

Childbirth: A Momentous Occasion
Muslim Women's Childbirth Experiences

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ABSTRACT

This thesis explores the perception of three Muslim women's experience of childbirth, in a setting surrounded by health professionals who largely have little understanding of their needs and experience of being in the world. The women's stories reveal that giving birth in a cross-cultural setting is stressful. The women had to adjust to an environment which challenged their beliefs and values, in one case with no extended family or cultural support. This stress is long lasting as evidenced in the women's stories.

Various forms of narrative such as a letter, excerpts from conversations, and interviews, have been used in presenting this research, in order to illuminate Muslim women's birthing experiences particularly to health colleagues in Aotearoa-New Zealand.

Given the opportunity to tell their story, all the women highlighted both the positive and negative aspects of their birth experiences. Excerpts from the narratives of Khadija, Ayesha, and Amina, describe the reality of their experiences. The overarching theme in this thesis reveals the uniqueness of each woman's story.

This thesis identifies situations that heightened the vulnerability of the women. It concludes by identifying recommendations and reading material for nurses and midwives in education or practice to become informed, so that 20,000 Muslims in Aotearoa-New Zealand may receive an acceptable level of culturally safe practice.

PREFACE

The impetus to conduct this research originated from my interest in women's issues, particularly childbirth, and the paucity of literature on Muslim women's childbirth experience in Aotearoa-New Zealand. It draws upon my personal knowledge of Muslim women's childbirth experiences, as a mother, an immigrant, a midwife, a nurse educator, and from having an interest in the experience of being culturally safe.

For me, this interest of being culturally safe has been reinforced by the recognition and implementation of the concept of 'Cultural Safety' in the nursing and midwifery programmes in Aotearoa-New Zealand. While the model has been developed specifically to address the needs of Maori clients, currently it has been suggested that the principles of Cultural Safety can be utilised for all those who receive care. The issue of being culturally safe raised in this project comes at a time when the cultural blend of the population of Aotearoa-New Zealand is changing through the migration, either by choice or forced, of people from different parts of the world.

It is not within the scope of this thesis to give a full explanation of Islam, and therefore, the reader is guided to the reference and bibliography lists for further reading.

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CHAPTER ONE

INTRODUCTION

The childbirth experience has been described as a deeply felt, multifaceted, and significant event in a woman's life. Not only is it a physiological process, it is also an emotional, cognitive, possibly spiritual event, and the culmination of nine months of learning, planning and social influence (Callister, 1995; Callister, Semenic & Foster, 1999, Callister, Vehvilainen-Julkunen & Laurie, 1996; Nichols, 1996; Sherr 1995; Simkin, 1996;). In fact, Jordan succinctly points out:

“Childbirth is an intimate and complex transaction, whose topic is physiological and whose language is cultural” (1983, p.1).

While the birth process itself has not changed in all of human history, what has changed is the context in which birth takes place (Simkin, 1996). Economic patterns, cultural attitudes, migration, and the amount of support a woman has, all have an impact on how a woman perceives her birth experience (Sharts-Hopko, 1995; Simkin, 1996). Worldwide there are culture-based ceremonies to mark these special events in a woman's life (Choudhry, 1997).

The celebration of life has been spoken of in literary terms by Buck who wrote in *Pavilion of Women*, “Nothing was so exciting in a house as the birth of child” (1947, p.182).

For a woman, it 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 (Dawson, 1983; Simkin, 1996). Dawson illustrates this point by quoting an old Vietnamese proverb “When men cross a bridge, they cross with friends, but when a woman crosses a bridge, she crosses alone” (1983, p.5).

For women who move from country to country in their lives, they cross cultures no matter where they live. They live in two cultures and try to live by balancing the values of their cultural heritage with those of their host country. Within the health care system they are expected to conform to the mainstream values (Meleis, 1991). Consciously and unconsciously, such women are always considering their children’s safety and chances for a good life.

Similarly, those who work within the health field also cross cultures. They cross the cultures of their work environment, and those of their clients, who may come from “different” ethnic, cultural, and socio-economic backgrounds. Nurses and midwives cross such boundaries, and are similarly challenged in how to create care that is considered safe by the clients and to keep themselves safe as nurses and midwives. I am one such woman who has crossed cultures and boundaries, and I am also a nurse and midwife. I am particularly sensitive to Ford’s reference to caring for a woman from a different ethnic background during the birth process, when he writes, “learn to be sensitive and listen for those silent messages that the women and their families communicate” (1999, p.61) This suggests that

sensitivity and empathy are just the beginning of a relationship, and profound human-to-human respect is powerful and integral to this relationship.

This chapter outlines the aims of the research project, my motivation for conducting the project, and my underlying personal philosophy, which is based on caring and partnership.

The aims of this research project were primarily to enable Muslim women to tell the stories of their childbirth experiences in Aotearoa-New Zealand. We utilised a storytelling/narrative approach, situating the project within the qualitative research paradigm to surface specific factors that enhanced or hindered the women from having a positive experience. Secondly, the aim was to identify the commonalities and differences between us as Muslim women, which I believed, would be of interest to all Muslim women. The third aim was to record my own reflections as a nurse, midwife, and educator, and make them available to nurses, midwives, and other health professionals. I kept the aims of this project deliberately broad from the outset to avoid predetermining the outcome, and creating early closure through my own preconceptions. This could have created rigidity of the research project in my approach, hence losing the integrity of natural intimate storytelling.

My motivation to conduct this research project was generated from drawing on my personal knowledge of Muslim women's childbirth experiences, being a mother, being involved in nurse education, and being familiar with overseas

literature that corroborated my experience, which indicated Muslim women had poor child birth experiences in their new countries.

Locating myself as the researcher, nurse and midwife.

In order to conduct this project I had to reflect on my own life as a Muslim woman born in East Africa of Indian descent, who had gone through the migration process twice; firstly to Britain with my family of origin, where I trained as a nurse and midwife, and then to Aotearoa-New Zealand with my husband and our young children. To locate myself, I reminisced by writing a series of autobiographical texts over a year. This process of reminiscing in order to write was both sensitive and necessary; sensitive because I recalled separation, decisions, losses, and the loneliness of being apart from my extended family; necessary, because in order to converse authentically with other Muslim women, I knew I had to stand with clarity, strength and courage as a Muslim woman, mother, nurse, midwife and researcher in Aotearoa-New Zealand society.

The first three chapters in this thesis reveal the flow of my thoughts as I wrote pieces of text that are my story. Each time I wrote a piece of text I thought, “I have shared enough,” as it is not part of my cultural background to openly portray one’s personal life. I wondered if I could present the women’s stories with the depth of insight that I knew I could bring to this project after only few hours of interview. The gradual unfolding of my story has taken time, and while it has been ‘tough beyond measure,’ it has been an enriching experience. I have learned what is required to present our stories because I have sought guidance from members of the Muslim community who are well versed on Islamic matters, and I have taken

time with the project to find my sense of what is correct culturally and yet politically astute as a thesis.

As I recalled my own childbirth experiences in the late 70's and early 80's in the United Kingdom (UK), these occurred in an era when pregnancy, childbirth and health were still seen through the eyes of the medical world rather than through the eyes of midwives. The mother to be was supervised by her general practitioner or the obstetrician, and the majority of babies were born in hospitals (Oakley, 1979). Having trained as a nurse and midwife in the early 70's in professions that were heavily influenced by the medical model, I accepted this model of care. I believe most women did in those days, without comment, but not without dismay and disillusion. The concepts of partnership and empowerment were rarely heard in nursing or midwifery practice during that period, and cultural safety, as a concept in the delivery of client care, was simply not recognised.

My professional background and development

Whilst in the UK I practised as a midwife for two years before I returned to the general nursing field, working mainly in medical and surgical areas for five years. On arriving in Aotearoa-New Zealand I worked in a small hospital setting which offered a range of experience, before beginning my teaching career, firstly in the Diploma of Nursing Programme, and after its phasing out, in the Bachelor of Nursing programme. I have worked in the role of a nurse educator for 14 years. This has provided me with the opportunity to reflect on the general lack of awareness amongst health professionals with regard to providing care in partnership with clients/patients going through what Christensen (1995, p.25)

refers to as a “health related experience.” Caring and partnership are terms that have become very familiar within the nursing and midwifery culture and language, and yet at times there is incongruence between what is being advocated and what is being practised, as the women’s stories reveal in this project. It is this incongruence and when it occurs that I have become increasingly aware, and concerned enough about to investigate. My initial interest was in the incongruence between the need for care and the experience of care.

The return to my own story of origin and to Muslim women has come about as I chose to explore my own postgraduate education. During this journey, and through my teaching experience, I have become more aware of the importance of the cultural, spiritual, and socio-economic issues that impact on an individual, whether in an education facility or in a healthcare facility, and how individuals negotiate these systems and maintain their integrity. Because of my own story, I am particularly interested in the issues migrants face when they choose to adopt a new country as their home, issues such as loneliness, job worries, and accessing services. Personally, the issue that I found profoundly difficult was that of loneliness. Gradually, I felt comfortable enough to share these long held concerns in this project, as I recognised this thesis and subsequent publications could be a vehicle to inform colleagues and transform care.

The significance of a personal philosophy

Through my participation in a postgraduate experience in which we have been encouraged to share our life story and dreams, I recognised the power of telling one’s own story, and the link between verbalising this story and shaping a

statement of one's philosophy of practice in nursing and midwifery. In writing my own philosophy, I found a medium to really focus a statement on how I actively worked in partnership with those who I am in contact with as a nurse educator.

My personal philosophy is based on understanding the concepts of caring and partnership. I consider these two foundation concepts in nursing and midwifery can only be fully effective through good interpersonal skills. These skills enable me to state and show how caring is vital to my way of life and in my practice. I know caring can build relationships based on trust. This requires superb communication, and when this happens it generates the relationship in which growth occurs. My thinking has been influenced by the work of nurse theorists related to the caring relationships.

Caring is the foundation for effective relationships

Caring has been defined as "actions directed towards assisting, supporting, or enabling individuals (or groups) with evident or anticipated needs to ameliorate or improve a human condition or life way" (Leininger, 1988 as cited in Mariner-Tomey 1994, p.429). For me, to care means that people matter to me, and I will do all that is possible within me to safeguard their well being, for to do otherwise would be inconsistent with my ethic of care. Gadow (1985) asserts caring is considered to be the moral foundation of nursing, which safeguards and enhances the human dignity of patients/clients receiving care. This is particularly relevant to my interest in preserving the dignity of women where things are being "done" to them. Benner and Wrubel (1989, p.1) suggest "caring creates possibilities" and I have observed this within my practice as a nurse educator. We know that when a supportive environment is provided, the students grow and reach their full

potential. In a similar vein, it has been suggested that if, in birthing, women's physical, psychological and cultural needs are met, and they feel supported throughout their birth experience, they are much more likely to express satisfaction with their birth experiences (Simkin, 1996). Arif (1992, p.45) suggests "when interpersonal skills are allied with understanding and sensitivity, culturally aware nurses can discover a new dimension to the word 'caring'".

Partnership is key to empowering others

Nursing is recognised as the partnership that exists between nurse and client. According to Christensen (1995, p.25) the Nursing Partnership Model offers a "new way of looking at what happens when a nurse offers a learned expertise to a person who is passing through a health-related experience". This model implies both nurse and patient/client are experts, and each party works through certain activities. The concept of "enabling" within this model includes the empowering aspects of nursing's work and encompasses "Coaching, Conserving, Extending, Harmonising and Encouraging" (Christensen, 1995, p.126). The active involvement and implied empowerment of the client will lead to nursing or midwifery care that is appropriate and acceptable.

Keegan (1994, p.7) believes "a nurse healer uses the art of guiding to help others discover and recognise new health behaviours and discover insights about how to make choices and how to cope effectively". Keegan's (1994) concept was well illustrated by the practice of a midwife colleague, (an independent midwifery practitioner), who I met a number of years ago. She preferred to work with her clients from as early as the confirmation of pregnancy, so she could work in

partnership with the woman and her family to prepare her psychologically and physically for the birthing event. The reason for doing this, apart from building a close trusting relationship with the woman and her family, was to enable the woman to recognise her own strengths and to build on them, and to recognise the choices she had, so that when she began the labour process the woman would be able to draw upon the strength of her inner resources as well as being supported by all those present during the event.

Midwifery Partnership

As my research project is concerned with Muslim women's childbirth experiences it is appropriate for me to describe "The Midwifery Partnership - A Model for practice" which was developed in Aotearoa-New Zealand in the early 90's in response to the political climate of the time. This model views the partnership as "a relationship of sharing between the woman and midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding" (Pelvin, 1990 as cited in Guilliland & Pairman 1994, p.5). Two statements in the Philosophy and Code of Ethics of the New Zealand College of Midwives (NZCOM) endorse this: "Midwifery care takes place in partnership with women. Continuity of Midwifery care enhances and protects the normal process of childbirth"(NZCOM, 1993, p.7); and "Midwives work in partnership with women" (NZCOM, 1993, p.10).

Inherent in this model is the belief that midwifery is a woman centred profession which recognises individual negotiation, equality, shared responsibility and empowerment. (Guilliland & Pairman, 1994, 1995). The aim of this model is to

create a “sense of control which enables the woman who has had a normal birth, the woman who has had a forceps birth, or the woman who has had a caesarean birth, all to feel positive about their experience” (Guilliland & Pairman, 1994, p.8).

I fully support this position because it recognises the woman as having a control over her childbirth experience, and this control is only possible if those around maintain effective communication with her, support her by acknowledging her input as being valuable, validate her concerns, and act upon them.

However, I also recognise that not all midwifery care is independent, as in the case of hospital midwives who share care with a practitioner from another discipline. While it is possible for a midwife to share care with a practitioner from another discipline and still practise independently, this “requires both practitioners to have equal status and responsibility and both are equally involved in all decision making with the woman remaining as the primary decision maker” (Guilliland & Pairman, 1994, p.6). In the late 80’s this position was still unclear in the hospital setting; homebirths were a different parameter of care. Some of the births in this project took place in hospitals prior to 1994.

The concept of empowerment has been widely discussed in nursing literature since the 1980s. Chinn and Wheeler (1989, cited in Gray and Pratt, 1991, p. 396) define empowerment as "growth of personal strength, power and ability to enact one's own will and love for self in the context of love for others". Chinn (1994, p.2) in discussing the concept of empowerment suggests that empowerment

implies “there is more than one "actor" in a situation - that a person is in a situation in which greater power is called for in relation to people or circumstances”. Therefore, when discussing empowerment within the health context, there are two aspects that have to be taken into account, empowering of the nurse, and empowering of the patient/client. Empowerment of the nurse can be associated with the idea of shared governance, which was first introduced in the USA in the late 1970s. The philosophy is based on the move away from a hierarchical, traditional management, to one where staff nurses are more involved in the decision making process, and therefore have more control over their working environment (Farrington & Geoghehan, 1995).

For nurses to feel empowered, they must have the knowledge and skills that will lead them to that state of being (Jacono & Jacono, 1993). Knowledge is power, and by sharing the knowledge generated from this research I hope nurses, midwives and other health professionals, will be empowered practitioners.

It has been strongly advocated that nursing and midwifery education is the key to producing nurses who are responsible and accountable, but this will only happen if students themselves feel they have power. If students, our future nurses and midwives, are not personally empowered, they cannot manage to empower patients/clients and all those who they come in contact with in their professional lives. Nursing centres on empowering others in their lives.

In this introductory chapter I have included the relevant aspects related to childbirth, my motivation to do the research project, and my personal underlying

philosophy, which encompasses caring and partnership. The aspect of being exposed and vulnerable in birthing has already appeared and will return at a number of levels in this research project. The capacity to recognise people who are in a position of vulnerability and caring for them is central to my practice.

Through considering the concepts of caring and partnership and my own philosophy of practice, I was able to take a position to create this project and listen to other Muslim women's stories about birthing and their life choices. I recognise their need as women, and culturally as Muslims, to require the capacity for privacy about the personal and intimate things in the nature of care, which are rarely discussed in the nursing literature.

In the following chapters I will seek to describe, explore and provide reflections on the women's stories and personal reflections on conducting the research.

Chapter Two provides the reader with a starting point from which to understand the Muslim world in general, the Muslim population in Aotearoa-New Zealand, and aspects that relate to Muslim women in particular.

Chapter Three describes and discusses selected theories/models namely the Transcultural Approach, the Access Model, the Asset Model, the Melting project and the Cultural Safety Model that have all been put forward to provide culturally safe care for clients.

Chapter Four invites the reader to share my journey in the search for an appropriate methodology before I chose Storytelling/Narrative as an approach for my research project. Within this chapter I shall also describe some of the issues that I had to consider prior to seeking ethical approval for the study.

Chapter Five presents The Story Telling/Narrative methodology as a valid form of inquiry into human subjectivity, the research project design including the ethical considerations, and the process for gathering the narrative accounts.

Chapter Six includes the stories of the three Muslim women, Khadija, Ayesha, and Amina, who consented to participate in the research project. It reveals the uniqueness of each story, and the common themes across all stories.

Chapter Seven offers reflections on the themes from the women's stories with the support of literature, discusses the implications for nursing and midwifery education and practice, and offers recommendations.

Chapter Eight draws together the research project, offers personal reflections on the research project. Limitations of this research project are addressed. The chapter ends with suggestions for future research.

CHAPTER TWO

CREATING A PLACE TO STAND FROM WHICH TO GAIN INSIGHT INTO MUSLIMS IN AOTEAROA-NEW ZEALAND AND THEIR HEALTH CARE NEEDS

This chapter provides the reader with a starting point from which to understand the Muslim world in general, the Muslim population in Aotearoa-New Zealand, and aspects that relate to women in particular, with special reference to caring for Muslim mothers, which is the aim of this thesis.

Muslims around the world

In order to place this study in its global context, I would like to present a few facts and figures about Muslims around the world. It is estimated that there are more than 2 billion Muslims worldwide. The Muslim population is spread right across Asia, Africa, Europe, United States, Britain, South Eastern European countries, Middle Eastern countries, Pakistan, India, and down to Australia and Aotearoa-New Zealand (Esposito, 1991; Hutchinson & Baqi-Aziz; 1994; Mckennis, 1999; Shepard, 1996; Zaidi, 1994). This diffusion of Muslim population around the globe includes a number of ethnic cultures and languages.

Muslims have immigrated to various parts of the world during the last one hundred years for the same two reasons as have other ethnic and religious groups, either for economic reasons or as political refugees. A number of Muslims settled

in the West some generations ago. As a result, Muslims now have children who live in Western cultures, where, more often than not, they find it difficult to balance their Islamic heritage with the Western culture in which they are immersed when they step outside the secure sanctuaries of their homes.

As Muslims we follow Islam, which is a worldwide religion and the last of the great Semitic religions. Islam is a monotheistic faith embracing Allah as the one God who is the creator of the universe. Allah is the Arabic word which stands for the one and only God, the Merciful and the Compassionate. “Islam means submission to the Will of God and obedience to His Law” (ABDALATI, n.d. p.7). The Qur’an is the sacred book for us, the Word of God revealed to Prophet Mohammed (Peace be upon him-PBUH) through the angel Gabriel. It is the main source of Islamic law. Hadith traditions are the practices of the Prophet Mohammed (PBUH) showing us in practical terms what he did. These two sources serve as a guide to Muslims all over the world as to what is *halal* [lawful] and what is *haram* [unlawful]; what they are supposed to do and what they are not allowed to do.

While there are two main historic divisions within Islam, Sunni and Shi’a, with Sunni Muslims making up 85 percent of the world’s Muslim population and Shi’ias 15 percent (Esposito, 1991, p.4), the Five Pillars and the Sharia (Islamic law) remain the common basis of faith and practice for all.

Teachings of Islam give meaning to our perception about living, family life, childbearing, child rearing, maintenance of health, causes of illness, and dying.

There are five basic duties. They are referred to as the Pillars of Faith in Islam and these are *Shahadah* - [bearing witness] that there is no other object of worship except Allah and that Muhammad is the Messenger of Allah; *Salat* - Obligatory Prayer [five set times a day]; *Zakat* - Alms giving [Obligatory alms giving on certain assets above a prescribed quantity]; *Sawm* - fasting [from dawn to sunset during the month of Ramadan which is the 9th month of the Islamic calendar] and *Hajj* - pilgrimage [to Mecca at least once in a lifetime].

There is a cultural diversity within the followers of the Islamic faith with regard to the extent of their adherence to Islamic law (Hutchinson & Baqi-Aziz, 1994; Zaidi, 1994). This attitude varies from individual to individual and from community to community, in the sense that some Muslims are quite traditional in their practices while others are more liberal. Therefore, the uninformed assumption that all Muslims would act in one definite way is misleading and is best avoided. Such presumptions can lead to stereotyping of individuals, leading to unsafe practices.

Muslim Community in Aotearoa-New Zealand

The earliest record of Muslims living in New Zealand appears in the 1874 census, and it indicates them to be all males and of Chinese origin. Most of them were working in the gold fields (Tiwari, 1980). They were referred to as “Mahometans”. At times Muslims have been referred to as “Mahometans” or “Mohammadans” and Islam as “Mohammedanism”. This reference to Islam as Mohammedanism and addressing its believers, as Mohammadans is a rather offensive reference, as it implies the religion takes its name after a mortal

(ABDALATI, n.d. p.7). Between the years of 1907 and 1911 three Gujarati Muslim men came as part of a small group of Indians from India. While some of the men were married, their wives and younger sons and daughters remained in India in keeping with the tradition and culture of the time (Rahman, 1996; Shepard, 1996).

The first record of a “Mahometan” woman appears in 1906. Holdings of the Census records held at the Alexander Turnbull Library classed Islam under the category of “other” for the year 1906. (Catherine Cradwick, Personal communication, 12th January, 2001). It is certain though, that Muslim women began to come to New Zealand after the Second World War to join their husbands and fathers, where they were either on farms and restricted to the homes, or they helped run family businesses if they lived in the towns (Rehman, 1996).

At the time of writing this thesis the results of the 2001 census were not available, but according to the 1996 New Zealand census, there were 13,545 Muslims living in New Zealand. However, this number has since increased as statistics shown in Al Mujaddid (2000) indicate there are now some 20,000 Muslims living in New Zealand from 40 nationalities. While some are immigrants by choice, there are others who have come from war torn countries as refugees. The transient population consists of overseas students, embassy staff, and immigrants who move on after a few years. There are also a small number of Westerners who have adopted Islam (Shepard, n.d. cited in Tiwari, 1980; Shepard, 1996).

The majority of Muslims are married couples ranging from 20-40 years with young children, with some teenagers and elderly making up the rest of this population. The main concentration of Muslim population is in the city centres of Auckland, Wellington, Christchurch, Hamilton, Palmerston North and Dunedin (Shephard, 1996). However, there are Muslims living in other areas of New Zealand in smaller numbers. The Muslim workforce is comprised of university-educated professionals, government employees, business people and so forth and their income seems similar to those of other New Zealanders (Shepard, 1996).

Therefore one would expect the Muslim women population to reflect the above nationalities, coming from diverse racial, cultural, and historical backgrounds represented in the home and some in the workforce. The children attend local schools. At least one Muslim boys' school (Al Almadinah) has opened within the last few years in Auckland, and earlier this year (2001), Zayed's College for Muslim girls was opened in Mangere, Auckland.

There are a number of Muslim organizations and associations, which engage in religious and social functions. Within some of these associations, separate women's organisations have been established. Most of the bigger cities have mosques, but in the smaller towns and cities the community meets either in private houses or rented "Islamic Centres", for Friday prayers and other rituals.

Position of Women in Islam

In this next section, I have written a text through a story told by Nanee (maternal grandmother) to her granddaughter. She is telling a story, as that is what Nanee

would do in a typical Muslim family. Such stories/narratives have been used across cultures and generations as a wonderful way of preserving cultural identity, imparting knowledge and inspiring people.

Noorunnisa, my dear granddaughter,

I want to tell you the story of the position of women in Islam. There is much to tell you but for tonight we will cover certain aspects only. There are two reasons why I want to tell you all this, firstly from a religious and cultural perspective and secondly from a personal perspective. It has concerned me when I found out that some people think Muslim women are “uneducated child brides who bear numerous children, and are unglamorous, suppressed and helpless victims of their society” (Zaidi, 1994, p.8). This assumption is incorrect and best avoided.

On the contrary, women under Islamic laws derive their rights and duties from the Qur’an and Hadiths which were revealed to Prophet Mohammed (PBUH) fourteen hundred years ago. Any practises that are in conflict with the true Islamic teachings are related to the cultural traditions of the country from which the women come and not from Islamic teachings. Women have equal rights but different responsibilities. In Islam, women in the sight of Allah (*Subanaho Wa Ta’ala* (SWT=Glory be to Him, Most High) have spiritual equality with men with regard to their faith and deeds (Qur’an, *Surah, An-Nahl* 16:97). Other rights include, the right of inheritance, education, ownership of her own income, to seek work under the framework of Islam, to keep her maiden name, to choose a husband, and to seek divorce (Basic Principles of Islam, n.d).

Modesty and privacy are important to a Muslim woman. Modesty in dress (*Hijaab*) and behaviour is a virtue that Islam demands of Muslim women and the rules are there to guard the women and maintain their dignity. Some women may wear the clothes that reflect the customs of their countries of origin or where they are living, but they usually adjust their clothing to be modest. Women in Islam prefer to be attended by female health professionals, as it involves the matter of modesty and privacy and this is more so in issues related to private parts of the body.

With regards to education, Hadith '*Talbal ilm fareedatun 'alaa kullu Musliman wa Muslimatun*'—Seeking of knowledge, *ilm*, is *fardh*, obligatory on every Muslim male and every Muslim female. Throughout history there have been many Muslim women who became famous as religious scholars, writers, poets, doctors and teachers. One such woman was a Muslim nurse called Rifaida Al-Asalmiya who lived during the times of Prophet Mohammed (PBUH). Not only was she a nurse, she was also a social leader, a health leader, an educator, and the founder of the first nursing school in the Muslim world. (Jan, 1996). There are instances where girls are unable to access education, and possible reasons for this could be financial, isolation, or the family culture the girls are from.

As you know, a number of your mother's generation and younger women go out to work. That is acceptable under Islamic law providing it does not affect the woman's main responsibility, that is, the family and the house. Muslim women are not obliged to share their income with family (Basic Principles of Islam, n.d). As a matter of fact, the husband has to provide for the household expenses—the

wife can save up her wealth for herself and for harder times. This is because in Islam the man is fully responsible for the maintenance of his wife, his children, and in some cases, his needy kin. Those who do share household expenses with their husbands do it by choice, for their children and families, or because it is difficult to maintain household expenses with one person's earnings if they have migrated to a Western country.

In accordance with Islamic law women have the right to choose a husband. Upon marriage "A wife does not change her basic identity: She retains her maiden name, religion or school of thought if she so desires, and her legal personality" ('Abd al 'Ati, 1977, p.146). There are occasions when women do take on their husband's family name and the reasons for this may vary. In recognition of her right to choose a husband, the woman also has the right to seek an end to an unsuccessful marriage, but there are certain steps and prescribed waiting periods to avoid making hasty decisions.

Marriage is viewed as a strong bond within Islam, a partnership in which there are rights and obligations for both husband and wife. Men and women are seen as having different natures, strengths, and capacities. Men are defenders (guardians) and providers, and women are supporters and nurturers, involved with family and homecare ('Abd al A'ti, 1977; ABDALATI n.d; Waris-Maqsood, 1995).

The foundations of the family are blood ties and/or marital commitments, and strong kinship affection and responsibility are reserved not just for one's own children and parents but also for extended relatives. ('Abd al A'ti, 1977; Al Kaysi,

1986;). We have many social obligations, and in times of joy and sorrow we all support each other. We celebrate our *Eid* festivals, marriages, and the birth of our children. The gatherings are held as a thanksgiving and also to bring families, friends and neighbours together.

The Muslim women's role as mothers is a respected role, for they take enormous responsibility for nurturing their children, providing comfort, nourishment and so forth. Prophet Mohammed (PBUH) acknowledged this role by declaring that "Paradise is under the feet of the mother". In other words, Paradise awaits those children who respect their mothers and help them when they need help. (Basic Principles of Islam, p.9). Children too have rights under Islamic law, that is, the right to life, the right to have a legal father, the right to have a good caring and loving upbringing" (ADBAL-ATI, 1974; 'Abd al A'ti, 1977; Al Kaysi, 1986; Waris-Maqsood, 1995).

The birth of a child should be a welcome event and regardless of it being a boy or a girl one should be grateful to Allah (SWT). There are certain religious and traditional practices that are performed following the birth of a baby. The religious ceremony includes the reciting of 'Adhan,' (call to prayer) Praise to Allah into the baby's ear soon after it is born. The *Adhan* can be performed either by the father, or an elder from the community. It is preferable to bath the baby before the *Adhan* is performed but not necessary as the baby is 'Tayyab' [good]. It is more for aesthetic reasons and for the *Maudin* [one who calls the *Adhan*], so that he is not repelled by the sight of any birth products on the baby (Members of Muslim community, Personal communication, 1, August, 2001).

Naming the child is usually done within seven days of birth in accordance with Sunnah practice. The meaning of Sunnah must include the idea of following what the Prophet did or said, Rahman, (1987). Most people prefer to name a child at birth just in case the unforeseen happens and the baby dies. This supports the idea of hastening the naming.

There are some traditional events that take place on the seventh day, and these include two main events, the shaving of the baby's head with the recommendation that silver equivalent to the weight of baby's hair be given as alms to the poor and needy, and the slaughtering of an animal as a thanksgiving to Allah, asking for His protection for the new born child. The meat is distributed to family, relatives, neighbours and the needy. This whole ceremony is called '*Aqiqah*' (Al-Kaysi, 1986).

In raising a child, among many other important aspects, nutrition is considered important, and the best start a baby can have in his/her life is his/her mother's own milk, as this contains all the nutrients that are required for the baby to grow, and the colostrum which precedes the mature milk contains antibodies which help the baby to fight diseases.

Various passages about suckling in the Qur'an allude to different situations. For example, the ones in *Surah Luqmaan*, 31:14 and *Surah Al-Ahqaaf*, 46:15 remind the descendants to be grateful to their parents because of the hardship they underwent in bringing them up, whereas the passage from *Surah Baqarah* 2:233 implies the responsibility of the husband to allow or facilitate the wife – the

mother of his child – to undertake suckling, even in a situation where divorce is being considered or is in process, or divorce has already taken place.

We believe, as the Quran teaches us, that certain things are '*Najis*'. The word '*Najis*' is an Arabic word and it has several meanings, including being unclean, polluted or dirty. The best word to express this concept for those of us Muslims who come from the "South Asian sub continent - Pakistan, India, Afghanistan and even Iran is Paleed or Naa-Paak" (Chand, 1998, p.140).

In keeping with this concept of '*Najis*' there are some exemptions for women from worship rituals like performing prayers, fasting, and reading the Qur'an during specific periods like menstruation and childbirth. However these periods are treated as normal events for ordinary human activities. With regard to the placenta, back home during my time it was buried. Perhaps the idea was that animals like dogs wouldn't eat it, and of course it is something to be disposed of in some safe respectable way. Otherwise there are no special religious ceremonies involved in burying the placenta.

And now this brings me to that second reason why I told you this story. Your parents are thinking of sending you to Aotearoa-New Zealand for further education, and who knows, you might decide to live there for good, get married, and have children.

Whether you go to a new country for study or migrate, it is not easy, for with it come joys and sorrows. Joys come in the form of exciting new beginnings and

opportunities. Sorrows come in the form of being far away from your kin, your culture, your foods, and getting lost in new systems. At no time is this sorrow greater than when you are facing major life events like having a baby. Your beliefs and your values get challenged and these cause much pain and distress. That is why I wanted to provide you with this background to Islamic culture and the place of women in Islam.

Now “hurry along and get me a cup of tea for my throat is dry from all the talking”.

This story told by Nanee to her granddaughter gives an insight into the position of women in Islam, and within it are aspects that are of concern to the majority of Muslim women, whether they are immigrants or not, for example, issues relating to modesty and privacy, diet, and fulfilling their parental obligations. The women’s stories in Chapter Six give an insight into how their experiences were affected by some of these issues.

With reference to the midwifery partnership concept, discussed in Chapter One, this may need to be thought about carefully when used in a different cultural context. It may appear to those who are not familiar with Islamic teachings that Muslim women are not empowered or not capable of making decisions. Muslim women are very capable of making decisions for themselves, however, in Islam, men are the guardians, and therefore are protectors of their women and their role should not be misconstrued to mean anything other than that. In view of this, the men may be involved in the decision making process, and so any partnership that is formed within a health care setting may also need to involve the husband.

Harding (1983 as cited in Campbell & Bunting, 1991) proposes a stance that all women experience patriarchy differently and that all viewpoints are valid.

There may be some issues that pose a challenge, in that women or men would not want to discuss these openly within each other's presence, and these would need to be addressed in a sensitive manner.

In this chapter a description has been provided from which to understand the Muslim world in general. Included were the population spread of Muslims across the world and in Aotearoa-New Zealand, Islam and its teachings, and aspects relating to Muslim women in particular which health professionals may find useful to refer to in their practice in caring for Muslim mothers. It is crucial to state the obvious that each woman is an individual, and therefore no two women are alike, as the women's stories reveal in Chapter Six. As mentioned earlier on in the chapter there is diversity within the Muslim population, and from a nursing or midwifery point of view, care needs be individualised for the Muslim woman and her family who is going through a child birth experience.

In the following chapter I will discuss selected theories and models that have been put forward on how to provide care for people from different cultural backgrounds.

CHAPTER THREE

THE RULE OF THUMB HOLDS MANY WISE THREADS

Talk to me before you nurse me.

Your assumptions compromise my safety.

In this chapter I will explore the wise threads of the Transcultural Approach, Access Model, Asset Model, the Melting Project, the Cultural Safety Model and describe how I have learnt to identify the threads in my philosophy and position them in my practice. Through these particular threads I create a situation in research, education and nursing care, where effective communication occurs. These threads allowed me as a researcher to create an environment where the women were enabled to share their life story as a grand narrative. I regard the grand narrative as their ‘whole-truth story’, which encompasses their lineage, their health, and their own life journey, and have observed that it is disclosed only if the nurse, midwife, or educator makes no assumptions, and has respect for the uniqueness of each human being.

We say glibly that modern communication systems and mass travel seem to make the world smaller, when we are in fact becoming aware of details of many different cultures, and the journeys people of different cultures make to settle in different countries. The reasons people travel to resettle are many and I highlighted some in Chapter Two. For health professionals the challenge is how

best to provide care that respects the dignity and cultural heritage of each person in a relationship that is founded on a principle of partnership.

In my personal life and in my role as an educator I use personal reflections to identify the deep threads that connect our personal life and professional competence. I have discovered one thread that has enabled me to identify my situation as a Muslim woman, as a Hindi speaker, and as an educator. It made it possible for me to reveal the truth in ‘the rule of thumb’ that I share with students from my practice. “As you talk with me before you nurse me, you discover your story and your assumptions, and can release them as you give me space and quiet so I can tell you my story”. To create the environment and capacity in one’s self and to allow for this sharing to occur takes experience. I can share the above ‘rule of thumb’ with students, but until they experience their own story being heard fully, they unconsciously assume they know the person.

In my journey to develop my capacity to listen to others’ stories, definitions and theories in nursing have been profoundly important. Two definitions that have been very meaningful to me are “Safety” which is defined as freedom from danger or risks (Coulson, Carr, Hutchingson & Eagle, 1975, p.745). and “Culture” which is defined as the sharing of meaning and understanding (Nursing Council of New Zealand. 1996, July, p.40).

Safety of the client in nursing and midwifery practice is paramount, meaning the client is protected and guarded from harm, be that physical or psychological. It appears to me the boundaries that encompass physical safety are easy to

comprehend and put into practice, but those that affect one's psychological well being are not so easily recognised or given priority at times. Sharing and understanding the clients cultural needs in theory should lead to measures taken in practice. Sharing one's own cultural knowledge with another who is listening to gain an understanding can validate that the teller and the listener are mutually taking this knowledge on board, and gives the teller hope that their cultural needs are being met. Having one's cultural needs met enhances and sustains one's psychological wellbeing. This is both ethically and culturally correct. Both experiences are crucial for wellbeing but it is this latter context that is profoundly important to me.

I explored the literature and discovered theories/models that have been proposed to assist nurses and midwives in providing culturally safe care for individuals experiencing a health care situation. I will share how I encountered each of these and discuss its value to my practice.

Transcultural Approach

Madeleine Leininger is the first nurse academic to actively document the importance of cultural factors in influencing health status from her observations of children in health care settings (Reynolds & Leininger, 1993). As a result of these observations, she developed the theory of Culture Care Diversity and Universality and the field of transcultural nursing was born. The focus is on a "systematic study of different cultural groups to help the nurse understand multicultural health care and prevent undue cultural shock and cultural clashes related to transcultural

care problems” (Leininger, 1994. p.1). Therefore the assumption is that those nurses who have undergone this formal study are able to provide culturally congruent care.

The Access Model

The transcultural approach to meeting the cultural needs of Muslim patients in the UK has been advocated by Narayanasamy and Andrew, (2000) in their article ‘Cultural impact of Islam on the future directions of nurse education’. They believe this can be achieved by incorporating transcultural nursing practice into the education programmes for nurses and suggest the use of the Access Model as a framework for this purpose. The Access Model included the following aspects: assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity and safety. Narayanasamy and Andrew, (2000) suggest prayer, Muslim dress, and diet should be taken into account as part of the Access model in providing holistic care of Muslim patients.

The Asset Model

Narayanasamy and Andrew, (2000) also propose that nursing education curriculum should include the spiritual aspect of care, and for this they recommend the use of the Asset Model (Actioning, Spirituality and Spiritual care Education and Training). In proposing the use of this model for the care of Muslim clients, Narayanasamy and Andrew, (2000, pp.59-60) suggest the following aspects could be included “Islam as a living religion, its history and

global impact, the Qur'an, the Five Pillars of Islam and the nursing care of Muslim patients”.

However, Cortis, (2000) argues that, while it may be useful to have background knowledge on a cultural group, it would be dangerous to assume that all members of the group adhere to all the observable norms of that cultural group, and this may lead to stereotyping of people in terms of their cultures, races and faiths. Furthermore, Cortis, (2000) asserts that the transcultural approach leads to the notion of culture being static. It also fails to address the issues of class, gender, power and status as having a bearing on people's health care needs. In multicultural societies such as the UK, Germany and the United States, “elements of inequalities are experienced by minority ethnic groups” (Cortis, 2000, p.66). This view is supported by Bharj (2000) who goes on to say education of practitioners should include an antidiscriminatory curriculum in response to the points raised in Narayanasamy and Andrews (2000) in their article.

The ‘Melting’ project (Multiethnic learning and teaching in nursing)

Sookhoo (2000) discussed the need for the education curriculum in Britain to prepare health professionals who value cultural diversity and demonstrate culturally competent care. He also recognises the same points raised by Cortis (2000) and Bharj (2000) and adds that resources, access, equipment and epidemiological trends should also be included in the education of nursing students. In order to provide culturally competent care, he discusses the ‘Melting’ project as a way to address this need. This consists of “teaching and learning resources for students and academic staff that will facilitate learning about the

needs of people from diverse ethnic backgrounds,” Sookhoo (2000, p.40), with the ultimate aim being, that this resource be intranet-based and easily accessible.

The Cultural Safety Model

In Aotearoa New Zealand the above issues were recognised in the late 1980’s. The drive and the concept/model for cultural safety first emerged from concerns articulated by Maori nursing students. They identified that the education processes in place at the time put their own cultural identity as Maori and self esteem at risk, and in addition, it did not prepare them to give culturally safe service to the Tangata Whenua-te-iwi, their own people (Ramsden, 1990). The latter statement has recently been echoed by an Asian nurse, who had trained in Australia, but found upon returning home that she was inadequately prepared to work in her own country (Smith, 2000).

Maori are the indigenous people of Aotearoa-New Zealand, and the Treaty of Waitangi is the agreement made between the British Crown and some Maori leaders in 1840. It defined the relationship between Maori and the British Crown. The Treaty was developed in order to create an agreed basis for two different people to inhabit a country. Colonisation ensued, in which one group has used their wealth and power to determine the life and material and access to natural resources of Maori. Today in the 21st century, the Treaty is identified as the document through which people in Aotearoa-New Zealand debate a way to get together.

Information gathered over the years from health education, criminal justice and social welfare systems revealed Maori “had been poorly served (. . . .) the development of the nursing service and the education of nurses is part of that story” (Ramsden, 1993, p.5). The implication being the health services provided by nurses and other health professionals to Maori have been inappropriate and inadequate as compared to the dominant Pakeha (white) group (Polaschek, 1998).

In response to these concerns, a proposal was made for a model for a negotiated and equal partnership in nursing education. Irihapeti Ramsden, a Maori nurse, headed the project in consultation with Maori. In her paper entitled ‘Kawa Whakaruruhau - Cultural safety in Nursing Education in Aotearoa-New Zealand’ (1993), Ramsden highlighted that New Zealand nurses, without the benefit of a broadly based social education, were confusing the cultures of indigenous people with the culture of poverty into which indigenous people had been forced. She suggested that nurses needed to understand the broader contextual issues that impact on individuals, like unemployment, the poverty cycle, various histories, and socio-political conditions (Ramsden, 1993).

The Nursing Council of New Zealand adopted the concept, and incorporated cultural safety into nursing and midwifery education and the Standards for Registration in Nursing and Midwifery practice in 1992. Cultural Safety is defined as “The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse’s culture on own nursing practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and

wellbeing of an individual” (Nursing Council of New Zealand, 1996, p.9). This definition has since been redefined to include the consumer voice determining what is effective nursing and midwifery care. The term ‘Safety’ in Cultural Safety was specially chosen, as it is a term that is reflected in nursing and midwifery language; a term that implies a certain standard must be met otherwise the activity is considered unsafe (Ramsden, 1995; Polaschek, 1998; Ramsden, 2000).

The steps towards achieving cultural safety in Nursing and Midwifery practice include: Cultural-awareness, that is acknowledging and understanding that there is a difference. Cultural sensitivity is being aware that differences exist and through self-exploration and reflection discover and realise how one’s own life experiences and realities may have an impact on others with whom one comes in contact (Nursing Council of New Zealand, 1996). Finally “Cultural Safety is an outcome of nursing and midwifery education that enables safe service and is defined by those who receive the service.” (Nursing Council of New Zealand, 1996, p.9).

In Nursing and Midwifery action this equates to the client being free from danger or risks to their well being in any of the following aspects - physical, psychological, social, spiritual, and cultural, and as a recipient of care, giving them power to be involved in changes in any experience considered as negative.

Cultural Safety is a concept I support in principle and practice and on which I have reflected deeply until I felt I am familiar with it. Ramsden (2000) asserts, “Cultural safety should be the experience of all the recipients of nursing care”. It

is about safeguarding the most vulnerable from the culture of nurses, their attitudes and their power. We nurses and midwives are asked to examine our own attitudes and our power, and how we utilise these in our practice. We as nurses/midwives are in the position of making that health care experience either a positive one or a negative one for those in our care. The ‘trust moment’, as Ramsden (2000) contends, is one that we all try to establish or strive for, and it forms the basis for all future interactions. If trust is not formed early on in the relationship, individuals will carry on safeguarding their differences from nurses no matter how informed one is transculturally, and this sets the scene for us nurses to be seen as unsafe to practice (Ramsden, 2000).

In comparing these theories/models I find Ramsden’s Cultural Safety Model more appropriate as it challenges us all to examine our attitudes and our power and how we utilise these in our practice. Indeed it is important to go through our own “baggage” or beliefs, identify if they are good or bad, and recognise our potential to do good or harm before we enter into a caring relationship. My position is that no matter how informed I am about other cultures, it is not until I examine myself and discover what I value in my life and in my culture, that I can truly try to understand where the other person is positioned. To tell my story and to be who I am in my own heritage is central to my practice and philosophy, it determines how I practice, and because of it I was acutely conscious in this research that my overarching desire was for the women to be enabled to tell their story. I recognised that to conduct this project successfully I had to tell my story as a written text, reflect on the text, and evolve a quality in the conversation with the women in the project who were my friends. This enabled us to create a vision of

our unique stories having a place in the universal story of Muslim women and the new story of Aotearoa-New Zealand, which respects people's nationality, spirituality and culture.

Competencies and advanced practice

I have been further challenged to consider my philosophy by the document written by The Nursing Council of New Zealand, the body that governs the practice of Nurses and Midwives, and sets standards and criteria for the assessment of nursing practice, ensuring a safe and competent care for the public of New Zealand. In Nursing and Midwifery, 'Safety' is intrinsic to client care and to this end this concept of safety is inherent within the Standards for Registration of Comprehensive Nurses and Code for Conduct for Nurses and Midwives.

With regard to providing culturally safe care the following statements are indicated in the Nursing Council of New Zealand Code for Nurses and Midwives.

Principle 3.7 (1998, p.5) states the nurse or midwife:

'Practises in a manner which is culturally safe'

And in Standard 10.2 it is stated that the evidence to practise as a comprehensive nurse is shown when the applicant:

'Practises nursing in a manner which the client determines as being culturally safe' (Nursing Council of New Zealand, 1999, Appendix III, p.4.).

These two statements serve as a guide to me in my practice and serve as a reminder that it is the client who determines what is culturally safe care. For me,

culturally safe care goes beyond just taking biographical data and establishing baselines, and then not doing anything about them. The following text expresses my hope and desires.

“For me to feel safe in a health care environment means that I am protected from physical and psychological harm, and that my spiritual and cultural needs are met. This can be done for me by asking and listening to my needs without making assumptions, for assumptions compromise my safety. My outward appearance does not tell you that I am a Muslim woman; the fact that I express myself clearly in English does not mean, that when I am in a compromised situation, I am able to take in what you are trying to say to me. If I was in a health care facility, I would like to think that I was given information that is easily understood by a person for whom English is their second language. I would like to think I am given the options as to who provides my care so I can make an informed choice. I realise in an emergency it may be difficult, but I feel, even at times like that, my needs could be met with good communication and consultation” (Khurshid Mitchell, 2001).

In this chapter I have given an overview of selected theories/models that have been proposed for providing culturally appropriate care. Cultural Safety is the recognised model utilised within Aotearoa-New Zealand. My experience in practice has shown me the clients respond better when the client feels comfortable in an environment where their individual needs have been addressed. Theories and models are useless unless they can be utilised in practice. Wisdom comes slowly by connecting one’s story, reflections about life, and desire to live well. Wise

threads are only useful if the wisdom expressed in them has been threaded visibly into one's life and practice.

With this in mind, the next chapter delves into the search for an appropriate methodology and approach for the proposed research project into Muslim women's childbirth experiences.

CHAPTER FOUR

THE RESEARCH PROJECT

This chapter describes how the research project evolved through a series of stages, in which I explored the ontological and methodological principles that guided the research process, and I describe how I came to choose a Narrative/Storytelling approach as the most appropriate method for the project. I will discuss the dilemmas I experienced and the subsequent decisions I made in the process of selecting and shaping the methodology that I considered most appropriate to explore Muslim women's childbirth experiences in Aotearoa-New Zealand.

I have always been clear that my primary goal in the project was to use a methodology that was going to give voice to the women's stories, enable me to remain true to their stories, and to acknowledge the deeply felt memories of the experiences that were revealed to me. Knowing this, however, did not prevent me searching amongst many methodologies and the approaches within them, before I came to recognise that Narrative/Storytelling Inquiry was the approach that would respect the women in this research project. I felt satisfied after my exploration that this was the most suitable approach for what I aimed to achieve. This method and methodology enabled me to place the stories as texts in such a way that I could highlight the uniqueness of each woman's experience, and also identify the significance of certain experiences that Muslim women are particularly interested in sharing amongst each other.

For me, it was also important that the women and I were joint partners in this journey of discovery. Heron (in Reason & Rowan, 1981), Rowan and Reason (1981) and Glesne and Peshkin, (1992) all support the idea of the participants being co-researchers in the developing inquiry so that they are actively involved in the research and own the outcome. If I was to enquire into the subjective experiences of the women, then the only way I would gain an understanding of their experiences was to have them share their stories, and we would then have the chance to reflect over these stories, gain some meaning through sharing them with each other, and pass this new knowledge on to the readers of this research in published writings. The women as co-researchers are not just participants, as they have the opportunity to share their stories, and, in telling their stories, gain some meaning from their experiences and contribute to theory building as suggested by Anderson, Armitage, Jack and Wittner, (1990).

Crossroad - Qualitative or Quantitative Methodology

To reach this decision point, I considered many ways to proceed, and had to make important decisions for the project, as issues surfaced that I had to contend with enroute. Firstly, I faced the dilemma of making a choice between the two broad methodologies, these being Quantitative and Qualitative. This was because I had the perception that quantitative research was real research because of its formal, objective, systematic process. This suited my style because on the whole I am a linear thinker, and I like things to be in neat little packages, and so at first I decided this methodology would be the best choice for me. However on reflection I realised human beings do not come in neat little packages. We are complex beings. We come with a whole host of attributes that have been shaped by life and

culture. In nursing my aim is to view the person as a whole and not reduce the individual to the sum of their parts. “The concept of a holistic person means that nothing is reduced to discrete elements or isolated from its context” (Chinn & Kramer, 1995 p.47). From the holistic position I absolutely contend I cannot separate a woman’s childbirth experiences from the context in which the birth has occurred, or from her past experience and influences.

I recognised that “the choice to use either the quantitative or qualitative method was very much dependent on, or guided by, the research question” (Beanland, Schneider, LoBiondo-Wood & Haber (1999, p.241). This certainly applied to my project, as the questions in my research project were related to exploring Muslim women’s childbirth experiences in Aotearoa-New Zealand. As a Muslim woman, mother, nurse and midwife myself, the more I dwelled on my readings and thought about my questions, the more I recognised that a purely qualitative research process supported my research question. Also, I was not comfortable with the use of the term subjects to describe the women, as it conjured up images of the women being passive.

As I reached the point of making this final decision, I found empathy with Polkinghorne’s (1988) suggestion that the qualitative methodology is located in the interpretative paradigm, and that this is suited to the human sciences of which nursing is one. The main aim of inquiry for the human sciences is the reality of human experience, “both that present in, and that hidden from awareness” (Polkinghorne, 1988, p.159). Each person constructs their own reality from their personal experience. There is no single reality. Lincoln and Guba (1985) support

this notion of constructed reality and that multiple realities exist. This leads to the production of knowledge that is individualised and contextually bound. Ultimately it can be said that human sciences “do not produce knowledge that leads to prediction and control of experience but produce knowledge that deepens and enlarges the understanding of human existence” (Polkinghorne, 1988, p.159).

The women, in sharing their stories, shared the “secrets” which are in fact stories that have not had a safe place to be vented. Their stories revealed their “good” experiences and their “not so good” experiences. The sharing of their birthing stories has enabled me to understand their experiences at a deeper level, and this, combined with my reflections on the stories, will hopefully give the readers of this research a deeper understanding of the women’s experiences and their needs.

I could see why Streubert and Carpenter (1995, p.21) added, “the purpose of qualitative research is not about prediction and control but is rather description and understanding”. I wondered, on completion of the project, if the Muslim women in this project would have easily shared a deep level of description with rich detail with someone who was not their friend or who was not a Muslim. Burns and Grove (1995) suggest qualitative research invites a methodical, subjective approach to describe life experiences and give them meaning. In sharing their stories the women portrayed the meaning they attached to these experiences. I could see and use the text of their stories to reveal the words they used to describe their experiences. For example Khadija, one of the women in the project, uses the following specific words, “consulted” and “pleasant” in her good experience, while at another point in her story she uses the words “vulnerable”

and “suck up to” to describe how she felt in a bad experience. This intensity certainly correlates with Sandelowski’s (1986) challenge to pick good storytellers because narrative research is dependent on the women as co-researchers telling their stories in a vivid and lively way. This is also important in that hidden experiences when surfaced and shared bring new understanding. This lively storying and discovery was familiar to me as the best outcome in my practice. It required mutual goals of sharing and intense interaction.

Qualitative research begins by not knowing answers. At this inductive level the goal is to gain insight through mutually discovering meanings. Burns and Grove (1995, p.393) assert, "Within a holistic framework, qualitative research is a means of exploring the depth, richness, and complexity inherent in a phenomena". According to Munhall, (1989, p.27) in qualitative research, the researcher is either “seeking to discover knowledge or seeking to develop or reformulate theory from the authentic source by looking at the whole within context: the social, the experiential, the linguistic and cultural context”. I realised that in this type of research, as a co-researcher I would interview the women in their own environment, listen to their stories, and present the issues and ideas from their point of view. I would also be seeking to understand their concerns and their experience of the phenomenon of concern, what ever that phenomenon might be.

Munhall (1982) and Holloway and Wheeler (1996) suggest qualitative research is consistent with nursing's philosophical beliefs which are person-centred, holistic and vital for health professionals who focus on caring, shared experience, communication and interaction. Sandelowski (1997) has succinctly pointed out

that the objective of qualitative inquiry is to transform understanding, and not just to accumulate data. Indeed, if I intend to describe women's childbirth experiences, then qualitative research is the most appropriate methodology as the childbirth experiences are so personal to each woman and as Callister (1995, p.328) asserts, the "childbirth experience cannot be described adequately or comprehensively by quantitative means alone".

Having decided generally on the position of being a researcher using qualitative research, I next explored a number of the approaches within this methodology including ethnography, phenomenology and hermeneutics. I chose to put these methodologies aside, but not until I had carefully considered what I was attempting to achieve, and the actual outcome each approach might produce. I found that as I explored the different approaches and methods, I became more explicit about what I thought would work for us as Muslim women. I also made decisions about how to think about experience and story telling, and this eventually influenced decisions I made about conducting the conversations and creating and presenting the text of the women's stories in a culturally safe way.

Crossroad - Ethnography

Ethnography seemed the logical first choice as it gives the direct description of a culture or subculture (Holloway & Wheeler, 1996). However further readings on this approach illuminated to me that the data collection was through direct observations in clinical settings and interviews, and also one does not always investigate one's own cultural group members (Holloway & Wheeler, 1996). Furthermore, the women I was hoping to interview came from a number of

different ethnic backgrounds, and as I highlighted in Chapter Two, there is cultural diversity within the followers of the Islamic faith with regard to the extent of their adherence to Islamic Law. I had to acknowledge this and treat each woman's story for what it represented to her individually, and not collect the women into one homogenous group. Also, I did not want to use the ethnographic term informant which is described as "people who agree to collaborate with the field worker" (Barrett, 1991, p.33). In my perception, this term seemed more appropriate in custodial/police/war-like scenarios, than in nursing. In many parts of the world this term has implications to do with secret police and non-democratic institutions. It soon became apparent this was not the appropriate method to utilise for this project.

Crossroad - Phenomenology

Next I explored phenomenology as an approach for the project, as it allows for the exploration of people's experiences from their point of view. Initially it appealed to me as it acknowledges and values the meanings that people attach to their own being (life), and in this case I thought this approach would suit what I was trying to achieve in this research project. Phenomenology is the study of manifestations. It is an investigation of the lived experience, that is, it is a way of thinking about people's life experiences (LoBiondo-Wood & Haber, 1994). The two key ideas that underlie this approach are "bracketing" (suspension of belief) and "lived experiences" (an experience as it is lived by a person), for example the experience of hope as it is lived by the person (Roberts & Taylor, 1998).

I tried to make sense of this approach and find ways of using it for my project. As I looked deeper into this approach I discovered there were many viewpoints under the broad umbrella of what is termed phenomenology, and discovered there were great debates occurring as to the use of this approach in nursing. Personally, I could not work out how best to utilise it, do justice to it, and achieve my aims. Something seemed amiss. I let go of the idea of utilising the phenomenological approach. This seemed to be the right decision, as my readings also showed me that “research methods employed in one cultural setting may not always be appropriate or acceptable to the participants in another cultural context” (Clark, 2001, p.19).

I reflected on the aims of my research project, and came to the decision that its purpose was to explore, understand, and highlight the Muslim women’s childbirth experiences within the Aotearoa-New Zealand context. Therefore I made the decision to find an approach that was culturally appropriate for Muslim women and easy to relate to as Muslim women.

It is fair to say, having read widely across methodologies, that I have been influenced with regards to my ideas and approach to writing this thesis. My interest in hermeneutics (theory of interpretation) and phenomenology has enabled me to understand that my interpretation of the text of the stories is of value, and that I could represent this also as a text. Hermeneutics enabled me to understand that texts can be looked at and interpreted through my own experience, and that the way to do this is to look first at the whole text, and then to look at

particular words and sentences. Phenomenology enabled me to recognise the realities of lived experiences of the women as well.

Therefore, a combination of writings on ethnography, phenomenology, and hermeneutics have informed my thinking as I strove to find an approach that I felt was congruent with conversing with Muslim women as we shared their stories. It was also my desire that future readers of my research would be able to relate to the women's stories, and find some common meaning in them. It was important for me to avoid using terminology and jargon that would alienate potential readers of my research, as the ultimate aim was not only to highlight the women's experiences, but also for health professionals to read the research and implement care that was safe and congruent with Muslim women's needs.

Discovering Narrative/Story Telling

Having read about ethnography, phenomenology and hermeneutics, I reconsidered my ethical position and asked myself, "What am I doing?" I went through my application form seeking ethical approval for the project, and the words "stories" and "narrative" stared out at me. This prompted me to go back through my collection of research references, and I found Cheryl Moss's (1991) article, on the use of story telling as a basis for inquiry. While the idea of using storytelling/narrative was appealing, I still had my doubts, and I kept asking myself if storytelling and the narrative form was indeed a scientific way to conduct human inquiry? This doubt led me to read further and explore the field of Narrative/Storytelling as an approach for research inquiry.

My readings around Story telling and Narrative resulted in some confusion, as at times the two terms were used interchangeably. However, reading Polkinghorne's (1988, p.13) differentiation cleared up the confusion. He points out that Narrative can "refer to the process of making a story, to the cognitive scheme of the story, or to the results of the process" and he uses the term Story as being equivalent to Narrative.

Barthes (as cited in Polkinghorne, 1988) proposes the idea of narratives being on two levels. Firstly, at an individual level, people tell their own story and that helps them to interpret who and what they are, and where they are headed. Secondly, at a cultural level, the stories are used to convey values and provide unity to shared beliefs.

As I started to explore this approach further, I found the Narrative approach did not sit neatly in any particular scholarly field, but crossed many (Riessman, 1993). This was not an issue for me; rather what appealed was the freedom to use ordinary everyday language that gave me the possibility of revealing the richness of the Muslim women's stories.

Storytelling has been referred to as one of the oldest and curiously, also the newest of the arts (Greene, 1996). As an ancient art form it has been a powerful medium for imparting knowledge, motivation, inspiration, recreation, and preservation of cultural identity for generations in every culture (Bowles, 1995; Kirkpatrick, Ford, & Castelloe, 1997). As a new art it can be said that narratives/storytelling are key ways for participants to describe the subjective

reality of an experience. It has been suggested that stories are linguistic expressions of human connectedness of life (Ricoeur, 1992 as cited in Polkinghorne, 1997). Through our stories we make sense of our world and convey our beliefs, hopes, and wishes in an effort to explain ourselves and to understand others (Banks-Wallace, 1999; Greene, 1996).

Nursing historically has had a strong oral tradition, and the narrative form has been used to convey Nursing's values, beliefs and knowledge (Neville & Chenery, 1996). In fact Vezeau (1993, p.193) informs us "nurses have been telling stories forever". As nurses, each one of us has a story to tell, and as nurses we not only listen to clients/patients stories and their family's stories, but we also share our own stories with other practitioners to gain an insider's view of each other's practices, "where meaning can come together to shape, or be shaped by, our shared experiences." (Baker & Diekelmann, 1994, p.68).

"Stories refer to lived experiences." (Abma, 1998, p.824). Therefore, I understand that story telling is the single description of an occurrence that creates a memorable picture in the mind of the listener, and the way individuals make sense of and give meaning to their life experiences is by constructing them into narratives (Gee, 1985; Kirkpatrick, Ford, and Castelloe, 1997; Mishler, 1986; Polkinghorne, 1988;). Banks-Wallace (1999, p.20) contends "Story-ing helps to make sense out of our behaviour and the behaviour of others".

Kirkpatrick, Ford, and Castelloe (1997, p.38) assert "Well-chosen stories have the ability to motivate, inspire, teach or enhance the human sensitivity skills needed

by interdisciplinary healthcare providers”. They suggest that story telling and literature can be used to help nursing students to recognise patient/client experiences of human suffering and dying; a view reinforced by Attig (1992) and articulated by Bowles (1995, p.368) in the following statement; “the use of story telling leaves unforgettable impressions on students, and enables the students to remember the ideas as they remember the stories and the people in them”.

The advantage of storytelling as a tool for healing has been discussed by a number of authors (Bacon, 1933 cited in Banks-Wallace, 1999; Bowles, 1995; Heiney, 1995; Krysl, 1991; Sedney, Baker & Gross, 1994). According to Greene, the main purpose of story telling is to nurture “the spirit-self” (1996, p.33). She also refers to story telling as a sharing experience in which there is a readiness to be vulnerable and to express one’s innermost feelings. The process of storytelling sets up a common experience between the teller and listener, or story taker, thus creating a link between them.

The use of narratives is therefore not new, even if my appreciation of how to position myself as a researcher in relation to stories is new. The earliest model of personal narrative is the Labovian model named after William Labov, based on his work with Joshua Waletzky on the study of Black English in the United States and it entails linguistic analysis of interview narratives (Langellier, 1989). It has been suggested as a vital step in examining the ordinary everyday talk of minority culture (Langellier, 1989). Narratives have been used in social science fields, such as education (Gee, 1985) and in recent years there has been much renewed interest in the use of narratives to elicit stories from patients about their life experiences

(Langellier, 1989; Mattingly, 1991). Nurse clinicians are utilising narratives for describing unique experiences and the nuances of nursing care of clients/patients (Veseau, 1994).

It has been argued that narrative accounts are a sharp contrast to the scientific research and theory that currently informs nursing, as they are based in exploration of particular situations. Acknowledging their importance for generating and organising the experiences of patients/clients can refocus the human sciences to the realm of meaning and provide direction for future investigation (Polkinghorne, 1988; Veseau, 1994). Reason and Hawkins, (1988, p.79) suggest Storytelling as an “inquiry can work either to explain or express; to analyse or to understand”.

Gadow (1995, p.211) asserts, “narrative inquiry offers nursing an epistemology that is both ethically and aesthetically congruent with its practice of engagement (. . . .) narrative is a way of knowing because through it we offer one another our experience”.

Polkinghorne (1997, p.13) puts forward the notion that “the research narrative draws together into a story the diverse actions and events that contributed to the research outcome – the findings”. As a research product meaning the outcome of a research process e.g. thesis, Koch (1998, p.1182) asserts that if is well sign posted then the readers are able to journey “easily through the worlds of the participants and the makers of story and decide for themselves whether the story is a legitimate research endeavour”.

Having explored the literature on story telling and narrative I have concluded that storytelling and narrative as a methodology is appropriate for utilising with Muslim women, for it has the potential to capture the essence of a woman's experience at that point in time when she had been through an experience which had a powerful emotional impact on her, and she can recall it with clarity. Also, inviting clients to share their stories about their lives in general, and the meaning of a particular health issue within their overall life, may greatly enhance the ability of practitioners to develop appropriate plans of care. I have chosen not to explore storytelling in my culture in relation to this research, preferring to leave this for another point in the future, as it requires much more investigation and reflection than this present project allows.

Finally, to get the stamp of authoritative research needed, I found Veseau's (1994) argument that science has mirrored the dominant culture, and therefore has not always effectively served certain population groups like women, children, and minorities. She sees the narrative as reversing the Western focus on the general to focussing on particular responses in health and giving voice to these population groups. Meleis (1991) describes how, in some cultures, situations are better described through story telling than through specific statements, which implies that storytelling is an appropriate research methodology in some cultural contexts.

It was at this point that I felt I was on the right track. I could easily see the actual interview process occurring, and I began to think of the ethical considerations.

Having established my philosophical position, my desire was to respect each woman's uniqueness. Our story is our expression of our unique way of being in the world. How we reveal our everyday experiences is also unique to us. So I had to consider carefully, given that I believe everyone has a unique reality, if indeed it was possible to compare and then contrast individual women's stories. I have discovered over my nursing career, both in care settings and in teaching, that there is usually one thing that stands out as central when a person is conversing with me, which I summarise as follows: *each person has their own reality of a given situation. Whether that is my focus or a general human attribute I cannot decide. But I was determined for the purposes of this research that I would talk to each woman respecting her uniqueness, and allow for this focus or essence to arrive in our conversation. In this way I felt that I would know when I was empathic with the woman and when I checked with her I would perhaps have some sense she felt I was attuned with her.*

I decided that when I had transcribed the conversations, I would give it to the woman, so she could tell me if she was happy and willing for me to proceed. As an ontological position (way of being in the world), Muslim women are respected as unique beings, so this was consistent with my cultural identity. This position enabled me to further clarify the aims of the study so I could imagine conversing with the women, and the questions I was interested in would become a natural part of the conversation.

Having decided on how I would begin to do the project, I started to consider some of the other issues involved in carrying it out. These issues ranged from gaining

consent from the Muslim community elders to the number of women available from a small community, including the issue of maintaining confidentiality, as all the women are known to each other, the type of interviews I would conduct i.e. individual interviews versus group interviews, and asking women who are known to me, and are also friends, to participate in my research project. I did not want them to feel they had been coerced into participating because of my relationship with them. I also had to take into account the fact that newly immigrant women may not wish to disclose negative aspects of their healthcare experience, in case they had to use the services again, or that, in their perception they were seen to be complaining, which might somehow jeopardise their residency status with the immigration authorities.

In addition, I had to consider issues around gaining ethical approval from the Regional Ethics Committee to conduct the research and to apply for research funding.

In this chapter I have outlined my journey in search of an appropriate methodology and approach for my research project. The Quantitative methodology and some of the approaches within Qualitative methodology were inappropriate for me to utilise, because of the terminology that is used in them, or because my questions did not suit the approach. I refined my choice by exploring the Story telling/Narrative approach and utilising it for this project, for not only is it culturally appropriate in this instance, but it also has the effect of being cathartic for those involved in telling their story. Furthermore if we want to know about women's experiences, then we have to let women "do the talking", and listen to

the meanings that women attribute in the language they use. The following chapter shows how I created the research design for the research project.

CHAPTER FIVE

THE RESEARCH DESIGN

In this chapter I will describe the development of the design for this research project, that eventually facilitated the gathering of the women's stories and enabled me to record their stories as narrative accounts, the aims of the project, ethical considerations, the actual collecting of the stories, transcribing of those stories, and the process I used to organise the stories into themes. Finally this chapter will conclude with how I consider I achieved trustworthiness in this project.

The narrative/story telling approach was appropriate for the Muslim women's childbirth stories, for it uses normal everyday language, and is considered culturally appropriate as story telling is an activity that is spread across all cultures. Storytelling captures the essence of a woman's experience which had a powerful impact on her, and she can recall it with clarity. It also has the potential to reveal the richness of the women's stories.

Aims of the project

The aims of this research project were firstly to enable Muslim women to tell the stories of their childbirth experiences in Aotearoa-New Zealand, utilising the storytelling/narrative approach to specifically surface the factors that enhanced or hindered the women from having a positive experience. Secondly, the project aimed to identify the commonalities and differences of interest to Muslim women

through their individual stories as mutually identified by the storyteller and myself. Finally, to record my reflections and make them available to nurses, midwives, and other health professionals. I kept the aims of this project deliberately broad to avoid predetermining the outcome and creating early closure through my own preconceptions. This I believed would create rigidity within the research project which would preclude the freedom to be open to the new understandings that I sought.

The Method

In the previous chapter I explained the process and reasoning I went through to choose the appropriate methodology and approach for the research project. I had to go through a similar reasoning process to establish the method for the project. I will outline the original proposed method, and then the actual method and decisions I made as I progressed. The narrative method of inquiry involves the systematic carrying out of the research project, outlining the process which I would follow to gain ethical approval for the project and to invite the women to participate in the project.

The approach is one of Narrative/Storytelling. I recognised in this project that I only wanted to converse with Muslim women who have had children either in their own country of origin or in Aotearoa-New Zealand. I needed to involve Muslim women who could express themselves clearly in English. The rationale for this is that the community from which I was hoping to invite the women to participate in the project included women who come from a number of ethnic backgrounds, and it is not within my capacity to speak to the women in their own

language or dialect. I did not wish to use interpreters, as I felt the women might feel uncomfortable having a total stranger listening to their stories, and therefore not talk openly about their experiences. I was aware there was a possibility that the deeper and subtle nuances of meaning that are communicated through a shared language would not easily be noticed.

My first step was to approach the two elders in the Muslim community. This had to occur before I presented the project to the Regional Ethics Committee to discuss my request for ethical approval for my project. I approached the wives of the elders and explained the project to them, and then arranged a time to meet the elders individually in their homes. The meetings were informal and both the elders were very receptive to the idea, as they saw it as furthering other people's knowledge. They gave me a letter of support for the project. A similar process had to be followed to gain funding for the project from the appropriate agencies.

Formal documentation to seek approval from the Regional Ethics committee included a request to interview four to five Muslim women, a letter of consent from the Muslim elders of the community, Information Sheet for Participants (Appendix A), Client Consent Form (Appendix B), a set of Interview Guide Questions (Appendix C), Researcher Consent Declaration form (Appendix D), Transcriber Declaration (Appendix E).

I was invited to attend the Regional Ethics Committee meeting on the day my proposal was being heard. I took the opportunity to attend this meeting as I felt it was necessary to be there to answer any queries. At the meeting itself much

interest was expressed in the research proposal. Questions asked were related to the population number within the region and the ethnic mix. Other questions were related specifically to childbirth experiences of Muslim women. A point of interest to them was that on the consent form I had included the husband's name. I explained the reason for this inclusion was that in the teachings of Islam, the men are guardians and protectors, and I felt any issues related to consent had to involve the men in the family. Suggestions were offered for the interview guide questions (refer to Appendix C) and for the audiotapes. The latter were to be offered to the women, or erased or disposed of in a culturally safe manner. Upon receiving the appropriate documentation pertaining to the changes, the Regional Ethics Committee approved my research proposal (Refer to Appendix F).

Procedure for accessing the women and gaining their consent

The next task was to access women for the research project. While ethical approval was given to interview four to five women, I approached four women. I met with each woman in her home to discuss the research project, and explained to them what would be involved if they chose to participate. They did not have any questions for me. At this point I gave each of the women the package containing the Information Sheet For Participants (Appendix A), Client Consent Form (Appendix B), and an Interview Guide Questions (Appendix C).

The Information Sheet for participants covered several aspects, and these included the nature of the research, number and length of interviews, recording of data, releasing of data for transcription and for marking to my supervisor, the presence of a support person of their choice, and confidentiality ensured while the study

was in progress and for future publications. Also included were clauses relating to the return of audiotapes to the women, or destroying them as it was deemed culturally appropriate by the women, and the contact details of the supervisor and the Health Research Council in case the women needed further information.

Lastly, I reassured the women that their participation was voluntary, that they were under no obligation to participate, and had the right to withdraw at anytime without any repercussions to our friendship.

The women were invited to phone me if they were interested in participating, or I would ring them in a fortnight's time. It was at this stage that one of the women decided not to participate because of her other commitments. She felt quite awkward at declining my request, but I reassured her that it would be fine as there was no obligation to participate and guided her to the information sheet for participants.

The three women who agreed to participate in the research project signed the client consent form. All three women came from different ethnic backgrounds and their ages ranged from 31 years to 42 years with the first birth experience being 12 years ago and the last one two years ago. All but one childbirth experience of the women took place within Aotearoa-New Zealand, either in large metropolitan cities or in regional centres. I made the decision to address only those birth experiences that took place in Aotearoa-New Zealand, to narrow down the field of enquiry.

I agonised over the small number of women in my research project, especially the final number of three who participated. I questioned if I would have enough information to meet the aims of my research project. There were no other women I could approach because of the criteria I had set. I had two choices left. Either to abandon the research project or to go out of the region to access more women. Neither choice appealed to me. Abandoning the research at this point seemed unthinkable, as I had invested a great part of myself in it, and going to another region would have meant going through the whole process of seeking ethical approval from another regional ethics committee, not to mention the difficulty I would have accessing a community with whom I did not have previous links. I discussed the situation with my research supervisor who reassured me that the small numbers might enhance the project as it might allow greater depth being recorded in the text of the women's stories.

My review of the literature had indicated to me that there was no single rule for sample size, as this was dependent on the research design, and in qualitative research the sample tends to be small because of the intensive and prolonged contact with the research participants, and therefore there is a large amount of verbal data that has to be analysed (Streubert & Carpenter, 1995). Indeed, after the conversations, as I looked at the women's stories there were approximately thirty four thousand words to be read and reflected over!

Furthermore, Sandelowski (1995, p.183), in her discussion on sample size, states "an adequate sample size in qualitative research is one that permits - by virtue of not being too large - the deep, case-oriented analysis that is a hallmark of all

qualitative inquiry, and that results - by virtue of not being too small – a new and richly textured understanding of experience”. My agonising was put to rest by the reassurances I gained from my research supervisor, the literature I had read, and the rich data that resulted from the women’s stories.

Ethical Considerations

It was vital for me to adhere to the ethical guidelines I had established to ensure the safety of the Muslim women, as they would have been easily identified coming from a small community locally, and in fact even within Aotearoa-New Zealand the Muslim population is small. It is for this reason I have chosen to blank out the name of the Regional Ethics Committee from the ethics clearance letter and not to include the letter from the Muslim community elders. However, copies of these letters are held at the Department of Nursing and Midwifery at Victoria University, Wellington, Aotearoa-New Zealand.

Within the fields of Nursing and Midwifery, the concepts of anonymity, confidentiality, and privacy, are key principles included in codes of conduct that guide practice, and are key to the relationship between nurse/midwives and patients/clients. These concepts are used to protect the individual from being “exposed” and put in a vulnerable position.

According to Berg (1998), anonymity in its actual sense means research participants remain nameless, and confidentiality is an attempt to remove any aspects within the research project that would reveal their identities. Berg (1998) puts forward the argument that in qualitative research anonymity is almost

nonexistent as the researcher knows the research participants, and therefore it is vital to provide the research participants with a high degree of confidentiality. Badzek and Gross (1999, p.52) refer to confidentiality as “non disclosure of information regarding patients”. Hence in this project I have endeavoured to protect the women’s identities with the processes I put into place.

Further considerations included the use of pseudonyms chosen by the women, and as an additional step I had considered that I would withhold the pseudonym from some interview quotes. This latter step was not taken, as the women’s individual experiences could not be disguised. Interestingly enough, one of the women was not keen to use a pseudonym, and one of the other women wanted her ethnic background to be disclosed, even though it was in their interest to keep these details undisclosed and to protect them as a group. The argument from the woman who did not wish to use a pseudonym was, “how could one talk about one’s experiences if one had to assume a pseudonym”? This was a point I had not consciously thought of previously, and on reflection she was quite right. Our names give us our identity, our connections to our kin and to our experiences. Eventually, with great reluctance, she agreed to the idea of using a pseudonym.

Another issue that I took into consideration was for the women to have support person/s present during the interview sessions.

I would have preferred not to give them the interview questions guide, as I felt that this might cause the interview to be restricted, either narrowing the scope of the interview material gained or focusing the women on what they thought I wanted to hear. The reason for the inclusion of the questions was to take away the

fear of the unknown and to give the women a chance to think about their experiences, and also so they could show the intention of the interviews and project information to their husbands.

For the interviews, I had explored the idea of using the group method for the women to describe their experiences, but this idea was abandoned as I felt some of the women might be more articulate than others. For these women I imagined sharing their childbirth experiences in a group setting might be inhibiting, and I would not get the richness of their stories revealed. While group interviews have the advantages of being less costly, provide rich data, stimulating for the participants and helpful in the recall of memories, the group culture may interfere with individual expression, sensitive topics may be hard to follow through, and group thinking may be a possible outcome (Fontana & Frey in Denzin & Lincoln, 1994). I wanted each woman to feel free and comfortable with what she wanted to say. I had a professional obligation to care for the women, for they would be entrusting me with the intimate stories of the most precious and vulnerable time/s in their lives. The conversations were conducted using in-depth semi-structured interviews to surface their experiences.

The stories, which became the narrative in this thesis, were transcribed into text and the audiotapes, computer disks and transcripts were kept in a locked cabinet to maintain confidentiality. The women were given their transcripts to read and verify the details. In some of the audiotapes the children's names had been mentioned and these appeared in the typed transcripts, but have been omitted from the quotes that have been used in this thesis.

I had considered all these issues when preparing the research proposal, and I believe I addressed them responsibly. Having said this, there was always the possibility that the women would recognise each other in the project, through talking to each other and being part of a small community. I have agonised over this issue and I really cannot see a way out of it, short of abandoning the project. I did consider removing the pieces of texts that I had used in the thesis, either as whole text or as text the women spoke, and identifying the threads that were of common interest among the women and the essence of each story, but then I thought if I did not use the spoken texts, the depth, richness and integrity of their stories would be lost.

Potential Risks

I was profoundly aware this research might evoke traumatic memories for the women, and as it eventuated, two of the women were visibly upset as they recalled some of their childbirth experiences. They had been given the option of having a support person present but none of the women took that option. Neither of them wanted further professional support. Both these women were interviewed in their own homes. The place of the interviews was important as settings can have a disempowering effect even in friendships, and I was very much aware of this as in no way did I want this to happen to the woman who chose my home for her interviews.

Potential Benefits

Initially I naively thought that there was no direct benefit to the women, but I envisaged there would be long-term benefits if Islamic cultural awareness by health professionals would eventually be the outcome. However, I discovered the women benefited profoundly from talking about their experiences and having me, as the nurse researcher, listen to their stories in a careful way. Two of the women said just talking and reading the transcripts about their experience was helpful. Khadija said it was good to remember and recall what one had gone through, and in a way it was quite “therapeutic”. Her husband, who had been in the background, echoed similar sentiments, whereas Ayesha mentioned talking about the experience helped. Morse (1988, p.215) in discussing the benefits of participating in qualitative research for the participant states “the participation is undoubtedly a therapeutic process”.

Researcher-Participant Interaction

LoBiondo-Wood and Haber (1994, p.276) point out that over time, there is a possibility for the researcher-participant interaction leading to “the research experience becoming a therapeutic one”. Wilde (1992) suggests that as a nurse researcher, it is difficult to put aside other nursing roles, for example that of clinician, counsellor or educator in researcher-participant interaction. However, LoBiondo-Wood and Haber (1994) do give a caution regarding the issue of the professional boundary i.e. of researcher-participant, and suggests that the researcher gently refocus the participant to the purpose and task of the research. However Munhall (1988, p.151) argues that the “therapeutic imperative of nursing (advocacy) takes precedence over the research imperative (advancing

knowledge)”. That is, the nurse researcher will choose not to pursue the research if she/he is aware that the participant’s health is at risk by carrying on with the research. Within this research project, with two of the women I actually offered to stop the interviews, but neither women took this option.

The Interview Guide Questions

To achieve my aims, I had originally devised the following questions for myself. I imagined myself able to create an open and evolving conversation in which these questions would be answered:

Original questions

What is the experience of Muslim childbearing women?

What factors enhance a positive birth experience?

What factors hinder a positive birth experience?

What are the commonalities and differences across all the women’s experiences?

However, I realised after I had written the above questions that they would not lead us to storytelling. My initial mistake was to create questions desiring information rather than a narrated answer. I clarified this process by more careful positioning of the method and methodology.

To resolve the situation, I devised a set of new open ended questions that I felt would encourage and elicit the depth and richness of the women’s stories based on Patton’s (1990) suggested question types i.e. experience, feeling and knowledge based. These questions were further refined following suggestions from the Regional Ethics Committee. Prompt questions based on an interview

guide by Nichols (1996) were also utilised with her permission to extract more information.

New questions

Were your children born in Aotearoa-New Zealand?

Can you tell me about your childbirth experience?

What were the good things about it?

What were the not so good things about it?

If you had another child, how would you like the experience to be different?

Is there anything else you wish to discuss related to your childbirth experiences?

The interview setting

The place where interviews take place matters, for settings can be disempowering (Wilkinson & Myers, 1999). With this thought in mind, it was important that the women chose the venues for the interviews where they would feel comfortable and safe. I took great care in setting up the quality of their taped conversations. This was important to the detail revealed in the transcripts. The interviews were taped with the women's permission. It was vital that the women were comfortable with the equipment as the processed tapes are the key to rich data.

Working with the stories to highlight issues, threads of connection and the essence of each conversation

Berg (1998) points out that while inexperienced researchers may intellectually understand the processes of analysing the data, they usually become lost in the actual process of coding. Indeed this was so in my case. As the women's stories resulted in six audiotapes, I was faced with the problem of how to proceed. I began by listening to the tape recordings and re-reading the transcripts several times to establish broad themes. In listening to the audio taped interviews and reading the texts, certain words and phrases seemed to stand out to me, and this gave me an indication of the women's experiences. I acknowledge I was influenced in how to become involved with the text by what I had read about phenomenology. I started off by colour coding the key words or phrases that appeared frequently in each woman's transcript to determine the positive and negative themes. I identified positive experiences as those which included the words "comfortable", "pleasant", "considerate", "consulted", "bonded with the midwife", "owning the experience myself", "goodness coming out of her". I identified the negative experiences using the following words "vulnerable", "lonely", "desolation", "isolation", "worried", "scared", "sadness", "anxious", "sense of loss", "cross", "not being in an assertive position", "had to be assertive", "was not feeling assertive", "grief", "control", "sucking up to the nurses", and "assumption".

I kept returning to the transcripts, and it became apparent each woman's narrative had a central unique theme that I identified as her essence. I noted that there were also words and phrases that were indicative of common experiences. My next step

was to put on paper each woman's pseudonym and all the words and phrases that I had colour coded under her name, and then sit each of these pieces of paper side by side to visually look at the overall picture. This visual picture further enabled me to identify the similarities between the women's stories and the uniqueness of each woman's story. On the basis of viewing these words and phrases, I attempted to put what I had identified as key word themes together in some coherent way to present the women's overall experiences. Having come to some decisions about the similarities in their stories, I named the common themes and chose to address these and the unique theme of each woman's story.

These themes have been identified later on in the chapter. Many themes emerged and while there were some common themes across all the stories, the over riding theme was the uniqueness of each woman's story. The women determined this by referring to their own unique story repeatedly.

It was not the similarities that played on my mind, but the uniqueness of each of their stories. Their faces and their voices seemed to remain with me even when I was not working with the data. I felt saddened and even worried by the thought that perhaps I had caused them much distress and made them feel vulnerable as they shared their stories. My reflections on their truths helped guide me as I created the thesis text.

I have chosen the following descriptions to reveal the essence of each woman's story and their common themes.

Essence of each story

Relationship with staff (Khadija)

Loneliness (Ayesha)

Parental obligations compromised (Amina)

Common Themes across stories

Supportive actions

Vulnerability

Lastly, the storytelling approach and the last question facilitated special comments from the women and their inclusion was relevant as they illustrate the greater richness of storytelling. I have inserted these comments under the theme of "Individual expressions".

Trustworthiness of the research project

In qualitative research people are the main source of information, and as such their personal experiences and personal truths are theirs alone. These may or may not resonate with someone else's subjective life experiences, and therefore there is no single way to warranty truth (Roberts and Taylor, 1998). Streubert and Carpenter (1995) suggest qualitative research is trustworthy when it accurately reflects the experience of the research participants. A number of authors have identified ways of addressing rigor in qualitative research which I chose to

explore in greater depth, given my feeling about creating a text that best reflected the deep stories I had been gifted in our conversations. The following criteria of ‘Credibility’, ‘Auditability’, ‘Fittingness’ and ‘Confirmability’ are universally recognised as hallmarks of scientific rigor of qualitative research (Beanland, Schneider, LoBiondo-Wood & Haber, 1999; Lincoln & Guba, 1981 cited in Sandelowski, 1986; Roberts & Taylor, 1998).

To meet the criteria of ‘Credibility’, the transcripts were returned to the women for reading and checking to see if they accurately reflected the women’s experiences of our conversations. Apart from asking me to omit the names of their children, the women did not make any changes to the transcripts. This process is also referred to as “member checks” by Lincoln & Guba (1985, p.314).

‘Auditability’ was achieved maintaining by an audit trail that enabled me to trace the decisions I made regarding the processes in the design, and how I attended to a number of issues in the research project. These issues included choosing the appropriate methodology and approach, and the ethical processes necessary to achieve culturally safe passage to do the research project.

According to Beanland, Schneider, LoBiondo-Wood and Haber (1999, p.355) one way to judge the ‘Fittingness’ of a research project is through “the use of literature to support or refute the concepts emerging from the data”. In Chapter Seven, pieces of literature have been utilised to support the themes that have emerged from the data in this research project.

‘Confirmability’ of a project is attained through meeting ‘Credibility’, ‘Auditability’, and ‘Fittingness’. However I consider the first confirmation must come from the women themselves, and then the women generally in the Muslim community. To this end I have been able to give all the women a near final draft of the thesis text in which their stories feature so centrally. Two of the women commented that reading the text still had the power to move them whereas I have not heard back from the third woman.

In summary, in this chapter I have outlined the design processes that I used to create and conduct the actual research. I have described my reason for choosing the narrative/story telling inquiry approach for the research, my aims for the project, and the ethical considerations which included the risks and benefits of the research project. I have identified the issues and concerns I had around the interview process and the cultural issues surrounding the interviews, and finally I have showed how I undertook to ensure the trustworthiness of the project. The next chapter gives an insight into three Muslim women’s childbirth experience from their perspective.

CHAPTER SIX

WOMEN'S STORIES

Our stories, our identities, our health, our truth - our 'Narratives'

Our stories/our narratives reveal our whole being, our subjective experiences in a given situation and time. They also reflect our values and beliefs. This chapter is based on the stories told to me by Khadija, Ayesha, and Amina, three Muslim women who gave birth in hospital settings within Aotearoa–New Zealand, and it reflects the reality of their experiences. I will begin with a general background of the women, a description of the interview settings, and the women's emotional responses. Following this I will introduce each woman, and then present the women's stories, which includes the essence of each woman's story and the themes that emerged from their stories.

I have chosen to present the chapter through the themes rather than the questions identified in the research design, since the questions were woven into the conversation, and taking them as key at this point would have disrupted the more natural way of considering what flowed in our conversation. While some of the excerpts are lengthy, reducing them in any form would have lost the essence of the point the women were making.

Background

The background details of each of the women have been kept broad to protect their privacy. Two of the women are immigrants and have lived in Aotearoa–New Zealand for a number of years, while the third was born here and identifies herself as “Kiwi Muslim”. They all come from different ethnic backgrounds. Two of the women are professionals and the third woman is a tertiary student. They could all express themselves clearly in English, and some of the language used by the immigrant women reflects their knowledge of local speech patterns. I have also chosen not to disclose the specific details of the birth i.e. dates, places where the births occurred, and birth order, as again this may reveal the women’s identity. Their birth experiences occurred approximately from two to twelve years ago. They ranged from a normal delivery, to a premature labour and delivery of a baby at thirty-two weeks, with the baby remaining in the neonatal unit for a number of weeks, and the third woman having a story of births through Caesarean sections.

All the women were keen to participate in the research project, as they saw that the knowledge gained would help other Muslim women living in Aotearoa-New Zealand, through offering feedback to health professionals. What was surprising for some of the women was that, initially, they did not think they would have much to contribute, but once they started talking, their stories just flowed, and they talked openly about their experiences. On receipt of their transcripts for the verification of their stories, they expressed how surprised they were at the amount of information they had shared.

The interview settings

Two of the women chose their homes for the interviews, whereas the third woman chose my home, as she had relations staying at her home. As she said, it would be quiet at my home. Quietness is essential when people are going deeply inside their memory to recall to themselves the truth of a long ago experience. At each of the interviews it was important that we were seated in a way that would allow me to observe, listen, and tape record the interviews. The interviews took place in the lounge of each house. We sat quite close to each other, but at enough distance not to invade each other's personal space. We explored how to position the tape recorder in an area that was considered best for both our voices to be recorded. Prior to starting the actual interviews, I thanked each woman for agreeing to take part in my research project, and for making time available to accommodate my request in their busy schedules. I asked them if there was anything they would like to clarify with me before we commenced the actual interview, even though they had already signed their consent forms. I reiterated the reasons for my project and the use of a pseudonym, and that each interview would take about an hour. With no issues to clarify at this point we proceeded with the interviews. We had food and cups of tea as the storytelling, laughter and tears, progressed.

For the interviews I ensured that I had carefully prepared both the women and myself. I knew I was anxious, and was aware that there was a possibility that, while for some of the women the recalling of their birth experiences might surface pleasant memories, for others it would be the opposite as they recalled difficulties. I had suggested that the women could have a support person present with them, but none of them took up this option. During the interviews I checked with the

women at intervals and stopped if they needed time and/or space to compose themselves.

The interview itself started with the first two questions from the 'interview guide questions' (Appendix C) inviting the women to start unfolding their stories.

Were your children born in Aotearoa-New Zealand?

Can you tell me about your childbirth experience?

The next two questions from 'interview guide questions' were used, if necessary, to lead our conversation in the required direction.

What were the good things about it?

What were the not so good things about it?

Women's emotional responses

As the stories unfolded, the women's facial expressions and voices changed, depending on the particular event related to the childbirth experiences they were describing. It seemed to me that not only were they remembering their experiences, but also that they were virtually reliving the experiences. Two of them wept, either from the joy or from the loneliness and grief experienced. I chose to include the women's emotional responses as these came through quite strongly, leading me to think about the stress of the experiences, and the effect it had on the women as they recalled those memories.

Depending on what was being said, I would then seek clarification. My aim on the whole was to keep my questioning to a minimum, so that the women could tell

their stories uninterruptedly. There were times during the interview, though, that some of the women needed some guidance on how to proceed with their story. I offered supportive comments, indicating they were proceeding well, and that I was interested and pleased to be listening to them sharing their story.

Introduction to Khadija

The first woman I approached was Khadija. Her enthusiasm to be involved in the project gave me the courage to ask the other women. She had already chosen the name 'Khadija' for me to use in the interviews and transcripts, and this was consistent with giving the women control of their story and text. Both the interviews, at her request, took place in the evening, in her home. I was made very welcome. The children were getting ready to go to bed, but not before they had all greeted me, with one of them bringing us a drink. The youngest of the children was in her lap and she was rocking the child to sleep. Khadija apologised, as she said she had hoped they would have all been in bed by the time we began to talk. Once every thing had settled down we decided to go ahead with the interview.

As Khadija recalled the events of all her birth experiences she laughed a lot and made the odd joke. She started by telling the story of the childbirth experience that was the "most pleasant one". Her husband had been the support person during her birth experiences, and in recalling one of the experiences, she mentioned that at one of the births he was sent home when she needed him there, and this made her feel "cross" even now, after all these years. At one point during the second interview she got quite tearful recalling one of the experiences, and at this point I did ask if she wanted to carry on with the interview. She was happy to carry on as

she said it was good to remember and recall what she had gone through, and in a way it was quite therapeutic. Her husband, who had been in the background, echoed similar sentiments.

Introduction to Ayesha

Ayesha's interviews took place at her home in the afternoon. On each of the occasions I was made very welcome, and after the initial social chat I proceeded with the interviews. The second interview took place during the school holidays, and at this one her youngest child was lying across her lap, and she was stroking her hair.

The question of using a pseudonym came up and, as already discussed in Chapter Five, Ayesha was not initially comfortable with that idea, but she eventually agreed to the use of the name Ayesha for the transcripts.

My observations of Ayesha were that as she started to recall her childbirth experiences, especially one of them, her facial expressions changed from smiling to sadness, with a sad sounding voice, and from being quite animated to start with she became quiet and thoughtful. At times she seemed far away and lost in her memories. Her husband was her main support person during the childbirth time. Her whole being gave me the feeling that, as she spoke, she seemed to be making sense of it all. In the silences I observed her face. It lost its entire spark and she looked so sad. Sometimes her eyebrows would knit together. There were some long pauses during that first session. She appeared to have gained her composure

by the time I had left her. However, I know I came away from that interview feeling quite sad, because I had obviously touched a tender spot in her life.

Introduction to Amina

Amina chose to have her interviews at my home, because, as mentioned earlier in the chapter, she had relations staying at her home. I made a strong effort to make our lounge conducive for the interview. My assumption is she must have felt comfortable, as she chose the same venue for her second interview. During the interviews she spoke freely, and we seemed to be laughing over certain events she remembered, which were indirectly related to the birth of one of her children. We would then backtrack to her childbirth experiences. She recalled feeling embarrassed when she went to the hospital for the birth of one of her babies as she was quite young, and added to that, her husband was overseas. She wondered what people would think of her situation? While her children were born in Aotearoa-New Zealand, she was in her 'home country' for part of her pregnancies and also later, after the birth of her babies, where her extended family supported her. We discussed the issue of a pseudonym and after some thought she decided on the name that has been used in this project.

The women's stories

Simkin (1991, p.203) states "every woman who has given birth seems to have a story to tell". Khadija, Ayesha and Amina certainly had their stories to tell. In exploring the long-term impact of birth experiences Simkin, (1991 & 1992) found women remember their birth experiences for a long time, except for those women

who through the use of drugs were unaware of their labours and birth, and their memories are vivid. I have chosen the following excerpts from Khadija, Ayesha and Amina's stories to reveal how these women remembered their childbirth experiences.

Essence of Khadija's Story

The essence of Khadija's story... Khadija had to work really hard at building relationships with the staff, when as she put it, she should have been recovering from the operation and spending time with her child. She graphically described her situation using the following powerful words.

"I remember counting the rosters, and working out who was going to be on and waiting for an hour when the next person was on who would be all right, and actually some of the old timers were real dragons. One of them got on all right with me but I really had to suck up to her and be so perky that's not quite the right word, be so cheerful, and I wasn't feeling well, I had to really act, and then I got the results from her. Like I had to milk the kindness out of her. That's awful". (Khadija)

"Fair enough, I mean they are doing it for it to be a job, but I mean it is a bit hard if you are on the receiving end of having to feel so guilty and so bad and having to suck up to them, so that you don't have to feel too uncomfortable about other things. I should have been recovering from this operation, spending time with my child and I was really working hard on a relationship with the nurses. It was just as well I wasn't planning on going

home on the 4th or 5th day or whatever, I had to wait until the 9th or 10th day. It was just as well I had worked so hard on this relationship, you see, you couldn't afford the luxury of being sick. You had to be independent and responsible". (Khadija)

"I worked really hard, no matter how much pain I was in; no matter how hard it was with the baby crying or having wet naps, and we needed to get some more, that I concentrated really hard so that if they told me they were going to do something or other when they were off work, then the next time I was with them I asked how that thing had gone. Boy, what a trial". (Khadija)

"To have left me on my own and my poor baby obviously not getting fed very much, but he went blue and when I complained about it there was very little reaction from the nursing staff, they went and got a hat and a hot water bottle and gloves. This baby wasn't interested in sucking but I mean I was still holding him. Then they took him off me and put him in the bed thing with a hot water bottle to try and keep him warm, and then his breathing started to fail. So they monitored him for another hour, which was a very uncomfortable hour, because he just seemed to be getting bluer and bluer and breathing less and less and they would come every 15 minutes. I really wanted somebody to be there all the time to really monitor because if anything had suddenly happened I really don't know what we would have done. We seemed to be in a room in the middle of nowhere. Anyway, he did continue to deteriorate. They put him in the

Neonatal Unit at 2-3 days. They took his photo and that's all I had of him because I was not really very mobile". (Khadija)

"It was like I was very much inconveniencing this anaesthetist by not agreeing to have a general (meaning a general anaesthetic)". (Khadija)

Essence of Ayesha's story

In Ayesha's story, I felt the essence was in her feeling 'lonely' and not being 'nurtured', and a sense of regret over her childbearing experiences. While she had a good network of friends, her extended family lived overseas. She went into premature labour and had the baby while on a visit to another city. The following excerpts reveal the extent of her loneliness and the feeling of not being nurtured.

"I remember feeling quite lonely anyway, being so far away from family... I didn't feel nurtured at all. I mean I had to seek for some nurturing, to be nurtured. The closest to be nurtured is going to a friend's place where there is food, where I didn't have to cook, and just sit there and then just eat what was there". (Ayesha)

"I think that sense of isolation is what really gets you, you know, that makes you more vulnerable to lots of things". (Ayesha)

"Yes, that's how I felt and, looking back, I feel sad in a way because it is one of those times in my life that has sort of gone and it won't come back. My 40 days, I feel that my 40 days have come and gone and that the more

that has gone that I have never retrieved or got that back. You know that is also part of that nurturing. And I think that is a really important component of the whole point of being a woman, I suppose, whether you are a Muslim or not, I think that 40 days would be quite paramount for any woman after a childbirth experience because so much of you comes out of your body and then you have to recompose yourself and get to become a person without the baby and then, you know, you have to be so much a part of the baby, and then of course all the other people who are around you who want you so much too, isn't it, so yes ...(long pause).

(Ayesha)

Essence of Amina's story

The essence of Amina's story was that her parental duties were compromised, as her request to bath her babies had been overridden by the hospital rules and regulations. It was important for her to have her babies bathed as that was what happened in her family culture prior to the religious duties being performed, and also because of her own discomfort of others handling the babies before they had been bathed. As mentioned earlier in this chapter her husband was overseas at the time of the birth of her first baby, therefore another family member would have had to perform the Adhan. (Refer to Chapter Two).

“Even though I asked for both my children to bath the baby, they said “no”, according to our health this and that, it is good for the baby to not be washed for seven hours so that they have the good skin, and I didn't

think much of that, but if it was in my hands I would have bathed the baby instantly". (Amina)

"Back home as soon as the baby is born...we bath the baby, Here, I found it a bit funny (. . . .) we would say the baby is dirty. We feel funny to hold the baby or kiss the baby. We will say the baby is not clean because it has been out of the tummy and they have just rubbed it around. The baby not clean is like 'naa-paak', apart from my husband, if my brother or someone else touches the baby I would feel uneasy, because it is my own dirt on the baby itself". (Amina)

"According to Islam, being a mother and being an Islamic parent, we would like to have the baby being in Islam (. . . .) so even if the husband is there, or family member is there, you could say the Adhan has to wait until the baby is bathed. This is a disadvantage". (Amina)

Common Themes across all stories.

I have identified the following themes as threads that the women had as women, mothers, and Muslims.

Supportive actions

The theme "supportive actions" encompassed a number of actions that were taken by health professionals in recognition of the specific needs of the women. Some of these actions included providing an environment in which religious activities could be performed, and being perceptive of each woman's need and attending to

it, for example like the midwife who organised her work schedule to be with Khadija; the Plunket nurse who created a supportive relationship which made Ayesha look forward to her visits, and the midwife, who although should have been going off duty, stayed behind to be with Amina who had no support persons with her. The women certainly remembered the special actions that contributed to them having a positive experience as the following excerpts reveal.

“There was one midwife that was just wonderful. She was wonderful. She was so chirpy and she was so friendly and she must have seen me, that’s right, she came and saw me on the morning of the birth before I got wheeled off and we must have hit it off then because then she told somebody else that they had to look after her rounds or whatever, and she was coming to the birth. She came to the birth. She was the one that told my husband to cut the cord, and she sort of generally organised everybody. She was very chirpy, very outgoing, very happy. She helped me a lot with the breastfeeding. When the baby had (. . .) bath she got the dad to give (. . .) the bath and I just videod it. She was very good. She was a lovely person and there was no ...(long pause) it was all goodness coming out of her”. (Khadija)

“My husband was there for the birth too and he was holding my hand and reading the Qur’an the whole time (. . . .). It was very comforting for me and possibly for himself as much as me. Then when the baby was born ... it was a comfortable environment for him to call to prayer”. (Khadija)

“But I remember with the (. . .) what was nice was, even at home, the Plunket Nurse that came showed me how to bath the baby, you know, came and checked on me every other day or something. I actually looked forward to that visitor. I remember looking forward to that person coming, so that I can just natter”. (Ayesha)

“There was a midwife who became very close to me since I was staying in the hospital. It was from Tuesday, Wednesday, the shift, she was always with me and we became very close friends, sort of. I could talk openly to her, so even though she was supposed to go home, but I think she knew that I was going to have my baby soon so she stayed with me, so it was a very good thing that even though I didn’t have my family around I knew somebody was going to be with me, and I was free to talk to her”. (Amina)

Vulnerability

Vulnerability is a common theme with all the women in this project. The women were able to recall a number of events from which it can be inferred that they felt particularly vulnerable for a number of reasons. The following sub themes reflect this issue of vulnerability: feelings of anxiety, dignity compromised, postnatal - being left on her own, having to deal with male health professionals, inappropriate diet, assumptions and unclear explanations, relationship with staff, parental duties compromised and feeling lonely. The last three of the sub-themes will not be included in this section as these have already been addressed in the essence of each woman’s story.

Feelings of anxiety

For some women the childbirth experience lends itself to feelings of anxiety for a number of reasons. These may include being in an unfamiliar environment, going into premature labour, not having support persons or not having control over a situation.

For Ayesha this anxiety was heightened by her going into premature labour and being in a totally new environment. Most women expect to reach to term, and to have a normal delivery and a healthy infant, however, when events take a different course i.e. going into premature labour and having the baby early, as in the case of Ayesha, this unexpected course of events leads to a highly stressful situation for the parents.

"I can remember that as soon as I got there to the hospital I was left in this room for quite a while and I felt really quite scared because I was alone, it was like an examination room and it didn't really permit my husband to come in for some reason, I don't know, it was like a surgical place, but I remember being there wondering "what on earth is happening, why are they taking so long? For me I had no clue about what was happening to me. All I knew was that something was wrong, because with seven and half weeks to go, and the mucus blood had come out, and I am bleeding and I am having this pain in my back and it keeps coming and going and nothing is happening. And I knew that it was not good for the kid, the baby who was inside me, because it was still a long way to go. I was very worried about all that, because that was about all, and I didn't have anybody actually address any of my anxieties, I can't really

remember anybody being soft and gentle and kind and telling me its OK, the baby will be all right, these are the things that might happen to you but when these things happen, this is what is happening to you, it means, either we will have to do this, or the other. After the baby was born everything was just nice, but I do remember being very anxious for him, because he was so small". (Ayesha)

"I remember crying a lot because I was so scared about what would happen to him. Can anything happen to him? How am I to cope with that sort of thing, but I also didn't realise how much grief you have after you have a baby, the post natal depression and that sort of thing, how could you feel so helpless. All of that I think I felt. Looking back now I think I understand all those things, but at that time I remember being so neurotic in the way that I used to cry a lot for him. I am saying that I was upset and crying only in private times, like with my husband and things. Other times I was being very brave, not really showing or telling them". (Ayesha)

Dignity compromised

Khadija experienced situations where her dignity and privacy were compromised (Refer to Chapter Two). The situation which seemed to be the worst, was the operating theatre experience, for not only were there a number of people but there also happened to be a male Muslim doctor, as she pointed out.

"Now then the next day. It was probably just about the only significant thing, is my bad news about it. I had to have a shower and I may have

been groggy or whatever, but like I saw I wasn't feeling assertive, I was just recovering from what was really major surgery, and plus the shock, I had had a really horrible pregnancy, my self esteem was probably negative something, and I wasn't able to assert myself to say how I thought about things, and this nurse, she was an older nurse, stood with the shower curtain open and watched me have my shower and that was just really to me the most awful thing and I just felt so uncomfortable with it as a Muslim, you know... It was just awful, an awful thing to do, what an awful thing to go through, and probably a lot of women that shower with other women in the showers wouldn't give two hoots about it or think twice about it, it was just that she was keeping an eye on me to make sure I don't faint, but for me I would have rather she had heard the thump as I hit the deck in a faint than have her standing there watching me because I still remember her, hands on hips and holding the shower curtain open, like toe tapping waiting for me to hurry up, and it was just awful".

(Khadija)

"It was really quite awful. I think I had to go in the morning and then lie down on the shopping cart or whatever it is that they push you around in, and be wheeled right across the hospital, through corridor after corridor after corridor (. . .) Then I was wheeled off and there were about, there must have been about, eight parking spaces for people going to have whatever operations they were going to have, and there were all sorts of things, there were old men coughing and there were heart things and, I don't know what sort of operations there were, but there were heaps of

different people all over the place and I had to go into this little curtained off, it was really just a parking bay, and I was asked about having a student of this and a student of that and a student of something else, and this, that and the other, so it seemed to be about six students, and I said that was OK, and then I was wheeled into the room and there were a couple of people, a Paediatrician and the Paediatric nurse and they each seemed to have students, and there was the Anaesthetist who was very nice and very friendly and explained everything in great detail with lots of interesting anecdotes throughout the operation. He was very good, very interesting. He had an assistant and they seemed to have a couple of students as well, and then there was a House Surgeon who was actually a Muslim guy, of Indian background I think, and my Obstetrician, and all these students. And what was really horrible, this one, was that everybody was standing around leaning against the wall, all around this huge room, I mean the room was like a big hall, it wasn't very warm, and I had to sit up on the side of the trolley thing and bend forward while they put the epidural in, which isn't a fast operation, and I had to bend forward, and I had one of those hospital gowns and the back was all open so I had no clothes on except this horrible gown, and there I was bending forward exposing the crack in my backside to all these people leaning against the wall. And that was just awful, but again I was in this state of being, you know, not in a position of being assertive, things were being done to me and I was just having to accept them (. . .) I felt really vulnerable because I don't expose my body to people, I just go around showing my hands, feet and face, and then to have all my back and the top of my backside all

exposed, and the gowns are short, so it would have been from my knees down and everything, and I was sitting up with everybody standing there, the spectators, that was just awful”. (Khadija)

“I have just had a thought, that perhaps I was lucky to have had a room of my own because I am not sure how I would deal with it if I was in a room with a number of new mothers with covering and dressing as a Muslim, but one difficulty anyway, even though I had a room of my own it was still awkward that Doctors and whatever that were coming around would pop their head around the door without knocking and come in and, I mean, it wasn’t really any big deal because I had pretty much covered myself up the whole time although I was breast feeding a lot of the time that they did that and it is just a pity”. (Khadija)

“I went to a lot of trouble to find suitable clothes.. You know, clothes that covered me. I don’t normally wear a nighty or pyjamas, at home I just wear a tee shirt and shorts or shirt or whatever, which I can’t wear in hospital because people will be coming into my room and as a Muslim I cover everything except my face and hands and feet, so I spent a lot of time finding suitable clothes. But actually I ended up having to spend the whole time wearing a scarf or little wee bonnet sort of thing to cover my hair because I knew that people were just going to come in any old time”. (Khadija)

Postnatal - Being left on her own

Ayesha described being left on her own after the baby was born. Her perception was that there was a lot of attention focussed on her during the labour and delivery phase, but after the birth she felt ignored. From a cultural point of view the new mother is not usually left alone. She is surrounded by other women who take care of her and her baby.

“And the worse part is, once the baby is born, everybody leaves you behind and they put all the emphasis on the baby and that was it, and I thought, that was another thing, that just blew me away and I thought well, all of the fuss in a way beforehand, and waiting to know what is going to happen and next, and next, and next, and suddenly when the baby was born we were just...(long pause) And there is a sense of loss, and a sense of desolation (. . . .) And then getting shuffled back to my little bed and then the worst part was it was not like any other mother having a normal baby who would have the baby in your arms to keep company (. . . .) I would think, if people can think carefully, I think you can actually look after the person to ensure that somebody stays with the person, with the mother, to stay with them, because there are some many things that go on in your mind and you don’t know what to do or what to say, and you know, you are just all by yourself and just thinking, not a very nice thing to contend with”. (Ayesha)

Having to deal with male health professionals

Although the women allowed the male doctors to attend to them as there was no other choice available, from their conversations it became apparent they would rather have had female health care givers in keeping with the modesty issues, (Refer to Chapter Two) as the followings excerpts indicate.

“We had to settle for who sounded like the best man Obstetrician and he was very good, but he wasn’t a female”. (Khadija)

“Well during my pregnancy my doctor was a male. I was feeling uneasy all the while when I went to see him, like I don’t feel easy with doctors touching my body and things like that, and I was not happy about it, but since it was not in my hands to state that I want to change my doctor to a female one. But the midwife was there to do the delivery and the rest of the things so I was pretty happy about that, and I didn’t have a male doctor around me. So there was privacy for me. If there was a male doctor around I would have been uneasy because I felt uneasy during pregnancy”. (Amina)

Inappropriate Diet

Only Amina brought up the subject of diet. This issue was the main reason for her going home, but she also qualified it by saying it was in the days when there were not that many Muslims in Aotearoa-New Zealand. She was implying it would be hard for people to understand her dietary needs, because even though she ate meat, it had to be “halal” before she could eat it. (Refer to Chapter Two).

“Due to my religion I couldn’t eat anything. They had some European food around but it was not what I could eat... they sent me meat which I couldn’t take. It was at that time when Muslim people were not that much in New Zealand, so it was pretty hard for them to understand as well. I eat meat but it is hard for them to understand what I am talking about. The food was the main thing for me, and so I preferred to go home”. (Amina)

Assumptions and unclear explanations

Assumptions and unclear explanations by health professionals seemed to be one woman’s experience with health professionals. The excerpt below from Ayesha’s story illustrates this same point.

“What I’m trying to say is they were not really explanations that reached me, you know, it was never really worded in the manner that a woman in labour and in anxiety like that would ever identify with (. . . .) There is a sort of assumption that you know how to manage yourself by people who were dealing with me, and now I think that assumption is really quite predominant in the manner that everybody handled everything. They seem to think that I had got first hand knowledge about what was going on”.
(Ayesha)

How could things be different?

Each of the women was asked these last two questions

If you had another child, how would you like the experience to be different?”

Is there anything else you wish to discuss related to your childbirth experiences?”

Khadija’s Response:

“Well, I think the Obstetrician that I have had for (. . .) has been very good, but I think that having a woman Obstetrician was something special and you noted yourself looking at the photos, that there was like a bonding between myself, the Obstetrician and the baby, and she was part of the whole experience, and very important and involved in it, whereas as a Muslim woman I can’t have that closeness and I wouldn’t have that closeness with a male Obstetrician. So I think having a female would improve it a lot”. (Khadija)

Ayesha’s response:

Given the conditions that you make a choice to come to a different culture you know, ideally I would have liked to have gone home and had the child, you know, if I felt so strongly about cultural influence and religious aspects, that would be the only way that you could have it well and have it truly, and to have all that religious ceremonies that bless the children, all of that, so it’s not only just at the point of having the child, at childbirth, that I would have thought of the religious part of it, you know, it’s the first 40 days that is so important for it and I think that would have been the nice part, even if I had the child and had gone home for the 40 days, it would have been more like what would have been ideal. That’s all, but then we can dream couldn’t we? I think the 40 days is crucial, I reckon.

When I think of my first 40 days with my little (. . .) they were such a traumatic 40 days, you know the fact that (. . .) came early, (. . .) was there the two weeks, and then (. . .) was flown down to (. . .) and (. . .) was here for another two weeks almost trying to catch up for the eight weeks. So my 40 days, it seems like it was a whole lot of up and down and all over the place sort of 40 days. Whereas, in our tradition, I suppose we would have everything done for us and it would be great and then you know we wouldn't have had to cope with all the other elements of normal life I suppose, and that would have been the nurturing that would have come on which is sort of really so important". (Ayesha)

"I was thinking more about how could things be different for women, especially Muslim women, and women who have got cultural and traditional links to specific ways of childbirth and pregnancy and rearing. You can't really do it, I don't think, haphazardly, it has to be a holistic approach. Even if the hospitals try to implement that I don't know whether they could ever do a good job of it, because you have got to understand the whole person, the people where they come from and that whole perspective I suppose, the cultural roots of people and where their values and thinking and traditions really influence the way they do things. Unless they understand that I don't think they could ever really cater for the needs of Muslim women as such, but even then in general, for women, because sometimes the women who service the women don't necessarily understand how to help the women, isn't it, and there seems to be a real

sort of a breakdown in sort of thinking, I suppose, thinking approach or whatever you want to call it”. (Ayesha)

Amina’s response

“Well, if I have another child I would like everything to be in a religious manner. Yes because previously when I came from home to have my babies here, whichever doctor or nurse I was given, I just took it see, because I didn’t create a fuss ... there was not plenty of time where I could make choices or stuff like that. Like now, I know where I can go and see, whom I can go and see, whom I can go and talk and things like that”.

(Amina)

Individual Expressions

The expressions below describe things that were important to the women. I do not intend to introduce them but instead will let them speak for themselves.

Asking questions but not necessarily doing anything about them.

“But what fascinates me is that they ask all those things but you can’t really see them taking any of that on board, you know. So, that might just be a formality and not really a meaningful thing really. Just maybe being seen to be doing something, but not necessarily doing something about it”.

(Ayesha)

Embarrassed at being young

“Well, to tell you the truth, when I went to the hospital for my (. . .) baby I was really quite embarrassed just because of my young age. Since my husband was not with me, what must they have been thinking”. (Amina)

Family support

“You find a big problem when the family is not there, because you don’t know what to do for the first one (. . .) when the family is there they know how to take care of the kids, how to bath them, how to oil them, then in 1-2 weeks you learn from them”. (Amina)

Societal Expectation

“I sort of felt that I had to get out of there really quickly, because a friend of mine in the next room had only stayed there for four days after her Caesarean and I sort of thought well I had just better get myself together and get out of here quickly and somebody did point out that her operation was slightly different to mine (. . . .) I don’t think that I was really keen to get going, and on the fifth day I was just feeling so sick and the room was going around and around, but I still felt I had to move out because the bed was probably needed for somebody else. I don’t think anybody said anything to me, but I certainly felt like that, and I know on that fifth day when I was supposed to go I am sure that I mentioned that I wasn’t feeling very well, and then they came to take my temperature before I went home and it was really really high and I had an infection, that’s why I had to stay a bit longer. I remember crying because I didn’t want to”. (Khadija)

“And feeling like I was just on my own, trying to do all the things, and having very high expectations of trying to keep up with everything, working, having a house that is good and doing all the other things that you usually keep up with when you are working full time. I think that is something that I really remember very much, and I didn’t have anybody else who could say to me, that is not the way to be or it’s Ok if you didn’t do some things (. . .) you end up having high standards in your mind, that you think you have got to keep up with, and physiologically you can’t”. (Ayesha)

Stories within stories

Khadija, in telling her story, told of a friend who had a hard time in hospital

“we know somebody who really had a hard time and wasn’t looked after very well. I think it was because that person wouldn’t have sucked up to the nurses and that was the only reason it worked for me” (Khadija).

Ayesha recalled the story of her sister’s childbirth experience at their parent’s home and the rituals that surrounded the event.

“I remember when I was little, my sister having her baby at home. There was no calamity about going here and there or anywhere, you know, she had the baby and the whole room was set up for that and everybody else did everything for her you know, and I remember in the evenings when the baby was washed and so fresh and everything and then there would be prayers and the incense would come out and how everybody would come and bless the baby and they would all put incense for the little one and,

you know, it's all those little rituals that I know that didn't happen for me but I thought.. Just now, it just brought it back for me. And it's a lot of, you know, it's in the family, in the home, there are so many people to do so many things for you. And yes, I remember that very well, that's what brought it back, when I was thinking of my family members and my sisters and how wonderful that was, because there was some godliness about the whole home when the little one was born and counting 40 days and then we had this big ceremony on the 40th day and when the child's hair was shaved off and lots of people coming and you know all these gifts arriving and all the sort of rituals, it takes you back. Maybe, maybe subconsciously I have felt sadness about all of that too. It comes back to you about each sister's childbirth experience and what happened to their children and when I look back it really brings back those memories about how well off the children were, you know, and how many people would handle them and how many of them would kiss them and how many of them were going to change the nappies and, you know, there is not just one person, there would be plenty of people who would be willing to do that sort of thing and wanting to do it so badly as well and it is really quite a nice warm feeling when you think of those memories for my nieces and nephews, especially for my sisters' children, I think back. And I remember being a part of that myself and I remember carrying my nephews and having a special touch about it that he will fall asleep in my arms, that kind of thing. I was about 12, maybe, and being able to carry and rock the baby to sleep and things like that, that was really quite amazing, so it was really

nice that those children had so many people around them to really spoil them as such, in a way. (Ayesha)

Momentous occasion of birth

“I cried at them because it is such a spiritual experience”. (Khadija)

“But it was worth it. But after delivery it was so lovely. It’s nice it is a small miracle of course. It makes you very humble and it makes you wonder how much at mercy you are with life experiences like that, because it makes you realise that I think if it were in your control you can change within seconds. All the time, and how revolving everything is and how much a part we are of the big picture. That was what was really special. All that pain and all that trouble. (. . .) was such a lovely (. . .) and it was nice when I held (. . .) in my arms, that made all the troubles and anxiety go away”. (Ayesha)

“But when you first hold your own baby you don’t think of that. It was really good, and (. . .) was a beautiful little (. . .) and (. . .) was a bit chubby as well. Well, all the while I have been holding babies which are my nephews, nieces, now I have my own, and like, it was part of me which I had inside me for 9 months, and everything I used to ask the midwives, the doctors, how the baby was, but now I could see”. (Amina)

The women’s stories in this chapter gave a moving account of their childbirth experiences, their pain and their joy, the health professionals who recognised their

needs, and those who did not. The texts from conversations that reveal truth, the essence, highlight that childbirth is a deeply felt significant event, and is remembered for a long time. It is the representation of the women's reality in a given situation.

In the following chapter I will review some of the literature that is available on childbirth experiences, and provide my reflections on some of the issues raised in the women's stories with references to literature.

CHAPTER SEVEN

POSITIONING THE RESEARCH IN PRACTICE

The intention of this chapter is to bring to the fore the themes that emerged from the stories of Khadija, Ayesha, and Amina. These themes included Supportive actions, Vulnerability and Individual expressions. In order to address the themes I will begin by presenting selected pieces of general literature that discuss childbearing/childbirth as one of the most important cultural and spiritual events in many women's lives, and literature specifically relating to Muslim women. This will then be followed by my reflections on the themes that emerged from the women's stories, specifically the themes I have chosen to relate to the positive and negative experiences of the women. Literature will be incorporated within my reflections as deemed appropriate.

It has to be noted that, while I was influenced by phenomenological ideas, I have not utilised any specific methodology for the analysis of the themes, instead themes have been identified to generate discussion points.

Finally the implications for nursing and midwifery education and practice will be discussed.

A point to note is that for nurses and midwives to understand a person they need to recognise Muslim women as individuals with their own identity, and also to recognise that Muslim women stand with all other Muslim women, not only as unique to themselves, but also expressing who they are collectively.

Childbirth has been described as a significant and deeply felt physiological, cognitive, social, and spiritual event (Callister, 1995; Callister, Semenic, & Foster, 1999; Nichols, 1996) and is remembered by women for a long time (Simkin, 1991, 1992). A number of authors, including Callister (1992); Callister (1995); Callister, Vehvilainen-Julkunen and Laurie (1996); Callister, (1997); Callister (1998); and Callister, Semenic, and Foster, (1999) have discussed the cultural and spiritual meanings of giving birth. Some of the discussions in their papers included the importance of bearing children in obedience to religious law, beliefs surrounding pregnancy, childbirth and support for the woman. Dawson (1983, p.5) in her book 'Customs of Childbirth' states "it is at times of birth, marriage, and death that everyone learns more about the culture into which they were born. It is at such times that the manifestations of culture mean most". In recognising and acknowledging the importance of this factor, Callister (1995) makes an important point to nurses that they should attempt to create a therapeutic relationship with the childbearing woman that respects the social, cultural, and spiritual context of her life.

Rubin (1984), in her writings related to maternal identity and maternal experience, recognised that the childbearing woman in a foreign country is deprived of the close networks that provide her with role models. In fact Sharts-Hopko's (1995)

study of American women having babies in Japan provides valuable insights into some of the cross-cultural experiences of the American women in the Japanese context. She asserts that childbearing in a cross-cultural context is a stressful experience. Some of the issues she raised in her paper are mirrored in this research project. These issues included the expectations of the host culture versus the woman's own cultural expectation, a point also raised by Meleis (1991), isolation from the family, the need for affirmation, and the need for cultural support.

Having identified some general literature around childbirth that discussed the significance of this event in a woman's life, and the recognition of cultural meanings that are attached to it, I next searched for literature around Muslim women's childbirth experiences. A Cumulative Index to Allied Health Literature (CINAHL) search revealed an emergent

nursing and midwifery literature relating to the care of Muslim patients from countries like the United States of America, Britain, and Australia, where large communities of Muslims have made their home.

Literature by the following authors (Bradshaw, 2000; Gatrad, 1994; Homebirth Australia Newsletter, 1990; Hutchinson & Baqi-Aziz, 1994; Luna, 1989; McDonald, 1985; Zaidi, 1994) highlighted many of the needs and practises of Muslim women as discussed in Chapter Two. These included the practice of specific religious duties, namely *Salat* (obligatory prayers five times a day), *Sawn* - fasting, reciting of *Adhan*, (the call to prayer) in the baby's ear following delivery, modesty (*hijaab*), privacy, dietary observances i.e. *halal*, [lawful - permitted] *haram*, [unlawful.-forbidden, and therefore avoided], the concept of

Najis, [polluted, unclean or dirty], and not leaving a Muslim woman alone with an unrelated male other than her husband or a *mahram* (male relative she is forbidden to marry).

Other issues discussed in the literature are the avoidance of physical contact, i.e. touches and hugs between non family members of the opposite sex, the importance of family support, availability of female carers in keeping with Islamic teachings of segregation of the sexes, Nahas (1997), and the issue of informed consent in the case of female patients, as generally the husband, father, or elder brother would give consent for the care of a female relative (McKennis, 1999; Sheets & El-Azhary, 1998). The use of alcohol-based medications is best avoided (Robertson, 1993).

In Aotearoa-New Zealand, Dawson's (1993) book on 'Customs of Childbirth' gave an insight into aspects of Islamic culture and ethnic culture through the story of Azra, a Muslim woman from India who had a child in Aotearoa-New Zealand. Also, an article by Isa appeared in the New Zealand College of Midwives journal in 1994.

Qualitative studies by Woollett and Dosanijh-Matwala (1990) conducted in Britain, Vose's (1996) Australian study, and Katbamna's (2000) British study used interviews to gain insights into Muslim women's childbirth experiences within hospital settings.

Woollett and Dosanih-Matwala's (1990) study of 32 Asian women, (whose families had originated from the Indian subcontinent), who were interviewed regarding postnatal care, their attitudes and their experiences, highlighted the following issues which centred on feeding, rest and recovery in hospital and at home, bonding, mother child relationship, communication and relations with staff. Of the 32 women interviewed 10 were Muslim. One of the excerpts from a Muslim woman revealed "the behaviour of the nurses was really bad, that's why I ran home. I left hospital before time" (Woollett & Dosanih-Matwala, 1990, p.182).

The Australian study by Vose (1996) of eight Muslim women from non-English speaking backgrounds, who had received prenatal care and had subsequently given birth to their babies in Queensland, revealed the women had received care that was unacceptable and culturally insensitive. The study described the lack of privacy, the attendance of male staff despite the women having made the staff aware of their cultural needs, the provision of diet that included products that are considered 'haram', communication problems, and lack of places to pray. All this led to the women being distrustful and suspicious of the nursing care they received.

Katbanna (2000) explored the experiences of pregnancy and childbirth from the perspectives of two groups of South Asian women in Britain, one group were Gujarati Hindu women, and the other, Bangladeshi Muslim women. The women's personal stories were examined within the context of the vast diversity that exists within South Asian communities in terms of socio-economic, cultural, religious

and immigration history. The study found Bangladeshi Muslim women were anxious to observe purdah (hijaab) restrictions, and because of their previous knowledge of traditional management of pregnancy from their home country delayed seeking medical attention relating to confirmation of pregnancy or attending antenatal classes. This was noticeable in some women who had had previous experience of antenatal care in Britain. However, Katbamna, (2000) points out that while the women did not overtly set out to defy medical control, the decision to delay seeking advice was seen as a form of resistance to medical control. There were other reasons for not coming forward as well, and these were related to communication issues, transport problems, and lack of childcare facilities.

It appears the worries of both groups of women were similar to those of white women with regards to management of childbirth in hospital, and the sense of powerlessness women feel when faced with medical experts. Issues of control have been discussed by a number of authors (Oakley, 1980; Windsor-Richards & Gillies, 1988; Zaidi, 1994). Harcombe (1999, p.81) suggests that “Women’s power is important as powerlessness is known to have negative effects on health”.

Concerns expressed by the Bangladeshi women included care given by male health professionals, and pressure to reject their cultural beliefs when they went outside their community to access maternity care. It was also noted some of the Bangladeshi women found it difficult to attend a male doctor, especially if he was from their own community, as they were concerned about breaking the modesty restrictions. They also voiced their concerns over the failure of the hospital to

recognise their dietary needs, and the women were often concerned about “attracting derogatory comments from health professionals if they observed their cultural diets, remedies or rituals” (Katbamna, 2000, p.133).

The findings from Windsor-Richards and Gillies (1988) comparative study of three racial groupings in Britain (Caucasian, Afro-Caribbean and Asian), of 89 women’s birth experiences found 71 women (81%) were satisfied with the amount of control they had over their deliveries. The assumption is made that there were some Muslim women in the group because data included refers to ‘the whispering of the call to prayer’. The majority of the women were generally satisfied with their experience of giving birth in a hospital. However the authors do make a note that had the women been interviewed in their homes, it is possible the findings may have been different.

Khalaf and Callister (1997), in providing an insight into the cultural meanings of childbirth of 32 Jordanian Muslim women living in Jordan, identified “a strong sense of the spiritual dimensions of giving birth within women’s traditional, religious, and cultural context”. Harrison (1991) investigated the pain reports of Arab women (Kuwaiti, Palestinian and Bedouin) delivering in Kuwait. While the demographic data in Harrison (1991) study did not include the religion of the women, there is a strong possibility there would have been Muslim women taking part in this study as the countries the women came from are recognised as ‘Muslim countries’.

Reflections on the three stories

The text now moves into considering the themes 'Supportive actions', 'Vulnerability, 'and 'Individual Expressions' that emerged from the women's stories in relation to the literature that is available.

The context within which a birth occurs influences a woman's perception of her experience. Simkin (1996) points out that how a woman responds to the childbirth experiences is decided by her previous life experiences, for example her family life, friendships, physical and mental health, the influence of other adults, and the emotional support she receives at the time. She also suggests that satisfaction with birth experiences is linked with feelings of accomplishment, control, and the type of care received. It has been suggested that the support provided to the labouring woman by nurses and midwives can enhance positive feelings in her about her coping abilities and positive feelings about her labour (Holroyd, Yin-king, Wong Pui-yuk, Yau Kwok-hong & Leung-Lin 1996; Tarka & Paunonen, 1996).

In relating the positive experiences, the women gave heart-warming accounts of their interactions with the midwives, some of the nurses, and in one case the woman obstetrician as revealed by the women's excerpts under the theme 'Supportive Actions' and under the question 'How could things be different?' in Chapter Six. They remembered with appreciation all those who had been supportive of them in their time of need, even after all these years. This seems to resonate with Simkin's (1991) findings that women remember their birth experiences and their caregivers for a number of years.

Vulnerability during the childbirth experience has been discussed by a number of authors, such as Dawson (1983), Lundgren (1999), Rubin (1984), Sharts-Hopko (1995), Simkin (1991), and Simkin (1992). From the women's stories as highlighted in Chapter Six, it is apparent from the negative experiences that this feeling of 'Vulnerability' was increased by a number of factors, which specifically affected the women from a religious and cultural point of view, even though research has made appropriate information available to health professionals.

For example in Khadija's operating theatre her privacy and dignity were compromised. There must have been nurses and midwives present, yet there was no support for her, and in the operating theatre incident it seems she had become a 'non person', an object of the health professionals attention as suggested by Taylor (1995). Had the nurses or midwives become so desensitised that they were unable to recognise a woman's fundamental rights of privacy and dignity? They may be accustomed to seeing unclothed bodies, but women are not used to exposing their bodies to anyone present, especially Muslim women as this related to the modesty requirements highlighted in Chapter Two. It appears the health professionals who cared for Khadija did not have an awareness of her religious/cultural need of covering her body and hair, and even though she had her own room, people entered without any warning.

Badzek and Gross (1999, p.52) refer to privacy as "the right to be left alone and free from intrusion, including the right to choose care based on personal beliefs, feelings, or attitudes; the right to govern bodily integrity (accepting or rejecting treatment or exposure of the body)". As highlighted in Chapter Five, the concepts

of anonymity, confidentiality, and privacy, are key principles included in codes of conduct that guide practice, and are vital to the relationship between nurse/midwives and patients/clients. These concepts are used to protect the individual from being “exposed” and put in a “vulnerable” position.

Khadija in her conversation revealed she felt it necessary to make special effort to achieve a good relationship with the staff. Vose (1996) suggests that trying to appear appeasing and be pleasant leads to added stress. Patient/client and staff disharmony has been discussed by Woollett and Dosanih-Matwala (1990), Vose (1996) and Katbamna (2000) in their studies of women who have given birth in hospitals.

Ayesha experienced having a premature first baby away from her home country and her extended family, and her state of anxiety seemed to go unnoticed following the birth of her premature baby. She felt quite lonely at a crucial time in her life, when the extended family would normally provide social and emotional support, and performed religious duties and cultural rituals. She also raised the issue of being left on her own after the birth of the premature baby. This agrees with the experiences of some of the South Asian Gujarati women described in Katbamna’s (2000) work. From a cultural point of view Ayesha would not have been left alone. She would have been surrounded by other women who would have taken care of her and her baby. Callister (1995) makes a vital point when she suggests that inquiry into the woman’s feelings about her birth experience, in the immediate postpartum period, offers the woman a chance to share the details of a life changing event, her concerns and feelings, with an interested listener. This

sharing leads to cultural reciprocity, with the woman sensing that the nurse or midwife respects and is sensitive to her needs.

In Amina's story, her requests to have her babies bathed had been overridden. The result was that Amina's parental duties were compromised which in turn compromised her spiritual and psychological safety needs. It is fair to acknowledge that from my recent conversations with colleague midwives, rules are not so rigid nowadays, and parents' wishes are adhered to wherever possible. Her story serves as a reminder that respecting a woman's religious and cultural needs are so vital and the need to provide individualised care.

Settings have the power to affect patients/clients and this is apparent in the women's stories. Two of the women in this project were professional women who had been in the workforce in Aotearoa-New Zealand, and all three women could express themselves clearly in English, yet it appears they became powerless in certain situations. In each of these situations, time spent with the women could have resolved some of these issues.

Ayesha, in her story mentioned the lack of reassurances and the lack of clear communication at the time of the birth of her premature baby. In nursing and midwifery practice, reassurance and giving explanations are seen as part of good interpersonal communications skills, in order to gain patient trust and build rapport. Taylor (1995) suggests there are multiple reasons for poor communication between patient and health professionals, and some of these include the use of jargon and technical language, not listening, or not enough time

spent on explaining. From a cultural point of view in her poignant article Kuhni (1990) wrote, “When your patient is from another culture, do not assume you’re on the same wavelength just because that patient speaks English, and went on to say “since she spoke excellent English, I assumed she was familiar with our ways as well”. This article was based on her own experience of caring for a young Indian woman from India, who was having her first baby, and was away from her home country. Anxiety as a factor has also been known to hinder concentration and processing of incoming information (Taylor, 1995). Time spent with Ayesha may have made a difference to her experience.

Ayesha, in looking back over her childbirth experiences, expressed the regret she felt that her childbearing experiences were over and that her “Forty days having come and gone”, and the premature birth of her baby and the anxieties she felt seem to have had an impact on her. Rubin (1984, p, 38) suggests, “pregnancy is a time for preparation and becoming a psychosocial mother”. During this time the pregnant woman looks for role models i.e. experienced population group, peers, or mothers, who have been through the same situation, and they serve as a frame of reference on which to base her behaviour and adaptation to pregnancy. This group of people also serve as a guide to her in what to expect. This suggests it is harder for a woman to cope if she has no role model as it was for Ayesha. Ladewig, London and Olds (1986) and Sherr, (1995) point out that the parents of a premature baby have the added worry over the health of the child, and this was no different for Ayesha as highlighted in her story.

With reference to the period ‘forty days’, this is a period of confinement, which is observed by many cultures and is seen as a crucial time for the mother’s recovery from the birth experience (Rice, 1993). In some cultures, first time pregnant mothers go to their parental home during the last weeks of pregnancy and remain there until forty days after the birth of the baby. During this postpartum period the new mother is nurtured and supported by her mother and other people. She is exempt from the normal household chores, given nutritional foods to build her strength, and generally pampered. The literature identifies the mother helpers as “doulas”, the Greek word referring to experienced women who guide, support and help the new mother during childbirth and postnatally (Nolan, 1995; Raphael, 1988). It is harder for women who are from these cultures when they migrate for they are without the close support networks that would assist them through this transition.

Two of the women, in narrating their stories, also told stories of their family life and how they handled situations to make life easier for them in a healthcare setting. McMahon (1996, pp. 320, 321) describes these stories as “Significant Absences – “These are the hidden selves and shadow others that are present in our stories...leaving them invisible means leaving important parts of the story untold and gives us false confidence in our understanding of others and ourselves”. Indeed, revealing these aspects of the women’s stories provides us with an insight into their background, and why certain feelings were expressed and actions took place.

Implications for nursing and midwifery education and practice and recommendations

Throughout the stories that Khadija, Ayesha, and Amina shared in this project, it has become apparent that birthing in a cross-cultural setting is not without stress, in spite of literature being available to guide practice. While acknowledging the positive practices demonstrated by midwives and some nurses, the women's stories have surfaced issues, some of which have already been raised in other research studies e.g. Woollett and Dosaniyh-Matwala (1990); Vose (1996); Katbamna (2000) which affected the women adversely. It is these negative experiences that are the cause of concern and have implications for nursing and midwifery education and practice, as I believe we need to ensure care that is considered safe by women is a foundational part of nursing and midwifery practice.

It has become apparent from the women's stories that the negative experiences overshadow the positive experiences. It seems experiences that are traumatic to our well being become etched in our memory far more than the good experiences.

Polkinghorne (1988, p.22), in asserting that there are three kinds of story presentations, proposes that one of these is "the representation of the experience in a language message directed to others". This statement well describes the way in which the three women, Khadija, Ayesha, and Amina spoke candidly, with depth and insight, of their childbirth experiences, both positive and negative, within a health care setting. Emery (1978 cited in Lincoln & Guba, 1985) suggests our individual reality is made up of our understanding of the way things are and

what has happened to us. In telling their stories, the women revealed the realities of their childbirth experiences in a given situation and time, thus supporting the notion that women construct their own realities when given the opportunity to share their perceptions of a significant life event such as childbirth (Campbell & Bunting, 1991). Also, given the opportunity to share their feelings of a significant event in their life, they described in detail their childbirth experiences and their deeply felt emotions, thus becoming co-creators of research.

In our conversations the women also shared their thoughts in response to the question in the Interview Guide Questions (Appendix C) “If they had any more children, how would they like that experience to be different?” (Refer to the question “How things could be different” in Chapter Six). Their replies coincide with Parse, Coyne, and Smith’s (1985, p. 96) statement that “the meaning given reflects the values and cherished beliefs and is language in patterns of expressions”. I identified these statements in particular, as they are very important in terms of future recommendations. The women identified the need for female health carers and the need to provide holistic care, which includes the need to respect a woman’s religious and cultural beliefs (Refer to Chapter 2).

While it is recognised that some of the literature regarding Muslim women appeared after some of the babies were born, it is fair to comment that there was literature available to guide practice, especially with the birth experience, which took place only two years ago. In the 1980’s the Nursing Process, with its problem solving approach to providing individualised care, was being implemented in many areas in nursing generally in Aotearoa-New Zealand. Leininger’s (1994)

Theory of Culture Care Diversity and Universality was put forward as a way of recognising that people from different cultural backgrounds had different perspectives on how they managed their health care, and these had to be recognised, and finally the concept of Cultural Safety was implemented in Aotearoa-New Zealand in the early 90's with the intention of providing safe care for the patients/clients. With all this knowledge readily available, I am left wondering if some health professionals actually read the available literature and research findings, and make changes or evolve in their day-to-day practice. This project has made me realise that there is a long way to go to change practice generally, before we can say professionally both nurses and midwives respect a woman's fundamental needs.

There is a tendency in some health care settings to use standardised care plans, however, the success of these is very much reliant on the communication processes between the woman and her caregivers, shared partnership and a common goal. Too (1996) puts forward the notion that continuity of care by one primary care giver may make the care plan redundant.

My desire is that the issues that have been raised in this project lead nurses, midwives, and other health professionals to read research findings and to re-evaluate their practice and be cognisant of how to provide care for Muslim women, especially in view of the negative experiences the women revealed in their stories.

As a nurse educator, I hope that Nursing and Midwifery education will gain information from this project that can be used in teaching future students of nursing and midwifery. Excerpts from the women's stories could be used as teaching tools. If students read the stories, they would learn at the simplest level what the women said of their experiences, and learn from some of positive role modelling demonstrated by the nurses and midwives in the women's stories.

Earlier on I posed a question linked to the outcome of care regarding the health professionals use of literature on Muslim women's needs. Roberts and Taylor (1998) put forward the notion that in an ideal world, when faced with a nursing problem, nurses would access or 'look up' and utilise the research findings with respect to that problem. They suggest the primary reason for nurses not utilising research findings is that they are not aware of them, simply because they do not read research articles. Other reasons given for not reading research journals include, researchers write research for other researchers, which makes the text less user-friendly for clinicians, research jargon used in the published papers, bureaucratic systems which do not respond to change readily, and lack of time to access libraries within working hours (Roberts & Taylor, 1998).

Many strategies have been suggested to encourage research utilisation amongst health professionals, and these include nurses and midwives ability to access data bases which contain abstracted and researched journal articles on computer terminals in the wards, and nurse consultants and managers actively encouraging staff in reading, carrying out and utilising research in their clinical practice (Roberts & Taylor, 1998).

In conclusion, in this chapter I explored some of the literature that discusses childbirth as an important event in a woman's life, and also literature that identified many of the needs and practices of Muslim women. Khadija, Ayesha, and Amina, in narrating the rich details of their childbirth experiences, validated what has been suggested in the literature, that is, women remember their childbirth experiences for a number of years. Some of the issues raised in the literature, such as loneliness, vulnerability, and the stress of giving birth in a cross-cultural setting are mirrored in the stories of Khadija, Ayesha, and Amina. It has become apparent that despite the availability of literature and research findings to guide practice that Muslim women in this research project experienced unsafe care in a number of areas.

The following chapter brings the project to a conclusion by my providing an overview of the previous chapters, my personal reflections on conducting the research project, limitations of the project and suggestions for future research.

CHAPTER EIGHT

REFLECTIONS AND CONCLUSIONS

In this research project I explored three Muslim women's childbirth experiences through their stories within the Aotearoa-New Zealand context. I see their stories as gifts to us all, for through narrating their stories, they have given us poignant accounts of their lives through their childbirth experiences. Their stories have revealed both the positive and negative experiences they had during this special time we call the 'childbirth experience', a time which is considered by a number of authors to be a culturally and spiritually significant life event (Callister, Semenic, & Foster, 1999; Khalaf & Callister, 1997). The women were able to recall the events with great clarity, which confirms Simkin's (1996, p.252) findings that women do remember their childbirth experiences for at least twenty years or longer, and their "memories are vivid, accurate and deeply felt".

The research identified important factors of modesty/privacy, strong preference for female health caregiver, ineffective communication, and generally not comprehending the religious and cultural needs of the women, which contributed to the negative experiences. These are the factors that health professionals will find useful to consider when deciding how to best to provide holistic and culturally safe care for Muslim women.

Listening to their stories and dwelling upon them, has made me aware how important it is for me to not only to articulate my own philosophy of caring and

partnership, but also to ensure they actually are part of my practice, for I truly believe they are key to successful relationships in which growth occurs. From my own personal experience of being a migrant, crossing cultures, and being a nurse and a midwife, I acknowledge that people who come from different cultures that have differences, whether in ethnicity, gender, economic or religious bases, have different ways of viewing the world, and I take this into consideration in discussions with students as an educator. Exactly how and why the person's world-view is central to who they are as a person has been explored particularly in Chapter Three, and I regard my beliefs created an integrating central thread in this project.

While Chapter Two gives an insight into Islam, its teachings, and aspects that relate to Muslim women in particular, it has to be recognised that Muslim women come from diverse backgrounds, historically, ethnically, economically and socially, and the needs of each woman will be different as the women's stories reveal. Assumptions are therefore best avoided when it comes to delivering health care to Muslim women.

In Nursing and Midwifery theories and models have been postulated to deliver care that is congruent with the patient/clients values and beliefs. However, theories and models are only a guide. I believe a nurse or midwife is only able to incorporate these into practice if they recognise what they value in their own life, for it is only then that they can truly understand where the person is coming from. Being cognisant of this made me seek out a culturally appropriate research methodology that would enable the women to share their stories.

The literature review supported the use of storytelling/narratives as the culturally appropriate choice of methodology to explore Muslim women's childbirth experiences for this research project, and I consider this is evidenced by the depth and richness of the women's stories. But I also feel the quality and depth of the interviews was partly due to the friendship connection between the women and myself. Also, as a method of inquiry, storytelling/narratives are consistent with Nursing's oral tradition, for in nursing and midwifery, practitioners tell each other stories of their clinical practice to give and gain meaning.

Stories reflect the complexity of life as we experience it, and they have a power to heal not just the storyteller but also the listener. Krysl (1991, p.37) suggests by not telling our stories we not only impoverish ourselves but "we starve those we might feed". She quotes a Nunamiut's definition of a storyteller "the person who creates the atmosphere in which wisdom reveals itself". The women in sharing their stories revealed this wisdom through which we can enrich ourselves

The therapeutic effects of story telling are well documented, (Heiney, 1995; Koch, 1997; Sedney, Baker, & Gross, 1994). Two of the women said telling their stories helped them, thus confirming what is said in the literature. Through telling our stories we make sense of what has happened to us, and it gives us an understanding of why something happened. It helps us to come to terms with certain events in our lives. Through the story sharing, and expressing beliefs and values, we can evolve a deeper appreciation of what has occurred and move to contain our silences and secrets with pride as insights in our grand narrative.

In order to conduct this research project it was vital to put processes in place that took into consideration issues that safeguarded the women's privacy, and the credibility and the trustworthiness of this research project. Initially I thought the small number of women would limit this research study but the depth of the conversations reveal otherwise. The data that resulted from the women's stories posed a challenge in how best to present it, but devising a way to present the stories without revealing the women's personal details was the biggest challenge.

The richness and the depth of women's stories surfaced many issues. The women's stories give an in-depth insight into both their positive and negative experiences. It appears in this research project the negative experiences overshadowed the positive experiences in the women's stories, and this has implications for nursing and midwifery education and practice as already discussed in Chapter Seven. I acknowledge that there are many nurses, midwives and other health professionals who do wonderful work with their patients/clients under extreme duress, and some of this was acknowledged in the women's stories, but as is often the case, we don't hear those stories so readily.

Perhaps the salient turning point will be in the promotion and application of research in practice. To this end in Aotearoa-New Zealand, the Nursing Council of New Zealand has produced competencies, standards, and criteria for the assessment of practice for registration of Nurses in Aotearoa-New Zealand which includes the recognition and demonstrated use of evidenced practice.

Personal reflections

At this point I feel it is appropriate to include some reflective comments on my personal research journey. They may be of interest and helpful to other researchers. I am going to begin with a story from my practice in the past which left me with a lasting impression.

This is a story of crossing cultures and being with one's own which was a special occasion, and even though I was only a student midwife, I could bring much cultural knowledge to the situation. I remember caring for a young Indian woman in labour in a new culture. The situation was difficult and awkward for all of us. The husband was the only one who spoke English in the family and he was translating for his wife. I did not speak the same dialect and therefore I could not directly communicate with the woman to support her with encouraging words or with her mother in law who was with her. The women's body language indicated to me that they were pleased to see me even though I could not converse with the women. I remember feeling very conscious of having the husband present during labour and delivery. It was not that I was not used to having husbands present with their wives, as that was encouraged. I just was not used to the idea of having an Indian man present during labour and delivery, as in my own Indian family culture in those days, birth was considered to be a womanly affair and therefore husbands stayed out of the situation, and the labouring woman was supported by her female relatives. I suspect he too might have been equally embarrassed as he was quite young himself, an immigrant, and in the unfamiliar territory of being a support person and interpreter for his wife. "Back home", in India, or where I grew up for that matter, each of those present would have had a specific role. I

remember thinking about the mother in law, who, as an elder, would have known what to do had she been within her own culture. I recall wrestling in my mind with the cultural norms of giving her the respect that was due because of her age, and trying to work within my responsibilities of a Registered nurse and student midwife coming from a Western model of nursing.

As I reflect on this story, I realise that so often when we are faced with the unknown we unconsciously use the 'fight or flight' response. At that point in my practice I settled with what I knew as a junior and acted in the way I had been taught. Now, I would act radically differently. To look at changing something means to look through a new lens, and this can be challenging to us and to others, and it can pose some degree of risk to self and others (Pat Bracken, Personal communication, September, 2001).

As a nurse, midwife, and nurse educator, I espouse 'care' as the overriding safeguard enabling us to protect an individual's dignity, and we are entrusted then to prevent situations that make a person feel vulnerable. On reflection I raised the question here, how do I protect myself from feeling vulnerable? Do I unknowingly, in order to protect myself, adopt what is known as the 'clinical gaze,' (Wilkinson & Miers, 1999) and treat the individual as an object of enquiry? I feel if I do this then I would fail morally in providing ethical care. I reflected on the question: at what point do I change from feeling sympathetic or empathetic to being in neutral space?

Research Process

In conducting this research I feel very privileged that the women were willing to share their stories with me in a sincere, open manner, and at great depth. Self-disclosure, regardless of whether it is for a research interview or for sharing of oneself with another to gain some comfort, opens the person to being vulnerable. I wondered how they would feel after having revealed so much of themselves to me? It made me think of the statement by John Powell (1969, p.12) “Why am I afraid to tell you who I am...I am afraid to tell you who I am, because if I tell you who I am, you may not like who I am, and it’s all that I have”. In a way, presenting this project to the women and to the readers of this research also puts me in a similar position.

The following three situations, Khadija in her theatre experience mentioning the presence of a Muslim male doctor, the Bangladeshi women in Katbamna (2000) study avoiding the male general practitioner from their own cultural group, and my own discomfort at having an Indian man present at birth, leads me to believe that when you are the only one in a cultural group that is unfamiliar with your cultural norms you feel almost protected by their ignorance, but having a member of your own cultural group present in the wider group leads to dissonance, as there is a shared unspoken understanding, and when certain expectations are breached these cause discomfort to us. The relevance of the above point is that the doctor /client relationship is submerged by the cultural male/female relationship.

In any research that involves creating a relationship with others there is the trepidation that one may not find people who would be willing to participate in

one's research. My fear was no different. What if, after having gone through the process obtaining support from the elders of the community and gaining ethics committee approval to proceed with the project, I could not find women willing to participate in the study? I was also very much aware of not wanting to take advantage of the friendships and making the women feel obliged to take part because they knew me. This concern was tested when one of the women pulled out at the information sharing stage. As mentioned in Chapter Five I had to reassure her that it was fine for her to do this, as there was no obligation to be involved in the research project and that it would not affect our friendship. I have seen her since then and our friendship remains the same.

Interviews are a test of practised skills. Over the years I have been involved in many and varied interviews. Prior to the interviews in this project, I refreshed my interview skills through readings and other mediums. I found even with my experience, I was halted at times. In retrospect, I wondered if I should have conducted a pilot interview.

During the interviews two of the women became visibly upset in recalling their memories. At one point I did turn off the tape recorder as I felt the situation was too personal to be recorded. I remember coming away from the women's homes with my own feelings in a state of flux. I had obviously brought to the surface deep hurts. While neither woman wanted any outside help, their sadness on recalling their experiences played on my mind. As a relatively inexperienced researcher, this was the moment when I began to wonder whether I was really doing the right thing in asking the women to narrate their stories, open up their

closely held treasures regardless of the content, happy or sad, and then just walk away from it all. Eventually I resolved my concern by continuing to write this project, thus respecting the women's stories and our common goal.

In our stories the words we use matter. Words are powerful tools (Leap, 1992). For it is through language we are able to express our feelings and beliefs, and explain why something has happened (Mishler, 1986). And depending on the context in which they are used, words have different meanings as in Amina's story when she uses the word "open" in the excerpt shown below.

"So it was really nice for her to stay (meaning the midwife) and she delivered my baby and, like for me, I feel a bit open when men are around, and so I asked this midwife if she could deliver the baby for me, because I feel more open with ladies than with men". (Amina)

Although I knew what she meant I still had to ask her to clarify the use of the word "open" in the two different contexts she had used it in. Through clarification I realised that the word "open" meant "comfortable" when she used it in relation to the ladies, but when it was used in relation to the men, it meant "uncomfortable" or "feeling exposed". People whose first language is not English tend to translate concepts from their language by using the nearest applicable English word. However they often do not have an English vocabulary of great subtlety, which means their ideas are not truly translated. People whose first language is English can often be misled listening to the conversation, as they put their own understanding on the words being used, and may quite often misinterpret the concept being communicated.

As I reflected on my documentation for the conducting of the research I noted that consent form needs to be modified for future use, to reflect the couple's involvement to agree to the research process. Instead of using the pronoun "I" the consent should read "we" to reflect that a couple were involved.

Sharing stories with migrant women from other cultures, I have found similar issues of loneliness emerging, and especially that of not having their mothers around during pregnancy and childbirth. An immigrant friend pointed out she would have very much liked her mother to have been present during her childbirth experience, because her mother would have understood what she had been through, and this comment from her sums up the affirmation a new mother seeks from those loved ones around her who are part of her family. "It would have been nice to have your family around to see your baby, give praise, affirm its place in the world and acknowledge your new status" (P.R. Personal Communication, September, 2001).

An aspect that came to light through doing this research project and talking to other women was the feeling of being 'exposed and vulnerable' by women, particularly those who are in the presence of other women undergoing examinations of an intimate nature. It is not something that I had heard women talk about openly. My belief is, these shared experiences are deeply rooted in being truly emphatically engaged with someone, i.e. being truly present in that 'moment' of time with that person. I found when I explored my own story that I recalled such moments, and I could recognise the feelings and experience of other women. This aspect of being exposed and being vulnerable has returned on a

number of levels in this research. On reflection, I realised these experiences have profoundly shaped me in my life and my practice, and while it is not the question or focus of this project, this issue is of deep concern and something this project has revealed.

In conducting research as a Muslim woman, knowing the community and culture has assisted me to recognise the appropriate channels to use to create the project. For my project to be credible, it was necessary for me to get support from the elders of the community before I approached the committee. There was the apprehension of how to approach the gentlemen concerned as I am willing to be bound by my culture. However this was resolved through contacting their wives and organising a meeting in each of their homes. In creating the thesis from the research project, it was equally important for me to have scholarly mentorship from the Muslim community, for I had identified that there was much I needed to clarify for myself. As I pursued readings, which were all in English, I came across verses quoted from the Qur'an in various articles, and the English translations did not clearly convey the meaning of what had been originally written in Arabic. The Qur'an is in Arabic and I don't have a command of this language. It was through dialogue with members of the Muslim community who are well versed in Arabic that I found it was vital to comprehend the meaning and context for certain verses. It was equally important for me to separate ethnic or family cultural traditions from teachings of Islam, as over generations the two can become intermingled.

I feel I was fortunate to have mentorship from a respected member of the Muslim community, for without his support I would have struggled to address some of the

issues appropriately. I value the guidance, advice, and recommendations given, and followed these in my writings in the way I best understood them to be. Therefore, if there are any weaknesses or errors in what I have written pertaining to Islamic issues, they are not intentional.

I had considered the idea of pursuing further postgraduate studies after having completed my undergraduate degree, and also because for many years my father had encouraged me to continue to develop my thinking to its potential but I had kept putting the idea on hold until the timing was right. However, the implementation of the Bachelor of Nursing programme at the tertiary institute where I work hastened the decision for me to enrol in the Master's programme at Victoria University. And so I embarked on this journey in search of new knowledge. Little did I realise then, how the years of study, and this research project especially, would have such an impact on me, not just on my professional life, but also on my personal life.

Finally, Wiltshire (1995, p.75) in differentiating a story from a narrative refers to the narrative as being "meditative and theoretical". This means in writing a story as a narrative "the writer is able to rehearse the experiential material and organise, or structure it, so that it now represents in some form or other, an emotionally and morally coherent series of events" (Wiltshire, 1995, p.80). In writing up this thesis project I hope I have reflected the above statement of Wiltshire.

Limitations of the project

It is acknowledged there are some limitations to this research in that it is recognised that some of the issues raised in this project are also issues for non-Muslim women as childbirth experiences are of extreme importance to all women, but my focus in this project has been Muslim women's experiences of childbirth.

Another limitation is that keeping within the requirements of this thesis project has possibly prevented an in depth study of all issues.

It would be impossible to deny that my own personal experiences and reflections as mother, nurse, midwife and immigrant have helped shape this research.

Suggestions for future research

A potential research question from this project could be asking nurses and midwives "what is their experience of caring for Muslim women?".

Future research could involve exploring the 'feeling of being exposed and vulnerable' that women experience when they are in presence of other women who are having things "done to them" i.e. What causes this feeling to occur?

Another area for future exploration could be in asking the women to share what is good and what has been hard, and helped them create a good story as they go forward in their life journey.

Concluding comments

This research project utilised the narrative/story telling approach to explore three Muslim women's childbirth experiences in Aotearoa-New Zealand. Their stories gave examples that illustrated nursing and midwifery practice at its best in which the women's needs were met, and examples of practice which compromised their wellbeing during a period in a woman's life which is considered very special.

It is envisaged the knowledge gained from these women's stories has the potential to be transferred into other healthcare settings where professionals are caring for Muslim women, and that generally the study might encourage nurses and midwives to think about their story, and how their beliefs and values impact on their practice. It is important that health professionals are cognisant of providing individualised care for Muslim women as this project has also shown that each of the women in this project identified different needs.

At the point of presenting the thesis I am not aware of any other published research that specifically addresses Muslim women's childbirth experiences within Aotearoa-New Zealand. My hope is that the knowledge I have gained from this research project has the potential to add to the body of knowledge that already exists regarding Muslim women's childbirth experiences overseas, and particularly to create dialogue and bring an understanding of the Muslim women's experiences so safe practices can be implemented.

My intention is to disseminate the findings of this research project widely where nurses and midwives work, and also to nursing and midwifery educational

centres, so that by reading the findings and the excerpts of the women's stories, colleagues will have the opportunity to become aware of how, knowingly and unknowingly, as health professionals we can make a positive difference to a woman's experience.

Finally, Khadija, Ayesha, and Amina, through their story telling, have given an insight into their experiences so others may benefit.

APPENDICES

APPENDIX A

INFORMATION SHEET FOR PARTICIPANTS

Project Title: Childbirth: A Momentous Occasion. Muslim Women's Childbirth Experiences

Assalaamalaikum

I am currently enrolled in the Masters (Applied) programme in the Department of Nursing and Midwifery at Victoria University in Wellington.

As part of my requirement to complete this study I am hoping to carry out a piece of research which will explore Muslim women's childbirth experiences. I would like to know if you would like to participate in the study.

I have chosen this subject to explore, as there is not much information about it, especially in Aotearoa/New Zealand.

There are a number of Muslim women living in Aotearoa/New Zealand and for most of them the first time they come across a health professional (midwife, nurse and doctor) is during pregnancy and childbirth

The reasons for doing this piece of research are to:

1. Provide an insight into Muslim women's perception of childbirth experiences.
2. Increase awareness and understanding of the needs of Muslim women amongst health professionals so that culturally safe care can be implemented to make it a positive experience for the women in Aotearoa/New Zealand.

The following have approved the study and its procedures:

Department of Nursing and Midwifery, Victoria University,
Wellington.

(...) Regional Ethics Committee

(...) Academic Board Ethics Committee

The study procedures involve no foreseeable risks or harm to you or your family.

The procedure will involve two separate interviews each lasting sixty minutes. A third interview would take place only if clarification is needed. You may have a support person of your choice present at the interviews. These interviews will be tape-recorded. The tapes will not be shared with anybody other than my supervisor and the typist of the transcripts.

Your participation in this study is voluntary; you are under no obligation to participate. You have the right to withdraw at any time.

The information from the study will be coded so your identity will not be revealed while the study is in progress, or when it has been completed or published.

In the final report of the study, examples from the interviews will be given but these and the quotes will remain confidential, as all the participants will choose a pseudonym to be used.

Upon completion of the research project the audio tapes will be offered to you and should you not wish to keep them, they will be destroyed in the way which you deem culturally appropriate.

Additional information can also be obtained from my supervisor:

Margaret Southwick (Senior Lecturer)

Department of Nursing and Midwifery

Victoria University of Wellington

78, Fairlie Terrace, Kelburn, Wellington

Phone 04 463-5233 Ext. 8491 or Freephone 0800 108 005

Email: Margaret.Southwick@vuw.ac.nz

Health Research Council of New Zealand

P.O.Box 5541

Auckland. 1

Finally there is no financial incentive to participate in this study.

If you are interested in participating, please ring me on 06 7579984 or I will ring you within a fortnight to see if you are interested in participating in the study,

Thank you for taking the time to read this information

Wassalaam

Jazak Allah Khairan

Khurshid Mitchell

APPENDIX B

CLIENT CONSENT FORM

CLIENT CONSENT FORM IN ACCORDANCE WITH THE PRIVACY ACT 1993

Project Title: Childbirth: A Momentous Occasion, Muslim Women's
Childbirth Experiences

CONSENT FORM

- 1 I have read/had explained to me and understand the Information for Participants sheet about the study to be conducted by Khurshid Mitchell (BHlthSc (Nurs), Registered Nurse, Registered Midwife, Nursing Tutor
- 2 I have had an opportunity to ask questions about participating and have had those questions satisfactorily answered.
- 3 I have been informed that there is no obligation for me to participate in this study and that I may refuse to participate or withdraw from the study any time.

- 4 I understand that there will be no identifying information in the researcher's study which could breach my privacy and that the researcher and transcriber are under obligation to keep the information and participant's identity confidential.
- 5 I understand that if I so wish, research findings will be shared with me.
- 6 I understand that at any time I may communicate with the researcher and/or research supervisor.
- 7 I do/do not consent to the interview(s) being taped.
- 8 I understand the researcher may discontinue the research at any time.
- 9 I understand that the transcriber and supervisor of the researcher will have access to the recorded information and transcripts.
- 10 I understand that recorded information and transcribed information will be kept in a lockable place at the researcher's home during the research. Upon completion of the research project the audio tapes will be offered to me and if I do not wish to keep them, they will be destroyed in the way which I deem culturally appropriate. The transcripts and computer disks will be kept for five years and then destroyed.

For further information please contact:

<p>Researcher</p> <p>Name: Khurshid Mitchell</p> <p>Address:</p> <p>77, Heta Road</p> <p>New Plymouth</p> <p>Ph: 06 7579984</p> <p>Fax: N/A</p> <p>Email</p> <p>dkmitch@taranaki.ac.nz</p>	<p>Or Research Supervisor</p> <p>Name: Margaret Southwick</p> <p>Senior Lecturer</p> <p>Address:</p> <p>Department of Nursing and Midwifery</p> <p>Victoria University of Wellington</p> <p>78, Fairlie Terrace, Kelburn</p> <p>Ph: 04 463 5233</p> <p>Freephone: 0800 108 005</p> <p>Fax No: 04 463 5442</p> <p>Email Margaret.Southwick@vuw.ac.nz</p>
<p>(...) Regional Ethics Committee</p> <p>P O Box (...)</p> <p>(...)</p>	

FULL NAME: (Please print)

SIGNATURE:

(Participant)

DATE:

FULL NAME:(Please print)

SIGNATURE:

(Husband)

DATE:

I have fully explained this research study to my participant(s)

FULL NAME: Khurshid Mitchell (Please print)

SIGNATURE:

(Researcher)

DATE:

APPENDIX C

Project Title: Childbirth: A Momentous Occasion, Muslim Women's
Childbirth Experiences

Interview Guide Questions

Were your children born in Aotearoa/New Zealand?

Can you tell me about your childbirth experience?

What were the good things about it?

What were the not so good things about it?

If you had another child how would you like the experience to be different?

Is there anything else you wish to discuss related to your childbirth experiences?

APPENDIX D

RESEARCHER CONSENT DECLARATION

I, Khurshid Mitchell

hereby declare I have met the conditions for obtaining informed written client consent for my study.

I will keep all information and identification confidential to myself, my group (if any) and my research supervisor.

Researcher Signature _____

Date_____

Research Supervisor Signature _____

Date_____

This document will be kept in the researcher's file.

APPENDIX E

TRANSCRIBER'S DECLARATION

I have accepted the task of transcribing the research data collected by Khurshid Mitchell.

I understand that the data gathered for this research is confidential, and I agree to take all necessary steps to ensure that any material permanently captured on any media containing data from interviews relating to the research will be:

- (a) Heard only by me, and transcribed to disk in private
- (b) Stored safely until all material returned to the researcher
- (c) Treated as confidential

Signed:

Date:

1 copy to Researcher

1 copy to Transcriber

APPENDIX F

REFERENCES

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