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Maternity Needs during Delivery: Islamic Perspective.

Redhwan Ahmed Al-Naggar[1]*, and Samiah Yasmine abdul Kadir[2].

[1]Population Health and Preventive Medicine, Faculty of Medicine, Universiti Teknologi MARA (UiTM), Malaysia.
[2]Faculty of Medicine, SEGi University.

ABSTRACT

To date, research on the Islamic perspective of women's maternity needs and access to care has grossly been neglected. With one fifth's of the world's population being Muslims and scattered in countries around the globe, understanding the needs of Muslim women in order to fulfill the health care needs of this important community is crucial. The aim of this study is therefore to explore and showcase the Malaysian Muslim women's maternity needs with the hope that the findings and recommendations of the study will usefully be applicable to other Muslim communities worldwide. In-depth interview was conducted among 20 Muslim women aged between 25 and 40 years who delivered at least one of their children in a hospital and able to communicate in Malay language and are Malaysian citizens. The data obtained were categorized and analysed manually into various themes namely: Feeling of embarrassment, women's rights violation by doctors and nurse, medical students' involvement, feeling of guilty and regret due to the involvement of male healthcare workers in delivery, absence of government policy on maternity issues, the degree of risk taking in find female doctor, private hospitals and cost issues. Most of the women interviewed felt embarrassed when they are checked by male healthcare providers during vaginal delivery. Most of them also felt guilty when they recalled their experiences of not having the option to choose female healthcare providers to facilitate their delivery. The Women interviewed, emphasized the fact that they are Muslims and living in a largely Muslim country, and therefore feel obliged to follow and practice the Islamic values in all aspects of their lives. Most of the participants have reiterated that caring for them during delivery is a sensitive issue. The government should therefore look into ways of managing the affairs of Muslim women and their health care service needs during delivery and in a more ethical manner. Establishment of the pink wing model (special wards for women) is highly recommended.

Keywords: vaginal delivery, Islamic ethics, maternity needs, social impact, Malaysia

Corresponding author

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INTRODUCTION

Globally, there are an estimated 211 million pregnant women and 136 million births occurring yearly. It is a basic human right that pregnancy be made safe for all women. Pregnancy and child bearing processes have put every woman at risk of complications. This is in spite of available evidence that 99% of the maternal complications and deaths occurring in developing countries are avoidable and preventable. [1] According to WHO, safe delivery is one of the most important maternity care issues for expectant mothers. Delivery is performed by someone with midwifery skills who is able to manage a normal delivery, and who can recognize and manage obstetric complications and refer patients to specialized care in a timely manner [WHO 2005]. WHO also emphasizes the importance of evaluating the structure, process and outcome of health services to improve the quality of care. [1] In this context, it is important to understand how structure, process and outcome ease social impact and quality of cares to patients. Structure refers to the overall ability of a midwifery service to provide care. Thus, it includes elements of office space, equipment, staff and documentation. Process refers to the way in which such care is provided. The place of birth should provide a distraction-free, comfortable, supportive, and reassuring environment for mothers and their families. [2] Women need confidence and freedom to respond to their contractions in any way that works for them, and have continuous emotional and physical support throughout labor. [3]

In developed countries, despite many have selected to deliver in the hospital, the lack of promoting social values has influenced and forced some women not to choose hospital delivery. One of the reasons is the belief and socio-demographic factors. [4] Women feel more comfortable and safer to deliver at home rather than in the hospital for various reasons including home intimacy with familiar and comfortable environment, to avoid unnecessary medical interventions with hospital setting and to avoid mixing with strangers. They may also have had previous negative hospital experiences or that the hospital may be neither accessible nor affordable. [5, 6]

In Islam, chastity is a fundamental value for both sexes. Sexual relationships outside marriages are prohibited, and the need to protect 'awrah' (i.e. parts of the body to be covered) is extremely important. For a man, 'awrah' includes the parts of the body from the navel to the knee, whereas a woman must cover all the parts of her body except her hands and face. There is no religious or cultural requirement for gender separation in all caring encounters. Patient expectations of gender-based caring depend on the degree of conservatism within cultures. However, gender-specific caring and considerations are more important in maternity or gynecological care. [7, 8] Cultural values with regard to gender have an impact on caring interactions and the use of touch. Islamic teachings restrict or prohibit touching between unrelated males and females in order to prevent immoral behavior. However, this does not preclude physical contact when there is justification and extraordinarily unavoidable needs. [7, 8] Islamic beliefs and practices raise important issues in relation to the provision of health services, including maternity care. Maintaining privacy is a particularly important concern for Muslim parents when they are in hospital, during childbirth and in the immediate postnatal period. The absence of privacy can cause embarrassment and discomfort to both mothers and fathers alike.

Gender preference of the health care providers is a very sensitive issue among Muslim women. Studies have shown that female Muslim patients prefer female health care providers, and conversely, male Muslim patients preferring male health care providers. Although services under certain limiting situations, from a health care provider of the opposite sex to treat a patient have been tolerated [9], the overall acceptance of services from opposite gender provider has been traditionally disliked at the minimum and out rightly rejected at the extreme measure. [10]

Other themes relevant to female Muslim health beliefs include a culture that involves caring of other family members and a sense of community, honour and respect for family members, and feminism as viewed in the context of Quranic value system. [11, 12] With regards to "Islamic feminism", the definition relates to Islamic women returning to traditional Islamic dress, including wearing the "hijab" (head covering) and in some cases the "niqab" (veil) and finding a sense of empowerment through the Quranic teachings that provide certain "rights" for Muslim women, including decisions about health care. [11] So, while the western health care provider may interpret the return to traditional dress and Islamic values as an "oppression", for Muslim women it may be interpreted as a "liberating experience" that provides them with "empowerment" regarding the ability to make autonomous health care decisions. [11]

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A study on the specific cultural needs of Midwestern American Arab subculture suggests fundamental health beliefs essential to culturally competent care to include support, nurturance, physical presence of male or female, modesty issues, and behaviours that bring honour or embarrassment. [13] Muslim women have special beliefs, attitudes, and perceptions that may directly impact healthcare received within a westernized health care system that may not share the unique sensitivities of the Islamic culture. [14] Health care providers are able to better advocate for their patients when they have an awareness of the unique cultural beliefs and background of their patients and how to provide a safe and comfortable place for patients to openly participate in health care decision making. [15] To date, Islamic religion has been neglected in research on women's maternity needs and access to care although there are some exceptions. [16] Therefore, the aim of this study is to explore the Muslim women's maternity needs in Malaysia. It is important to explore the beliefs of practicing Muslim women in order to fully comprehend as well as meet the health care needs and expectations of this community.

METHODS

A purposive approach was used in recruiting the participants for in-depth interviews intended to collect information about maternity experiences from the perspective of Muslim women. The sample consisted of 20 Muslim women aged between 25 and 40 years who delivered at least one of their children in a hospital and are able to communicate in Malay language and are Malaysian citizens. A small sample size is common in qualitative research that depends on the concept of saturation to collect credible and trustworthy data. Saturation refers to the point at which a researcher is confident that no new data are emerging. Each potential participant was informed about the purpose of the study as well as their rights as participants and our obligations as researchers before agreeing to participate with the signing of the consent form. The interview protocol consisted of semi-structured open-ended questions about maternity health needs during their delivery in hospital. The duration of interview for each participant is approximately 60 minutes. The protocol also included questions about barriers to maternity health care services. Follow-up questions were posed to either clarify or explore further a participant's response.

The development of the interview guide for this study was conceived by a review of existing literature. In-depth interview was conducted among 20 female in 2015. The study participants were screened for eligibility following their responses to the invitation placed on social media. Those who met the inclusion criteria were informed about the purpose of the study the confidentiality of their answers. Those who fulfilled the inclusion criteria were interviewed by female research assistance who also facilitated our interview approach to the women. The protocol of this study was approved by the Ethics and Research Committee. Consent was obtained from all participants before the in-depth interview began. The questions asked during the interview were designed based on the literature review as presented in table 1.

Table 1: The main questions of the in-depth interview

No.	Question
1	Are you comfortable with the participation of both male and female health care providers during delivery? Why?
2	Are there any cultural practices that you need healthcare providers to be aware of in caring for you when you're giving birth?
3	What are the challenges you faced during delivery?
4	Can you tell me about your experiences in using health facilities during delivery?
5	How have your expectations been met or changed as a result of the care you have received?
6	What are the main aspects would you consider most important for the delivery of maternity care?

The data obtained were classified into various themes: feeling of embarrassment, women rights violation by nurses and doctors (scolded, angry, fuss face), medical students, feeling of guilt and regret, no kids any more, forbidden job for male, absence of government policy to maternity healthcare, willing to take risk to find female doctor, cost and private hospitals, and analyzed manually.

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RESULTS

Most of the female participants felt embarrassed to have been checked by male physician during vaginal delivery.

Feeling of embarrassment, regret and guilty

Most of the participants felt ashamed and guilty when they recalled their experiences because they did not have the option to choose female healthcare providers to facilitate their delivery. They understood that the shortage of the female physician was responsible, however, they also felt that the government especially ministry of health can do more to solve this very sensitive issue.

The following are personal accounts and narrations from the participants

One of them said:

"I am going to give birth to my 2nd child next year…I surely understand the shortage of doctor...but for the situation I already experienced, I just want to request for a female doctor…the nurses are already making fuss face over it…and more so the doctor….because of the pain being experienced in giving birth.. we just follow…but after we give birth, we feel so ashamed…coz the one who helped to deliver my baby is sister…but those who came inside to watch are nurses and 3-4 male and female doctors watching as if it was a charity run…I have a feeling of regret because actually this problem can be overcome but the authorities but they just see this issue as small matter and entertain it as unnecessary and non- issue to solve….I hope Allah will forgive me…"

Another said:

"Maternity doctor should be female doctor."

Haram men works as gynaecologist (The "prohibition" of men to work as gynaecologiats)

In terms of Islamic practices, one of them mentioned that to be a Gynaecologist is forbidden for male because women's "awrah" cannot be seen by any male except her husband.

One of them said:

"Among one of the 'Haram' [forbidden] work chosen by the male is being Gynaecologist. 'Haram' [forbidden] for male doctor to check the women vagina during the birth process, unless in the provisional condition whereas there is no female doctor."

Negative attitude in government hospitals

All women mentioned that the nature of communications with healthcare providers is important during delivery, such as, the behaviour of healthcare provider's and their attitudes towards women. Women also described the importance of staff spending time listening to their concerns, answering questions, providing options for care is very important to them specially when dealing with the subject of delivery and making decisions.

One of them narrated:

"In some government hospitals, if patient requests to be attended by a female doctor, she would likely be scolded, why should such a thing happen?"

Another woman

"My sister in-law had an embarrassing experience right before giving birth; when a male doctor came to check on her, she requested for a change to female doctor and the hospital staff were angry".

One study participant

"In 2009, I sought the hospital's permission to bring my husband along to labour room in a government hospital and they rejected my request….and even when I attempted to choosethe health workers that will attend to me, the tone of the staff talking to me changed negatively… I also had similar experience in the year 2007, being scolded when giving birth to my 2nd child …what we should do under these situations?"

The male doctor issue discourages us from having more children

A very serious consequence of having male doctors to attend to Muslim female during child birth has been observed. One participant narrated that she has no desire to have more children in the foreseeable future because of her bad experience with a male doctor during delivery, as she is not comfortable with male doctors.

"Of course I want more kids in the future…but may refuse to give birth anymore because I don't want to experience having male doctors putting their hands into my vagina…"

The absence of Government policy on female health and maternity issues

One of the most importantly expressed concern of the women was the rather nonchalant attitude or inaction by the Ministry of Health to put in place a favourable policy on women health and maternity problems. Some participants have suggested that the Ministry of health should be more proactive in this regard by making it a policy, the allocation of only female doctors to serve at the maternity wards of both the government and private hospitals.

One of the participants remarked:

"Why does the Ministry of Health not allocate only female doctors to serve at the maternity ward…is Malaysia facing shortage of female gynaecology doctors?"

Another participant also remarked

"Why doesn't Malaysia come up with laws making it mandatory for only female doctor to be placed at O&G?!...we know that Malaysia have lots of medical graduates & we have not become a failed country yet, whereas countries overseas still give priority to female doctor to handle O&G cases. We are a Muslim country...I'm really aggrieved because within one week I'm going to give birth...but there will be male doctor to attend to me even if I request for female doctor. Also, I'm going to give birth at government hospital because we cannot afford a private one."

Another participant also remarked:

"In my opinion, this matter can be resolved if only our government become more concerned and alert about this issue. For example, to encourage and train more female staff on maternity related issues. The problem is that I did not see that the maternity problems which we face becoming matter of public concern in this country. This unfortunately is the circumstance when the government separate politics from the religion."

One of them said:

"It appears we don't have the choice of who should look at our 'aurat' since it can be seen so easily by non 'muharam"….for example if we want to give birth at government hospital…do we have the choice of who is going to attend to us during childbirth?…sometimes students on clinical practice also join…just imagine at that time more than one student can see our 'aurat'…It is only the government that can change all this… they should put in place the guideline for only women professionals to be serving at the maternity hall."

Willing to take risk to find female doctor

Some of the participants mentioned that they are willing to travel for hours to find a female doctor to facilitate in their delivery rather than going to government hospital and be checked by male doctors while few female medical students watch.

One of them said:

"After having my first child I feel that 'that's it'… I will have no more delivery in government hospital...instead, I will try to find a Muslim centre to give birth the next time. Now we have 6 kids already and I live in Melaka. I gave birth to the last two kids, one in Nilai and the other in Kuala lumpur respectively, because in Melaka, we don't have a Muslim centre to give birth. Even the private hospitals cannot guarantee that we would be taken care of by the women professionals during childbirth. For our fifth child, after the water bag (referring to the amniotic fluid) has broken, we travelled to Nilai for one hour and 3 minutes. For the 6th child, I had an opening of about 5cm (referring to vaginal opening) when I met the doctor in KL, we knew it was dangerous but were determined to go through it with our prayers to Allah."

Respect for Muslim choices in other countries

Another important theme extracted from the participant's interview is that in other countries, when a Muslim woman come to the ward to deliver, the hospital authorities call for the attention of female doctors and female nurses to deliver the woman's baby. Some of them mentioned that we are from a Muslim country and we should therefore follow and practice the Islamic values in all our aspects of life.

One of them said:

"I have read one article about the experiences of a woman giving birth oversea...but cannot recall which country it is…when the doctor see the patient wearing the hijab, he instantly called a female doctor and female nurse to take over to deliver of the woman's baby."

One of the participants said:

"Malaysia is an Islamic country…why has the government not put a restriction that only female doctors should handle cases during childbirth?….It is by far easier for women to take care of women's 'aurat'."

Another woman said:

"The Western people can do it but Malaysia cannot...Subhanallah…the bad experiences of giving birth is really unforgettable."

Cost and private hospitals

Another theme was the cost and private hospitalization. Most of the participants mentioned that if they have enough money they will deliver their babies at private hospitals. The flexibility of the private hospitals and caring for the needs of the patients make it their best choice,

However, the prohibitive costs involved is the main problem for most of the participants.

One of them said:

"I was blessed with a caring husband that is also concerned about this issue, every time I go for my check up at the clinic, he always advise me not to allow myself to be checked by a male doctor. Further, because of my numerous medical problems I have to be careful while being checked. As I can only give birth by caesarean section, my husband is willing to save money to find a suitable hospital that provides all female staff services, including staff at the operation theatre…thank you My Love."

Another woman said:

"Last time I worked as a clerk. But when giving birth, my intention was for my baby to be attended by a female doctor...Alhamdulillah, Allah made it easy for me to give birth at a private hospital because at the government hospital, there was no guarantee that our baby will be attended by female doctor."

One of the participants said:

"If I have the opportunity to go to a private hospital, we can ask for female doctor...but if we are unable, it, is very tough at the government hospital to even request for female doctor, hundreds of excuses will be given."

Another woman said:

"In 1987, I gave birth in a government hospital…it was a male doctor who attended to me ….at that time I was so embarrassed and we has less money for a private hospital. After that delivery, our second child, now 6….Alhamdulillah got a female doctor and midwifes also female to attend to me"

Nurse issues

Another issue is the attitude of the healthcare works in the government hospitals, one of the participants mentioned that some nurses purposely asked the patient to take off all the clothes and be naked without any justification or consent.

The participants said

"Some nurses purposely direct the patients to take off all their clothes and be naked…already we are in pain, it is a very inconsiderate action to do at that time, although the nurse is female, it is a lesson to all the patients who're going to give birth….It doesn't matter how much pain we are struggling with…please try to defend your rights…because there is no rationale at all to force us to be totally naked."

Issues with teaching hospitals

Many male medical students surround the patients during labour, all the participants complained and they are not happy with this practice.

One of them said:

"Sometimes mother's that are about to give birth become an experimental item to them (medical students) and being surrounded by them for the reason of learning is a regular occurrence in the government hospitals…this happened to my sister's friend."

Another woman added:

"When we were in the middle of giving birth…we had lots of male doctor trainee and they were there till we finished everything because they wanted to learn."

Another participant said:

"My friend narrated to me her experience with a male doctor who was attending to women and seeing the women's 'aurat' while giving birth., when this practical doctor come to check on her pregnancy, 6 other male doctors came and surrounded her and wanted to see her 'aurat'. My friend felt very embarrassed and wanted to cry, where is our right as patients in this situation?"

"This is my experience when my wife gave birth at the government hospital...while waiting for the delivery, two male doctors came to do the check-up..I asked why since I have requested for female doctor to attend to the delivery but the staff told me that it depends on which doctor is on duty and we have more

male doctors...why not make it compulsory for female doctors only at maternity...this is a Muslim country right…those giving birth are women…I need your explanation"

"I already gave birth to two kids…my husband always prefer female doctor to deliver our baby…but will sometimes have male doctor together with a female doctor while she's doing the check-up…..how do we handle this situation?...I become embarrassed…thank you"

DISCUSSION

In this study most of the participants felt embarrassed for being checked by male physician during vaginal delivery. Similar study reported that all participants expressed a strong preference for having a female attendant to care for them during their labor and delivery. Most agreed that having a male physician was acceptable only if there was no other option. This option, however, made them feel ''bad'' and ''uncomfortable.'' All women strongly preferred having a female attendant at their delivery. A study from Bangladesh has shown that while planning for birth, potential complications appear to be more common. This is because barriers still exist for women such as women hesitating to seek services at formal health facilities since they fear that a male provider may ultimately attend the birth. According to the participants, this is culturally unacceptable. [17] Arab Muslim women reported that the embarrassing sensitive nature of vaginal examination for women by health providers is particularly true and not accepted. Vaginal examination is a very sensitive subject to communicate, women prefer female providers and do not accept exposing parts of their bodies unnecessarily. [18, 19] In a study conducted in Palestine, It was reported that despite the conservative Palestinian Muslim culture, feeling embarrassed seems to be of less importance for Palestinian women compared to reports from other countries. [18, 20, 21] Feeling of embarrassment may have received less attention from Palestinian women compared to their feeling of pain, discomforts and other experiences during their vaginal examination. Furthermore, the active busy event of childbirth that assumed to have a happy end may distract these women from feelings embarrassed compared to the vaginal examination if conducted for gynecological purposes. [21] Not only do Muslim women prefer female providers, there is evidence that women from western cultures also prefer female providers. [22]

Not only do the women find this matter embarrassing, their husbands also felt the same way. Kululanga et al., 2012. [23], reported that men were asked to describe negative incidents that they encountered during labour and childbirth process. Commonly, all the men stated that they felt uncomfortable and somehow distressed during some of the routine procedures undertaken during their partner's labour and birth, particularly the vaginal examinations. While the men realized that these were necessary to assess the progress of labour, they nonetheless felt ashamed and embarrassed. [23]

If Muslim females prefer to have a female health care provider and do not feel comfortable with a male health care provider, their access to qualitative health care may be diminished due to perceived barriers from the patients' perspective. On the other hand, if one is sensitive to the special needs of the Muslim female patient and a female health care provider is chosen, the patient will be more comfortable, be more likely to access further medical treatments, and may yield better treatment outcomes. Women's right to information is protected by the basic human rights conventions. [22]

Hospitals would be more responsive to the needs of Muslim women if procedures were put in place to ensure that a female obstetrician, physician, midwife or medical student were routinely available. Moreover, a procedure would be in place to ensure that women were informed that these options were available to them.

In general, the literature on caring for Muslim patients identifies the importance of covering the body in order to maintain modesty during procedures and examinations, the need to avoid touch between male healthcare workers and female Muslim patients, and expectations of gender separation in some settings. [7, 24, 25, 26] The need to protect modesty and dignity in the healthcare encounter arises from the religious requirement to preserve chastity and purity. Hijab, literary meaning separation, is the Islamic value that underpins expectations of gender specific caring and gender separation as interpreted through a cultural lens.

In Islam, chastity is a fundamental value for both genders. Sexual relationships outside marriage are prohibited, and the need to protect 'awrah' (i.e. parts of the body to be covered) is of vital importance. For a

man, 'awrah' includes the parts of the body from the navel to the knee, whereas a woman must cover all the parts of her body except her hands and face. There is no religious or cultural requirement for gender separation in all caring encounters. Patient expectations of gender-based caring depend on the degree of conservatism within their culture. Gender-specific caring is more important in maternity or gynecological care. [8, 24] Cultural values with regard to gender have an impact on caring interactions and the use of touch. Islamic teachings restrict or prohibit touching between unrelated males and females in order to prevent immoral behavior. However, this does not preclude physical contact when there is justification and need. [8, 24] It is a basic human right that pregnancy be made safe for all women. [1] Islamic beliefs and practices raise important issues in relation to the provision of health services, including maternity care. Retaining privacy is a particularly important concern for Muslim parents when they are in hospital, during childbirth and in the immediate postnatal period. The absence of privacy can cause embarrassment and discomfort for both mothers and fathers alike.

In our study, Participants reported that it was important that their attending physician is familiar with and respected their health-related cultural and religious beliefs, practices and sensitivities. Women are expected to experience pain during labour and delivery; however, they also expected to receive culturally appropriate interventions to help them control and manage their pain and discomfort.

Pregnant women have the expectations that their nurse/s would support them during labor by making them comfortable, keeping them calm, providing reassurances that everything would be well and fine, and providing assistance with breathing and relaxation techniques. [27, 28] They expected their nurse/s to periodically keep them updated about the progress of their labour. They also believe that they could ask questions without the feeling of being a nuisance to the nurse/s. Prior to going into labour, women expected that the nurse/s would "Focus on me, my needs, and what experiences I want". [28] Women expected to have the continuous presence of the nurse during labour and believed that the nurse would leave the bedside only to notify the physician of labour progress. Before the onset of labour, women expected that the nurse would provide direct care activities during labour, including monitoring of labour progress, maternal physical status, and foetal status. They also expected the nurse to perform technical nursing tasks such as starting the Intravenous therapies, doing vaginal examinations, and responding to emergency situations professionally. [28]

The demonstration of caring and provision of emotional support to laboring women were recurrent themes of the reviewed studies. Perceptions of emotional support included the caregiver being friendly, open and gentle, communicating a warm positive regard for the labouring woman, and being able to convey a sense of security and tranquillity. [29, 30] Words of encouragement and positive affirmations promoted a sense of caring and helped protect the woman's self-esteem.

This sense of "being cared for" allowed the woman to feel free to be herself during labour. One woman described her feelings as follows: "This connection was very natural, and that was very important for me, to be able to be completely myself and not having to put up some kind of front"

A friendly, relaxed atmosphere and the nurse's "positive mental attitude" seemed to set the tone for the nurse-patient encounter. [28, 31] It was important that the nurse was cheerful, positive, and trustworthy, as well as understanding and considerate. "All her conduct was very kind, she listened to you. She answered questions, for example, from my husband regarding things that he found odd". [31] The manner in which the nurse communicated with the labouring woman influenced the mother's perceptions of support.

In contrast, Fowles, 1998 [32], reported that women who perceived their nurses as negative or uncaring tended to have more negative perceptions of the labour experience. Chen et al., 2001 [33], reported that nurses who were perceived as unhelpful by women in labour failed to (a) provide emotional support, (b) promote comfort, (c) provide correct or adequate information, or (d) perform technical duties.

Women valued information, explanations, advice, and individualized nursing care while in labor. [34] Personalized information from the nurse was important during all stages of labour, especially prior to the performance of procedures. [30] Some women reported feeling frustrated during labor due to a lack of information about what was happening to them. [32]

Advocacy was an important aspect of perceived labour support. One mother described the essence of advocacy: "The nurses are supportive of what you want, who you are, and how you want to do things". [27] Women reported they wanted to have real options from which to choose, including the location of the birth and designation of their birth companions.27 During labour, women were very sensitive to sources of conflict and needed to be involved in decision making. Mothers appreciated when the nurse timed required interventions to accommodate the women's needs and wishes. [27, 34]

Lack of privacy is another concern raised by the participants. Participants reported that women are not comfortable when they expose their genitals to be examined by health professionals. They are particularly uncomfortable and feel embarrassed with vaginal examination**.** The increased number of health care providers attending the labour also makes the labouring mother embarrassed. When eight or ten professionals come around, it is difficult for labouring mother. They are not comfortable to expose their genitalia when such number of professionals are around and particularly when exposed for repeated vaginal examination. [35]

There are many strength for this study. The study is a qualitative one conducted through In-depth interview, intended to explore deeply, the feelings and sensitivities of pregnant mothers and their expressed encounters and experiences with maternity healthcare provisions. This is a very important and sensitive issue particularly affecting pregnant Muslim women due to cultural and religious peculiarities. Another important strength is that this is the first study conducted in this country focusing on Muslim women's needs during delivery. However, the limitation of this study is the exclusion of participants who are in villages or not reachable during the study

CONCLUSION

All participants mentioned that the importance of practicing the Islamic values in all our aspects of life, particularly when dealing with delivery. Most of them felt embarrassed for being checked by male physician during vaginal delivery and they also felt embarrassment and guilty recalling their experiences because they did not have the option to choose female healthcare providers to facilitate their delivery. All women mentioned that the nature of communications such as spending time listening to their concerns, answering questions, providing options for care is very important to them especially when dealing with decision on delivery.

Recommendation

This study suggests that promoting social impact value in health care delivery and practices through the establishment of the pink wing model is highly and urgently needed. These pink wards are exclusively meant to cater issues related to social and Islamic value practices and to be pursued by all government and private hospitals for women during delivery. Ultimately, this study also proposes that only female healthcare professionals be made in-house attendants to render their healthcare services for women on maternity. Further national quantitative study is needed to examine the finding of this study.

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