'I did my first when he was 8 months on the NHS and the second son when he was 3 months and a half in a private clinic. The recovery was different; I would say to everyone have it as early as possible. I went to the children's hospital and they do not do it early because of the risk of putting the baby to sleep. With my first, I did not want to go to a private surgery just in case anything goes wrong because with the NHS it has its standards and they will follow it up if anything goes wrong.' (Gp4; P4)

All participants explained that they had no form of information given to them by the health services; they explained that they would have benefited and felt supported if they were provided with information on circumcision from the NHS and signposted to private clinics that are accredited by the NHS.

'I could not find anything like a leaflet in the hospital about where we can go for the circumcision; we ended up doing the research by ourselves on the internet. I do not think that the NHS services will ever advertise something like circumcision because it is something that they would not approve of if it is done for religious reasons. Yet the Muslim communities are going to do it regardless if they approve of it or not, so may be just to aid us by signposting us to an NHS private clinic instead of making us go to private clinics that we do not trust.' (Noor)

Shaving the hair of a new born

This was a practice that participants briefly discussed; traditionally on the seventh day of child's life the scalp hair that has grown in utero is removed, and an equivalent weight in silver is given to charity. Only Noor, Hanan, Eman and some mothers engaged in this practice; once they were home the husband or a family member would shave the hair or bring someone to do so and distribute silver money that is equivalent to the weight of hair to the needy.

Aqiqah

This is a practice that was implemented by all participants. In the Islamic tradition, a sheep is offered in sacrifice for every newborn child as a sign of gratitude to *Allah*. This is recommended to take place on the seventh day after the birth of the child and the meat is distributed among family members and the needy. Some participants did the *Aqiqah* in a form of a celebration meal; the sacrificed sheep was

cooked and served to family members and friends. As for others the sacrificed sheep was divided into portions and given to family member and neighbors.

Community visits the mother after childbirth

It is a common tradition amongst Muslims to visit a mother after her birth; participants explained that visits start straight after birth and continue for two to three weeks. The purpose of these visits is to celebrate the coming of a new child and health of the mother. Visitors will bring food and gifts, and will sit with the mother for a friendly chat. Some participants said that these visits can be overwhelming, they explained that the first two weeks of the child's life is the time for them to bond with their new born and get used to the changes that were happening in their lives. Hanan, Sahar and Nesreen managed to send a message asking the community visiting to not visit in the first week after their birth, this gave them a chance to settle back home with their child. Meanwhile the others felt that it is impolite to stop people from visiting, they explained that it was a blessing to have people visiting you but it was difficult to maintain the demands of their child and hosting guests at the same time. Some participants stayed at their mother's home and others had family members staying with them for support during this time. Most mothers praised this practice, they explained that it helped everyone to check on each other.

'Traditionally we have visitors come see the baby but I was not very keen about them because you need time to get used to the changes that happen in your life with the baby coming in to it. But when the guests came you have to be very formal, presentable to people and talk to them. I really did not want them to come in the first week but I could not say to them 'do not come in the first week', I was embarrassed to say that, so I just left them to come.' (Fatimah)

Writing a birth plan

Every woman was given the opportunity to discuss and write what she wished to practise during labour, this can include her choice of pain relief, where she would like to give birth and any specific practice that she would like the midwife to be aware of. A birth plan sheet is provided in the hand held notes; many participants were not aware of this sheet. Even though participants expressed many practices that they were keen on implementing, the majority did not prepare a birth plan sheet. Some said that they do not think that midwives would have a chance to look through their birth plan at the point of labour and some said that they were not sure if the midwives would understand their religious needs.

'My disappointing birthing plan appointment with my midwife that lasted 10 minutes of a simple tick list and just assumed things without asking me; Gas and air tick, information leaflet tick, birth at home no. She did not explain anything about water birth or types of pain relief. She confused me so much that I forgot to mention some of the Islamic practices that I wanted to do during labour. Like silence when the baby is born so the first word they hear is the name of Allah and my husband whispering the call for prayer in the ear of the child at birth. It really kept me up at night so I planned to talk to her about

it in the following appointment, but when I came to tell her that I wanted to add points to my birth plan she looked annoyed and said “we have done this last week and in terms of what points you want to add?” I just could not say it was about the religious aspect and just left it and my friends told me that midwives do not look at the birth plan any way.’ (Sahar)

Some participants like Noor gave a detailed birth plan after being reassured by Rufaidah that it would be acknowledged by midwives. Samah in the other hand wrote out a brief birth plan, mentioning things such as type of pain relief, use of the birthing pool and some brief religious practice like no male professional and refused the Vitamin-K injection. Khadija, Hanan and Fatimah said that they did not find the need to mention their religious practices as they were practices that they would be able to vocalise at the time, if not them then their birth partners would do that for them. Mothers did not mention that they prepared a birth plan; none of the mothers seemed to be keen on writing out a birth plan. When they were asked whether they wrote out a birth plan, many looked confused and were unaware of what is a birth plan.

‘I did my birth plan but there was no section on what you want to do after the child is born, the after section was just about the vitamin k injection- as basic as that. It did not give me the option of mentioning any religious practice that I wanted to practise. Maybe it was not that black and white, maybe it was down to me to write it on there, but I do not think they have the time to look at it any way. Especially with my second child everything just went very quickly, there was no time for them to read the birth plan. (Gp4; P1).

In conclusion this theme highlights the main religious practices discussed by Muslim mothers. These practices include recitation of the Quran, fasting *Ramadhan*, *Adhan* and *Tahneek*. There was a mix of opinion amongst the women whether they would discuss such practices with their midwives and whether the midwives would acknowledge them. There were concerns by the majority of women that healthcare professionals would not understand certain practices, such as fasting, *Tahneek* and male circumcision.

6.5 Muslim women perceptions of healthcare professionals and seeking support

In this study, participants often expressed their perceptions of healthcare professionals while discussing certain encounters during their motherhood journey. There were mixed feelings expressed regarding the type of care provided, awareness and understanding by healthcare professionals of their needs and how these influenced their relationships with their midwives and their confidence in discussing certain religious topics. Lundgren and Berg (2007) highlighted that the relationship between the midwife and

the woman is essential for a positive experience for a woman during the childbearing period (pregnancy, birth and postnatal).

Perception of care provided

Antenatal

The majority of participants said that they found the healthcare provided during their maternity journey had a greater focus on the clinical aspects of care. Participants praised the clinical standards of the UK maternity services; the regular antenatal appointments, blood test, scans, records, delivery services and postnatal checks were all part of what the participants liked. It gave them a sense of reassurance that they and their baby were progressing well, this was particularly important for Hanan, Fatimah and Eman. They were seeking clinic reassurance after they had experienced maternity services outside the UK that they were not confident with and said that those services were not of the standard of the UK's maternity services.

However, all participants said that emotional support was an important need for them throughout their journey. During the antenatal care, participants said that their midwives were keener on doing the routine clinical checks and not really focused on how they felt. For the majority of participants antenatal care became routine for clinical needs, which fell short in the fulfilment of their emotional needs. Some mothers mentioned that the continuity of care with the same midwife throughout their first pregnancy and the following pregnancy helped in building their mutual relationship with their midwives and helped in fulfilling their emotional needs.

'The midwife focus was the checks and never was how I felt. Like even on the tick list that the midwife had, it was something like emotional wellbeing or emotional risks; I was always classed as low risk and she never asked me how I was feeling and she must have gauged that in how I was coming across because I never complained and she never actually asked me how I am feeling. The appointments were just going through the motions really and the only thing for me was hearing the baby's heartbeat, but for the midwife it was just kind of blood pressure check, "let me feel your tummy" 'check' and that was it.' (Sahar)

The participants pursued emotional support from family, friends, and community members. They said that this made them less dependent on their midwives for emotional support. They sought reassurance on how they felt towards the physical changes that they experienced at each stage of their pregnancy from people who had experienced motherhood. Just like Noor and Hanan mentioned earlier, some participants explained that if they had never had the emotional support from their family and friends they would have felt alone and would have needed more attention from their midwife.

'If I never had my mum with me at home I would have felt alone; and imagine if I gave birth away from my mum, I would not have been able to do it. I think you need support, if you do not have family, then

the healthcare professionals need to give the women more attention like the Bambis team do. The Bambis text us to reassure us and it does not take a lot, and they phone up and check on you. I think it is more important for the midwives to do that too.' (**Eman**)

Labour

Labour was another stage in the participants' journey where they felt that their midwives in labour did not show enough empathy and were still focused on the clinical aspect of care. The majority of participants were not pleased about their midwife leaving them in the labour room as labour progressed. They said that it was noticeable that midwives were busy dealing with other women and other duties, which gave them less time to be with them in the early stages of labour. Some mothers compared their experiences of labour, mentioning that the labour in which they had the midwife spend more time in the room with them made them feel reassured and not alone.

'The midwife I had in labour was patronizing, she was more concerned that we had moved house even though we told our GP but they may not have updated their records. I also was part of a student case load and she was concerned about that, asking me if I had contacted the student. I was so anxious and the fact that I was in so much pain and that my mum was not with me in the hospital yet added to my anxiety. I think if someone had told me just "calm down you are going to be ok" I would have felt better, but I was like "please I need pain relief" she was like "well I am not a mind reader, you know how we can know that you are in labour only if we give you an internal examination, have you ever had one before?" It was awful and I was begging her and she kept leaving me all the time. I was trying to explain to her that I have been in slow labour for two days so she can have some empathy on me but she was like "you cannot be in that much pain; you are only 2 cm". I was trying to explain to her that I had not slept for two days and the fact she would leave me was just causing me anxiety. I was left far too much on my own and I needed her to talk to me more and ask me how I am. The other midwife that I had during labour was a lot nicer than the first one, even though she was leaving me too but she was more aware. She would tell me do not worry I will be back, but with the first one, it felt like she was making up excuses to leave the room and she would be a bit harsh. She was like "this is labour it would not be easy", it was horrible. I just wanted the midwife to have more empathy; I appreciated that they need to leave me but tell me why, how long for, offer me techniques to get through the pain and just tell me what is happening. Like the atmosphere in the room may have been so relaxed but to me it was frustrating, it was like I was put in this dark overheated room and just left there.' (**Sahar**)

Postnatal

The majority of women from the interviews still felt that midwives and home visitors gave more attention to the wellbeing of the child and did not really focus on their needs. Samah, Sahar, Eman, Khadija and Hanan said that the home visits did not really benefit them personally, but Fatimah and Nesreen said that both the midwife and health visitor also focused on their needs. Mothers from the

focus groups did not discuss their thoughts or experiences of postnatal care. The majority of mothers briefly mentioned that they were keen on returning back home to their children and the home visits were regular checks in order to check on them and their child.

'I opened up with the midwife that I saw after birth at home more than my first one in pregnancy because she was really honest. Like she did not act really formal but she was like "oh I went to the takeaway and I had this" she was really relaxed and friendly. We would have chats and not like the others that just do baby checks and just go because if she was like that I would be different and I will think of her as just same as the others.' (Nesreen)

Perception of healthcare professionals

More than half of the participants had the impression that healthcare professionals may have some negative opinions regarding their religious practice. Participants explained that they did not think that healthcare professionals have enough awareness or understanding of their religious practices. Some participants have highlighted that Islam as a religion and Muslims were not presented in the western media positively, they believed that this could fuel negative opinions generally. Mothers explained that the images presented by the western media created the assumption that Muslim women were oppressed, vulnerable, male dominated, a migrant or refugee. For example, Samah, Sahar and Nesreen felt that their midwives had the assumption that they became Muslims because they were forced by their husbands.

'One of the things that I always get is when they ask me about my ethnicity because I tell them that I am white British; they start asking questions like "are your parents English or white" I say "yes" and they will ask me "why did you convert?" "Did you convert for your husband?" "Is he a husband nice?" They know in all my forms that my husband's name is Mohamed, so they know he is a Muslim. They assume that I have been forced, they see it as oppression and they do not see it as an informed choice that I made this decision to be a Muslim.' (Samah)

Hanan, Fatimah, Khadija and some mothers from the focus groups believed that there was more awareness around Islam and its practices amongst healthcare professionals. Some mothers mentioned certain encounters where they felt that the healthcare professionals expressed some form of awareness regarding their religious beliefs, which they appreciated.

'I was feeding him and the male doctor was going to come in, so the midwife covered my legs, she helped me with my head scarf and she even knew that I have to also cover my neck. I was breastfeeding and he came in, she stood next to me the whole time holding the scarf just in case it falls while I was breastfeeding. I was so surprised I did not even say to her that I needed to cover and even when I was getting stitches she was making sure that I was covered and not too exposed. That was so nice of her to have that respect and understanding as a midwife.' (Gp5; P1)

Yet all the participants felt that they needed to clearly explain and justify themselves every time their religion or religious needs were acknowledged to help ensure understanding.

'I think people are more alert about Islam now and they are more aware of our needs; when you explain to them clearly they kind of understand, I did explain to the sonographer, if there is a female available I prefer her but if there is no female then a male is fine on those grounds of the need of treatment. I think because I explained it well they understand; I know I had my rights and I know people are more aware of Islam and even if they are not, then you should explain to them.' (**Hanan**)

Some participants said it was easier to 'hide' some of their religious practices rather than having to explain them to the healthcare professionals. The majority preferred not to mention or discuss certain religious practices out of fear of being misunderstood or adding to the negative false image that the western media had projected about their faith. The religious practice of fasting is a practice that most participants avoided discussing or informing their midwives about. Some mothers explained that they were 'told off' for fasting without them mentioning that they were fasting or intended to fast.

'They do not understand the fasting; I could not do the fasting in this pregnancy anyway, I tried it last time but this time I was weak. When I was pregnant with my third, it was in Ramadhan, I had a little car crash. So I went in and I said I need to get a check and they were saying "you are not fasting are you?" and they deliberately asked me "are you fasting?" and I said "no, no, I am not fasting, I am not well so I cannot". They said "you should not be fasting anyway", but I did not even say anything anyway. It was not like I said that I am fasting and then they gave their opinion on it. I just felt like it has nothing to do with them even if I was fasting, you know what I mean.' (**Gp1; P3**)

Samah for example decided not to give an honest reason when trying to reschedule her antenatal appointment. She explained that she felt that healthcare professionals would not have accept fasting as 'a good enough' reason for her rescheduling her appointment.

'I had an appointment for my Anti-D injection during the first week of Ramadhan, so I phoned up to change my appointment so it can be before the start of Ramadhan. When I was asked the reason for me changing the appointment, I could not say that "' will be fasting for Ramadhan" so I just said that I will be traveling out of the country. I think people do not understand actually how important our religion is to us and where there is a loophole for a pregnant woman not to fast they see it as "you do not have to fast, why do it?" I feel we are forced to hide certain things to make it easier for people not to think our religion is demanding.' (**Samah**)

There were other religious practices that participants did not feel confident enough to discuss with their midwives out of fear of being misunderstood or the practice being considered as taboo. In this study, *Tahneek* and male circumcision were recognized practices that all participants did not feel confident that healthcare professionals would understood or accept. The majority preferred to first seek the advice

of a Muslim healthcare professional within the services or from within the local Muslim community. They also sought advice from family and friends, Nesreen in particular said that male circumcision was a practice that she was not able to discuss with a non-Muslim healthcare professional. She asked the GP surgery to arrange an appointment for her with a Muslim GP, only then she felt confident to discuss this practice and was able to ask for advice on what was available.

'I would never mention it in front of a clinician, maybe if the clinician was Muslim then I would mention it because they should understand. But to a non-Muslim - no because they are just going to look at it as if it is a taboo. This is a prejudiced point of view, you know, unless there was an intermediary who understands and has knowledge on the benefits of circumcision or the benefits of fasting, or the benefits of not getting immunisation, then they could state that to the clinician. Then maybe I would mention it to get advice, if I did not know where I was going. If not, I would just Google it, rather than mention it to a clinician.' (Gp3; P1)

The majority of participants expressed the desire to be cared for by a Muslim healthcare professional, they felt that they would not fear being misunderstood or perceived negatively when expressing their needs. They believed that they would be more understanding and more sensitive to their needs. More than half of the participants pursued support and advice from Muslim healthcare professionals within the local Muslim community. Participants said that the Muslim healthcare professionals were well known within the Muslim community.

'I think with a Muslim midwife you would feel more comfortable telling her things, like "if I have to have stitching I prefer a woman" but maybe non-Muslim midwives will think "this is your health and you should not be thinking of that and it does not matter as long as your baby is ok". Things that are not obligatory you would not bring up, but things like covering up - you would bring that up and you would make sure that you tell a midwife. But things that are recommended you feel that you can leave, depending on how comfortable you feel with your midwife. If I am not confident then I do not mention it because I do not want to go into trying to explain it to her and I just say leave it. I think the one that people find a bit difficult is telling a non-Muslim woman when they want the first word that the baby hears is Allah because at the point the head comes out and the midwives would say "come on you can do it push" but you can easily tell a Muslim midwife that you want your child to hear Allah and she would completely understand.' (Noor)

Finally, all participants believed that healthcare professionals needed to make more of an effort in acknowledging their needs, not necessarily by having religious knowledge but by being sensitive and opening to their needs and choices. Some participants suggested that healthcare professionals might benefit from training that brings about awareness and understanding of religious needs and practices. Mothers highlighted that healthcare professionals need to express awareness and give more time to ask

and listen to their needs without make the assumption that all the decisions or practices they witness from Muslim women were associated with only their religion.

'Midwives may think that they are getting bombarded with information and random request from everyone, and it may interfere with their work. So I think the midwife needs to have the conversation with the woman at different stages of her pregnancy, when she is fit enough like before labour and say 'are there any special requests?' that is all it takes, then having to learn about different religions. Just for them to take the time with the mother, and not just assume- but instead to give the woman the chance to speak of her needs.' (Gp4; P1)

'I would suggest the services acknowledge some one's religion and background, and do not be afraid to ask if there are any special needs instead of just having a list. So acknowledging my religion would have made the whole experience less frightening - knowing it had an Islamic element to it.' (Sahar)

In conclusion, this theme highlights that Muslim women felt that healthcare professionals had a clinical view of care and were less focused on the emotional aspect of care. Muslim women sought family and friends for emotional support and noted that they would have struggled if they did not have that support. They also felt that some healthcare professionals may have had negative assumption of Islam that may have been influenced by the negative media of Muslim in the West. All mothers felt that healthcare professionals need to express more religious awareness and understanding.

6.6 Summary

This chapter presented the overall themes across the data sets of phase one and two. The four main themes were discussed highlighting the shared experiences common motherhood experiences among all Muslim women in this study. They told of the spiritual and religious value of motherhood and how a child is a gift from Allah. They discussed certain religious practice/customs that are part of their motherhood journey. They told of how healthcare professionals received such religious practices and how they perceived healthcare professionals understanding of them as Muslim women and their needs. Chapter Seven will discuss the experiences of healthcare professionals' experiences when caring for diverse populations and specifically Muslim women.

Chapter Seven: Professional Perspectives: Exploring the Views of those providing care.

7.1 Introduction

The previous chapters presented the unique motherhood experiences, capturing and exploring these experiences provided an in-depth understanding of what this complex phenomenon means to English-speaking Muslim women. However, understanding this phenomenon is not complete without exploring the views of some providing the maternity care. This chapter presents detailed findings of the experiences and perspectives of 12 healthcare professionals. It was important to present the experiences of healthcare professionals in details before discussing them in relation to the early findings of phase one and two to create a rich understanding of the study's phenomenon and a deeper insight to the unique experiences of delivery of care to Muslim women.

Twelve semi-structured one-to-one interviews with healthcare professionals were transcribed and thematically analysed. Five main themes emerged from the data analysis:

- 1) Perceptions of Muslim women
- 2) Understanding and awareness of religious practices
- 3) Source of cultural and religious knowledge and awareness
- 4) Addressing the needs of Muslim women
- 5) Training culturally competent healthcare professionals

7.2 Perceptions of Muslim women

Saraglou et al. (2009) suggest that it is important to understand the Western attitude toward Muslim women to improve intercultural relations. The current study explored healthcare professionals' attitudes when providing care for Muslim women. The attitudes and perceptions expressed varied; when asked about Muslim women, all healthcare professionals associated them with a language barrier. They repeatedly mentioned encounters they had with non-English speaking Muslim women; two of the participants made a general statement that 'women need to learn English'. When there is a language barrier it is often challenging for healthcare professionals. Puthussery et al. (2008) study illustrates this indicating that language competency plays a role in healthcare professionals' perceptions of non-white English mothers. According to Puthussery et al. (2008) healthcare professionals found it easier to

provide services to UK-born mothers, because of the women's language ability they felt that the women's needs were more like those of White English mothers than those of migrant mothers.

Seven healthcare professionals perceived Muslim women to be male dominated. They found Muslim women to be shy and noted the husband would often speak on their behalf. This may be associated with a language barrier, since non-English speaking women will often depend on someone that is able to communicate their needs and often this will be the husband. However, they also mentioned that some husbands still communicated the needs on behalf of their wives even in the presence of an interpreter. Five participants explained that they had encounters where they felt that the husband was the decision maker. This was challenging, especially in an emergency situation.

'I have been in a situation where there has been a very dominant male partner and I have said to the interpreter, you are not speaking to the lady, you must speak my words to her. And she (interpreter) looked at me and I said, do not talk to him (husband), talk to her. It made no difference because she (Muslim lady) looked at him for advice. But, you know, I did my best. Because we want to treat everybody equal.' (HP-5)

Three other healthcare professionals explained that on the first encounters with Muslim women they too had the assumption that Muslim women were male dominated; however over years of exposure and experience with many Muslim women in different situations they changed their perception. These healthcare professionals would disregard such stereotyping. Two healthcare professionals (a Muslim and a non-Muslim) showed concerns when they had encountered colleagues that assumed that Muslim women were male dominated. They explained that often these colleagues would make such assumptions without considering the overall circumstances of each Muslim woman they encountered. For example, non-English speaking Muslim women would often allow their husbands who are English speakers to speak on their behalf. Therefore, in such situation if one was not to be mindful, it may seem like the husband is the dominant figure.

Five healthcare professionals in this study were bilingual (for example, Arabic, Somali, Bangladeshi, Punjabi and Urdu), their ability to speak and understand the language of the women they cared for enabled them to communicate directly with some women, overcoming language barrier and the making of assumptions.

'I think they do kind of see that the male is dominant, because the man is the one that usually speaks that little bit of English. So they are more likely to come forward and explain, and be the one that is interpreting for his wife. But because I speak to them directly in a language they can speak and understand, I tend to have my conversation with the woman, and the man would be asking his thing and they kind of leave me and the woman to ourselves. I have been asked this question a while back as well about domestic violence and whether I should be seeing the women on their own, and how do I feel,

you know, the men being there. I am not saying domestic violence does not exist but for my group of women (Arabic speaking Muslim women), the men are absolutely brilliant. I am really, really, proud of them. I am proud of the involvement that they have and being so positive and so motivated.' (HP-3)

All healthcare professionals believed that Muslim women are very family orientated. They noted that Muslim women often depended on their families for support, family members such as mother, grandmother, mother-in-law, aunties, sisters and cousins are often the main support for Muslim women. They noted such family members provided support to the women throughout their pregnancy, labour, post-labour for up to 40 days and in initiating and maintaining breastfeeding. The healthcare professionals reported that Muslim women were fortunate to have a strong supporting network throughout their motherhood journey, they also believed that this network is key in the information women receive and adhere to. Healthcare professionals believed that Muslim women often learned from each other, the women were more like to have been in an environment where they have engaged in or witnessed motherhood through the experience of other family members.

However, only a few healthcare professionals were mindful that it is important for them as professionals not to make assumptions that all Muslim women are supported by their family, as having a big family does not mean that a woman is supported. Healthcare professionals need to communicate with the women to find out where they may need extra support.

'We see a lot of Muslim ladies here, it seems very much a natural progression (pregnancy). They learn from their mothers, aunties and sisters. I think things like breastfeeding, they just automatically will breastfeed their babies and do it well. Whereas we in the Western world we have made it into a science and unless the Western women tend to be, I think, more persuaded about the benefits of breastfeeding, whereas the non-Europeans tend to just automatically do it. I think, again, they have been more involved and see how their mothers did it. I do not know; it just seems to come far more naturally. So I think maybe families are just so much more involved with each other. You get many of the young girls because they have had little brothers and sisters, they have dealt with their siblings. I am not saying every Muslim does not have problem breastfeeding, but they seem to do it so much more naturally.' (HP-1)

Communicating needs is essential in the delivery of high quality care. All healthcare professionals were asked about their thoughts on Muslim women expressing their needs. More than half of them reported that the majority of Muslim women generally express their needs well, but there are some who are 'shy'. What was important to them is building a mutual relationship with the women, as this eased possible communication barriers. Midwives mentioned that caring for the same woman throughout her pregnancy has great benefits; they explained that this helps them understand each woman as an individual and helps the woman become more familiar and confident with them as midwives.

Midwives also mentioned that their being female healthcare professionals enhanced Muslim women's confidence that their modesty would not be breached. They explained that this was important to all women and is significant to Muslim women's covering, specifically those that are fully veiled (wearing a face veil 'Niqab' or 'Burka'). Muslim women often feel confident to remove their *Niqab* when they are attended to by female healthcare professional, helping them as care givers to see beyond the women's veil. One healthcare professional described how she reacted toward a veiled Muslim woman and how this experience made her realize how important it is to remember that there is a woman behind the veil and not to make the veil a barrier in meeting women's needs.

'There was an instance where I was helping a woman to hand express, no one else had managed to get any milk. We tried a different position, we managed to get loads of hand expressed milk. It was wonderful and the pair of us were just buzzing, we were just over the moon. I said to her, I need to go to the office to do your paperwork and I will be back in a minute. When I came back, I walked in and family were getting ready to go to the see the baby in the hospital with the expressed milk. She had changed into a full Burka with just her eye showing. It really took my breath away; I was really taken aback by it. I do not see it (Niqab) that often, and obviously, there is different levels of covering and I do not have an understanding of that, whether it is different types of faith; I do not really understand it. But I was shocked actually at my own reaction, it was almost like my heart started to race a bit faster, I did not quite know how to speak to her. Am I allowed to make eye contact with her, was I not meant to talk to her, because there was no facial expression, there was no body language really, it was all very switched off. I was really shocked actually how much it impacted on my behaviour towards her. Had she been dressed like that when I walked in originally, I do not know whether I would have been anywhere near as helpful, do you know what I mean, because I would have felt that it was her way of keeping me at a distance almost. Whether that is right or wrong – it is wrong probably - but that is how it made me feel. I felt just five minutes ago, I had been helping her to express milk, you know, so she was completely exposed to me. Then five minutes later she was switched off, it was crazy. It made me realise that, do not judge a book by its cover, I guess, I know there is someone underneath there. At the end of the day, she is a person like anyone else.' (HP-12)

As for Muslim healthcare professionals in this study, they found that Muslim women felt confident and open with them almost instantly. They explained that the shared factors between them, such as shared religious values, culture, language and ethnicity, were the major influences on women becoming being open and confident with them. Some mentioned that women spoke to them in their own language as soon as they found out they could speak the same language. Some explained that their *Hijab* (headscarf) was an obvious indication for the Muslim women to see that they share a religion and their names that were common within the Muslim community. The women would often greet them with the Islamic greeting *As-salamu alaykum* 'Peace be upon you', which they would also respond to in an Islamic

manner. They found that this got the women to easily feel confident in starting an informal conversation with them, they would ask them about their language, their country of origin, their family name and whether they are local Muslims. Some Muslim healthcare professionals noted that some non-English speaking Muslim women but who speak the same language as them would send their husbands home when they were in their care. The women often needed their husbands during their antenatal appointments or during their stay in hospital to help communicate their needs, however when looked after by a healthcare professional that they could speak to directly in a language they understand, the presence of their husbands was no longer necessary.

'I think they are open with me, especially when they start speaking to me in Arabic, it is automatic because it is something, a bond between two people that nobody else shares. You do not just share a language; you feel like you share a culture. So even though we might not be from the same country, we have the same Arabic language makes us understand each other in a way, so they definitely would disclose things to me that they would not disclose otherwise. Or they can express things to me that they might not be able to express in English, for example. I am visibly Muslim with wearing the headscarf. When you walk into the room, for example, in labour and they see you, you can automatically tell that they are happy, just because there is a connection. They think you maybe understand their needs a bit better than somebody who is not Muslim.' (HP-6)

Muslim healthcare professionals also mentioned that once Muslim women were familiar with them they would often seek their support and advice. Muslim women would ask for their direct contact number so they could contact them if they were in need of health advice, or in some cases to interpret for them. All healthcare professionals reported that they made the effort to signpost these women to the support they needed, such as informing them of the Trust numbers they could call for their health concerns or making notes on their medical file that they would need an interpreter in following appointments. In addition, Muslim women would often approach them with questions about how religious issues related to their health; such as fasting during the month of Ramadhan, contraception, and Vitamin-K injections. Muslim healthcare professionals' understanding of such religious matters enabled them to provide women with sound advice.

'You know, for example understanding how certain contraception's work has meant that I can tell them which one is legally valid for them in religion and which one is not. The fact that, you know, understanding how Muslims approach things in life, we always call upon God in every situation, happy, bad or indifferent. So labour is no different and we call upon God in the same way, and we see every single sort of thing that we do in life is a way to become closer to God.' (HP-9)

In conclusion, this theme highlights that healthcare professionals' perceptions of Muslim women varied, many associated them with a language barrier, male domination, and family orientated. However, the perceptions that Muslim women were male dominated was disregarded by healthcare professionals who had many experiences with Muslim women and healthcare professionals that were familiar with the language spoken by non-English speaking Muslim women.

7.3 Understanding and awareness of religious practices

Rassool (2015) suggests that delivery of high-quality care for Muslim patients requires an awareness of the implications of Islamic faith and beliefs. Interviews with healthcare professionals revealed that overall they had a vague understanding of some religious customs practised by Muslim women. The religious practices highlighted by Muslim women in the previous two chapters were discussed with healthcare professionals. Not many were aware of customs such as the recitation of the Quran, the use of dates at the initial stages of labour, silence at birth, *Adhan*, and *Tahneek*. Only a few mentioned that they had encountered some Muslim women reciting the Quran during their stay in hospital or witnessed the *Adhan*, which some considered as a form of chanting, but not knowing specifically what it is.

'They just tend to do it, in the ear when the baby is born, like, either the mother or father does it. But in terms of rituals and things, nobody really played the Quran. I remember a lady on antenatal clinic who used to play the Quran. She was a long term inpatient, so she used to play it of an evening, just to calm herself down. Either play it or read it. I remember the lady in the next room said, oh, that lady next door does her chanting every night. I do not know if she was disturbed by it or she was just commenting.'
(HP-6)

Through many encounters with Muslim women more than half of the healthcare professionals recognized that Muslim women do not like to expose certain parts of their body, even with the presence of a female healthcare professional, and most certainly some would not like to be exposed at all to a male healthcare professional. They desire to maintain their modesty, some would communicate this need variably and some would not but it would be apparent from the body language of some that they are uncomfortable.

'I am aware Muslim ladies are to cover up and they are not meant to expose certain bits. I can tell that some Muslim ladies do feel uncomfortable in the hospital environment, they do not want to be there because they are not private. There is only a curtain, and people do just pop in. I understand that they find that uncomfortable, which is understandable. But it is sometimes hard, it is very rare that I have done hand expressing with a Muslim woman because they do not get their breasts out. They do not mind

lifting a bit of fabric up and putting baby on the breast, but when it comes to the hand expressing side, you can tell they do not really feel comfortable doing that. Even when I talk about skin to skin; I say to them, it does not matter if you do not want to do it in the hospital, I understand, but when you go home, it is really good. I am assuming that you can do that at home, you know, Muslim ladies can actually take their top off, you do not have to be in all your scarf.’ (HP-11)

Healthcare professionals explained that they will always try to work with the women’s desire to maintain modesty and their preference for a female healthcare professional. A few healthcare professionals reported that at times they found it challenging to deal with Muslim women that do not easily accept being seen by a male healthcare professional if a female is not available. Especially in an emergency, it became very difficult to facilitate a female healthcare professional to attend the care. Most believed that in this situation Muslim women needed to recognize the overall situation and prioritize their wellbeing. More than half of the healthcare professionals were aware that there is a religious exception for Muslim women; on the unavailability of a female professional, they can be attended to by a male healthcare professional. They reported encounters where Muslim women considered this religious exception. However, in a situation that does not require immediate intervention some Muslim women would preferred to wait or reschedule an appointment until a female healthcare professional is available. A few healthcare professionals mentioned encounters where Muslim women did not accept a male healthcare professional even in an emergency situation, where they tolerated labour pains even though they wanted an epidural because the anaesthetist was a male. They found it difficult to understand why some Muslim women would go through such situations without considering their religious exemption.

‘I was uncertain that in certain situations, some Muslim ladies would judge the situation appropriately. Now, I am going to put a caveat on that, and the caveat would be one scenario where the Muslim lady did not want a male doctor, she was bleeding internally. She had an accident but would not let a male doctor touch her. Well, there were no female registrar surgeons, consultant surgeons in that hospital at that night, and she was dying. Still she refused, she refused, and she refused. It is her right to refuse but I think people were saying, come on, love, you are about to die, do not be so stupid. So yes, in that situation, that was a true situation, in the end she relented when it was apparent that she was on death’s door. Then they operated on her and saved her life. But everybody was like, for goodness sake. I think perhaps most people would think that would be horrendously stupid, you know. It is not just about Muslims, most people think that if your kid needs a blood transfusion and you are a Jehovah’s Witness and you’re not going to give them the transfusion, even the courts will overrule you, you know.’ (HP-5)

Fasting during the month of *Ramadhan* is another religious practice that most healthcare professionals discussed in this study. Overall, they were aware of *Ramadhan* and believed there is wide awareness amongst the Western community regarding this fasting month. More than half of healthcare professionals had a brief understanding of the religious exception that is given to a pregnant or a breastfeeding woman during *Ramadhan*. Generally, they all were not in favour of fasting during pregnancy or breastfeeding, however how they dealt and approached the idea of fasting with Muslim women differed. Less than half of the healthcare professionals reported that they would not immediately discourage women from fasting if they intended to do so, but would instruct them be mindful of their overall wellbeing. Others discouraged women from fasting.

Few healthcare professionals mentioned encounters when Muslim women were dehydrated during their fast. For that reason, they become more inclined to discourage all Muslim women not to fast during their pregnancy. All healthcare professionals noted most Muslim women wanted to fast the month of *Ramadhan*, some attempting the entire month, some a few days. A few healthcare professionals explained that this was challenging when some women were not well enough to fast, it became difficult to advise them that fasting for them may not be beneficial to their overall wellbeing. Half of the healthcare professionals mentioned that some Muslim women did not inform them of their fast, which made it challenging for them as healthcare professionals to advise or assess the women.

'I think some women do not hide it but they do not verbalise it because they assume that we know, or perhaps they do not think it is important to discuss. I would not feel that women would offer that information because it is so normal for them. They would not think that it is an important thing to say that they are fasting, and that they do not feel very well. That is usually the conclusion we come to without it being said. Sometimes the partners will say, my wife is fasting, she is not feeling very well. But it is usually us being aware that there might be a possibility that they would be fasting during Ramadhan. I cannot remember a woman saying to me, I am fasting, coming in to the appointment, and I cannot even recall a woman saying to me, well, it is Ramadhan, I am fasting and I think that is why I am feeling a bit tired or whatever. I cannot ever recall that being a key topic of information that the women give me. They might say, I feel a bit faint or I feel very tired, but they never link it with fasting [laugh]. Until you delve a bit deeper or say, are you fasting, then that information comes out. So it is strange, it is like the wrong way round. Or women have fainted or whatever and you say, are you fasting, they will say yes. Argh, well, that is why you are feeling so ill [laugh], argh, why are you fasting.' (HP-4)

Muslim healthcare professionals reported that they approached the topic of fasting in a way that is relatable to Muslim women. They informed women of their overall wellbeing and informed them of the religious opinion in regards to fasting. A few believed that some Muslim women may not be aware of the religious exception and this is why they fast during pregnancy. They were also considerate that

those who were aware of the religious exemption may still fast due to them wanting to engage in a practice that all the community is taking part in. They reported fasting is often a difficult topic to discuss and it is important for them as Muslim community members to promote the understanding of fasting and pregnancy amongst the Muslim community.

'I do not think you can ever be so direct because then you are hitting a line, where she thinks you are judging her and you are being rude. I think it is always about asking, have you been fasting? this is probably what is causing this and if you do end up dehydrated, you end up poorly more quickly, so do you know that it is acceptable in our faith that, you know, I know people who do not fast because they are in your condition and it is acceptable. You can always go to the mosque and ask the Imam, but this is what I have found women do. It is trying to explain it in an empathetic way, it is not a direct way where you are judging them and telling them what to do, like, no, I don't want to see you in this hospital again with this problem because it is your own fault.' (HP-7)

Down's syndrome (DS) screening was another contention issue healthcare professionals discussed. They all noted that most Muslim women tend to disregard the DS screening, however there are Muslim women that would only do the first stage of the screening and would not take further investigation if their DS screening appeared high risk or terminate their pregnancy. Half of the healthcare professionals reported that they are aware that in Islam similar to other faiths, terminating the foetus was not acceptable except only in certain situations such as the life of a mother being at risk.

'I have had feedback from colleagues that work in the foetal centre that have said that a lot of Muslims do not actually do anything further about the screening. Some women do not actually know exactly what the test is, but as soon as you say, it is obviously for Down's syndrome and there might be a 1% risk of losing your baby, eventually the whole aim of the test is to offer you termination. Sometimes they will just disregard it from that point on. Because it is accepting for what Allah has given them, that pregnancy is a gift and a blessing, and take it from there. I think it depends what stage they are at in their pregnancy as well, obviously, there is certain stages, you know, that you cannot go for a termination Islamically. So really there is no option for them after that.' (HP-3)

Some healthcare professionals found the Islamic concept of fate challenging. More than half of the healthcare professionals were familiar with the Arabic term '*Inshallah*' meaning 'in God's will'. They reported that they had encountered Muslim women using such a term when disregarding the DS screening and when refusing to go through a planned or emergency caesarean section. Muslim women would say '*Inshallah* the baby will be okay' and '*Inshallah* I would not end up in a caesarean section'. Healthcare professionals mentioned that they acknowledged the importance of giving women choice, however, when a woman was at high risk it is often difficult to prioritize the choice of the woman if it

puts her life at risk. When dealing with such situations, healthcare professionals reported that they would ensure that the woman was fully aware of the benefits and risks when offering her a needed surgical procedure. They mentioned once women understood the risks they eventually gave their consent, but there were a few Muslim women who were more resistant. In such cases some healthcare professionals said that they had to directly give the bitter truth, telling women direct that they would die if they did not go through with the caesarean section.

'We had a lady who was very high risk and she had a twin pregnancy, both the twins were lying across. She - not her husband - she would not consent to a caesarean section because, in her eyes, it was inshallah (God's will). I saw that also in Saudi that sometimes the lady would refuse a caesarean section and it was 'inshallah'. Not quite as bad as the other lady because that could have actually killed the babies and maybe killed her. It is like she truly believed that it was God's will. Even when we explained everything, how the babies might die, she was still it was God's will. Should we respect that? We should really, if that is the lady's true belief. Anyway, in the end, the doctor actually said she was not prepared to keep the lady in this hospital because she was afraid that the babies were going to die and she was going to die and the husband actually persuaded her to have the caesarean section. Inshallah is said a lot in Saudi Arabia and it is said a lot here too.' (HP-1)

Muslim healthcare professionals mentioned that they approached Muslim women who were refusing a caesarean section without conflict. They explained disagreeing and not accepting the women's choice in this situation would only cause a gap between them as healthcare professionals and the women. Communication is key, they highlighted. They used religious values to remind women of their duty toward the welfare of themselves and their child.

'When you explain to them, their responsibility, what it is that they are here for 'the only objective that you have', reminding them of their objective and say, your objective right now is to have a healthy baby. It does not matter how you have it, whether it is normal delivery, caesarean section, it is to safely bring that healthy baby into the world. Obviously, the normal delivery is the best way but if you cannot achieve it that way, then look at what is the next safest thing for you to do. If a woman understands that when she goes into labour, her objective is to come out with a healthy baby, then it does not matter how you do it. It is all down to the way you communicate that. In any scenario, whatever comes up where you feel there is some sort of conflict, if we react in a reflective way, the woman's going to back off even more. We are there to communicate to her what is the best for her baby and explain why. I can say to her, I am a Muslim also, Allah says tie your camel⁴³, and have belief, so where is the tying of the camel

⁴³ Relating to the *Hadith* by Anas ibn Malik. He reported: A man said, "O Messenger of Allah, should I tie my camel and trust in Allah, or should I untie her and trust in Allah?" The Messenger of Allah, peace and blessings be upon him, said, "Tie her and trust in Allah." (At-Tirmidhi)

but here in this aspect. If she decides not to and she does not want to do anything, we leave her be, you know, you cannot do anything, that is her decision to do that.' (HP-9)

Male circumcision was discussed. Healthcare professionals expressed awareness of this religious practice amongst Muslims and other faith. Muslim healthcare professionals mentioned that services need to make efforts in promoting awareness of male circumcision amongst staff.

'I think I used to tell them (Muslim women) about how, if you get it on the NHS, you might have to wait a while. Then there are private clinics, I am not aware of any in Liverpool, but I know there is in Manchester because of larger Muslim population. I am not sure I would advise that now because I have realised that it is probably better to go to a certified clinic and many of these private clinics are not certified. There is very few actually that are certified. I am not sure how long you have to wait for the NHS. You might have to wait a good while. Then possibly, the baby might have to have general anaesthesia as well, which obviously they have to be a certain age before they would do that. So it is quite a while to wait and most Muslim parents want to get it done quicker. I actually went to an event recently where there was some information about circumcision, which there is only a handful of centres that are certified. So I took the information and I thought, you know, in future if I get asked or if I wanted to send this information that this is what we can advise Muslim women that would be helpful.' (HP-6)

Finally, breastfeeding was discussed, healthcare professionals found that the majority of Muslim women were breastfeeding. They noted that Muslim women are normally very good in initiating and maintaining breastfeeding. Muslim healthcare professionals were aware that breastfeeding was a religious recommendation, the other healthcare professionals believed that Muslims women breastfed because it was something they see as natural and they have seen other members in their family do it too.

'They think it is silly. When we start talking about breastfeeding, they look at you as if you are mad [laugh]. You know, if you did say are you going to breastfeed or whatever, some women just look as if you are mad, what a stupid question to ask. I think the breastfeeding workshops that is useful in terms of other things like, you know, if you do have a problem, like, sterilising, all the practicalities of reducing infection for the baby and all that sort of stuff really, all those things are very good for a workshop. So I do not know how useful that would be for Muslim women honestly because I think they are going to do it anyway. They will always know somebody who's breastfed. They have got women, very supportive women in the community, you know, they have all breastfed before, someone's going to help them do it.' (HP-4)

In conclusion, this theme highlights that healthcare professionals had a vague understanding and awareness of Muslim women's religious practices, such as Quran recitation, fasting the month of *Ramadhan*, and desire to maintain modesty. Healthcare professionals found some practices challenging and how they dealt with women's religious practices varied.

7.4 Source of cultural and religious knowledge and awareness

Rassool (2015) also suggested that it is important for healthcare professionals to understand when caring for Muslim patients why certain practices are carried out and why adherence or non-adherence to treatment may occur. The interviews discussed the sources through which healthcare professionals gained their knowledge of religious practices. Healthcare professionals described three sources: exposure to Muslim women, work colleagues and self-learning. Overall, healthcare professionals believed that there was a general awareness of the diverse Muslims population in the UK and the Islamic faith within the Western community. More than half of the healthcare professionals mentioned that Western media does not truly show Islam and Muslims in a positive way. Encountering Muslim women and their families in practice helped them to understand the women and disregard the negative images shown in the media. Healthcare professionals, who all had more than 10 years' experience within different healthcare services, found that it exposed them to wide diverse population. This exposure and experience provided them with awareness of the different minority groups, and helped them recognize women's different ethnicities and some religious practices. Some healthcare professionals mentioned that there were some clues that they have picked up over the years of experiences with diverse populations, such as dress code, language on record, and women's name. These clues made them mindful of the different aspects that make up women's identity and specific needs.

'I do not understand at all that they had to cover up. I remember once, I was talking to a mum and we were chatting about breastfeeding. She was quite comfortable, I did not even realise she had a scarf on, to be honest, it was around her neck. We were just chatting and a lady kind of popped her head round and I said, come in. As I did, the mum that I was talking to, a lovely conversation, all of a sudden just frantically trying to get this scarf on her head, because it was obviously her culture and that was what she felt she had to do. I felt awful because I had not checked with her is it all right for this lady to come in. I felt like I had let her down almost, I was quite naïve then, and then it was all very awkward then. I have definitely learnt from that; when someone knocks at the door now, I almost step back, I do not allow people in, I check with the woman first.' (HP-12)

Some healthcare professionals reported this exposure developed their confidence in exploring beliefs or practices that were new to them with the women. They explained that when women express a need

that is new to them, they would take that as an opportunity to explore it this was part of their culture or religion.

'I am the type of person if I do not understand something, I will go in and ask. A Jewish woman delivered on a Saturday, and she wanted food but I could see she was hesitant. She did not want any food that had been cooked, so she wanted whole vegetables and stuff. I took her a whole cucumber and tomato and she was able to eat that. Sometimes if I do not understand something, I will say to her, can you explain to me why you do that practice in that certain way? So if I come across another woman, I can do the same thing with her.' (HP-9)

Learning through the knowledge and experiences of other work colleagues was another source of learning. Healthcare professionals often discussed encounters and knowledge they had with Muslim women with other work colleagues. They found this sharing of knowledge and experiences useful in developing their understanding of certain practices and clarifying any misunderstanding they had of cultures and religions.

'I had voluntary for 12 months in this department, and I had never heard of a culture where they did not give colostrum⁴⁴ for the first few days because they deemed it as dirty. I remember thinking, are they thick [laugh]? Because to me, I could not comprehend and I was, like, why would you not give that to your baby? With talking with other colleagues, they explained it is actually quite normal to come across and it is just a cultural thing, once the milk comes in, they are happy to feed baby off the breast, it is just the first few days they are not. So now I get it, I go into the situation and I am sort of, like, no, that is fine and, sort of reassure them instead of questioning them. So you do learn a lot more, which is good. We have colleagues that come in and tell us about an experience they have been through. So we learn all sorts and we use the little tips we get of each other.' (HP-11)

Healthcare professionals reported that learning from work colleagues from different ethnic and religious backgrounds was a great advantage. They gave them a great understanding of different cultural and religious values and practices. Most healthcare professionals sought their support while providing care for Muslim woman, which helped them better understand the women's need and provide appropriate care. Muslim healthcare professionals also mentioned encounters when their colleagues would approach them enquiring about religious and cultural matters. They reported that was an opportunity for them to clarify many misconceptions and spread awareness surrounding Muslims and Islamic values.

⁴⁴ A yellowish liquid, especially rich in immune factors, secreted by the mammary gland of a female a few days before and after the birth of their child.

'Being in a diverse clinic was completely new to me. I had, sort of, come from labour ward and looking after teenagers specifically, all English speaking, so working class teenage girls. So it was a big cultural shift for me, to appreciate all those different cultures and religious beliefs and lifestyles, in just one day a week. I think it was a very quick learning curve for me really, but I was very lucky because I was supported by those other three midwives who are fantastic and the Link workers are just brilliant? Very lucky because [name] is Muslim, so there is only four of us in the team, [name] is Chinese and [name] is Nigerian. So I was really lucky because they were coming with that huge wealth of knowledge. I learnt lots of things from them really, the culture, practice; they were community midwives for a long time, they had great, fantastic expertise. So they shared that with me and with other people in clinic.' (HP-4)

Muslim healthcare professionals reported that they would not wait until a colleague was to approach them with an enquire about a cultural or a religious matter, they felt that it was their responsibility to help bring about awareness. They informed other colleagues of certain Islamic practices such as fasting and what Muslim women may feel comfortable with. They mentioned encounters when other colleagues made comments that were not appropriate or incorrect about certain religious or cultural values. In such situation they would correct the comment made, they found the majority of their colleagues open and quickly apologetic.

'Thanks to Allah I have been in a position where I can help and where I have been able to. I'm quite vocal and I'm quite passionate about some of the things that I find; a lot of my colleagues are very receptive towards this, or they will come and say "I had a lady who was, she did not have this, she did not have that, and I am glad you told me because I was then able to go and do this because I knew from what you said'. I have taken the taboo out of those things and I have said to them, never feel like, there is not a question you cannot ask. I am always very open. So even in terms of the food that we serve the women, the way that we approach them, how to keep them covered in labour, that dignity to be maintained as much as possible, they are not going to want to be completely naked. Having the awareness that they may prefer a female practitioner to a male practitioner. I have kind of told them all of this information, which I hope has helped them a little bit. Some of them will come back to me and say to me, I had such and such a lady and I knew this about her, and I knew that about her, and that's helped.' (HP-9)

Finally, more than half of the healthcare professionals reported that if they were to come across anything that they are not familiar with they would research about it. They explained that learning has not stopped at their degree, it was important for them to keep self-learning and develop as professionals. They sought knowledge from books, online, scholars of religion (specifically Muslim healthcare professionals) and attended events and training.

'As practitioners, we have to educate ourselves on cultural sensitivities, not even just that. They used to assume that every woman that comes in has got female circumcision. They do not realise that that is not part of religion. There are lots of things like that, for example, that is just the way they behave because in their culture they all like to scream. You tell me one woman who is not going to scream when she is in pain. Name one woman. There is not. The only difference is, a woman who understands what that pain is will react differently to the woman who does not understand what that pain is. So I am the type of person if I do not understand something, I will go and ask or explore it. Like we had a mattress in work and it is a new, the midwives were saying, I hate using this because I feel like I am breaking my back, and this, that and the other. But it is really good because it is got like a little cut-out C-shape. That's because it doubles up as a birthing stool as well. I was saying to these midwives, you know you can change the position of that mattress, do not you? And she said, what do you mean, change the position? I said, you use it in the second stage, the delivery stage in one way, but you use it in the first stage in a different way. They said, no, we did not know that, show me. So I went into the room and when I showed them, they were like, oh my God, nobody told us. I knew because I looked at the mattress, looked at the manufacturer, went online and read about why these mattresses are designed in the way that they were, and what is the best way to use them for labouring women.' (HP-9)

In conclusion, this theme highlights three sources of learning that healthcare professionals use to develop their understanding of diverse populations. Contact with Muslims, learning from other work colleagues, and self-learning; healthcare professionals found all sources useful and learning from Muslim colleagues was a great advantage.

7.5 Addressing the needs of Muslim women

Healthcare professionals discussed how they would approach the care of Muslim women and addressing their needs. Overall, healthcare professionals would not treat a woman any different to another, but would treat all women as individuals with unique needs.

'It is about being sensitive to each individual's needs, if it is cultural aspects providing privacy if that is required, being respectful as you would with anybody really. Using the appropriate services to meet the needs of the women whether that is translated information, providing a separate room if you are providing a breastfeeding assessment or if she is having problems. For example, I saw a lady a while ago who wore the full Burka, a face veil, which you might think would be difficult but I took her to a private room as she had difficulty with breastfeeding. She was very happy to remove her veil to show me how the baby is fed. So we always ask if it is ok and check with the women if they are comfortable with the care we plan to deliver beforehand.' (HP-10)

Communication needs were first discussed; healthcare professionals mentioned that ensuring that women understand the care was fundamental for high quality care. To ensure this they used available services such as face-to-face interpreters, language line⁴⁵, and Health Link workers⁴⁶. On occasions when these services were not immediately available, a woman's husband spoke English and would communicate on her behalf. Healthcare professionals preferred the support of colleagues who are bilingual, to directly communicate reliable information. Four healthcare professionals found that allowing midwives who were bilingual to use their language skills in communication with the women without having to use interpreters had been of great benefit to high quality care.

'I think it is great having Arabic speaking midwife in the clinic and obviously the Muslim women, the Arabic speaking, must absolutely adore it, because they do not need that third person. We still use the interpreters but we have an Arabic list where this midwife will see to these women. I know the women who come and see her on the Arabic list absolutely love it. I would love that if I was in a different place, different culture and I was going to be an English speaking midwife in that place when I was pregnant. I would just think wow, which is fantastic, I would feel relaxed straightaway. So I think it helps with women's perception about what we are trying to offer them in terms of healthcare in the community. I think we should be embracing it and trying to encourage it more, but it is difficult to do if staff do not want to do it or to be singled out.' (HP-4)

Healthcare professionals also would use body language and simple English words for simple communication, for example during a simple scan they would point at the body parts of the foetus on the screen, while carrying out a simple check-up in antenatal appointments they would point to the woman's tummy, while instructing women in labour (e.g. taking deep breaths). These gestures were often useful in breaking down some of the communication barriers and an indicator that they were sensitive to women's needs. Certain objects and leaflets were also used by healthcare professionals to demonstrate to the mother. For example, they used dolls to demonstrate to the mother how to bath the baby or breastfeed, used leaflets with pictures or their language to help them understand a set of instructions.

What was also interesting was that a few healthcare professionals were keen on communication, they managed to learn a few simple words from different languages that they used when communicating with a non-English speaker. Such as words for certain body parts, 'yes', 'no', 'is it or are you okay', 'Inshallah' or greet them with 'As-salamu alaykum'. They found that using such words in the language

⁴⁵ Language Line is a telephone interpreters service.

⁴⁶ Health Link Workers act as the language link between healthcare professionals and patients. They can accompany healthcare professionals when they visit patients at home and are also able to be present in some appointments to interpret between patients and healthcare professionals. The team can also facilitate translation.

of the women, did not only help to bring about understanding but acted as an icebreaker that helped women feel comfortable and relaxed during their care.

'We have got props as well, we use dolls and woollen breasts, and things like that. So if a mum's positioning her baby and I want her to try something different, I can use my doll to show her. We have also got UNICEF leaflets in different languages we can draw on. We have got it in English as well, so I can hold the English one and they can hold the Arabic one, and we can go through it together. So there are things you can do definitely to overcome communication barriers.' (HP-12)

Healthcare professionals discussed Muslim women's preference for female healthcare professionals. More than half reported that they would acknowledge this without the women having to request it. They would approach Muslim women informing them of the staff available and giving them an opportunity to express any specific preference. The male healthcare professionals reported that they would introduce themselves to all women and ask them if they were happy with him as a male professional providing their care. If a woman was to express her preference for a female, they would try to facilitate if possible. For example, they would ask for a female to attend, if not available they would inform the woman and reschedule the appointment based on the woman's preference if it was a non-emergency situation.

'I have had every situation you could possibly imagine. I have had two ladies that were sat in the waiting room, and I called out and I thought my God, they are not going to want me to scan them. They were both dressed identically in blue with just the eyes showing (veil). I called her over and I always say, "my name's [name], I'm a sonographer, is it okay for me to do the scan?" That is how I introduce myself to everybody, does not matter where you are from in the world. They said, "yes, not a problem". My preconception obviously would be that they were very religious and I bet they did not want a man to scan them. Then on the other hand, I have had quite westernised Muslim ladies who have refused me. They said, no, I would rather have a lady. I have had a non-practising Muslim - this is recently - she was on her own and she did not know whether her husband would want me to do the scan. I said, "well, just ring him up, see if he is alright". She said, "I am alright but I do not know whether he will be", she said, "it is not something we have not even discussed, what am I going to do?" I said, "ring him up". And he was quite happy, he said, "yes, do not worry about it". So if a woman was to say no I would see if there is another female that is on (shift) and see if she can fit her on her list and I can have one of hers on my list. If not, then I would inform them that it is only me and the only way I can address this if I rebook an appointment with a female sonographer.' (HP-5)

Healthcare professionals mentioned that they would provide a private room or have the curtains drawn while the women breastfed, made sure that the women were covered appropriately (head and legs) while in a theatre gown taken to theatre.

'We have Muslim women when they are in the little hospital gowns and they stay in bed all day, and people do not understand why they are in bed when they should be walking around. It is probably because they have not got anything to cover their legs. So I can get them, stockings or something just to put on their legs, or just look for something to cover their legs. I had one lady, that just walking around with a blanket around her legs, because she understood she had to get around but she just kept pointing to her legs because she had to cover up, that is her culture, so she just felt uncomfortable.' (HP-7)

In terms of DS screening, healthcare professionals would always offer the screening to all Muslim women. They reported that it was important for the individual not to make assumptions that all Muslim women would disregard the screening, rather what was important is that all women get equal opportunities and understands what was available for them.

'My biggest thing is choice and understanding really. I would spend a long time absolutely making sure women understood what they were being offered, where it is going to lead to. I do not care whether they take up screening or not because many other women do not have screening because they would not have a termination, for religious reasons. But I think I would approach it from, I do not care what your choice is, as long as you really have a choice and as long as you understand the choices that we are offering you, and you're making that decision in your own right.' (HP-4)

Half of the healthcare professionals would provide the women with a CD player if available for the Quran recitation. However, Muslim healthcare professionals made more of an effort to address this need. One Muslim healthcare professional mentioned that when a CD player was not available, she would give the women her personal device that has a Quran application to use for the Quran recitation. Another Muslim healthcare professional printed out some Islamic supplications and kept them in the office for Muslim women who were struggling in labour and may require some specific supplications to read. Muslim healthcare professionals noted their deeper understanding of the faith enabled them to be more sensitive to the needs of women of all faiths. Overall, all healthcare professionals showed great potential of cultural sensitivity and competency.

'I had a lady - she had a miscarriage and she was really traumatised by it. It was an early miscarriage and she had to go to theatre, the foetus was sent off to another hospital. She wanted to bury her baby, say prayers for her baby, her and her husband were all upset. I tried to arrange that with the other hospital, it is something that we have never done before. I ended up bringing Father [name] he was our priest, to speak to her and reassure her, because she was quite religious. Then I spent all day on the phone to the other hospital, to the lab, to try to get the foetus back. They said "we have never done this

before, we will have to clear this up with our manager”. They were really nice in the end, they put it in a taxi and couriered it over to us. It was not the best, after it has been the labs and tested, but we got it in like a little blanket and a little cot, a tiny one, and took her and her husband into the quiet room. The next day she come in the morning and Father [name] come too. We took her to the quiet room and he said a little prayer. So just sitting with her, even though I do not believe in the same God as her, I am a Muslim. But just sitting there while she was praying, she wanted me to sit there with her and pray for her baby who she had lost, which we did. Doing this for this lady, it was rewarding in the end. We will just try, as much as we can and usually if you work hard at it, you will get it in the end.’ (HP-7)

In conclusion, this theme highlights healthcare professionals’ potential in delivering sensitivity and competent care. All healthcare professionals were keen on delivering care that best meets the need of Muslim women, and highlighted the importance of communication.

7.6 Training culturally competent healthcare professionals

Healthcare professionals discussed training methods that can bring about awareness and promote competency in addressing the needs of diverse populations. They were not in favour of the method and content of the equality and diversity training that they complete every three years. This training did not specifically cover religious or cultural values and specific needs, it was a general training that emphasized treating people equally and recognising differences. Healthcare professionals noted that recognizing differences was important but not enough to equip them with knowledge and skills that enables them as healthcare professionals to acknowledge and address the needs of diverse populations, focusing on specific cultural or religious aspects linked to maternity care.

‘Culture and religion is a big thing, and people do not really seem to understand that there is a culture and there is a religion, and they are not the same. I think that is something that needs to be identified. For example, some colleagues think that I know all about everyone else’s culture, I am a Muslim and I am Somali, but that is as far as I go. I do not know everyone else’s. They do not seem to know the difference between you and everyone else. I had a lady the other day and she was from Sri Lanka, and they assumed that because she was dark skinned that I knew the same language as her. I was, like, “no, she is from the other side of India”. It is hard. So training should help highlight the difference between culture and religion.’ (HP-7)

‘To have training specifically for Muslim women that includes things to expect, like, give her privacy, which you would with every woman but take that into consideration. Or things that might happen in the birth room that the midwife might be thrown back by, like the Adhan, that is a good thing to highlight

that they might see happening. Give them the opportunity, show them where the prayer room is if their husband's there, a little map and just say that is where the prayer room is, if you want to go and pray whilst you are with your wife. Obviously, foods that they cannot have, pork and things like that. ' (HP-3)

Healthcare professionals discussed different methods which they believed can be effective and beneficial in promoting cultural and religious awareness amongst healthcare professionals. They were not in favour of individual online training that consists of multiple choice questions. They found that is a training method this is not effective in bringing about understanding nor was it helpful in provoke discussion. Healthcare professionals preferred training methods that promoted group discussion and sharing of experiences. They believed that this was an effective method of learning that would give them the chance to question and reflects the reality of the healthcare professionals' daily experiences.

'The online training is only ten questions, it is more about the Human Rights Act, disabilities, is it true or false multiple choice training. I think it probably would be better to do an actual session where people can openly discuss. Previously, the equality and diversity training was in a group, so everyone can discuss different beliefs and then you get other people's experience. But if you are sat at a computer, multiple choice, ten questions, doing the training by yourself, having no input from anyone else. It ticks a box and that I have done the training but really I do not feel it is adequate. I do not feel like it is going to benefit the staff. I think they need to look at that training and maybe revamp it and make it more in-depth and address it to what we deal with on a daily basis, rather than a Human Rights Act and ten questions about general equality and diversity. I think it needs to be about women coming to hospital, I would definitely involve a religious kind of aspect to it. Because if somebody who was Jewish came, I would not have a clue what her beliefs are, what would help her or how to deal, I would not know to do anything special. I do not know if they would like a female or a male, does it matter to them, I don't know. ' (HP-8)

Healthcare professionals noted that the Link clinic was the cradle of many diverse populations, and healthcare professionals working within this clinic gained rich and various experiences with diverse groups. They suggested that the Link clinic could be used for cultural competency training, it would enhance healthcare professionals' exposure to diverse populations and prompting first-hand experiences.

'In the clinic you could see ten women with ten different languages, from ten different cultural backgrounds, in one morning. I have been shocked by the midwives' reaction to doing the Link clinic and how difficult they have found it really. Like the three-way discussion with an interpreter or on the phone with Language Line, how difficult they find women who turn up late, and all that sort of stuff.

But this does not faze us; women's approaches and women's concerns are different, depending on the cultural background, which we accept and understand. So to me, that is a much more powerful teaching tool, to actually do the clinic and look after those women, than an online book or even me sitting talking about it in a classroom. I think that is why it is such a useful clinic to have really in terms of students and different midwives from different areas coming to shadow. So one day in clinic is a really good introduction, I always say I do not need to travel the world because I do Link clinic on a Monday [laugh]. I think it is a very powerful teaching tool, to actually look after real women from real backgrounds and different countries, and different problems, who do not speak English. I think it is brilliant for clinicians as well because we have medical students now who are allocated to do the clinic with us, midwifery students, who may never look after women from different countries, definitely in those numbers, and have no understanding apart from textbooks about FGM or haemoglobinopathy or chronic anaemias. I think it is fantastic in terms of teaching and learning for the whole clinical group really across the board. It is multicultural, it has very diverse cultural needs and very diverse clinical needs, it is a fantastic asset for the hospital. ' (HP-4)

Healthcare professionals also noted that it was essential for universities give more focus to cultural competency training. They suggested that education institutes should further equip students with knowledge, skills, openness to continuous self-development. Training should include different aspects of cultural and religious values, recognizing diversity and encounters with diverse populations.

'I think the trust puts on these alternative study days; I think when you become a midwife, your training is what makes the biggest difference. So really, we need to get into the universities and get the universities to champion this type of midwifery, for them to start telling the midwives, you need to be dynamic, you need to continue on with education, once you finish that is when your real learning begins. They should be producing midwives that are of a certain mind frame, of a certain way of thinking. They realise that I have been a midwife for a year, how have I improved my practice; I have been a midwife two years, how have I improved my practice. The hospital does its best, it has its cultural awareness days, but professionals do not believe in them, they do not have conviction in them because they have not been taught them from the beginning. The university, the opening up of how things should be, so that when these girls come in, they realise that, yes, this is how this works and this is how that works. It is too late after university and sometimes it is too hard if you have been doing something for 15 years one way and for someone to just come along and change it. As practitioners, we understand that we are in a job that is ever changing all the time. There is new things coming out all the time and we have to keep up to date on it. ' (HP-9)

In conclusion, this theme relates to interest in training that will help enhance their knowledge and skills when dealing with the services' diverse population. All healthcare professionals preferred training that provokes group discussion and reflects the reality of the healthcare professionals' daily experiences.

7.7 Summary

This chapter presented the data as a thematic analysis of healthcare professionals' experiences when caring for diverse populations and specifically Muslim women. They discussed their understanding of Muslim women's religion and needs. They told how communication was a priority in the delivery of care, they articulated the challenges posed to them when dealing with certain religious values and practices, and explored the approaches they used to develop their ability in dealing with Muslim women's specific needs.

Chapter Eight will summarise the key findings of this thesis, by discussing the overall main experiences of Muslim mothers in relation to healthcare professionals' experiences and discuss these in the context of existing literature on Muslim women, motherhood experiences and competency of care.

Chapter Eight: Discussion and Conclusion

8.1 Introduction

Motherhood is a complex journey that unfolds differently for all women. This study explored the experiences of English-speaking Muslim women experiencing birth in the UK. The study aimed to investigate women's perceptions, perceived needs, and the factors that influenced their experiences and health seeking decisions when engaging with maternity services in the UK. This chapter discusses the study's major findings in relation to the existing and current body of literature. It begins with a description of how Muslim women perceived their motherhood journey, drawing attention specifically to their religious needs. It then discusses Muslim women's interactions with maternity services and what we can learn about providing appropriate care for Muslim women. The implication of the findings and suggestions for further research will be outlined.

8.2 Motherhood - A spiritual journey

Women in this study all shared the same religion - Islam - but differed in their ethnic and cultural backgrounds. Religious identity, rather than culture, was the central organising concept because religion and culture are practically synonymous in many parts of the world (Rassool, 2014). In this study women often used the terms 'Muslim culture', 'Islamic culture' and 'my/our culture' when talking about their religious beliefs and practices. Rassool (2014) emphasises that Islam can be regarded as a religio-cultural phenomenon, whereby behaviours are shaped by religious values and practice rather than cultural practice.

Islamic beliefs and practice that have roots in the Quran and *Sunnah* (traditions) were at the core of the women's motherhood journeys. Women discussed many and varied occasions when decisions were made primarily on the basis of Islamic teachings (for example, declining Down Syndrome screening or abortion, male circumcision, fasting, preference to be seen by female professionals, declining vitamin-K vaccines, breastfeeding). They were conscious of Islamic teachings both in general terms and specifically relating to childbearing, motherhood, being a mother and parenthood. Islamic teachings encompass all aspect of life and ethics, and these injunctions and commandments concern virtually all facets of a person's life, family and civil society (Rassool, 2014). Those Islamic practices relating specifically to motherhood were discussed in chapter 5-6, but are revisited in this chapter.

What unites Muslim women in this study is that they experience motherhood as a sacred journey, not just a biological process. For Muslim women, becoming a mother is an act of worship that accords mothers a lofty position in the sight of Allah and great respect within the community. Motherhood is a

spiritual act that Allah has allotted only to females, an opportunity to obtain Allah's blessing and rewards, and a vehicle to open the doors of Paradise. For every ounce of effort, physical, emotional or mental, exerted in motherhood, the mother is elevated to a higher position in the eyes of her family and society, and thereby gained a place for herself in the hereafter (Schleifer, 1996). Islamically, even if the woman does no more than simply bring her child into this world, Muslims are bound to respect and have concern for her.

Quranic verses highlight the obligation for other Muslims to revere motherhood:

'We have enjoined man concerning his parents - his mother carries him in her womb while suffering weakness upon weakness and then weans him for two years – That is why We commanded him: Give thanks to Me and to your parents, and keep in mind that, to Me is your final goa' (31:14)

The study revealed that Muslim women feel they are in a state of God-consciousness and gratitude to Allah's recognition of their efforts and struggles throughout their motherhood journey. As one participant described it:

'I am more aware that it is a gift (child), Allah is forming the baby out of part of the soil where it will be buried and I am more aware of the miracle of pregnancy rather than just the fact that "oh I am pregnant". I sit with my husband reminding each other (of certain Islamic teachings) of things like when a mother wakes up at night to breastfeed her child, it is as if she has been up in Tahajjud⁴⁷. Such a gift that you would never be able to fulfil without being pregnant'. (Samah)

This God-consciousness that women expressed gave their journey a spiritual dimension, which they believed was independent of their level of religiousness. Some women from both interviews and focus groups felt that they may not necessarily be continuously observant of certain religious recommendations or practices, but the divine meaning that is woven into the act motherhood made their journey spiritual. In the West, some academics have argued that religion is not interchangeable with spirituality. For example, Wright (1999) gives spirituality a broader meaning than religion, whereby religion is a pathway appropriate to a God of a particular faith and spirituality is the summation of one's values that determines the way in which one interacts with the world. However, for the Muslim women in this study, Islamic beliefs and practices towards motherhood were the essence to their spiritual journey. Rassool (2000) highlighted that in the Islamic context, there is no spirituality without religious thoughts and practices, and religion provides the spiritual path for salvation *and* a way of life.

This spiritual meaning surrounding motherhood played a significant role in women's experiences. Muslim women reported that it helped them to stay positive, optimistic and resilient when faced with certain challenges during their pregnancy. Islam means submission, which is to create peace in one's

⁴⁷Tahajjud, also known as the "night prayer" is a voluntary prayer, performed by followers of Islam

self, family, and society by actively submitting to the will of God. This was demonstrated on different occasions when, for example, there was an unplanned pregnancy or a delay in conceiving, the women regarded these occurrences as fate created through the will of Allah. For some women the acceptance of Allah's will caused them to disregard the termination of an unplanned pregnancy or hasten 'seeking fertility medical interventions. Most women refused DS screening because they believed that children should be accepted with patience regardless of what may be considered as a biological abnormality. Rassool (2015) reported that Muslim patients tried to accept illness and death with patience, meditation and prayers- and when faced with significant challenges Muslim patients (practising and non-practising) generally called for spiritual intervention. Muslim women in this study, when faced with struggles during pregnancy, labour and post-labour, regardless of their perceived levels of religiosity, tried to face challenges with patience and called for spiritual intervention through prayer, *Dua'a* (supplications), or calling on Allah's name and recitation of the Quran. This was highlighted in Syed's (2003) study where patients who suffered from anxiety and panic after surgery or from a terminal illness reported that they experienced a wonderful physical comfort after making *Dua'a* to Allah. Through the daily comfort of *Dua'a* patients regain confidence both in body and their ability to face the twists and turns of life.

However, we should not assume that Muslim women depend only on spiritual intervention when in need or faced with a challenge, as they all sought medical intervention when needed and used maternity health services. Women regularly attended antenatal appointments, contacted their midwife for advice, contacted their GP to address medical needs and used emergency services when needed. However, this also had a religious dimension to it; Muslim women reported that they sought medical advice from healthcare professional because they believed that it is a Muslim's duty to look after their wellbeing and seek a cure to treat one's self.

In the Prophetic traditions, it is narrated that the Prophet Muhammed said: *'There is no sickness that Allah has created, except that he also has created its remedy'* (narrated by Bukhari 7.582), also in another narration *'O Allah's Messenger! Should we seek medical treatment for our sickness?' He replied: 'Yes, you should seek medical treatment, because Allah, the Exalted, has let no sickness exist without providing for its cure, except for one ailment, old age.'* (Narrated by Trimidi).

Generally, most women reported that seeking treatment or medical intervention does not contradict reliance on Allah or the acceptances of one's fate. Women said that their belief in Allah helped them to stay positive throughout their journey. Most Muslim women reported feeling low at some point in their postnatal period but were able to manage through spiritual attachment to Allah. Bonab et al. (2013) highlight that a secure attachment to God is associated with a wide variety of better health outcomes, including reducing a sense of loneliness, a choice of effective coping strategies, lower depression, anxiety and physical illness, and substantially higher general life satisfaction. Through the analysis of Islamic texts such as the Divine names, the stories and direct revelation in the Quran, Bonab et al. (2013)

concluded that Allah is portrayed as having key attributes of an attachment figure; such as one who is close, responsive, compassionate, and who provides security and protection. They consider these as sound theoretical reasons for hypothesizing that part of a Muslim's relationship with Allah can be regarded as an attachment bond.

This spiritual attachment to Allah as a key feature of Muslim women's accounts of their motherhood journey. This is not surprising given that a key element of Islamic spirituality is 'submission' or 'wholeheartedly giving one's self' (Islam) and this submission is based on divine love that resides in the hearts of believers (Bonab et al., 2013). This mutual relationship between the Divine and Muslim women in this study was often spoken about, especially the belief that one's child is a personalized gift from Allah which instantly connected the women to Allah. The elevated spiritual status women believed they gained through Allah's appreciation drew them closer to Allah and infused their journey with a spiritual meaning. Moreover, the study revealed that Muslim women's spiritual worldview of motherhood also encouraged spiritual rituals and practices at different stages of their pregnancy. Bonab et al. (2013) have also described how religious rituals are essential to Islamic spirituality as they demonstrate and maintain a relationship with Allah. The study revealed common religious practices that Muslim women practised during their motherhood journey can be linked to what Bonab et al. (2013) described as outward expressions of the believer's desire to maintain a closeness to Allah.

This study echoes Rassool (2014) that Islam has a major influence on the way Muslims view and understand the world in which they live. Muslims' cultural practices are very strongly linked to their religious beliefs. Spirituality is evidently a key feature in the study's Muslim women's motherhood journey. Gulam (2003) also suggests that spirituality and health are intertwined for many individuals and it is important as healthcare providers to recognise this.

8.3 Spiritual Care for Muslim women

Earlier chapters discussed the medicalization of maternity care. Over the past century, advances in medical technology changed the focus of medicine from a caring service-oriented model to a technological cure-oriented model (Puchalski, 2001). Even though there has been some shift away from this medicalized model of care to a patient-centred model in the last few decades, this study revealed that the concept of medicalized or cure-orientated model of care still dominates Muslim women's experience of care. Generally, similar to other women in the UK, Muslim women in this study shared a feeling that maternity services are inadequately resourced for midwives to provide empathetic and comprehensive care (National Maternity Review, 2015). Their care focused on the physiological /biological elements of motherhood, with less attention to the psychosocial and emotional interactions. Since the psychosocial and emotional element was lacking, most Muslim women in this study treated

their antenatal appointments as regular physiological checks and depended on family and friends for psychosocial and emotional support.

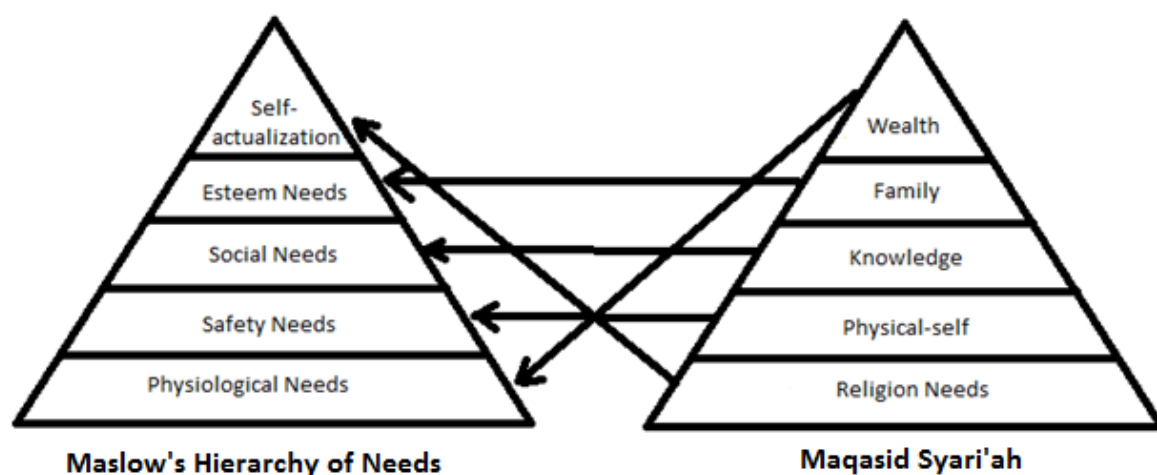
Providing healthcare is by nature demanding and stressful, however the NHS Staff Survey (2014) provides evidence that this affects maternity staff more than most. Muslim women in this study reported that midwives were so busy completing routine medical check-ups that it left little opportunity to explore their psychosocial and emotional needs. Midwives in this study also reported that they work within a demanding environment that has many responsibilities, such as looking after more than one woman at the same time, short appointment times, busy maternity units, completing medical checks and documentation. The NHS Staff Survey (2014) highlights that fewer midwives are satisfied with the quality of their work than the overall NHS workforce. Similarly, some midwives in this study expressed that they would like to do more and be with women more. The National Maternity Review (2015) highlights increasing administrative burdens as a particular difficulty, as this reduces the amount of time that staff could spend with women. This is an issue for all women but particularly for women from BME backgrounds, since they require greater engagement. Midwives may need extra time to understand cultural differences and even more communication barriers, whereby it will require providing information in a format which is easy to understand and providing an interpreter or translated materials (National Maternity Review, 2015).

Above all, Muslim women in this study also wanted healthcare professionals to understand and respect their religious, cultural and personal circumstances as well as their decisions (National Maternity Review, 2015). With such work pressures, it is important for healthcare professionals to have competency in understanding significant attributes that are part of the women's identity, such as religion for Muslim women in this study, for the future development of maternity services (McFadden et al., 2013).

There are different ways in which healthcare professionals can approach the needs of Muslim women and understanding Islam and the role it has on an individual's life is one of them. For example, Islam to Muslims is considered an important basic need (Zakaria, 2014). It takes a holistic approach in the fulfilment of an individual's needs, Rashidi and Rajaram (2001) explain that the Muslim worldview emphasises the whole human being, it integrates and balances the '*Rouh*' (spirit), '*Badan*' (body) and '*Naphs*' (soul - emotion). The Quran and *Hadith* principle of jurisprudence, namely, the *Maqasid al-Syari'ah* (*Maqasid* is the objective and *al-Syari'ah* refers to Islamic law) refers to the higher objectives behind the Islamic law. According to *Maqasid al-Syari'ah* humans have five basic needs; *Al-Din*' (Religion), '*Al-Nafs*' (Physical-self/life), '*Al-Aql*' (Knowledge), '*An-Nasb*' (Family) and '*Al-Mal*' (Wealth) (Zakaria & Abdul Malek, 2014; Rosbi and Sanep, 2010). When reflecting on these five elements of human needs, they are similar but somewhat different to Maslow's hierarchy of need. Maslow's regards the physiological needs as the foundation for human needs and puts self-actualization

needs at the top of the hierarchy, however in relation to the *Maqasid al-Syari'ah* elements of needs these needs are reversed. When putting the *Maqasid al-Syari'ah* five elements of need into a hierarchy, *Al-Din* religion needs (self-actualization needs) would sit at the foundation of the hierarchy and *Mal* wealth (physiological needs) would be at the top. Zakaria and Abdul Malek, (2014) highlighted that *Al-Din* religion needs are considered to be essential in achieving individual happiness and satisfaction in the quality of one's life.

8.3 Figure 1: Integration of Maqasid Syari'ah and Maslow's hierarchy of needs (Rosbi & Sanep 2010)



Maslow's model has been helpful in encouraging healthcare professionals to consider one's entire operating system, and it can be used as a tool for understanding needs and providing logical, comprehensive services that address a patient as a whole. McEwen and Wills (2014) highlighted that the model provides a blueprint for prioritizing clients care according to a hierarchy of needs, whereby it guides nurses to create and implement individualized care plans that work toward achieving patients' optimal health, with physiological and safety needs being the nursing priority. This may be useful for some people but may not be adequate for others, particularly people of religion. For example, similar to Islam, in Christianity, the ultimate foundation and priority for one's life is Jesus and the Word of God; '*For other foundation can no man lay that is laid, which is Jesus Christ*' (I Corinthians 3:11, King James Version). Compared to Maslow's model that is based upon the fulfilment of the needs of the self, the Bible shows that God is the provider of human needs and people are commanded to take no thought for their food or their stay and be content. The scripture states '*But my God shall supply all your need according to his riches in glory by Christ Jesus*' (Philippians 4:19). Brown & Cullen (2006) suggested that religious behavior is an enabling mechanism not only for survival but also for overall human well-being.

Likewise, for Muslim women in this study the most important needs are religious followed by the needs of the physical-self. This reflects the first two elements of needs in *Maqasid al-Syari'ah*, Muslims are required to act in accordance with *al-Syari'ah* (Islamic law) in all aspects of life and seek blessing of Allah to fulfil their potential to the fullest and reach harmonious life, today and hereafter. Therefore, Muslims are committed to fulfil certain religious obligations throughout their lives such as the five pillars, 1) testimony of faith, 2) performing daily prayers, 3) fasting the month of *Ramadhan*, 4) paying *zakat* (obligational charity) and 5) performing hajj (pilgrimage to Macca) for those who can afford to.

This study also highlights many religious obligations that influences Muslim women's physical-self and decision-making during pregnancy. According to *Maqasid al-Syari'ah* the needs of physical-self refers to daily needs such as healthcare, nutrition, shelter, safety, utilities and transportation (Zakaria & Abdul Malek, 2014). The *al-Syari'ah* imposes on Muslims to provide basic needs for themselves and their families' and to refrain from anything that might be harmful to themselves or their families. For example, fasting was a religious practice that most Muslim women in this study sought to fulfil, however, Muslim women who felt that fasting was not healthy option for them during pregnancy or breastfeeding decided take the religious exception of not to fast while pregnant or breastfeeding. This highlights the importance for healthcare professionals to consider the individual's religious and spiritual beliefs as well as cultural mores when provide competent and sensitive care (Gulam, 2003). Jesse et al. (2007) suggested that healthcare providers do not necessarily need to be religious but need to have a broad view of spirituality that accommodates diverse views.

However, diversity in the definitions of spirituality within the health literature can be a problem when trying to identify or implement spiritual care. Smith & Gordon (2009) highlight that spirituality is hard to define, quantify, audit and discuss; the diverse definitions of the term spirituality can present difficulties not only amongst healthcare professionals but also amongst patients themselves, whereby the concept of spirituality can be alien or have no meaning. As much as Muslim women in the current study described their motherhood journey as spiritual, they did not consider using the term spiritual or spirituality when describing needs that are linked to their religious beliefs.

There are four common themes that are apparent within the definitions of spirituality in the nursing and health related literature; spirituality is considered 1) as the same as religion, 2) as meaning and purpose in life and relationships, 3) as non-religious beliefs and value systems and 4) as transcendent or metaphysical (Sartori, 2010). However, Evans & Mitchell (2014) indicate that there is a clear understanding that within a healthcare setting spiritual care is very separate from religiosity. McSherry (2006) highlights that there is a notion within literature that is construed as anti-religious and a desire to move away from or eradicate the religious element of spirituality within definitions. Although historically spiritual care and religious care were one and the same, now the debates on spiritual care and religious care emphasize the difference between the two. Sartori (2010) highlights that

differentiating between spiritual and religious needs is complex, as the two are not synonymous and individuals may be non-religious but still be spiritual. Generally, the definitions used for spirituality within healthcare can be problematic, as the definitions suggest that spirituality is concerned with the idea of goodness, morals and behaviours that are socially acceptable (McSherry, 2006).

This may lead healthcare professionals to judging individuals' spirituality in terms of right and wrong against their own cultural standards and expectations. This was not immediately apparent amongst the current study's healthcare professionals, yet a few non-Muslim healthcare professionals considered some practices as unusual, such as wearing the full veil (including covering of face), fasting in pregnancy, and regarding males as the dominant figure in the family. When dealing with women in a full veil one healthcare professional found herself less open, more formal and somehow unable to relate. Fasting in pregnancy is another practice that some non-Muslim healthcare professionals cast in a negative light. There are different studies within the literature that highlights the possible outcomes of fasting during pregnancy. Such as Ziaee et al (2010), that indicates that there is no evidence that fasting is harmful to intrauterine growth and birth-time indices in healthy women with appropriate nutrition, and Savitri et al (2014) that revealed that Muslim women's adherence to Ramadan fasting during early pregnancy could lead to lower birth weight of new-borns. There is an urge for large-scale research that could explore the potential perinatal morbidity and mortality. Likewise, for this study, the importance of the availability of initiatives for healthcare professionals to gain access to evidence based information on providing support and advice for pregnant Muslim women in make an informed decision regarding fasting during Ramadan (Savitri et al, 2014; Jamali et al, 2013).

Sartori (2010) argues that to completely exclude the religious aspect or separate it from spiritual needs could be detrimental to some individuals and this is most certainly the case for Muslim women in this study, simply because their spiritual needs are religious in nature. The study suggests that separating Muslim women's spirituality from religion can be almost impossible and Yanez et al. (2009) suggest that both spiritual and religious aspects of care should be supported rather than trying to separate the two. Rather than specifying a spiritual or religious approach to care, this study supports the notion of a holistic approach to care that recognises that spirituality and health are very much intertwined for most individuals. There have been attempts at reconnecting medicine with the spiritual aspect of holism, which incorporates mind, body and spiritual dimensions. The Midwifery 2020 Report (2010) aims to re-focus midwifery care on maximising the possibility of normal pregnancy, childbirth and postnatal well-being within a context of birth as a life event where the physical, spiritual and emotional aspect are equally important, safety is paramount and women feel a sense of privacy and dignity.

However, simply being aware of the importance of spiritual care is not enough. Smith & Gordon (2009) report that many healthcare professionals experience barriers to addressing spiritual issues in practice. This is evident in Funning's (2010) survey, where only 5% of nurses felt they achieved 'spiritual care'.

McSherry (2006) argues that healthcare professionals working within diverse care settings are already providing effective spiritual care without being aware that they are doing so. Most healthcare professionals in the current study reported that through encounters with Muslim women, they developed an awareness of certain needs linked to Muslim women's religious beliefs, and some attempted to fulfil these without the women having to raise them, for example, Muslim women's preference to be attended to by a female healthcare professional. Healthcare professionals wanted to address this need without making a generalized assumption that only or all Muslim women would have this preference. Hence, healthcare professionals reported that they addressed this by making sure that all women were aware in advance of the gender of the healthcare professional attending to their care e.g. some healthcare professionals would say '*we have a male e.g. consultant, (name) that will be seeing you today, are you ok with this?*'. This allowed women to express their preference and for healthcare professionals to facilitate the preferred choice where possible, and, if not possible, a chance to inform women of what is possible so they can make further informed decisions during their care.

The study revealed that some Muslim women had encountered approaches from healthcare professionals during their care, which had been empowering. This gave them the confidence to express their needs and make choices, without feeling forced to accept care that they may not prefer or have no control of. Speier (2001) points out that supporting women to having self-confidence in making choices and having control throughout their pregnancy is essential if motherhood is to be experienced as empowering. On the other hand, the study revealed that there is still lack of awareness of Muslim women's needs amongst some healthcare professionals, which led to inaccurate assumptions. When approaching Muslim women, the majority of healthcare professionals assumed there would be language barriers. Such assumptions act as barriers to women making informed decisions about their care and having their individual needs met (McFadden et al., 2013). Yardley et al. (2009) suggest that difficulty in identifying specific spiritual needs and lacking confidence in delivering care that meets those need are the main barriers in hindering the delivery of optimal spiritual care. The current study suggests that healthcare professionals can only meet these needs if they are aware of them, and may only be inclined to meet those needs if encouraged by policy. Bharj and Salway (2008) indicate that unless more is done to bridge the gap between policy and practice, women from BME communities will continue to have poorer maternity experiences and outcomes than the white majority. Sartori (2010) suggests that although certain healthcare professionals appear to be aware of spiritual needs, lack of clear definitions and practical guidance means they are often uncertain about how these needs can be addressed alongside clinical care. This demonstrates that being aware and understanding the needs of particular groups of women extends far beyond language needs; it is about creating understanding, recognising individual cultural difference and removing any barriers that are unconsciously created by not allowing for the importance of culture for a childbearing woman (Esegbona-Adeigbe, 2011). Esegbona-Adeigbe (2011) highlights that such knowledge is vital in today's healthcare services - in the context of this study a

better understanding of Muslim women's religious needs will not only equip midwives with important skills but will create a stepping-stone to cross the gap between healthcare professionals and patients.

8.4 Interactions: Key principles of quality care

The High Quality Care for All Report (DoH, 2008) highlights that 'quality care' means care that is personal to each individual. It includes three components; care that is safe, care that is clinically effective and care that provides as positive an experience for the patient as possible. To enable these three components healthcare professionals within the maternity services should work in partnership with women and their families, respecting their views and striving to ensure safe and positive outcomes for women and babies at all times (RCOG, 2008). The key foundation for this idea of partnership is effective interactions between healthcare professionals and women and their families, empowering women to become active partners in decision-making and in their overall care (RCOG, 2008). The NHS Mandate aims to improve inequalities faced during pregnancy and maternity and improve the experiences of women and families during and in early years through giving women the greatest possible choice of providers, building better relationships between women and midwives by personalising their care. The NHS Mandate and the NICE antenatal and postnatal quality care standards both state that 'every woman should have a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern' (Sandall, 2014).

However, like other studies, the current study reveals that most Muslim women lacked confidence in discussing their concerns specifically related to certain religious practices and sometimes felt reluctant to ask midwives questions (Berggren et al., 2006; McLeish, 2005). More than half of the Muslim women in this study assumed that healthcare professionals do not have a positive opinion of Muslim women in general and of their religion as a whole. For most women this was not specifically an outcome of a negative encounter during their care, but was associated with the Western media portrayal of Islam and western attitudes towards Muslims in general. Like other Muslims in Britain and across the Western world, they expressed their concerns about the way Islam is portrayed in the media (both visual and printed) and felt that the public's perceptions of their faith are adversely affected by such representations (Ameli et al., 2007). Ever since the late 1980s, Muslims have been the topic of frequent public discussion in Western Europe and they are often viewed as social outsiders separated from non-Muslims, with their religion seen as a 'barrier' to inclusion (Foner and Alba 2008). Shadid and van Koningsveld (2002) mention there has been a persistent inclination to assume that Western norms and values are the sole point of reference in any analysis and to regard these as incompatible with those of Islam. This approach emphasizes points of conflict between Islam and Western culture and simultaneously ignores all the existing similarities between the two cultures. Noor (2007) also argued

that Muslim identity and the concerns of Muslims are increasingly being defined in terms of an oppositional dialectic that pits Islam and Muslims against the rest of the world.

In the past three decades, people in the West are confronted with media, both visual and printed, in which Islam and Muslims are the main topic. Unfortunately, the representation of Muslims in Western media has worsened following the events of 9/11. Bleich et al. (2015) assessed the portrayal of Muslims in the British print media between 2001 and 2012 and concluded that Muslims are typically cast in a predominantly negative light and are depicted in a substantially more negative way when compared to analogous groups. The tone of headlines about Muslims was systematically more negative than headlines about Jews, Christians or other comparable groups. Saeed (2007) highlighted that British Muslims in particular are portrayed within the British press as the 'alien other' or 'alien within' British culture, and often represented as 'un-British'. Muslim women in the current study were very conscious of such media, and expressed concerns that healthcare professionals' understanding of their faith and beliefs might be influenced by it. All Muslim women in the current study considered themselves as British Muslims, however, some Muslim women who were White-British, those born in the UK and those who were fluent English speakers, felt that their British identity was somehow doubted. One Muslim woman explained:

'I went in with my sister-in-law when she was having a baby, she was screaming with pain and the attitude of the midwife was not nice. She said to her "stop screaming or I will put you in a scream proof room". I was like "what is that?" I think she was trying to frighten her and as soon as she realized I was British and I can speak English her whole dialect changed and her attitude changed. She even made me tea at 3 in the morning. As soon as they find out that you are British and even in a profession they do look after you but if you are to them a Muslim housewife, they just do not care.' (Gp5; P6)

Ameli et al. (2007) propose that this may stem from the historical assumption that Islam is not compatible with Europe, or the West, or modern secular principles, which makes Muslims inherently 'different' or 'other' even if they were born and grew up in Britain and display all the visible signifiers of British youth culture. David Cameron stigmatised Muslim women in the UK with his English language policy, warning that Muslim women who fail a language test may have to leave the UK, making Muslim women 'alien within' their own society (Saeed, 2007).

The birth of radical groups such as *Daesh*, has worsened the situation and dramatically increased the coverage of Muslims, further highlighting the 'otherness' of Muslims/Islam from mainstream society. Ameli et al. (2007) indicated that media often makes distinctions between the actions of radical Muslims and the beliefs and actions of 'mainstream' or 'moderate' Muslims. This filtering of 'good' and 'bad' Muslims can prove to be counterproductive, as it portrays Muslims as having a potential to develop such radical views and behaviours regardless of their moderate standing. Meanwhile, the vast majority of Muslims do not spend their lives involved in conflict, are not 'scroungers' and do not condone the

sorts of violent actions carried out by terrorists or advocated by ‘hate preachers’ (Baker et al., 2013). Some Muslim women in the current study reported that policies such as The Prevent Strategy (2011)⁴⁸ adds to the polarization of Muslims. Two mothers mentioned that certain healthcare professionals made an assumption based on what appeared to them as risks of extremism rather than exploring or hearing from the mothers before making assumption or actions. For these women negative assumptions and the Prevent Strategy can act as barriers when interacting with healthcare professionals.

‘I think that there should be a lot of petitioning on the government to take away the anti-terrorism laws [Prevent Strategy], need to take away the pressure of GPs and medical professionals on being on the lookout for extremism and watching their patients, because that puts a lot of pressure on you as a parent when you have just had a baby and you are trying to do everything well, it is a really vulnerable position to be in. You can be going through postnatal depression, there can be loads going on but to then think that your doctor is potentially watching to see if you are putting your child at the risk of extremism is really stressful. Someone [healthcare professional] who is responsible for your mental health and your wellbeing at the most vulnerable stage of your life, for them to potentially be someone who is raising a red flag of something you are harming your child because of extremism. It is a conflict of interests, you cannot have them working together.’ (Gp3; P3)

‘They think that we are oppressed, young and married, and all these things they have about us that is negative. When I got married, some worker came to my house and they said they work with young teenage women, she used to come to my house every week. I never knew what it was, it turned out to be a program they started, I think looking after vulnerable teenage women and I did not ask for them. She was just asking questions every time, when she finally realized that I have a supporting working husband at home and I have a supporting family, they were like “ok we will come to see you after you have the baby” and I was like “I do not need your support” then they stopped coming because they realized that I am ok. They just sent them because I was pregnant, 19 years old, and Pakistani, so they think I was forced into marriage.’ (Gp5; P1)

Against this backdrop, Muslim women in the Western world tend to be portrayed as victims and oppressed and the face veil (*burqa*) has long been used as symbol of oppression and the patriarchy of the Islamic world (Baker et al., 2013; Janson, 2011). This image has run through the media, politics, arts and literature, even though it is estimated that 90 percent of Muslim women world do not wear the *Burqa* even in most Muslim countries (Janson, 2011). In addition, debates and policy in Europe about banning or regulating wearing the veil contribute to the assumptions that if Muslim women wearing Islamic garments had a choice they would not wear headscarves, *burqa* or any such clothing. Therefore,

⁴⁸ The Prevent Strategy is part of the government’s counter-terrorism strategy (CONTEST). Its aim is to stop people from becoming terrorists or supporting terrorism.

the prevailing discourse is that Muslim women are oppressed or even enslaved and need to be saved or forcibly emancipated (Janson, 2011).

The current study revealed that Muslim women felt they needed to negate and/or not add to such negative images of Islam and made an effort to present and explain their religious practices to help avoid misconceptions or misunderstandings. White-British Muslim women in this study reported that they felt the need to explain that they were not forced into the religion by their Muslim husband and would often emphasize in conversations with non-Muslims that being a Muslim is their choice.

'I felt that I was treated as a convert as opposed to a full Muslim, if that makes sense. I felt like I was treated like I come into the religion, and not a proper Muslim or that I have just converted for my husband. Especial after a story the midwife had told me; she asked about my husband's family and if any of my family were Muslim. So I explained briefly my background and she said, "You look nice because you are like a modernized Muslim, you cover nice". I was thinking, "What are you talking about? Just because I cover, you would not say that to anyone else about their dress sense". She said "we had one woman wearing a veil; I do not like them; the full veil scares me. She had her husband with her; I just did not have a good feeling about him at all, we had to have an interpreter and he refused, Uh God I did not like him". I just thought you do not have the right to talk to me like that. I felt that she was seeing me as an equal; you are white, you are English and we are the same, so I can talk to you about it this. So the next appointment I said to my husband, "You are coming with me to show how beautiful Muslim men are and you are not like that". I was a little bit annoyed because as usual I always try to show Islam in its best and not get defensive but try to empathize with the midwife, I explained, yes you may be scared to see their face covered but my friend wears it and she is not even married so do not always think it is the man. It felt like she presumed that covering was because of a man; she pictured this image of a woman covering in front of this strong man and she could not speak English and [the] vulnerable little woman cowering and face covered. It really disappointed me, because I was not expecting this of her.' (Sahar)

A few healthcare professionals in this study reported that before they had experience of working alongside Muslims and had also assumed that Muslim women deferred in most instances to husbands, fathers or brothers. They explained that sometimes it was easy to make such assumptions when encountering Muslim couples where the man and not the woman is an English speaker. This emphasizes Schott and Henley's (1999) point that such assumptions and generalisations can sometimes seem like a useful short cut, but they block the ability to understand, communicate and meet an individual's specific needs.

There has not been much effort made from the political perspective in properly understanding Britain's minority population (Sunak and Rajeswaran, 2014). Anti-Muslim attitudes continue in Europe in the speeches of popular political parties calling for action against Muslim minorities, such as policies that

restrict dress, Muslim activities, and the building of what are perceived to be overly large mosques, and in public opinion polls across Europe (Bleich, 2009). In the UK, Muslim politicians on all sides have implored British Muslims to make strenuous efforts to ‘integrate’ into British society and confirm their loyalty to the British state in a manner no other group would ever be instructed to (Ogan et al., 2014). Oddly, as if integration within a society is a one sided activity, this is like telling Muslims alone to make efforts to ‘fit in’ or be the ‘same’. The Department for Communities and Local Government (2012) specifically states that the meaning of integration is creating the conditions for everyone to play a full part in national and local life; it is achieved when neighbourhoods, families and individuals come together on issues which matter to them, committed to rebalancing activity from centrally-led to locally-led action and from the public to the voluntary and private sectors.

All have a role to play in creating an integrated society. The current study revealed that both Muslim women and Muslim healthcare professionals considered themselves integrated members of this society and made constant efforts to integrate. Muslim healthcare professionals reported that they used their professional roles to advocate for religious awareness amongst healthcare professionals and an acknowledgement of Muslim women’s needs. This is a major principle of cultural competence, which involves working in conjunction with natural, informal support and helping networks within diverse communities (NCCC, 2004). The role of Muslim healthcare professionals in this study exemplifies the concept of cultural brokering, as they acted in bridging the gap between healthcare providers and the Muslim community by communicating differences and similarities between cultures (Jezewski & Sotnik, 2001). More than half of the Muslim women in this study reported that they would not discuss certain religious practices with healthcare professionals if they thought that healthcare professionals might view them as different or at odds with Western norms. This is a serious aspect which if healthcare professionals are not mindful of will make the idea of improving inequalities and experiences of women during maternity through continuity of care model, which aims to build better relationship between women and healthcare professionals, ineffective and a daunting experience for women.

“My midwife’s attitude was not nice, I would not even think of opening any religious matter with her. The basic things she would not understand never mind religion and in general even if you ask for a religious need you will be explaining to them how and why and all this details”. (Fatima)

Cultural competency training has been proposed as a strategy for eliminating racial inequalities and ensuring culturally appropriate services (George et al., 2015), however, cultural competency is not as simple as learning lists of ‘do’s’ and ‘don’ts’ about ‘other’ cultures, it is a process of understanding and working with different individuals from diverse cultural and social backgrounds. Therefore, one cannot overlook directly or indirectly the role of the Western media in portraying negative images of Islam and in particular Muslim women (Bleich et al., 2015; Baker et al., 2013; Shadid & van Koningsveld, 2002), and its effect on Muslim women’s motherhood experience in the current study. Hence, it is important

when developing a competence model of care that is appropriate for Muslim women and other religious groups to recognize that culture is inseparable from the political-economic climate that we live in (Benson, 2006).

8.5 Competency in providing care for Muslim women

Every healthcare encounter provides an opportunity for a positive effect on an individual's health, but when an individual's value system (ethnic heritage, nationality of family origin, religion, culture, age, or socioeconomic status) is at odds with that of the prevailing medical establishment, the individual's value system generally will prevail, which will often strain the healthcare professional-patient/client relationship (Committee Opinion, 2011). Therefore, it is suggested that healthcare providers maximize the potential for positive effects on an individual's health by increasing their understanding and awareness of the value systems of the individuals' they serve, or by being open minded and educating themselves regarding those that they do not know (Committee Opinion, 2011). The current study revealed that more than half of healthcare professionals had some overall awareness of Islam, but not of specific aspects relating to motherhood and the religious customs practised during this journey. Most non-Muslim healthcare professionals were not aware of practices such as the recitation of the Quran, eating dates at the initial stages of labour, silence at birth, *Adhan*, *Tahneek* and breastfeeding as a religious recommendation. Most had not witnessed such customs during their encounters with Muslim women; this is no surprise, as most Muslim women in the current study reported that they did not feel confident to express views on such religious customs in the presence of non-Muslim healthcare professionals, in particular *Tahneek* and fasting.

Most Muslim women felt that healthcare professionals had some awareness about their faith in general but not enough to understand such practices without disapproving or perceiving them as taboo. Fasting is a practice that most Muslim women avoided talking about in front of midwives, as they thought midwives would advise against it. Even though this perception turned out to be somehow accurate, it is important to bear in mind that the healthcare professionals interviewed in phase three of this study are not necessarily the healthcare professionals that Muslim women in phase one and two encountered during their maternity journey. Healthcare professionals in this study reported that they would not approve of fasting during pregnancy and explained that when Muslim women enquired about fasting, some healthcare professionals quickly disapproved of it without discussing it further, and others who did discuss it provided advice on how the woman could be mindful of her nutritional needs. Therefore, it is important for healthcare professionals to be all encompassing of that which makes up the women's value systems and appropriately addresses the women's specific needs. Often lists of facts of different value systems in the wider literature can lead to confusion and complicate the delivery of care. Laird et al. (2007) indicate that cultural competency literature tends to provide 'laundry lists' of cultural traits

and practices of particular groups, thereby reinforcing stereotypes. A suggestion in the literature includes that healthcare professionals should minimise unnecessary touching and unnecessary body exposure to maintain the modesty of Muslim women especial from the opposite gender (Wehbe-Alamah, 2008). Should this not be a recommendation for every individual regardless of his or her faith?

Another is that as Muslims are prohibited from being alone in private with the opposite gender except with a family member, therefore healthcare professionals need to accommodate female Muslim patients by arranging for the presence of a female chaperone or family member during procedures that breach traditional Muslim modesty or expose a private body part (Wehbe-Alamah, 2008). The General Medical Council (GMC) *Maintaining Boundaries* (2006) states ‘whenever healthcare professionals examine a patient they should be sensitive to what the patient perceives as intimate- therefore wherever possible, they should offer the patient the security of having an impartial observer (a chaperone)’ and the NHS *Guidance on the Role and Effective Use of Chaperones in Primary and Community Care settings* (2005) states ‘this applies whether or not the healthcare professional is the same gender as the patient, this is because a chaperone is present as a safeguard for all parties (patient and practitioners) and is a witness to continuing consent of the procedure.’

Furthermore, healthcare professionals are to avoid prolonged eye contact with Muslims of the opposite gender because Muslims are discouraged to look directly to the eyes of the opposite gender for prolonged periods of time (Wehbe-Alamah, 2008). Certainly, there are verses in the Quran that advise the believers to lower their gaze to encourage modest behaviour and for the Muslims to carry themselves humbly between one another: ‘*Tell the believing men that they should reduce/lower their gaze/vision and guard their private parts... Tell the believing women that they should reduce/lower their gaze/vision and guard their private parts...*’ (24:30-31). However, the verses are not literally about eye contact but have a higher meaning concerning one’s ethics, to take such religious texts out of context will only lead to confusion when providing care for Muslim. For example, some healthcare professionals in the current study were aware of the religious exception that pregnant Muslim women are exempt from fasting during the month of *Ramadhan*. They reported that they used this fact when responding to Muslim women who enquired about fasting in an effort to deter women from fasting. Yet, they found that Muslim women still fasted regardless of reminding them of their religious exception. Meanwhile, Muslim women in the current study who have encountered such responses from healthcare professionals (not necessarily the healthcare professionals interviewed in phase three) reported that they found it inappropriate; they explained that they were aware of such religious exceptions and did not wish to be reminded of them. *Ramadhan* is a sacred month celebrated by the Muslim community and even though pregnant or breastfeeding Muslim women are exempt from fasting, many women found it difficult to not engage in such a sacred community celebration, hence they sought nutritional and wellbeing advice in making an informed decision that would promote the welfare of themselves and the child.

This illustrates that 'laundry lists' of beliefs and practices are not the way forward for assessing the delivery of appropriate care for Muslim women or any other religious or cultural groups. The notions of categorisation and generalization have been identified as adaptive strategies to make the social world more manageable, however such strategies fail to consider individual difference within groups and hinder healthcare professionals from giving the required information to make an informed choice (Puthussery et al., 2008). The current study also highlighted some of the healthcare professionals' perceptions were rooted in encounters they had with Muslim women. For example, when asked of their encounter with Muslim women, they reported that they found Muslim women preferred to have a natural birth; consider caesarean section as bad; have good tolerance for labour pain; breastfeed naturally; often turn down the DS screen as terminating the pregnancy is not permissible; and have good family support. This reflected what Muslim women in this study reported, whereby they also mentioned that they prefer natural birth, considered caesarean-section as bad, one of the reasons why they refuse DS screening is because the religious ruling on termination of the pregnancy, and most reported that they have good family support.

However, it is important to highlight that not all Muslim women in this study expressed such beliefs, some expressed the opposite of such beliefs. Consequently, there is a risk that such conscious and unconscious generalized perceptions by healthcare professionals may influence clinical decision-making and may contribute to ethnic inequalities. Puthussery et al. (2008) highlights that if for example, African woman are perceived to prefer an intervention-free natural labour this might lead professionals to avoid discussing the options for pain relief with them. Some Muslims women in this study felt that the midwives made notes of their birth preference but did not really discuss what options is available for them in a Midwife Led Unit or options for pain relief. They were advised to attend an antenatal class that introduced the options of pain relief, which the majority of Muslim women in this study decided not attend.

Religious identity within the West is routinely assumed voluntary and partial, rather than the comprehensive world view it is for Muslims (Laird et al., 2007). Muslims of all nations hold common religious beliefs and specific health needs, yet they are not a homogenous group; there are broad ethnic categories of Muslims living in the UK with many cultural values and most of all they are individuals. Determining an individual's religious affiliation is not really assessing religious/spiritual needs. Puthussery et al. (2008) suggest that to typify any group of people in care based on just one aspect of who they are such as their ethnicity or religion or culture, can lead to unsafe stereotyping and disadvantages. Therefore, it is important to provide care that is all-inclusive and accepting of differences, that is competent in creating an atmosphere where women can discuss spirituality (Jesse et al., 2007). This will depend on the education, professional confidence and competence of healthcare professionals in providing care that understands and acknowledges the needs of a multi-diverse population of today (McIntosh & Hunter, 2014). Healthcare professionals reported that they did not

experience training that focused specifically on bringing awareness of different religious or cultural values and practices in line with the Code for Nurses and Midwives (2015). This code advises nurses and midwives to keep knowledge and skills up to date, by taking part in appropriate and regular learning and professional development activities that aim to maintain and develop one's competence and improve one's performance. All healthcare professionals in the current study engaged in self-initiated learning to improve their knowledge and understanding of the value systems and the needs of the women they care for.

Through self-initiated learning healthcare professionals tried to develop their knowledge of Muslim women's value system, they sought to develop their knowledge through experiences, liaising with work colleagues and self-study. Most healthcare professionals reported that their encounters of caring for Muslim women are key in developing their understanding and developing their competency in addressing Muslim women's needs. Some had their first encounter with Muslim women here in the UK, others had their first encounter while working in a Muslim country. They explained that such encounters helped in developing their understanding and in recognizing Muslim women beyond religious membership - as women with common beliefs and unique differences. These encounters also made them aware of specific practice such as a preference for female healthcare professionals, the importance of maintaining modesty, fasting the month of *Ramadhan* and its exceptions, halal diet, the obligation of male circumcision, specifically for some understanding why women use terms such as '*Asalam Alykom*' (traditional Muslim greeting), '*Allah*' and '*Inshallah*'. Also certain cultural practices such as taking off shoes on entering the house, the elder mother taking charge in looking after the birthing mother and new-born, 40-day rest for the mother after birth, and the ability to recognize Muslim women's different ethnicities. In addition, some healthcare professionals reported that coming into contact with Muslims helped in negating the negative image of Islam and Muslims portrayed in the Western media. This emphasizes the importance of personal and practice-based knowledge beyond the forms of knowledge typically promoted in evidence-based practice (Callister & Khalaf, 2010).

Liaising with work colleagues was also a significant learning avenue for most healthcare professionals in the current study. The diversity within the workforce helped with this learning process. Muslim healthcare professionals reported that other non-Muslim work colleagues would often approach them when there was uncertainty surrounding religious or cultural matters. They reported that they found their position as healthcare professionals beneficial in supporting and enhance awareness of cultural and religious matters amongst the healthcare professionals. Kai (2007) reports that the absence of support to develop cultural competence and professional uncertainty is disempowering and detrimental to service users. Robinson (2002) indicates that healthcare professionals who act as cultural brokers can increase the confidence of professionals and services users from different background to engage with each other effectively.

The level to which cultural brokers may serve as intermediaries varies; some will serve at the most basic level, bridging the cultural gap through communicating difference and similarities between cultures, others can resolve conflict and establish a connection between the patient and the healthcare provider (Jezewski, 2005). The current study revealed that some Muslim women sometimes sought Muslim healthcare professionals within the community rather than their own midwife and Muslim healthcare professionals reported that they encountered this often. Muslim healthcare professionals reported that they would counsel the women on basic matters and mainly build their confidence in staying in contact with their own midwife without fearing that their religious/cultural needs would be misunderstood. Meanwhile, they would often act as a point of reference for both other healthcare professionals and Muslim women, as they were knowledgeable in two realms (1) the health values, beliefs, and practice within their cultural/religious group or community and (2) the healthcare system that they have learned to navigate effectively for themselves and their families (NCCC, 2004).

Other cultural brokers may serve in a more sophisticated role - mediating and negotiating complex processes within organizations, government, communities, and between interest groups (NCCC, 2004). For example, NCCC (2004) highlights that cultural broker can act as a guide in assisting in developing educational materials that will help services users to learn more about the healthcare setting and its functions. Muslim healthcare professionals reported assisting in the development of educational materials produced in other languages, others assisted in the delivery of antenatal class for non-English speakers, and most used their bilingual skills to enable more direct communication, which is recommended by Research In Practice For Adults [RIPFA] (2008). All Muslim healthcare professionals aspired to be a catalyst for change as they tried to break down bias, prejudice and other institutional barriers in the healthcare setting (NCCC, 2004). For example, a Muslim healthcare professional raised the issue surrounding the Vitamin-K vaccinations to managers, pointing out it contained a substance that is impermissible for Muslims and other groups such as Hindus, Jews, vegetarians and vegans. They advocated for a vegetarian option, which is now being explored further within the Trust. Overall, cultural brokers have the potential to enhance the capacity of individuals and organizations to deliver healthcare services to culturally and linguistically diverse populations (NCCC, 2004).

Meanwhile, the delivery of competent healthcare services to culturally and linguistically diverse populations is the responsibility of everyone within the healthcare workforce. Almost anyone can fulfil the role of a cultural broker; cultural brokers may not necessarily be members of a particular cultural group or community but must have a history and experience with cultural groups for which they serve as broker (NCCC, 2004). This includes the trust and respect of the community; knowledge of the values and practices of cultural groups; an understanding of the traditional and indigenous wellness and healing networks within diverse communities; and experience in navigating healthcare delivery and supportive systems within communities. A male healthcare professional, who was not Muslim, illustrated the potential to be a cultural broker, as he had knowledge and understanding of the value systems of Muslim

women and used this knowledge in reducing conflict or producing change. He experienced working within the Muslim community to establish a connection between the community and the healthcare service, and was trusted within the Muslim community.

'It was very interesting when I worked in in a small town, when I first started working there, there was a lot of rejection of me. I worked there six months back in 1998. A lot of ladies said no to me delivering, initially, the Muslim ladies. But at the end, it was a lot less. Now, I had not noticed this until the Link worker said when I was leaving – "they know who you are, they all talk and they all think you are alright, and they have all said it is fine if you are the one that does their scan, he is alright". You know, which was quite an accolade really for six months working in that place, you know, the community started to trust me and my judgement, and would be more open and agreeable to me delivering their care.' (HP-5)

Cultural brokers are not currently recognised or remunerated in the NHS. The healthcare services could use the recruitment criteria highlighted in NCCC (2004) in recognizing their cultural brokers. This includes the ability to assess and understand their own cultural identities and value systems; recognize the values that guide and mould attitudes and behaviours; understand a community's traditional health beliefs, values, and practices and changes that occur through acculturation; understand and practise the tenets of effective cross-cultural communication, including the cultural nuances of both verbal and nonverbal communication; and advocate for the patient, to ensure the delivery of effective healthcare services.

Self-directed learning is also an important concept. NMC (2009) guidelines include that midwives must be equipped as life-long learners, able to recognise and rectify knowledge gaps by locating, analysing, critiquing, using and disseminating evidence in practice. Foley (2001) highlighted that we learn as we act, and our learning is both tacit and explicit; self-directed learning encourages self-understanding and professional skill development. The idea of learning is to develop cross-cultural skills to deliver appropriate care, having the knowledge of women's value systems is essential but also transferring such knowledge into skills is as important. Healthcare professionals expressed some knowledge regarding Muslim women's religious needs but not all showed skills in assessing such needs. Effective engagement with minority ethnic communities requires action at the institutional as well as individual level. At the institutional level the workforce needs to be motivated and equipped to engage effectively with individuals from ethnic minority groups, policies and procedures should demonstrate an expectation of effective communication skills from staff at all levels and set out opportunities for training, and partnerships that will support the development of this kind of competence in the organisation (Audit Commission, 2004). The study revealed that both healthcare professionals and Muslim women suggest that healthcare professionals would benefit from training that will develop understanding and skills in delivering competent care.

Finally, at an individual level healthcare professionals may need to develop their personal knowledge and skills in order to develop attitudes such as openness, flexibility and confidence in their own ability to develop and practice cultural competence (Zoucha, 2000; Wells, 2000). As in Callister & Khalaf's study (2010), healthcare professionals suggested that they would all benefit greatly from training that includes real birth stories told by women themselves. They recommended that training should be facilitated in a way that enhanced their knowledge and skills; they all reported that strategies such as e learning, which includes multiple question, do not really help in connecting them to the true voices and feelings of the women (Gardner, 2008). Most healthcare professionals highlighted the nature of their demanding work environment and sometimes having to attend additional training can increase their workload without really giving them much benefit. However, they indicated that if training was available that involves the telling of real life-birth experiences told by the women themselves they would be more enthusiastic about attending and would benefit greatly. Callister & Khalaf (2010) also mention that birth narratives can provide insights to the connection between childbearing and spirituality, and can be utilized as an effective intervention for childbirth educators.

8.6 Development of Culturally Competent Care

Ever since the late 1990s and 2000s when a number of cultural diversity policies emerged, recognising the changed demography of British, there are continuous calls for healthcare professionals and healthcare services to be 'culturally competent' so that services user's needs can be met (George et al, 2015). However, despite increasing reference to the term cultural competence in Department of Health (DoH) and National Health Service (NHS) documents in recent years there is limited consensus around an exact definition of what constitutes cultural competence and a particular absence of what it means for the service users. George et al (2015) highlight that there was a lack of conceptual clarity and consistency in defining cultural competence, and how cultural competence can be learnt and established.

Overall, this study revealed that there is potential among healthcare professionals and healthcare services to deliver competent care that responds effectively to the specific needs brought by Muslim women to the healthcare encounter. Although there are a range of health policy documents about 'cultural competence' which are important guidelines to achieving and setting good practice; these alone are limited in what they can achieve (George et al, 2015). Education and training are the mechanisms by which these guidelines and standards of good practice are operationalised and instilled in individuals (George et al, 2015). The use of appropriate training can help support services develop and equip service providers with the knowledge, attitudes, skills and confidence needed. Cultural competence training may enable healthcare professionals to broaden their cultural horizon, which provides healthcare professionals with awareness of their own cultural identity and prejudices, ability

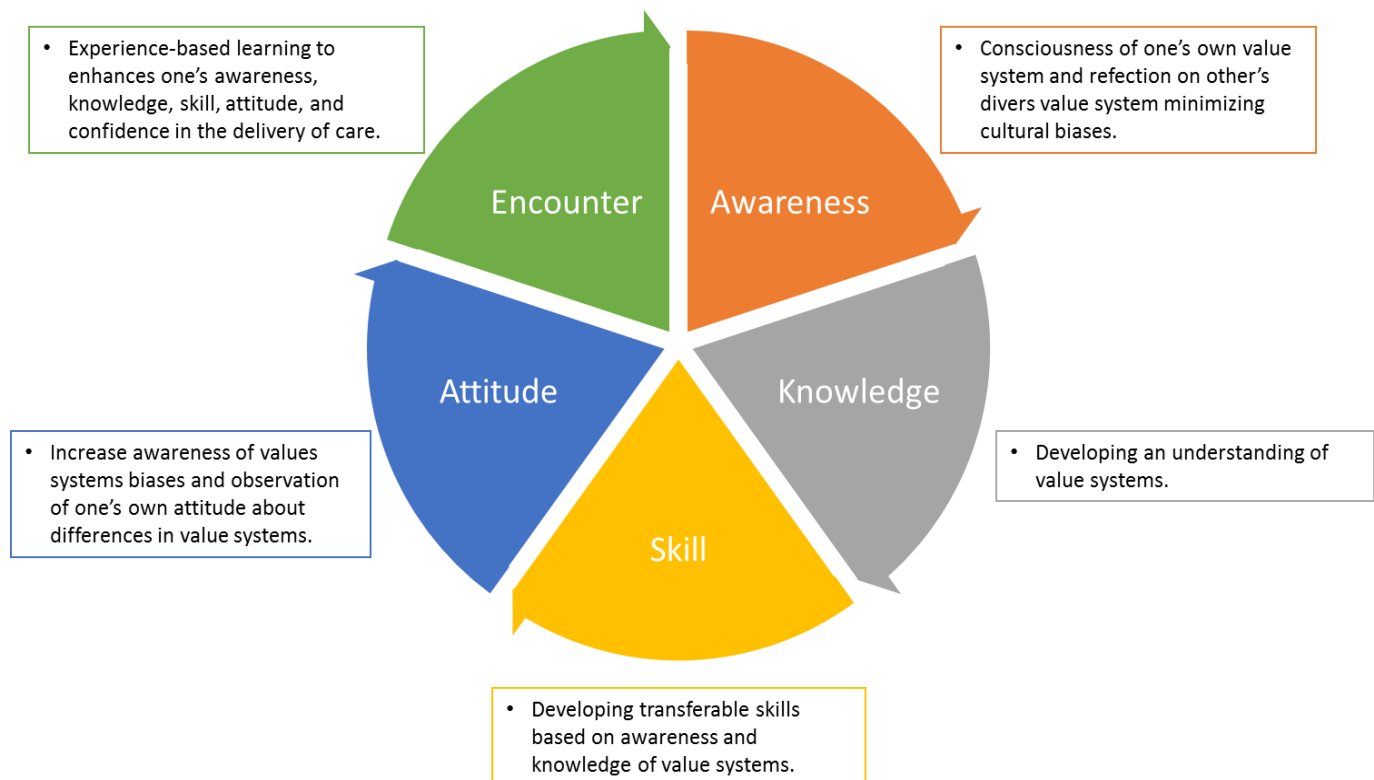
to question their own stereotypes, as well as their ability to show empathy across cultures (Schouler-Ocak et al., 2015). Schouler-Ocak et al. (2015) suggest that cultural competence should be considered at both the individual level as well as institutional level. Whereby staff need to value diversity, assess their own cultural values, be aware of cultural interactions, incorporate cultural knowledge, adjust service delivery accordingly, and where services also include access to suitable and professionally trained interpreters or culture brokers and a healthcare professionals' ability to work with them. Cultural competency is at the heart of good practice. Padela et al. (2011) suggest that cultural competency would lead to a greater understanding of Islam and Islamic culture, thereby improving patient-provider relationship and improve Muslim experiences within the healthcare system, resulting in reduced challenges (such as recognising differences among different groups or people, communication, trust) and an increased accommodations of needs.

The notion of cultural competency training has blossomed on a policy level but has not been translated to actual changes in clinical practice and service provision (George et al., 2015). A systematic review of the UK literature regarding cultural competency training in healthcare highlights that current approaches to this type of training are fundamentally flawed and are predominantly empirically, rather than theoretically driven, and as a result, the field lacks conceptual clarity and rigour in addressing cultural issues in practice when caring for a diverse population (George et al., 2015). George et al. suggest that it is important to recognise that cultural competency training is not a single-handed strategy for eliminating healthcare inequalities, but it is important in ensuring high quality care to the entire population, if practiced effectively and should be available in all clinical areas. Schouler-Ocak et al. (2015) mentioned that cultural competency is not about learning the language or adopting the cultural values of a patient, but about respecting differences and making sure that these are bridgeable in order that they do not negatively affect the process of care. Therefore, different models for cultural competency training should be regularly used, evaluated and properly adjusted if necessary.

Cultural competence is a process rather than an ultimate goal; it is not a static phenomenon but a developmental process that is often developed in stages by building upon previous knowledge and experience (Schouler-Ocak et al., 2015). The learning objective and training programs of cultural competence must be adapted to the different healthcare professionals' specialties, which would create a comprehensive response to healthcare needs of Muslims and other ethnic groups rooted in cultural knowledge and transferable skills.

This study suggests that the five constructs of cultural competency gathered from the various definitions in the literature can be useful to guild the delivery of cultural competency literacy and training. The notion of cultural competency within the health literature circulates around these five concepts; Awareness, Knowledge, Skill, Attitude and Encounter.

8.6 Figure 1: Cultural competency framework (figure created by researcher)



The current study suggests that every one of these concepts is essential in the development of cultural competency and assist in the delivery of effective care for Muslim women and other diverse groups of women.



- Awareness is a major element of cultural competency, which lays the foundation to acquire the other elements. Cultural awareness includes self-reflection on one's own beliefs; it is a process in developing consciousness of one's own value system and reflection on other's diverse value systems. To recognize one's own cultural identity and prejudices to minimize cultural biases, healthcare professionals need to show sensitivity to the values, beliefs and practices of the women they care for, and reflect on their own values and not impose them on others (Rassool, 2014; Leavitt, 2010; Campinha-Bacte, 2010; Papadopoulos et al., 1998).

In terms of caring for Muslim women, for example, healthcare professionals need to develop awareness that Muslims are not a homogeneous group of people, as cultural and linguistic diversity exists amongst

them, with each having their own cultural characteristics and worldview of health and illness (Rassool, 2014). Healthcare professionals need to reflect on their own values that are different to the values of Muslim women, removing any biases by respecting such values and not imposing their own values. Healthcare professionals need to be aware that religion is a major aspect in Muslim women's life and there are common religious values and practices that Muslim women share.

Using fasting as an example to illustrate awareness; healthcare professionals may have an awareness that Muslims engage in the act of fasting during a certain month and that Muslim women may take part in such practices while pregnant. Healthcare professionals need to reflect on their own values and biases in regards to fasting, thereby avoiding imposing their own values and giving themselves the opportunity to respectfully explore this further with the women.



- Knowledge is about developing a deeper understanding of value systems driven by both individual and organization learning, and making use of meaningful contacts with cultural brokers, understanding the theoretical and conceptual frameworks for the worldviews of other people. A learning process that will enhance knowledge on specific beliefs and practices related to health that will develop the healthcare professionals' confidence in providing care for other cultures.

In terms of caring for Muslim women for example, healthcare professionals need to develop knowledge of Muslim women's cultural and religious beliefs and practices, and develop an understanding of the issues they may face during their care. Using fasting as an example, a deeper understanding of the fasting month of *Ramadhan* - when it is practised, why it is practised, how it is practised and by whom – would give staff a better understanding of how fasting may impact a pregnant or a breastfeeding woman. This will develop their confidence to plan individualised courses of care.



- A commitment to lifelong learning to develop transferable skills will enhance the delivery of appropriate care. It is important for healthcare professionals to demonstrate skills that are informed by sound cultural knowledge, this includes interpersonal and clinical skills, and to reflect skills that explore and assess the needs of people of different cultures effectively and appropriately.

In terms of caring for Muslim women, for example, healthcare professionals need to take appropriately action systematically collect information relevant to Muslim women's needs with consideration of religious values and practices, and interpret these for the purpose of providing culturally appropriate care.

Using fasting as an example, healthcare professionals may explore with Muslim women their intentions of fasting, their overall wellbeing and the hours in which they have to fast. Based on such information healthcare professionals can plan individualised courses of care based on what is suited for the women, whether it is involving a nutritionist or assessing the women on a regular basis during the fasting period.



- Changing attitudes, emphasizing the difference between training that increases awareness of cultural bias and beliefs in general, and training that has individuals carefully observe their own beliefs and values about cultural differences. It is important for healthcare professionals to reflect on their changing attitudes to other cultures to minimize generalization and stereotyping attitudes. One may have the right knowledge and skills but the attitude may not be appropriate, therefore it is important that healthcare professionals demonstrate respect, openness, tolerance, empathy and trust.

In terms of caring for Muslim women for example, healthcare professionals need to reflect on their attitudes towards Muslim women's values and practices and try to ensure culturally sensitive care through good communication and open dialogue (Gulam, 2003). Healthcare professionals need to create an atmosphere that allows women to express their value systems and discuss their needs with healthcare professionals confidently.

Using fasting as an example, healthcare professionals may not necessarily agree with the practice of fasting during pregnancy, but show openness and empathy - to see and feel the fasting as the women sees and feels it, and to explore the meaning it has for them.



- Personal encounters are key to becoming culturally competent. A process encourages experience-based learning through continuous exposure to people from different cultures. Through encounters, healthcare professionals will be able to strengthen and develop the elements of awareness,

knowledge, skill and attitude, and enhance confidence and reduce confusion in the delivery of care. According to Okrentowich (2007), learning and experiencing different cultural backgrounds will result in ethno-relativism, which will enable the healthcare professional to appreciate the needs of different cultures.

In terms of caring for Muslim women for example, it is important that healthcare professionals have exposure to Muslim women, as through such exposure healthcare professionals will be able to evaluate the four elements of awareness, knowledge, skill and attitudes. This will allow them to enhance each element and to always engage in becoming more competent.

Using fasting as an example, during the month of *Ramadhan* healthcare professionals may discuss fasting with Muslim women, which will help them explore the women different opinions and their specific need in regards to the fasting. This will help enhance healthcare professional knowledge of such practice, reflect on their skills and attitude when encountering such practice, and promote high quality care and delivery of individualised care.

Does having more knowledge about Islam makes healthcare professionals more competent? Not necessarily, what is fundamental in culturally competent care is being responsive to the health beliefs and practices of Muslim women, and to their cultural and linguistic needs (Rassool, 2014). The emphasis must be on the improvement of professional practice and evaluation, be an integral part of the commissioning of training, and should aim to measure both short-term and long-term change (George et al., 2015). George et al. (2015) suggest that with the ever-changing demographics, the desire for cultural competent training will increase. Therefore, given the receptive climate towards recognising the importance of cultural issues in the clinical context, the best time to reform cultural competence training is now.

This study's cultural competency framework is an important framework that can be used in the development and delivery of cultural competency training. The framework is made up of five essential concepts that define the principle of cultural competency as a whole, which makes it transferable to Muslim women in any context, not just healthcare, and to other religious groups.

8.7 Understanding Muslim women's practices

This study revealed that majority of Muslim women lacked some confidence in healthcare professionals understanding of their religious practices. They explained that they would only discuss their religious practices if they gauge openness and understanding of the healthcare professionals. Muslim women were confident in discussing concerns, seeking and accepting advice for religious practices from Muslim healthcare professionals rather than non-Muslim healthcare professionals. The shared religious beliefs were enough to give Muslim women confidence in anticipating openness and understanding

from Muslim healthcare professionals. As Ross's (2006) research findings showed, Muslim women valued religious input from non-Muslim healthcare professionals but did not expect such input to be as part of their professional role. Ross's (2006) findings indicate that the acceptance of spiritual care depended on the healthcare professionals having adequate time for the women, spiritual awareness, sensitivity and good communications skills. Rassool (2014) suggests that it should be possible for healthcare professionals to develop levels of awareness, skills and religio-cultural sensitivity that can be applied to interactions with Muslim patients, their family, and their significant others.

Meanwhile, creating a static care model for Muslim women can sound appealing yet challenging; the value systems of Muslim communities are not static, the diversity of ethnicity and linguistic groups, with each having its own cultural characteristics and worldviews of health and other specific matters among Muslims presents constant challenges to healthcare providers and services (Rassool, 2014). As much as Muslims are diverse, there are some similarities or homogeneity that are found within Muslim communities that relate to health beliefs and practices, access and utilisation of healthcare, health risks, family dynamics, decision-making processes (Rassool, 2014).

Based on this thesis's findings, a guide is shaped to help support and guide healthcare professionals when dealing with Muslim women common religious practices. The guide divides the religious practices of Muslim women into practices that require the involvement of healthcare professionals and practice that do not require their involvement. Rossaal (2014) indicates that healthcare professional need to be fully aware of and sensitive to Muslims customs and religious beliefs.

8.7 Table 1: Guide to Muslim women religious practices during Motherhood

Religious Practice (No HP involvement) These are religious practices that are commonly practiced by Muslim women and do not necessary required the involvement of healthcare professionals. Yet it is important for healthcare professionals to acknowledge them and give support if required.	Religious practices (HP involvement) These are religious practices that are commonly practiced by Muslim women and require the involvement of healthcare professionals to facilitate. It is important for healthcare professionals to be aware of these practices to enable them meet and support Muslim women religious needs.
Quran recitation- The recitation of the Quran was a common practice among Muslim women during the entire journey of motherhood. Women recited certain Quran chapters at different stages of their pregnancy (e.g. the chapter of <i>Maryam</i> (Mary) in the last trimester). The recitation and listening to the recitation of the Quran was also a	Prayer- Muslims have an obligation of five daily prayers. The woman or partner may need to perform the prayer while they are waiting for their appointment or during their stay in hospital. Muslims need to perform Wudu a ritual washing to be performed in preparation for prayer.

<p>common practice during the initial stages of labour; the woman or the birth-partner would recite the Quran and/or they would use audio devices such as CD player or a smartphone to listen to the recitation.</p> <p>Role of Healthcare professional – Awareness and respect for the recitations while it is recited. Can assist by provide an audio device such as CD player device if requested.</p>	<p>Role of Healthcare professional – Awareness of the five daily prayers, the location of the prayer room if one is available and appropriate washing area if available for signposting. May facilitate for a temporal space for the prayer to be performed and may provide a clean sheet for them to perform the prayer on.</p>
<p>Supplications (Dua’a) - This is a common practice among Muslim women seeking Allah's blessing, mercy and support at the time of their struggle. They tend to make verbal supplications calling on Allah's name and His attributes most commonly in the Arabic language.</p> <p>Role of Healthcare professional – Awareness and acknowledge that women or their birth-partner may call out certain supplications or Arabic terms for example during labour.</p>	<p>Modesty- This is often an important practice for the majority of Muslim women. They would often prefer not to be too exposed during examinations or labour. Some may prefer not to be exposed or examined by a male healthcare professional only if necessary.</p> <p>Role of Healthcare professional – Acknowledge this and facilitate for the woman not to be too exposed by providing an extra sheet or an extra gown if necessary. Give time for the women to cover, for example if she wanted to wear a headscarf or a veil before moving them to a different room or allowing another healthcare professional into the room. Enquire with the woman if she prefers for her curtains to be open or close, for example during visiting hours in the ward or while she is breastfeeding. Inform the woman if she was going to be consulted by a male healthcare professional and explore what would be her preference and facilitate if possible.</p>
<p>Eating dates (fruit) during initial stages of labour- Some Muslim women would eat dates for energy and for pain relief during the initial stages of labour. It is recommended in religious teachings, imitating the action of <i>Maryam</i> (Mary) during her labour. Some Muslim women will bring their dates with them when they arrive at hospital.</p> <p>Role of Healthcare professional - Awareness and acknowledge of this practice.</p>	<p>Lawful (Halal) food, medicine and vaccine - It is common for Muslims to consume and accept what is considered lawful by the Islamic teachings. Some may reject certain medication or vaccine (such as Vitamin-K) if they contain any unlawful substance. There are certain exceptions within religion that Muslim can take that allows for animal based medications or vaccine if there is no other lawful option available and it involves the greater benefit of the person. Note: that some may consider the religious exception and some may not.</p> <p>Role of Healthcare professional – acknowledge this and it is important to check the dietary requirement for all women.</p>

	<p>Note that not all women will eat a halal curry; some may prefer something else such as a vegetarian option. Therefore, it is important to explore this with the woman.</p> <p>In terms of medication and vaccine, it is important to be aware of the content of the medication or vaccine provided if it contains any animal extracts within it. It is important that women are informed and are given an option if another suitable option is available.</p> <p>Note that not only Muslim women that may not prefer an animal based medication or vaccine but also other women who may be vegetarians, vegans, Hindu, Jews and others.</p>
<p>Silence at birth- Some Muslim women would like the first word that their child hears at birth is Allah's name or the word of Allah. Therefore, some would prefer a moment of silence at birth so they can mention Allah's name for the child to hear and some may call the word of Allah at birth slightly louder than the other voices in the room for it to be significant for the child to hear than the other voices.</p> <p>Role of Healthcare professional – Awareness and acknowledge that some may prefer this moment of silence or may request healthcare professionals to speak low during the birth.</p>	<p>Fasting – is a common practice commonly practices during the fasting month of <i>Ramadhan</i> that all Muslims engage in.</p> <p>Some Muslim practicing fasting sometimes during other times of the year as voluntarily fast or if one had to make up the fast they have missed of during <i>Ramadhan</i>.</p> <p>There is a religious exception for pregnant or breastfeeding women not to fast the month. It is common for Muslim women who are pregnant or breastfeeding in <i>Ramadhan</i> to attempt fasting; not all women will take the religious exception. For some they prefer not to miss on the community fast and find motivation to engage in the fast with the rest of their family.</p> <p>Some will attempt the fast and keep mindful of their ability, if they find that the fast becomes a struggle they will then considered the religious exception and break their fast.</p> <p>Role of Healthcare professional – acknowledge this and it is important to be aware of when is <i>Ramadhan</i> within the annual calendar.</p> <p>Telling Muslim women not to fast can often discourage discussion. It is important to explore this with the woman; allow for discussion of her intentions during the fast of <i>Ramadhan</i>, explore how she is finding the fast if she is fasting. Provide advice and guidance depending on the situation.</p> <p>Give nutritional advice or refer to nutritionist if necessary to help guide the woman during this period.</p>
<p>Adhan and Iqamah – It is common practice for the Muslims to whisper the <i>Adhan</i> (first call of prayer) in the right ear of a new-born and <i>Iqamah</i> (second call of prayer) in to the left ear soon after birth. The birth-partner tend to do this practice, they may move to one side of the room with the</p>	<p>Birth position- This is practised by some Muslim women, whereby they do not prefer to be in a laying down position during labour imitating <i>Maryam</i> during her birth. It is also believed that labouring in a laying down position can complicate the labouring process for the woman.</p>

<p>baby to have a personal moment and some may wait until there is no interruption in the room. Some may wait for a member of family or community with high status such as grandfather or Imam to care out this practice.</p> <p>Role of Healthcare professional – Acknowledge and allow some space for this to be performed if possible.</p>	<p>Role of Healthcare professional – Awareness of this and explore this with the women when discussing the birth plan and during labour.</p>
<p>Tahneek – This is a common custom, commonly practices soon after the child is born, preferable before the child's first feed. A small piece of softened date being gently rubbed into the child's Mouth on the upper palate. Some Muslim women tend to bring dates with them to hospital so they can carry out this practice as recommended. Others will delay this practice until they are home.</p> <p>Role of Healthcare professional- Awareness.</p>	<p>Burial of placenta- It is a custom that is religiously recommended, however some Muslim women, those who have the facility to bury the placenta, practise it. Some may prefer to bury their placenta but do not have the facility to do so.</p> <p>Role of Healthcare professional - Acknowledge this and explore this with the women to give guidance on how and where they can bury the placenta.</p>
<p>Shaving the head hair of a new born child- It is practiced by some Muslim women commonly on seventh days after birth and an equivalent weight in silver is given to charity.</p> <p>Role of Healthcare professional – Awareness.</p>	<p>Breastfeeding- This is a common practice among the majority of Muslim women. It is recommended for women to breastfeed for a period of 2 years; the majority of women attempt breastfeeding and continue to the best of their ability. Maintaining modesty during breastfeeding is a very important aspect to all Muslim women.</p> <p>Role of Healthcare professional - Acknowledge this and explore this with the women; exploring the possible challenges and discussing the support that women may require. Acknowledge that women need to maintain modesty during breastfeeding; this can be challenging in the ward. Therefore, it is important to bear in mind that some women may prefer for their curtains to be closed while in a ward to help them breastfeed. A breastfeeding apron can support the women maintain modesty.</p>
<p>Aqiqah – This is commonly practised by Muslims seven days after birth. A sheep is offered in sacrifice and the meat is distributed among family members and the poor within the community.</p> <p>Women differ in how they implemented this practice; some distributed the sacrifice as cooked food in a family gathering and some pay for a sacrifice to take place in country other than the UK to be distributed to the poor.</p>	

<p>Role of Healthcare professional- Awareness.</p>	<p>Role of Healthcare professional – Acknowledge this and explore this with mothers whom have gave birth to a male child. Information on what is available on the NHS and signposting on NHS accredit private clinics will benefit the mothers.</p>
<p>Community visits mother after childbirth- It common for mothers to receive visits from other women within the community soon after birth. These visits can start at hospital and continue at the women's home or at their family home. Mothers often receive gifts, cooked food, and gets to hear the experiences and the advices of other Women regarding motherhood.</p> <p>Role of Healthcare professional- Acknowledge and awareness that is time can be overwhelming for some mothers, especial first-time mothers.</p>	

This guide will support healthcare professionals in the process of understanding and acknowledging the religious needs of Muslim women, giving them the confidence to explore and assess the needs appropriately. The current study also suggests that the idea of the Explanatory Model (Kleinman, 1981), will support healthcare professionals in exploring each need further without the care becoming a series of 'do's and don'ts'. The idea of the Explanatory Model gives healthcare professionals knowledge of the beliefs the patient holds about their illness, the personal and social issues attached to their illness, their expectations about what will happen to them and what the healthcare professional will do, and their own therapeutic goals. The Explanatory Model uses a set of targeted questions that act as an important tool for facilitating cross-cultural communication, ensuring patient understanding, and identifying areas of conflict that will need to be negotiated (the wording and number of questions used will vary depending on the characteristics of the patient, the problem, and the setting). Below are a set of questions suggested by the Explanatory Model:

- *What do you think has caused your problem?*
- *Why do you think it started when it did?*
- *What do you think your sickness does to you? How does it work?*
- *How severe is your sickness? Will it have a short or long course?*
- *What kind of treatment do you think you should receive?*
- *What are the most important results you hope to receive from this treatment?*
- *What are the chief problems your sickness has caused for you?*

- *What do you fear most about your sickness?*

This study proposes that a similar approach will open healthcare professionals to human communication and set their professional knowledge alongside the Muslim women's own explanation and viewpoint, prompting more woman-centred care. Finding out what matters most to another person is not a technical skill, interpersonal skills become an important part of quality care. Above all, like other women, Muslim women in the current study wanted to be listened to; about what they want for themselves and their baby, and to be taken seriously when they raise concerns (National Maternity Review, 2015). What was clear in the National Maternity Review (2015) and also in this study, is that all healthcare professionals had the interests of the women and baby as their priority - where they differed was their perspectives on how to secure the best possible care for them. Therefore, this thesis proposes that the idea of the Explanatory Model can enhance the ability of healthcare professionals in exploring Muslim women's need more effectively. Exploring Muslim women needs with 'what', 'how' and 'why' type questions creates a deeper understanding that will help healthcare professionals plan care that is appropriate for them. For example, healthcare professionals can address fasting by using explanatory questions such as:

- *What do you do in the month of Ramadhan?*
- *Why is it important to you?*
- *What are your plans for this month? Do you have any religious exceptions?*
- *How do you feel? Will you consider the religious exceptions?*
- *What kind of information or support do you think you should receive?*
- *What are the most important results you hope to receive from this information or support?*
- *What do you fear the most about fasting?*

In conclusion, interactions and care with women using the healthcare services can be improved and enhanced if healthcare providers can bridge the divide between the culture of medicine and the beliefs and practices that make up the women's value systems (Committee Opinion, 2011). The current study revealed that healthcare professionals have potential in delivering high quality care and they would benefit from training that will enhance their awareness, knowledge, interpersonal skills and confidence when addressing Muslim women and other cultural groups. Meanwhile, healthcare professionals should not be intimidated or anxious about doing the wrong thing; if there is uncertainty about a specific value or practice they should use the idea of the Explanatory Model and asking the women or their families, the women will appreciate the healthcare professional attempt and effort to provide sensitive care.

8.8 This study's unique contributions

This study is the first of its kind to explore Muslim women's experiences of maternity care within the North West (UK). The research opens a new breadth that expands the knowledge and understanding of Muslim women's motherhood experience in the UK. The connection between religious values, religious identity and maternal care has not previously been discussed for this group of women. The findings will help the development of cultural competency educational interventions to enhance healthcare professionals' awareness and competency in delivering high quality care.

Some of the concerns highlighted by Muslim women in this study are shared by women from the majority population; for example, short appointments, clinically focused care, and less empathetic, sensitive and competent care. However, the unique contribution of this study is the rich findings demonstrating the specific needs of Muslim women and their unique motherhood experiences.

Creating this in-depth knowledge and understanding of the women's motherhood experiences helped in identifying a framework and a guide that will help develop the literacy and competency of healthcare providers and maternal services in addressing the needs of Muslim women.

8.9 Implications

The findings of this study include some important issues for consideration for institutions, healthcare professionals, Muslim women and further research.

Implications for institutions:

- To deliver effective training programmes that enhance the knowledge and understanding of religion, culture and ethnicity for all healthcare professionals. These programmes should start at university level and be developed further within maternity organisations.
- Maternity services should assess and reassess the cultural competence of all healthcare professionals and encourage the development of lifelong learning. This will give healthcare professionals the ability to keep up to date with the needs of a fast growing diverse population.
- The development policies of NHS organisations should acknowledge the needs of a diverse and growing population. They should take into account Muslim women's religious values and practices, such as prayer, modesty and nutritional requirements. This should help develop a culturally sensitive Trust, which will help enhance the Muslim women's confidence in the services.

- NHS organisations should make information about services more accessible for Muslim women to better understand the available options of antenatal classes, breastfeeding support, Midwife-Led Units, delivery suite, use of pain relief, and all procedures surrounding pregnancy.
- NHS organisations should show sensitivity and awareness towards the religious needs of Muslim women. For example, the majority of Muslim women would prefer a female healthcare professional to comply with their religious recommendation, but would also consider the religious exception when a female is not available. They should be informed about the healthcare professional attending to their care, giving the option if a female is available.
- NHS organisations should make Muslim women aware of the specific options and facilities available, such as prayer rooms and washing areas, male circumcision within the NHS and NHS accredited provider clinics, the Trust's Muslim Chaplain, Islamically lawful medications, vaccinations and food.
- Institutions should acknowledge the importance of culture brokers in developing the cultural competency of services and Muslim women's trust in the services. Culture brokers should be given the opportunity to contribute to the development of cultural competency training programmes, deliver outreach programmes to diverse groups within the local community and to use their bilingual language skills in effective communication. It is important to enhance the use of services by allowing cultural brokers to advocate NHS services within the Muslim community.
- NHS organisation, especially maternity services should be conscious of the women's specific needs when developing and delivering antenatal classes and other outreach programmes. They should considered given clear details of what each class or programme will include, apply it in a way that women can relate to it and it have information that women are seeking. Some women may not feel confident in attending classes that are mix gender or of a certain social class, therefore organization should consider delivering classes that is appropriate for the women's needs, for example within their local community through existent women groups.
- NHS organisations should make use of this study's suggested cultural competency framework (figure 8.6) that is transferable to Muslim communities in any context and other religious or cultural group in the development and delivery of cultural competency training

Implications for healthcare professionals:

- Healthcare professionals should understand that motherhood for the majority of Muslim women is a spiritual journey, and it is important to appreciate the religious values that are closely tied with this journey to enhance care outcomes. Healthcare professionals should enhance their cultural competency using this study's suggested cultural competency framework (figure 8.6) to reflecting on their own values and biases, acknowledging the diverse cultural values involved and seeing all women as individuals.

- Showing religious understanding is important to enhance Muslim women's confidence and trust in healthcare professionals. Healthcare professionals should show understanding and knowledge when discussing what is important for the woman and how her needs can be met. Using the explanatory model suggested by this study will help healthcare professionals explore women's and any other clients' needs more effectively and help Muslim women and other religious groups express their religious needs with less fear of not being understood.
- Healthcare professionals should be particularly aware of the religious and spiritual customs highlighted in table 8.7. This will help them differentiate between customs and give them understanding of how to deal with such customs. There are certain customs that healthcare professionals need to be particularly aware of, such as modesty, throughout maternity Muslim women should be ensured appropriate covering.
- Muslim healthcare professionals should continue to enhance their role as culture brokers engaging with the Muslim community. This will help in creating a bridge between the services and the community, where they will help in developing the women's confidence in the services' competency in addressing their needs and develop services by feedback of the needs of Muslim women to the services.

Implications for Muslim women:

- Awareness of the availability of services is important to enhance their use of services that cater for their needs. They should be aware of all procedures surrounding pregnancy and childbirth and be encouraged to attend antenatal classes. This will help them build their confidence in the services and empower them in making informed decisions.
- Removing assumptions and stereotypical views of islamophobia is also important if Muslim women are to build mutual relationship with healthcare professionals. They must be aware and encouraged to reflect on the diverse society they live in and the importance of creating knowledge of their unique values.

Implications for further research:

- Further studies could include a greater number of Muslim women within the North West of England, including Muslim women who do not speak English.
- Further studies could including Muslim women who do not speak English. It would be beneficial to explore how the motherhood experiences of non-English speaking Muslim women may differ to the experiences of English speaking Muslim women.
- This study has allowed a detailed understanding of the motherhood experience from Muslim women's perceptive. It would be beneficial to conduct quantitative research to explore the religious values and practices with a wider population of Muslim women across the UK.

- Further studies could attempt to explore this study's framework of culture competency within education and healthcare institutions, and how it applies to Muslim women in any context not just healthcare, and to other religious groups. To better understand its effectiveness.

8.10 Limitations

Although this study has addressed the research question, it is acknowledged that it has some limitations.

- This study recruitment strategies using the mosque and local Muslim organizations/ community groups may have limited the sample to those affiliated with such organizations/ groups and may exclude secular participants. Possible other avenues that could be used for recruitment would be local children centres, ethnic community centres, local multi ethnic community groups, hospital or GPs.
- This study recruitment strategy using one specific maternity Trust may have also limited the sample to those healthcare professionals employed by this Trust and the snowball sampling may have limited an outreach to other potential participants. Other possible approaches that could be used, to approach healthcare professionals in GPs, children centres, family planning clinics, or study's invite through Trust's main website.
- The researcher's position as insider in the community and amongst healthcare professional could have been a potential blind spot for the researcher. However, the researcher was not a mother herself nor was she a clinic healthcare provider by profession, which may have reduced the risks of significant blind spots.
- This study did not capture non-English speaking Muslim women
- It excluded Muslim women receiving maternity care outside of Liverpool.
- Finally, the limited research within the wider literature in relation to Muslim women's motherhood experiences in the UK could be a limitation to this thesis.

8.11 Conclusion

This research study applied a generic qualitative research approach, which included longitudinal interviews, focus groups, and one-to-one interviews to reach an understanding of the motherhood experiences of Muslim women in the North West (UK). It is anticipated that exploring and understanding these experiences will benefit future Muslim women in the UK achieve better maternity care. The knowledge obtained from this research has revealed some essential aspects that healthcare professionals should be aware of when caring for Muslim women.

This study makes an important contribution to the wider understanding of Muslim women's opinions of motherhood and their use of UK maternity services. The important lesson in this study is that Muslim women all share the same religion – Islam – and while women from the wider population share some of the concerns highlighted in this study, religion is at the centre of Muslim women's worldview. Becoming a mother is described as an act of worship that accords mothers a lofty position in the sight of Allah and great respect within the community. Women discussed the many and varied occasions when decisions were made primarily on Islamic teachings (for example, DS screening or abortion, male circumcision, fasting, preference to be seen by female professionals, declining vitamin-K vaccines, breastfeeding). They also discussed the occasions when decisions were not based primarily on Islamic teaching but still was part of it (for example, decision to have children, number of children, use of contraception) and the common religious practices that are specific to motherhood (for example, silence at birth, *Adhan*, *Tahneeq*). This close religious connection with motherhood is what unites Muslim women in this study, these religious meanings woven into their motherhood journey allowed them to experience motherhood beyond the biological process.

However, they are not a homogenous group and neither are their experiences of motherhood, the religious importance of it will depend on each individual woman, and therefore it is important that the care of healthcare professionals should not be based on the assumptions of homogeneity. This study highlights a lack of confidence on the part of healthcare professionals in providing competent care for Muslim women. This is due to their lack of knowledge about religious and cultural worldviews, the relationship of spirituality to healthcare, limited education on spiritual care within the healthcare framework and insufficient time to provide such care. Study also revealed that Muslim women lacked confidence in discussing certain religious practices and felt reluctant to ask healthcare professionals questions. They were of the assumption that healthcare professionals having a negative opinion about Muslim women in general and about the religion Islam. The political-economic climate that we live in and the Western media portrayal of Islam was of a major influences to such assumptions. Therefore, one cannot overlook directly and indirectly the role of the Western media in portraying negative images of Islam, in particular Muslim women. It is important when developing competence models of care that is appropriate for Muslim women and other religious groups to recognize that cultural is inseparable from the political-economic climate that we live in.

This thesis argues that transcultural knowledge and specifically knowledge of Muslim women's worldview should be incorporated into healthcare professionals' training to enhance the competency of the healthcare services. This extends far beyond language needs and lists of 'do' and 'do not' or facts about other value systems. Therefore, it is important that competent care is all encompassing of that which makes up women's value system, accepting of differences and competent in creating an atmosphere where women can discuss their specific needs.

Competency is a process of understanding and building upon previous knowledge and experiences. The majority of healthcare professionals in this study had a general overview of Islam but not of specific religious aspects relating to motherhood. Meanwhile, Muslim women lacked some confidence in healthcare professionals understanding of their religious values and practices; their willingness to discuss their needs depended on their perception of healthcare professionals' openness and understanding. The variety of these findings only enriches our understanding of the motherhood experiences of Muslim women and shows the crucial importance of the woman-healthcare professional relationship.

This thesis suggests that healthcare professionals would benefit from training that will broaden their vision of spirituality accommodating diverse views. The five concepts of cultural competency within the health literature (awareness, knowledge, skill, attitude and encounter) can be useful in guiding the delivery of cultural competency literacy and training. These concepts can be used as a framework to create awareness of one's individual cultural difference and biases, develop understanding of other value systems, develop cross-cultural skills that are based on knowledge, and building confidence in the delivery of effective care.

Finally, this thesis argues that static models of care may hinder healthcare professionals' ability to deliver competent care that acknowledges and addresses the religious practices of Muslim women. Therefore, the study proposes a guide that divides the practices of Muslim women into two categories; practices that require the involvement of healthcare professionals and practices that do not necessary require the involvement of the healthcare professionals. This will help support in understanding and acknowledging specific religious practices. This thesis also suggests a similar approach to the idea of the explanatory model to support healthcare professionals further, by enabling them to explore such religious practices further with 'what' 'how' and 'why' questions. This will enhance healthcare professionals understanding, communication and capability in delivering competent and high quality individualised care for Muslim women.

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Appendices

Appendix 1: Ethical approval

WoSRES

West of Scotland Research Ethics Service



West of Scotland REC 5

Ground Floor, Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT

DR CONAN LEAVEY
Lecturer/Senior Lecturer
Liverpool John Moores University
Henry Cotton Building
15 - 21 Webster Street
Liverpool
L3 2ET

Date 4th April 2013
Direct line 0141-211-6270
Fax 0141-211-1847

Dear DR LEAVEY

Study title: Exploring Muslim Women's Transition to Motherhood within the NHS.
REC reference: 13/WS/0087
IRAS project ID: 117529

The Proportionate Review Sub-committee of the West of Scotland REC 5 reviewed the above application on 03 April 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Sharon Jenner, sharon.jenner@ggc.scot.nhs.uk.

Ethical opinion

The Committee requires the investigator to ensure the wellbeing of the mother and baby before the telephone interviews take place.

The Committee assume that the majority of Muslim women will be able to speak either English or Arabic.

The following minor amendments is required to the ethics application form :-

- a. Question A36 addresses and telephone numbers to be ticked
- b. Question A59 sample size to be completed

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation,

subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity		09 July 2012
Interview Schedules/Topic Guides	1.0	27 March 2013
Investigator CV		
Letter of invitation to participant	1.0	27 March 2013

Letter of invitation to participant	1.0	
Other: Student CV - Shaima M Hassan		27 March 2013
Other: A6-2 Summary of main issues document	1.0	27 March 2013
Other: Risk assessment tool	1.0	27 March 2013
Participant Consent Form: Study 1 - Health Professionals Interviews	1.0	27 March 2013
Participant Consent Form: Study 1: Muslim Women Interviews	1.0	27 March 2013
Participant Consent Form: Study 2: Muslim Mothers Focus Groups	1.0	27 March 2013
Participant Consent Form: Study 2: Health Professionals Focus groups	1.0	27 March 2013
Participant Information Sheet: Study 1: Muslim Women Interviews	1.0	27 March 2013
Participant Information Sheet: Study 1 - Health Professionals Interviews	1.0	27 March 2013
Participant Information Sheet: Study 2: Muslim Mothers Focus Groups	1.0	27 March 2013
Participant Information Sheet: Study 2: Health Professionals Focus groups	1.0	27 March 2013
Protocol	1.0	27 March 2013
REC application		27 March 2013

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

13/WS/0087

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



On behalf of
Dr Gregory Ofili
Chair

Email: sharon.jenner@ggc.scot.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

"After ethical review – guidance for researchers" [SL-AR2]

Copy to: *Sue Spiers, Liverpool John Moores University*

West of Scotland REC 5

Attendance at PRS Sub-Committee of the REC meeting on 03 April 2013

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr James Curran	GP	Yes	
Dr Gregory Ofili	Consultant Gynaecologist (CHAIR)	Yes	
Mrs June Russell	Retired (Research Chemist)	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Dr Judith Godden	Scientific Officer/Manager
Miss Sharon Jenner	Assistant Administrator

24th April 2013

Dr Conan Leavey
Lecturer / Senior Lecturer
Liverpool John Moores University
Henry Cotton Building
15-21 Webster Street
Liverpool
L3 2ET

Dear Mr Leavey

[REDACTED]: Exploring Muslim Women's Transition to Motherhood within the NHS

Following submission of project documents, associated paperwork and approvals to the Trust's Research & Department, I am pleased to inform you that your research project has been approved by Trust R&D. This approval relates to the documentation listed below:

- Ethics approval letter 13/WS/0087 West of Scotland REC 5 dated 4th April 2013
- Protocol Version 1.0 dated 27th March 2013

The research is registered on the Trust's R&D database under the reference [REDACTED] which I would be grateful if you could quote in all future correspondence regarding the project. **Please note that this letter approves the participation of Trust staff in the research study but not its patients.**

The Sponsor(s) of this research project under the Research Governance Framework for Health and Social Care (RGF) is Liverpool John Moore's University.

Having gained approval to conduct this research under the auspices of [REDACTED] Foundation Trust, you will be expected to comply with the principles and guidelines set out in ICH Good Clinical Practice and the Department of Health RGF. Please refer to your delegated duties outlined overleaf. Our Trust R&D Department must be kept informed of regulatory amendments, updates and approvals – this is your responsibility as site investigator.

It is also your responsibility to assure the confidentiality and protection of patient identifiable information. To gain a thorough understanding of your information governance responsibilities, the Trust R&D Department recommends that you refer to the NHS IG Toolkit, accessing the online training materials where necessary (www.connectingforhealth.nhs.uk/igtrainingtool).

I would like to take this opportunity to wish you the best of luck with this research and to request a copy of the final report and any subsequent publications.

Yours sincerely



Gillian Vernon
Research & Development Manager

Appendix 2: Risk Assessment



Risk Assessment for Exploring Muslim Women's Transition to Motherhood within the NHS

School/Service Department...Health and applied Social Sciences.....

Activity...Qualitative

Research project: Exploring Muslim Women's Transition to Motherhood within the NHS.

Date of Risk Assessment...March 2013.....

Assessment carried out by...Shaima M Hassan.....

Persons consulted during the Risk Assessment...supervisory team
.....

STEP 1 What are the Hazards?	STEP 2 Who might be harmed and how?	STEP 3 (a) What are you already doing?	STEP 3 (b) What further action is needed?	STEP 4 How will you put the assessment into action?		
				Action by whom	Action by when	Done?
	Researcher safety may be at risk when travelling and conducting interviews at participant's homes.	Researcher to ensure colleague is aware of whereabouts; expected time of completion of session and an action plan in place if researcher has not contacted after	Ongoing assessment during interactions to ensure that the level of risk remains controlled	Shaima Hassan	Ongoing during research	

		expected time of session completion.				
	Researcher not being covered by works insurance with regard to any of the above hazards due to lack of ethics committee approval.	No active research work will be started without ethics approval having been obtained.	None.			
Emotional Harm	Emotional distress when recalling negative experience.	If any of the participants exhibit any signs of emotional distress during the interviews the researcher will offer a break for a few minutes or to rearrange the interview. The researcher will provide participants with details of counselling, self-help and healthcare services from which they may wish to obtain	Ensure that the counselling routes and support contacts are available and clearly understood before beginning interviews.	Shaima Hassan	Before interviews start and Ongoing during research	

		support, such as PALS (Patient Advice & Liason Service), Trust Safeguarding Lead, Safeguarding Midwife, Domestic Abuse Midwife, Specialist Midwife, Prenatal Mental Health				
	Postnatal depression may accrue in certain participants	Postnatal depression is not easily detected. If the researcher notices a marked change of mood during or between the interviews or if the participant mentions that they have been feeling upset, then, with the permission of the participant, the researcher will inform	The researcher will report this back to one of the Trust Safeguarding Lead or leading midwife in the service.	Shaima Hassan	Ongoing during research	

		the Safeguarding Midwife. If the participant mentions that they will harm themselves or their baby, the researcher will report this immediately to the Safeguarding Midwife.				
	Problems such as miscarriage, still birth, death of child, etc	If problems occur during or after pregnancy, participants will be reminded that they have the right to withdraw without providing any reasons and that this will not effect their rights or quality of care.	Ensure that the counselling routes and support contacts are available and clearly understood before beginning interviews.	Shaima Hassan	Before interviews start and Ongoing during research	
	Researcher bias	The researcher will analyse the transcribed data using a thematic approach with aid of NVivo software,	This will then be reviewed by the supervisory team to address any researcher bias and to feedback their comments on	Shaima Hassan	Ongoing during research	

		<p>The initial themes of stage one will be fed back to a larger community focus group for comments. Arabic interviews will be transcribed by the researcher in to Arabic and then translated in to English</p>	<p>the researchers analysis of the transcripts. The Arabic and English transcript will be reviewed by a qualified interpreter to discuss the nuances of the context of the Arabic language into English. Back translation is important to ensure the best possible representation and understanding of the interpreted experiences (Van Nes et al, 2010).</p>			
Travel Time	<p>Stress, fatigue or strain from excessive travel, whether by car, train or bus</p>	<p>Travel times are flexible and the distance to travel is not high, therefore the time taken travelling is controlled.</p>	<p>None.</p>	<p>Shaima Hassan</p>	<p>Ongoing during research</p>	

Appendix 3: Participants Information Sheets

LIVERPOOL JOHN MOORES UNIVERSITY **Participant Information Sheet** **Phase One: Muslim Women Interviews**



Title of Project: Exploring Muslim Women's Transition to Motherhood within the NHS

Name of Researcher and School/Faculty: *Shaima M Hassan, Faculty of Health and Applied Social Science*

You are being invited to take part in a research study to explore Muslim women's experiences of care during the transition into motherhood. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask me if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.

1. What is the purpose of the study?

The purpose of this study which is being conducted as part of my PhD programme of research is to gain insight from Muslim women regarding their experiences when engaging with the maternity service in the UK; to develop an understanding of their perceived needs and their traditional childbearing beliefs and practices. To provide maternity services in the UK a unique opportunity to recognise what is important to these women during their transition to motherhood and to respond in a way that will acknowledge, enhance and improve their experience of maternity care.

2. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights/any future treatment/service you receive.

3. What will happen to me if I take part?

You can choose how long you are involved in the study for, but if you agree to take part, you will be asked to partake in approximately three sessions of one to one interviews, lasting around one hour each. The first interview will be within the final trimester your pregnancy (6-9 months), the second interview will be within the second month after the birth of your child and the final interview will be after four months of the birth of your child.

The sessions will be held at a place comfortable for you that may be in the comfort of your own home to prevent you from the hassle of travelling to places that you may not be familiar with or within the local Mosque. This will be at a time convenient for you.

The research is not a formal process i.e. it is not a set of questions and answers, but both you and I will discuss and explore a range of issues together. This may involve discussions around your experience of maternity/ pregnancy at different stages and the care provided. All interviews will be audio recorded and written up. Following this I will complete an analysis on our discussions / sessions and complete a project on the results. This project will be available to the public. You are welcome to a copy of the completed research if you so wish.

4. Are there any risks / benefits involved?

It is hoped that the research will inform maternity services in UK with knowledge and understanding of Muslim women maternity needs which will help them make sure that the work they do is as effective as possible.

There are no envisaged Risks. While some of the questions of the study will cover potentially information that may be considered as sensitive and private, however participants are given the option of omitting questions and they can withdraw at any time.

5. Will my taking part in the study be kept confidential?

Yes. All personal information collected during the research will be anonymised and remain confidential. It is expected that the results of this study will be published but your individual details will not be mentioned. Any information about you will not be disclosed to anyone and it will be stored securely. Only the supervisor, co-supervisors and the researcher will have access to the data.

Contact Details of Researcher

If you would like to talk about any aspect of the research, please feel free to get in touch.

Shaima M Hassan

Email: s.m.hassan@2012.ljmu.ac.uk

Supervisor: Conan Leavey

Email: c.leavey@ljmu.ac.uk

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

LIVERPOOL JOHN MOORES UNIVERSITY
Participant Information Sheet
Phase Two: Muslim Mothers Focus groups



Title of Project: Exploring Muslim Women's Transition to Motherhood within the NHS

Name of Researcher and School/Faculty: *Shaima M Hassan, Faculty of Health and Applied Social Science*

You are being invited to take part in a research study to explore Muslim women's experiences of care during the transition into motherhood. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask me if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.

1. What is the purpose of the study?

The purpose of this study which is being conducted as part of my PhD programme of research is to gain insight from Muslim women regarding their experiences when engaging with the maternity service in the UK; to develop an understanding of their perceived needs and their traditional childbearing beliefs and practices. To provide maternity services in the UK a unique opportunity to recognise what is important to these women during their transition to motherhood and to respond in a way that will acknowledge, enhance and improve their experience of maternity care.

2. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights/any future treatment/service you receive.

3. What will happen to me if I take part?

You can choose how long you are involved in the study for, but if you agree to take part, you will be invited to join one of the study's focus group session, lasting around one 90 minutes. The session will be held at a place comfortable for you that may be in your local community centre (mosque), at the 'Mother and Toddler' group meeting place, to prevent you from the hassle of travelling to places that you may not be familiar with. This will be at a time convenient for you.

You will be joining seven other Muslim women for a group discussion. The research is not a formal process i.e. it is not a set of questions and answers, but you, I and rest of the group discussions and exploring a range of issues together. This will involve discussions the themes that were apparent in stage one of the study and to have your thoughts on these themes.

The Focus group session will be audio recorded and written up. Following this I will complete an analysis on our discussions / sessions and complete a project on the results. This project will be available to the public. You are welcome to a copy of the completed research if you so wish.

4. Are there any risks / benefits involved?

It is hoped that the research will inform maternity services in UK with knowledge and understanding of Muslim women maternity needs which will help them make sure that the work they do is as effective as possible.

There are no envisaged Risks. While some of the questions of the study will cover potentially information that may be considered as sensitive and private, however participants are given the option of omitting questions and they can withdraw at any time.

5. Will my taking part in the study be kept confidential?

Yes. All personal information collected during the research confidential will remain and you will be anonymous when the data is transcribed and analysed. It is expected that the results of this study will be published but your individual details will not be mentioned. Any information about you will not be disclosed to anyone and it will be stored securely. Only the supervisor, co-supervisors and the researcher will have access to the data.

Contact Details of Researcher

If you would like to talk about any aspect of the research, please feel free to get in touch.

Shaima M Hassan

Email: s.m.hassan@2012.ljmu.ac.uk

Supervisor: Conan Leavey

Email: c.leavey@ljmu.ac.uk

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

LIVERPOOL JOHN MOORES UNIVERSITY
Participant Information Sheet
Phase Three: Health Professionals Interviews



Title of Project: Exploring Muslim Women's Transition to Motherhood within the NHS

Name of Researcher and School/Faculty: *Shaima M Hassan, Faculty of Health and Applied Social Science*

You are being invited to take part in a research study to explore Muslim women's experiences of care during the transition into motherhood. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information. Ask me if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part or not.

1. What is the purpose of the study?

The purpose of this study which is being conducted as part of my PhD programme of research is to gain insight from Health professionals regarding their experiences of providing care for Muslim women when engaging with the maternity service in the UK; to provide a clear vision of the experience of staff when providing the care. To provide maternity services in the UK a unique opportunity to recognise and to respond in a way that will acknowledge, enhance and improve their experience of maternity care.

2. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do you will be given this information sheet and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw will not affect your rights/any future treatment/service you receive.

3. What will happen to me if I take part?

You can choose how long you are involved in the study for, but if you agree to take part, you will be invited to a one to one interview, lasting around one hour. The sessions will be held at a place comfortable for you that may be within your work place (in your office/ private meeting room) to prevent you from the hassle of travelling to places that you may not be familiar with. This will be at a time convenient for you.

The research is not a formal process i.e. it is not a set of questions and answers, but both you and I will discuss and explore a range of issues together. This may involve discussions around your experience of providing care for Muslim women.

The interview will be audio recorded and written up. Following this I will complete an analysis on our discussions / sessions and complete a project on the results. This project will be available to the public. You are welcome to a copy of the completed research if you so wish.

4. Are there any risks / benefits involved?

It is hoped that the research will inform maternity services in UK with knowledge and understanding of Muslim women maternity needs which will help them make sure that the work they do is as effective as possible.

There are no envisaged Risks. While some of the questions of the study will cover potentially information that may be considered as sensitive and private, however participants are given the option of omitting questions and they can withdraw at any time.

5. Will my taking part in the study be kept confidential?

Yes. All personal information collected during the research will be anonymised and remain confidential. It is expected that the results of this study will be published but your individual details will not be mentioned. Any information about you will not be disclosed to anyone and it will be stored securely. Only the supervisor, co-supervisors and the researcher will have access to the data.

Contact Details of Researcher

If you would like to talk about any aspect of the research, please feel free to get in touch.

Shaima M Hassan

Email: s.m.hassan@2012.ljmu.ac.uk

Supervisor: Conan Leavey

Email: c.leavey@ljmu.ac.uk

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

Appendix 4: Participants Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY **CONSENT FORM**



Exploring Muslim Women's Transition to Motherhood within the NHS

Researcher: Shaima M Hassan, Faculty of Health and Applied Social Science.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.
3. I understand that any personal information collected during the study will be anonymised and remain confidential
4. I agree to take part in the above study's interview
5. I understand that the interview session will be audio recorded and I am happy to proceed
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.
7. I am happy to be contacted by the researcher for follow up interviews.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

LIVERPOOL JOHN MOORES UNIVERSITY
CONSENT FORM



Exploring Muslim Women's Transition to Motherhood within the NHS

Researcher: Shaima M Hassan, Faculty of Health and Applied Social Science.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.
3. I understand that any personal information collected during the study will be anonymised and remain confidential
4. I agree to take part in the above study's interview
5. I understand that the interview session will be audio recorded and I am happy to proceed
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.
7. I am happy to be contacted by the researcher for the feedback session

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Name of Person taking consent

Date

Signature

(if different from researcher)

LIVERPOOL JOHN MOORES UNIVERSITY

CONSENT FORM



Exploring Muslim Women's Transition to Motherhood within the NHS

Researcher: Shaima M Hassan, Faculty of Health and Applied Social Science.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.
3. I understand that any personal information collected during the study will be anonymised and remain confidential
4. I agree to take part in the above study's Focus group
5. I understand that the interview session will be audio recorded and I am happy to proceed
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

☐☐☐☐☐☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Appendix 5: Email to Participants

LIVERPOOL JOHN MOORES UNIVERSITY



Exploring Muslim Women's Transition to Motherhood within the NHS (Phase one)

Shaima M Hassan
Faculty of Health and Applied Social Sciences

Asalam Alykom Wa Rahmato Allah Wa Barakath Dear Sisters (Dear All)

My name is Shaima Hassan; I am currently undertaking a PhD at Liverpool John Moores University which aims to explore Muslim women's experiences of care during the transition into motherhood.

The main objectives of my research are:

1. To explore Muslim women's experiences of care during the transition into motherhood
2. To identify the traditional childbearing beliefs and practices of Muslim women.
3. To explore health professionals' experiences when providing care for Muslim women

It is anticipated that this research will provide maternity services in the UK with an insight into the religious and cultural perspective of Muslim women. It will explore what is important to Muslim women during their maternity journey and hopefully improve maternity care in the future.

I kindly invite first time pregnant Muslim women living in Liverpool to take part in 3 one to one interviews session to explore their personal experiences and views on the maternity journey. I have attached the research information sheet for further details of the research of you would like to read and any questions if you wish.

I would greatly appreciate if you are interested to share your maternity experiences; please do feel free to contact me on the following telephone number or email:

Mobile number: 07920434297/ 0151 231 4441

Email: s.m.hassan@2012.ljmu.ac.uk

If you know if any other Muslim women that would be interested in this research feel free to forward my contact details to her.

Thank you in advance.

LIVERPOOL JOHN MOORES UNIVERSITY



Exploring Muslim Women's Transition to Motherhood within the NHS (Phase two)

Shaima M Hassan
Faculty of Health and Applied Social Sciences

Asalam Alykom Wa Rahmato Allah Wa Barakath Dear Sisters (Dear All)

My name is Shaima Hassan; I am currently undertaking a PhD at Liverpool John Moores University which aims to explore Muslim women's experiences of care during the transition into motherhood.

The main objectives of my research are:

1. To explore Muslim women's experiences of care during the transition into motherhood
2. To identify the traditional childbearing beliefs and practices of Muslim women.
3. To explore health professionals' experiences when providing care for Muslim women

It is anticipated that this research will provide maternity services in the UK with an insight into the religious and cultural perspective of these women. It may provide a unique opportunity to recognise what is important to these women during their transition to motherhood and to respond in a way that will acknowledge, enhance and improve their experience of maternity care.

The research involves four focus groups with Muslim mothers' from the North West of England to examine the initial themes derived from Stage One of the research.

I kindly would like to invite Muslim mothers from the North West of England who have had at least 1 child and whose last pregnancy was within the last 18 months to join a group friendly discussion with 8 other Muslim mothers. The group will discuss the findings of the first stage of the research and reflect on your similar experiences that you might have experienced during your maternity journey. I have attached the research information sheet for further details of the research of you would like to read and any questions if you wish.

I would greatly appreciate if you are interested to share your maternity experiences; please do feel free to contact me on the following telephone number or email:

Mobile number: 07920434297/ 0151 231 4441

Email: s.m.hassan@2012.ljmu.ac.uk

If you know if any other Muslim women that would be interested in this research feel free to forward my contact details to her.

Thank you in advance.

Appendix 6: Interviews and Focus Group Schedule

Interviews and Focus groups Schedule

Interviews and focus groups that will be used in the study are semi-structured. In keeping with the semi-structured approach an interview and focus group guide will be followed rather than a specific list of questions. This will facilitate exploration of pertinent issues identified prior to data collection whilst also facilitating identification of other issues that participants may feel are relevant.

Initially the following themes will be used to guide the interviews of the stage one of the research:

Phase One: Longitude interviews with first time pregnant Muslim women

Antenatal Interview guide:

- Demographic (Age, occupation, education level, country of origin, birth place)
- Experience of living in the UK (if lived outside the UK before)
- Finding out you were pregnant (feelings, concerns)
- Beliefs about pregnancy (religious and cultural customs)
- Accessing services when first pregnant (where and how accessed information about services and assistance), including difficulties that occurred, who was the first point of contact (midwife, Gp, hospital?).
- Booking appointment (how was it and where did it take place? Home, children centre, hospital, other?)
- Ongoing antenatal care
 - Continuity of care
 - Parent education classes and health education
 - Communication during care experiences
 - Investigations: information received
 - Antenatal visits (with who and where?)
 - Support from family/friends
- Religious and cultural issues relevant to maternity care (was service sensitive to their needs)

After Labour Interview guide:

- Beliefs about labour and delivery (What are the Islamic religious beliefs and practices or customs during labour)

- Did you have a Plan of birth before labour or did you have anything in mind in how you would have preferred your birth to be? :
 - What was your preferred mode of delivery/ birth plan (normal delivery or a planned Caesarean
 - preferred pain relief to use
 - location of birth [home planned/unplanned, MLU or delivery suite in hospital or any other place]
 - preferred staff to conduct delivery [doctor/ midwife/ gender/ ethnicity/ religion]
 - companion during labour
- What happened during your labour?
 - Accessing maternity services
 - what did you do when labour came along
 - Companion during labour and delivery
 - Who was the person who conducted the delivery (Midwife/ Doctor /Midwifery, nurse, doctor student, Gender; did you have a choice in how attended your labour?)
 - Mode/type of delivery normal
 - pain relief, time spent with you, communication/ reassurance/ explanation from staff during labour,
 - Mobility/ position in labor. Did you have a choice/ wishes in this?
- Were you able to practice religious beliefs during labour?
 - What were the practices you were able to implement?
 - How did the staff deal with your religious wishes?
 - Was there any religious practice that you wished to do during your labour?
- Baby issues:
 - Contact with the baby after delivery and skin to skin with the baby
 - Breastfeeding? How was your knowledge of it breastfeeding (did you attend classes before)? Did you prefer
 - Midwife advice/ support when dealing with your baby
 - Were you able to feed your baby as you wished?
 - What are the religious beliefs regarding breastfeeding?
- Beliefs about new born:
 - What are your religious beliefs and practices in regards to new born?
 - What were the practices you were able to implement?
 - How did the staff deal with your religious wishes?
 - Was there any religious practice that you wished to do with your baby?
- Care received in hospital after delivery before discharged

- regards to information, support, guidance e.g. bathing the baby, cot death, traveling home with baby, protection measures for health of child, looking after surgical wound and medication if needed)
- Health status after discharge:
 - How did you feel after being discharged?
 - Did you feel that you were ready to go home with your baby?
 - Did you feel that you had everything you needed before leaving (e.g. guidance to how to do things in regards of looking after your baby)?
 - Would you have liked more help and support from the hospital before discharge?
- Suggestion to improve the care during labour

Postnatal Interview guide:

- Being a mother:
 - How do you feel about Motherhood/ parenting now?
 - How has your life been after having the baby? Have there been any change/ improvement / difficulty / etc. in your life?
 - Religious belief and practices regarding being and mother?
 - Religious belief and practices regarding your child E.g. circumcision of the child
- Postnatal home visits:
 - Who came to see/ visit you at home? Midwives, health visitor, Gp, Community Maternity Care assistant, BF peer supporter, children centre staff, other?
 - How often did they visit?
 - What did the visitors do for/offered you? E.g. contraceptive advice, feeding, etc.
 - How did you feel about these postnatal visits?
 - Beliefs about postnatal period?
- Social support
 - What other forms of support do you have?
 - How do they support you?
- Any suggestion to improve care postnatal

Phase Two: Focus groups with Muslim mothers

The focus groups will not have certain questions, but it will be driven by the participants themselves. The initial themes of phase one will be discussed in focus groups. The focus groups will be given the chance to comment and discuss these themes. And will be asked to

discuss some suggestions that they believe will help in improving any barriers or difficulties that have occurred.

Phase Three: Interview with Health professionals

- Health professional
 - What is your profession? How long have you been in this profession?
 - How long have you been working in Liverpool?
 - Have you worked anywhere else before? E.g. in a different country.
 - Do you follow a particular faith or come from a certain cultural group?
- Working with ethnic groups
 - Have you provided care for women from different ethnic groups? Who?
 - What is your experience (feel) of providing care for women from different ethnic groups?
 - Are you able to differentiate between the ethnic groups that you care for?
 - Are you able to differentiate between or recognise their cultural values/ needs?
- Care for Muslim women?
 - Are you able to recognise Muslim women?
 - What do you understand of Muslim women belief and practice in regards to:
 - Their faith in general,
 - Dress code for women,
 - Pregnancy,
 - Labour,
 - New born, being a mother.
 - What are some of the practices that you have come across?
 - Do you do anything differently when providing care for Muslim women?
 - What are the women's responses to certain interventions:
 - Treatment (Infertility, IVF)
 - Screening (Downs)
 - Injections (Vit. K)
 - Contraceptions
 - Breastfeeding
 - Labour and pain relief
 - Education Classes (are they attending)
 - Knowledge of services (use of services, booking)
 - What kind of things do they request of you?
 - How do you feel/ respond if they make choices out of realms of accepted guidelines?
 - (Responding to a certain religious practice/belief)
 - How do you do the trust of the women? Do you do anything to further the relationship?
 - How do you feel about the women expressing their needs?
 - Have you ever come across a time when the women are not being open with you? How do you ensure women remain engaged with the services?

- How do you feel about the women social support? Does the social advice concern you (unfavourable influence of family to women or baby care).
- Can you recall any experiences that you had with Muslim women?
- Training?
 - Do you receive/ have you attended any training that gives insight to providing care for ethnic groups or religious groups or special needs?
 - What are your thoughts on the training that you have received in regards of dealing with women from different ethnical and social groups?
 - Do the training sessions enable you to develop/ further your knowledge and skills relating to the care of those from specific religious groups?
 - If I was to provide training in regards to caring for Muslim women; what would be your thoughts about it and what would you suggest that would be useful in this training? What is important?

Other questions that will be used when interviewing Muslim Health Professionals

- How do you feel about being a health professional and a Muslim?
- Are there any Islamic teachings in regards to your profession?
- As a Muslim what are your thoughts on the health setting/system that you work in?
- Do you feel that you have a special role in providing care for Muslim women?
- Do feel that you do it in different way when caring for Muslim women?
- Do you feel that your position as a health professional helps in providing care for Muslim women?
- How might you suggest the experience of care be improved for Muslim women?

Appendix 7: Coding and Analysis process

Stage One interview Coding.xlsx - Excel									
Tell me what you want to do...									
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Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral
Calculation	Calculation	Calculation	Calculation	Calculation	Calculation	Calculation	Calculation	Calculation	Calculation
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Document1 - Word

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Phase 1 themes	Description of theme and subthemes
Perceptions of Motherhood	<ul style="list-style-type: none"> • Gift/ blessing from God (religion was not main reason for their pregnancy; it's a blessing that women show gratitude toward; personalised gift) • Fate and acceptance (since it is a gift of God, women accepted their pregnancy (even non-planned), and did not hasten to seeking medical advice if their pregnancy was delayed; the down syndrome screening was rejected by most due to the belief in fate (if the child had an abnormality then it is destined from God and they are in acceptance); they also do not consider Termination as it is forbidden in Islam- there for women preferred not to do the screening to maintain in a state of acceptance) • Rewarding experiencing (the religious reward within this motherhood was a spiritual support for all women throughout the journey, women maintained positive when faced with challenged during pregnancy, labour & postnatal; when faced with challenges when reminded themselves with the rewards they will gain through the challenge and used Quran recitation and supplications meaning to overcome the challenges (e.g. in labour) • Journey of increasing in Islamic knowledge (women had some brief understanding of the Islamic teachings regarding motherhood and its practices, the motherhood journey was a learning period for them understand their roles as mothers from an Islamic perspective – women attended Islamic classes, read Islamic books and sought advice from Islamic teachers within the community) • Responsibility (women highlight the Islamic teaching calls for them to become responsible parents- and should be responsibility of the child's welfare- the upbringing on the child in what is healthy for the child and in what is pleasing to God; some mothers were anxious of this – whether they are doing enough)
Information needs and Service awareness	<ul style="list-style-type: none"> • Information needs through the maternity services (women felt that they needed more information during pregnancy (about the physiological changes), labour (information on the methods that will be considered if labour does not unfold normally), before discharge women felt that they were well informed, and postnatal visits - not satisfying information received during postnatal visits. Some women felt that they

Page 1 of 2 478 words English (United Kingdom) 90%