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Middle Eastern Muslim women: Beliefs, behaviors, and expectations during childbirth

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The University of Arizona, 1990
MIDDLE EASTERN MUSLIM WOMEN: 
BELIEFS, BEHAVIORS, AND EXPECTATIONS 
DURING CHILDBIRTH

by

Anna O'Bannon Guerra

A Thesis Submitted to the Faculty of the 
COLLEGE OF NURSING 
In Partial Fulfillment of the Requirements 
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1990
STATEMENT BY THE AUTHOR

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APPROVAL BY THESIS DIRECTOR

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3 December 1990
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ABSTRACT

The purpose of this study was to identify and describe the beliefs, behaviors and expectations of immigrant Middle Eastern Muslim women during childbirth in Western health care systems. Ethnographic methods of personal narratives, semi-structured interviews, and field notes were used with a purposeful sample of seven informants. The informants represented diverse ethnic backgrounds from the countries of Egypt, Iraq, Kuwait, Palestine-Lebanon, and Saudi Arabia. The multiparous women were students or wives of students from a southwestern university. Five informants compared their Western birth experiences with births in their home country. Religious and cultural beliefs influenced the numerous behaviors and expectations identified during phases of childbirth: early labor, active labor, delivery, and post-delivery. The informants shared reasons for not attending childbirth classes, methods to increase labor, preferences for labor without intervention, rituals at birth, specific expectations of the nurses, and others. Recommendations for culturally and religiously congruent nursing care were offered.
CHAPTER I
INTRODUCTION

An increasing number of immigrant Middle Eastern Muslim women are presenting themselves in the midst of childbirth at hospitals across the United States. Maternity nurses in the Western health care system state that an inadequate knowledge base exists regarding the Middle East culture and the Islam religion. Additionally, nurses admit that difficulties often emerge when providing care for the Middle Eastern Muslim patient, newborn, and others involved in the childbirth event. The purpose of this nursing research study is to identify and describe the beliefs, behaviors and expectations of immigrant Middle Eastern Muslim women during childbirth in a Western health care system, from an emic point of view.

Background of Problem

Quality nursing care in the United States is generally equated with providing the same type of care for all patients. Cultural and religious practices which appear foreign to the dominant Western health care system are often excluded. Several studies (Lipson & Meleis, 1983; Luna, 1989; Meleis, 1981; Meleis & Jonsen, 1983; Meleis & Sorrell, 1981; Reizian & Meleis, 1987; Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989) concur that misunderstandings between nurses and Middle Eastern Muslim patients, regarding the significance of particular beliefs, behaviors, and expectations, are directly related to a deficit in the nursing knowledge base.
I have observed maternity nurses’ confusion, agitation, hostility, and even refusal to care for Middle Eastern Muslim patients and their newborns. A change of shift report included the following information regarding a seventeen year old patient who had delivered a firstborn son ten hours prior:

She does what her mother-in-law tells her to do, instead of following my instructions. She is not bonding with her newborn son. Her mother-in-law cares for the baby while she just lays in bed. She claims she needs to rest and refuses to shower. She rejected the breakfast and lunch trays. But, when her mother-in-law brought food from home, she sat on the floor and ate with her fingers. Her husband and his friends have been laughing and talking in another room, like they don’t even care about her. I don’t understand her or her family; and, I will refuse to take her as a patient if she is still here tomorrow!

I established a rapport with this family, utilizing a limited knowledge base gained while living in the Middle East many years ago. However, I discovered that what I knew was not enough to provide culturally and religiously congruent nursing care.

This discovery generated an ethnographic pilot study of three Middle Eastern Muslim women’s perceptions of the puerperal period (Guerra, 1989). Informants in this study confirmed that their beliefs, behaviors, and expectations were commonly misunderstood or even disregarded by the nurses caring for them. The study revealed that the women’s roles as
a wife, daughter, daughter-in-law, and new mother were structured by both tacit and explicit beliefs. Desirable and undesirable behaviors were described by the informants within the cultural and religious boundaries of each role. The informants agreed that their behavior, as well as other individuals' behaviors, had a direct impact on the health of the new mother and newborn. Additionally, they recognized that these behaviors determined how they were perceived as fulfilling their respective roles by members of the culture and religion. Therefore, the informants' expectations of how nurses respond to their behavior and provide care cognizant of their beliefs is crucial.

Review of the nursing literature revealed limited research on Middle Eastern Muslim women who seek care in a Western health care system. Although some nursing research examined this ethnic group during the postpartum period, the information regarding women's beliefs, behaviors, and expectations during childbirth was negligible and superficial.

This may be attributed to the fact that Middle Eastern Muslim women, stereotyped by ethnocentric attitudes which are not research based, are misunderstood by the nursing profession in the Western health care system. Since an immigrant status is considered a temporary one, it is highly probable that these women will maintain their cultural and religious beliefs, behaviors, and expectations while seeking care in the unfamiliar Western health care system. Therefore, identification of undiscovered beliefs, behaviors, and expectations during childbirth is needed to provide culturally and religiously congruent nursing care.
Statement of Problem

Consequences of an inadequate research base regarding immigrant Middle Eastern Muslim women are related: (a) Maternity nurses in Western health care systems admit that difficulties emerge when providing care, and (b) the women perceive the care as culturally and religiously incongruent with their beliefs, behaviors and expectations.

Statement of Purpose

The purpose of this research study was to identify and describe the beliefs, behaviors and expectations of immigrant Middle Eastern Muslim women who have given birth in a Western health care system, from an emic point of view.

Research Questions

The following research questions regarding immigrant Middle Eastern Muslim women who received nursing care during childbirth in a Western health care system were raised:

1. What words and phrases did the women use to describe their childbirth experience?
2. What tacit and explicit beliefs provided cultural and/or religious meaning for the women?
3. How did the women describe their behaviors and the behaviors of individuals present during the childbirth experience?
4. What expectations or ascribed roles did the women identify for themselves, other individuals, and nurses who provided care during the childbirth experience?
Definitions of Terms

Definitions of words and phrases, relevant to this study, provide clarification.

Immigrant Middle Eastern Muslim Woman

Any female individual who claims ethnic affiliation with a country in the Middle East, professes belief in the Islam religion, and has migrated to the United States with the intent of temporary residence is considered an immigrant Middle Eastern Muslim woman.

Western Health Care System

The Western health care system is the predominant biomedical system utilized in the United States and is concerned with providing scientific diagnoses of multiple health-illness symptoms for medically based prevention and treatment of human individuals (Lipson & Meleis, 1983; Meleis, 1981; Shiloh, 1968).

Childbirth

Childbirth encompasses the time period beginning with the onset of labor (early labor), continues through all stages of labor (active labor), includes delivery of the newborn and expulsion of the placenta (delivery), and concludes four hours following the delivery (post-delivery).

Emic Point of View

The identification and description of meanings for particular beliefs, behaviors, and expectations of the specific cultural-religious group are derived from the informant’s perception and words, as opposed to the nurse’s ethnocentric perspective (Aamodt, 1989; Field & Morse, 1985; Kay, 1982).
Conceptual Framework

Guerra’s Conceptual Model of Nursing (see Figure 1) guided this research study. The philosophy of this model is based on the assumption that the nursing metaparadigm concepts interact and are interdependent. The concepts of person, environment, health and nursing, are viewed in a past, present and future status of dynamic and continuous change (Hultsch & Deutsch, 1981). A nurse needs to evaluate each concept within its context, at a given time. The concepts are continually changing as the person develops, the environment changes, and the perception of health and practices are adjusted. This is especially important when the person is removed from their cultural environment, such as an immigrant who is temporarily residing in the United States. The nurse interacts with the person, and the interaction is reciprocal. This model is an “original conceptualization of nursing” (Flaskerud, 1983, p. 225) and integrates portions of nursing frameworks and models by Kay (1982), Leininger (1985), Reed (1987), Schlotfeldt (1987) and Wiedenbach (1964).

Definitions of Nursing Metaparadigm

Concept of Person

The concept of person refers to any individual, family, group, or community and is classified as a biological, psychological, sociological, cultural, and spiritual entity (Schlotfeldt, 1987; Leininger, 1985). The person “. . . cannot be understood by analyzing the parts without an understanding of the whole” (Reed, 1987, p. 37). The person’s patterns of beliefs, behaviors, and expectations are influenced by the dynamics of time and the environment (Leininger, 1985).
Figure 1. Guerra’s Conceptual Model of Nursing.
Concept of Environment

The environment is a very influential concept in this model and consists of a variety of variables. These variables determine how the person will subsequently perceive their health status and delivery of nursing care. The economic, educational, ethnic, family, historical, physical, political, social, and religious variables within the environment are influential factors in the formation of and changes in the person’s bio-psycho-socio-cultural-spiritual patterns (Kay, 1982; Leininger, 1985; Reed, 1987). Therefore, the diversity of and changes within the environment directly affect the person’s perception of health.

Concept of Health

The concept of health is perceived differently by each person, at different points in time, related to the context in which it is viewed (Schlotfeldt, 1988; Leininger, 1985). The person’s “perception of illness and health and the behaviors associated with these states are culturally influenced” (Auvenshine & Enriquez, 1986, p. 70). Health is a dynamic process that is not a single point on a continuum but occurs in varying degrees over a period of time. Health is also dependent upon the person’s environment and recognition of effective health care practices, which may include a bio-medical health care model and/or folk model systems (Kay, 1982; Leininger, 1985; Reed, 1987). For this reason, the nurse’s perception of the person’s health status may differ from the person’s self-perception of health status.
Concept of Nursing

The final concept of nursing is defined as the reciprocal interaction, both verbal and nonverbal, between the person and the professional nurse. The practice of nursing is dependent upon an empirical and theoretical foundation obtained from a liberal education (Reed, 1987) and contextual learning (Bevis & Clayton, 1988). Therefore, nursing is considered both an art and a science (Wiedenbach, 1964). Nursing involves the integration of teaching, service, and research which is projected in practice through the processes of comprehensive caring, professional judgement, and ethical leadership. Professional nursing is provided when the integration of person, environment and health is considered holistically, rather than as separate, unrelated variables.

Application of Conceptual Framework

Middle Eastern Muslim women’s childbirth experiences, which occur in the Western health care system, involve environments different from their home country and preferred health care system. These experiences are perceived differently by the women and the nurses caring for them. The interrelated concepts of person, environment, health, and nursing in Guerra’s Conceptual Model of Nursing encourage a holistic approach to describe and identify the beliefs, behaviors, and expectations of Middle Eastern Muslim women during the childbirth experience. Therefore, the application of this conceptual framework meets the stated purpose of this study and guides the provision of culturally and religiously congruent nursing care for these women, from the Middle Eastern Muslim women’s point of view.
Significance of Problem

The increasing numbers of immigrants to the United States from Middle Eastern countries who profess a faith in the Islam religion are individuals who deserve congruent nursing care within the Western health care system. The provision of this nursing care is dependent upon the profession's astute recognition of each individual's right to cultural and religious beliefs which guide their patterns of behavior. Development of a firm nursing knowledge base, sensitive to cultural and religious beliefs, behaviors, and expectations, is essential to provide congruent nursing care with a minimum of disruption. (Lipson & Meleis, 1989; Lipson & Meleis, 1983)

Middle Eastern Immigrants in the United States

Middle Easterners have immigrated to the United States to avoid political unrest in their country, escape from the ravages of war, enroll in higher education programs, or advance in their profession. This has been brought to the attention of nursing professionals providing care in Western health care systems during the last quarter of this century. (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989; Lipson & Meleis, 1989; Lipson & Meleis, 1983; Meleis, 1981).

Determination of the exact number of individuals who have immigrated to the United States is difficult because many move frequently or are here without legal visas and are not counted. The 1980 United States Census data revealed a scant 17% who reported Middle Eastern ethnicity on the long form. Estimates of the population, reported by embassies and leaders of communities where a majority of the immigrants
reside, contradict the numbers represented by the Census (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989; Lipson & Meleis, 1989; Lipson & Meleis, 1983).

The 1980 Census report included 223,000 Middle Eastern ethnic individuals who filled out the long form. A total of 71% of these individuals were between the ages of 15 - 44 years old, considered within the childbearing age. It should be noted that the short form included Middle Easterners under the category “White.” This may be the reason many individuals were not counted (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989). Arab consulates estimated a more realistic population of between 2 and 3 million immigrants, plus an undetermined number of immigrants from Cyprus, Turkey, Israel, Oman, Qatar, and Iran (Lipson & Meleis, 1983; Reizian & Meleis, 1986, Reizian & Meleis, 1987).

Analysis was performed on a composite listing of international students enrolled for the 1990 spring semester at a major southwestern university, “rated as 8th in the nation in international student population” (D. Martin, personal communication, March 7, 1990). A total of 464 students, from seventeen Middle East countries, represented 22% of the total international student population. The most numerous population of students listed their country of ethnicity as Saudi Arabia (71), Lebanon (66), Iran (52), Jordan (32), and Oman (31). Those who indicated they were married and in the childbearing age bracket accounted for 10% of the Middle Eastern population. An additional 5% did not indicate any marital status, but listed their address in married student housing.
It is obvious from these data, both estimated and confirmed, that the influx of Middle Eastern immigrants is significant. Their presence in the United States increases the probability that they will be seeking attention from the Western health care system. Therefore, a firm nursing knowledge base is essential to plan and provide care that is congruent with their cultural background.

**Existing Nursing Research and Practice**

Nursing literature which examines childbirth from the immigrant Middle Eastern Muslim woman’s emic point of view is negligible. However, literature does exist which conveys Middle Eastern patients’ expectations of Western health care professionals and identifies nursing professionals’ confusion concerning approaches to patient demands which are incongruent with the system. (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989; Lipson & Meleis, 1989; Lipson & Meleis, 1983; Luna, 1989; Meleis, 1981).

An ethnographic pilot study (Guerra, 1989) of three immigrant Middle Eastern Muslim women’s perceptions during the puerperal period verified the previously mentioned findings. The informants confirmed that their beliefs, behaviors, and expectations were commonly misunderstood or even disregarded by the nurses caring for them. Their tacit and explicit beliefs provided structure for their cultural and religious roles, directed desirable behavior, and guided their expectations during the puerperal period. Perhaps this is the reason why Western health care providers who attempt to link Middle Eastern behaviors to a physiological cause are ineffective in meeting patient expectations.
In order to understand the nature of the health needs of immigrant women, it is imperative to examine the unique roles they enact" (Meleis & Rogers, 1987, p. 206). Meleis & Rogers suggested that Middle Eastern women are often viewed in a negative way by the Western health care system. This is related to nurses’ misconception of the roles they are expected to assume as members of the culture and religion. Certain nursing interventions for Middle Eastern patients are often made in response to their behavior without regard to the underlying cause.

An example of this was noted in the pilot study by Guerra (1989). All of the informants revealed that the new mother’s role is structured by the tacit belief that she is highly vulnerable to misfortune at this time. She should protect herself with the expected behavior of resting seven to forty days, varying by country. The mother-in-law’s role during this time is structured by the explicit belief that she is older and in control of her family, which includes her daughter-in-law. She is expected to provide total care for the newborn and instruct the new mother in the care to be given. This was, and often is, perceived by nurses as the new mother’s failure to bond with her newborn. Nurses are known to respond to “failure to bond” by sitting in a chair while insisting that the mother hold, change, and talk to her newborn. If unsuccessful, she might refer the mother to social services. Any of these Western health care policies and procedures which attempt to address a behavior without regard to the underlying beliefs or expectations could be extremely detrimental to a Middle Eastern family.
Meleis & Rogers (1987) recognized that understanding the roles of Middle Eastern women also involves examination of the religious values within the cultural context. Faruqi (1979) supported the idea that religion is inseparable from a culture’s history and traditions and thereby has potent effects on an individual’s behavior. Since many individuals from the Middle East are faithful followers of Islam, understanding the meaning and direction it provides in their lives is important to provide religiously congruent nursing care. Although Islam emerged in the seventh century A.D. and has existed along with Christianity and Judaism, it is the most misunderstood of the major religions of the world (Faruqi, 1979). This fact is represented by nurses’ acknowledgement of an extremely limited or nonexistent knowledge base about the Islam religion, as well as the meager amount of inquiry devoted to the religion in nursing research. The inclusion of the impact of Islamic beliefs on childbirth is, therefore, warranted to establish a nursing knowledge base which will direct religiously congruent nursing care.

**Summary**

The current provision of care, by nurses with best intentions for meeting the needs of immigrant Middle Eastern Muslim women, is appropriate by Western health care policies and procedures. However, patients and family members are responding to the care with confusion and dissatisfaction because nurses misinterpret their behaviors and utilize interventions which are incongruent with their expectations. The overwhelming frustration is felt by all: the nurse, the patient, and the family members present.
With an increasing number of immigrant Middle Eastern Muslim women presenting themselves in the midst of childbirth at hospitals across the United States, justification for further research to scrutinize the meaning of beliefs, behaviors, and expectations are profound. With the establishment of a research guided knowledge base, professional nurses will be enabled to provide culturally and religiously congruent nursing care, sensitive to the beliefs, behaviors, and expectations of Middle Eastern Muslim women.
CHAPTER II
REVIEW OF THE LITERATURE

A review of the literature is presented in this chapter as background to understanding the Islam religion and the diversity of the Middle East. Muslims' and Middle Easterners' perceptions of health care are discussed. Childbirth practices of Middle Eastern Muslim women in their home countries of the Middle East and in hospitals of the Western health care system are compared.

The Islam Religion

Islam is one of the world's three major religions which embrace a monotheistic doctrine, or the worship of one God as the Divine Creator. Muslims believe that God is the one and only Divine Being. The world was created by God for human beings to enjoy, prosper, and improve for the benefit of God. Of paramount importance is the belief that all humans are created equal in the sight of God. Therefore, there are no clergy in the Islam religion; every human has an equal right to intercede with God without a third person; and, no prejudice or distinction between race, sex, or social class exists. Muslims also believe that humans are not perfect, but they are born innocent and remain innocent until they commit an error in judgement. Therefore, a common thread among Muslims is that human nature is originally pure and that humans naturally strive to do good deeds, avoid evil, and obey God's laws. (Faruqi, 1979).
Early History of Islam

Muhammad the Prophet was born in 570 A.D., a member of the tribe of Quraysh, clan of Hashim, in the town of Mecca, Saudi Arabia. He began receiving revelations from God in 610 A.D. at the age of 40. On July 16, 622 A.D., Muhammad was forced to flee for Medina (250 miles north of Mecca). This is known as the Hijrah, or emigration flight to avoid persecution, and marks the beginning of Islam and the Islamic calendar. (Faruqi, 1979; Fernea & Bezirgan, 1988)

A story revealed in the Muslim’s Qur’an (Holy Book), indicated that Muhammad embarked on a night journey flight to heaven. The night flight to Heaven is known as Israh Mi’raj. Muhammad mounted a horse in Medina, which was provided for him by an angel, and flew through the air to Jerusalem. Jerusalem was the seat of Judaism and Christianity at this time, adding importance to the story for devout Muslims. He tied his steed to a large rock (now enclosed in the Dome of the Rock) near the Wailing Wall, and ascended to Heaven. He was joined in Paradise (the highest level of Heaven) by God and all the other prophets who preceded him, including Abraham, Moses, and Jesus. The Sura XVII (chapter of the Qur’an) explained that they all worshipped the One God and recognized Muhammad as the last Prophet. God directed Muhammad to establish salat (ritual prayer, five times a day). Before departing, Muhammad was taken on a tour of Janni (Heaven) and Nar (Hell). This enabled Muhammad to describe the next life for Muslims in Heaven, after their life on earth ends in death. (Carmody & Carmody, 1983; Faruqi, 1979)
The first Islamic war ensued between the people of Mecca and the converted Muslims of Medina. The outcome came with Mecca surrendering and most converting to Islam. Muhammad entered the *ka'bah*, a building where Abraham was believed to have first worshipped the monotheistic God. He destroyed the false idols on the altar and the holiest place in creation was reconsecrated. Muhammad instituted an Islamic state with laws and a constitution. He allowed those who wished to remain Jews and Christians to maintain their religious beliefs and traditions, with the Islamic state as their protectorate. Messengers were sent across northern Africa to the west, to the east through Persia and China, and to the west through southern Europe. Islam was widely accepted and continues to grow.

Islam began to experience fragmentation following Muhammad’s death in 632 A.D. Since Muhammad was not survived by any male heirs, two major sects of Islam developed: the Shi’a and the Sunni. Members of the Shi’a sect (Shi’is) were known as Islam’s loyalists because they favored Ali, Muhammad’s son-in-law married to Fatimah. The Shi’is considered the *Qur’an* explicit in direction and excluded practices followed prior to Muhammad’s revelations. Members of the Sunni sect (Sunnis) were known as traditionalists because they integrated pre-Islamic practices and traditions into the new religion revealed by Muhammad. In other words, the Shi’is and Sunnis interpreted the *Qur’an* and the *Hadith* (a Holy Book containing examples of the Prophet’s life) differently. This led to the eventual split in Islam (see Figure 2) which still exists.

(Carmody & Carmody, 1983, Faruqi, 1979; Ferdows, 1985)
Figure 2. Distribution of Shi’a and Sunni sects of Islam.

From U. S. Central Intelligence Agency Map Collection. February, 1984, Muslim Distribution, #701067 (A04019).
Islam’s Holy Books and Laws

The Qur’an

The Qur’an is the Holy Book containing the words of God which were revealed to the Prophet Muhammad in the Arabic language, between 610-632 A.D. The Prophet is considered the rasul (mouthpiece or messenger) of God, and not a part of God. The exact words of Allah (God) were revealed to the Prophet, transcribed verbatim in the kufie script (calligraphy), and passed down through the years in the original form. Followers of Islam are universally bound by the Qur’an.

The Qur’an contains over 100 sura (chapters), comprised of ayah (verses). The sura are preceded by Bismallah al Rahman al Rahim (Arabic for “In the Name of God, the Beneficent, the Merciful”). They are arranged in the order from longest to shortest in duration, not in the chronological order revealed to Muhammad. The Qur’an dictates five pillars of faith: shahadah, salat, zakat, siyan, and hajj. (Carmody & Carmody, 1983; Esposito, 1982; Faruqi, 1979; Ferdows, 1985)

The shahadah.

The shahadah is known as the witness or the profession of faith, which translates, “There is no God but Allah, and Muhammad is His Prophet.” Reciting the shahadah is the only requirement for becoming part of the Muslim community of faithful. Since there is no intermediary person, anyone can recite the profession of faith and accept that the revelations of the Qur’an came directly from the only God, Allah, through His last prophet, Muhammad. (Carmody & Carmody, 1983; Faruqi, 1979)
The salat.

Salat is the ritual worship or prayer which is performed five times a day: sunrise, noon, afternoon, sunset, and prior to retiring. The purpose of salat is to remember that God dominates an honorable Muslim’s thoughts, emotions, and actions. Prior to salat, Muslims must perform ablutions (ritual washing) to make themselves clean. The purpose of washing is a physical and symbolic preparation for communication with God. The Muslim always moves from right to left, and cleans the teeth, face, ears, neck, hands to the elbows, feet to the ankles, and wears clean clothes. A clean prayer rug is spread out on the ground, facing Mecca. Salat may be performed anywhere, because no ground is considered holy. The mosque is not considered consecrated but is available for worship of the community. Friday is the day Muslims will gather at the mosque, facing the niche in the wall called the mihrab (direction of Mecca), and be guided in salat by an imam (leader of worship). The imam must be capable of reciting the Qur’an perfectly while leading the faithful in their synchronized movements of bowing and genuflecting before Allah, in straight rows to symbolize the equality of humans in Allah’s eyes. (Carmody & Carmody, 1983; Faruqi, 1979)

The zakat.

Zakat (Arabic for sweetening) is the sharing of wealth with other members of the ummah (community). Since all Muslims are not born wealthy, it is important to give to others who are not as fortunate. This promotes a moral obligation for the members of the Muslim community. (Carmody & Carmody, 1983; Faruqi, 1979)
The siyam.

The Arabic word for fasting is siyam. This pillar of faith is performed by all adult Muslims during the holy month of Ramadan, the month in which the first revelations from God were revealed to the Prophet Muhammad. Ramadan is celebrated in honor of Muhammad’s self-discipline and devotion to God. All faithful Muslims abstain from food, water, and sex from sunrise to sunset. The purpose of this abstention is to develop an ability to resist the temptations of human nature and turn toward a religious and morally clean life. Women who are pregnant or breastfeeding are exempt from siyam. (Carmody & Carmody, 1983; Faruqi, 1979)

The hajj.

The pilgrimage to Mecca is known as hajj. It is undertaken only once in a lifetime by adult Muslims who wish to reconfirm their faith. Muslims begin their hajj by circling the ka‘bah (a black stone building) inside the mosque, in the center of Mecca. The ka‘bah is located on the spot known as omphalos (the navel), where Muslims believe the world was born. This point is also believed to be where Abraham built the first place of worship for a monotheistic God. Several rituals take place over a period of days, in what is considered the holiest place in creation. (Carmody & Carmody, 1983; Faruqi, 1979)
The Hadith

The Hadith represents a collection of the Prophet’s teachings and prophetic examples which guide Muslims’ lives. The sunna (stories) in the Hadith were transcribed by religious individuals in the 9th century A.D. and subjective bias is acknowledged. The sunna are considered al sahihah (verified, reliable support), hasan (good support), or daif (weak support). For this reason, a Muslim’s reference to a belief or behavior based on the Hadith may vary according to the verifiable support, importance, and interpretation of the sunna. Additionally, the different interpretations of the sunna by Shi’is and Sunnis result in different beliefs, behaviors and expectations in everyday life. (Carmody & Carmody, 1983; Esposito, 1982; Faruqi, 1979; and Ferdows, 1985; Fernea & Bezirgan, 1988)

The Shari’a

The Shari’a is the Islamic canon law which “governs the personal status of Muslims” (Ferdows, 1985, p.14), including marriage, divorce, and issues of inheritance. Individuals, the family, the community, and the world of faithful Muslims are guided by the laws located in the Shari’a. The Shari’a is comprised of laws which are arranged at five different levels, including obligatory, recommended, permitted, disapproved, and forbidden. The laws vary between geographic boundaries of countries and are based on the divine words of the Qur’an and the interpretation of the Hadith. (Carmody & Carmody, 1983; Esposito, 1982; Faruqi, 1979; Ferdows, 1985)
Islam’s Influence on Women

Many differences exist between the two major sects of Islam. However, modesty and bearing many children are both considered important to the Shi’a sect and Sunni sect. (Ferdows, 1985; Mahdavi, 1985)

Importance of Modesty

The Qur’an (Sura XXIV:31) explicitly outlined the proper behavior for a Muslim woman:

And tell the believing women to lower their gaze and be modest, and to display of their adornment only that which is apparent, and to draw their veils over their bosoms, and not to reveal their adornment save to their own husbands, or fathers or husband’s fathers, or their sons or their husband’s sons, or their brothers or their brother’s sons, or sister’s sons, or their women, or their slaves, or male attendants who lack vigour, or children who know naught of women’s nakedness. And let them not stamp their feet so as to reveal what they hide of their adornment. (Fernea & Bezirgan, 1988, p. 20)

The Qur’an (Sura XXXIII: 59) identified the type of behavior expected of a Muslim woman when she leaves her home:

Tell thy wives and thy daughters and the women of the believers to draw their cloaks close around them . . . . That will be better, that so they may be recognized and not annoyed. Allah is ever Forgiving, Merciful. (Fernea & Bezirgan, 1988, p. 25)
These *ayah* (verses) are used by the Sunnis and Shi’is to justify the need for women to be veiled (covered) in public or when they leave their houses. However, the extent to which this is followed is determined by the area where the women reside, whether urban or rural, and the diversity of ethnic groups (Bauer, 1985; Ferdows, 1985; Fernea, 1985). Reference to the term adornment (*zinah*) has been interpreted in a variety of ways: “... those that are self-evident and those that are hidden unless a woman displays them purposely” (Mahdavi, 1985).

Ironically, The veil was used prior to the birth of Islam, as a custom of people who lived in the general area extending from Greece to Persia (Ahmed, 1982; Beck & Keddie, 1978). The first record of veiling was noted in the 1st century A.D. in Palmyra, and continued with the Byzantine empire. It was viewed as being quite adaptable to Islam through interpretations of the *Qur'ān*, and became a part of what is now referred to as Islamic dress. Islamic dress varies by geographic region and includes one or more of the following: the veil covering the woman’s head (*hijab*), black shawl type of head scarf (*milayah*), a long cloak or dress (*abayah*), or a complete covering of fabric from head to toe with slits cut for the eyes (*chador*). The Muslim woman’s choice of dress is directly related to the cultural or traditional expectations of her community. In other words, proper dress for a Muslim woman is based on the interpretation of the words in the *Qur’ān*; but, the extent or style of dress chosen to protect a Muslim woman’s modesty is dependent upon the cultural expectations (Fernea, 1985).
The Bèdouin woman in Egypt (Abu-Lughod, 1988) perceived modesty as a means of denying her sexuality. This was exhibited by her behavior of silence or soft manner of speech, avoidance of laughter, deferral of eye contact, covering with the veil, resisting interaction with her husband in public, and general shyness. “The basis for a woman’s good reputation and her sense of self-worth is a respectability that centers on her modest behavior. . . . The best thing that can be said of her is that she has not been seen by men” (Abu-Lughod, 1988, p. 649).

In Iran (Bauer, 1985), modesty was perceived by how a woman presented her body in the presence of others. A woman’s hair was considered very stimulating and this necessitated covering it with a veil. The woman was also concerned with the manner of walking, sitting, and talking which did not attract attention. In other words, the woman’s morality was defined by her manner of dress, method of movement, and not being seen in the company of strangers or unrelated men (besides her husband, father-in-law, father, and her brothers). Of particular interest was that “more attention was given to what kinds of persons in whose presence one could display certain behaviors or uncover parts of the body than to understanding the processes of the body” (Bauer, 1985, p.123).

Mernissi (1975) and Abu-Lughod (1988) presented the fact that a woman who is post-menopausal is not required to veil. This is because she is no longer able to reproduce, is considered unattractive, and is sexually undesirable. This fact is supported by Sura LX:24 in the Qur’an.
Importance of Bearing Children

Pregnancy is considered very important for a Muslim woman's sense of identity. Bauer (1985) explained an Islamic belief: "Women were expected to reproduce. In fact, many men stated that a woman without children was like a fruit tree that had dried up without producing fruit - useless" (p. 122).

Morsy (1980) discovered that women in the small Egyptian village of FatiHa expressed a need for children and considered the children's births as a source of status and power within the family. In fact, the more children they had, the more status they acquired. Eickelman (1984) found that the women of Oman also perceived the birth of many children as being important to their social status. According to Friedl (1985), "children are inevitable, a part of the scheme of things, of God's order. Their presence is expected, 'normal,' their absence has to be explained" (p. 197).

As important as pregnancy is for the Muslim woman, pregnancy is evidence of the woman's sexual activity and reason for a loss of self control (Abu-Lughod, 1988).

Paradoxically, the children, who later secure a woman's position, initially make her more dependent on her husband, thus increasing his control: she is tied to him by her children, whom she would lose if she left through divorce or her own choice. (Abu-Lughod, 1988 p. 133)
Diversity of the Middle East

The geographic region referred to as the Middle East is an area consisting of seventeen countries, extending from Egypt to Iran and encompassing a distance of approximately 3,400 miles (see Figure 3). Progressing in a eastward direction around the Mediterranean Sea, the countries are: Egypt, Israel, Lebanon, Syria, Cyprus, Turkey, Iraq, Jordan, Saudi Arabia, Yemen Arab Republic and People’s Democratic Republic of Yemen (combined as one country in May, 1990), Oman, United Arab Emirates, Qatar, Bahrain, Kuwait (invaded by Iraq on August 2, 1990), Palestine (with undefined boundaries), and Iran (Hammond Universal World Atlas, 1990; Lipson & Meleis, 1983; Reizian & Meleis, 1986).

Being from the Middle East does not necessarily mean the individual is Arab. An Arab is a direct decedent from the Semitic race, the original inhabitants of the Arabian Peninsula. Individuals from Iran do not consider themselves Arab. They refer to themselves as Persian, and speak a different language known as Farsi. Assyrians and Armenians also consider themselves non-Arab, despite the fact that their language is Arabic. The Turks and the Kurds respectively speak Turkish and Kurdish, and consider themselves non-Arab. The Jewish state of Israel is populated predominantly by non-Arab individuals. Therefore, it is quite important to remember that individuals who claim Middle Eastern ethnicity are quite diverse, and acknowledgement of being from the Middle East does not necessarily mean the individual is an Arab. (Lipson & Meleis, 1983; Luna, 1989; Reizian & Meleis, 1986)
Figure 3. Geographic region of the Middle East.
From U. S. Central Intelligence Agency Map Collection. February, 1989. Middle East, #801298 (545530).
The Middle East countries are individualized by the diversity of traditions. However, certain similarities are attributed to most of the countries. The most influential part of all Middle Easterners' lives is the family affiliation and kinship ties. The oldest male is considered head of the family and lineage is patriarchal by design. Extended families are the norm and the family generally depends on the socioeconomic support of all members of the family. If the family does not live in the same house, they live close by. Arranged marriages are still common in some countries. This practice involves the formal agreement between father of the bride and father of the groom, with an emphasis on strengthening the family ties. One way of strengthening the family is through the arrangement of cousin marriages. The birth of male children, after the marriage is consummated, is desired. (Reizian & Meleis, 1986; Abu-Lughod, 1988)

According to Lipson & Meleis (1983), the Middle East countries place great emphasis on the aspect of trust. When Middle Easterners offer food or drink, this is a sign of their acceptance of an individual and the opportunity to develop trust. However, the proper behavior expected of the recipient is polite refusal of the first offering. Refusal allows the Middle Easterner to offer again, giving them status as a proper host. “Drinking coffee is the symbolic act that cements all ties . . . . To refuse to drink coffee with someone signals an active desire to cut existing ties with that person . . . or implies that one is unworthy of consideration.” (Eickelman, 1984, p. 71).
Health Care Perceptions

Perceptions of appropriate health care practices are influenced by the tenets of the Islam religion and the cultural (or traditional) beliefs of the diverse Middle East countries.

Perceptions Related to Islam

Rahman (1987) compared the different philosophies of the Sunni and Shi’α sects concerning medicine. Sunnis were encouraged to seek medical treatment, and even considered it a religious obligation. This was based on a Sunni Hadith where the Prophet said, “God prefers you to be in good health” (Rahman, 1987, p.48). The Shi’is (followers of Shi’α Islam) were encouraged to bear the discomfort and not seek medical attention until it became unbearable. According to the Shi’α interpretation of the Hadith, “A person who passes one night in the discomfort of illness earns greater merit than would be gained by worshipping God for one whole year” (Rahman, 1987, p. 37). However, both sects acknowledged the fact that a woman who died in childbirth is considered a martyr for Islam and is assured of going to Paradise.

This invokes the question raised in Islam concerning whether it is religiously proper to seek medical treatment, or resort to tawakkul (placing trust in God). Lipson & Meleis (1983) presented one recurrent Muslim belief: Whatever happens is the will of God. The Qur’αn states that every new life is predetermined by God at the minute the fetus is ensouled, believed to be approximately 120 days after conception. Despite the fact that God is aware of the predetermined plan, no human knows the plan or outcome.
Perceptions Related to the Middle East

Lipson & Meleis (1983) suggested that "... quality health care includes respect for the cultural values of a patient and that it is a health professional's responsibility to maintain a flexible approach to accommodate patients from varying backgrounds ... to improve rather than impede their care" (p. 859). The ethnic origin of individuals from the Middle East is quite diverse. To adequately care for these people in a Western health care setting, consideration of some of their traditional traits is necessary to plan congruent care.

Lipson & Meleis, (1983) discussed certain traits which are attributed to the Middle Eastern individual. An individual from the Middle East feels an intense need for affiliation with family and will depend on them anytime a life change occurs, such as illness, hospitalization, or childbirth. For this reason, a family member will often accompany the individual who is seeking health care. The individual will complain of loneliness if the family is not present for support. An innate mistrust of people outside the family inhibits the individual’s acceptance of help from an unrelated health professional. This is evident in the Middle Easterner’s attempt to learn more about the person caring for them, contrary to what a Western health professional is accustomed. The Middle Easterner’s need at this time is to be saturated with attention from the numerous family members and the health professional who is providing care. (Lipson & Meleis, 1983; Meleis & Jonsen, 1983)
Generally, Middle Easterners describe a health problem or situation in vague terms. This is somewhat related to the fact that they are not aware of the body’s parts and functions. Unfortunately, the word of the health professional is not questioned, as this would be a form of showing disrespect. The possibility of misdiagnosis or incomplete treatment exists if the professional does not attempt to learn more than is offered. It is important to remember that the Middle Easterners value their privacy. They will either not divulge the information of a personal nature, or provide an answer which they think is expected. When the health professional does establish a rapport with the Middle Easterner, the verbal interaction will become more amiable. (Lipson & Meleis, 1983; Meleis & Jonsen, 1983)

Middle Easterners attempt to appear better than the next person. Requesting the “best” person available to care for them is part of their desire for social status. In fact, members of the family will demand it. This demanding character shows they care deeply, and is not considered a negative trait by Middle Eastern standards.

According to Lipson & Meleis (1983), Middle Easterners do not seek preventive health care. They prefer injections over oral medications, and larger pills over smaller ones. A genuine fear of being admitted to the hospital is a great concern. This concern is related to the belief that the Western health professional is unable to follow the religious and traditional customs, including proper bathing, keeping the body covered, and burial in the case of death. The Islamic belief is to bury the body in the earth without an autopsy or process of embalming.
Childbirth for Middle Eastern Muslim Women

Pregnancy and the birth of many children were supported by the literature as being very important for Middle Eastern Muslim women. However, literature which explored the behaviors and expectations during the birth of a child, by Middle Eastern Muslim women, is negligible.

Childbirth in Middle Eastern Countries

Childbirth was portrayed as a predominantly female occasion and a normal event in the life of a woman residing in a Middle Eastern country. Eickelman (1984) learned that motherhood was the woman’s most honored position in the country of Oman. The woman’s ability to have many children, especially sons, increased her social status. The women of Oman stressed the value of the children, despite a high infant mortality rate and deterioration of maternal health due to frequent pregnancies.

Friedl (1985) reported that Iranians believe a pregnancy with a daughter is more difficult than one with a boy. However, the birth of the daughter is easier. The birth of any child brings a warning to not become too attached. This is because a newborn is vulnerable and may die.

Childbirth in an Egyptian village (Abu-Lughod, 1988) involved a network of women who supported each other during the delivery. The relationship between a woman and her mother was close and interdependent at this time. The man, on the other hand, stayed “as far away as possible” (Abu-Lughod, 1988, p. 650). Morsy’s (1980) study revealed that the birth of many children established the woman’s power in the Egyptian family. Many children were an advantage and prevented her husband from divorcing her.
Childbirth in Western Health Care Systems

Preparing for the birth of a newborn, according to Lipson & Meleis (1983), is not valued by the Middle Eastern woman. Everything should be left to the will of Allah. If the woman prepared things prior to the birth, she would be defying God’s ultimate plan. This would result in a difficult situation for the mother and/or newborn. For this reason, the baby’s room and clothing are not prepared before the birth.

Meleis (1981) stated that the childbirth experience for an “Arab American . . . is not glorified or cherished. The sooner the woman gets it over with, the sooner she is able to get on with more important matters” (p. 1183). Meleis revealed that childbirth is primarily an event involving women where husbands do not wish to be with their wives. Furthermore, the women do not really want the husbands there. These women are not interested in assistance or instruction in relaxation techniques or breathing patterns. They have a genuine fear of epidurals and spinals, but are not opposed to other types of medication for pain relief. Reizian and Meleis (1986) conveyed that women who are experiencing pain during labor and delivery, are expected to moan, groan, and scream.

Middle Eastern Muslims never give up hope that God will help them, no matter how difficult the situation. Confronting a pregnant woman in labor with a plan for C-Section, or the possibility of losing a baby, would be devastating. This would signify that the health professional has taken the situation out of God’s hands. Health professionals should be very careful with their wording because “to speak of death is to bring it about” (Lipson & Meleis, 1983, p. 859).
Summary

A review of the literature provided a background of the Islam religion. The early history of Islam was discussed to provide a foundation. The Holy books (the Qur'an and the Hadith) and the laws governing personal issues (Shari'a) defined the Islamic beliefs in a Muslim's life. The emphasis placed on Muslim women's modesty and bearing children was related to interpretations of the Holy books and laws of Islam.

The diversity of the Middle East countries was discussed. Seventeen countries were identified in the geographic area known as the Middle East. Ethnic groups residing in the Middle East (Arabs and various non-Arabs) were included in the discussion. Although diversity exists, similarities were noted in the culture and traditions of Middle Easterners.

Health care perceptions related to the Islam religion and Middle Eastern beliefs were conveyed. Different philosophies of the Sunni and Shi'a sects of Islam, regarding health care, were presented. Similarities involved putting trust in God and the power of God's will. The Middle Easterner's strong need for family affiliation, mistrust of individuals who were not members of the family, unawareness of the body's functions, and no desire for preventive health care influenced their perception of health care delivery.

An integration of religious and cultural beliefs was responsible for the behaviors and expectations of Middle Eastern Muslim women during childbirth. Examples of the childbirth experience, in Middle Eastern countries and the Western health care system, were presented.
CHAPTER III
METODOLOGY

The purpose of this nursing research study was to identify and describe the beliefs, behaviors and expectations of immigrant Middle Eastern Muslim women during childbirth in a Western health care system, from an emic point of view. The study was guided by a qualitative research approach, a descriptive research design, and ethnographic methods to collect and analyze the data.

In this chapter, a description of the protection of human informants, selection of sample, and selection of setting by the informants are presented. The collection of data was conducted in systematic steps which integrated the three ethnographic methods of personal narratives, semi-structured interviews, and field notes. Integration of Middle Eastern cultural patterns provided a sensitive and individualized approach to the collection of data. Limitations to data collection were presented in the appropriate sections and the importance of qualitative reliability and validity were discussed.

Analysis of the data was accomplished through a process of coding and categorizing the data into cultural and religious domains of meaning. Subsequent identification of related cultural and religious themes, which reflected the informants' point of view, provided interpretation of the beliefs, behaviors and expectations of Middle Eastern Muslim women during childbirth in a Western health care setting.
Research Design

Qualitative nursing research, guided by a descriptive research design, explores the breadth, depth and meaning of phenomena within a given context, through rich descriptions (Burns & Grove, 1987; Field & Morse, 1985; Knafl & Howard, 1984). This inductive and dialectic process encourages description and interpretation of the meanings of behavior, facilitating development of nursing theory (Field & Morse, 1985). The paucity of literature available, and the related nursing knowledge base deficit concerning beliefs, behaviors, and expectations of immigrant Middle Eastern Muslim women during childbirth, were strong indicators for the application of a qualitative research approach in this study. Therefore, it was advantageous to select a qualitative approach to identify unknown concepts, challenge the perceived knowledge base which was lacking in scientific support, and provide descriptively rich data to better understand human behavior patterns (Morse, 1989a).

Research Method

Burns & Grove (1987) stated that the purpose of ethnography is to describe a culture. Aamodt (1989) defined ethnography as a method which incorporates data collection and analysis of human patterns of behavior within the context of a specific cultural setting, with meanings of the cultural behavior determined from an emic viewpoint. Ethnographic research methods provide a means of obtaining access to beliefs, practices, and rituals of a culture, to discover the "... culturally embedded norms which guide the actions of individuals in a specific culture" (Field & Morse, 1985, p. 22).
The gathering of data from an emic point of view provides rich descriptions of human experience which are categorized into domains, and reveal the meaning of behaviors identified as themes (Spradley, 1979). Meanings may be either tacit (unspoken but subconsciously understood) or explicit (stated and consciously understood) in origin and are identified by the researcher during the data collection and analysis stages (Aamodt, 1989; Field & Morse, 1985; Spradley, 1979).

Munhall (1988) stressed that nurses commonly expect their clients to change or adapt individual behaviors which differ from the Western health care system's expected behaviors. An example of this was the behavior identified in a pilot study by Guerra (1989) of a woman's attempt to stay in bed and rest while her mother cared for the newborn. Nurses in a Western health care system would have insisted that the mother get out of bed to begin caring for and bonding with the newborn. Munhall suggested that the ethical thing to do is understand and support the differences which are meaningful yet harmless in a given situation.

Ethnographic research methods promote a realistic understanding of predominant cultural patterns and the meanings which elicit certain behaviors. Identification of domains of meanings and the related themes will encourage provision of nursing care based on the patients' beliefs and meaningful behavior patterns (Aamodt, 1989; Field & Morse, 1985). Therefore, the decision was made to utilize the qualitative research method of ethnography to describe the beliefs, behaviors and expectations of the childbirth experience for Middle Eastern Muslim women, and help develop a knowledge base to provide congruent nursing care.
Protection of Human Informants

Disclaimer

An oral disclaimer consent form (see Appendix B) was approved by the Human Subject Review Committee of the College of Nursing. The contents of this form were verbally explained prior to the collection of data, using terms easily understood by informants with limited English language skills. The content of information explained included statements regarding (a) title and purpose of the research study; (b) no risk or immediate potential benefits for the informant; (c) potential benefits for women seeking future care, based on sharing the study’s research findings with the nursing profession; (d) freedom of inquiry to ask any questions related to the study or request clarification of the researcher’s questions; (e) freedom to refuse to answer any question without explanation, or withdraw from the study at any time without penalty or researcher’s discouragement; and (f) guaranteed confidentiality (Burns & Grove, 1987; Field & Morse, 1985; Lipson & Meleis, 1989; Munhall, 1988).

Several studies (Lipson & Meleis, 1989; Meleis, 1981; Meleis & Jonsen, 1983; Meleis & Sorrell, 1981) revealed that Middle Eastern individuals place a high value on verbal commitment. The importance of body language and verbal delivery of information are more important than the material being presented. Written consent is viewed as an insult by the Middle Easterner and implies that the researcher distrusts the verbal commitment. Therefore, obtaining an oral disclaimer consent recognized and respected the importance of the informants’ cultural values in this sample.
Confidentiality

To insure protection of their anonymity, pseudonyms were chosen from a pool of popular Middle Eastern names. These names were suggested by the informants and included names of the Prophet’s wives and daughters, as well as famous women in Middle Eastern history. Several of the informants stated that they would not mind retaining their given names (“I like my name” or “I don’t mind if someone knows I said this”). However, all informants were randomly assigned pseudonyms. Informants were reassured that their names would not appear in the transcriptions of the audiotaped sessions or field note entries.

Each informant’s session was recorded on audiotape. Permission to tape was granted by the informant, prior to taping. The data were later meticulously transcribed verbatim by the researcher, and the field note entries were added. Audiotapes, transcriptions, and field notes were stored in the researcher’s home during data collection and analysis. Each audiotape was erased upon completion of transcription of the data to further protect the confidentiality of the informants.

Ethical Considerations

“Perhaps the most critical, ethical obligation that qualitative nurse researchers have is to describe the experiences of others in the most faithful way possible” (Munhall, 1988, p. 153). This requires the researcher to be aware of and set aside personal value systems which may influence the collection and analysis of data (Burns & Grove, 1987; Field & Morse, 1985; Munhall, 1988; Spradley, 1979). These ethical considerations were addressed throughout data collection and analysis.
Selection of Sample

The sample for this study was obtained by purposeful sampling techniques. An urban community in the southwestern United States, where representation of immigrant Middle Eastern Muslims existed, was chosen for sampling. Two mosques serving the population, location of an International Student Center at the university, and several international clubs for students from individual Middle Eastern countries verified existence of a population for sample selection. Individuals who had knowledge of the personal experience being studied and a willingness to share their perceptions of the experience were selected (Morse, 1989b; Spradley, 1979). Original criteria for selection of informants included women who:

1. possessed the ability to speak and understand the English language.
2. were temporarily residing (five years maximum) in the United States while maintaining permanent ethnic ties to a Middle East country.
3. professed a faith in the Islam religion.
4. acknowledged at least one childbirth experience in a Western health care system of the United States.

The sample included seven informants who were university students and/or wives of university students. These informants were all married and represented diverse characteristics related to: country of ethnic origin or permanent tie, religious sect, level of education, age, sex and age of children, age at first childbirth experience, number of pregnancies, and number of childbirth experiences in the Western health care system.
A deviation from the original criteria resulted in the inclusion of two women who had been born and raised in the United States. The women converted to Islam several months prior to marriage. Both women married Middle Eastern men over 7 years ago. Each woman volunteered that she perceived herself as a Muslim woman who was totally immersed in the traditions of the Middle East culture. One woman acknowledged that her conversion to Islam "was not without its difficulties." She explained the process of learning Arabic, assuming Islamic dress, and reevaluating her whole lifestyle. One woman legally changed her American name to a popular Middle Eastern Muslim name. This was a reflection of her commitment to her new religion and ethnic ties. Each woman indicated that she had lived in her husband’s home country during breaks in the school year and intended to establish permanent residence in her husband’s country, following graduation.

Individuals who convert to any given religion and/or marry into any culture often provide excellent data. This is a result of their having to learn the particulars of the cultural or religious beliefs and consciously assimilate the behaviors driven by these beliefs. Criteria for selecting a reliable informant in an ethnographic study were addressed by Spradley (1979), which included any individual who is: (a) totally immersed in the culture, (b) presently involved in the cultural community, (c) eager to discuss experiences and (d) not in a role of analyzing the culture. Both of these American born women met these criteria. Therefore, it was agreed by the researcher and the thesis committee chairperson that the two women were both valid and reliable informants for this study.
Characteristics of Informants

Each informant was provided with a pseudonym to guarantee confidentiality and add a personal quality. The names selected, in alphabetical order, were Aishah, Aminah, Fatimah, Kadijah, Lila, Zahrah, and Zaynab. All the women in this sample were married, and two of the women were married to their cousins. The informants’ ages ranged from 23 years old to 36 years old. The ages of their children ranged from 3 months old to 12 years old, and three of the women were presently pregnant. Two women had only female children and the remaining women had female and male children. The informants represented a highly educated sample and the level of education varied among the informants. This high level of education was expected, secondary to the researcher’s decision to recruit informants from a university community and require them to speak and understand the English language. Three of the women were students and all of the women’s husbands were students at the university. Two of the women had graduated from high school and had attended at least one year of college. Four informants had earned B.S. degrees and one informant had earned the M.S. degree.

The original criteria for sample selection influenced the other characteristics of the sample: (a) ability to speak and understand the English language, (b) temporary residence in the United States with permanent ties to a Middle East country, (c) profession of faith in the Islam religion, and (d) a childbirth experience in a Western health care system.
English as a Language

All the informants possessed the ability to understand and speak the English language quite well, with the exception of one. The husband of this informant requested permission to assist his wife in the “translation of her limited English.” His presence and translation did not hinder her ability to quietly express herself in clear phrases of English, accompanied by understandable body language and eye contact. Occasionally, she would disagree with what he was translating and begin conversing with him in Arabic, persisting until he translated to her approval. As anticipated, the researcher’s rewording and clarification of some questions were helpful for informants using English as a second language.

Middle Eastern Ethnicity

The informants and the Middle Eastern countries represented were indicative of a diverse sample: (a) one informant was from Egypt; (b) two informants were from Iraq; (c) one informant was from Kuwait; (d) one informant was from Palestine and a temporary resident of Lebanon; and (e) two informants were from Saudi Arabia.

All of the women stressed the importance of dressing appropriately and referred to the Qur’an as the source of direction. Two women who were born in the Middle East were dressed very conservatively in Western style dress, with their upper arms and elbows covered. One wore long slacks and the other wore a long skirt. They stated that this was appropriate and similar to what they would wear in their home countries. The remaining three women who were born in the Middle East were attired in Islamic dress, with full length abayah and hijab.
The ethnicity of the two women who were born in the USA was undetectable to the researcher when they entered the room. They were attired in full Islamic dress with abayah and hijab, sat down carefully, and rearranged their clothing to maintain cover with only the ovals of their faces and hands visible. Their feet were covered with opaque hosiery or socks and remained sole down. They were soft spoken and their eyes deferred downward with discussions of sensitive nature. Frequent breastfeeding of children was accomplished without exposure. Although their English was noticeably more fluent than other informants, Middle Eastern inflections, recurrent Arabic phrases, and body language were convincing. Their ethnic origin remained totally undetected by the researcher until they volunteered their place of birth.

**Profession of Faith in Islam**

All of the women professed a faith in Islam. One woman was a member of the Shi'a sect and the other six women were members of the Sunni sect.

**Childbirth Experiences**

Ages of the informants at their first childbirth experience ranged between 18 and 26 years old. The women individually reported a range of two to five childbirth experiences, and three of the women were pregnant at the time of the data collection. The number of experiences acknowledged by the women in the Western health care system varied from one to five experiences. Five of the women were able to compare a Western health care experience in the U.S.A. with an experience in their home country. This added to the quality of the data collected.
Limitations in Sample Selection

Difficulty in obtaining a diverse and representative sample of Middle Eastern Muslim women was acknowledged prior to selection. This was related to the researcher's need to establish trust, the informants' comprehension of the real intention for the study, and the criteria for the informant to speak and understand the English language.

Distrust of individuals outside the family is a common Middle Eastern trait. The researcher needed to gain the informants' acceptance and trust prior to the collection of data. This was facilitated by two students of Middle Eastern ethnicity and two college professors who had established a trusting relationship with the researcher and the informants.

Suspicion concerning the real intention of the research study resulted in refusal of one prospective informant to arrange a convenient time. The informant said, "I have to ask my husband." When a second request was made one week after the first, the reply was, "My husband is asleep." One husband's attempt to translate what the informant was trying to express in Arabic was interpreted by the researcher as trying to "save face," a Middle Eastern trait identified by Lipson & Meleis (1989).

The requirement for gathering data in the English language eliminated several otherwise qualified informants. No informants in this study had difficulty understanding the questions in English format. One husband requested that he be permitted to assist his wife in the "translation of her limited English." However, this informant was quietly assertive in sharing her experience in her clear and to-the-point English, with the aid of her body language and eye contact with the researcher.
Selection of Setting

The informant’s right to privacy and confidentiality of data being shared with the researcher are most protected in the informant’s home, where the informant has control (Munhall, 1988). Reliability of the data collected are increased by the informant’s perception of the researcher as a collaborator in her home, instead of an intruder (Munhall, 1988). Additionally, the researcher’s ability to set aside preconceived ideas or personal bias, prior to data collection in the selected setting, promote the establishment of trust (Burns & Grove, 1987; Field & Morse, 1985; Munhall, 1988; Spradley, 1979).

Data were collected for this study in a variety of locations. Each informant chose a location to assure the amount of privacy she felt comfortable with. The locations included private living rooms of the informants, classrooms at the university, a meeting room at the university student housing center, the telephone, and even a park bench under a 50 foot tree on the university campus.

Variety existed in the number of informants present at each of the primary sessions. Only one woman chose to be interviewed alone. One woman requested to be interviewed with her husband present. Two women preferred being interviewed together. Two other women were interviewed in a group setting of five women. Three women in the group setting were not retained as informants because they did not meet the original criteria set for the study. Follow-up sessions were scheduled with each woman on an individual basis, to validate and clarify information obtained in the primary sessions.
One of the follow-up sessions was unexpectedly interrupted when the informant's husband returned home early. Her response was to very politely hide the conservatively dressed researcher in the kitchen behind a box of onions. She spoke quietly to her husband in the other room, closed the door so neither the researcher nor the husband could see each other, apologized to the researcher for terminating the interview abruptly, and very politely asked the researcher to leave. It was determined that she was not at risk, because she encouraged the researcher to arrange another time to finish. A telephone call to the informant, later that day, provided assurance that everything was under control. The informant volunteered more information and finished the interview session via telephone. The informant never offered an explanation regarding who was being protected during the incident: herself, the researcher, or the husband.

**Data Collection Methods**

Qualitative nursing research, guided by a descriptive research design, uses ethnographic methods to obtain rich, descriptive data of a specific culture. The availability of several ethnographic methods encourages matching of methodology to the purpose of the study. The purpose of this study, to identify and describe the beliefs, behaviors and expectations of Middle Eastern women during childbirth, lends itself well to a variety of ethnographic methods. Therefore, a focus on obtaining reliable and valid data to develop domains and themes influenced the selection of three ethnographic methods: (a) personal narratives, (b) semi-structured interviews, and (c) field notes.
Personal Narratives

Meleis & Lipson (1989) revealed that the most descriptive and qualitative data were acquired from Middle Eastern informants during preliminary and post interview informal discussions, when the researcher was establishing rapport and trust with the informant. Therefore, this study incorporated a method for obtaining rich ethnographic descriptions identified as personal narratives. The idea for identifying this method as personal narratives was derived from studies by Early (1982) and Garro (1982). Early (1982) defined a therapeutic narrative method “... as a commentary on illness progression, curative actions, and surrounding events - both relevant and irrelevant” (p. 1491). Early’s utilization of this method in the baladi (traditional) section of Cairo, Egypt, to elicit mothers’ perceptions of health and illness decisions made concerning their children, resulted in very descriptive stories. These stories alluded to the culturally rational meanings behind their behaviors and explained reality in a cultural context.

Aamodt (1989) stated, “What people do, say they do, and say what they want to do provide beginning ethnographic information to clinical nurse-researchers” (p. 33). Therefore, incorporating the method of personal narratives in the present study was considered beneficial. A grand tour statement, “Tell me what it was like for you when you gave birth to a baby here, in the United States” initiated the method. When the informant told her story, with cultural expressions and voice inflections denoting emphasis, she revealed thick descriptions of the beliefs, behaviors and expectations during her childbirth experience.
Semi-structured Interviews

Utilization of a second method to collect data increases the reliability and validity of the study. The interview, the most dominant method used in ethnographic studies, elicits information from an emic point of view (Field & Morse, 1985; Lipson & Meleis, 1989; May, 1989; Rosenthal, 1989; Spradley, 1979). Various levels of interviewing are possible. Selection of a semi-structured interview was indicated to obtain the information desired while allowing the informant flexibility to control the amount of data shared within specific cultural boundaries (Field & Morse, 1985; May, 1989).

Lipson & Meleis (1989) indicated that the semi-structured interview was most appropriate for Middle Eastern immigrants because their style of communicating very rarely involves response to a direct or formal question with a direct answer. They are, however, enculturated with a communication pattern involving circular, indirect means of answering questions, and often do not even provide an answer. This was evident in varying degrees throughout the collection of data, when the informants shared their experiences.

Field Notes

Field notes were the third ethnographic method used in this study. The researcher’s field notes included descriptions of the setting, observations of the informant’s non-verbal communication, and the researcher’s impressions (Burns & Grove, 1987; Field & Morse, 1985; Rosenthal, 1989; Spradley, 1979). Writing field notes concurrently while another method is being utilized adds reliability to the data collected.
May (1989) indicated that another good time for taking field notes occurs at the completion of an interview or narrative. The informant continues talking at a more casual level to establish a deeper rapport with the researcher and is compelled to "... make sure the investigator has the 'whole story' before leaving or because the informant has never discussed the topic in such depth and new insights have been stimulated" (p. 1180). This occurred with every informant in this sample. One informant telephoned the researcher to share additional information which she considered very important. Another informant showed enthusiasm when the researcher expressed a desire to learn the words and phrases relevant to Islam. She photocopied a pamphlet which translated common Islamic expressions from Arabic into English and presented it to the researcher. These situations are examples of the informants being stimulated. These examples were added to the field notes.

**Data Collection Process**

The data for this study were collected by the researcher in various locations selected by the informants, as previously described. A preliminary time was devoted to establishing a rapport and trust between the researcher and informant. This involved the researcher's sharing of personal experiences related to family, as recommended by Lipson & Meleis (1989). The researcher's status as a married, middle-aged mother with a son and daughter was considered desirable by Middle Eastern standards and was helpful in establishing a common ground.
The researcher's culturally appropriate behavior demonstrated sincerity and respect for the informants' cultural and religious beliefs. Particular attention was given to proper dress for the interview sessions. In honor of the Muslim women's protection of modesty, long sleeves, a long dress or skirt which rested at midcalf, and dark opaque hosiery were worn by the researcher. The researcher's sharing of information, about her family and her experience as a maternity nurse and teacher, set the foundation for trust. Lipson & Meleis (1989) indicated a symbol of trust is established by the sharing of food offered by the informant. Drinks of coffee, juice, and water were offered along with cookies at three of the private homes and were politely refused when offered the first time, as was culturally expected. Following the host's second offering, they were graciously accepted by the researcher. These strategies for encouraging trust and rapport were recognized as the first stage in collecting data within a cultural context, and was also referred to as entrance to cultural immersion.

The length of the interviews varied, dependent upon the informant's willingness to share and time constraints. Data collection sessions lasted between one and one half hours to three hours in duration. Each session progressed at a rate appropriate for each informant to elicit thick descriptions without inducing fatigue or distrust. Additional sessions to gather more data, clarify confusing areas, or validate the previously gathered data were scheduled with all informants.
Aamodt (1989) and Spradley (1979) presented two suggested protocols for collecting ethnographic data. Systematic steps were developed by the researcher (derived from Aamodt and Spradley) which integrated the three selected methods of personal narratives, semi-structured interviews, and field notes. These steps provided guidelines for collection of data in this study:

1. Observe the informant in the context of the cultural setting while establishing rapport and trust.

2. Encourage informant’s sharing of personal narratives with grand tour questions and record field notes.

3. Present broad or general questions in a semi-structured interview (see Appendix C) and record field notes.

4. Identify informant’s culturally and religiously recurrent expressions and non-verbal behavior.

5. Present focused questions (see Appendix C) to elicit more descriptive data in a semi-structured interview and record field notes.

6. Carefully transcribe content of interview, personal narratives, and field notes.

7. Code and categorize culturally and religiously specific domains of meaning.

8. Ask informant to validate domains of meaning.

9. Identify culturally and religiously specific themes.

10. Repeat steps 2 through 9.
Reliability and Validity

The importance of determining reliability and validity in any qualitative study is reflected in how the sample was selected, setting was determined, data were collected, and data were analyzed in an ethical manner (Brink, 1989; Burns & Grove, 1987; Field & Morse, 1985).

Reliability in qualitative research, according to Brink (1989), is evaluated by the researcher's accurate recording and reporting data collected within a given context which (a) reflects stability of information gathered over time, (b) is consistently verified by the informant, and (c) is answered similarly, independent of the manner of questioning. The issue of reliability was addressed throughout the study. The data were gathered over a 3 month period of time from seven informants, who were interviewed in at least two sessions each. Stability was established by the recording of similar answers to questions phrased differently in subsequent interview sessions.

The competency of both the researcher and the informants is instrumental in the subsequent validity (Brink, 1989; Field & Morse, 1985). Establishing validity in a qualitative study involves (a) collection of data, (b) utilizing more than one method, (c) transcribing field notes and data collected over a period of time, and (d) verification of content and meaning by the informants (Brink, 1989; Burns & Grove, 1987). Validity of the data was established by involving three different ethnographic methods, a variety of settings, and the assortment of individuals, couplets, and a group in data collection. Verification of the data collected was offered by the informants over the three month period.
Data Analysis

Brink (1989) stated that “analysis in qualitative research refers to the categorization and ordering of information in such a way as to make sense of the data and to writing a final report that is true and accurate” (p. 163). Qualitative data analysis involves narrative deep descriptions of phenomena, domains, and themes, instead of the statistical analysis of precisely measured numerical data found in quantitative studies (Aamodt, 1989; Burns & Grove, 1987; Knafl & Webster, 1988).

Analysis of the data was accomplished through the process of coding the data, categorizing the data into cultural and religious domains of meaning, and identifying related themes. These domains and themes reflected the informants' point of view regarding beliefs, behaviors and expectations during childbirth in a Western health care system.

Summary

The purpose of this nursing research study, to describe and identify beliefs, behaviors and expectations in immigrant Middle Eastern Muslim women during childbirth in a Western health care setting, was guided by a descriptive research design with a qualitative approach, utilizing ethnographic methods of personal narratives, semi-structured interviews, and field notes.

A purposeful sample of seven informants was selected from an urban community in the southwestern United States, following explicit criteria. Informants chose a variety of settings which were convenient and comfortable for data collection sessions.
Collection of data commenced after the researcher gained the trust of the informant, explanation of the oral disclaimer form was understood, and permission to audiotape the session was granted. Informants’ communications of their experiences during childbirth in personal narratives, semi-structured interviews, and concurrent field notes were collected over a three month period of time. The data collection sessions lasted approximately one and one half hours to three hours. The collected data were meticulously transcribed after each session. Each informant was interviewed at least twice to increase reliability and validity of the data. Reliability and validity were determined by the informants’ validation and clarification of the data. Analysis of the data was accomplished through the process of coding the data, categorizing the data into cultural and religious domains, and identifying related themes.
CHAPTER IV
PRESENTATION OF FINDINGS

The purpose of this study is to identify and describe the beliefs, behaviors, and expectations of immigrant Middle Eastern Muslim women during childbirth in a Western health care system, from an emic point of view. Presentation of the findings will be provided in this chapter, based on an analysis of the data. Analysis of the data included coding of the data, classification of domains of meaning, and identification of themes.

Coding the Data

Following each data collection session, meticulous transcription of the audiotaped personal narrative and semi-structured interview was completed with the inclusion of field note entries. The data were entered on the left side of the page. A wide right margin was utilized for coding and categorizing the data. This facilitated follow-up interviews which clarified and validated the appropriateness of the coded data.

The coding of data focused on identification of recurrent words and phrases used by the informants. This coding later delineated expressions which represented explicit or tacit beliefs. Codes were entered when the informant discussed her own behavior during the childbirth experience or the behaviors of family members, friends, and health professionals. Patterns of non-verbal behavior recorded in the field notes were also coded. When the informants indicated certain behavioral expectations of the individuals present during their childbirth experiences, these were coded appropriately.
Primary coding of 327 pages of transcribed data resulted in the categorization of data into four groups. These groups focused on the sequential phases of the childbirth experience: (a) early labor, (b) active labor, (c) delivery, and (d) post-delivery. Secondary coding within these groups resulted in the classification of sixteen domains of meaning for beliefs, behaviors and expectations of Middle Eastern Muslim women.

Domains of Meaning

Descriptive examples of beliefs, behaviors, and expectations during the childbirth experience, which were shared by the sample of seven Middle Eastern Muslim women in this study, supported the classification of relevant domains of meaning in the sequential phases of early labor, active labor, delivery, and post-delivery.

Early Labor

The domains of meaning during the phase of early labor included: (a) recognition of labor signs, (b) methods to “induce the labor,” (c) significance of Islam and (d) going to the hospital.

Recognition of Labor Signs

Middle Eastern Muslim women recognized the beginning of labor by the occurrence of several signs. The signs identified included “the sign” of blood (allama or ishara), the presence of contractions (taqaualas), and breaking of “the head water“ (maah al ras).
"The sign" of blood: \textit{allama} or \textit{ishara}.

All women in the sample expressed that their first recognition of labor occurred when "I went to the bathroom and I have blood," "I lose some blood," or "it’s like a blood from where the baby come out."

Fatimah shared the belief that "most of the women know that when they got the labor, or before the labor, they have to lose some blood and we call it ‘the sign,’ we call it \textit{allama}.” The word \textit{ishara} also means "the sign" and was suggested by Aishah and Kadijah as being a “traditional” equivalent to the word \textit{allama}.

Presence of contractions: \textit{taqaulas}.

The presence of contractions (\textit{taqaulas}) is another sign of labor recognized by all the women in the sample. This was supported by Fatimah’s statement, “We have learned traditionally from our culture that when a woman is going to get contractions, that means she is in labor.”

All agreed that the presence of \textit{taqaulas} was an indicator to “have the baby as soon as possible.” Fatimah experienced \textit{taqaulas} for 52 hours prior to delivery. She described them as being “like every two hours.” Aishah, Amina, Kadijah, and Zahrah reported that the contractions of their first labors began 24 hours prior to delivery. Additionally, they didn’t “have that much pain, you know. It was like medium labor.” All informants agreed that the duration or quality of contractions was not a determinant of labor. The fact that contractions were present was a sign of labor.
Breaking of “the head water”: *maah al ras*.

The predominant belief of Middle Eastern Muslim women is that the “head water” (*maah al ras*) is observed in a later stage of labor, caused by the “baby’s head breaking the water before it come out.” The timing of this “normal” occurrence was often placed between fifteen minutes and two hours before the actual birth. However, Aishah stated that this event occurred prior to the onset of contractions in one of her childbirth experiences. Breaking of the head water is equivalent to the Western health care system’s term “spontaneous rupture of the amniotic membranes with leakage of amniotic fluid.”

Methods to “Induce the Labor”

Middle Eastern Muslim women identified the phrase “induce the labor” as a set of methods initiated “to make the *taqaulas* stronger and closer together.” Methods of “inducing the labor” were initiated following recognition of the previously identified labor signs. Preventing labor from progressing, even if the contractions begin prematurely, was not acceptable. This was related to the belief that, “When labor start, we have to get it over with as soon as possible.” Several examples of methods employed to “induce the labor” were included in the women’s experiences: massage with oil and *josa*; drink warm tea with cinnamon; drink warm water boiled with cardamom; drink special oil; take a hot bath; and, increase activity.
Massage with oil and *josa*.

Massaging the body with oil and *josa*, a spice which is shaped like a very small egg prior to being ground, "induces the labor."

A spice called *josa* is put in some oil and rubbed or massaged on the back, stomach, thighs, and this area (woman pointing to the pelvic area), or wherever the labor hurts you. Then cover yourself with blankets to keep it warm, to be more effective. If it is real labor, it will induce you. If it is not, it will just go away.

Kadijah and Aishah experienced contractions that were closer together and stronger after using this method. Aishah stated that her contractions disappeared following the massage by her mother, as predicted.

Drink warm tea with cinnamon.

A warm drink of tea with cinnamon will "induce the labor and make the contractions stronger and closer together." Aminah, Kadijah, and Aishah reported using this method and concluded that it was influential in improving their patterns of labor. Aishah stated that when she was admitted to the hospital for the medical induction of labor (not to be confused with the women's term "induce the labor"), she was unable to use this method. She emphatically stated that this was one of the reasons this particular labor was so long.
Drink warm water boiled with cardamom.

Another drink, created by boiling one cup of water with 1/2 teaspoon of cardamom, will “induce the labor” and make the contractions stronger and closer together, “within one or maybe two hours.” According to Fatimah, the woman in labor should only drink one cup of this because “if you drink more than once, you’re going to bleed, the contractions will get too strong and you might going to kill the baby.” This method was deemed very effective by Fatimah.

Drink special oil.

Mothers of women in early labor also make suggestions for increasing the effectiveness of labor. “I remember during my contraction time with my first baby, my mom give me some special oil to drink to let that constipation go away and make diarrhea. She say that will make you deliver more normal, more easy.” Kadijah continued to discuss the effectiveness of this method. “I did this in my country and it helped.”

Take a hot bath.

Aishah shared the advice of a friend who encouraged her to “take a hot bath in water and it will induce the labor.” Her friend had been successful three times using this method. However, Aishah tried it twice and was unsuccessful. This resulted in her conclusion that “women are different. Maybe it works for some.”
Increase activity.

Aishah and Kadijah stated that “traditionally at home, they lay you down in labor and say don’t move.” Contrary to this, they agreed with other informants that the importance of “getting it over with” and “fast labor” are facilitated at home by walking around, cleaning the house, and cooking meals. All informants shared experiences of walking to “induce” their labor, resting only when the pain became unbearable and signalling “time to go to the hospital.”

Significance of Islam

Aminah revealed that every Muslim accepts the importance of 
*tawakkul*: “Trust the God, *Allah*, and He will help us.” Every woman repeatedly used the expression, “Only God knows what will happen.” They recognized *Allah’s* ability to determine “when we are going to get the *allama* and when the baby is going to come out.”

Aminah, Zaynab, and Zahrah specified that “When you are bleeding with *allama* and after delivery, you cannot pray.” Zahrah adhered to her interpretation and enjoyed having her husband read the *Qur’an* to her. Contrary to the preceding belief, Aishah and Kadijah said, “You can recall the words of the *Qur’an* when you have the *allama*. But, you cannot touch the *Qur’an* because a woman is considered unclean at this time.” Aishah remembered that her husband helped her to recall the verses of the *Qur’an* when she forgot them with the pain of labor. Kadijah recalled the words of the *Qur’an* “to help me feel closer to God.”
All the women emphasized the importance of spending time during labor to “talk to God,” and Aishah shared her concern for “calling Him by all the names I can remember.” Fatimah revealed that the Qur’an includes “45 to 99 names that God is called by. It is difficult to know them all.” Zaynab stated that one of the common ways Muslims will call their God is the Bismallah. This should be said by all Muslims before they do any activity or talk to God. A common request of the women who talked to God was “God, please help me to make it fast and get it over with.”

**Going to the Hospital**

Going to the hospital was identified by the women as something that was delayed as long as possible. Stories were shared which included memories of Middle Eastern hospital experiences where they shared a “dirty room with four other women.” Others spoke of “very modern hospitals, just like here.” However, each woman expressed the idea that they did not spend any more time in the hospital than was necessary.

**Preparation for going.**

Prior to going to the hospital, every Muslim woman stated that she must “make the body clean.” Aminah, Fatimah, and Zaynab were quite embarrassed and reluctant to discuss how this was accomplished. With eyes deflected downward and speaking in a whisper, Aminah replied, “To keep clean, the woman she do these things, in preparation of the baby.” When questioned further regarding the process, she responded, “Whatever I want. Just regular amount.”
Zahrah was more responsive to the question. “The Hadith instructs us to observe sunna fitra, translated into English as the sunna of nature. Muslim women don’t have long nails or body hair because dirt will get underneath and that’s not clean.” Aishah and Kadijah were quite open in discussing how the sunna fitra was adhered to.

This is part of our religion, you know. When you deliver your baby, you have to be clean. We do this after the menstruation period time once a month, and before we go to the hospital to have a baby. We do it with the wax, you know. We just remove everything under the arms, in the area where the baby come out, and the legs. It hurts, but not too much. It is better than shaving. When you shave, it makes it rough and a lot of itching when it grows.

Lila acknowledged that the removal of body hair was an “influence of the culture” and dependent upon the interpretation of the Qur’an. Her belief was reflected in the statement, “I didn’t do that (referring to the act of removing pubic hair). I just clip it short.”

Reasons for going.

Kadijah stated, “Don’t go to the hospital until you have seen the allama.” Recognition of “the sign” resulted in several women going to the hospital to “just check.” They returned home and initiated methods to “induce the labor.” All the women stated, “I prefer to stay at home” during early labor. Aishah and Aminah expressed discouragement with doctors who admitted them to a Western hospital when they had requested “just check me” and “let me labor normal at home.”
Several women acknowledged learning of the Western health care practice of admitting women in early labor and avoided going to the hospital “just to check.” Kadijah respected her mother’s words of wisdom. “My mom gave me great advice. Don’t go to the hospital until the contractions are every two minutes. Then you stay maybe two, maybe three hours.” Zahrah went when “I noticed the contractions were coming closer and I couldn’t carry on a normal conversation.” Several women waited to go to the hospital until they were experiencing “real pain.” An example was Lila, who shared, “I’m starting to scream but I’m not the kind of woman who likes to scream. So I said we’re going to the hospital.” Aminah humorously added, “I prefer that when I have the pain or labor to stay at home until you can’t stand up. Then I say ‘that’s it! You can come out right now!’ That’s the time you have to go to the hospital.”

Active Labor

Domains of meaning identified during the active labor phase of childbirth included (a) perception of active labor, (b) preparation for what will happen, (c) interpretation of medical interventions, and (d) expectations of the nurse.

Perception of Active Labor

According to the Middle Eastern Muslim women in the sample, the active phase of labor should progress “very fast” and last “two or maybe three hours.” The women repeatedly referred to this time period with anticipation to “get it over with.” The ultimate goal was to “have it normal” and “with just nothing.”
To achieve this ideal, the women reported that they "labored normal at home" utilizing the previously described methods to "induce the labor." They arrived at the hospital in the active phase of labor, driven by their husband and accompanied by either a mother, mother-in-law, or other female member of the family. Arrival at the hospital marked the beginning of a new experience for women who had not been prepared for the active labor phase of childbirth in the Western health care hospital.

**Preparation for "What Will Happen"**

Zahrah was the only woman in the sample who attended any childbirth education classes. She went to childbirth classes when she was pregnant with her first baby because she was "scared to death." Neither her mother nor her mother-in-law were available to explain things to her with her first pregnancy. She took a friend along because she knew her husband would not feel comfortable in class.

Although Zahrah attended the classes, her participation was limited. This was related to the presentation of class material which was in direct conflict with her Islamic beliefs. Zahrah, and other Muslim women in the sample, offered many reasons why Muslim women do not attend childbirth education classes to prepare them for the childbirth experience:

1. The films show too much of a woman’s body and husbands should not look at any woman except his wife.
2. The woman has to sit with her legs open and this exposes parts of the body that should be covered.
3. The closeness required between husband and wife is considered showing affection in an intimate manner, which is not allowed in public.

4. The clothes worn by non-Muslim women attending the classes are too revealing and this would be uncomfortable for a Muslim husband.

5. Telling the husband where to touch his wife to help her relax is very personal and embarrassing.

6. Our mothers taught us everything we need to know.

The women of the sample revealed that Middle Eastern mothers “traditionally” instruct their daughters in “what will happen.” The women stated that important information was shared by their mothers which helped them cope with the active phase of labor. These items were considered to be the most important:

1. Don’t be worried and don’t be scared.
2. It’s going to be hard; it’s not going to be easy.
3. There’s going to be some pain, except the last 15 minutes is going to be very hard.

When they were questioned concerning their understanding of the anatomy and physiology of labor or the equipment which was used, one reply was, “My mom didn’t tell me these things because she thought I didn’t need to know that before it happened. If I want to know, I can ask the nurse or I can ask the doctor.”
All of the women in this sample had selected a female physician or midwife during the prenatal period and received prenatal care. This selection was based on the Islamic belief which emphasized protecting their modesty. Aminah expressed the Muslim woman’s preference for a female physician and emphasized that “it is not *haram* (forbidden) by Islam to go to a male doctor, but the female is preferred. But, if it is an emergency, you can go to a male doctor.”

Zahrah and Fatimah selected midwives, rather than physicians. Zahrah explained the rationale for this selection.

Doctors don’t like to let women labor naturally. They do more surgery and I think they should be used only for complications or when surgery is needed. The midwives take better care of you because they are women and know how we feel.

Whether they chose a physician or a midwife, all the women based their choices on the recommendations of other Muslim women. It was very important to find someone who would honor their perception of childbirth and allow them to “just labor, with nothing, and have it normal.”

**Interpretation of Medical Interventions**

Stories which included interpretations of the medical interventions were numerous. Items which received the most comments included the electronic fetal monitors, medication, artificial rupturing of the amniotic sac, and the medical induction of labor.
Electronic fetal monitors.

Lila and Kadijah were the only women in the sample who expressed a feeling of reassurance when the electronic fetal monitor was on during labor. They saw the monitor as being a means of determining that "my baby is safe." Kadijah had used the monitor in her country with the labor of her first child. Other women disliked having it on. Several admitted being frightened when "the baby's heart beat went up and down, up and down." Aminah said that she thought that meant her "baby was going to die, right before my eyes." Aishah was very straight forward with her comment, "I don't like it! They put something inside on the baby's head and that was very bad! With the cords coming out you can't walk."

Medication.

Aishah said "I don't remember the pain. I only remember it was hard." Kadijah explained this religiously with "I read somewhere that God created our bodies so that we can deal with the pain, or we would never have a second baby. I remember this. It is true." Every woman in the study was adamant about their perception of labor and expectation to "get it over with and have it normal." This influenced the women's statements, "I prefer not to take anything, no medicine, no IV's, nothing!

However, there were exceptions. Zahrah and Aishah recalled their reasons for requesting an epidural: exhaustion, and having a nurse who was "not helpful with my pain," and the need to be quiet. They both regretted their decision, most discouraged by the "small army of people that came in." Zahrah stated, "I felt bad for my husband, knowing all those people were looking at me."
Artificial rupturing of the amniotic sac.

Concern over breaking the “head water” was expressed by Kadijah. “Here they broke the head water before the head came out, 15 minutes before my daughter was born. They don’t break it at home. Just let it go normal.” Aishah added her displeasure with rupturing the amniotic sac by artificial means. “When they break the head water before the baby is coming out, I believe that is why it took me 15 hours longer. With my other it was like only two hours.”

Medical induction of labor.

The medical induction of labor should not be confused with the term used by the women, “induce the labor.” Medical induction of labor involved the admission to the hospital, insertion of an IV with medication to initiate contractions, and artificially rupturing the amniotic sac for medical reasons (such as post-maturity or a baby in stress). Lila, Aminah, and Aishah each experienced a childbirth which was a result of medical induction.

Lila was the only woman who was not discouraged by the medical induction. She was induced because “when we reach the 40 weeks and you don’t have the sign of labor, you’re supposed to go for it because there might be something wrong with the baby.” Many women expressed this belief and their concern always included the additional statement, “Maybe the baby is going to die or maybe the mom is going to need surgery.” No one, however, ever expressed a concern if the labor started prematurely, because this was “Allah’s will.”
Aishah and Aminah shared stories which reflected a conflict with their perception of birth without intervention. Aminah was quite proud of the fact that she had previously delivered two babies with no interventions, in a hospital in her country. She said, “I love it! I have my kids very easily and fast!” She was induced because the baby was ten days overdue, but considered it to be Allah’s will that “something is wrong with the baby or maybe I’m going to die.” Her memories of the Western health care system were not pleasant. “The foreign nurses, they put everything on my stomach, and the IV, and even if I want to move I can’t. The oxygen, everything. I wanted to be free. I hated this!” Aminah complained that they gave her “double the medicine to make contractions. And it made me crazy! It was very hard labor. But for nothing (throwing hands up in the air) My cervix was still open the same. It didn’t help me.”

Aishah expressed similar displeasure. “I wish she wouldn’t induce the labor or break the head water. When they break the head water before the baby is coming out, I believe that is why it took me 15 hours longer.” She discussed the fact that she was capable of having labor “normal,” supported by the fact that her last labor was only two hours. “There were no contractions so they gave me medicine to make contractions. Twenty women delivered the same day. I was the first one there and I was still sitting down when they delivered! I didn’t like it!”
**Expectations of the Nurse**

Review of the data revealed that the Middle Eastern Muslim women, who experienced childbirth in a Western health care hospital, were able to express what was positive, as well as negative about their experience. Stories were told about the nurses who made them feel “like they cared.” Additionally, they shared nurses’ behaviors which made them feel “uncomfortable.” Suggestions were made concerning their future expectations of the nurse, in an ideal world where their perception of labor would be honored.

The nurse should encourage the woman when she arrives at the hospital to “labor normal,” “with nothing,” and help her to “get it over with fast.” This can be accomplished through nursing actions of encouragement, recommended by the women in the study and stated in their own words (in bold face type for emphasis).

*Stay with me* because the nurse “knows when I am going to have the baby” and “if something goes wrong she knows what to do.” “My husband can’t help me because he doesn’t know what is happening.”

*Offer words which reassure me* “to help me keep my mind off the time and the pain,” such as “don’t worry,” “It’s going to be OK,” and “you’re going to have the baby soon.”

*Explain things to me* which “will happen,” because “my mother didn’t need to tell me these things.” Explaining things also includes “what the baby is doing” and “what certain words mean that I might not understand.”
Talk to me is something “I really feel a need for” to “show me that you care” and “it helps me keep my mind off the pain.” “Ask me questions about my country or my religion.” “Ask me why I am dressed the way I am.” “Treat me like a woman, not something strange.” “Just say something nice to me.”

Lie to me. “Don’t tell me bad things.” Tell me “your cervix is thin and it’s good to be thin” not “you’re still only 5 cm. dilated.” Tell me “if it’s a difficult labor, it’s going to be a boy.” “Even if the baby isn’t going to came out right now, tell me ‘You doing good job and the baby going to come out in 15 minutes.’ And maybe if you lie to me, it will encourage me and the baby will come out.”

Tell me about things when it is time. “It was discouraging to hear ‘It’s going to take two hours’ and better if you say ‘maybe you will be closer in 15 minutes,’ you know.” “Don’t tell me ‘maybe your baby is going to die in two hours,’ tell me I need to do surgery right now!”

Help me stay covered to show respect for my religious beliefs and values. This could be done by hanging a sign on the door that says “Please knock first,” and “check with me before bringing in an army of people to look at me.”

Don’t say words which discourage me “You are still only 3 cm. dilated” is very discouraging. “If it’s too much pain you should have an epidural” is not something I want to hear. “When the nurse say, ‘Oh, the baby didn’t come out yet?’ it makes me think something is wrong.”
**Delivery**

The domains of meaning identified during the delivery phase of the childbirth experience included: (a) significance of Islam, (b) rituals performed at birth, (c) preference of newborn gender, (d) naming the newborn, and (e) death during delivery.

**Significance of Islam**

The significance of Islam permeated the phase of delivery, known as *waladdah* or *wiladeh*. Rich descriptions of the women’s beliefs and behaviors during delivery were shared when they told their stories about “when the baby come out.”

Zaynab was the first woman to share the significance of Islam in the birth of her children.

It is written, that at the moment you are giving birth, the heavens will open and it is the closest you will ever be to heaven in this life. And some women will ask, “When you are in labor, ask for this for me because you are close to God.” And He will give it to you, whatever you ask for. If you offer anything, The God will accept it.

Aminah revealed a certain amount of precaution in her belief that all the requests would be granted.

We remember this when we are delivering. Because at this time, if you ask the God for anything, maybe it will happen. Not exactly 100%, but most of the things for myself or for my friends. If they have some problems or something, maybe I
ask the God and I try with the God. I ask for Him to solve this problem. Most of them, they come true, you know.

Aishah expressed the effects of pain during delivery and the importance of dealing with the pain. If you deal with the pain at the time of birth, *Allah* will reward you.

When the head come out, anything you ask God will be granted. It is hard to remember when you are having pain. And we believe it is better to be quiet. If you handle the pain very good and didn’t shout or anything, afterward you have all your sins gone away. You are clean from your sins.

Being quiet and soft spoken is valued as the proper behavior for a Muslim woman. Even in the pain and intensity of labor, the Middle Eastern Muslim women expressed their attempts to control their behavior and refrain from screaming. Zaynab shared her experience and belief which guided her behavior during a childbirth experience.

Islam says we are supposed to be quiet. And, I was very good during my labor. But at the very end, you know when I pushed him out, and all of a uh . . . uh . . . I let out one little scream and I felt great!

Aminah confirmed this behavior, sharing how childbirth was for her mother. She stressed the importance of a Muslim woman’s quietness during the labor but admitted acceptance of a small scream at the end.

Even my mom, she is very quiet when she had the babies - she have eight babies. She never scream. Even we don’t know if she have the labor or anything. She’s very quiet. But
sometimes you know, the women don’t scream until the end, or something. Like when it comes, you know when the baby comes out. Like me, in the last 15 minutes. That make the nurse nervous if you scream and scream and scream. She come and look like she going to kill you! (smiling as she says this) Or sometimes she say a bad word to make you stop. But it very, very hard pain sometime and you can’t handle it. But I only screamed in the last 15 minutes, you know. When I screamed my husband felt really bad and he say, “No more kids!”

Some women avoided screaming throughout the delivery phase and replaced it with crying. One woman’s husband described his wife’s behavior, while she nodded her head in agreement, and smiled with pride:

When the pain was there, she just grinded her teeth and grabbing whatever available. (wife was shaking her head in agreement and demonstrating how she grabbed the sofa arm) And she cried a little, but she didn’t scream. And that’s what the midwives realized, she said, “How come you didn’t scream? All women scream in the labor.”

Zahrah also agreed that crying was acceptable with her first childbirth but noted that the help from the nurse with the another experience eliminated the need to cry or scream.

I cried a lot at the end when I delivered my first one. The pain was very bad and the nurse was not very helpful. And
another, it was very natural and very normal. She helped me so I didn’t need to scream.

Expressions of emotions were also shared related to the delivery. Kadijah stated, “When the baby came out, I felt like the whole world changed. When I looked at the room, it changed. Something nice, really nice.” Aishah remarked, “I was so excited when they said, ‘you can push!’ And, the delivery was a really good feeling, even if I did have a girl. I want to do it again!”

Congratulations were offered by everyone in attendance at the delivery. If the woman gave birth to a son or a healthy baby girl, *Mabruk* was exclaimed with kisses and affectionate hugs. However, “if the new parents or relatives were not happy with the newborn, then they would say something different: *Al hamduo waladdah, Allah sallam*. This is Arabic for, The delivery is over, God be praised.”

**Rituals Performed at Birth**

Religious and traditional rituals were performed by the father of the newborn immediately after birth. Two of these rituals were identified by the women in the sample: reciting the *shahadah* and *adhan*, and placing honey or a piece of chewed date on the newborn’s tongue. These rituals were performed for both boys and girls.

All the women in the study expressed the importance of initiating the newborn into the faith of Islam. Kadijah shared the specifics of this ritual:
There is something we have to do for the baby right after the baby come out. The father says the *Shahadah*, the testimony of faith: “I believe that there is no God but *Allah*, and Muhammad is his Messenger.” It is followed by the *Adhan*, the chord for the prayer: “Let’s go to pray, Let’s go to pray, Let’s go to pray.” And it continues with the prayer. Then it ends with the *Shahadah* again. The father begins by recalling the words softly into the baby’s right ear and then goes to the left ear. And why do we do this? We believe that when the baby come out, the devil is born with him. We call this devil spirit *jinn*. When we say the *shahadah* and the *adhan*, the devil will be far away from him or her all the time of their life. We believe this is the real faith and the baby has to have it when he is born.

Another ritual, which was identified as being performed by the father immediately after delivery, was the placement of honey or a small piece of chewed date on the baby’s tongue. The amount was described as “not enough to choke them, just enough to give them a taste.” Zaynab, Zahrah, and Aminah stated that their husbands performed this ritual, which they believed was a directive of the *sunna* in the *Hadith*. However, they were not sure why it was done.

The nurse must recognize the importance of these rituals. Middle Eastern Muslim women communicated their expectation of the nurse to locate the father following the delivery to perform the newborn’s rituals.
Preference of Newborn Gender

All Muslim newborns are initiated into the faith, regardless of gender. The preference for a male newborn was revealed by some of the informants. The integration of historical events, family organization, and religious influences were often explicitly involved. Some women explained that, in the past, people always wanted boys because they could support their parents later on and they could help more than girls. “But now it is not that way.”

Aishah shared a story about her expectations of giving birth to a male baby during the delivery of her last child:

The nurse told me that a difficult labor means you are going to have a boy. I was so relieved because my labor was very difficult and the delivery was very hard. I remember that I say, “I’m going to take every pain just to have a boy!” When the baby come out I asked the nurse, “It’s a boy?” The nurse said, “No, it’s a girl.” I was so disappointed that I just went to sleep. “But I love her now very much.”

Aishah continued to discuss her intentions. “I have had three girls now, and one of them died at three months. I am going to keep having more kids until I have my boy. It is important, you know.”

Zahrah discussed the issue of male versus female newborns from a broader scope.

My husband’s family said they would be so happy if we had a boy, because they need more boys who are fighting for my country. Girls can fight too but it just is not quite the same. I
said, “Oh sure, sure.” (laughing) For some people in the Middle East, this is a big thing for them. For the men, they think it is very important to have many sons. I don’t know where they get it from. Too much testosterone maybe. (laughing) You know, I think it transcends cultures. But in the Muslim religious society, a woman can not be a leader. The Imam has to be a man to lead the prayer. She can be the leader of a woman’s study group, but a Muslim woman can not lead a Muslim nation.

One woman stated that her husband experienced difficulty in accepting a girl as one of his children. The women participating in the study acknowledged the truthfulness and present day relevance in the following statement made by one informant:

Throughout all history of all countries, the weak nation is going be considered by how many men it has. And that’s why people have known from their generation that to have boy or to have man is better than woman. Because a boy can fight and handle hard situations and help his family. Women don’t. But it’s not really true because there are a lot of families who have only boys and their kids do nothing for them.

Naming the Newborn

Middle Eastern newborns were named following their delivery. Their names always reflected three patrilineal generations. The baby received a first name which was selected by his or her parents; the second name was the first name of the newborn’s father; the third name was the
first name of the newborn’s paternal grandfather. Both boys and girls were named in this manner and they retained this name for life. For this reason, a married Middle Eastern woman who delivers a newborn gives her name as the one she received at birth. Her husband gives his name received at birth. The birth certificate, therefore, should be completed in accordance with this custom.

Selection of the newborn’s name involves Islamic direction. The women expressed their selection of Muslim names for people “religiously attached to the Prophet in terms of his relatives” and “important Muslims in history.” In addition, the names were selected for their meaning in Arabic. Some daughters were given Arabic names which meant “gift of God” or “taste of honey.” The sons were often named after the Prophet Muhammad, or other important religious people.

The choice of the name was made by either the mother or father of the newborn, but the decision for the name given was made together with the influence of Allah. Aminah explained how Muslim newborns receive their names.

They say when he starts moving, when the spirit comes into his body, that The God knows his name and how long he’s going to live, when he’s going to die, if he going to live a good life, if he is going to live a bad life, everything. And before I deliver the baby, The God knows what his name is. It is written. Everybody thinks about the name so we have a name before the baby comes out. But at the last minute, when the baby comes out, the name comes into your mind. I don’t
know how it comes up. Maybe your husband thinks about another name. He says, “Maybe we should name him this.” And so you change the name. Or somebody might have a dream that you had a boy and you named him Muhammad. And they might tell you this. So when you have the baby, you might remember this and say “Yes, I will name him Muhammad” But only The God knows what will happen. Aishah confirmed this belief and gave an example when her second daughter was born.

I was thinking about the name before she was born. We believe that Allah names the children and every baby is born with his name. My grandmother said, when my second one was born and I wasn’t sure of the name, “Don’t worry, The God will name her.”

Many women acknowledged family involvement in the selection of a name. Lila shared a story concerning her mother-in-law’s attempt to support her son in his choice of a name.

My husband said we going to name her “this name,” and I said we going to name her “another name.” Then his mom said, at the time I have the baby in the hospital, “I going to name her this name.” She wants as if this thing is coming from her! You see what I’m talking about? But she knows that her son wants his daughter to be “this name.” We have to give her some respect, some credit, because you know she is his mother. So we said, “Oh, that’s a wonderful name!” She is
really good because she is not that kind of person to interfere in your life and to make that kind of decision for you. I know some families, mothers-in-law, who just interfere when you’re trying to make decisions. So he picked the name, but it was still my decision. I said, “You are right. This name is better and makes better meaning.” Sometimes a name has better meaning than others, you know.

Death During Delivery

Many women mentioned the predetermined status of their lives as Muslims. They accepted *tawakkul*, putting their trust in *Allah*. Repeatedly, they made reference to how God knows when their babies would be born and when they would die. In discussing the subject of childbirth, the question regarding miscarriage, stillbirth, and death of the mother was received and responded to. The women stressed that Islam teaches them “only God knows what will happen.”

All the women agreed that any Muslim woman or baby who dies during the childbirth experience will go directly to Paradise (*Janni*), which is the highest level of Heaven. Aminah stated, “We are going to die anyway whether today or tomorrow. The God knows when we going to die. But we don’t think about we going to die or not.” Death during childbirth was not something they feared. The women agreed that they were most concerned with who would care for their children after they were gone. An emotional reaction to the death of a baby was expressed by Aminah.
If the God want to make him die, it’s OK by me. It’s like the baby is alive and then at the last minute, when you deliver, the baby is going to die. You know what I mean? You know, I don’t want this to happen, not because I don’t believe in God, or anything. But I don’t want him to die right in front of my eyes. That’s what I don’t like.

Expectations of care following the death of a Muslim were also discussed. Since Muslims do not have clergy, they do not call anyone of a religious nature during the time of death. The need for a nurse’s professional expertise was not a concern for these women during their experiences with death. Aminah expressed this well. “If the baby is already dead, what can you do?”

The women expressed their need for the nurse to be like a “friend or member of the family.” Suggestions for expected behavior included: “Give her encouragement by telling her you feel what she feels;” “share your experiences with us to show us you care;” and “maybe you could cry with us.” It is unknown whether the Muslim’s body of “this life” is the same in “the next life.” Therefore, it should be handled carefully, washed, and wrapped in a clean white sheet for burial in the earth. Autopsy of the body and donation of body organs, although not haram, were strongly discouraged.

A story in the Hadith provided comfort for Aishah: A man asked the Prophet, “Muhammad, would you describe what it is like to die?” The Prophet replied, “Ask a mother when she has a baby, because she is the closest to God and Heaven in this life.”
Post-Delivery

The domains of meaning identified during the post-delivery phase included: (a) importance of rest, (b) treatment of “the blood,” (c) bathing for the mother and newborn, and (d) protection from the evil eye.

Importance of Rest

All women stressed the importance of resting during the immediate post-delivery phase. Aminah was specific in her expectations, “I want to rest after I see my baby, after they told me how he is doing. It is important!” The difficulty of labor was also a reason for Lila to rest. “After delivery I need to rest because the labor is very hard. This is very important!” The time frame for resting was addressed by Kadijah, “It is better I have rest first, for maybe three or maybe four hours.”

Treatment of “The Blood”

Treatment of the “the blood,” or the postpartum vaginal discharge known as lochia, should be washed away with water on a regular basis and attended to by the nurses if it becomes excessive. Excessive bleeding was experienced by Aminah and identified in her comment that “sometimes you know ‘the blood’ will come and sometimes it’s normal and not too much. But if it’s too much, they have to do something. The nurses know better about those things, you know.”

All women reported washing away the lochia with water during the post-delivery phase of childbirth, in their countries and the Western health care hospital. Fatimah used warm water and salt in her country because, “They do believe that a salty area will prevent any bodily infection.”
Zahrah identified the process of washing the perineal area with water as *stinga*. “This is part of being clean. As a good Muslim, this is something you do everyday whether you are a man, woman, boy, or girl.” For women, it includes washing after going to the bathroom, removing menstrual blood, or removing “the blood” following delivery. The utensil used for performing *stinga* is a “little garden can with a spout, like for watering flowers.” Some women, who were unfamiliar with the peri-bottle of the Western health care system, admitted bringing their utensils with them for use during the post-delivery phase.

**Bathing for the Mother and Newborn**

Different beliefs and behaviors regarding bathing of the woman who just delivered or the newborn baby were identified. They included a range of the woman’s bathing immediately after the rest period to waiting forty days. Bathing of the newborn ranged from during the immediate post-delivery phase to ten days post-delivery.

Zahrah stated that she bathed “as soon as I could stand up” and that her newborn was bathed in the post-delivery phase. When questioned concerning some women’s request to wait for bathing, she responded with, “No way! This is probably custom because I know it is not Islamic or in the *Qur’an*. In fact the *Qur’an* emphasizes being clean.”

Fatimah waited to shower until ten days after delivery. Her reason for waiting was offered:

It’s just tradition. They do believe that the woman who is over from her delivery, that all the belly parts are unstable because of the contractions, the pushing, and the nature of the
uterus. They don’t want to shower because they don’t want to get sick easily. But I keep myself clean. I wash my face, my hands, my arms, and my feet. I do this everyday to keep myself clean.

Not surprisingly, Fatimah did not wish to bathe her baby after delivery either. She reported, however, that when she arrived home from the hospital a few hours after delivery in her country, her mother-in-law “grabbed the baby and go right to the bathroom and start cleaning her with soap and water. My family were mad at my mother-in-law.”

Protection from the Evil Eye

Care for the newborn during the post-delivery phase was identified by all the women as being vulnerable for the infant and the “evil eye.” Although they wanted to be reassured that their newborn was healthy and nice looking, they also stressed the importance of complimenting correctly to protect their newborn from the evil eye. No one admitted protecting their newborns with amulets, beads, or miniature Qur’ans. However, recognition of these measures for protection was validated.

Aminah was the most adamant about the appropriate way to compliment a newborn. “Some people think that they going to get evil eye or something. But some, like for me, I feel happy to know when my baby nice and good-looking and healthy.” She presented examples of harmful comments: “Oh, your baby very big!” and “He is so strong!”

Lila commented that sharing basic information with the mother was encouraged, such as, “Your baby’s healthy, is this long, and has a good color.”
non-threatening. Lila also stressed the importance of not making comments of praise each time the baby is checked, “Because if you say something wonderful about the baby every fifteen minutes, that mom is going to think that maybe he is going to get the evil eye.” Prefacing your comments of praise with Ma’shallah indicates that you mean no harm. Ma’shallah means “It’s God’s will. He wants you to have this.”

A statement, which summarized the women’s comments about protection from the evil eye, was offered by Fatimah:

You cannot read what is in our heart, what is going on. But if you are honest with what you are saying and you don’t mean anything, that is okay. But if you are trying to say something which is good but you don’t mean it, this is the evil eye. You have to say what you believe.

Themes

Analysis of 327 pages of transcribed data were classified under the early labor, active labor, delivery, or post-delivery phases of childbirth. A total of 16 domains of meaning were identified. Three recurrent themes emerged, which were religiously and culturally relevant for Middle Eastern Muslim women during childbirth:

1. The will of God determines the progression and outcome of the childbirth experience.

2. Traditional beliefs influence behavior during the childbirth experience.

3. The nurse should encourage the woman during the childbirth experience.
The Will of God: Progression and Outcome of Childbirth

The will of God determines the progression and outcome of the childbirth experience for immigrant Middle Eastern Muslim women. This was expressed explicitly by the women of this study in many recurrent expressions and behaviors. Examples of the expressions and behaviors were included throughout the narrative description. The commencement of labor was considered determined by Allah and the time of birth was considered predetermined. This is supported by the belief in "tawakkul, trust the God." The utilization of medical interventions were considered ineffective in altering the time God had chosen for the baby to be born. "Making myself clean" and "talking to God" were means of ensuring His closeness and management.

"It is written" that, at the time of birth, God was responsible for hearing and granting the woman's requests, while "making her clean" of all her sins. The newborn's name, although chosen by the parents, is actually provided by God and "The God knows his name even before he is born." Performance of rituals on the newborn, immediately after delivery, protected him from the evil jinn. Even the subject of death during childbirth was in the hands of God. Comments such as "Only the God knows what will happen" and "If the God is going to make him die, that is OK with me" are examples.

Following delivery, the protection of the newborn from the evil eye is also related to God's influence. Prefacing a comment with Ma'shallah indicated that it was "God's will" that the newborn had certain attributes.
Traditional Beliefs: Influence on Behavior

Traditional beliefs influence behavior during the childbirth experience of Middle Eastern Muslim women. This was expressed explicitly by the women of this study in many recurrent expressions and behaviors. Examples of the words and behaviors were presented throughout the narrative description of this chapter.

The women said that recognition of the signs of labor were a result of traditional instruction by their mothers and their mothers-in-law. The recurrent expressions of “don’t worry” and “It’s OK” reflected their beliefs that the labor and delivery should be “normal,” and “with just nothing.” The intent to “get it over with” was accompanied by traditional methods to “induce the labor” and “labor normal at home” until it was time to go to the hospital.

Perception of labor and preparation for “what will happen” during the active phase of labor was influenced by the traditional instruction. Medical interventions identified as “not normal” and “making my labor longer” were in direct conflict with traditional beliefs of labor progression. The traditional beliefs of how the woman should “be quiet” and “don’t worry” reflected the belief of “the baby’s going to come soon.”

“Males are better than females” was traditionally explained as being the basis for preference of male newborn, with a name given from three patrilineal generations. Congratulatory words of “Mabruk” or “Al hamduo waladdah, Allah sallam” indicated their preference. The woman’s period of “rest” and variation in times for bathing mother and baby were traditional ways of viewing the post-delivery time.
The Nurse: Encouragement for the Woman

The nurse should encourage the Middle Eastern Muslim woman during the childbirth experience. Examples of expressions and behaviors which support this theme were included throughout the narrative description.

Women's expectations of how nurses should encourage them were recommended by the women in their own words, which included: "stay with me," "offer words which reassure me," "explain things to me," "talk to me," "lie to me," "tell me about things when it is time," "help me stay covered," and "don't say words which discourage me."

Encouragement also involved the nurse's recognition of the similarities as well as differences between women of various ethnic origins. The women repeatedly stated "some women are different" and valued the nurses who individualized the care. Support of the women's traditional perception of labor, the willingness to "stay with them" to help them "labor normal," "with nothing" for pain or medical interventions, and "get it over with fast" without "making surgery," were recognized as the most encouraging. Being aware of the religious requirements to stay covered, restrict people entering the room, and rituals that needed to be performed on a newborn by his father were viewed as encouraging the woman's religious beliefs. Many examples of words and actions used by the nurse were recognized by the women as genuine "caring for us, like we are women too." Respect for their religious and traditional values, as well as responding to them as "normal" women, were the most appreciated forms of encouragement.
Summary

The purpose of this nursing research study was to identify and describe the beliefs, behaviors, and expectations of immigrant Middle Eastern Muslim women during childbirth in a Western health care system, from an emic point of view. Presentation of the findings included a narrative description of the analysis of data.

Analysis of the data included coding of 327 pages of transcribed data obtained from personal narratives, semi-structured interviews, and field notes. The data were categorized into groups focused on the sequential phases of the childbirth experience: early labor, active labor, delivery, and post-delivery.

The subsequent classification of 16 domains of meaning were identified and supported by rich narrative descriptions. An integration of these domains emerged as three recurrent themes: (a) The will of God determines the progression and outcome of the childbirth experience; (b) traditional beliefs influence behavior during the childbirth experience; and (c) the nurse should encourage the woman during the childbirth experience. The identified themes were religiously and culturally relevant for Middle Eastern Muslim women during childbirth.
CHAPTER V
DISCUSSION

The purpose of this research study was to identify and describe the beliefs, behaviors and expectations of immigrant Middle Eastern Muslim women during childbirth in a Western health care system, from an emic point of view. A discussion of the interpretation of the findings, implications for nursing practice, limitations of the study, and recommendations for future research will be presented in this chapter.

Interpretation of Findings

The following research questions regarding immigrant Middle Eastern Muslim women who received nursing care during childbirth in a Western health care system were raised:

1. What words and phrases did the women use to describe their childbirth experience?
2. What tacit and explicit beliefs provided cultural and/or religious meaning for the women?
3. How did the women describe their behaviors and the behaviors of individuals present during the childbirth experience?
4. What expectations or ascribed roles did the women identify for themselves, other individuals, and nurses who provided care during the childbirth experience?
In this ethnographic study, seven informants provided thick descriptions of their childbirth experiences in the Western health care system and their home countries. As the interview sessions progressed, recurrent words and phrases occurred throughout. These recurrent words and phrases were placed in quotation marks and the Arabic words were set in bold italic type for emphasis. Examples of the most recurrent phrases which occurred throughout the four phases of childbirth included: “only the God knows what will happen,” “make myself clean,” “get it over with,” and “make it normal.”

The women in this sample were very explicit in identifying their beliefs. They were also capable of differentiating when the belief was religiously based and culturally based. The women used the word “traditional” when they referred to an area influenced by culture. An example of an explicit traditional belief was, “My mother taught me everything I needed to know.” An example of another explicit belief which was religiously based was, “When the baby comes out, the Heavens will open and God will grant me what I ask, and cleans me of my sins.” A culturally/religiously integrated explicit belief was revealed: Medical intervention during the childbirth experience was “not normal” and would not make a difference because everything that happens is predetermined by God, and only He knows how and when it will happen. Although a few of the informants denied that newborn gender made a difference to them, a culturally and religiously integrated tacit belief emerged which indicated that male babies are preferred over female babies.
Thick, descriptive data yielded a wealth of behaviors and subsequent expectations of the women during their childbirth experience. Sixteen domains of meaning emerged from the data. These domains were intricately woven as threads throughout the three identified themes. These behaviors and expectations were thoroughly described in the preceding chapter.

**Implications for Nursing Practice**

It was determined that the knowledge base which served as the foundation for nurses caring for immigrant Middle Eastern women during childbirth, was inadequate to direct congruent nursing care. Although some of the data gathered from this study strengthened the research base, new information revealed beliefs and behaviors which had not been identified in the literature. Communication of this study’s findings will establish a research guided, nursing knowledge base to provide the women with culturally and religiously congruent care.

**New Findings**

The literature revealed that Middle Eastern women do not prepare for their births. However, this study produced strong evidence that they did prepare for the childbirth experience. They all received prenatal care from either a physician or midwife. In accordance with the Qur’an, they chose a female to care for them to avoid being seen uncovered by anyone considered forbidden. An explicit list of reasons for not attending childbirth classes, both religiously and culturally based, was provided by the women. They stressed the importance of receiving “traditional” instruction from either their mothers or mothers-in-law to prepare them
for "what will happen." Although the inclusion of anatomy and physiology was not part of the instruction, the women were adamant that they expected the nurse to explain this when the actual event occurred. The Islamic requirement of "making myself clean" by removing all the body hair (underarms, pubis, and legs) once a month following menstruation, was not in the literature. However, the importance of performing this task in preparation for childbirth was a high priority for them, and was performed in varying degrees by each of the Muslim women. This information corrected the pre-conceived idea verbalized by American nurses: "They removed all their body hair because they didn't want us to do it before the delivery. They don't know that we don't shave the pubic area anymore."

A review of the literature indicated that Middle Eastern women have a low tolerance for pain and are extremely verbal in their expression of pain during the childbirth experience, with moaning, groaning, and screaming. A preference for large pills and injections used to relieve the pain and patient denial of spinal or epidural anesthesia was also suggested. The women in this study contradicted the literature. All the women revealed that they preferred to have "nothing" for the pain of labor. Two admitted getting epidurals, because they were more concerned with being quiet when the nurses would not help them. Great importance was placed on the anticipated behavior of a Muslim woman as soft spoken and quiet, based on a verse in the Qur'an. Every woman referenced the importance of being quiet and explained how they were rewarded by Allah for their adherence. The women who admitted letting out a small
scream “during the last 15 minutes” before delivery, justified this by “being good” throughout their labor. Reference was also concerning bearing the pain by one woman who grabbed something to avoid screaming. The literature indicated that Sunnis respond to pain differently than Shi’is. However, no difference was found between the six Sunni women and the one Shi’i woman in this study.

The literature relied heavily on the Middle Eastern woman’s family being there to provide her with considerable support during childbirth. Emphasis was placed on the importance of the mother, and the exclusion of the husband. However, no reference was found which indicated that the women expected or were dependent upon the nurses for a great amount of encouragement. An extensive list of these expectations was presented in the preceding chapter. The highest priority of ways to show encouragement was to “stay with me,” “talk to me,” “explain things to me.” and “lie to me.” The Western health care nurse is not trained to lie to any patient. However, saying encouraging things that the patient would like to hear, based on fact, would be an acceptable alternative for Middle Eastern Muslim women. It must be kept in mind that these women were students or wives of students who were here on an immigrant basis, many without their families. This was expressed as having little effect on their desire for the nurse to encourage them in ways which their families were unable to. Examples were provided of their mothers and/or husbands being present during the childbirth experience. Although husbands were traditionally not allowed in their home countries, most women expressed a need to have them present, satisfying a need which was different from
the nurse’s role. Although all the women experienced having their mothers available for support during childbirth (with one exception), five women stated that they preferred having the husbands present instead of their mothers. This was because the mother would cry and tell them what to do; the husband got them water and told them “It’s OK, you can do it.”

The rituals for the newborn (adhan and shahadah, and honey or dates placed on the tongue), were discussed by the women in fine detail, but, were not located in any of the literature. The importance of being aware of and understanding the requirements of a religion can not be stressed enough. Islam is one of the major religions of the world. Nurses need to be aware of the rituals which are expected to be performed by Middle Eastern Islamic fathers, following the birth. This information needs to be shared to honor the women’s beliefs and prevent the newborns from being unprotected from the jinn.

Some American nurses verbalized that the Middle Eastern Muslim woman’s process for naming a newborn was seen as a form of hesitation at birth and lack of bonding. If the newborn was another girl, the mother’s reaction of turning away was considered appropriate by the Middle Eastern women (preference for boys). However, this was a reason for concern in Western hospitals. This reaction was secondary to the previous nursing knowledge deficit regarding how Middle Eastern Muslim newborns are named and the gender preferred. The nurse’s knowledge of the Middle Eastern Muslim women’s method of naming and preference for male newborns will alleviate this misunderstanding. Each individual receives a given name, father’s first name, and paternal
grandfather's first name. This differs from the American method of naming. Additionally, Muslim newborns receive their names from Allah, and the mother may be hesitating until she is sure the right name was chosen. With this knowledge, nurses will no longer be concerned when woman has no name for the newborn, congruent with the beliefs.

Findings Supported by Research

The literature agreed with the findings of the study concerning the women's reluctance to go to the hospital in early labor and the women's preference to avoid medical interventions. This was based on cultural and religious beliefs. A cultural belief, that labors with male babies were harder, was identified by one of the informants in this study and supported by the research base. One informant's husband was identified as being shy and avoided the actual delivery, and this was congruent with the literature. However, the need for the Muslim woman's protection of modesty, need to stay covered, and be seen only female health professionals was apparent in both the literature and the findings of this study.

Integration of New and Existing Findings

Implications for nursing practice, based on the new and existing findings are evident. Nurses need to understand why the Middle Eastern Muslim women's behaviors occur, and that they are a result of cultural and religious beliefs. Nurses who understand the women's beliefs will not be confused by the related behaviors. Access to these integrated findings will direct the nursing profession in clinical practice and formation of emerging theory, guided by a conceptual model of nursing.
Conceptual Model

The Middle Eastern woman's perception of the childbirth experience was directly influenced by the four concepts of the nursing metaparadigm in Guerra's Conceptual Model of Nursing: person, environment, health, and nursing. Sixteen domains of meaning were identified and interwoven throughout the model by three primary themes (identified in preceding chapter). Each domain was represented in the variables located within each concept.

The concept of person was influenced by changes in the variables: biological effect of the pregnancy, psychological and sociological adjustment related to family's unavailability, cultural adaptations secondary to living in a foreign country, and spiritual implications related to Islamic beliefs. The environment was influenced by many variables in this study: the historical event of immigration, family organization changes imposed by living in a foreign country, separated from family, level of education which affects ability to understand differences, religious beliefs as a Muslim, and ethnic identity as a person from a Middle East country. The concept of health was affected by the impact of the environment and the person's impression of self. The conflict between the nurse's perception and the woman's perception of what a childbirth experience should be, and the differences between the Western health care practices and those of the woman's home country, were factors identified by this study which affected the concept of health. The concept of nursing integrated the concepts of person, environment, and health holistically to develop an empirical knowledge base, related to the
findings of this study. Communication of this knowledge base will facilitate the provision of congruent and comprehensive clinical care, based on professional judgement and ethical consideration for the Middle Eastern Muslim woman’s beliefs and expectations. Therefore, this model adequately met the stated purpose and provided continuity for the themes which transgressed each concept.

**Limitations of Study**

Limitations to this study were noted throughout the data collection and analysis phases. One primary limitation to this particular study was the invasion of Kuwait one day following receipt of the letter from the human subjects review committee, granting permission to proceed with data collection. Women initially were unwilling to talk, related to the volatile situation in their home countries and their expressions of distrust for Americans. When they finally agreed to meet in groups and couplets to support each other, the data collection phase progressed more effectively.

The limitation of time prevented further data collection from other women willing to share their experiences. Two women offered to arrange more interviews with the women’s group from their country. Their interest in the study was overwhelming. Informing them that the time allowed for completion of data collection had passed was quite difficult for the researcher.

Inclusion of equal numbers of Sunni and Shi’i women was limited by the fact that Muslims from different sects do not interact in this community. Therefore, referrals included members of the same sect.
Women agreed that they tended to remain involved with other women from the same home country. This was observed by Iraqis mingling with Iraqis, and never with women from Saudi Arabia. Although two women lived next door in an apartment complex, one did not refer the other. This placed a limitation on the recruitment of informants.

Another limitation was the presence of one husband who assisted his wife with periodic translations. More personal information might have been obtained in his absence. However, the positive side of this was his willingness to share the male point of view on several issues, which added quality to the data.

It is understood that the application of any qualitative study with a small sample size, such as this one, is not generalizable to the population. Although a diverse population was recruited, limited application to the immigrant Muslim population is affected by the fact that only one Shi‘i Muslim was recruited for the study. This resulted in the following question: Are the beliefs, behaviors, and expectations during the childbirth experience similar or different between Sunni Muslims and Shi‘i Muslims?

**Recommendations for Future Research**

Since the research base indicated that differences exist in the interpretation of the *Qur'an*, *Hadith*, and *Shari'a*, future research should include an equally proportionate sample of Sunni Muslims and Shi‘i Muslims to determine if similarities exist.
Replication of this study with a different sample would increase reliability and validity of the findings from this study. Consideration should be given to the selection of a sample from a university setting in another geographic area of the United States with a comparable Middle Eastern student population.

This study dealt with immigrants who were obtaining higher education in a foreign country. All of the women in this sample were from urban backgrounds. A comparative study of samples from rural versus urban backgrounds is recommended. A comparative study of highly educated versus minimally educated individuals is also suggested.

Individuals in a sample who immigrated for reasons other than education, such as freedom from political situations or escape from areas of war, might produce different findings. Therefore, this aspect should also be explored further.

Conclusion

An increasing number of immigrant Middle Eastern Muslim women are expected to arrive, in the midst of childbirth, at hospitals across the United States. The diversity of these women is related to their affiliations with different sects of Islam and ethnic ties to different countries where their cultural imprints were made. One individual does not represent the beliefs, behaviors and expectations of a whole country; and one country does not represent the beliefs, behaviors, and expectations of the entire Middle East. Although individual differences were expressed in the women's stories concerning childbirth, threads of similarities were identified in the recurrent domains of meaning and themes.
Identification of 16 domains and 3 themes were derived from this ethnographic study of seven Middle Eastern Muslim women during childbirth in the Western health care system. The women expressed their points of view during the phases of early labor, active labor, delivery, and post-delivery. Cultural and religious beliefs influenced and were manifested in the women's behaviors and stated expectations.

The findings from this study strengthened the existing nursing research base with examples of the women's beliefs, behaviors, and expectations. Additionally, interpretation of the findings revealed new data which were either previously unidentified or contradicted the existing knowledge base.

Implications for nursing practice were numerous. Research based findings affect how congruent nursing care is provided. Findings of this study include: (a) reasons for not attending childbirth classes; (b) ways to prepare for the childbirth experience; (c) Islamic removal of body hair to "make themselves clean;" (d) recognition of signs of labor (e) methods to "induce the labor;" (f) preference to "labor normal" at home and go to the hospital only for delivery; (g) importance of talking to God during labor (h) preference for a "quiet" labor, without medication or anesthesia; (i) request to labor without medical intervention; (j) influence of Islamic beliefs at time of delivery; (k) need for nurses to provide encouragement, including an explicit list of ways to accomplish this; (l) dealing with the death of a newborn or mother; (m) rituals for the newborn after delivery; (n) process of naming the newborn; (o) bathing and treatment of "the blood" after delivery; and (p) protection from the evil eye.
Interpretation of the research based findings from this study will eliminate previous discrepancies and preconceived ideas, which formally jeopardized the care of Middle Eastern Muslim women during childbirth. Communication of the findings will create a more accurate and comprehensive research guided knowledge base for the nursing profession. This knowledge base will convey numerous implications for nursing practice. Nurses will understand why the women’s behaviors occur and certain expectations exist, as a result of the cultural and religious beliefs. Frustration, dissatisfaction, and misinterpretation, which were previously expressed by the nurses providing care and the women receiving care in Western hospitals, will be prevented. Most importantly, Western health care nurses will be able to provide culturally and religiously congruent nursing care to Middle Eastern Muslim women during childbirth.
APPENDIX A
HUMAN SUBJECTS APPROVAL

MEMORANDUM

TO: Anna O'Bannon Guerra

FROM: Carolyn Murdaugh, Ph.D., R.N., F.A.A.N.
Director of Clinical Research

DATE: July 30, 1990

SUBJECT: Human Subjects Review: "Middle Eastern Islamic Women: Beliefs, Behaviors, and Expectations During Childbirth"

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

CM: dbbr
APPENDIX B
DISCLAIMER

Middle Eastern Muslim Women: 
Beliefs, Behaviors, and Expectations 
During Childbirth

You are being asked to tell your story about what it was like to give birth to a baby in the United States. Your story will help nurses to understand what you believe and how you would like to be treated when you or one of your friends gives birth to a baby. Your name will not be written anywhere in my report and no one will be able to tell which story belongs to you. You can ask any questions while we are talking and I will answer you honestly. You do not have to answer all of the questions. You can even choose which questions you want to answer. If you have another baby in the United States, your care will not be affected by your decision to share your story or your decision to not answer any questions. You may also drop out of the study whenever you feel like it and I will not be angry with you.

Anna O’Bannon Guerra
Graduate Student
University of Arizona
College of Nursing
APPENDIX C
INTERVIEW QUESTIONS

Broad Questions

1. How did you know you were in labor?
2. What did you do before you went to the hospital?
2. How did you know it was time to go to the hospital?
3. Who was with you when you were having your baby?
4. How did people help you when you were having your baby?
7. What did you do when the pains started hurting a lot?

Focused Questions

1. How did Allah help you during the birth of your baby?
2. What is done special for you or the baby in your home country?
3. What did the nurses do which was good for the birth of your baby?
4. What did the nurses do that was not helpful for you or the baby?
5. Who should the nurses talk to when they are trying to help?
6. What is forbidden or dangerous for you and your baby?
7. What did your husband do during the birth of your baby?
REFERENCES


