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FAITH, BIRTH, AND BELONGING: MUSLIM WOMEN'S EXPERIENCES OF CULTURALLY AND RELIGIOUSLY SENSITIVE MATERNITY CARE IN AUSTRALIA

Hajer Jemai[*], Mohamad Abdalla [**], Rhian Cramer[***], and Professor Gina Kruger[****]

Abstract: Muslim women in Western healthcare often experience maternity care that does not adequately address their religious, cultural, and spiritual needs, potentially impacting their sense of safety, dignity, and mental wellbeing. Despite increased focus on cultural safety and person-centred approaches, research on Muslim women's maternity experiences in Australia remains limited. This study explores their lived experiences with maternity care in Australia to understand how cultural, religious, and systemic factors influence their emotional and psychological wellbeing. Using an Interpretative Phenomenological Analysis (IPA) method, in-depth semi-structured interviews were conducted with 14 Muslim women who gave birth in Australian public hospitals within the past two years. Participants were recruited from Western Australia, Victoria, and New South Wales. Data was analysed iteratively to understand their meaning-making processes, interpreted through Islamic psychology and the Cultural Safety Model. Four key themes emerged: (1) cultural and religious insensitivity in maternity care, (2) navigating the system through advocacy and assimilation, (3) silencing, stigma, and emotional damage, and (4) positive experiences marked by respect, listening, and support. Participants reported that stereotyping, dismissiveness, and lack of institutional readiness often cause emotional distress, withdrawal from care, or hesitation to express needs. In contrast, culturally and religiously responsive interactions build trust and psychological safety. These findings emphasise the importance of maternity care that recognises religious identity as central to women's wellbeing. The study highlights the need for culturally and religiously sensitive maternity practices, health professional reflexivity, and systemic accountability to improve equity and maternal experiences for Muslim women in Australia.

Keywords: *Muslim women*, *maternity care*, *cultural safety*, *religious sensitivity*, *maternal mental wellbeing*

[*] PhD candidate (public health) at the College of Sport, Health and Engineering, Victoria University, Australia.

[**] Founding Director and Professor of Islamic Studies at the Centre for Islamic Thought & Education, Adelaide University.

[***] Senior lecturer – Midwifery Course Chair – Bachelor of Midwifery/Bachelor of Nursing. Midwifery Professional Practice Lead at the College of Sport, Health and Engineering, Victoria University, Australia.

[****] Head of Program – Nursing and Midwifery, Midwifery Discipline Lead, College of Sport, Health and Engineering, Victoria University, Australia.

INTRODUCTION

Women from marginalised communities in Western countries experience persistent disparities in maternity care, particularly when services fail to recognise and respect cultural and religious identities.[1] Such gaps in culturally and religiously sensitive care are associated with mistrust, disengagement from healthcare, and poor health outcomes.[2] This is especially relevant for the growing Muslim population in Australia, where women often navigate maternity systems that do not adequately account for their religious and cultural needs,[3] reinforcing experiences of otherness despite national commitments to multicultural inclusion.

The quality of maternity care has significant implications for maternal mental wellbeing. Experiences of being judged, misunderstood, or unsupported during pregnancy, birth, and the postpartum period are associated with increased risks of anxiety, depression, and trauma-related distress.[4] For Muslim women, the absence of culturally and religiously sensitive care may intensify feelings of loneliness, fear, and vulnerability during childbirth. These experiences are further shaped by broader social contexts, including Islamophobia,[5] which may manifest in maternity care through stereotyping, microaggressions, or systemic neglect, undermining trust and psychological safety.

The intersection of gendered and religious marginalisation can cause Muslim women to experience maternity care not as a place of support, but as one marked by exclusion and anxiety.[6] Recognising how cultural and religious insensitivity—exacerbated by Islamophobia—affects maternal mental wellbeing is therefore crucial for addressing inequalities in care and for re-evaluating maternity systems to ensure they are not only clinically effective but also culturally and religiously respectful.[7]

Within Islam, maternity care is understood through religious, emotional, and communal frameworks that shape how pregnancy and childbirth are experienced. Concepts such as modesty (*haya*), trust in God (*tawakkul*), and the framing of childbirth as a form of worship (*'ibadah*)[8] influence expectations of care, decision-making, and emotional safety. Challenges frequently arise when these needs are not recognised in clinical settings, including modesty,

1 Lynn Callister and Inaam Khalaf, "Spirituality in Childbearing Women," *Journal of Perinatal Education* 19, no. 2 (2010).

2 Mellissa Withers, Nina Kharazmi, and Esther Lim, "Traditional Beliefs and Practices in Pregnancy, Childbirth and Postpartum: A Review of the Evidence from Asian Countries," *Midwifery* 56 (2018).

3 Sukhpreet Bains et al., "Satisfaction with Maternity Care among Recent Migrants: An Interview Questionnaire-Based Study," *BMJ Open* 11, no. 2 (2021), https://doi.org/10.1136/bmjopen-2020-048077.

4 Gina M. A. Higginbottom et al., "Experience of and Access to Maternity Care in the UK by Immigrant Women: A Narrative Synthesis Systematic Review," *BMJ Open* 9, no. 12 (2019), https://doi.org/10.1136/bmjopen-2019-029478; Hala Bawadi, Zaid Al-Hamdan, and Muayyad M. Ahmad, "Needs of Migrant Arab Muslim Childbearing Women in the United Kingdom," *Journal of Transcultural Nursing* 31, no. 6 (2020).

5 Farah Elahi and Omar Khan, *Islamophobia: Still a Challenge for us all* (Runnymede Trust, 2017), accessed November 15, 2025, https://www.runnymedetrust.org/publications/islamophobia-still-a-challenge-for-us-all.

6 Higginbottom et al., "Experience of and Access to Maternity Care."

7 Aaliyah Shaikh, "Human Rights in Childbearing 10: Acknowledging Islamophobia and Discrimination in Healthcare: The Perinatal Experiences of British Muslims," *The Practising Midwife* 26, no. 6 (2023), https://doi.org/10.55975/OXKO1768.

8 Callister and Khalaf, "Spirituality in Childbearing Women," 18.

gender concordance, and religious practices.[9] When such concerns are dismissed or minimised, women may experience emotional distress, compromised dignity, and increased mental burden during an already vulnerable period.[10]

Despite growing attention to cultural safety and person-centred care, research on Muslim women's maternity experiences in Australia remains limited. Existing studies often categorise Muslim women broadly within "CALD" populations, overlooking the religious, cultural, and gendered dimensions that shape their care experiences, including modesty, spirituality, stereotyping, and Islamophobia.[11] This study addresses this gap by centring Muslim women's voices and exploring how religious identity intersects with maternity care experiences across the Australian public health system. Much of the available research lacks depth, varies in quality, or is conducted outside the Australian context,[12] and few studies prioritise Muslim women's voices.[13] This gap risks perpetuating maternity care practices that fail to support trust, safety, and mental wellbeing. Therefore, this article reports on the Phase 1 findings from a larger three-phase mixed-methods study aimed at developing a culturally and religiously sensitive maternity care framework for Muslim women in Australia.

RESEARCH QUESTION

What are the lived experiences of Muslim women navigating maternity care in Australia, and how do these experiences influence their mental wellbeing?

By centring Muslim women's voices, this study addresses a critical gap in the literature and contributes to a more nuanced understanding of how religious identity intersects with maternity care experiences in the Australian context. The findings offer insights to inform culturally and religiously sensitive maternity care practices, healthcare professional education, and inclusive policy development.

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9 Sean Tackett et al., "Barriers to Healthcare among Muslim Women: A Narrative Review of the Literature," *Women's Studies International Forum* 69 (2018); Emma Sacks et al., "Immigrant Women's and Families' Views and Experiences of Routine Postnatal Care: Findings from a Qualitative Evidence Synthesis," *BMJ Global Health* 9, no. 1 (2024), https://doi.org/10.1136/bmjgh-2023-014075.

10 Gina M. Higginbottom et al., "Immigrant Women's Experiences of Maternity-Care Services in Canada: A Systematic Review Using a Narrative Synthesis," *Systematic Reviews* 4 (2015): 13.

11 Aljawaharah al-Mubarak et al., "The Impact of Culture on Access to and Utilisation of Maternity Care Amongst Muslim Women in High Income Countries," *BJOG: An International Journal of Obstetrics & Gynaecology* (2025), https://doi.org/10.1111/1471-0528.18290.

12 Ibid., 2000.

13 Tasneema Firdous, Zoe Darwin, and Shaima M. Hassan, "Muslim Women's Experiences of Maternity Services in the UK: Qualitative Systematic Review and Thematic Synthesis," *BMC Pregnancy and Childbirth* 20, no. 1 (2020), https://doi.org/10.1186/s12884-020-2811-8; Shaima M. Hassan, Conan Leavey, and Jane Rooney, "Exploring English-Speaking Muslim Women's First-Time Maternity Experiences: A Qualitative Longitudinal Interview Study," *BMC Pregnancy and Childbirth* 19, no. 1 (2019), https://doi.org/10.1186/s12884-019-2302-y.

METHODOLOGY

Design

This study employs Interpretative Phenomenological Analysis (IPA) to explore how Muslim women in Australia perceive their maternity care experiences in the context of their religious, cultural, and sociopolitical backgrounds. IPA is suitable for investigating phenomena shaped by emotion, embodiment, faith, and marginalisation, as it emphasises participants as active meaning-makers and acknowledges the researcher's interpretive role.[14] This method supports the study's goal of highlighting Muslim women's perspectives in an area of maternity care that is still underrepresented in Australia.

Data Collection

Data was gathered through semi-structured interviews conducted in virtual meeting rooms via Microsoft Teams. This method offered a balance of structure and flexibility, allowing participants to delve into their experiences while enabling the researcher to pursue topics as they arose. Interviews lasted around 45 minutes to an hour and were audio-recorded with participants' consent. The recordings were securely stored before being transcribed verbatim for analysis.

An interview guide (see Appendix 1) was created to examine participants' experiences with maternity care, emphasising religious and cultural sensitivity. The open-ended questions prompted reflection on their pregnancy, birth, and postnatal care within the Australian healthcare system. Key topics included:

- Expectations of maternity care.
- How their religious and cultural needs were met (or unmet).
- Moments of comfort or discomfort during care.
- Views on modesty, dignity, and emotional safety.
- The influence of faith on coping or meaning making.
- Recommendations for more inclusive and sensitive healthcare.

Prompts and follow-up questions were used flexibly to facilitate in-depth discussion related to the participant's lived experience. The interview guide was based on the study's theoretical framework and piloted with two Muslim women to ensure the questions were precise and culturally sensitive.

Reflexivity

As a Muslim woman, mother, and doctoral researcher examining culturally and religiously sensitive maternity care for Muslim women in Australia, the primary researcher's positionality

[14] Jonathan A. Smith and Michael Osborn, "Interpretative Phenomenological Analysis," in *Doing Social Psychology Research*, ed. Glynis M. Breakwell (Sage, 2008), https://doi.org/10.1002/9780470776278.ch10.

has shaped the study's focus, interpretive lens, and emotional depth. The primary researcher's lived experience navigating Western healthcare systems as a visibly Muslim woman informed the research questions and enhanced my capacity to listen attentively to what is often unspoken in dominant maternity care narratives.

Reflexivity—analysing one's positionality, assumptions, and influence—is vital in qualitative research.[15] In this study, the primary researcher played insider (emic) and outsider (etic) roles.[16] As insiders, participants shared their religious and cultural perspectives, which built trust and enabled them to speak openly about topics such as modesty, fasting during pregnancy, *tawakkul* (trust in God), and respectful care expectations. As an outsider, the primary researcher kept a critical distance to examine systemic, relational, and institutional factors affecting women's experiences. Reflexivity was maintained through journaling, member checking, and supervision, ensuring that interpretations were rooted in participants' narratives rather than the primary researcher's personal views.

This research took place amid increased global scrutiny and hostility towards Muslim identity, especially after October 7 (the Gaza Genocide). This environment influenced the primary researcher's reflexive process, sometimes leading to self-doubt and internal pressure to tone down faith-based views in academic writing. Acknowledging this tension became a key part of reflexivity, encouraging the researchers to consciously maintain authenticity and integrity in the production of knowledge.

Experiences of overt and subtle Islamophobia—societal and academic—have informed the researchers' awareness of how Muslim voices are often marginalised. Rather than diminishing the research, these realities strengthened the researchers' commitment to foreground women's lived experiences with honesty and care. Support from supervisors and reflective practice reinforced that academic rigour and faith-informed perspectives are not mutually exclusive.

Guided by the Islamic principles of *amanah*[17] (trust) and *ihsan*[18] (excellence with sincerity), I approached this research as a responsibility to honour participants' stories and advocate for maternity systems that recognise Muslim women as whole persons. Reflexivity in this study is not only methodological but ethical—grounded in accountability, dignity, and justice.

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15 Linda Finlay, "'Outing' the Researcher: The Provenance, Process, and Practice of Reflexivity," *Qualitative Health Research* 12, no. 4 (2002).

16 Martyn Hammersley and Paul Atkinson, *Ethnography: Principles in Practice* (Routledge, 2007).

17 The Arabic term *amānah* (الأمانة) carries a rich meaning that encompasses trust, responsibility, integrity, and moral accountability. It is one of the foundational concepts in the Qurʾān and Islamic ethics, central to the formation of character (*akhlāq*), leadership, and social justice. Upholding *amānah* is the essence of *īmān* (faith); violating it erodes the foundations of character, leadership, and civilisation.

18 *Iḥsān* (الإحسان), from the root ḥ–s–n (ح–س–ن), and is best defined in the *ḥadīth* of Jibrīl (a.s.), where the Prophet ﷺ said: "*Iḥsān* is that you worship Allah as though you see Him; and if you do not see Him, indeed He sees you" – Muslim ibn al-Hajjaj, *Sahih Muslim*, trans. Abdul Hamid Siddiqui, Book 1 (Kitab al-Iman), no. 8. In essence, *iḥsān* is to perfect what you do because you know Allah is watching, the summit of *tarbiyah*, where knowledge (*ʿilm*), faith (*īmān*), and action (*ʿamal*) converge in beauty (*ḥusn*).

Theoretical Framework

This research is guided by two complementary frameworks: Islamic Psychology and the Cultural Safety Model. These frameworks allowed for analysis that considers internal meaning-making processes and the larger power structures within maternity care systems.

Islamic Psychology (*ʿIlm al-Nafs*) views humans as a complete entity, including emotional, spiritual, moral, and relational aspects.[19] Based on modern models rooted in classical teachings, like Rothman's Islamic Model of the Soul, this approach emphasises the *qalb* (heart) and spirit (*rūḥ*)[20] as key in influencing responses to vulnerability, trust, dignity, and emotional challenges. This study selectively applied Islamic Psychology, focusing on elements most relevant to maternity care and meaning making. These included *tawḥīd* (the integrated unity of the self),[21] the *nafs–qalb–rūḥ* relational model,[22] and processes of moral and spiritual development like *akhlaq* and *tazkiyah*.[23] Collectively, these aspects help to interpret how religious concepts—such as modesty, trust in God, and the spiritual perspective on childbirth—influenced women's care experiences and mental wellbeing, while also recognising diversity in beliefs and practices.

The Cultural Safety Model emphasises relational, organisational, and systemic influences on safety perceptions in care. Based on Māori nursing scholarship, it shifts focus from individual cultural abilities to tackling power imbalances, encouraging healthcare professionals to reflect, and holding institutions accountable.[24] This framework is particularly effective in examining how factors such as Islamophobia, stereotyping, and systemic practices within Australian maternity services affect women's capacity to communicate their needs, preserve dignity, and feel psychologically safe.

Integrating Islamic Psychology with Cultural Safety provided a comprehensive understanding of Muslim women's maternity experiences, considering their internal religious beliefs alongside the external healthcare environments. This approach enabled analysis that was culturally, religiously, and socially sensitive, aligning well with IPA's goals.

Ethical Considerations

This research was approved by the Victoria University Human Research Ethics Committee on 5 December 2024. Potential participants were informed about the research, including their role in the project, rights, and voluntary nature of their participation. After expressing interest,

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19 Abdallah Rothman and Adrian Coyle, "Toward a Framework for Islamic Psychology and Psychotherapy: An Islamic Model of the Soul," *Journal of Religion and Health* 57, no. 5 (2018); G. Hussein Rassool, *Islamic Psychology: Human Behaviour and Experience from an Islamic Perspective* (Routledge, 2021), 1–24.

20 Rothman and Coyle, "Toward a Framework for Islamic Psychology and Psychotherapy," 1735.

21 Ibid.

22 Ibid.

23 Abroo A. Andrabi, "Human Psychology and Spiritual Development: An Islamic Perspective," *International Journal for Multidisciplinary Research* 7, no. 3 (2025).

24 Irihapeti M. Ramsden, *Kawa Whakaruruhau: Cultural Safety in Nursing Education in Aotearoa* (Nursing Council of New Zealand, 1992), 22.

these women received an email with an information sheet detailing the study's goals, procedures, confidentiality policies, and their right to withdraw at any time without consequence. They then had the option to respond if they wanted to continue.

Potential participants who agreed to proceed received a consent form to review, sign, and return at least one week prior to their interview. This provided time for reflection and ensured that consent was given voluntarily and thoughtfully.

Due to the topic's sensitive nature, participants were informed that they could pause or end the interview at any time. They were also given contact information for free mental health and support services in case the interview caused emotional distress.

All interviews took place in a private online environment, with data securely stored and anonymised to safeguard participants' identities. Participants were assigned pseudonyms for reporting purposes. The research followed ethical standards for studies involving human subjects, prioritising informed consent, confidentiality, and respectful treatment of individuals from diverse cultural and religious backgrounds.

Participants

Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Muslim woman	Non-Muslim woman
Gave birth in the past two years in Australia	Has never given birth in Australia
Has lived in Australia for at least 12 months	Has lived in Australia for less than 12 months
Able to converse in English to participate in interviews	Non-fluent English speaker

This study involved 14 Muslim women who had given birth in an Australian public hospital within the two years prior to the interview. Participants were recruited from public hospitals in Western Australia, Victoria, and New South Wales. As shown in Table 2, participants were aged 21–40 years, and their parity ranged from first-time mothers to those with up to six children. All participants were fluent in English. One participant later withdrew due to concerns about the disclosure of personal information, and all associated data was removed.

Eligibility criteria included identifying as a Muslim woman, having resided in Australia for at least 12 months, and having experienced pregnancy, birth, and postnatal care within the public healthcare system. The 12-month residency criterion ensured participants had engaged with the continuum of Australian maternity care, from antenatal services to postnatal support, allowing for informed reflection on their experiences. Focusing on public hospitals provided consistency in the healthcare context.

Table 2: Participant demographics

Characteristic	n (14)
Age	
20-24	4
25-29	6
30-34	2
35-39	1
40+	1
Number of children	
Primiparous (first-time mother)	5
Multiparous (2 or more children)	9
2 children	2
3 children	3
4 children	2
5 children	1
6 children	1
Years lived in Australia.	
10 years or less	1
11-15 years	0
16-20 years	1
21-25 years	2
Born in Australia	10
Ethnic background	
Arab	4
South Asian	6
African	3
South American	1

Purposive and snowball sampling strategies were employed to recruit participants. Purposive sampling involves the deliberate selection of individuals with characteristics or experiences relevant to the research question—in this case, Muslim women in Australia who have experienced maternity care.[25] Snowball sampling involves asking initial participants to refer others who meet the study criteria, which can help reach individuals who might not be accessible through conventional recruitment methods. Recruitment methods included distributing flyers on social media and in community settings, such as mosques and community centres.

[25] Samantha J. Charlick et al., "Making Sense of Participant Experiences: Interpretative Phenomenological Analysis in Midwifery Research," *International Journal of Doctoral Studies* 11 (2016)

The target sample size of 12–15 participants aligns with recommendations for IPA, as smaller samples allow for in-depth data exploration and are generally sufficient to achieve data saturation.[26]

While the study aimed to capture diverse perspectives of childbirth, limiting participation to English-speaking women excludes insights from recently arrived migrants and women with limited English proficiency. These women may face additional barriers due to language-related challenges, which this study could not address because of a lack of interpreters and translated materials.[27] Collecting data in a single language, however, helped maintain consistency and reduce the risk of misinterpretation during the qualitative analysis.[28]

Data Analysis

Interviews were examined using IPA, following the approach of Smith, Flowers, and Larkin.[29] Transcripts were read and re-read to ensure complete immersion and familiarity. The initial analysis captured descriptive, linguistic, and conceptual comments, with IPA's idiographic commitment. Cases were analysed individually before conducting cross-case analysis to identify patterns and higher-order themes while preserving experiential nuance.

The analysis focused on how participants interpret their maternity care experiences within religious, cultural, and healthcare contexts. Reflexive journaling was consistently used to recognise the double hermeneutic process and to set aside preconceptions during analysis. For example, when a participant referred to a midwife's comment about having four children as indicating excess, reflexive notes helped explore how cultural norms, power dynamics, and subtle judgments shaped her perception.

Using inductive theme development, the participants' stories were analysed through Islamic Psychology and the Cultural Safety Model to reveal internal meaning making and wider relational and systemic influences.

Trustworthiness and Rigour

Multiple strategies were employed to ensure analytic rigour and trustworthiness throughout the IPA process. Credibility was supported through sustained engagement with the data, including repeated reading of transcripts, systematic line-by-line coding, and iterative movement between individual cases and cross-case patterns. Participants' accounts were

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26 Mohd. A. Majid et al., "Achieving Data Saturation: Evidence from a Qualitative Study of Job Satisfaction," *Social and Management Research Journal* 15, no. 2 (2018).

27 Andrew Clarke and I. E. Isphording, "Language Barriers and Immigrant Health," *Health Economics* 26 (2017).

28 Mandy Sha and Tim J. Gabel, *The Essential Role of Language in Survey Research* (RTI Press, 2020), https://doi.org/10.3768/rtipress.bk.0023.2004.

29 Jonathan A. Smith, Paul Flowers, and Michael Larkin, *Interpretative Phenomenological Analysis: Theory, Method and Research* (SAGE Publications, 2009): 8-32.

interpreted within their broader social, cultural, and healthcare contexts relevant to Muslim women in Australia.[30]

Reflexivity was integral to the analytic process. Guided by the Islamic Psychology principle of *murāqabah*[31] (self-awareness), the researcher maintained a reflexive journal to document assumptions, emotional responses, positionality, and interpretive decisions during data collection and analysis. This process enhanced transparency and supported careful engagement with the double hermeneutic.

Dependability and confirmability were strengthened through a clear audit trail, including coding notes, analytic memos, theme development records, and visual mapping of analytic decisions. Manual coding followed a consistent, systematic process, with themes developed inductively from participants' words and refined through iterative analysis.[32] A thematic mind map (Figure 1) illustrates the relationships between codes, themes, and subthemes, providing a transparent account of how interpretations evolved.[33]

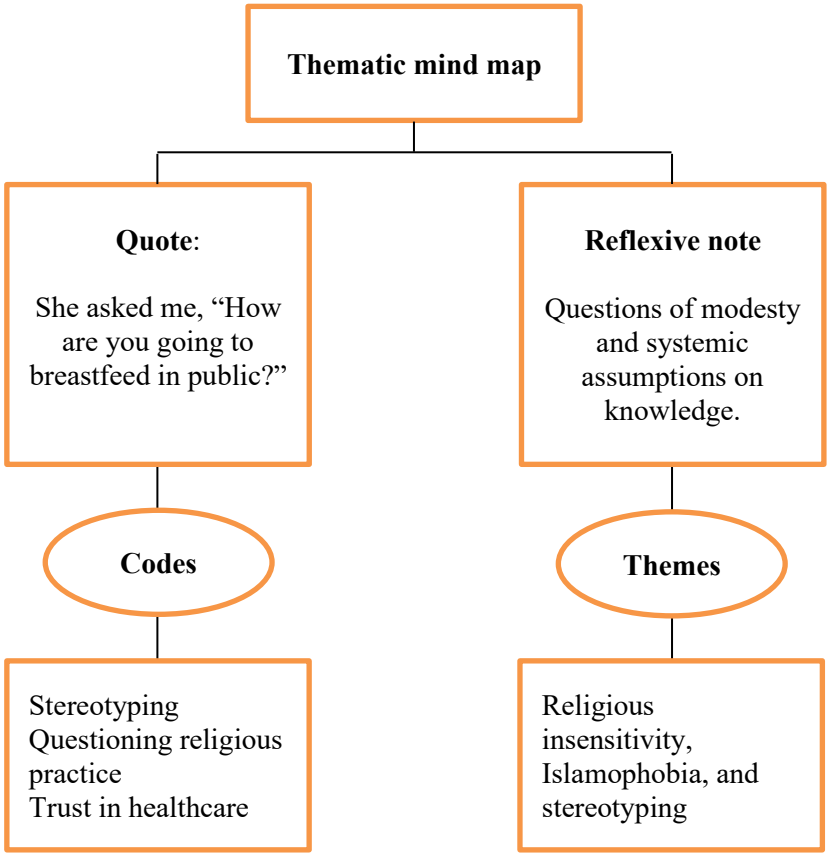

Figure 1: Example of a thematic mind map of codes and themes

30 R. Berger, "Now I see it, Now I don't: Researcher's Position and Reflexivity in Qualitative Research," *Qualitative Research* 15, no. 2 (2015).

31 Zubair Abdul Rahman, "The Lost Art of Contemplation," *Yaqeen Institute for Islamic Research*, updated August 27, 2024, https://yaqeeninstitute.org/resource/the-lost-art-of-contemplation.

32 Berger, "Now I see it, Now I don't," 223

33 Ibid.

Transferability was strengthened by detailed, contextual descriptions of participants' experiences in Australian maternity care.[34] Including verbatim quotations helps readers evaluate how the findings might apply elsewhere. For instance, one participant shared feeling judged when requesting a female doctor, which caused her to hesitate in advocating for her needs. This account was coded and expanded into the theme *Silencing, Stigma, and Emotional Harm*, contributing to the overall analysis of epistemic injustice and systemic marginalisation in maternity care.

Together, these strategies ensured the analytic process was rigorous, transparent, and grounded in participants' lived experiences.

FINDINGS

This study reveals the diverse experiences of Muslim women within Australia's healthcare system during maternity care. Through detailed interviews, key themes emerged, highlighting the difficulties and positive experiences associated with cultural and religious sensitivity. Participants shared feelings of being misunderstood or ignored but also noted how respectful care helped build trust and confidence. These insights emphasise the importance of culturally and religiously sensitive practices in enhancing maternal wellbeing and identifying opportunities for systemic improvements to better address the needs of Muslim women during pregnancy and childbirth.

The analysis identified four main themes, each with related subthemes. The first, *Cultural and Religious Insensitivity in Maternity Care*, describes experiences of stereotyping, insufficient provider training, and dismissiveness. These negative experiences often led to the second theme, *Navigating the System: Between Advocacy and Assimilation*, where women felt they had to assert their needs or conform to dominant norms. The third theme, *Silencing, Stigma, and Emotional Harm*, reflects the effects of these pressures, with women holding back concerns, facing mental health stigma, or disengaging from care. Conversely, the fourth theme, *Positive Encounters: Feeling Heard, Respected, and Supported*, shows how respectful communication, recognition of religious needs, and attentive care can reduce harm, build trust, and foster positive outcomes.

These themes together offer a comprehensive view of Muslim women's experiences with maternity care, emphasising the strong connection between negative and positive interactions. As illustrated in Figure 2, women's experiences rarely fit into clear-cut categories. Care that is culturally or religiously insensitive often forces women to choose between advocating for themselves and assimilating, which may result in silencing or emotional stress. In contrast, positive interactions are linked to other themes and can help diminish, challenge, or change negative experiences. The visual overlap of circles highlights IPA's focus on the interconnectedness of meaning making.

[34] Sarah J. Tracy, "Qualitative Quality: Eight 'Big-Tent' Criteria for Excellent Qualitative Research," *Qualitative Inquiry* 16, no. 10 (2010), https://doi.org/10.1177/1077800410383121.

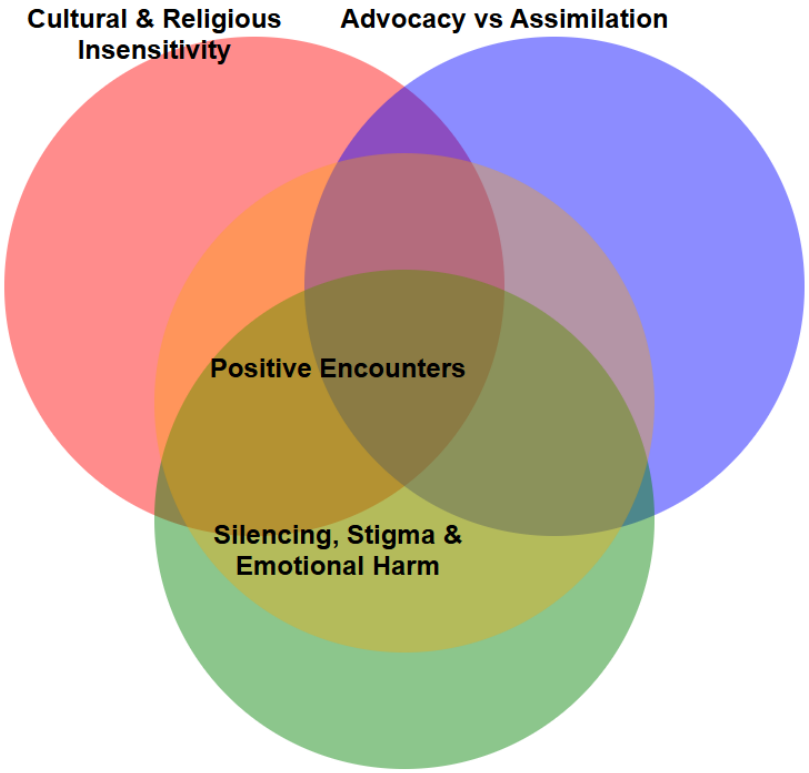

Figure 2. Interrelationships between the four primary themes

Cultural and Religious Insensitivity in Maternity Care

Participants consistently described experiences of cultural and religious insensitivity within the Australian maternity care system, often leaving them feeling marginalised, misunderstood, and emotionally vulnerable during pregnancy and childbirth. This theme captures how maternity care frequently fails to recognise Muslim women's identities as integral to dignity and safety. Three interrelated subthemes were identified: (1) religious insensitivity, Islamophobia, and stereotyping; (2) lack of provider education and cultural safety; and (3) disrespect, dismissal, and feeling misunderstood.

Religious Insensitivity, Islamophobia, and Stereotyping

Women shared experiences where their religious identity was misunderstood, questioned, or viewed as unusual. For visibly Muslim women, especially those wearing hijabs, assumptions and microaggressions were frequent—from casual comments to subtle exclusions. Reem recalled:

> "She asked me how I would breastfeed in public—because I was wearing a hijab…I went home and cried." – Reem

Rahma described stereotyping disguised as humour:

> "One of the midwives said (after the fourth child), maybe you should get your husband a PlayStation so he will have something to do." – Rahma

Requests related to modesty, privacy, or religious practice often became points of tension. Fatima shared:

> "I asked for a towel to cover myself during the ultrasound (with a male sonographer). He looked at me like I was a prude. I felt like I had to choose between my health and my religion." – Fatima

Participants noted that power imbalances hindered their ability to express their religious needs without fear of being labelled "difficult," often leading them to remain silent or compromise their values. Many explained that they constantly had to justify their practices—such as requesting female staff, scheduling appointments around prayer times, or observing modesty—perceiving that Muslim practices were seen as exceptions rather than valid elements of care.

Lack of Provider Education and Cultural Safety

Participants frequently attributed insensitive encounters to systemic gaps in provider education and institutional preparedness. Many reported having to explain basic religious needs during vulnerable moments, increasing emotional stress. Sarah remarked:

> "And they were teaching me how to feed. And I was like, can you just, you know, close the curtain, it's frustrating to tell them every time." – Sarah

Structural oversights reinforced exclusion. Hospitals often lacked halal food or awareness of postpartum Islamic practices, requiring families to organise alternatives independently. Mariam recalled:

> "I asked if the food was halal…they had no idea; I was starving the first night. So, I had to get Uber Eats." – Mariam

Antenatal and postpartum care rarely acknowledge practices such as *tawakkul*, *ghusl*,[35] or the 40-day postpartum period (*nifas*). Safiya reflected:

> "It's like the system isn't designed for people like us. We have to adapt to it. It never adapts to us." – Safiya

These systemic shortcomings sometimes led women to disengage from care:

> "Honestly, at some point I stopped going to the appointments…I'm just a number." – Reem

Disrespect, Dismissal, and Feeling Misunderstood

Experiences of dismissal and disrespect were reported across multiple stages of care, particularly during labour. Zahra described repeatedly requesting pain relief through her husband, only to be ignored until she was ready to push. Rather than being solely about analgesia, Zahra interpreted this experience as a broader pattern of not being heard. Such

[35] *Ghusl* (Arabic: غسل), the Islamic ritual of full body purification through washing, is required following states of ritual impurity such as sexual intercourse, menstruation, or postpartum bleeding. P. J. Bearman et al., eds., "Ghusl," *Encyclopaedia of Islam*, 2nd ed. (Brill, 1954–2005), 1125.

encounters lead women to question whether implicit bias related to race, religion, or cultural identity influenced how seriously their concerns are taken. In this way, inadequate responses to pain became emblematic of a deeper erosion of cultural and relational safety within the clinical encounter.

Religious preferences—such as declining prenatal testing or requesting female providers—were sometimes framed as non-compliance, requiring women to defend deeply held moral and ethical beliefs. Zahra's experience of pressure to undergo Down syndrome screening conflicted with her religious understanding of the sanctity of life and trust in God's will, highlighting gaps in provider awareness of Islamic ethical perspectives.

For many participants, the emotional impact of being dismissed persisted long after physical recovery. Women described leaving the hospital feeling invisible, unheard, and emotionally exhausted, leading some to avoid future care or seek alternatives outside the mainstream system.

Navigating the System: Between Advocacy and Assimilation

Women described managing their maternity care as a balance between self-advocacy and assimilation. Many took on roles as educators or negotiators, explaining Islamic practices and asserting their rights. While some felt empowered by this, others—especially younger or first-time mothers—felt unable to voice their needs. Hana observed:

> "My husband used to always go with me because I'm not really the confrontational type… that caused more issues because they dismissed everything he said." – Hana

To avoid conflict, some women modified their behaviour, language, or appearance to align with Western norms. Nour reflected:

> "Sometimes I feel myself talking like them, just to get things done. Because I'm part of the system." – Nour

Others avoided raising religious needs entirely:

> "I didn't really ask for much; it just makes it easier to do it their way." – Ruqayya

Over time, this emotional labour led to exhaustion and disengagement. Malika stated:

> "Next time, I will either go private or get a doula and do it at home. At least that way I know I will get the care I deserve." – Malika

Silencing, Stigma, and Emotional Harm

Fear of judgment led women to minimise or withhold concerns, particularly around mental health. Amirah said:

> "I didn't want to be that patient…So, I just stayed quiet." – Amirah

Reem added:

"I just wanted to say something without feeling judged." – Reem

Stigma and lack of culturally aware care compounded distress:

"I was really struggling after the birth. But I didn't know if it was safe to talk about it… What if they thought I was crazy or tried to take the baby?" – Zahra

"In our community, we don't really talk about mental health. But I needed someone who understood both my culture and my pain." – Reem

Prior negative experiences also led to withdrawal from services:

"The hardest part wasn't the birth, it was dealing with the racism and stereotyping." – Umayah

"Next time, it will be a home birth with a doula for us." – Fatima

Positive Encounters: Feeling Heard, Respected, and Supported

Despite these challenges, participants highlighted moments of affirming care. Small actions like knocking before entering, enquiring about preferences, respecting modesty, or proactively arranging female providers made a significant difference. Women stressed that respect does not depend on shared beliefs but on curiosity, humility, and openness to listen.

Fatima appreciated:

"He knocked on the door before he entered. He waited for permission." – Fatima

Yousra noted:

"He said if you would prefer, I can ask a female midwife to come in…that was thoughtful." – Yousra

Amirah highlighted:

"The midwife remembered I needed a female doctor…It was like she protected my dignity." – Amirah

Melissa stated:

"Because I trusted her, I could ask more questions, and I actually felt excited. I would definitely have baby number seven there…they were really nice." – Melissa

Women reported higher levels of trust, emotional safety, and engagement with care when their religious needs were met without resistance. These findings demonstrate that culturally and religiously sensitive maternity care is feasible and transformative, fostering dignity and enhancing the overall care experience.

DISCUSSION

This study explored Muslim women's diverse experiences within the Australian maternity care system, highlighting how religion, culture, and identity shape perceptions of safety, trust, and respect. Drawing on the maternity care literature, Islamic Psychology, and the Cultural Safety Model, the findings demonstrate that women's experiences are deeply influenced by how well maternity care recognises religious identity as integral to dignity and wellbeing. Together, these frameworks provide a comprehensive lens for understanding how marginalisation operates across emotional, spiritual, relational, and systemic dimensions.

From Islamic Psychology and cultural safety perspectives, marginalisation extends beyond physical health outcomes to affect emotional, psychological, and spiritual wellbeing.[36] Participants' accounts revealed disruptions to the *nafs* (self) through experiences of disempowerment, subtle judgment, and social exclusion, which shaped trust in healthcare providers and influenced engagement with care. At the same time, environments lacking cultural safety—particularly those that fail to acknowledge power imbalances, institutional bias, and relational accountability[37]—were experienced as emotionally unsafe. These findings illustrate how individual encounters are embedded within broader structural dynamics of maternity care.

A central theme across participants' narratives was cultural and religious insensitivity. Women described being misunderstood, dismissed, or subjected to oversimplified assumptions that compromised their dignity and emotional safety. These experiences reflect systemic patterns rather than isolated misunderstandings and align with broader research showing that anti-Muslim bias, whether explicit or subtle, can shape healthcare interactions for visibly Muslim women.[38] Such bias often manifests as microaggressions or epistemic injustice, where women's religious knowledge, practices, or explanations are questioned, minimised, or treated as unusual.[39]

The examples included joking comments about family size, discomfort with modesty requests, and assumptions based on secular norms. Although often seen as casual or unintentional, participants perceived these interactions as cues that their identities did not align with mainstream maternity care. According to Fricker's idea of epistemic injustice,[40] ongoing dismissal of women's perspectives can damage trust and silence patients, especially when their cultural or religious ways of knowing are marginalised.

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36 Rothman and Coyle, "Framework for Islamic Psychology and Psychotherapy," 1736; Ramsden, *Kawa Whakaruruhau*, 22.

37 Ramsden, *Kawa Whakaruruhau*, 23.

38 C. L. Clark et al., "Is there a Common Experience? Somali New Mothers' Childbirth Experiences in Norway and the United States," *Public Health Nursing* 35, no. 3 (2018), https://doi.org/10.1111/phn.12399; Goleen Samari, H. E. Alcalá, and M. Z. Sharif, "Islamophobia, Health, and Public Health: A Systematic Literature Review," *American Journal of Public Health* 108, no. 6 (2018), https://doi.org/10.2105/AJPH.2018.304402.

39 Clark et al., "Is there a Common Experience?"

40 Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (Oxford University Press, 2007).

Requests for female healthcare providers emerged as a significant issue. For many participants, this was not a personal preference but a religious obligation rooted in modesty and ethical boundaries.[41] When such requests were ignored or trivialised, women described feeling exposed, violated, or unsafe.[42] From an Islamic Psychology perspective, these experiences disrupt inner coherence and spiritual wellbeing, while Cultural Safety theory highlights failures of relational accountability and respect for bodily autonomy.[43] Participants' accounts suggest that breaches of modesty carry moral, emotional, and spiritual consequences that extend beyond discomfort, contributing to spiritual distress and loss of trust.

Importantly, participants did not frame these experiences as the result of deliberate prejudice by individual healthcare professionals. Rather, they situated them within a maternity system shaped by secular, Western biomedical assumptions that often exclude religious and spiritual perspectives from training and practice.[44] Limited cultural safety training and lack of guidance on incorporating faith-based needs meant these women were frequently required to justify or explain basic religious practices, reinforcing feelings of otherness and fatigue.

Several participants also described emotional harm linked to loss of autonomy, inadequate pain management, or pressure during decision-making. Zahra, for example, experienced not receiving timely pain relief, which reflects a common challenge in busy or resource-strained clinical settings, where systemic pressures can hinder person-centred care. While these issues are not unique to Muslim women, intersecting identities—such as being Muslim, racialised, or visibly religious—shape how participants interpret and experience these encounters. In some cases, lack of awareness of Islamic ethical perspectives contributed to miscommunication around prenatal testing or consent, creating moral distress and undermining trust.

Women often describe navigating care as a balancing act—trying to assert their religious identity while avoiding judgment or stereotyping. Their efforts to "blend in" or "talk like them" mirror broader institutional norms where whiteness and secularism are seen as neutral standards. From an Islamic Psychology perspective, this pressure threatens *niyyah* (intention) and *amanah* (trust), weakening women's sense of safety and moral agency. Cultural safety also

41 Aasim I. Padela and Pablo Rodríguez del Pozo, "Muslim Patients and Cross-Gender Interactions in Medicine: An Islamic Bioethical Perspective," *Journal of Medical Ethics* 37, no. 1 (2011).

42 Substance Abuse and Mental Health Services Administration, *Practical Guide for Implementing a Trauma-Informed Approach* (SAMHS, 2023), https://www.icquality.org/files/2024-06/SAMHSA%20Trauma%20responsvie%20care.pdf.

43 G. H. Rassool and Zuleyha Keskin, "Positioning the Self (Nafs) in Islāmic Psycho-Spirituality," *Journal of Spirituality in Mental Health* 27 (2023), https://doi.org/10.1080/19349637.2023.2264848; Ramsden, *Kawa Whakaruruhau*, 23.

44 Jayanthi Jayawickrama and J. Wright, "Coloniality of the Biomedical Model," in *Under the Gaze of Global Mental Health: A Critical Reflection on Experiences from Malawi, Sri Lanka, and the United Kingdom* (Palgrave Macmillan, 2025), https://doi.org/10.1007/978-3-031-78258-9_3; T. Naidu, "Coloniality Lives on through Medical Education," *The BMJ* 383 (2023), https://doi.org/10.1136/bmj.p2294.

highlights that care can become unsafe when patients feel pressured to minimise or fragment their identities to be treated with respect.[45]

Silencing emerged as a recurrent consequence of these dynamics. Some women internalised their distress, avoided advocating for their needs, or disengaged from care altogether. Cultural stigma around mental health, combined with spiritual distress arising from disrespectful care, intensified emotional harm. Islamic Psychology's emphasis on the interconnectedness of the *nafs*, *qalb* (heart), and *rūḥ* (spirit) underscores the inadequacy of maternity models that prioritise physical outcomes while neglecting emotional and spiritual wellbeing.[46]

Despite these obstacles, participants described moments of meaningful care in which healthcare professionals listened respectfully, acknowledged religious needs, and regarded women as complete individuals. These instances show that culturally and religiously sensitive maternity care is feasible and impactful. Small gestures of humility, curiosity, and respect can restore trust and ensure safety.

Overall, this research shows that mainstream maternity care models fall short in addressing the spiritual, cultural, and emotional needs of Muslim women. An over-reliance on secular, individual-focused approaches sidelines faith as a valid part of care. The findings underscore the urgent need for a framework grounded in cultural and religious understanding that incorporates Islamic psychological insights, cultural safety, and relational accountability. Without intentional reform, maternity care will persist in silencing and marginalising Muslim women. Respectful care that recognises their full humanity is not optional—it is vital.

IMPLICATIONS FOR PRACTICE AND SYSTEM REFORM

To address the gaps highlighted in this study, maternity care systems should incorporate culturally and religiously sensitive frameworks at structural, organisational, and interpersonal levels. Combining the Cultural Safety Model with principles from Islamic Psychology offers a more detailed approach to maternity care for Muslim women, focusing not only on visible religious practices but also on dignity, modesty, moral agency, trust, and spiritual meaning during childbearing.

At the policy level, this involves proactively integrating religious and cultural considerations into standard maternity protocols, rather than making reactive or ad hoc changes. At the organisational level, continuous professional development should shift from merely increasing cultural awareness to fostering cultural and religious humility, reflexive practice, and implicit bias training. These approaches help healthcare professionals to critically assess power dynamics and assumptions that could influence care interactions.

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45 M. Ikhwan, W. Walidin, and S. Mahmud, "Islamic Education's Alternative Approach to Nurturing Mental Health and Psychological Well-Being," *International Journal of Education, Language, and Social Science* 1 (2023).

46 R. Awaad and S. Ali, "Islamic Psychology: A Portrait of its Historical Origins and Contributions," in *Applying Islamic Principles to Clinical Mental Health Care: Introducing Traditional Islamically Integrated Psychotherapy*, ed. H. Keshavarzi, F. Khan, S. Ali, and R. Awaad (Routledge, 2020), 70.

Co-designing services with Muslim women and community representatives is crucial to ensure maternity services align with their lived experiences instead of institutional assumptions. This collaboration will empower Muslim women to be active contributors to the development of the services, rather than passive recipients.

From a decolonial viewpoint, rethinking maternity care means moving beyond assimilationist ideas that expect women to conform to mainstream biomedical standards. Healthcare systems should acknowledge diverse perspectives on dignity, embodiment, and childbirth as valid and foundational. Incorporating accountability measures that address discrimination and institutional bias will help ensure that cultural and religious sensitivity is an essential component of quality maternity care, rather than an optional add-on.

By shifting from generic care models to those that are relationally attentive and spiritually supportive, maternity services can build increased trust, promote equity, and enhance psychological safety for Muslim women.

LIMITATIONS

While this study offers valuable inductive insights into Muslim women's childbearing experiences and emotional wellbeing, the findings are limited in their generalisability due to the small, self-selecting sample of English-speaking participants in Australia. Broader validation and testing of these findings will occur in Phase 2 through the Nominal Group Technique and in Phase 3 through the Content Validity Index and elements of Diffusion of Innovations Theory, which will help evaluate applicability across more diverse contexts. Future research should also consider intersectional factors, such as immigration status, ethnicity, and socioeconomic background, as these may differentially influence women's experiences.

Despite these limitations, the findings align with existing scholarship on cultural safety, epistemic injustice, and reproductive health disparities. They highlight urgent areas for research and intervention, particularly the development of new models or practice tools designed to improve culturally and religiously sensitive maternity care for Muslim women and other marginalised populations.

CONCLUSION

This study offers detailed examination of Muslim women's childbirth experiences in Australian public maternity services, highlighting their voices to reveal structural and relational obstacles to culturally and religiously sensitive care. Instead of isolated events, participants' stories showed recurring patterns of being dismissed, ignored religious needs, epistemic marginalisation, and subtle pressures to conform to mainstream biomedical norms. These experiences made women highly visible as "others" and yet invisible in their expressed needs, weakening their psychological and relational safety during vulnerable moments of care.

This study integrates insights from Islamic Psychology and the Cultural Safety Model to recommend a framework that views childbirth as more than a medical event; it is also a

spiritually, culturally, and morally meaningful experience. The results highlight that cultural and religious sensitivity involves more than just supporting visible religious practices; it also means making sure women feel listened to, respected, and protected from unconscious bias and institutional neglect.

The call for a decolonial reimagining of maternity care, detailed in the discussion, questions the assimilationist views ingrained in Eurocentric biomedical models. Shifting maternity services to embrace diverse notions of dignity, embodiment, and meaning making demands institutional reflection, culturally and religiously sensitive training, community collaboration, and structural accountability. This reform will go beyond mere symbolic inclusion, ensuring Muslim women are genuinely recognised as knowledge holders who contribute to their care.

Ultimately, this research highlights the critical importance of maternity systems that go beyond basic accommodation of Muslim women. They should actively affirm their beliefs, identities, and knowledge as essential components in providing fair, psychologically safe, and culturally and religiously sensitive healthcare.

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APPENDIX 1. INTERVIEW GUIDE

This rough guide covers questions that may be asked during the interview.

Introduction

Welcome the participant, introduce myself, and explain the purpose of the study.

Briefly outline the structure of the interview (semi-structured, open-ended questions).

Reassure the participant that their responses will remain confidential and that they can stop the interview at any time.

Ask for consent to record the interview.

1. **Pregnancy and Childbirth Context:**
   - Can you tell me about your recent pregnancy and childbirth experience in Australia?
   - How long ago did you give birth, and was this in a public hospital?
2. **Experience with Healthcare Providers:**
   - How did you feel about the care provided by the healthcare professionals during your pregnancy and childbirth?
   - Did you feel that your religious beliefs were respected during your care?
   - Were there any moments where you felt uncomfortable due to a lack of understanding of your cultural or religious needs? Can you provide an example?
3. **Religious and Cultural Sensitivity:**
   - Did you have any specific religious or spiritual needs that were important to you during your childbirth experience (e.g., modesty, prayer times, dietary restrictions)?
   - How did the healthcare staff address these needs? Were there any challenges?
   - Do you prefer a female healthcare provider during childbirth? If yes, was this preference accommodated?
4. **Emotional and Mental Wellbeing:**
   - How did your healthcare team's cultural or religious sensitivity (or lack thereof) impact your emotional or mental wellbeing during your experience?
   - Did you feel supported emotionally and spiritually during your care?
   - Were you able to access mental health support that aligned with your religious beliefs? If so, what was that experience like?
5. **Communication and Information:**
   - How well did the healthcare professionals communicate with you throughout pregnancy and childbirth?
   - Did you face any challenges related to language or understanding medical information?
   - Did you know enough about your religious or culturally sensitive care options?
6. **Suggestions for Improvement:**
   - Looking back, are there any ways the healthcare services could have better supported you regarding your religious and cultural needs?
   - What advice would you give to healthcare professionals to help improve maternity care for Muslim women in Australia?

7. **Overall Experience:**
    - How would you describe your overall childbirth experience in Australia in terms of religious and cultural sensitivity?
    - If you were to have another child, what would you hope to see done differently?
8. **Additional Comments:**
    - Is there anything else you'd like to share about your experience that we haven't covered?

Closing

Thank the participant for their time and valuable insights.

Provide contact information for any follow-up questions or support.