Culturally–sensitive Maternity Care Needs of Muslim Mothers in a Rural Community of the Southernmost Province in Thailand

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Abstract: This study was conducted to better understand culturally-sensitive maternity care needs assessment for Muslim mothers. It was conducted in a rural community of the southernmost province in Thailand from May-December 2013. Community-based participatory research was used as the research methodology and involved three groups of participants: 1) 26 Muslim mothers (15-49 years old with at least one child under age three) and 17 of their husbands, 2) 14 community and religious leaders, and 3) 14 health care providers including village health volunteers and traditional birth attendants. Qualitative data were collected through focus group discussions, in-depth interviews, and participative observations. Data were analyzed using content analysis.

The results indicated that the culturally-sensitive maternity care needs for Muslim mothers comprised five themes: respecting the way of life, practicing religious and local traditional belief, harmonizing cultural care from traditional birth attendants, supporting mothers and families, and enhancing cultural competence among health care providers, and village health volunteers. The findings illustrate the elements of culturally-sensitive maternity care needs for Muslim mothers which can be a guide for appropriate community care.

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Introduction

Maternal and child health problems are a major health concern in the southernmost provinces of Thailand. The maternal mortality ratio (MMR) and infant mortality rate (IMR) in this area are very high, at 17.6 per 100,000 live births and 6.8 per 1,000 live births respectively.[1] Compared with the

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national level, the MMR in the southernmost provinces is more than three times higher (59.4).[2]

Postpartum hemorrhage (PPH) is a major cause of maternal death in the southernmost provinces.[2] There are several causes of PPH including atonic uterus which results in uterine inertia from prolonged labor.[3] The direct cause of atonic uterus is anemia which is associated with fatigue. Pregnant women with anemia may succumb more quickly to any subsequent blood loss.[3] Pregnant women with very severe anemia are a medical emergency due to the risk of congestive heart failure and maternal death.[4]

Many factors affect maternal health. Islamic perspectives on maternal health are associated with maternal age, fertility, family size preferences, contraceptive use, and TBAs.[5, 6] Maternal age, both for teens and older women increase the risk of adverse pregnancy outcomes.[7] Early and late pregnancy may put the life of the mother and fetus at risk and contributes to higher mortality rates.

The fertility rate of Muslim mothers is higher than that of non-Muslim mothers. While the fertility rate in all regions of Thailand has sharply declined to below replacement level, it has only slightly declined in area where Muslims are predominant.[8] In the southernmost provinces of Thailand, the birth rate is higher than both the southern region and national average.[1]

Family size preferences are significantly associated with the desire to have more children and result in the low contraceptive use among Muslims.[5] Most Muslim respondents said that whatever number of children God gave them was appropriate. This surrendering to God about family size before mentioning one's personal preference indicates a strong belief inspired by Islam.[5]

Islamic teaching forbids any form of family planning using contraception and sterilization. Conservative Muslims view contraception as a sin and accept as many children as God provides. Consequently, Malay-speaking Muslims in the south demonstrate higher fertility preferences and lower contraceptive use than Thai speakers.[5] Thus, religion and region are associated with the attitude and behaviors of Muslims in fertility and contraceptive use.

TBAs are still favored in the southernmost provinces.[6] According to Teeraworn's study in 2002, infant mortality was higher among women those attending antenatal care and being delivered by a TBA at home. Over half of deliveries were practiced by a TBA and more than 60% of deliveries occurred at home. It was observed that women at the beginning and end of their reproductive life mostly prefer to give birth with TBAs. Women aged 15-20 years are too young to make an independent decision for delivery, and most likely accede to family norms, and use traditional services. Women with past experience of childbirths (aged 35-49 years), may feel more comfortable with TBAs as they are an integral part of the religious practice. Typically, the TBAs can speak the local language, too.[6]

Gender sensitivity and the language barriers in the southernmost provinces where Muslims are the majority, make utilization of primary health-care difficult. They need modesty and privacy, and the appropriate use of touch.[9] Muslim women prefer female providers who respect their need to not expose intimate parts of their bodies to non-related males.[10] However, their preferences are often overlooked or not accommodated due to a lack of female staff.

Language barriers obstruct mothers' access health care, as well as the ability of HCPs to work effectively.[11] Muslim women who can speak Thai are more likely to utilize antenatal care (ANC), deliver at a health facility, and be attended at birth by a trained health worker, than those who cannot speak Thai.[6]

Healthcare in mainstream Thailand is seen as a universal right that draws closely from the Western paradigm. However, this Western bias is not very applicable to groups with distinct cultures and belief systems, such as Muslims, that need the tailor-made attention of health care providers. To achieve the Millennium Development Goals (MDGs) for improving

maternal health in the southernmost provinces, specific strategies and strong health care services are needed. Health care service leaders need to analyze the majority of maternal deaths that could be avoided by basic maternity care.[12] In Pattani Province in the deep south, only 70.2% of pregnant women utilize the ANC service.[2] Women who do not use ANC services believe that ANC is not necessary.[13] The under-utilization of maternity care service exists predominantly in the social context, which creates barriers to accessing health care services.

The utilization of all maternity care services — antenatal care, intrapartum care, and postpartum care — are lowest in the southernmost provinces of Thailand.[14] There women view pregnancy as a natural process and thus, there is no need to seek medical care. The complexities of religion and culture, as well as gender, modesty and language (inability to speak Thai), can limit accessibility to health services.[6,15] These may be intrinsically linked to negative attitudes, which in turn, cause barriers to access.

Although 47% of HCPs are Muslims in the southern provinces, it is unclear how religious and cultural concepts have been applied in the health care system.[16] Some HCPs do not understand the Islamic principles and are uninformed about the maternity needs of Muslim women, particularly those related to religious needs, such as fasting safety during pregnancy.

Existing maternity care is inadequate in meeting the desires of Muslim mothers. It was observed that Muslim mothers who received ANC at health care services came rather for treatment of complications during pregnancy, rather than for routine checkups. Thus the delay in deciding to seek, reach or receive obstetric care and delay in transferring to an appropriate birth center, both of which relate to maternal death, need to be further analyzed to find ways to reduce the MMR in this area.[17, 18] To improve the quality of maternity care, the most appropriate approach to respond to cultural constrains is to establish in-depth understanding of Islamic culture. To contribute to this process, it is crucial to assess culturally-sensitive maternity care needs in order to meet the needs of Muslim mothers in a rural community of the southern most province, Thailand.

Conceptual Framework

The concepts of cultural care and cultural competence, and critical social theory (CST) were used as theoretical frameworks to guide the methodology in this study in order to assess culturally-sensitive maternity care needs for Muslim mothers. Cultural care refers to subjectively and objectively learned and transmitted values, beliefs, and patterned way of life that assists, supports, facilitates, or enable another individual or group to maintain well-being and health, to improve the human condition and way of life, or to deal with illness, handicaps, and death.[19]

Cultural competence is "awareness of and sensitivity to cultural differences; knowledge of cultural values, beliefs, and behaviors; and skill in working with culturally-diverse populations".[20] Cultural competence aims to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency.

The purpose of CST is to view phenomena with an open condition, unconstrained by communication and to strengthen or empower participants to encounter their problems by themselves.[21] Community members seek to move the public health fields forward by generating new knowledge, identifying the factors associated with intervention success, and determining actions that will effect social and behavioral change in order to eliminate health disparity.[22]

Community-based participatory research (CBPR) is rooted in CST, and is a focal point to power, cultural diversity, and equity.[22] CBPR facilitates a direct interaction between researcher and community. It gives the researcher a better understanding of community needs, concerns, and capacities; and it opens new doors for exploration of community

resources.[23] The equal participation process with this research approach encourages the enhancement of cultural context, promotes co-learner and capacity building, changes in community norms, and constructs a network that supports the sense of belonging and sustainability of the program.[24,25] Thus, a CBPR process facilitates a connection, where cultural and linguistic gaps between researcher and community exist, and was considered most appropriate for this study in the Muslim southernmost provinces.

Study aim

The purpose of this study is to assess culturally-sensitive maternity care needs for Muslim mothers in Pattani Province.

Methods

Design: CBPR was used as an approach in order to assess culturally-sensitive community needs for Muslim mothers.

Study setting: Pattani Province, a border province in the deep south of Thailand, was used as the research setting. Data were collected from May-December 2013. Pattani was chosen because of high incidence of MMR. Pattani has a large (80.3%) population of Muslims[27] who mainly speak the local language, Yawee, in daily life.

Sample: Three groups of research participants were involved:

Muslim mothers and their husbands: 26 Muslim mothers, aged between 15-49 years, who had at least one child under aged three and living in the community setting were invited to this study, 10 for participating in in-depth interviews and 16 for two focus group discussions. There were two focus groups discussion with 17 their husbands, who take care of or are responsible for the women in the study.

Community leaders including community religious leaders: 14 community members/community leaders in the study area were encouraged to participate in two focus groups. They included five assistant village headmen, three religious leaders and six community members from eight villages.

HCPs: 14 HCPs comprised 2 nurses and a director of the primary health service who worked at health promoting hospital, three traditional birth attendants (TBAs) and eight village health volunteers (VHVs).

The researchers were prepared with knowledge and skills on CBPR regarding health culture and community. The open-ended questions of the interview guides were developed by the researcher's team and were pilot-tested with Thai and Yawee-speaking individuals. An observation guide and tape-recorders was used for in-depth interviews, focus groups discussion, group meeting, and project activities.

Rigor and Trustworthiness: Procedures to establish trustworthiness, credibility and confirmability were used.[27, 28] Credibility was achieved through a triangulation method including observation, focus group discussion, and interviews. To achieve confirmability, the transcript, field notes, as well as data analysis were checked and rechecked, and findings were shared with research team according to four steps of research procedures.

Data Collection: Qualitative data was collected through in-depth interviews of 10 mothers, three TBAs, three HCPs, eight VHVs. Six focus group discussions (FGDs) were conducted with 26 mothers, 17 of their husbands and 14 community and religious leaders. Each group consisted of eight to nine people. Participative observations was conducted about the contexts and activity of participants.

Preparing local researchers: Three local researchers (one VHV and two nurses) were prepared with knowledge and skills on the research process of CBPR through training by researcher (including ethical considerations) for one week in order to enhance their research ability.

Research Procedures

The researchers used the CBPR approach in the phase of situation analysis to *assess culturally-sensitive maternity care needs* through community collaboration along the following four steps:

Step 1: Establishing community collaboration

For building trust and establishing a collaborative relationship with the study community the researcher informally and formally contacted key informants who were the community gatekeepers including the sub-district chief, the village headman, and the chief executive of the sub-district administrative organization (SAO).They were informed about the study, its objectives, process, and potential benefit to the community in order to obtain their permission to conduct it.

The local researchers, as co-researchers, spoke Yawee and were recruited and trained in doing research along with promoting sustainability and creating a sense of belonging to the project from the beginning. For *establishing mutual trust and respect*, the researchers always participated in special events, and acted in an appropriate cultural manner. This step achieved good social relationships in *working partnerships.*

Step 2: Assessing culturally-sensitive community needs of maternity care

Community members as core working group consisted of three VHVs, three community leaders, and three HCPs who co-operated in the design of needs assessment by providing community-specific information on maternity care and patterns as well as providing insights into cultural issues that proved relevant in the design of the cultural maternity needs assessment. They were involved in raising knowledge and awareness, and gaining commitment in action and research. They helped by identifying maternal health problems and gathering preliminary data from the community with collaboration of its members, as well as suggesting potential strategies and feasible approaches for maternity care.

The maternal health problems were discussed during three meetings of stakeholders, in which they were free to provide suggestions and emancipator knowledge. The commitment to action and research was gained by the community members. The researchers' team conducted six focus group discussion (two groups of Muslim mothers, two groups of husbands, and two groups of community members/ religious leaders). In-depth interviews were conducted with 10 mothers, three TBAs, three HCPs, and eight VHVs.

Step 3: Analyzing and interpreting the data

All data was transcribed verbatim by the team. The problems related to maternal health were analyzed and interpreted using content analysis[29] and summarized. Content analysis began on the first day after interview, listening to the recording then later reading the transcripts line by line and considering for potential concerns and needs of culturally-sensitive maternity care. The themes were defined by categorizing and coding the transcripts.

Step 4: Reflecting and sharing the findings

The core working group (VHVs, HCPs, and community leaders) illustrated the pictures of activities during the process by organizing a community forum to reflect and share the assessment findings and to solicit community response validation of the findings. The reflection on concerns and needs regarding cultural maternity care was focused. The participants were asked to provide critical analysis of assessment results and members were encouraged to make additional suggestions and comments through open group discussion.

Data Analysis: The data were analyzed during the research process through content analysis.[29] The analysis began by reading the transcripts of each qualitative data and looking for potential concerns and needs regarding to culturally-sensitive maternity care. Themes were categorized and coded in the transcription line by line.

Ethical considerations: The study was approved by the Human Subjects Review Board of Chiang Mai University. All participants gave written informed consent, after explanation of their rights and a description of the study was given.

Results

Participants were 71 Muslim mothers, families, community members or leader, and HCPs/VHVs/TBAs. As shown in **Table 1**, the majority of the participants were: aged between 20-35 years of age; with 1 to 11 children; and primary school education.

Five themes of culturally-sensitive maternity care needs of Muslim mothers were identified as follows: respecting the way of life, practicing religious and local traditional belief, harmonizing cultural care from TBAs, supporting mothers and families, and enhancing cultural competence of HCPs and VHVs. Each need is elaborated below:

Table 1 Demographic background sheet

Characteristics	Muslim mothers n=26 (%)	Husbands n=17(%)	Community members/leaders n=14 (%)	HCPs/ VHVs/TBAs n=14 (%)
Age (yrs.)				
< 20	3(11.54)	1(5.88)	0(0)	1(7.14)
20-35	15(57.69)	9(52.94)	6(42.86)	2(14.29)
36-50	8(30.77)	5(29.41)	5(35.71)	5(35.71)
>50	0(0)	2(11.77)	3(21.43)	6(42.86)
Gender				
Male	0(0)	17(100)	14(100)	4(28.57)
Female	26(100)	0(0)	0(0)	10(71.43)
Marital status				
Single	0(0)	0(0)	1(7.14)	1(7.14)
Married	26(100)	17(100)	13(92.86)	12(85.71)
Widow/Divorcée	0(0)	0(0)	0(0)	1(7.14)
Number of children (average)	1-11(4.46)	1-6(2.58)	1-9(5.14)	0-7(3.42)
Education				
No formal schooling	1(3.85)	0(0)	0(0)	3(21.43)
Primary school	7(26.92)	4(23.53)	2(14.29)	3(21.43)
Secondary school	10(38.46)	10(58.82)	6(23.07)	2(14.29)
Certificate (vocational)	6(23.08)	1(5.88)	1(7.14)	2(14.29)
Undergraduate	2(7.69)	2(11.77)	5(35.71)	4(28.57)
Occupation				
Agriculture	3(11.54)	3(17.65)	2(14.29)	1(7.14)
Vendor	7(26.92)	4(23.53)	2(14.29)	2(14.29)
Worker	5(19.23)	2(11.77)	3(21.43)	2(14.29)
Entrepreneur	5(19.23)	7(41.17)	5(35.71)	2(14.29)
Civil servant	2(7.69)	1(5.88)	2(14.29)	3(21.43)
Housework	4(15.38)	0(0)	0(0)	4(28.57)
Family income per month (bath)				
< 3,000	1(3.85)	0(0)	0(0)	2(14.29)
3,000-6,000	6(23.08)	5(29.41)	4(28.57)	1(7.14)
6,001-9,000	15(57.69)	9(52.94)	5(35.71)	7(50.00)
> 9,000	4(15.38)	3(17.65)	5(35.71)	4(28.57)

1. Respecting the way of life; Muslim mothers have experiences of being a multi-para with normal labor at home. Giving birth at home with TBAs is considered normal among Muslim mothers in this community. They viewed pregnancy and childbirth as natural processes and the determination of God. Thus, they felt that pregnant women do not need to seek medical care. They believed that it is their way of life under Islamic doctrine. Therefore, pregnant Muslim women need HCPs to respect their spiritual beliefs. They do not want HCPs to judge them through the eyes of modern Western, using loud voices and disrespect. They feel stigmatized by others, as if people perceive their ways of life as incorrect or wrong. They feel loss of choice and control when they leave their community to give birth at the hospital. One Muslim mother described her voice in the hospital as a silent voice. Nobody heard it:

> *When we arrived at the hospital, they* (HCPs) *do what they want to do. If we spoke or requested something more, they would be looking disapprovingly. Any more, they would be doing badly to us. That's why we did not talk, and just waited quietly. The hospital is their place, not ours. In the hospital, health care providers are big, we are small. When I went there, I was just endured quietly when I felt pain. When I felt more back pain or felt stiff, I just had to tolerate it.* (Muslim mother 1, in-depth interview)

> *Firstly, it should be accepted as they are. What do they want in the whole? They want respect of their way of life, the number of children they have and being delivered by a toa be-dae* (TBA). *These are the main parts of life here. Health care providers don't judge about whether to have more children, or, the age at which they get pregnant. The women feel bad if they are judged* (by the HCPs). *That can lead them to avoid delivering at the hospital.* (Community leader 1, FGD)

2. Practicing religious and local traditional beliefs. The participants reflected on their needs for spiritual care that they mostly performed. Two types of spiritual care were manifest and discussed below. Note that while the first one is based on Islamic faith, the other rituals discussed are local traditions unrelated to Islam but inherited through generations.

2.1 Pray and recite the Holy Quran. While pregnant, Muslim mothers and their husband would pray more than they usually do to receive blessings from God. They also spend more time to recite the *Holy Quran*. In addition, pregnant women prayed to express *zhukor* (to give thanks to God) for blessing them with a child. Every day after prayer, the women (and/or husbands) prayed at dawn and dusk. Before giving birth, the *Quran*, especially the *surah* (chapter) *baqarah* (the cow), *lugman* (a wise man), and *Maryam* (Arabic name) were read to the women. It is believed that such action would bring to parents a good and attractive baby. According to them, the prayer and the *Quran* reading would also help ease the painful process of delivery. As two Muslim mothers explained during FGDs:

> *After prayer, we recited the Quran all day. And then after the makrib* (dawn prayer) *we recited surah, baqarah, lugman and Maryam for a pretty and handsome child and for easy birthing were important. The surah lugman prays for intelligence, and we recited that by ourselves.* (Muslim mother 2, FGD)

> *When I asked the doctor about my pregnancy he was quiet so I was nervous. The day before, he asked me if I was diabetic and on the third day I had to check blood sugar. I was scared and thought that there was a threat to my baby's life. I feared that the child would be disabled. We prayed hayat* (seeking for God blessing and to get rid of bad things) *to be far from that possibility.* (Muslim mother 3, FGD)

2.2 Nae-Ngae worship and Sama-ngat worship: this ritual is one of the traditional beliefs in the study area, not based on Islamic principle. Although there are fewer formalities, the ritual remains a tradition in the setting, performed by TBAs. Generally, the TBAs conduct the worship when the pregnancy is at seven months (thus no risk for abortion). The purposes are to ease the delivery and to predict the baby's sex. In the *nae-ngae* (forecast) ritual, the TBAs used a half of a peeled coconut and then put it on the abdomen of pregnant woman. For the *sama-ngat* (hearten) worship, three-color rice and sticky rice are used in the ceremony.

> *Nae-ngae ritual depends on the TBAs. The TBAs cut the coconut and ordered us to lay down. Later, the TBAs ordered me to kick the coconut as far as I can, and then she would peel and cut it on our abdomen to predict the sex of the baby.* (Muslim mother 4, FGD)

> *A small coconut was used representing a little baby's head, believed to ease the birthing process. Somebody formulated the sama-ngat together with some homemade colors rice and sticky rice.* (Husband 1, FGD)

3. Harmonizing cultural care from TBAs: Muslim mothers in this community need to harmonize care from TBAs in the antenatal, intrapartum, and postpartum periods. For traditional antenatal care, TBAs implement worship at seven months to hearten soon-to-be mothers. Receiving warm and close care with gentle touch on her abdomen most satisfies the pregnant women before and during giving birth. After giving birth, mothers receive the TBAs' herbal body massage for three days. The herbal healing comforts them and helps them to be relaxed. Moreover, TBAs also perform a ceremony for mothers to eliminate bad things in order to prevent them from seizures.

> *In the labor room, the nurse midwife was so busy with her documents. She always bends her head over her working desk. ...not attending to us. That is different from the behavior of the toe-be dae* (TBAs)*....they are always attending to us...touching our abdomen...making a dua* (beg God for something) *for easier birthing... We felt good. But at the hospital, the nurse midwife is sitting far away.* (Muslim mother 5, in-depth interview)

As mentioned earlier, concerns about gender, experiences and religion of HCPs are the main underlying reasons for Muslim mothers' preference to give birth at home with TBAs who are female, experienced, and Muslim. Plus, TBAs also speak the local language and this helped Muslim mothers to express how they felt. In addition, because of not receiving ANC from the hospital, Muslim mothers are not familiar with HCPs staff. This further discourages them from seeking delivery services at the district hospital.

An important reason for giving birth at home is the desire to respond to Islamic traditions. As especially expressed among husbands of the participants, they prefer their wives to give birth at home because they desire that their child's first sound to hear is the *athan* (the call to prayer) in the name of God, not the noise of nurse midwives talking to each other.

The participants would use postpartum care from the hospital only to take the medication to heal the wound from giving birth, though they also use the herbal remedy from TBAs. However, according to our participants, the after-birth medicines they received from the hospital were not sufficient. They need not only medicines from hospital, but also herbal fire, pills, and herbal medicines prepared by TBAs. In their words, what a mother needs is beyond healing or cure, and is a harmonized care for physical and mental health, a caring care that integrates modern health services with culture and belief.

4. Supporting mothers and families: It is clear from our study that Muslim mothers and their husbands need cultural and psychosocial support for both psychological and physical health. Psychologically, there is a need to keep mothers' spirits strong during pregnancy. Muslims need the right knowledge about performing religious practices, such as the recommended chapters of *Quran* to be recited during pregnancy. They may need an *ustaz* (religious teacher) to teach them. They may also need an *ulama* (an expert in Islamic knowledge) to *fatwa* (judge) some practices whether they have the religious indication such as birth spacing. For physical health, participants mentioned the need for *halal* (Islamic approved consumption) food appropriate during pregnancy.

> *When I was pregnant, I kind of needed someone to help me, especially during my first pregnancy. I was worried that either I or my baby wouldn't make it. I performed dua* (prayer) *from Allah but sometimes I wasn't sure how to do it properly, so I asked a ustaz* (Islamic teacher) *to teach me some chapters from the Quran.* (Muslim mother 6, in-depth interview)

> *While pregnant, there were many things that I wanted to eat. It's like eating a useful food, as well as halal. I needed someone to advise me about which halal food in order to make my baby a good life.* (Muslim mother 7, in-depth interview)

In everyday life, pregnant Muslim women need care from their families, especially care from their husband, physically, mentally, and economically. They need their husband to be available to care for the elder children and to bring them to ANC. Lack of care experienced by Muslim mothers in this setting was exacerbated by a husband's migration to work in Malaysia. We also found that some husbands did not provide care or assistance to their pregnant wife but were concerned about the pregnancy. Thus, some husbands actually felt that care should be performed by health personnel.

> *Well, I don't know. We don't know about this. I am a man, and I don't know about pregnancy issues. She should go to the public health center for ANC. The doctors know best, they know how to take care of it. I can't help much.* (Husband 2, FGD)

> *Perhaps it is the father* (husband) *who will take care of our baby... by trying to hold the baby ... to watch over them. If he's around... Yor* (he; baby) *and the baby was not silent.* (Muslim mother 8, in-depth interview)

> *Most of the problem is that her husband is not home. The husband has to work remotely* (Malaysia). *For those whose husband is at home, it is not a problem.* (Muslim mother 9, in-depth interview)

> *No one brought me to the hospital for antenatal care. It seemed....* (Shaking her head)*... Bae* (followed by husband's name) *gave some massage, legs massage* (laughs). (Muslim mother 10, in-depth interview)

5. Enhancing cultural competence of health care providers and village health volunteers. All HCPs and VHVs in this area are Muslims. Three of HCPs and eight of VHVs responded that they were unsure how religious and cultural concepts could be utilized in health care services. As they do not have depth understanding of the Islamic principles, and they do not really know how the pregnant woman inform about the maternity needs relating to religion such as fasting safety during pregnancy. Therefore, HCPs need to upgrade VHVs to a new category of practice called Maternal care volunteers (MCVs) who can provide Muslim mothers with cultural care.

Although we are Muslim. We learned science. Sometimes, we don't know. It seems that the religious beliefs are stronger than science. We don't know how to fast safely during the fasting period and what is permitted or prohibited. We would have to be trained to better understand those concepts. Training on culture and religious beliefs are needed in addition to training as a volunteer. (HCP 1, in-depth interview)

Discussion

Results from this study revealed that Muslim mothers in this particular setting need culturally-sensitive maternity care which mainly relies on Islamic beliefs. Five needs regarding culturally-sensitive maternity care for Muslim mothers were identified.

The participants strongly desired more respect for the way of life as they live it. They did not want HCPs to judge them because they did not follow modern medical procedures as in an earlier study.[30,36] Prejudice from HCPs was an obstacle to participation among members and groups from non-dominant cultures.[31] Knowledge of this opens dialogue and encourages HCPs to be thoughtful as they work in the broader community. The importance of treating women with respect has been underscored in previous studies.[30,32] Respecting their culture by HCPs in this study was different from many studies that focus on the cultural differences between HCPs and clients. Health care services are more attuned to cultural care in this area of Thailand's deep south. Most HCPs in the study were Muslim, just like their clients. In this area, Muslims are not the minority population, but rather, they are the majority.

In this setting, fertility is high and contraceptive use is low. Pregnancy at an advanced age is a reason which prevents women from utilizing ANC. In our study, there was a pregnant woman aged 45 years with 11 children. Women with many children who became pregnant were too embarrassed to go to the hospital.

Women who avoid ANC and give birth at home without trained attendants have a greatly increased risk of perinatal and maternal death.[30] Promoting Muslim mothers to utilize maternity care, especially ANC at early pregnancy is a real challenge for primary HCPs and VHVs. Early ANC can prevent maternal complications including those related to anemia, common among Muslim mothers in this area. Maternal anemia is a predisposing factor which increases the risk of postpartum hemorrhage, infection delivery and low birth weight.[3, 33]

In fact, health practices can be merged with worshipping. Hence, to increase access to maternity care among Muslims, health care services should provide cultural care in an environment that allows Muslim mothers and their family to comfortably perform religious practice. Female public health midwifes must be trained to address modesty and gender preference, and respect needs in practicing religious and local traditional belief.

Participants believed that TBAs offer harmonizing cultural care for Muslim mothers at all stages maternity care. Accordingly, Muslim mothers prefer to give birth at home by a TBA. This is contradictory to the Thailand's government policy of encouraging all women to give birth in the hospital. [2] However, existing maternity care services are fragmented. While ANC and postpartum care are provided at health promoting hospitals at sub district level, but intrapartum care is provided at the district hospital, which is unfamiliar and unknown to Muslim mothers. Moreover, at a hospital, mothers cannot choose with whom they will deliver their baby, being unable to choose creates more stress.

The findings indicate that Muslim mothers still needed services from TBAs and HCPs in the community in which similar to previous study [6, 10] which found that Muslims mothers in Pattani Province

used mixed care from HCPs and TBAs for ANC and postpartum care. TBAs provided traditional care for ANC using body massaging and herbal healing for postpartum care.

The need for cultural care during maternity among Muslim mothers has not yet been achieved in the formal health care service setting. Improvement is thus needed. For example, there should be better linkages and referral system/information between the health promoting hospital and district hospitals. Integrating traditional practices such as herbal healing and TBAs massage in the hospital should be allowed, encouraged, and facilitated.

Cultural and psychosocial support for Muslim mothers and their families is needed. In the high fertility context, Muslim mothers are in need of a caregiver for their other young children and themselves during pregnancy. The common view of the community, however, is that maternity care is the responsibility of the individual or their families, and not a public concern. In fact, Islam view mothers as the "greater one", which we need to support in all aspects in order to promote a good *ummah* (nation). Motherhood is a great responsibility, not only for mothers and their family, but also for all community members, especially community leaders and community religious leaders. Therefore, collaborative supports for mothers and their family from all levels and networks within and outside the community are needed.

Health personnel need Islamic knowledge and skills to provide culturally-sensitive maternity care for Muslim mothers. Our study shows that although HCPs and VHVs are Muslim, they do not always know how to adapt Islamic beliefs to their routine care. This is similar to Muslim HCPs concerns in USA and Scotland [36, 37] as none of the available approaches has been shown to overcome the problems of providing culturally- appropriate care. [38, 39] The knowledge and understanding of these cultural practices and beliefs helps HCPs provide cultural care for Muslim mothers in this area. [35] HCPs and VHVs should acquire cultural competence through training and education in maternity care from the Islamic perspective. This should be a collaborative effort among health care services, community religious leaders, and community leaders, and the nursing education institutes. One of the outcomes of this effort should be a guideline for cultural care for Muslim mothers.

Assessment activities played a critical role in building capacity of collaboratively partnerships, creating a sense of ownership, and ensuring its sustainability, fulfilling its mission to collaboratively promote maternal health and systematic change in the formal and informal health care system. In fact, the result of this collaborative effort should serve the goal of maternal care in the study community, which is declared by community members' goal as "*Salamat ibu, salamat anokku, salamat kapong* (save mothers, save children, and save community)".

It is important to raise the awareness of how underserved groups of Muslim mothers contribute to high maternal complications and high MMR. To effectively address the many issues affecting maternal health of Muslim women, culture and belief must be included. The achievement of needs regarding cultural maternity care for Muslim mothers as an underserved group requires concerted effort.

Better understanding of the needs for cultural maternity care among Muslims is crucial for improving maternity care that realizes the needs of Muslim mothers in this setting. Strengthening the capacity of the community to actively participate is a crucial strategy for establishing an appropriate cultural-based care for Muslim mothers that contributes to enhance cultural sensitivity of maternity care in the southernmost provinces of Thailand.

Conclusions, Limitations and Recommendations

The CST and cultural care concept provides in-depth understanding of Muslim maternity care needs regarding their cultural contexts in the Muslim

community. The four steps, establishing community collaboration, assessing cultural community needs of maternity care, analyzing and interpreting data, and reflecting and sharing the findings, illustrated needs on cultural maternity care among Muslim mothers through CBPR process.

The results highlight five themes of needs regarding culturally-sensitive maternity care for Muslim mothers: respecting the way of life, practicing religious and local traditional belief, harmonizing cultural care from TBAs, supporting mothers and families, and enhancing cultural competence of HCPs and VHVs.

The findings are able to explain specific phenomena covering only this rural community with a specific culture and belief in an area of civil unrest. Recommendations for future research include increasing the involvement of religious leaders in *Pondok* (traditional Islamic school) and HCPs in hospital. For nursing and midwifery practice, it is important to make care services more efficient safe, and culturally-appropriate in the Muslim community as well as in the health system at-large. Emphasis should be placed on maternity care competencies for preservice and in-service education.

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ความต้องการการดูแลเชิงวัฒนธรรมสำหรับมารดามุสลิมในชุมชนชนบทของจังหวัดชายแดนใต้ในประเทศไทย

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บทคัดย่อ: การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อประเมินความต้องการเชิงวัฒนธรรมในการดูแลมารดามุสลิมในชุมชนชนบทของจังหวัดชายแดนใต้ในประเทศไทย จากเดือนพฤษภาคม-ธันวาคม พ.ศ. 2556 ใช้วิธีวิจัยเชิงปฏิบัติการชุมชนมีส่วนร่วมโดยศึกษาใน 3 กลุ่มของ 1) *มารดามุสลิม* (อายุ 15-49 ปี และมีลูกที่มีอายุน้อยกว่า 3 ปีอย่างน้อย 1 คน) จำนวน 26 คน และสามี จำนวน 71 คน 2) *ผู้นำชุมชนและผู้นำศาสนา* จำนวน 14 คน และ 3) *บุคลากรทางสุขภาพ* รวมทั้งอาสาสมัครสาธารณสุขหมู่บ้านและผดุงครรภ์แผนโบราณ จำนวน 14 คน เก็บรวบรวมข้อมูลเชิงคุณภาพ ด้วยการสนทนากลุ่ม การสัมภาษณ์เชิงลึก และการสังเกตอย่างมีส่วนร่วม ใช้การวิเคราะห์ข้อมูลเชิงเนื้อหา

ผลการวิจัยพบว่า ความต้องการเชิงวัฒนธรรมในการดูแลมารดามุสลิม มี 5 ประเด็นดังนี้ 1) การยอมรับในวิถีชีวิต 2) การปฏิบัติศาสนกิจและการปฏิบัติตามความเชื่อของประเพณีในท้องถิ่น 3) การดูแลเชิงวัฒนธรรมอย่างกลมกลืนจากผดุงครรภ์แผนโบราณ 4) การสนับสนุนแม่และครอบครัว และ 5) การพัฒนาศักยภาพด้านวัฒนธรรมสำหรับบุคลากรสุขภาพและอาสาสมัครสาธารณสุขหมู่บ้าน ผลการศึกษาแสดงให้เห็นถึงความต้องการการดูแลเชิงวัฒนธรรมสำหรับมารดามุสลิม เป็นแนวทางในการให้การดูแลเชิงวัฒนธรรมสำหรับมารดามุสลิมในชุมชนได้อย่างเหมาะสม

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คำสำคัญ: วิจัยเชิงปฏิบัติการชุมชนมีส่วนร่วม การดูแลเชิงวัฒนธรรม ความไวเชิงวัฒนธรรม การประเมินความต้องการ มารดามุสลิม ชุมชนชนบท ประเทศไทย

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