Beliefs About Childhood Immunisation Among Lebanese Muslim Immigrants in Australia

DEBORAH BROOKE, RN, BN
Royal Alexandra Hospital for Children
AKRAM OMERI, PhD, RN, CTN, MCN, (NSW), FRCNA
University of Sydney

The aim of the study was to describe and analyse care values, beliefs, and practices relating to immunisation by Lebanese Muslim immigrants in New South Wales (NSW), Australia. This ethnonursing study explored the importance of care related to immunisation, knowledge of informants relating to vaccines, diseases, side effects, and contraindications. Family responsibilities relating to immunisation care services as well as expectations and evaluations of care services provided were also examined. Data were collected via observation-participation-reflection, including in-depth interviews. The findings revealed significant care themes for Lebanese Muslim informants based on their cultural values, beliefs, and practices related to health and immunisation. Culturally congruent nursing care practices related to immunisation for Lebanese Muslims in NSW, Australia, were identified.

Immunisation has been identified as the cornerstone of primary health care. It is widely recognised as a cost effective and readily available preventative health measure. Bigbee & Jansa (1991), Pender (1987), and Spellbring (1991), in describing the relationship of immunisation and nursing as the nexus of health promotion, highlight that nurses are an underused resource in the provision and facilitation of immunisation and preventative health.

In Australia, the establishment of the Community Health Program and Universal Health Insurance, a program similar to Medicare, was based on social justice policies and initiated by the elected Labor Government in 1973. These were also moves to redistribute health services and redress the imbalance of funding between curative/institutional and preventative/rehabilitative services based on policies of equality of access and a fair go for all (Bates & Linder-Pelz, 1990).

Global trends in recognition of the importance of primary health care and preventative measures have had a direct influence on immunisation practices. The World Health Organisation's (WHO) Extended Programme on Immunisation (EPI), developed in 1977, set as its goal to immunise 80% of the world's children before 1990. Later, in September 1990, at the World Summit for Children, this plan was extended to increase immunisation rates for children to 90% by the Year 2000 (Hartvelt, 1993). The Children's Vaccine Initiative (CVI) was set up as a strategy in an attempt to meet this objective. The objectives of the CVI, based on WHO's Declaration of Alma Ata and Health for All 2000 were the following: facilitation of affordable, safe, and effective vaccines; development of new and improved vaccines; and ease in distribution of vaccines (Hartvelt, 1993).

In Australia, the National Health and Medical Research Council (NHMRC) devised three goals relating to childhood immunisation to be met by the Year 2000. These goals, which are in accordance with international movements in prevention of illness, were (a) to ensure greater than 90% coverage of children two years of age for all diseases listed in the standard schedule, (b) to achieve near-universal coverage of children of school age entry for the eight diseases for which vaccines are available, and (c) to achieve near-universal coverage of girls and boys age 17 or younger for measles, mumps, and rubella (NHMRC, 1993).

The government of Australia has examined its immunisation rates and the effectiveness of its programs based on the above goals. To meet these goals, the impact of various external factors that may influence compliance rates have also been examined. An immunisation survey (Children's Immunisation Survey, Australia) compiled by the Australian Bureau of Statistics (1983) revealed disappointing low rates

Journal of Transcultural Nursing, Vol. 10 No. 3, July 1999 229-236

for immunisation, well below the recommended WHO target of 80% of the population at the time. However, a follow-up study by Ferson and Christie (1992), in the Eastern Sydney Health Service, showed an encouragingly higher rate of vaccination of 91.3% for measles, mumps, and rubella. Language difficulties were also identified as an influential factor showing variation between schools.

Childhood immunisation in Australia follows the schedule developed by the NHMRC (1991, 1993). Vaccination services are available through medical practitioners or through immunisation-specific public clinics by medical and nursing professionals. Opportunistic immunisation services are also practiced in some parts of Australia. This practice asserts that every occasion of service is a potential opportunity to vaccinate, and it highlights that immunisation is a basic responsibility of nurses in a variety of settings such as casualty clinics, antenatal clinics, early childhood centres, community health centres, acute care settings, schools, and childcare centres. In such settings, nurses can play an active role in educating the public about immunisation, providing the services, and improving immunisation rates at a reasonable cost (Hattenfels, 1995).

The immunisation status of children against vaccine preventable diseases frequently receives media attention. Isolation of factors that influence compliance rates for immunisation has been sought by many researchers. In particular, parental factors have been examined including factors such as economic status, social class, age, occupation, and culture. In relation to culture, the status of immunisation for children from non-English-speaking backgrounds has been some cause for concern. Statistics demonstrate that a significant problem with compliance exists among children of Middle Eastern born parents. However, examination of other research findings raises questions about the link between culture and compliance among the Lebanese people relating to immunisation.

Statistics demonstrate that children from Middle Eastern backgrounds have lower rates of compliance with immunisation schedules. Health care practices are influenced by cultural factors, and health and illness are culturally defined. Discovery of cultural beliefs and attitudes about immunisation practices will reveal transcultural knowledge relevant to the understanding of specific care beliefs that affect immunisation compliance practices.

Islam influences the lifeways of Muslim people exerting a significant impact on all areas of life. There is a need to understand Islamic beliefs relating to parenting roles, responsibilities, illness, and health maintenance in order to appreciate the influence of religion on general care beliefs and immunisation practices.

Culture influences beliefs about care and what constitutes care in health settings. Understanding cultural expectations regarding care will provide information about the way in which services are used and can be beneficial in planning health and nursing care services.

PURPOSE AND DOMAIN OF INQUIRY

The purpose of this ethnonursing study was to identify the care views, meanings, beliefs, and practices of Lebanese Muslim immigrants related to immunisation and nursing care. The domain of inquiry focused on care and specifically on nursing care related to immunisation for Lebanese Muslim immigrants residing in southern Sydney in new South Wales (NSW). This study sought to discover health-related care knowledge based on their cultural values, beliefs, and practices related to childhood immunisation. The research specifically addressed the following questions.

Research Question 1: What are the care views, meanings, and beliefs of Lebanese Muslim immigrant informants relating to immunisation?

Research Question 2: What are the Lebanese Muslim family/community care responsibilities for childhood immunisation?

Research Question 3: What care knowledge do Lebanese Muslim informants have regarding the diseases and the vaccines (particularly in relation to side effects and contraindications)?

Research Question 4: In what ways do social structure factors (especially religion and worldview) influence Lebanese Muslim health care practices related to immunisation?

Research Question 5: What are the health/nursing care service expectations for Lebanese Muslim informants in relation to immunisation compliance?

Research Question 6: Are existing health/nursing care services culturally congruent to meet the health care practice beliefs and needs of Lebanese Muslim informants?

CONCEPTUAL FRAMEWORK

The study was conducted using "culture care diversity and universality" as a theoretical framework to guide the investigation of this cultural group and direct the findings (Leininger, 1991b). Within this framework, care is universal, present in every culture, and varies only in form and expression, making care culturally based. Therefore, understanding culture and applying this understanding to nursing practice is integral in the provision of nursing and health care. This is achieved by focusing on eliciting the differences and similarities in the way a cultural group perceives areas of life such as worldview, social structure, environment, technology, kinship, religion, education, and economics. These differences and similarities are then used to guide and plan appropriate nursing care.

REVIEW OF THE LITERATURE

The Australian Department of Health, Housing, and Community Affairs (1993) reported that there was some evidence to suggest that those children with parents born overseas were less likely to get immunised, particularly if a language other than English was spoken at home (Department of Health,

Housing and Community Affairs, 1993, p. 144; Powles & Gifford, 1990, p. 82). Powles and Gifford (1990) related the findings of a study that used the data collected in the 1986 National Immunisation and Infectious Diseases Survey and reported that compliance rates for immunisation were particularly low among Arabs, Chinese, and families from former Yugoslavia (p. 62). A National Survey of Children's Immunisation and Dental Care indicated that for those children whose mothers were born overseas, the proportion of immunisation increased with the increase in length of residence of the mother in Australia (National Health Strategy, 1993, p.62).

Blaze-Temple (1991) examined the relationship between demographic features and compliance rates with measles vaccination. There was no statistical association between compliance with vaccination and factors such as the child's age, parental cultural background, child order, family size, parental level of education, or parental ignorance of the severe consequences of measles. The findings indicated that to gain a definitive view of the relationship between cultural factors and compliance, a larger sample size of particular cultural/ethnic groups was needed (p. 24).

A study was conducted by Zakhary and Lee (1995) in the Fairfield and Bankstown areas in western suburbs of Sydney, NSW, relating to immunisation. Findings revealed significant factors regarding the attitudes of the Arabic-speaking community living in the two municipalities of western Sydney, the geographical location for this study. These research studies found no single factor or barriers in attempting to explain the low rates of compliance among these cultural groups. The findings did show that immunisation was regarded favourably, with little anxiety about vaccine safety, with parents expressing a sense of security in that immunisation had been performed. Immunisation records cited in this study demonstrated that all children had received some vaccinations. Knowledge about immunisation, vaccines, and the diseases varied among the informants. However, there appeared to be no understanding of the community benefits conferred by individual vaccination.

Luna explored the health care beliefs of Lebanese Muslims in a large midwestern urban area of the United States. The universal care themes identified were (a) care as an equal but different gender role responsibility, (b) care as a family obligation to care as taught by the religion of Islam, and (c) care as related to individual and collective meanings of honour (Luna, 1994, p. 12).

Nurses in Australia have also explored the value of cultural understanding and have recognised that cultural knowledge is fundamental in understanding issues in health care service provision (Cameron-Traub & Stewart, 1994; Kanitsaki, 1988; Omeri, 1991). Omeri (1996) studied the care values, beliefs, and practices of the Iranian immigrants in the western region in NSW. Using the ethnonursing qualitative research method, three universal and a number of diverse care themes were discovered and described. Care as family and kinship ties (*hambastegie*), care as gender roles and new emerging roles for women (*azadie zan*), and care as preservation of Iranian identity (*inhamani*, *hamonandi*) were major findings of this study.

Although the use of health care interpreters and multilingual immunisation pamphlets for people from non-English-speaking backgrounds have been encouraged, no specific strategies have been put in place for planning and implementation of immunisation services based on cultural beliefs and practices. To discover the views and beliefs of Lebanese Muslim immigrants relating to immunisation, this research focused on the care meanings related to immunisation for Lebanese Muslim immigrants in NSW.

RESEARCH METHOD

The study used the qualitative research method of ethnonursing, in which the researcher is considered the learner and the informant is assumed to be the expert on the domain of inquiry. This method involves the researcher becoming close to the people under study, to gather and combine the local or insider's viewpoint (*emic* knowledge) with the outsider's view (*etic* knowledge). In this way, a comprehensive understanding of the phenomena and culture is obtained. The ethnonursing research method provides contextual understanding for the researcher yielding data about the "recurrent and patterned lifeways of people" (Leininger, 1985, p. 40).

Selection of Informants

The sample consisted of 6 key and 16 general informants. Key informants were selected based on the following criteria: (a) had a strong network within their community, (b) were born in Lebanon, (c) strong belief in the practice of Islam, and (d) knowledge and ability to articulate about the domain of inquiry. Criteria for selection of general informants were (a) Lebanese Muslim women and/or mothers who attended the activities of the Muslim Women's Association, (b) parents encountered at and during visits to the general practitioner's surgery, and (c) parents of children who attended the Arabic-Australian Childcare Center. These general informants were interviewed in the familiar naturalistic context of their homes. Semistructured interviews were conducted to obtain reflections about the findings from key informants. Key informants were interviewed for 45 to 90 minutes, with two or three follow-up interviews of about 30 to 60 minutes duration for each interview.

After informed consent was obtained, the informants were selected by means of purposeful selection, which implies that they were selected according to the needs of the study (Glaser & Strauss, 1967). To assist in selection of informants, professionals who were involved with immunisation care ser- vices were approached. Gradually, more information was obtained through encounters with key informants

(professional health care informants) who were deeply involved with the care of the Lebanese Muslims. During data collection, immunisation records were not inspected, and hence, immunisation rates for Lebanese Muslims were not collected during this study.

RESEARCH CONTEXT OR SETTING

The research study was conducted within the Canterbury district in southern Sydney. The Lebanese worker based at the Community Health Centre approached the community leaders or gatekeepers to facilitate access to information. Once these gatekeepers identified potential informants, they became the links to other Lebanese Muslim informants. Gatekeepers were those involved in a number of organisations, such as the Lebanese Welfare Center, Muslim Women's Association, Arabic Australian Childcare Centre, and local Arabic-speaking Muslim general practitioners. Other important contacts were developed with the health professionals at the Early Childhood Centres who were responsible for immunisation services within the surrounding and nearby districts.

ETHNOHISTORY OF LEBANESE PEOPLE IN AUSTRALIA

Ethnohistorical information is important because it provides contextual background. Lebanon is a country located in southwestern Asia and is dominated by two major mountain ranges dividing the country into three major land areas. As part of the Middle East, it is bordered by Syria on the north and the east, Israel on the south and the southeast, and the Mediterranean Sea on the west. The country is a republic, with geographic dimensions of 217 kilometres long and between 40 to 80 kilometres wide (Worldbook Encyclopedia, 1995, Vol. 12, p. 146).

The total population of Lebanon is approximately 3 million. Beirut is the capital of Lebanon and is a major port. Other major population centres are Tripoli and Sidon. The Lebanese population is diverse, and Lebanese ethnohistory can be traced to the ancient Phoenicians, Hebrews, Philistines, Assyrians, and Arabs. Today, the population of Lebanon retains diversity, with representation from other Middle Eastern groups, including Palestinian Arabs and Armenian refugees due to geographical and sociopolitical factors influencing migration and settlement (Worldbook Encyclopedia, 1995, Vol. 12, p. 144).

The major language spoken in Lebanon is Arabic; however, English, French, and Spanish are also spoken. The ancient language, Aramaic, is used in some religious contexts. The major religions practised in Lebanon are Christianity and Islam, with a number of subdivisions in each religion (Shapiro, 1984, p.19).

Lebanese people have been migrants to Australia since the early 1900s. Migration by this group continued steadily, increasing measurably during the Arab-Israeli conflicts in the 1950s and into the 1970s. The Australian Bureau of Statistics (1991) reported a Lebanese population of 129,235 people, with 46.9% born outside Australia for the Canterbury Local Government area. The Lebanese-born population was reported as the largest proportion (42.3%) of the overseas born (7.5%) (Australian Bureau of Statistics, 1991, p. 3). The 1991 population census demonstrated that there were 147,656 Muslims in Australia, and it estimated that half this population lived in Sydney. Canterbury and Bankstown were identified as having the largest Muslim populations at the time of this study.

DATA ANALYSIS

The data were analysed and coded using the Four Phases of Ethnonursing Analysis for Qualitative Data (Leininger, 1991a). The first phase involved collecting, describing, and documenting raw data, and elaborating on basic research ideas and findings. This stage also consisted of transcribing field notes, tape recordings, data collected from observation-participation-reflection (OPR) process, and naturalistic interviews.

In Phase 2, descriptors and components were identified and categorised. The key informant interviews were based on the broad and particularistic dimension of Leininger's Sunrise Model. General informant interviews were categorised into the three main areas of general beliefs about illness, health and care, attitudes toward and responsibilities for immunisation, and an examination of attitudes toward service delivery.

Phase 3 involved pattern and contextual analysis. Data were studied for recurrent patterns and similar ideas to assess the data meanings within context, to establish credibility, and to confirm findings. The final phase consisted of identifying major themes and research findings.

The evaluation criteria used in this study were credibility, confirmability, meaning in context, recurrent patterning, and transferability. These evaluation criteria were (a) credibility as the truth value established between the researcher and the informants to ensure accuracy of findings; (b) confirmability, which is the process of reaffirming what the researcher has heard, seen, and experienced with respect to the phenomena under study and with confirmed informant checks and by audit trails; (c) recurrent repatterning, which refers to sequenced patterns of repeated experiences, expressions, events, or activities over time; (d) meaning in context, which refers to and focuses on the significance of interpretations and understanding of the actions, events, communications, symbols, and other activities within specific or total contexts; (e) saturation is reached when data were redundant and there was no new information as all had been shared; and (f) transferability, which refers to any general similarities of findings that can be transferred to another similar context or situation in new research (Leininger, 1985, 1991b).

FINDINGS

The first care theme related to general values about care, health, and illness and how these were understood within the framework of Lebanese culture and the religion of Islam. The theme will be stated, followed by a description of recurrent patterns and descriptors.

> Theme 1: The meaning of care for Lebanese Muslim immigrants was related to the prevention of illness and maintenance of good health through the responsibility of parents to maintain protective care roles for their dependent children and others who are vulnerable in their community.

Care Pattern 1

Maintenance of health was viewed as a parental responsibility grounded in both religious and cultural values and beliefs. These views were evident in such statements as

> We are to take care of these children because they are a trust in our hands. God gave them to us, and we have to look after them. And as long as we know there is some way to protect them by giving them these immunisations, we have to; we don't have a choice.

Another stated,

> Because our Holy Book said to take care of our body and make sure we protect our children, so a part of our protection was to make sure to give these children the immunisation, so it would help keep them healthier.

Maintaining good health is based on cultural and religious beliefs. These factors influence and are the basis of the protective roles required of parents toward dependents and the vulnerable in the community, which makes prevention of illness of great significance to Lebanese Muslim immigrants. Verbatim descriptors highlight the significance of prevention and demonstrate the parental protective roles toward their children related to immunisation practices. "An atom of prevention is worth a ton of treatment." "Your body is a gift from God. You have to look after it. You can't ignore it, and you can't abuse it." "In Islam, there should not be any form of abuse to your system, and to keep healthy is part of one's religion."

> We have to take care of these children because they are a trust in our hands. God gave them to us, and we have to look after them. And as long as we know that there is some way to protect them by immunising them, we make sure this is done.

Care Pattern 2

Gender roles and responsibilities within the family related to health and illness for children and vulnerable dependents are grounded in the cultural and religious values, beliefs, and practices of Lebanese Muslims. One key informant stated, "It is the mother's responsibility; she should think about the children."

Islam obligates the follower or believer to care about health and maintaining one's own health and those of any dependents. It is a responsibility placed on individuals. Illness is a state to be avoided. Prevention of diseases and care of the body, both physically and mentally, is encouraged. Parents are responsible for these practices on behalf of their children.

The importance of protection of oneself and dependents in relation to maintaining health was illustrated by the positive attitude found among Lebanese Muslim immigrant informants about immunisation. Immunisation is viewed as a routine practice, a parental responsibility, and part of the family's duty to care, rather than a health care choice. This finding, related to the general attitude about protective responsibility of parents toward the health of their children, was described as being indirectly reinforced by religious beliefs.

Generally, the mother is regarded as the caregiver and the father as the provider. Therefore, there are complementary roles fulfilled by parents in ensuring the provision of immunisations for the children. The mothers, as informants, described being responsible for knowing when immunisations were required and where they could be obtained, but there was reliance on the fathers to ensure that this responsibility could be met practically and economically.

> Theme 2: Culturally congruent care for Lebanese Muslims meant obtaining immunisations for their children to protect them from childhood diseases and to maintain their health as grounded in the teachings of Islam.

Care Pattern 1

Lebanese Muslims viewed immunisation as part of their traditional caring practices and not as new questionable technology. This view is reflected in statements such as "Actually, immunisation is being looked at as something which is an ancient cultural thing." "Immunisation would not be seen as a form of technology. It's been part of the upbringing and the religion, so it is not seen as an advancement. It has traditionally been there." These verbatim descriptors reflect an attitude of responsibility and protective care of children in relation to vaccine preventable diseases guided by religious beliefs.

Care Pattern 2

Lebanese Muslims believed that positive health outcomes related to immunisation care practices were primarily important for their children, rather than for their community. Knowledge of the way immunisation provides protection against disease varied among the informants. Although all informants recognised at some level the protective and preventive benefits for the individual recipient, the community benefits were not emphasised. Knowledge about the diseases

and their effects also varied. Side effects of immunisation were recognised by informants. However, the different levels of understanding about the particular aspects of the process and practice of immunisation did not appear to adversely influence compliance as indicated by statements such as "So if the doctor telling me that this means it's a trustful thing. So . . . I can go ahead and do it. So if I secure myself with him." Other verbatim descriptors confirmed the findings that doctors are highly respected and trusted as the primary health caregivers among the Lebanese community.

Care Pattern 3

Culturally congruent care for Lebanese Muslim immigrants meant receiving immunisations within the preferred context of the family physician's office. This care pattern was illustrated by statements such as

> In our country, because of the good relations in the family, each family might have a family doctor which is related to the family. . . . so that they know that there is this person who is there for them. . . . He's there for us to assist us if we are in need.
> In our mentality, we have this great respect of doctors, in the Muslim or in the Lebanese cultures, it still has this respect . . . because . . . 20 years ago, only people who had money were able to study medicine. . . . People had to go . . . out of their own country, live on their own, and study. They come back; means they have proved they are of stamina; they are actually worthy of this respect.

Several general informants in the study expressed the following: "I prefer going to the doctor because I could talk to the doctor about things in more detail. . . . At the local council, it was like a bulk thing . . . like you are standing in a line. . . . You didn't really enquire about anything." "I think with the doctor, it is more straightforward. . . . You're in familiar surroundings . . . feel more secure." "It becomes a lot more personal, and you can ask direct questions of the doctor knowing that he has knowledge of your child".

In relation to service delivery relating to immunisation, it was found that the local general practitioner who was usually of a similar cultural and religious background was most frequently the preferred provider of immunisation service. This was explained by key and general informants as being due to the fact that at a practical level, this not only eliminated any possibility of a language barrier but also resulted in a greater sense of security and familiarity.

Care Pattern 4

Care for some Lebanese Muslim informants meant receiving immunisation care services within the context of the local council clinic. "It is just a feeling of confidence. . . . I have always gone to the council, and it has always been clean. . . . The atmosphere is friendly, . . . and there is not a long waiting list." "They will send you a card saying they are due on this date. . . . I like their times, and they are very friendly, and there is not much of a wait."

Care Pattern 5

Culturally congruent care for most Lebanese Muslim immigrants meant receiving the actual immunisation injection information about the health benefits related to the immunisations from a nurse within the context of a physician's office. The findings revealed the significance of the status and the role of general practitioners in the delivery of immunisation for Lebanese Muslims. Although there were no particular reasons specified, in general, nurses were not identified as a significant group to have a primary role in provision of immunisation services. However, nurses were regarded highly for their support to parents and for giving information regarding the sequence and schedule for vaccinations.

CULTURE-SPECIFIC CARE MODALITIES FOR LEBANESE MUSLIM INFORMANTS

Leininger (1991b, 1993, 1995) predicted that the use of the care expressions and practices of a particular cultural group could lead to provision of culturally congruent and competent care through consideration of the three modes of actions and decision. The three action modes are described by Leininger as cultural care preservation or maintenance, cultural care accommodation or negotiation, and/or cultural care repatterning or restructuring. These action modes are discussed in relation to the findings for Lebanese Muslims and immunisation.

Cultural Care Preservation and Maintenance

Culturally congruent care for Lebanese Muslim informants means preservation of the importance that Lebanese Muslims place on health protection, guided and based on their religious beliefs. Cultural beliefs and the value placed on immunisation as a protective and preventative aspect of health, particularly in protection of children, should be preserved to provide cultural congruent care.

Immunisation is regarded as a traditional generic caring mode. This cultural belief relating to immunisation is significant and must be known, respected, and preserved by nursing and other health practitioners. This belief, which is culturally determined, is congruent with professional health care practices of prevention and health promotion.

Cultural Care Accommodation or Negotiation

Several aspects in health service delivery related to immunisation need to be accommodated or negotiated with administrators of immunisation programs. Care values and beliefs of Lebanese Muslims could be shared by nurses during or prior to consultation for immunisation. The findings specifically demonstrate that the informants highly valued personal care and consultation. This belief is contingent on the

establishment of trust, a sense of security, and ease of communication. Nurses or other health service providers of immunisation services may need to negotiate with healthcare administrators, so they have more time to be with the mothers who bring their children for vaccinations.

Cultural Care Repatterning or Restructuring

Culture care repatterning is a process of change that involves a great deal of negotiation with family members. If the process of immunisation is affected, restructuring or negotiation regarding roles and responsibilities for the health of the children may be required. Repatterning of cultural attitudes regarding the values placed on nursing and medical staff may need to be addressed if nurses are to be effective in interactions regarding health education relating to immunisation services with Lebanese Muslim immigrants. Nurses, by demonstrating a role in primary health care, can facilitate the process of repatterning views of Lebanese Muslim to enable them to use immunisation services provided by primary care nurses.

DISCUSSION

The findings of the studies included in the literature review reveal conflicting and variable findings related to immunisation care values and practices for Arabic-speaking Australians. The studies by the Department of Health, Housing, and Community Affairs (1993) as well as the 1986 National Immunisation and Infectious Diseases Survey reported by Powles and Gifford (1990) reported low vaccination compliance rates for non-English-speaking background clients including persons from Arabic-speaking communities. The findings did not include a breakdown of nationality among different Arabic-speaking Middle Eastern communities; hence, specific immunisation rates of Lebanese Muslim immigrant families in Australia are unknown. In addition, in a study by Zakhary and Lee (1995), which reported low immunisation compliance rates among Arabic- speaking people in Australia, positive views toward immunisation were reported.

The findings of this study demonstrated that health is highly valued by Lebanese immigrants. Within the Islamic religion maintaining one's own health and the health of dependents such as children is seen as part of one's family care obligations based on a worldview of Islam. Illness was discovered to be a state to be avoided whenever possible. The study offers a different approach for examining immunisation. An understanding of the way in which immunisation issues are viewed is helpful to nurses making related health care actions and decisions. The findings of this study (Brooke, 1996) reflect positive and preventative care views of Lebanese Muslims toward immunisation. Therefore, further studies are indicated to allow for confirmability and credibility of the findings and allow for clarification of the low immunisation rates among Middle Eastern immigrant families in Australia, in spite of positive views toward immunisation. In particular, immunisation rates of Lebanese immigrants in Australia need to be specifically identified to determine whether this cultural group does indeed have low immunisation rates—especially in light of the positive and preventative care views of Lebanese Muslims towards immunisation practices.

CONCLUSION

The findings of two universal themes and the universal and diverse patterns related to each theme support the sixth assumptive premise of the theory of culture care which states, "concepts, meanings, expressions, patterns, processes, and structural forms of care are different (diversity) and similar (toward commonalities or universalities) among all cultures of the world" (Leininger, 1991b, p. 45). The discovery of universal and diverse aspects of human care relating to Lebanese Muslim informants in the NSW study confirmed that care is culturally defined. The universal theme based on care protection and prevention is related to Lebanese Muslim cultural and religious beliefs and is congruent with Western care beliefs and practices related to immunisation.

The diverse patterns, which supported Theme 2 as described by Lebanese Muslim informants, reflect the necessity for a variety of contexts for immunisation care services. In summary, this ethnonursing study revealed that the culture care theory can be used to guide the discovery of new insights into culture specific beliefs, values, and practices that could be used to provide and preserve culturally beneficial care related to immunisation congruent with Lebanese Muslim cultural beliefs and practices.

REFERENCES

Australian Bureau of Statistics. (1983). *Children's immunisation survey, Australia.* Canberra, Australia: AGPS.

Australian Bureau of Statistics. (1991). Canterbury Council, 1991, Census Population Breakdowns, 1, 3. NSW, Australia, South-West Sydney: Canterbury Council.

Bates, E., & Linder-Pelz, S. (1990). *Health care issues* (2nd ed.). Sydney, Australia: Allen & Unwin.

Bigbee, J., & Jansa, N. (1991). Strategies for promoting health. *Nursing Clinics of North America, 26*(4), 895-913.

Blaze-Temple, D. (1991, May). Immunisation non compliance, what parents know and understand about measles. Immunisation the old and the new. *Proceedings of the second National Immunisation Conference* (pp. 19-24). Canberra: Public Health Association of Australia.

Brooke, D. (1996). *An inquiry into the way in which childhood immunisation is viewed by people of Lebanese Muslim background living in Australia.* Unpublished bachelor of nursing honour's thesis, Faculty of Nursing, University of Sydney, Australia.

Cameron-Traub, E., & Stewart, A. (1994). Clients from Eastern countries: A new worldview in Australian nursing. In G. Grey & R. Pratt (Eds.), *Issues in Australian nursing* (pp. 115-128). Melbourne, Australia: Churchill Livingstone.

Department of Health, Housing and Community Affairs. (1993). *Goals and targets for Australian health in the year 2000 and beyond.* Canberra: Australian Government Publishing Service.

Ferson, M., & Christie, D. (1992). Measles immunisation compliance: Poor impact of bicentennial measles control campaigns on children under five. *Australian Journal of Public Health, 16*(1), 31-34.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory.* New York: Aldine.

Hartvelt, F. (1993). The children's vaccine initiative. *World Health, 2,* 4-6.

Hattenfels, J. (1995). Immunisation. In G. Grey & R. Pratt (Eds.), *Issues in Australian nursing 5: The nurse as clinician* (pp. 163-178). Melbourne, Australia: Churchill Livingstone.

Kanitsaki, O. (1988). Transcultural nursing: Challenge to change. *Australian Journal of Advanced Nursing, 5*(3), 4-11.

Leininger, M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 33-71). Philadelphia: W. B. Saunders.

Leininger, M. (1991a). Ethnonursing: A research method with enablers to study the theory of culture care. In M. Leininger (Ed.), *Culture care diversity and universality: A theory of nursing* (Vol. 2, pp. 73-115). New York: National League for Nursing Press.

Leininger, M. (1991b). The theory of culture care diversity and universality. In M. Leininger (Ed.), *Culture care diversity and universality: A theory of nursing* (pp. 1, 5-72). New York: National League for Nursing Press.

Leininger M. (1993). Culture care theory: The comparative global theory to advance human care nursing knowledge and practice. In D. A. Gaut (Ed), *A global agenda for caring* (pp. 3-18). New York: National League for Nursing.

Leininger, M. (1995). *Transcultural nursing concepts, theories, research and practices* (2nd ed.). New York: McGraw-Hill.

Luna, L. (1994). Care and cultural context of Lebanese Muslim immigrants: Using Leininger's theory. *Journal of Transcultural Nursing, 5*(2), 12-20.

National Health and Medical Research Council. (1991). *Immunisation procedures* (4th ed.). Canberra, Australia: AGPS.

National Health and Medical Research Council (NHMRC). (1993). *National immunisation strategy.* Canberra, Australia: AGPS.

National Health Strategy. (1993, March). *Removing cultural and language barriers to health* (Issues Paper No. 6, Sec. 1: Setting the context). Canberra: Australian Government Publishing Service.

Omeri, A. (1991). *Survey of all faculties of nursing in Australia, to determine the status of transcultural nursing education.* Unpublished report, Faculty of Nursing, University of Sydney, Australia.

Omeri, A. (1996). *Transcultural nursing care values beliefs and practices of Iranian immigrants in NSW Australia.* Unpublished doctoral dissertation, Faculty of Nursing, University of Sydney, Australia.

Pender, N. (1987). *Health promotion in nursing practice* (2nd ed.). Norwalk, CT: Appleton & Lange.

Powles, J., & Gifford, S. (1990). How healthy are Australian immigrants? In J. Reid & P. Trompf (Eds.), *The health of immigrant Australia: A social perspective* (pp. 3, 77-107). Sydney, Australia: Harcourt, Brace Jovanovich.

Shapiro, W. B. (1984). *Lebanon.* New York: Franklin Watts.

Spellbring, A. M. (1991). Nursing's role in health promotion—An overview. *Nursing Clinics of North America, 26*(4), 805-813.

Zakhary, I., & Lee, E. (1995). *Identification of barriers to immunisation among the Arabic speaking communities of Fairfield and Bankstown.* Sydney, Australia: Fairfield Bankstown Immunisation Taskforce, Public Health Unit South Western Sydney Area Health Service.

Deborah Brooke is a registered nurse in the Department of Nursing at Royal Alexandra Hospital for Children, Hawksbury Road, Westmead, New South Wales (NSW). She received her BN in first class honours from the University of Sydney at NSW Australia. Her interests include paediatrics.

Akram Omeri, PhD, RN, CTN, MCN, is a senior lecturer in the Department of Nursing Practice at the University of Sydney, NSW. She received her PhD in transcultural nursing from the University of Sydney, Australia. Her interests include transcultural nursing, community nursing, immigrant women, and maternal and child health.