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Cultural Sensitivity in Antenatal Care for Muslim Women in Eswatini: A Case Report

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Abstract

Introduction: Antenatal care is crucial for safeguarding maternal and fetal health. However, systemic and cultural barriers disproportionately affect minority populations, including Muslim women, in Eswatini, a predominantly Christian country. Addressing these challenges is essential to achieving equitable and culturally responsive healthcare. **Objective:** This case report describes the cultural sensitivity challenges and ethical dilemmas encountered in providing antenatal care to Muslim women in Eswatini. **Method:** Researchers used a case report approach to examine the experiences of three pregnant Muslim women over six weeks at a resource-limited public hospital. The analysis, guided by Leininger's Transcultural Nursing Theory, focused on clinical interactions, environmental challenges, and systemic barriers, incorporating nursing diagnoses to contextualize the findings within a care framework. **Result:** The case identified significant barriers to culturally sensitive antenatal care, including inadequate privacy, limited access to female healthcare providers, and insufficient cultural competence among staff. These issues contributed to emotional distress, discomfort, and reduced patient engagement. Interventions such as private examination spaces, prioritizing female providers, and mandatory cultural competence training showed promise but were inconsistently applied due to staffing and resource constraints, limiting their effectiveness. **Conclusion:** Significant cultural and systemic barriers hinder the delivery of culturally sensitive antenatal care for Muslim women in Eswatini. **Recommendations:** Maternal healthcare systems are encouraged to integrate cultural competence training, enhance privacy infrastructure, and adopt gender-sensitive practices to promote equitable and culturally responsive care.

Keywords: antenatal care, cultural sensitivity, ethical dilemmas, privacy, transcultural care

INTRODUCTION

Antenatal care (ANC) is essential for promoting maternal and neonatal health, providing services such as health education, screenings, and nutritional guidance to identify and reduce pregnancy-related risks. Globally, ANC has contributed significantly to reducing maternal and neonatal mortality and morbidity while fostering trust and communication between healthcare providers and patients (1). Despite its critical role, the equitable delivery of ANC is often delayed by systemic cultural insensitivity, particularly for minority populations whose cultural and religious needs are insufficiently addressed.

Cultural insensitivity in maternal healthcare significantly contributes to health disparities, particularly affecting pregnant Muslim women. Islamic cultural values such as modesty, privacy, and the preference for same-gender healthcare providers are deeply rooted principles that shape their healthcare-seeking behavior and expectations (2). When these values are not respected, pregnant Muslim women often face discomfort, emotional distress, and mistrust, which can lead to disengagement from antenatal services. This disengagement increases the risk of adverse maternal and neonatal outcomes, exacerbating existing health disparities (2, 3).

Globally, studies have highlighted the importance of culturally sensitive care in improving healthcare access and outcomes for Muslim women (4, 5). However, such research has largely focused on countries with significant Muslim populations, where systemic barriers differ from those faced by minorities in predominantly non-Muslim settings. In Eswatini, a country where 90% of the population identifies as Christian and only 2% as Muslim, these challenges are uniquely pronounced (6). The healthcare system in Eswatini is shaped by Christian cultural norms, which frequently marginalize minority groups. For pregnant Muslim women, this translates into systemic barriers such as insufficient privacy measures (e.g., examination spaces separated by torn curtains), a shortage of female healthcare providers for intimate procedures, and a general lack of cultural competence among healthcare staff. These barriers not only conflict with Islamic values but also force pregnant Muslim women into ethical dilemmas, where they must choose between compromising their cultural and religious beliefs or foregoing essential healthcare services (2). These systemic limitations weaken trust in healthcare and worsen maternal health disparities by hindering women's engagement with essential services (7).

While global research has acknowledged the importance of culturally sensitive maternal healthcare, it has largely neglected contexts where Muslim women form a small minority in predominantly Christian societies. Such contexts present distinct challenges, as healthcare systems are often shaped by the dominant cultural and religious values, leaving minority populations underserved. Specifically, in Eswatini, a predominantly Christian country, there is a critical gap in understanding how systemic barriers, cultural insensitivity, and resource constraints intersect to impact pregnant Muslim women. These women face unique obstacles, including a lack of privacy, insufficient access to female providers, and inadequate cultural competence among healthcare staff. Without targeted research to document their lived experiences and needs, these gaps perpetuate health inequities and limit the effectiveness of maternal healthcare services. Addressing this gap is vital not only to improve maternal health outcomes in Eswatini but also to offer valuable insights for designing culturally inclusive healthcare systems in other diverse, multicultural societies.

This case report addresses a critical gap by documenting the lived experiences of pregnant Muslim women navigating antenatal care in Eswatini. It examines how systemic barriers such as inadequate privacy, limited access to female providers, and insufficient cultural competence compromise their

engagement with care and contribute to maternal health disparities. Additionally, the study explores the ethical dilemmas healthcare providers face in balancing resource constraints with the need to deliver culturally appropriate care. Guided by Leininger's Transcultural Nursing Theory, this study offers evidence-based recommendations to enhance cultural competence among healthcare providers, strengthen privacy measures, and implement gender-sensitive practices. Addressing these systemic challenges, the findings aim to inform the development of inclusive healthcare practices that respect cultural diversity and uphold ethical principles.

STATEMENT OF THE PROBLEM

Healthcare systems often overlook the cultural and religious needs of minority populations, including Muslim women. In predominantly Christian Eswatini, healthcare practices frequently fail to provide culturally sensitive antenatal care, posing significant challenges for Muslim women (8, 9). Key issues include the lack of privacy in healthcare settings, with open-plan clinic layouts and torn curtains that fail to ensure confidentiality during examinations. While female healthcare providers are present, male nurses are often tasked with conducting intimate procedures due to high patient volumes, creating discomfort for Muslim women who culturally prefer gender-congruent care. In some cases, requests for female providers may be misunderstood within the cultural context of Eswatini, where male authority is highly regarded, further complicating the situation (4, 5). These systemic gaps in cultural sensitivity contribute to emotional distress, delays in care, and increased health risks, worsening maternal health disparities among Muslim women. The disconnect between the ethical standards of care and the lived experiences of marginalized populations highlights the urgent need for culturally responsive healthcare practices (10) .

SIGNIFICANCE

This case report underscores the urgent need to address the cultural and religious needs of marginalized populations in maternal healthcare. Examining the barriers Muslim women face in accessing culturally sensitive antenatal care highlights the systemic challenges that hinder equitable care, including cultural insensitivity and the lack of gender-sensitive healthcare provisions. The findings emphasize the importance of integrating cultural competence into healthcare practices, mainly through training healthcare providers to navigate cultural and religious sensitivities (11). Such interventions are critical to fostering trust, improving patient engagement, and ultimately reducing health disparities. This report is aligned with global health priorities, such as the Sustainable Development Goals (SDG 3), advocating for inclusive access to quality healthcare for all women, irrespective of cultural or religious background (12). By addressing these gaps, this case contributes to the ongoing effort to ensure that maternal healthcare systems are equitable, inclusive, and capable of improving outcomes for diverse populations globally.

OBJECTIVE

This case report describes the cultural sensitivity challenges and ethical dilemmas encountered in providing antenatal care to Muslim women in Eswatini.

METHOD

Research Design

This study uses a case report method to explore the cultural sensitivity challenges and ethical dilemmas encountered by healthcare providers in delivering antenatal care to Muslim women in Eswatini. The study was guided by Leininger's Transcultural Nursing Theory, emphasizing cultural preservation, accommodation, and repatterning in clinical practice. This theoretical framework provided a structured approach to analyzing how cultural values and beliefs impact antenatal care

experiences. The case report method was selected for its ability to provide a detailed, real-world examination of cultural and ethical barriers within a specific healthcare context (13).

Observations of Case Report

Observations were made over six weeks at a public antenatal care clinic in Eswatini. The focus was on interactions between healthcare providers and Muslim women, as well as the clinic's physical setup, cultural challenges (e.g., privacy, gender dynamics, and cultural congruence), and systemic barriers faced during antenatal care. Real-time clinical practices and environmental dynamics were documented in detailed field notes. This approach avoided direct interviews or surveys, instead relying on unobtrusive observation to capture authentic clinical practices and environmental factors.

Data Analysis

The analysis began with an in-depth review of observational field notes, which captured healthcare practices, infrastructural limitations, and interactions between providers and patients within antenatal care settings. These observations were then thematically analyzed using Leininger's Transcultural Nursing Theory to examine how systemic barriers and cultural dynamics shaped pregnant Muslim women's access to antenatal care. Key themes: privacy, gender-congruent care, and communication were identified and aligned with Leininger's framework, organized into cultural preservation, accommodation, and repatterning, to ensure a culturally sensitive interpretation of the findings.

Cultural Preservation

The results highlighted challenges in maintaining cultural and religious values, particularly privacy. Examination spaces were inadequately designed, often separated by torn curtains or shared with others, compromising the modesty valued in Islamic culture. This lack of cultural preservation contributed to discomfort among patients and reduced trust in the healthcare system.

Cultural Accommodation

Efforts to meet the cultural needs of patients were observed, such as assigning female healthcare providers to perform intimate procedures. However, these accommodations were inconsistent due to staff shortages and high patient volumes. In some cases, male providers had to perform these procedures, which went against the cultural and religious preferences of the patients. This inconsistency highlighted systemic barriers that made it difficult to provide consistent cultural accommodation.

Cultural Repatterning

The findings revealed the need for systemic changes to improve cultural responsiveness. Healthcare providers displayed gaps in cultural competence, particularly regarding awareness of religious practices such as modesty and the significance of the hijab. Communication strategies were also found to lack cultural sensitivity, reinforcing the necessity for cultural competence training and infrastructural improvements to align antenatal care practices with the expectations of pregnant Muslim women.

Ethical Considerations

The Eswatini Health and Human Research Review Board confirmed that formal ethical approval was not required for this study, as it involved a case scenario illustrating typical clinical practices rather than direct patient contact or intervention. A letter of consent was obtained from the hospital to allow observations of the case scenario, which is included in the appendix for reference. It is important to note that the hospital does not issue ethical approval numbers but grants permission through formal correspondence. The case strictly adhered to established ethical protocols. Observations were conducted in a manner that ensured no disruption to patient

care and upheld patient privacy, dignity, and autonomy. No direct interaction with patients occurred, and no interviews were conducted. Furthermore, no identifying information was collected, and pseudonyms were used to maintain confidentiality. All findings were anonymized to protect identities while addressing the healthcare challenges observed. The research team rigorously followed all ethical guidelines and standards to safeguard the rights and well-being of patients and healthcare providers involved in the clinical setting.

RESULTS

Nursing Assessment

The nursing assessment examined the experiences of three Muslim primigravida women attending antenatal care in a resource-limited public hospital in Eswatini. Each case highlighted systemic, cultural, and interpersonal barriers that conflicted with the patient's cultural and religious expectations. Detailed observations of patient behaviors, healthcare interactions, and systemic shortcomings were central to this assessment.

Case 1: Mrs. F.Z.

Mrs. F.Z., a 26-year-old woman in her second trimester, faced significant challenges during her antenatal visit. She was attended by a male nurse because the female nurse was occupied with other duties. Despite the male nurse's explanation that rescheduling her appointment could delay her care, this arrangement conflicted with her cultural expectation for same-gender care providers. Observations captured her discomfort as she avoided eye contact and responded to questions with short, hesitant phrases. Her stiff posture and reluctance to fully engage in the examination reflected her internal conflict and cultural distress.

The situation worsened when her husband, who had accompanied her for emotional support, was asked to leave the room due to space limitations. Without his presence, Mrs. F.Z. appeared visibly isolated, shifting uncomfortably in her seat and displaying signs of emotional distress, including restlessness and an unwillingness to proceed with the exam. This experience highlighted systemic limitations such as staffing shortages and inadequate examination spaces, which disrupted her sense of comfort, dignity, and cultural safety. These challenges emphasized the importance of providing culturally sensitive care to foster trust and engagement.

Case 2: Mrs. H.A.

Mrs. H.A., a 34-year-old woman in her second trimester, demonstrated visible distress during her antenatal care visit. When asked to remove her hijab for a physical examination, she hesitated, glancing repeatedly at the nurse and fidgeting with her hands. The hijab, a deeply rooted symbol of modesty in Islamic culture, represents privacy and religious identity, particularly in the presence of men outside the family. The male nurse conducting the examination requested without offering culturally sensitive alternatives, such as arranging privacy or scheduling a female provider.

Observations revealed Mrs. H.A.'s hesitation to comply, as she delayed the examination, shifted uncomfortably, and avoided eye contact. These behaviors reflected her internal struggle to balance her cultural and religious values with the healthcare provider's request. This scenario highlighted the systemic failure to provide culturally competent care, with the absence of gender-congruent care and privacy accommodations intensifying her vulnerability. The lack of cultural awareness from the nurse further strained the patient-provider relationship, creating a sense of disrespect and emotional distress for the patient.

Case 3: Mrs. R.T.

Mrs. R.T., a 30-year-old woman in her first trimester, encountered barriers related to insufficient communication during her antenatal care. The male nurse performing her examination failed to provide clear

explanations of the procedures. Observations noted her tightly crossed arms, tense expression, and frequent glances toward the door. Her non-verbal cues conveyed a sense of discomfort and uncertainty regarding what to expect during the examination.

This lack of culturally sensitive communication intensified her anxiety, as she struggled to understand the purpose of the assessment and how it aligned with her cultural expectations. The absence of detailed explanations and reassurance reduced her trust in the care process and contributed to feelings of disempowerment. This case emphasized the importance of effective, culturally appropriate communication strategies to ensure patients feel informed, respected, and supported.

Nursing Diagnoses

The nursing diagnoses presented in this study were derived exclusively from detailed clinical observations, as no patient interviews or subjective reports were included in the data collection process. While this methodology limits access to patients' verbalized experiences, the observable behaviors and contextual factors provided critical insights into the challenges faced by Muslim women in accessing culturally sensitive antenatal care. The diagnoses reflect the psychological, emotional, and behavioral responses of patients to systemic and cultural barriers.

Patients demonstrated distress related to unmet cultural and religious needs, as evidenced by observable discomfort, emotional vulnerability, and visible hesitancy during clinical interactions. For instance, patients demonstrated signs of distress through behaviors such as avoidance of eye contact, rigid posture, and delayed responses to instructions. These behaviors suggested an internal conflict as patients attempted to reconcile their deeply held cultural and religious values such as the expectation of gender-congruent care and modesty with a clinical environment that failed to meet these expectations.

Anxiety related to a perceived lack of control and inadequate cultural accommodation was also observed. Patients displayed intensified emotional responses, including tightly crossed arms, frequent glances toward the door, and restlessness during assessments. These non-verbal cues reflected unease and uncertainty about the care process, further worsened by insufficient communication and the absence of culturally sensitive explanations provided by healthcare staff. The inability to establish a sense of trust between patients and providers appeared to amplify this anxiety, reducing patients' engagement with care.

Impaired coping is attributed to ethical dilemmas and systemic healthcare barriers patients encounter. Behaviors such as delayed compliance with instructions, visible tension, and reluctance to engage with male providers highlighted the difficulty patients experienced in navigating a healthcare system that did not align with their cultural and religious expectations. These behaviors highlighted the emotional strain placed on patients when forced to compromise their values to receive necessary care.

Implementation and Evaluation

The clinic introduced measures to address gaps in culturally sensitive antenatal care. A private examination room was established to improve privacy, and lightweight curtains in shared spaces were replaced with more robust partitions. Female providers were prioritized for intimate procedures, and when unavailable, patients were offered the option to reschedule or proceed with a trusted companion present. Staff underwent mandatory cultural competence training, focusing on understanding diverse practices, fostering effective communication, obtaining informed consent, and providing culturally sensitive explanations of procedures to reduce discomfort and build trust. The interventions yielded mixed results. Patients who received care in private spaces or from female providers

reported feeling more respected and comfortable. However, staffing shortages and resource limitations hindered consistent application, leaving some patients dissatisfied. Follow-up observations indicated that initial negative experiences continued to shape patients' perceptions of care, reinforcing the need for systemic reform.

Summary of Results

The experiences of these three women reveal significant gaps in culturally sensitive antenatal care, illustrating how systemic insensitivity forces difficult choices between faith and health, undermining trust and engagement. Although some interventions showed promise, their inconsistent application underscored the need for institutionalized cultural competence. This case reinforces the importance of culturally sensitive care as a cornerstone of equitable healthcare, especially in diverse and multicultural settings.

Theoretical Framework: Leininger's Transcultural Nursing Theory

Leininger's Transcultural Nursing Theory, also known as the Culture Care Theory, provides a comprehensive framework for integrating cultural considerations into healthcare delivery. Developed by Madeleine Leininger, this theory emphasizes the need for culturally congruent care, care that aligns with an individual's cultural values, beliefs, and practices to achieve optimal health outcomes (14).

At the core of the theory are three interconnected modes of action: cultural preservation, cultural accommodation, and cultural repatterning. These modes provide actionable strategies to address the systemic challenges identified in this case. Cultural preservation is especially relevant for Muslim women, whose beliefs prioritize modesty, privacy, and same-gender care. Implementing measures such as private examination spaces and ensuring access to female healthcare providers aligns with these values, enabling patients to receive care without compromising their cultural identity. The absence of such accommodations, as documented in this case, resulted in distress and reluctance to engage with the healthcare system, highlighting the urgent need for culturally sensitive practices (15).

Cultural accommodation becomes essential in scenarios where systemic limitations limit the preservation of cultural values. For instance, when female providers are unavailable, offering culturally sensitive alternatives, such as permitting a trusted companion to be present during examinations, can help reconcile institutional limitations with cultural expectations. Additionally, training healthcare providers to deliver culturally appropriate explanations of medical procedures, particularly those involving physical exposure, can reduce patient discomfort and foster trust. In this case, the absence of such accommodations exacerbated patients' emotional distress, underscoring a significant gap in service delivery that Leininger's theory aims to address (16).

Cultural repatterning offers a framework for addressing systemic inequities by transforming institutional behaviors. In this case, barriers such as insufficient cultural competence training, inadequate privacy measures, and resource constraints contributed to inequitable care. Repatterning involves integrating cultural competence into policies and practices through ongoing staff training, improved privacy measures, and recruiting more female providers (17). Leininger's theory highlights the need for systemic reforms to align care with the cultural and religious needs of Muslim women. Strategies like staff education, patient feedback, and cultural competence audits foster trust, reduce disparities, and support equitable, culturally sensitive care.

DISCUSSION

In the case of the three pregnant Muslim women observed, systemic, cultural, and psychological barriers within Eswatini's

healthcare system were evident. These barriers reflect broader challenges faced by minority populations in healthcare systems that lack cultural sensitivity, worsening patient vulnerability and undermining equitable maternal health outcomes (2, 4, 5). The women's experiences align with findings from other studies globally highlighting the universal nature of these challenges in settings where healthcare practices fail to consider cultural and religious diversity. For instance, a study revealed that 93.8% of Muslim women reported that their healthcare providers did not comprehend their unique cultural needs (18).

One of the primary challenges identified was inadequate privacy during antenatal care, as thin curtains in examination cubicles failed to ensure confidentiality, causing significant discomfort and disengagement for Muslim women, whose values strongly emphasize privacy. Similar findings have been reported in resource-constrained settings such as Nigeria and Kenya, where inadequate infrastructure compromised patient dignity and fostered mistrust in healthcare systems (7, 8). These findings emphasize the universal need to prioritize privacy as a critical component of patient-centered care, particularly in multicultural environments. The lack of consistent access to female healthcare providers worsened the discomfort experienced by participants. Despite the presence of female staff in the clinic, systemic inefficiencies often resulted in male nurses conducting intimate examinations, conflicting with participants' cultural and religious expectations for same-gender care. Similar findings have been reported in the UK, where Muslim women expressed dissatisfaction with male providers performing intimate procedures, highlighting a misalignment between cultural values and healthcare practices (16). In contrast, healthcare systems in Muslim-majority countries like Saudi Arabia have effectively implemented gender-sensitive practices, leading to greater patient satisfaction and improved maternal health outcomes (16, 19). This comparison highlights the need for clear protocols that respect patient preferences for same-gender care, particularly in culturally diverse settings.

The psychological impact of these systemic barriers was significant, with participants expressing feelings of vulnerability, frustration, and emotional distress. These findings align with studies conducted in the United States and the UK, where culturally incongruent care has similarly resulted in emotional harm and disengagement from healthcare systems (2, 20). These emotional challenges underscore the consequences of cultural insensitivity, which harm individual well-being and erode trust in healthcare systems. Integrating empathy and cultural competence can foster inclusion, preserve dignity, and improve patient outcomes (4, 5, 17).

The challenges in Eswatini reveal structural inequities in healthcare systems, where Christian cultural norms often marginalize minority groups like Muslim women. Globally, dominant cultural frameworks similarly fail to address the needs of minority populations, perpetuating disparities in access and outcomes (21, 22). Studies from multi-ethnic societies stress the importance of moving beyond equitable access to ensure care aligns with the diverse cultural and religious values of all populations (23). Evidence consistently shows that prioritizing privacy, gender-sensitive care, and effective communication fosters culturally inclusive maternal healthcare, enhancing patient satisfaction, trust, and outcomes (5, 24). The challenges observed in this report emphasize the urgent need for systemic reforms to embed cultural competence into healthcare delivery, ensuring inclusive care that respects diversity and eliminates marginalization.

CONCLUSION

This case report highlights the significant barriers Muslim women face in accessing antenatal care in Eswatini, including inadequate privacy, lack of female healthcare

providers, and cultural insensitivity. While interventions such as improved clinic infrastructure and gender-sensitive staffing showed promise in addressing these challenges, their inconsistent implementation limited their effectiveness. Despite efforts to improve culturally congruent care, the barriers led to emotional distress and diminished trust in healthcare services. This case underscores the critical need for systemic reforms, including cultural competence training and enhanced privacy measures, to ensure respectful and equitable maternal care, ultimately fostering trust and improving maternal health outcomes for minority populations.

Recommendations

This case illustrates the critical need for healthcare systems to implement actionable strategies that support culturally competent care in diverse settings. Practical training programs tailored to cultural awareness should be a priority, equipping healthcare providers with the necessary skills to identify and respectfully respond to various cultural and religious needs. Beyond training, healthcare infrastructure must be adapted to include private examination areas and access to female providers for intimate care, thereby fostering an environment where patients feel secure, respected, and dignified. Clear policies that mandate culturally responsive practices are essential to maintain consistency in care delivery. By establishing these policies, healthcare institutions can ensure that cultural sensitivity is built into the standard of care rather than relying on the judgment of individual providers. Together, these programs create a structured approach to culturally sensitive healthcare, directly enhancing patient trust, satisfaction, and overall health outcomes.

Implications for Future Studies

Future researchers are encouraged to incorporate qualitative methods, such as interviews, focus groups, or surveys, to capture subjective perspectives and emotional experiences of Muslim women navigating antenatal care. These methods would complement observational data and provide a deeper understanding of how cultural and systemic barriers impact their well-being. Evaluating the effectiveness of specific interventions, such as cultural competence training, gender-sensitive staffing, and enhanced communication protocols, across diverse healthcare settings would offer valuable insights into improving culturally responsive maternal healthcare.

Additionally, research is recommended to explore the role of tailored communication strategies in building trust and reducing patient anxiety during antenatal care. Investigating the impact of privacy-enhancing measures, such as private examination rooms or robust partitions, on patient comfort and satisfaction would provide practical recommendations for improving care environments. Studies are also encouraged to assess how allowing patient companions during antenatal visits fosters emotional support and strengthens patient engagement. Furthermore, exploring innovative staffing models to prioritize gender-sensitive care in resource-limited settings would help identify feasible solutions for addressing systemic barriers in maternal healthcare.

Strengths and Limitations

This study provides valuable insights into the challenges faced by Muslim women in accessing antenatal care in a predominantly Christian setting. However, certain limitations must be acknowledged. The study focused on the experiences of three specific cases, and the findings are contextually limited to the observed clinical setting and cannot be generalized to broader populations. Additionally, the study exclusively used observational data, as no interviews or subjective reports were collected. While observations allowed for an authentic representation of clinical dynamics, the absence of patients' verbalized perspectives limited the

depth of understanding regarding their emotional and psychological experience

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REFERENCE

(1) McCauley H, Lowe K, Furtado N, Mangiaterra V, van den Broek N. What are the essential components of antenatal care? A systematic review of the literature and development of signal functions to guide monitoring and evaluation. BJOG. 2022;129(6):855-67.

(2) Attum B, Hafiz S, Malik A, Shamoon Z. *Cultural competence in the care of Muslim patients and their families.* StatPearls Publishing, Treasure Island (FL); 2023.

(3) Mayra K, Matthews Z, Padmadas SS. Why do some healthcare providers disrespect and abuse women during childbirth in India? Women Birth. 2022;35(1):e49-e59.

(4) MacLellan J, Collins S, Myatt M, Pope C, Knighton W, Rai T. Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. J Adv Nurs. 2022;78(7):2175-90.

(5) Firdous T, Darwin Z, Hassan SM. Muslim women's experiences of maternity services in the UK: Qualitative systematic review and thematic synthesis. BMC Pregnancy Childbirth. 2020;20(1):115.

(6) Khumalo M. *Faith-based social protection: An approach to reducing poverty and vulnerability in Eswatini.* (2021).[Master Thesis], Life Changing and Ministry University, Zambia

(7) Gillani S, Ahmad TI, Wang F, Shafiq MN. Antenatal care (ANC) coverage, health infrastructure, and postnatal care (PNC) services utilization: A district level analysis of Punjab-Pakistan. iRASD-JOE. 2021;3(3):318–31.

(8) Kabue MM, Palestra F, Katwan E, Moran AC. Availability of priority maternal and newborn health indicators: Cross-sectional analysis of pregnancy, childbirth, and postnatal care registers from 21 countries. PLOS Glob Public Health. 2023;3(1):e0000739.

(9) Christie S, Chahine T, Curry LA, Cherlin E, Linnander EL. The evolution of trust within a global health partnership with the private sector: An inductive framework. Int J Health Policy Manag. 2021;11(7):1140.

(10) Gwebu AS, Kabir MH. *Investigating Culture and Its Influence on Socio-Economic Development in the Kingdom of Eswatini.* Crowther D, Seifi S, editors: Emerald Publishing Limited; 2024.

(11) Feijen-de Jong EI, Warmelink JC, van der Stouwe RA, Dalmaijer M, Jansen DE. Interventions for vulnerable pregnant women: Factors influencing culturally appropriate implementation according to health professionals: A qualitative study. PLoS One. 2022;17(8):e0272249.

(12) Amu H, Aboagye RG, Dowou RK, Kongnyuy EJ, Adoma PO, Memiah P, et al. Towards achievement of Sustainable Development Goal 3: Multilevel analyses of demographic and health survey data on health insurance coverage and maternal healthcare utilization in sub-Saharan Africa. International Health. 2023;15(2):134-49.

(13) Hassan SM, Leavey C, Rooney JS. Exploring English speaking Muslim women's first-time maternity experiences: A qualitative longitudinal interview study. BMC Pregnancy Childbirth. 2019;19(1):1-10.

(14) McFarland MR, Wehbe-Alamah HB. Leininger's theory of culture care diversity and universality: An overview with a historical retrospective and a view toward the future. J Transcult Nurs. 2019;30(6):540-57.
(15) McFarland MR. Madeleine M. Leininger: Theory of culture care diversity and universality. Nursing Theorists and Their Work E-Book: Nursing Theorists and Their Work E-Book. 2021.
(16) Hassan SM, Leavey C, Rooney JS, Puthussery S. A qualitative study of healthcare professionals' experiences of providing maternity care for Muslim women in the UK. BMC Pregnancy Childbirth. 2020;20(400):1-10.
(17) Claeys A, Berdai-Chaouni S, Tricas-Sauras S, De Donder L. Culturally sensitive care: Definitions, perceptions, and practices of health care professionals. J Transcult Nurs. 2021;32(5):484-92.
(18) Zagloul M, Mohammed B, Abufares N, Sandozi A, Farhan S, Anwer S, et al. Review of Muslim Patient Needs and Its Implications on Healthcare Delivery. J Prim Care Community Health. 2024;15:21501319241228740.
(19) Khosravi M, Mojtabaeian SM, Aghamaleki Sarvestani M. A systematic review on factors influencing Middle Eastern women's utilization of healthcare services: The promise of mHealth. SAGE Open Med. 2024;12:20503121241276678.
(20) Alomair N, Alageel S, Davies N, Bailey JV. Muslim women's views and experiences of family planning in Saudi Arabia: A qualitative study. BMC Womens Health. 2023;23(1):625.
(21) Alligood MR. *Nursing Theorists and Their Work E-Book*. 10th ed: Elsevier Health Sciences; 2021.
(22) Lima AFS, Santos CEB, Alves NR, Lima Júnior MCF, Jorge JS, Tigre HWA, et al. Nursing care for the Warao people: An experience report based on transcultural theory. Rev Esc Enferm USP. 2024;57:e20230035.
(23) Assari S, Cuevas A. Diminished health returns of own and parental education for immigrants in the United States. J Psychol Res. 2020;2(4):18-28.
(24) Nair L, Adetayo OA. Cultural Competence and Ethnic Diversity in Healthcare. PRS Global Open. 2019;7(5):e2219.