# Pakistani Muslim women birthing in northern England: exploration of experiences and context

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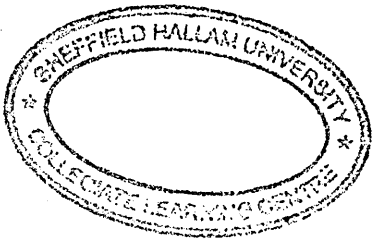

# ABSTRACT

This study examines Pakistani Muslim women's experiences of labour and maternity services against a backdrop of the National Health Service and the history of Black people in Britain. It sets out to develop an understanding of how Pakistani women see their relationships with midwives and to address the paucity of available research about their intrapartum experiences. The study also aims to contribute to the development of responsive and sensitive midwifery care, and midwifery knowledge and theory.

An interpretive ethnographic approach was adopted to obtain narratives from twenty-seven participants: thirteen primigravidae Pakistani Muslim women, nine interpreters and five midwives. The primary method of data collection was conversational qualitative interviews, although a small number of participant observations of women's labours were conducted. Content analysis was utilised for data analysis.

The findings of this study reveal that many Pakistani Muslim women generally reported a positive experience of their encounters with maternity services. They valued western obstetric and midwifery services, believing that the midwives and doctors know best; they were grateful for the care they received. The study revealed that adequate and timely information, constructive relationships with the midwives, and support during labour were some of the key factors that shaped women's experiences of labour. Whilst some women expressed satisfaction in these areas, others voiced concern about the variable levels of availability of information, and consequently women laboured without knowledge of the available methods of pain relief and processes of care during labour. The findings show that Pakistani women value emotional support in labour. A minority of these women were supported by their husbands or female relatives, and some received support from midwives. However for many, when support from midwives was not forthcoming, 'Allah' was the only available source of support. Other key factors highlighted were communication and linguistic barriers, and the role of perceived stereotypes and discrimination, which shaped the context in which women birthed as well as underpinning women's experience of maternity services. The study highlighted that whilst women's ability to speak English played a role in developing relationships with midwives, a lot depended on the attitudes and behaviours of the midwives, and the way they responded to the women. Resources such as interpreters, which may have assisted in overcoming some of the communication barriers, were found to be lacking.

The study showed that midwives were the orchestrators of women's labouring experiences, manifesting 'power' in terms of influencing or controlling women, birthing events, processes and resources. Many women appeared to be passive recipients of care; they did not exercise choice and control over the care they received, and the majority did not perceive that they were able to work in partnership with the midwives.

These findings are discussed in the context of the way in which service delivery is organised. In addition, the findings are very timely in view of the NHS Plan and the NSF's commitment to women having informed choice and individualised care.

# Dedication

This thesis is dedicated to my father, **Mr Dhian Singh Bharaj,** he has been a pioneer, mentor and a life-coach and continues to be so and in the memory of my late mother, **Mrs Ajit Kaur Bharaj** (29.09.1934 to 29.05.2001), who has been my leader in every way – she has taught me to be me.

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First of all I show my gratitude to '**Waheguru**' for providing me with the strength, sustaining me through this long but exciting journey.

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I acknowledge the help and guidance of all **colleagues** who were instrumental in facilitating fieldwork for the study as well as providing access to the participants – thank you, I am extremely grateful to you. To **Margaret and Vina** for keeping me going. Vina your words of encouragement "you are nearly there" were my backbone - I thank you for always being there when I have needed a friend, a guide and mentor. Particular thanks to **Robina** for all her help and support to provide insights into Islam – you enabled me to understand some of the faith prescriptions. **Jean and Ruth** – thank you for all assistance to get this work in shape.

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## List of abbreviations

| Abbreviation | Full detail |
|---|---|
| **ASA** | Association of Social Anthropologists of the UK and the Commonwealth |
| **AMBC** | Asian Mother and Baby Campaign |
| **BME** | black and minority ethnic |
| **BSA** | British Sociological Association |
| **CCR** | Changing Childbirth Report |
| **CMB** | Central Midwives' Board |
| **CRE** | Commission for Racial Equality |
| **DH** | Department of Health |
| **EC** | European Commission |
| **ENB** | English National Board for Nursing, Midwifery and Health Visiting |
| **NAHA** | National Association of Health Authorities |
| **NAHAT** | National Association of Health Authorities Trust |
| **NCT** | National Childbirth Trust |
| **NHS** | National Health Service |
| **NHSE** | National Health Service Executive |
| **NHSME** | National Health Service Management Executive |
| **NMC** | Nursing and Midwifery Council |
| **PBUH** | Peace Be Upon Him |
| **PhD** | Doctor of Philosophy |
| **PREPP** | Post-Registration Education and Practice Project |
| **RRA** | Race Relations Act |
| **RES** | Race equality schemes |
| **RCM** | Royal College of Midwifery |
| **RCN** | Royal College of Nursing |
| **RCOG** | Royal College of Obstetricians and Gynaecologists |
| **SA** | South Asian |
| **UK** | United Kingdom |
| **UKCC** | United Kingdom Central Council for Nursing, Midwifery and Health Visiting. |
| **WHO** | World Health Organisation |

# Glossary

| Term | Definition |
|---|---|
| Asian or South Asian | The broad term of South Asian or Asian is often used to refer to people who originate in the countries from Indian- Subcontinent which includes India, Pakistan, Bangladesh and Sri Lanka. However, more commonly the term is limited to people from India, Pakistan and Bangladesh. |
| Black | Refers to people of African and African-Caribbean background.<br><br>Also used to define people from non-White minority ethnic communities; implying political solidarity. The word is capitalised when used for political purposes. |
| Black and minority ethnic | As there is no single term that embraces all members of minority ethnic groups, there is a tendency to use definitions such as black, Asians, minority ethnic groups or African-Caribbean. These definitions are often used interchangeably and can lead to confusion on behalf of the reader.<br><br>In the absence of a single acceptable terminology, the term 'black and minority ethnic' groups/communities has been used. For me, this term refers to those individuals or groups who experience discrimination and inequalities associated with 'race', ethnicity, language, culture and/or religion. |
| Burqa | Burqa also referred to as burka or burqua is a garment which covers the whole body; it is worn by Muslim women who observe purdah. It covers the entire face and some women may have only the region of eyes which remains uncovered and others may choose to cover this part with a net. |
| Dai | An untrained birth attendant and in many parts of India and Pakistan is the primary caregiver during childbirth. |
| Ethnocentrism | This refers to the when people evaluate other groups and their cultures firm their own perspective. They perceive their own culture to be the best and perceive other's culture as stranger. |
| Hijab | This term means to cover, hiding from the view or conceal. It refers to covering of women's head and body. Although in a broader sense hijab is means modesty, privacy, and morality. |

| | |
|---|---|
| The Great Transformation | This concept encompasses industrialisation which brought about changes in "European societies from rural, agricultural to predominantly urban industrial formations" (Mason 1995: 20). |
| Gulf War | The Gulf War was later known as the War on Terror, Islam or Muslims being classified as terrorists by the Bush administration. |
| Islam | Islam is the way of life for those who believe in Allah and want to live a life in worship and obedience to none but Prophet Muhammad (Peace of God Be Upon Him). The reward is forgiveness from God and an everlasting life in the Heaven. |
| Islamaphobia | Is "the fear or dread of Islam" (Abbas 2005: 11). It is unsubstantiated and "unfounded hostility towards Islam" and Muslims (The Runnymede Trust 1997: 1), contributing to the victimisation felt by all Muslims worldwide (Said 1997). |
| Muslim | Muslim, sometimes written as Moslem is a person who is a follower of Islamic faith. |
| Pakistani people | Pakistani people are those whose ancestry lies in the Islamic Republic of Pakistan and often the term Pakistani is used by those who were born before the formation of Pakistan in 1947 (Bhopal 2007). |
| 'Peace Be Upon Him' (pbuh) | is a salutation that Muslims are required to say following the mention of Islamic prophets including the ones cited in Quran. |
| Purdah | Purdah is a practice observed mainly by the communities practicing Islam, where women segregate themselves from men either by separation or by wearing a Burqa - a garment which covers the whole body (a veil over the face may be worn to conceal the eyes). Women refrain from participating in activities in which males are present. Wikipedia, the free encyclopedia: http://en.wikipedia.org/wiki/Purdah accessed 2 January 2006. |
| 'Race' | The term race is often expressed within inverted comas, suggesting that it is a disputed term. The term 'race' was well excepted in mid nineteenth century to denote "human diversity as a division between fixed and separate races rooted in biological differences and a product of divergent heritages" (Mason 1995). However this view has been challenged arguing that 'race' is an ideological construct (Miles 1982. 1993). |

| | |
|---|---|
| Second feature of the open view | Muslims believe in the four Holy books "Torah, Injeel, Bible and Quran"<br><br>"O Mankind! We have created you from a male and female, and made you into nations and tribes, that you may know one another...." (Quran 49:13) |
| South Asian or Asian | The broad term of South Asian or Asian is often used to refer to people who originate in the countries from Indian- Subcontinent which includes India, Pakistan, Bangladesh and Sri Lanka. However, more commonly the term is limited to people from India, Pakistan and Bangladesh. |
| Surma | Surma, sometimes referred to as Khol, is an eye cosmetic traditionally used throughout Asia, Africa and the Middle East. It serves two purposes: first is to enhance the appearance of the eyes and second is for medicinal purposes. It is available in powder form, paste and liquid form and it is high lead content which has a number of adverse effects on adults and children (Al-Ashban, Aslam and Shah 2004). It was in 1970's that the hazards of high lead content in this cosmetic was linked with deaths in children (Smart, Madan 1990), however the evidence confirming links of surma and high level of blood levels are not conclusive (Aslam et al 1980). Nevertheless the Government instigated the Surma campaign, designed to raise awareness of the adverse affects of surma amongst the communities and healthcare professionals. |
| White | The term white is used to refer to people from European countries (Mason 1995) |

## Transcription conventions

Tape recorded interview extracts and field notes appear in *italics.*

All tape recorded materials and documents are verbatim transcriptions.

Data have only been edited where there was a need to preserve anonymity.

All names of people and places have been omitted from the extracts.

To protect the anonymity of respondents, pseudonyms have been used.

| | |
|---|---|
| ..... | indicates a pause in speech |
| [.....] | words, phrases or sentences of the extract have been omitted |
| [XXX] | explanatory or descriptive material added by the researcher in order to make the meaning or context clear |

# Chapter 1

## Prologue

**It's In The Way**

It's in the way you patronise
The way that you avert your eyes
The way that you cannot disguise
Your looks of horror and surprise

It's the assumptions that you make
On my behalf, and for my sake
and in the way you do not hear
The things we tell you loud and clear

It's in the way you touch my hair
The way you think, the way you stare
It's right there in your history
Just like slavery for me

It's in the language that you use
The way that you express your views
The way you always get to choose
The way we lose

It's when you say "No offence to you"
And then offend me, as you do
It's in your paper policy
Designed by you, for you, not me

It's in the power you abuse
It's on TV, it's in the news
It's in employment, in your school
The way you take me for a fool

It's in the way you change my name
The way that you deny me pain
It's in the way that you collude
to tell me it's my attitude

It's in your false democracy
It's in the chains you cannot see
It's how you talk equality
And then you put it back on me

It's in the way you get annoyed
And say I must be paranoid
It's in the way we have to fight
For basic fundamental human rights

It's in the invasion of my space
It's how you keep me in my place
It's the oppression of my race
IT'S IN MY FACE

**By Andrea Cork**

## 1.1. Introduction

There is extensive literature examining childbirth experiences of women postulating that the majority have positive experiences of childbirth (Audit Commission 1997; Garcia et al 1998). However, some women, particularly those from the black and minority ethnic[1] (BME) backgrounds, have not enjoyed their childbirth experience to the level of their White[2] counterparts. Numerous underlying factors contribute to this inequality. These women's accounts focus on their invisibility, providing evidence of issues spoken in Cork's poem through being ignored, excluded, not being heard including the way that others look at them, verbal torment and use of power to oppress.

In this introductory chapter I provide the context and the rationale for this study, explaining the factors that propelled me to examine maternity experiences of Pakistani Muslim[3] women. I then consider the study's purpose, and state its primary aims before outlining the structure of the thesis.

## 1.2. Context

Childbirth, particularly in terms of physiological explanations is the same for all women. However, its meaning to each woman is individual, because it is shaped by factors such as cultural beliefs, ethnicity, traditional practices (Jordan 1993), faith beliefs (Jeffery et al 1989; Van Hollen 2003), education, social class, as well as other aspects, influencing the social context of childbirth.

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[1] The use of terms to describe different ethnic groups in society is a sensitive issue leading to much debate; it is not the intention here to enter into such discourses but to make use of terminology understandingly and explicitly through out the study. Self-assigned ethnic label may be more accurate then being assigned by others (Bhopal 1997), because for some individuals there may be multi ethnic identities existing at the same time, for example, my ethnic identity based on my heritage is Indian, though I describe myself as Black, placing myself within the context of my experiences of racism. Whilst others label me as Asian or South Asian, I rarely categorise myself as such. I ascribe my ethnic identify depending on the context in which I have to answer the question. Nevertheless as there is no single term that embraces all members of minority ethnic groups, there is a tendency to use definitions such as Black, Asians, minority ethnic groups or African-Caribbean. These definitions are often used interchangeably and can lead to confusion on behalf of the reader. In the absence of a single acceptable terminology, the term 'black and minority ethnic' communities has been used. For me, this term refers to those individuals or groups who experience inequalities and disadvantage associated with 'race', ethnicity, language, culture and/or religion.

[2] The term White, is used to refer to people who are white British. Often, this term is ascribed to people from European countries, with pale complexion (Bhopal 2007). Almost all terms to identify ethnic groups within society are flawed and yet terms to ascribe non-white groups receive much scrutiny; the analysis of the term White is equally overdue.

[3] Pakistani people are those whose origin lies in the Islamic Republic of Pakistan and often the term Pakistani is used by those who were born before the formation of Pakistan in 1947 (Bhopal 2007). Muslim, sometimes written as Moslem is a person who is a follower of Islamic faith. From here onwards, the term 'Pakistani women' will be used instead of 'Pakistani Muslim women' purely for shorthand purposes and this is not meant to cause any offence.

Britain's maternity services are based on the premise that all women want a service that offers safety, is flexible and responsive to their individual needs, and one that communicates effectively and provides quality information that allows informed choices (Department of Health (DH) 1993a; 2004a). Correspondingly, recent government proposals and recommendations reflect these aspirations, advocating that maternity services must also be responsive to the individual needs of the women and their families, listen to their views and respect their ethnic, cultural, social and family backgrounds (DH 1993a; 2004a). Midwives recognise that meeting individual and unique needs of every woman during childbirth will lead to a fulfilling experience. However many argue that achieving individualised care in a multiethnic context has been a challenge (Hart et al 2001).

In the twenty-first century context, the influence of women's cultural beliefs on their perceptions of childbirth are coupled with society's culture of "*informing participants regarding the proper who, where and how of birth*" (Jordon 1993: 48). Perceptions of childbirth are important because they can affect women's self esteem and influence early interactions with their babies (Mercer 1986). Many factors affecting experiences of childbirth are socially constructed, resulting from social processes and the interaction of social forces within midwifery discourses and are often beyond women's control (Thompson 2003).

This thesis focuses on understanding birthing experiences of Pakistani women in northern England against the organisational culture of the National Health Service (NHS), which shapes and controls the provision of maternity services. I want to examine Pakistani women's relationship with midwives, and understand the factors which shape their experiences of labour. At a broader level the study contributes to debates about maternity service provision to women from vulnerable groups. It is set in northern England, charting the journeys of Pakistani women, interpreters[4] and midwives, identifying patterns in their experiences. This thesis offers an opportunity to focus on Pakistani women's experiences of labour and on maternity healthcare professionals' perceptions of services. It sets these experiences against the overlapping 'structural' framework of the history of the NHS and the history of Pakistani women's migration to Britain.

[4] To preserve anonymity of the participants, collective term 'interpreters' is used to refer to the interpreters, liaison officers and advocacy worker who participated in this study.

The study design draws upon the traditions of ethnography (Atkinson and Hammersley 1994; Hammersley and Atkinson 1995). Its philosophical assumptions are located within the constructivist paradigm; the theoretical framework is informed by critical inquiry and symbolic interactionism (Blumer 1969). The main methods of data collection are conversational qualitative interviews and some participant observations are utilised. Content analysis is utilised as an approach to the data.

## 1.3. Rationale

As a midwife educator, practitioner and researcher, I have a strong interest in the area of service provision and delivery of maternity services to all women, in particular to women from 'excluded' communities.

There is extensive literature about women's perceptions and experiences of labour in the United Kingdom (UK) (Kitzinger 1978; Cartwright 1979; Oakley 1979; 1980; Reid and Garcia 1989; Green, Coupland and Kitzinger 1990; Green 1993; Bluff and Holloway 1994; Audit Commission 1997; Dowswell et al 2001; Gibbins and Thomson 2001), but this tends to focus on White women. In large scale surveys that seek women's views, responses from Pakistani women are too low to draw meaningful conclusions (Audit Commission 1997). Although literature related to Pakistani women is on the increase, research has centred on the antenatal and postnatal periods (Woollett and Dosanjh-Matwala 1990a; 1990b; Bowes and Domokos 1993; 1996a; Ullah 1994; Hirst and Hewison 2002; Richens 2003; Sivagnanam 2004; Dartnall et al 2005). My thesis is timely in that it addresses this gap in current literature.

As a midwife practitioner and educationalist, I became increasingly aware that many women from the BME communities did not have the same benefit of maternity services as their White counterparts. Published literature suggests that whilst the majority of these women are satisfied with maternity services, there are others who feel their needs are not being met (Bowler 1993a; Bowes and Domokos 1993; Katbamna 2000). Many women from disadvantaged[5] groups including those from the BME communities are more

[5] The term 'disadvantage' is used here for brevity. Other terms such as 'vulnerable' could have been used, however I have used disadvantage to refer to women who are more likely to experience prejudice and discrimination based on factors such as ethnicity, gender and poverty. There is much published literature suggesting there are other service users who experience inequalities are women from lower socio-economic groups (Salmon and Powell 1998) and travelling families (Churcher 1997), women with disabilities (Wright 1997), women seeking asylum (Mcleish 2002) and young women (Phoenix 1991) are only some of the examples.

likely to be dissatisfied with care than women from white middle classes. Identifiable barriers included inaccessibility and inequality in utilization of maternity services, inappropriate service provision, insensitive service delivery and discrimination within the NHS.

Two independent studies, one conducted in England (Procter and Smith 1992) and the other in Norway (Vangen et al 1996), examined the provision of maternity services for Pakistani women. Both raised interesting issues that led me to explore intranatal experiences of women from the Pakistani communities. These studies found a significantly higher proportion of Pakistani women than White women received no analgesia during their labours, made more use of Pethidine, less use of epidural analgesia, and were more likely to receive general anaesthetic for caesarean sections. Although there is no explanation for these differences, a number of assertions may be made: either Pakistani women refuse analgesia or receive insufficient amounts, or white women are offered unnecessary analgesia. It is possible that the Pakistani women are able to 'work with pain' (Leap 1996) and possibly prefer 'intervention-free' labour. Conversely they may be unaware of the options for pain relief because of communication and language barriers. Alternatively, communication difficulties may prevent Pakistani women articulating their needs. It could also be the midwives' belief that South Asian (SA)[6] women have a low pain threshold and they withhold pain relief from them in the belief that these women are neither in real need nor deserving it (Bowler 1993a). Literature suggests that midwives commonly hold stereotypes of Pakistani women, possibly making judgements about the care women deserve, or about what individuals are likely to want during childbirth (Bowler 1993a; 1993b; Bowes and Domokos 1993). Care based on inaccurate assumptions may be inadequate or inappropriate. In addition, a number of studies highlight distinct adverse variations in both obstetric health and access to health services amongst BME communities in comparison to the white population in the UK (Townsend and Davidson 1982; Modood et al 1997; Nazroo 1997; Acheson 1998; Lewis 2004).

Such inequalities propel me to examine the social context of birthing for Pakistani women; greater understanding of their ideology and social discourses in midwifery would assist in redressing the stereotype of the 'Asian patient'. Examination of the

[6] The broad term of South Asian is often used to refer to people who originate in the countries from the Indian-Subcontinent which includes India, Pakistan, Bangladesh and Sri Lanka. However, more commonly the term is limited to people from India, Pakistan and Bangladesh.

attitudes and experiences of women from diverse communities will therefore assist in the provision of responsive and sensitive maternity services. However, women from the BME backgrounds are not homogenous; they differ not only from the majority of the British population, but also from each other in terms of ethnicity, culture, lifestyle, language, and religion, and it is likely that these factors affect their experiences of childbirth. Studies that provide comparative analysis of experiences of women from diverse ethnic backgrounds, for example Katbamna (2000) and Hirst and Hewison (2001; 2002), are useful in offering opportunities to identify similarities and differences. These authors justify the rationale for comparing the views of white and black women. However my belief is that this can effectively racialise the experiences of women from the BME groups, as their experiences are measured against that of the White women. Experience of the women from the BME communities should be seen as standalone and be interpreted from their world views. In Yorkshire and the Humber region, where this study was carried out, the number of people of Pakistani origin is higher than other ethnic minorities, and the lower age profile makes it likely that they will make greater use of maternity services (Census 2001). It is against this backdrop that I have chosen to explore the needs of only Pakistani women.

My personal belief is that the principles underpinning equality in maternity services are important not because they promote equality but because it is an issue of social justice and business efficiency. Furthermore, equitable service provision will go a long way in promoting good health and reducing inequalities.

## 1.4. Study Purpose

In the light of the above background, it is essential to understand the factors that shape Pakistani women's behaviour and experiences during labour. The ideology of quality and consumerism is embedded within the NHS, influencing and informing health policy by underpinning the framework within which maternity care is offered. Health policy advocates a shift in the care of maternity clients from the homogeneous to the individualistic and holistic, taking the women's cultural and faith needs into account, thereby empowering them to have control and choice over the care they receive (DH 1993a, 1994; 2000; 2004a). Whilst midwives understand the principles of providing individualised care, operationalising these in practice is a challenge, particularly for Pakistani women (Hart et al 2001). For many care operate around cultural stereotypes

based on inappropriate assumptions (Bowler 1993a), failing to take into account the significance of racial discrimination and socio-economic disadvantage (Ahmad 1993; Smaje 1995).

This study will provide a platform for the voice of Pakistani women, promoting and enhancing their role as consumers of maternity services in shaping future maternity services. It is timely given that numerous Government led initiatives place emphasis on 'client perspective and choice', underpinning healthcare delivery (DH 2000; 2001a; 2004b; 2005a; 2006a; b; c). The findings can be proactively utilised to shape service development that is sensitive to Pakistani women's needs.

Organisations and individuals have moved a long way to provide 'good quality' midwifery care, albeit based upon an ethnocentric model. As the body of knowledge that underpins midwifery care is largely drawn from European studies, it is likely that midwives' lack of recognition of cultural cues of Pakistani women may result in cultural insensitivity during labour. Discovering culture-specific expectations in labour is essential, as well as subsequent incorporation of this knowledge into midwifery education, enabling practitioners to provide anti-discriminatory, ethnically sensitive individualised care. In order to avoid overly stereotypical service level responses, however, it must be recognised that there is no single model of care to 'fit all Pakistani women'. This is not denying the fact that the relationship between midwives and the women is based on the hierarchical racialised power differentials (Ahmad 1996); the study will serve to explore this relationship.

Published literature including my experience of working with Pakistani women and with midwifery students has influenced the purpose of this research study. I have intentionally kept the research proposition fairly broad as I would like to draw upon the knowledge gained from the women and their carers to further develop the research questions, thus giving voice to the women to articulate their wishes and experience of maternity services. Therefore I begin with a single broad proposition, which intends to explore the 'Pakistani Muslim women's experience of birthing in northern England'.

## 1.5. The aims of this research

The primary aims of this thesis are:

(a) To illuminate and understand Pakistani women's experiences of labour and maternity services against the backdrop of the framework of the NHS maternity service and of the history of Pakistani people in Britain.

(b) To explore the views and experiences of interpreters working with Pakistani women.

(c) To further contribute towards the provision of responsive and sensitive midwifery care by utilising the learning from the labour experiences of Pakistani women, and to develop recommendations for employers and policy makers.

(d) To produce a report and disseminate study findings to service users, midwifery healthcare professionals, NHS commissioners and providers of maternity services and relevant professional organisations.

## 1.6. Research questions

Three research questions are posed:

**(a) What are the maternity experiences of Pakistani women during labour?**

I want to know the participants' views and experiences of labour including pain relief. Given that expectations play an important role in determining a woman's response to her childbirth experience (Beaton and Gupton 1990), I wish to know whether the care delivery met with their expectations.

**(b) What opportunities and barriers are identified by Pakistani women during their labour?**

I want to explore the opportunities and barriers that affected Pakistani women's ability to receive equitable maternity services within the current context of NHS, and to discover how these structures influenced the achievement of women's goals.

**(c) What factors influence Pakistani women's ability to access maternity services?**

This question explores the factors and processes contributing to inter group differences in maternity experiences of the Pakistani women.

## 1.7. Outline of the thesis

To understand the birthing experience of Pakistani women, it is critical that their historical position in Britain is understood. In order to pursue these issues, Chapter 2 sets out to examine the historical development of race relations legislation in Britain and the direction of policy debates centering on issues of 'race', ethnicity, and the specific maternity needs of minority ethnic groups. In this chapter I will outline briefly SA and Pakistani people's migration into Britain, exploring their location in British society. There is also an outline of relevant legislative and policy frameworks that have responded to the needs of people from the BME communities to ensure that they receive treatment equal to their white counterparts.

Chapter 3 explores the contextual background pivotal to answering the research questions about Pakistani women's experiences of labour. It provides an overview of the contemporary maternity service provision and delivery, including some of the influencing forces driving the development of maternity services. Some of the key milestones in the history of midwifery since 1902 are outlined, as well as the available evidence on the maternity experiences of women (particularly those from SA communities), in order to explore women's views and experience of maternity services. An attempt is made to explore how maternity services have responded to the needs of women from SA backgrounds. Evidence is drawn from studies and surveys conducted in UK to explore women's views and experience of maternity services.

Chapter 4 addresses the research design and its methodology. Central to the discussion are the four key elements of the philosophical assumptions, theoretical framework, methodology and methods that have shaped the design of this study.

In Chapter 5, I detail the sampling framework coupled with recruitment strategies and chart the steps taken during my journey of data collection and management. In addition to general issues of the credibility, dependability and transferability of qualitative data, I

focus on the specific issue associated with translating data from Urdu into English by including a description of the transcription and analytic approaches adopted.

From here on, the thesis takes a qualitative, ethnographic perspective that draws on empirical data to elaborate participants' experiences of accessing maternity services during childbirth particularly during the intranatal period. Thus Chapter 6 examines how Pakistani women's knowledge of service provision and delivery influences their ability to access services.

Chapter 7 examines the resources that provide the participants with social support during labour, and focuses on the nature of support that is available; insights are provided into the accessibility of these resources.

Chapter 8 examines factors such as the attitudes and behaviours of the women and the midwives that form the basis of the woman-midwife relationship. It seeks to identify factors that women perceived were important to the development of a conducive relationship with the midwives, and subsequently the importance of the woman-midwife relationship and its implications for service delivery.

The main focus of Chapter 9 is to discuss the findings of the data derived from the interviews with interpreters, liaison officers, and advocates who had experience of working with the Pakistani women.

In Chapter 10, I return to the fundamental research purpose and demonstrate how the research questions have been addressed, explain the new understanding of the emergent issues related to the research purpose, thereby contributing to the development of midwifery theory. I then consider how employers in the public, private and voluntary sectors could use these findings to provide maternity services during the intranatal period that provide equal opportunities to Pakistani women.

# Chapter 2

## Journeying through swampy lands: racial equality in provision and delivery of services

**To deny our fullness: Asian women in the making of history**

We find ourselves
in the debris of poverty ridden alleys
Children of an enterprise seeking class
the underclass of a metropolis
Migrants fleeing cast iron bonds
We leave the comforting embrace of our families
Seek solace freedom in the
cold slums of long decaying cities

Transients exchange smiles words
Ask no name nor caste
Breathe in the contradiction
of alienation and liberation
in the waste ground of dockland and
in the creaking of doors in the
backyards of an area designed for demolition
Inhabited by the ill-clad ill-fed
for a century or more

Hunger defines historical platitudes
Poverty the lost ambitions of a shifting past
Alienation crystallizes
Seeks its contradiction
in the cold slums of long decaying cities

**Parita Trivedi 1984: 37**

### 2.1. Introduction

There has been an ongoing growth in the British Black[7] population since the sixteenth century (Alexander and Dewjee 1984; Fryer 1984); the 1900s saw a particularly significant demographic change, resulting from 'the Great Transformation'[8] (Kumar 1978), post-war immigration and settlement, and more recently the influxes of refugee populations. These population changes challenge the NHS to respond to ethnic diversity in the provision of healthcare services to ensure "*its policies and practices are soundly based to avoid discrimination and promote equality of opportunity*" (Waldegrave 1992: 5).

[7] The term Black is often used to denote people of dark skin who originate from countries such as Africa or the Caribbean. Many, however, suggest the use of the term 'black' serves political purposes to refer to people who share experiences of oppression and are victims of exclusionary practices (Mason 1995). There is some opposition to the term as not all people experience similar forms of oppression (Modood 1988). I use it here in the former sense.

[8] This concept encompasses industrialisation that brought about changes in "*European societies from rural, agricultural to predominantly urban industrial formations*" (Mason 1995: 20).

To understand development of health policy in addressing challenges created by ethnic diversity, it is critical to examine broader historical perspectives, demography of the country and the development of attitudes and policies concerning 'race relations'[9]. In this chapter, the historical development of race relations in Britain will be explored together with the direction of policy debates centering on issues of 'race'[10], ethnicity[11] and the specific maternity care needs of SA women. A brief insight will be provided into SA people's migration into Britain, and their location in British society. I also focus on legislative and policy framework that has responded to the health needs of SA people to ensure that they receive equal treatment.

## 2.2. Britain's BME population

According to the 2001 census, there are approximately 4.6 million people of BME backgrounds residing in the UK, constituting 7.9 percent of the population. However, there is considerable variation in the distribution of the BME population within the UK countries[12], with approximately 9 percent located in England and Wales (for details see Table 2.1), and an uneven distribution within the Regions. It is therefore possible that whilst some organisations cater for approximately 1 percent of clients from the BME communities, others care for more than 30 percent.

These statistics are important for maternity services, assisting in responding to the demographic composition and diversity of BME populations. However, Britain's BME population not only differs from the majority of the population but also has sub-groups

[9] The theorisation of the concept of 'race relations' has evolved over time; in the 1950s and 1960s it was referred to as "types of social relations between people of different racial characteristics, particularly morphological features" (Solomos 1989a:5). However as the existence of races became disputed on the basis of scientific theories (Miles 1982; 1993), John Rex's (1983) attempt at defining what is meant by race relations seems appropriate. He argues that race relations "*refers to situations in which two or more groups with distinct identities and recognisable characteristics are forced by economic and political circumstances to live together in a society. Within this it refers to situations in which there is a high degree of conflict between the groups and in which ascriptive criteria are used to mark out the members of each group in order that one group may pursue one of a number of hostile policies against the other*" (Rex 1983: 159-160).

[10] The term race is often expressed within inverted commas, suggesting that it is a disputed term. 'Race' was well accepted in mid nineteenth century to denote "human diversity as a division between fixed and separate races rooted in biological differences and a product of divergent heritages" (Mason 1995: 6-7). However the term has been a subject of controversy for some time amongst the anthropologists, biologists and social scientists. The scientific theories reject the notion that there are biological differences in groups (Rose and Rose 1986) with some arguing that 'race' is an ideological construct (Miles 1982; 1993). Despite this there has been little change in the "every day social life and ideology: people of all classes in Britain continue to believe and act as if there are 'races'" (Miles 1987: 293).

[11] The term ethnicity is increasingly being used instead of 'race'; it is socially constructed and refers to where people have a sense of belonging to a group on the basis of their ancestry and geographical origin as well as sharing the culture, language, and religion that distinguishes them from others (Smaje 1995: 16).

[12] The BME population in Scotland and Wales it is approximately 2 percent each and in Northern Ireland it is less than 1 percent.

which differ from each other in terms of culture, lifestyle, language and religion. It is noteworthy that the age profile for the BME populations is much younger than the white population. For instance, twenty percent of the White British population is under 16 years of age, whereas among Pakistanis this is thirty-eight percent, and thirty-five percent amongst the Bangladeshis (Office for National Statistics (ONS) 2001), suggesting that these communities will grow in size both in proportion and absolutely during the next two decades; this is dependent on the rates of fertility, mortality and future net migration. Whilst the rate of childbearing is falling in all ethnic groups, Pakistani and Bangladeshi women continue to have higher numbers of children than women from White, or other minority groups, and start having children at a much younger age than the other ethnic groups (Berthoud 2001). It is likely that because of the younger age profile, the use of maternity services by Pakistani women will increase in the next decade.

The commissioners of maternity services must have an accurate understanding of the profile of their population so they can plan services that meet needs. However, use of statistics can be "*racialised*" (Ohri 1988:11). For instance, fears were expressed in the health sector where increasing numbers of people from the BME groups were seen to drain scarce resources, and this may have contributed to racist practices within maternity services (Phoenix 1990). Nonetheless, if equality in service provision is to be achieved then healthcare services need to be responsive to demographic composition and diversity.

**Table 2.1: The population of England and Wales by ethnicity, 2001**

| Ethnicity | Total Population | Total Population Percentage | Non-White Population Percentage |
|---|---|---|---|
| **White** | | | |
| British | 45,533,741 | 87.5 | n/a |
| Irish | 641,804 | 1.2 | n/a |
| Other white | 1,345,321 | 2.6 | n/a |
| **Total white** | **47,520,866** | **91.3** | **n/a** |
| **Mixed Heritage** | | | |
| Caribbean and white | 237,420 | 0.5 | 5.2 |
| African and white | 78,911 | 0.1 | 1.7 |
| Asian and white | 189,015 | 0.4 | 4.1 |
| Other | 155,688 | 0.3 | 3.4 |
| **Total mixed heritage** | **661,034** | **1.3** | **14.4** |
| **Asian & Asian British** | | | |
| Indian | 1,036,807 | 2.0 | 23.1 |
| Pakistani | 714,826 | 1.4 | 15.8 |
| Bangladeshi | 280,830 | 0.5 | 6.2 |
| **Total South Asian** | **2,032,463** | **3.9** | **45.1** |
| Other Asian | 241,274 | 0.5 | 5.3 |
| **Total Asian (not including Chinese)** | **2,273,737** | **4.4** | **50.4** |
| **Black & Black British** | | | |
| Caribbean | 563,843 | 1.1 | 12.6 |
| African | 479,665 | 0.9 | 10.7 |
| Other black | 96,069 | 0.2 | 2.1 |
| **Total black** | **1,139,577** | **2.2** | **35.4** |
| **Chinese & Other** | | | |
| Chinese | 226,948 | 0.4 | 5.0 |
| Other | 219,754 | 0.4 | 4.8 |
| Total Asian and Black | 4,521,050 | 8.7 | 100.00 |

Source: Census, April 2001, Office for National Statistics

[Approximately two million white people in England and Wales, i.e. 2 percent of the total population of these countries, did not describe themselves as British. About a third of these were Irish. Others would have been from a range of European countries, including Turkey and the Middle East, and from North America and Australia.]

## 2.3. Migration pattern of Pakistani women

The partition of India in 1947, the ensuing political upheaval, service in the armed forces in World War II, and the labour needs of post-war Britain, all provided powerful impetus for migration to Britain of many Pakistanis[13] in the 1950s. The majority of early migrants were single men who, because of poorer working conditions and economic circumstances, settled in rundown inner city houses with overcrowded

[13] Indian people have been present in the UK for much longer then the Pakistani and Bangladeshis. They occupied a slightly better economic position than the Pakistani communities then and even today. Bangladeshi on the other hand arrived in 1960s, the majority of the Bangladeshi population originating from the district of Sylhet (north east Bangladesh).

conditions (Visram 1986; Coxall and Robins 1998; Phillips and Phillips 1999). The employment and housing situation thus determined the class position of the Pakistani communities in Britain, and even today remains the key determinant of their life chances. There was a further influx between 1968 and 1972 of migrants of SA origin from Kenya and Uganda, who arrived in Britain under completely different circumstances to those from the Indian subcontinent. Their migration was not staged: they arrived with their families over a very short space of time. Many of them were of urban middle-class background, spoke fluent English and had experience of professional, technical or commercial employment, or had run their own business in Africa (Bhachu 1986).

It was usually the men who migrated initially, generally from poor economic backgrounds, and their incentive to come to Britain was to earn money before returning home. In reality this didn't happen, and about a decade later most of the migrants were still no closer to earning their fortunes, and this influenced gradual migration of women and families who joined the men in the late 1960s and early 1970s[14] (Abercrombie et al 1994).

Pakistani women, because of their later arrival in Britain, were subjected to different economic and political policies from the Indian women, so they had different concerns (Brah 1992). They experienced the full brunt of the sex and race discrimination of immigration legislation, being constructed as 'dependents'; they were underrepresented in paid employment because of domineering men (Wilson 1978; Parmar 1982; Brah 1992), constructing 'Muslim women' as a racialised category (Brah 1996a:30). Such explanations fail to acknowledge that Pakistani women entered Britain at a time of great economic restructuring and recession. Education and financial independence have contributed to Pakistani women leading more independent lives, but many remain vulnerable to the various forms of discrimination and oppression that exist more widely in British society, so it is not surprising that they are still largely dependent on male relatives (Brah 1996a). However the experience of Pakistani women should not always be assumed to be different from that of white women. In all contexts the subordination

[14] The pattern of migration of South Asian women corresponded to that of men. They were underrepresented in the early 1950s and 1960s. Indian women, who were mainly Sikhs and Hindus, arrived in Britain first around the late 1960s, followed by Pakistani women; Bangladeshi women are relatively new to Britain. This pattern is reflected in the explanation of the utilization of maternity and reproductive services including the epidemiology of maternal health.

of Pakistani women in health is compounded by inequalities inherent in UK society. The experience of Pakistani women is mediated through such factors as race and class as well as gender, with similarities and differences depending on context; it should not be assumed to be the same for all.

## 2.4. 'Race relations' in Britain

The migration of Pakistani[15] people and the host community's response to increasing numbers predominantly shaped 'race relations' in Britain. The 'host-immigrant model' suggests that the conflict between the host community and Pakistanis was at the heart of the formation of hostile attitudes (Patterson 1965; Pooley and Turnbull 1998). Although the migrants were recruited by the Government to address labour shortages, they encountered hostility from the host community. Much has been written about the host community's reaction to the BME migrants, with displays of open hostility and racism towards the growing minority groups (Glass and Pollins 1960; Fryer 1984; Joshi and Carter 1984), as well as racial exclusion of immigrants within employment, housing, education, and trade unions (Carby 1982; Fryer 1984; Solomos 1988; 1989b; Phizacklea and Miles 1987). The perceived threat to British culture, and moral panic whipped up by the media contributed further to the development of racial prejudices (Ohri 1988; Hiro 1992).

Racial exclusions created an atmosphere of growing suspicion and the SA communities became more determined to maintain their cultural identities, shying away from adopting British ways (Fryer 1984). They were primarily frustrated by active denial of equal participation in employment, housing and education mainly through discriminatory practices. Consequently, black resistance against racial discrimination was the force behind the 1958 riots in Nottingham and Notting Hill that effectively served to bring the issue of 'race' to the forefront (Solomos 1992).

In response to these challenges, the government adopted a double-edged approach towards policy development. On one hand, the immigration control policy limited the number of black migrants into Britain, enabling integration and promoting good 'race' relations in Britain (Ohri 1988). On the other hand, Race Relations legislation

[15] The host communities' hostile responses were towards all people from the Black and South Asian communities and not just Pakistani communities (Fryer 1984; Ohri 1988; Hiro 1992).

addressed potential conflict and curbed discrimination, thereby promoting equal opportunities. This led to a series of immigration controls,[16] and the Race Relations legislation of the 1960s; Table 1 provides a summary of the main legislation. However, these restrictions applied to those from the New Commonwealth, who were mainly Black or Asian (Owen 1995), and White migrants from the old commonwealth countries were exempted, causing many to argue that this was a form of institutional racism (Fryer 1984; Wilson 1978).

Despite legislative attempts to outlaw racial discrimination, there is evidence that this is not happening. Racial discrimination, violence and harassment continue to exist at disturbing levels in employment, service provision and delivery, and in society (Smith 1977; Modood et al 1997; Virdee 1997). Many new migrants and refugees continue to face similar struggles to those groups who migrated in the 1950s and 1960s. It is disappointing that even though migrant communities have been settling in Britain for over five hundred years (Fryer 1984), they have yet to overcome the stigma of being regarded as 'outsiders', 'others' or 'the enemy within,' as well as continuing to be seen as 'problems' by many British people. Disappointingly, even today many British people remain negatively influenced by skin 'colour' and the 'culture' of migrants (Young 1995: 205). Whilst prejudice and racist views against SA communities have softened, 25% of white participants in a national survey disclosed that they were prejudiced against Asians and Muslims as opposed to 20% who confessed that they were prejudiced against Caribbeans (Virdee 1997). It is therefore not surprising that many SA people report continued experience of racial harassment and discrimination, creating a culture of fear and anxiety, constraining the way they lead their lives (Virdee 1995; 1997; Chahal and Julienne 1999), and having detrimental effects on their mental health (Karlsen and Nazroo 2002).

[16] With the introduction of each Immigration Act, black immigration was curbed, for example the 1962 'Commonwealth and Immigrants Act' introduced a system of employment vouchers limiting intake of immigrants (Mason 2000). While the 1968 Act sought to curb black immigration, in particular of Kenyan Asians with British passports, many citizens of old commonwealth countries, mainly white people, were exempt from the provisions of this Act (Fryer 1984; Phillips and Phillips 1999; Mason 2000). The Immigration Act of 1971 "put an end to all primary immigration" severely restricting immigration to dependants of those already in UK (Mason 2000:28). The Immigration Act which followed in 1988 made it difficult for the families of the immigrants to come to Britain. It rescinded the automatic right of the families of men who had settled in Britain before 1973 to join them in Britain. Dependants of those who had settled in Britain were only allowed if assurance could be provided that there was adequate housing and financial support was available. Table 1 provides a summary of the main legislation.
For detailed discussion of the politics of immigration legislations see chapter 4 – 'The politics of immigration since 1945' in Race and Racism in Contemporary Britain by John Solomos (1989c) and chapter 2 'Immigration' in 'Race' in Britain today by Skellington 1996.

No general theory of 'race relations' can be sustained (Gilroy 1990) because new racisms[17] vary and are historically specific. The association of hostility and discrimination towards minority groups has shifted from being linked with skin colour, physical appearance, culture and language, to religious characteristics and 'otherness' (Banton 1955; Rex and Moore 1967; Modood et al 1997; the Runnymede Trust 2000). Many have theorised the image of Islam[18] in the West for some time (for example see Said 1981, 2003; Esposito 1992; Huntington 1996). To counteract this, a number of publications have set out to improve the knowledge of non-Muslims about Islam (see for example Trifkovic 2002), although they "*portray Islam and Muslims in the worst possible light*" (Abbas 2005: 11; Poole 2002).

The overall situation of British Muslims is disturbing; examination of the manifestations of Islamophobia[19] suggests that there is continuation of prejudicial views, discriminatory policies and practices, social exclusion and different forms of violence (The Runnymede Trust 1997; Richardson 2004), leading to serious consequences worldwide. This situation goes against the assimilation/integration model that suggests with increased length of stay an ethnic group will integrate. Many contributory factors which caused disaffection in the 1950s and 1960s remain predominantly unaltered, and British Muslims continue to experience social exclusion in the areas of education, employment, housing, social and welfare services, the media and public life. However, many British Muslims have responded to their circumstances with resentment, anger and despair, and it is most likely that it is for these reasons many of them remain excluded from mainstream British society (Weller et al 2001).

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[17] Although racism has its roots in ideological assumptions based upon biological sciences, it occurs in terms of culture and ethnic differences as being seen as inferior to others; this is referred to as the 'new racisms' (Goldberg 1993; Solomos and Back 1996).

[18] Islam is the way of life for those who believe in Allah and want to live a life in worship and obedience to none but Prophet Muhammad (Peace of God Be Upon Him). The reward is forgiveness from God and an everlasting life in the Heaven.

[19] Islamophobia is a form of hostility directed towards Muslims (The Runnymede Trust 1997; 2000; Weller et al 2001). It is "the fear or dread of Islam" (Abbas 2005: 11). It is unsubstantiated and "unfounded hostility towards Islam" and Muslims (The Runnymede Trust 1997: 1), contributing to the victimisation felt by all Muslims worldwide (Said 1997). Islamophobia is not about "stereotyping of physical characteristics" but is about "misrepresentation of the Muslim world and the representation of their life-style as alien from Western society" (Marranci 2004: 107). The West has effectively constructed Muslims as the 'other' and characterised them as "barbaric, ignorant, loose minded, semi-citizens, maddened terrorists or as intolerant religious zealots" (Abbas 2001: 249). This has led to assaults levelled at the entire religion of Islam, consisting of a wide spectrum of actions and behaviours, extending from physical assaults to systematic discrimination. The role of media in projecting Islam in a negative light has been criticised by many for flaming the stereotypes of Muslims as being demons, women oppressors, fundamentalists and terrorists (The Runnymede Trust 1997; Said 1981; Poole 2002).

## Table 2.2: Immigration and Race Relations Legislation in UK since 1962

| Year | Legislation | Impact |
|---|---|---|
| 1962 | Commonwealth Immigrants Act | Restricted admission of Commonwealth settlers to those who had been issued with employment vouchers. Entry control established that conviction of an offence within five years of arrival leading to deportation. |
| 1965 | Race Relations Act (RRA) | Made it unlawful to discriminate on grounds of colour, race, ethnic or national origins in places of public resort. Outlawed discrimination in public places; established Race Relations Board and National Committee for Commonwealth Immigrants (NCCI). |
| 1968 | Commonwealth Immigrants? Act | Controlled black immigration in particular Kenyan-Asians with British passports, many citizens of old commonwealth countries, mainly white people, were exempt from the provisions of this Act (Fryer, 1984; Phillips and Phillips, 1999; Mason 2000). |
| 1968 | Race Relations Act | Extended the 1965 Act into the areas of employment, provision of services and housing provision. NCCI replaced by Community Relations Commission. Introduction of local community relations councils. |
| 1971 | Immigration Act | Abolished work vouchers scheme and established "partiality" grandfather clause. Introduced a system of work permits. Overall affect was that the migrants entered Britain as short-term contract workers and not settlers although they could apply for the time limit to be lifted after four years. This virtually ended all primary immigration. |
| 1976 | Race Relations Act | Replaced all previous RRAs. Redefined discrimination, introducing the concept of indirect and institutional discrimination to the areas of 'race'. This Act created the Commission for Racial Equality (CRE) by bringing together the Race Relation Board and the Community Relations Commission, and introduced different procedures for the handling of complaints. |
| 1981 | British Nationality Act | Harmonised nationality and immigration legislation; created three categories of citizenship: British Citizenship; Citizenship of British Dependent Territories; British Overseas Citizenship. Not surprisingly, however the category British Overseas citizens, who were mostly of the Asian origin, were excluded from the right of abode in the UK. |
| 1988 | Immigration Act | Rescinded the automatic right of the families of men who had settled in Britain before 1973 to join them in Britain. Dependants of those who had settled in Britain were only allowed if assurance could be provided that adequate housing and financial support were available. |
| 1993 | Asylum and Immigration Act | Accelerated and streamlined asylum decision making and appeal procedures. Introduced in-country right of appeal and 'fast-track' procedures for assessing asylum applications and restricted applicants' access to housing. |
| 1996 | Asylum and Immigration Act | Removed benefit entitlement to in-country asylum applicants and further restricted access to housing. Tight time limits for appeals for asylum applicants who came from these countries, or for asylum applicants who lacked credibility, were set. |
| 1999 | Immigration and Asylum Act | Removed remaining benefit entitlement from all asylum applicants and created the National Asylum Support Service. Introduced vouchers and dispersal of asylum seekers and new restrictions on illegal working. |
| 1999 | Human Rights Act | This brings the European Convention of Human Rights into legislature, including public authorities. |
| 2000 | Race Relations (Amendment) Act | It places a general duty on public authorities to actively promote racial equality and prevent racial discrimination. |
| 2002 | Nationality, Asylum & Immigration Act | Places emphasis on the control and removal of unsuccessful applicants. |
| 2006 | The Equality Act | Duties are 1. to establish the Commission for Equality and Human Rights; 2.to make discrimination unlawful on the grounds of religion or belief in the provision of goods, facilities and services, the disposal and management of premises, education, and the exercise of public functions, and 3. to create a duty on public authorities to promote equality of opportunity between men and women, and to prohibit sex discrimination in the exercise of public functions. |

Source: amended and updated from Skellington (1996)

## 2.5. Languages spoken and literacy

People from Pakistani Muslim communities speak a variety of languages, with many variations in the spoken dialect, although most of these languages are not normally in written format. The main languages spoken are Urdu and Punjabi, but many young Pakistani Muslims in the UK are unable to fluently speak or read either. Small-scale studies have been undertaken by local health authorities to identify patterns of spoken or written languages so the information needs of the service users can be met and accessibility to healthcare improved (Leeds City Council 1994; Tuffnell et al 1994); there have been two large-scale surveys that have reported on language issues (Rudat 1994; Modood et al 1997).

Rudat's study, although now over ten years old, reported that younger Pakistani women, aged 16-29, were more likely to report either English or Punjabi as their main language, while women aged 30-49 were more likely to report Punjabi rather than English. Younger Pakistani women were more likely to report that they were able to read English and Urdu whereas those aged 30-49, were more likely to report their ability to read Urdu rather than English. Speaking a language, however, does not denote literacy and when responding to the literacy levels twenty-three percent of the women in the younger age group stated they were unable to read English, compared to sixty-nine percent of the women aged 30-49. However there are no details in this survey of the additional regional dialects[20] spoken, and owing to these omissions it is likely that Pakistani people who spoke different dialects such as Mirpuri identified Punjabi as their main language and those who spoke Pushto reported Urdu as their main language. Having details of such information should assist healthcare providers in communicating information.

Modood et al's (1997) findings are not dissimilar, and have identified factors such as age[21], gender, age on arrival in the UK and ethnic composition of neighbourhood as being associated with Pakistani women's ability to speak English fluently. Length of stay correlated positively with ability to speak English. The findings suggest that nearly all of the 16–24 year age group speak English well. However, the ability to speak

[20] Dialects such as Mirpuri or of Pushto which are a different language to Punjabi and Urdu that is spoken by some people originating from Pakistan.

[21] The findings suggest that whilst the ability to speak English fluently increases with the length of settlement, age apparently is a more significant determinant.

English declines markedly in women in the 45-64 year age group, with marked gender differences in all age groups where more men than women are able to speak English well. There is a positive correlation between fluency in spoken English and age on arrival in the UK, with more men and women able to speak English fluently when arriving in the UK at an earlier age. Pakistani women aged between 45 and 64, who have been in the UK for less than 25 years and who live in neighbourhoods with high populations of Pakistani people, are less likely to speak English fluently (Modood et al 1997).

This suggests that in order to engage Pakistani women in issues of healthcare and convey healthcare information, the principal mode of communication for women aged 16 to 29 is likely to be English, because they are more likely to speak it, and report it is their preferred reading language. This does not however take into account the needs of the new migrants. However, as the ability to read English declines amongst the women aged 30-49 (their preferences for spoken language are for Punjabi and Urdu, and preference for reading is Urdu), the mainstream mode of communication needs to be supplemented. Use could be made of outreach activity and audio-visual material, though the level of need for interpretation is likely to be higher in respect of technical language. The findings of this survey suggest that written material produced for the Pakistani Muslim communities should be made available in both English and Urdu. In addition, such information should be backed up with spoken communication because of levels of illiteracy.

## 2.6. South Asian communities and health policy

Whilst the NHS has attempted to respond to the health needs of Britain's Pakistani population through policy initiatives (a summary of these is provided in Table 3), it has been increasingly criticised for its ineffectiveness (National Association of Health Authorities (NAHA) 1988; McNaught 1988; Bhat et al 1988; DH 1992; Balarajan and Raleigh 1990, Johnson 1993; Rudat 1994). Disappointingly, there remains a distinct variation in both health status and access to health services amongst the BME groups and between the BME communities and the indigenous population (Marmot et al 1984; Balarajan and Bulusu 1990; Smaje 1995; Nazroo 1997; Modood et al 1997; Acheson 1998; DH 2001b). Whilst it is true that mortality rates have declined over time in all ethnic groups (Balarajan and Raleigh 1990), there remain clear differentials in perinatal

mortality, infant mortality, maternal mortality and low birth weight (Amin and Oppenheim 1992; Acheson 1998). For example, women from the SA communities are significantly more likely to die in childbirth compared to their white counterparts (Grimsley and Bhat 1988; Parsons et al 1993; Lewis 2004). Similarly, mortality rates are higher in babies born to women from the SA communities than in babies born to white women (Grimsley and Bhat 1988; Parsons et al 1993; Lewis 2004; Confidential Enquiry into Maternal and Child Health 2006).

Initially the policy emphasis was on the 'assimilation and integration' theory (Williams 1989; Stubbs 1993), based on the principle that all health services were adequate and accessible, so once people from Pakistani[22] communities adopted the British way of life, their needs would be fulfilled (Joshi and Carter 1984). The policy directives adopted a 'colour blind' approach where migrant communities were seen as 'the same as us' and needed no particular service, and "*planning took place in a vacuum informed by myth and prejudice*" (Johnson 1993: 191). However, over time it became increasingly apparent that the health needs of the Pakistani communities were not being met. The difficulties they encountered with various institutions were located in a cultural explanation, in terms of their own 'individual' shortcomings, and they experienced ill health mainly owing to their own 'strange' and 'idiosyncratic' culture (Ahmad 1993). This ideology focused on Pakistani women - rather than the ethnocentric delivery of maternity services - being the 'problem'.

[22] Although the term Pakistani is being used in the context of this thesis, this approach of 'assimilation and integration' in policy formulation was adopted towards all people from the BME communities. So, for brevity in this chapter, where the term 'Pakistani' communities is used in terms of policy formulation and implementation such policies also applied to wider BME communities.

**Table 2.3: Health needs of the black and minority ethnic communities in Britain: the Health Policy Response**

| Year | Event | Comments |
|---|---|---|
| 1965 | Letter to Medical Officers of Health and GPs | Encouraged local efforts to prevent and treat tuberculosis among immigrants. |
| 1965 | Commonwealth Immigrants White Paper | Noted that immigrants placed a heavy burden on health services; their needs are different in degree rather than kind and should be met in the same way as the needs of other citizens. Suggested employment of immigrant community nurses, health visitors and midwives to overcome communication problem; Regional Hospital Boards were made responsible to consider the presence of immigrants during their hospital building programme. |
| 1977 | Asians in Britain Project | Department of Health and Social Security (DHSS), Kings Fund and National Extension College established a project to produce educational and training material for SA people and NHS staff. |
| 1978 | Health Circular (36) | Outlined implications of 1976 Race Relations Act for the NHS. |
| 1980 | Yellowlees Report | Study of migrant health in response to the parliamentary and public concern regarding 'virginity test' on Asian women and the use of x-rays to assess the age of children. Although tuberculosis was identified as a major immigrant health problem, there was no major difference between the health of immigrants and the indigenous population. |
| 1980 | Black Report | Examined inequalities in health in Britain and commented briefly on race and ethnicity as a dimension of inequalities in health. |
| 1980 | Short Report | Recommended health authorities to make 'positive efforts to seek out pregnant women in minority groups'. |
| 1980 | Multi-ethnic women's health project | City and Hackney Community Health Council established a project pioneering the concept of the 'health advocate'. |
| 1981 | Stop Rickets Campaign | DHSS established campaign – administered by the Save the Children Fund –arising out of earlier health education efforts among the SA population. |
| 1981 | Health circular (6) | District Health Authorities (DHAs) to have 'suitable' representation from ethnic minorities among their members. |
| 1983 | Health circular (6) | Suggested ethnic minority interests should be considered in arrangements for care in the community and joint finance, where appropriate. |
| 1984 | Asian Mother and Baby campaign | DHSS established campaign – along similar lines to Stop Rickets – in 16 DHAs to improve antenatal and postnatal care and the sensitivity of the services provided. 'Link workers' pioneered. |
| 1984 | Health circular (19) | Suggested Family Practitioner Committees to consider 'ethnic origin' in membership nominations. |
| 1985 | Haringey DHA appointed ethnic adviser | The first appointment in the NHS. |
| 1986 | Equal Opportunities Task Force | DHSS part funded a King's Fund Task Force to help health authorities develop equal opportunities policies and address equality of opportunity more generally. |
| 1987 | NHS Management Seminar | Minister for Health hosted NHS seminar on ethnic minority health. |
| 1987 | Black Health Forum | National Community Health Resource established Forum as a network for community workers in black health issues. |

| Year | Event | Comments |
|---|---|---|
| 1988 | Routine sickle cell/thalassaemia screening | Brent DHA first health authority to introduce routine screening. The government reviewed its sickle cell/thalassaemia policy. |
| 1988 | Action Not Words | National Association of Health Authorities produced a 'strategy to improve health services for BME groups', which the government endorsed. |
| 1989 | Ethnic Health Advisor | Department of Health (DH) appointed a special advisor on ethnic minorities' health. |
| 1989 | Department of Health Continuing Fund | £500,000 fund established for project work on the health of minority ethnic population. |
| 1990 | The NHS and Community Care Act | NHS Reforms required purchasers to assess the health needs of their local populations and to consult with them. |
| 1990 | Department of Health/ Kings Fund Grants | DH funded 3 projects at the King's Fund Centre to examine ethnic dimensions in mental health, carer issues and purchasing. The King's Fund awarded four DHAs with grants to examine purchasing issues. |
| 1990 | Departmental Working Group | DH established a Group to examine health and ethnicity issues. |
| 1991 | The Patient's Charter | Establishes a clear framework for patient entitlements and to ensure that the NHS is more 'user friendly' responding appropriately to the faith and cultural needs of the population. |
| 1991 | SHARE | DH funded King's Fund Centre to develop an information exchange on health and race issues. |
| 1991 | Primary Care Code of Practice | Secretary of State for Health voluntary code drawn up by the Commission for Racial Equality. |
| 1991 | NHS Contracts and Racial Equality | CRE publishes guide for contracting for health authorities. |
| 1992 | Chief Medical Officer's Report | Devoted a chapter to minority ethnic health issues. |
| 1992 | Health of the Nation White Paper | The government's health strategy identified people from BME groups as a 'special group' with a number of particular needs. |
| 1992 | Guidelines on patients' spiritual needs | NHS Management Executive issued guidelines on spiritual needs of patients from different faiths. |
| 1993 | King's Fund Grants | Grants provided 4 statutory/voluntary partnerships to improve access to health and social care for people from minority ethnic populations. |
| 1993 | Ethnic Health Unit | DH established the Unit for a period of 3 years to encourage research and support health purchasers and providers in improving access to health services for minority ethnic populations. |
| 1993 | Equality Across the Board | National Association of Health Authorities and Trusts/King's Fund Centre published DH-funded report and recommendations on increasing minority ethnic non-executive NHS membership. |
| 1993 | Ethnic Minority Staff in the NHS | Secretary of State for Health launched 8-point action plan to achieve equitable representation of minority ethnic groups at all levels in the NHS (including professional staff groups), to reflect the ethnic composition of the local population. |
| 1993 | Changing Childbirth Report | Advocated services to be woman-centred; flexible and responsive to the individual needs of the women and their families, listening to their views and respecting their cultural |

| Year | Event | Comments |
|---|---|---|
| | | background. |
| 1993 | Patient Charter – Maternity services | Guidance on the application of rights and standards of Patients Charter to maternity services. |
| 1994 | Maternity Services Code of Practice | CRE published guidelines to assist NHS organisations to eliminate racial discrimination and give examples of good practice. |
| 1994 | NHS Executive letter | Collecting Ethnic Group Data for Admitted Patient Care – declaring that ethnic group is to be recorded for all hospital inpatients. |
| 1997 | The New NHS: Modern and Dependable | Governs the way health services are planned, purchased and provided, requiring commissioners and provider units to be more responsive to the needs of their local population; proposals recommend that due consideration is given to offering greater choice, higher standards and better quality of health care provision. Seeks to 'rebuild confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views'. |
| 1998 | Health Service Circular (1998/129) | To support Health Authorities, Trusts and Primary Care Teams provided guidance on different aspects of health needs assessment in relation to BME communities. Suggested that assessment of health needs of people from minority ethnic groups to be taken into account within the health needs assessment process. |
| 1998 | Department of Health Announcement | 30 % increase in Ethnic Minority appointments to NHS Trust Boards. |
| 1998 | Launch of the Birmingham and Solihull Development Programme for Black and Ethnic Minority Managers | The development programme created by a consortium of 12 Birmingham NHS Trusts, Birmingham Health Authority and other health and social service organisations. It is supported and part funded by the NHS Executive's Equal Opportunities Unit, which provided £77,000 for the initiative. The development programme aimed to develop black and ethnic minority managers and support them in developing their personal and management skills, and to provide a catalyst for positive change within NHS Trusts to promote equality of opportunity. |
| 1998 | NHS Equality Awards | Initiatives set up to reward outstanding equal opportunities practice in patient care and employment. |
| 1998 | Positively Diverse Programme | Service-wide development which provides a strategic approach to managing and improving equality of opportunity for all staff and befitting for the diversity of culture, skills and experience they bring to the workplace. |
| 1998 | Working Together – Securing a quality workforce for the NHS | National Framework document to manage human resources in the NHS. |
| 1998 | Tackling Racial Harassment in the NHS – a plan for action | Provides guidance and support in developing and implementing action to tackle racial harassment in line with recommendations of the Steven Lawrence Inquiry |
| 1998 | Department of Health Continuing Fund | £1.3 million funding established for pilot projects to improve minority ethnic health, which were to ensure effective access to health services for people from BME groups as part of the DH's programme to reduce social exclusion and inequalities in health provision. |
| 1999 | A First Class Service | Introduces a new approach to improving the quality of patient |

| Year | Event | Comments |
|---|---|---|
| | | care in the NHS – clinical governance – that requires a shift towards a culture, which is 'truly patient-centred'. |
| 2000 | The NHS Plan: A plan for investment, a plan for reform | Sets out overall direction and priorities for the NHS over the next 10 years to modernise it. At the heart of the NHS Plan is a vision of a service 'designed around the patient'; Chapter 10, Changes for Patients, describes a range of initiatives to improve patient information, patient choice and patient and public involvement in the NHS. |
| 2000 | The Vital Connections: An Equality Framework | Integrated approach to achieving equality, fair treatment and social inclusion based upon specific priorities and actions. |
| 2000 | A health service of all Talents: developing the NHS workforce | Review of workplace planning and development for all professional groups within the NHS. |
| 2001 | DH's Health Survey for England 1999: the health of minority ethnic groups. | The most extensive survey into the health of minority ethnic groups ever carried out in England, and the first national survey to include minority ethnic children as well as adults. |
| 2001 | Improving working lives: BME staff networks: guidance | Guidance to encourage the setting up of BME staff networks. DH promised that funding would be provided to "pump-prime" these networks; the development of BME networks is a key component of the overall diversity and equality strategy in each NHS organisation. |
| 2004 | Celebrating our Cultures | New guidance to help Primary Care Trusts deliver better health services for black and ethnic minorities with mental health problems. Guidance provided to identify and deliver better, personalised services for people from BME communities who have mental health problems; consult, commission and promote mental health services; and evaluate mental health promotion for impact and effectiveness with BME communities. |
| 2004 | Race Equality Action Plan | Action plan developed to provide greater prominence to race equality as part of DH's drive to improve health for all sectors of the community. |
| 2004 | New equality champion for the NHS | The first ever equality and human rights director for the NHS was appointed. |
| 2005 | Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett | An action plan for achieving equality and tackling discrimination in mental health services in England for all people of BME status, including those of Irish or Mediterranean origin and east European migrants. |
| 2005 | Department of Health Continuing Fund | £1.5 million funding boost for young BME people with mental health needs to projects that specifically work with BME children and young people. |
| 2005 | Department of Health | Practical guide to ethnic monitoring – new guidance issued |

Source: amended and updated from Smaje (1995: 115)

When it was recognised that people from Pakistani communities were not going to integrate the 1970s and 1980s saw a shift towards promoting multiculturalism. The

focus of this approach was on the assumption that linguistic, faith and cultural differences between the SA and white communities hindered effective communication and access to health services. The belief was that understanding the cultures of Pakistani women would assist healthcare professionals in dispelling any myths and stereotypes that existed about the service users and to overcome linguistic and cultural barriers; this would facilitate a better understanding of diverse cultures, and enable delivery of more culturally sensitive services (Ohri 1982).

Explanation of patterns of morbidity and mortality in the Pakistani communities have been strongly linked with cultural practices such as purdah[23], vegetarian diets (Stop the Rickets Campaign 1981), the use of traditional medicines and cosmetics (Campaign against Surma[24]) and first cousin consanguineous marriages (Honeyman et al 1987). When such a causal link is assumed, then solutions to problems appear clear, so the status of Pakistani women's health became constructed and explained in terms of cultural differences that were equated with deviance and pathology. Based on the assumption that Western practices are "*normal and superior*" and those of 'others' are "*inferior*", the Pakistani women must then be re-educated to abandon their cultural practices and to adopt Western approaches (Ahmad 1993: 18). The pathologisation of Asian cultures served to shift the problem from the power differences to the individuals, ignoring the effect of the social-psychological needs of the groups including the detrimental effects of marginalisation and hostility that many people from the Pakistani communities faced. For example, the Stop the Rickets Campaign in 1981 singled out the 'Asian community', homogenising it and denouncing Asian culture and lifestyle as the main problem; Asians were advised to change their diets and lifestyles to Western ways (Torkington 1984; Donovan 1986). Similarly the Asian Mother and Baby Campaign (ABMC) was criticised for adopting a victim-blaming ideology where the high perinatal mortality/morbidity rates amongst Asians were seen as the fault of their cultural practices: they seek antenatal care late, they

[23] Purdah is a practice observed mainly by the communities practicing Islam, where women segregate themselves from men either by separation or by wearing a Burqa. Burqa also referred to as burka or burqua is a garment that covers the whole body; it is worn by Muslim women who observe purdah. It covers the entire face and some women may have only the region of eyes uncovered; others may choose to cover this part with a net. When purdah is practised, women refrain from participating in activities in which males are present. Wikipedia, the free encyclopedia: http://en.wikipedia.org/wiki/Purdah accessed 2 January 2006.

[24] Surma, sometimes referred to as Khol, is an eye cosmetic traditionally used throughout Asia, Africa and the Middle East. It serves two purposes: first is to enhance the appearance of the eyes and second is for medicinal purposes. It is available in powder form, paste and liquid form and it has a high lead content which has a number of adverse effects on adults and children (Al-Ashban et al 2004). It was in the 1970s that the hazards of high lead content in this cosmetic was linked with deaths in children (Smart et al 1990), however the evidence confirming links of surma and high level of lead in blood is not conclusive (Aslam et al 1980). Nevertheless, the Government instigated the Surma campaign, designed to raise awareness of the adverse affects of surma amongst the communities and healthcare professionals.

do not know how to sterilise baby milk bottles and they cannot communicate with healthcare professionals (Rocheron 1988; Ahmad 1993). Cultural pathologisation emphasised the notion that the Pakistani communities have extraordinary needs, which require special provisions. This shifting of the blame onto the victim fails to address inequalities of power and resources and obscures structural bases of inequalities; it fails to address the ethnocentric delivery of services. This multicultural approach did little to equip health care professionals' understanding of providing individualised care; it reinforced stereotypes and promoted homogenous care delivery. It effectively ignored structural issues and key determinants of health inequalities such as socio-economic and environmental factors.

It was not until the late 1980s that Britain's health services witnessed a rise in the antiracist approach, which has as its starting point anti-racism and not culture (Stubbs 1993), focusing "*on transforming the unequal social relations shaping interaction between black and white people into egalitarian ones*" (Dominelli 1988: 3). Many public and private sector organisations started to see the developments in anti-racist strategies, and a promotion of equal opportunity programmes propelled by the Race Relations legislation and NHS reforms. However such developments were predominantly in areas of employment and have been slow in gaining popularity in the field of service delivery where the "*ethnically sensitive approach*"[25], and the focus on culture, remained central. (Stubbs 1993: 38; Ahmad and Jones 1998).

The Government has acknowledged the NHS's inability to respond to the needs of consumers, and has proposed many radical changes through the NHS Reforms, governing the way health services are provided so they are more responsive to the needs of their local population (DH 1990; 1997). Policy directives recommended that due consideration be given to offering greater choice, higher standards and better quality of health care. These proposals may have been a catalyst in some organisations, but in others they were met with inaction, mainly owing to differences in understanding of equal opportunities in employment and in service delivery, as well as varying levels of commitment. Current NHS developments (DH 2000; 2005b) are placing patients at the heart of the services, giving them a real say in the way services are planned and

[25] Ethnic-sensitive approach tends to place greater emphasis on the cultural differences, customs and traditions, and fails to take account of other structural factors such as racism which underpin inequalities in access. This approach focuses on issues by pathologising the culture and traditions and is based on the victim-blaming philosophy (Stubbs 1993).

delivered. These proposals offer encouragement and a platform for increasing minority ethnic participation, although it is rather early to comment on their effectiveness. Critics argue that such calls for equality in service provision were highlighted in early 1990s, but regrettably little appears to have changed (Johnson 1993; Bhopal 2007).

It is worth noting that the Race Relations Amendment Act (2000) places a duty upon service providers to ensure that discrimination does not take place. Section 20 of the Act makes it unlawful for anyone involved in the provision of services to discriminate on racial grounds by a) refusing, or deliberately failing to provide them with services; b) providing them with poorer services; c) treating them differently, or setting different terms and conditions for them. To assist organisations to comply with the Race Relations Legislation, the Commission for Racial Equality provided detailed guidance (CRE 1994). However it is not clear how organisations utilised this guidance because some of the issues identified in early 1970s remain a challenge even today (Bhopal 2007).

## 2.7. Summary

Over time the composition of Britain's population has significantly changed and the statistical data from the Census 2001 suggests that this trend will continue. Policies and practices of the DH and the NHS will need to be constantly reviewed in response to the changing needs of its ethnically diverse population. From the above account it can be seen that issues of equity are very much on the NHS agenda. It is evident that the Government has been grappling with these issues since the early 1980s and has made variable progress in overcoming these inequities. There is firm commitment at the centre declaring that *"racism, discrimination, or inequalities have no place in modern society, and they certainly have no place in the modern NHS.* [However] *change might not come overnight .....*" (Winterton 2004). Such statements demonstrate the NHS's commitment to redress the balance in equality, including its inability to make change happen at the pace to meet the needs of its service users. Unless more is done to bridge the gap between policy and practice, people from the BME communities will continue to experience inequality in health patterns and in accessing and utilising health services (Rudat 1994, Smaje 1995; Nazroo 1997; Bhopal 2007).

The NHS and the healthcare professionals have a professional obligation to ensure equal opportunities in provision and delivery of maternity services for Pakistani women and

all other service users. Achieving this is a challenge. First, the pattern of service provision and delivery has not kept pace with the changing population profile; second, the change and progress required to address the needs of diverse communities has not been universal; third, some key issues have not been addressed effectively; fourth, NHS provision is still based on the concept of homogeneity, and finally introduction of initiatives to overcome some of the challenges have experienced funding problems and as a result have been disbanded or have not been mainstreamed.

In this chapter I have given an overview of the historical development of race relations in Britain and the state response to promote racial equality, as well as the developments of health policy in addressing the challenges created by ethnic diversity. I have briefly outlined the position of Pakistani women within Britain to provide a contextual background. The next chapter moves to examine the existing evidence on SA women's views and experiences of maternity services.

# Chapter 3

## Social context of maternity services: women negotiating maternity services

**Birthing in Britain: a vortex**

..... a complex set of policies and practice .....
in the interests of mothers and their babies
justified on medical and evidence based grounds.....
Midwives balancing cultures and competing priorities
like puppets on a string
dancing to different tunes
Is it unspecialised, normalised births
or specialised technocratic births
Technological surveillance, fetus under the gaze
drug induced labours
medical management of pain
each stage being timed
Woman centred care is this
you have choice and control
I am flexible as long as you do what I say....

**Kuldip Bharj 2007**

### 3.1. Introduction

This chapter provides a contextual background specifically outlining the contemporary social discourses of maternity service provision, focusing on recent developments within maternity services. It will provide an overview of contemporary maternity services, including some of the forces driving their development. It outlines some of the key milestones in the history of midwifery in the twentieth century, and explores the maternity experiences of women from the SA[26] communities. Evidence is drawn from studies and surveys conducted in the UK to explore women's views and experience of maternity services. Reference is made to how maternity services have responded to the needs of SA women.

[26] The broad term South Asian (SA) is used despite the fact that this study is about women from Pakistani heritage. Much of the literature addresses South Asian women collectively, taking into account women from India and Pakistan. It is for this reason that it has been difficult to find literature specific to Pakistani women. Often in studies there is no relevance to the finer distinctions within the South Asian category that assumed a generic meaning because it was analytically valid to do so.

## 3.2. Contemporary Midwifery services

The twentieth century saw the transformation of birth from a social, domestic event into a highly technological, medical procedure. In the early 1900s, the majority of the women in England were attended by female friends and relatives during childbirth, with the place of birth predominantly in the home. Towards the end of twentieth century care was mainly provided by health care practitioners, and the place of birth was almost always the hospital; childbirth was managed within the technological arena (Macfarlane and Campbell 1994), propelled by the philosophy that hospitals were places of greater safety (Oakley 1986, Towler and Bramall 1986; Donnison 1988). As childbirth became more hospitalised, it became "*doctors' business*" (Doyal 1995: 135), based on the assumption that they were superior in knowledge to midwives (Oakley 1986, Donnison 1988; Oakley 2000). The role of midwives became that of doctors' subordinates, giving doctors a competitive advantage by reducing midwives' power and status. Many midwives and women opposed these moves, but even the lack of evidence that hospital births were safer than home births made little difference to the prevailing ideology; maternity care remained hospital-centred (Campbell and Macfarlane 1987; 1990; Tew 1990; 1998).

## 3.3. Medicalisation of childbirth

Much has been written about the growth of power of the medical profession, with the increased involvement of obstetricians in childbirth and the role this played in the medicalisation of childbirth (Stacey 1988, Wraight et al 1993). With hospitalisation, childbirth was increasingly treated like an illness, subjected to greater use of technology and intervention (Oakley 1984; Arney 1985; Devries 1989; Kitzinger 1990). The process of childbirth, once a 'normal' event, came to be seen as 'pathological' and 'a risk'; associated dangers meant it was normal only in retrospect (Lewis 1990). With this prevailing ideology childbirth required a "*medical expert to oversee the event*" (Murphy-Lawless 1998: 22); hospital settings for births were regarded as appropriate because emergency facilities were readily available (Maternity Services Advisory Committee 1982; 1984; Oakley 1984). Childbirth became a "*crisis event*" requiring medical surveillance and technological gaze (Finkelstein 1990:29). Many women supported the move towards

hospitalised births, particularly those who saw that "*hospitalisation was part of a scientifically based modernist culture* [...]" (Symonds and Hunt 1996: 92). These views reinforced the normalisation of hospital births including the intervention that went with it. Similarly, organisations such as the National Childbirth Trust (NCT) reinforced these ideologies by aligning themselves with doctors, advocating women to trust medical knowledge and condemn "*old wives' tales*", encouraging women to portray themselves as just "*mothers*" (Kitzinger 1990: 101-105).

Doctors took control of negotiating the demarcation between normal and abnormal, exerting professional dominance over midwives and women, thereby disempowering them (Oakley 1984); the process was aided and abetted by patriarchal ideology, underpinned by oppressive discourses (Pateman 1989; Starhawk 1990), bound within which were concepts of power and knowledge. With doctors knowledge professed to be superior (Oakley 2000), women and midwives found themselves increasingly dependent on medical science and technology, with a widespread view emerging that "*doctor knows best*", and a location of control in both patriarchal and strategic discourses (Kitzinger 1990: 111). The dominant values and beliefs that underpinned the medical model were supported and reinforced by many social groups, including midwives. Midwives were socialised in this model and over time have become technocrats and managers of labour using intervention and invasive techniques (Oakley 1984; Arney 1985; Bryar 1995).

**..... Who knows best? .....**

The ideology of medical knowledge being best is based on the assumption that there are different bases of knowledge for women and for professionals. Professionals' knowledge is superior and authoritative, located within scientific epistemology whereas women's knowledge is subjective and grounded more within the relational epistemology (Belenky et al 1986, Jordan 1993; Gilligan 1993; Oakley 2000). "*Science and knowledge are socially produced; that is, they are subject to the very influence of social processes and partialities that their common-sense representations would dismiss as quite beyond their frames of reference*" (Oakley 1992: 335). However this ideology influences what is considered "*authoritative knowledge*", typified through its dominance and authority and is

"*persuasive*" (Jordan 1993; Davis-Floyd and Sargent 1997: 57). Such knowledge is seen as 'objective', 'truthful' and 'superior' ways of knowing.

In contrast, women's way of knowing is constructed as 'subjective' and is devalued by authoritative knowledge (Jordan 1993; Davis-Floyd and Sargent 1997). Women and men develop and produce knowledge in different ways (Harding 1996). Women utilize five "*ways of knowing*" to perceive themselves and approach the world (Belenky et al 1986; Goldberger et al 1996). The five strategies[27] of knowing are: silence, received knowledge, subjective knowledge, procedural knowledge and constructed knowledge. The struggle about who knows best is not only between professionals and women but also between doctors and midwives, suggesting that "[the] *power of authoritative knowledge is not that it is correct but that it counts*" (Jordan 1993: 56). The authoritative medical knowledge occupies a superior position, devalues and "*subjugates*" feminist ways of knowing (Jordan 1993; Davis-Floyd and Sargent 1997; Kirkham 2000: 246). The relationship of authoritative and nonauthoritative knowledge is a complex tapestry of issues. Authoritative medical knowledge subjugates "*traditional and experiential*" knowledge of midwifery on one hand, and the authoritative knowledge of medicine and the professional knowledge of the midwives subjugate cultural and experiential knowledge of the women on the other (Hunt and Symonds 1995; Kirkham 2000).

### ..... Challenging medicalisation .....

The prevalent medicalisation thesis, has not gone unchallenged. Towards the latter half of the twentieth century there was resistance to medical control from both midwives and women's organisations. Women expressed dissatisfaction with childbirth, citing undesirable factors such as fragmentation and insensitivity, lack of emotional support, lack of

[27] Silence is where women "*experience themselves as mindless and voiceless and subject to the whims of the authorities*" (Belenky et al 1986: 15); they see authorities as all-powerful. Received knowledge is when women believe that they are able to learn from others, and pass on what they have learned from "*the all-knowing external authorities*" (ibid page 15), but they do not see themselves as capable of independently creating knowledge. Subjective knowledge is where women place emphasis on authority within self, "*truth and knowledge are conceived of as personal, private and subjectively known or intuited*" (ibid page 15), as such external authority is less powerful and relies on a strong inner voice with which they develop their thoughts. In contract, procedural knowledge is the development of women's knowledge solely on objective, scientific procedures, recognising that there may be more than one 'right' answer in a particular situation. Constructed knowledge is where women see "*all knowledge as contextual*", and produce knowledge on both subjective and objective methods to arrive at truth (ibid page 15).

information, medical control, inflexibility of hospital routines, dehumanisation aspects of hospitalisation, and increase in reproductive technologies (Kitzinger 1978; Oakley 1979; Cartwright 1979; Reid and Garcia 1989, Kitzinger 1990). Midwives called for strengthening of their professional autonomy and for effective use of midwifery skills in uncomplicated childbirth and in public health (Page 1995; 2000; Gould 2000; Anderson 2000; Downe 2001). Concomitantly consumer organisations such as the NCT and the Association for Improvements in Maternity Services (AIMS) campaigned for accessible maternity services and individualised midwifery care, urging increased choice and greater control over childbirth for women, reduced medical intervention, and increases in natural childbirth (Kitzinger 1990; Durward and Evans 1990).

Although schemes to improve maternity care were pioneered (Flint and Poulengeris 1987; Flint et al 1989), it was the publications of the Winterton Report (DH 1992) and the Changing Childbirth Report (CCR) (DH 1993a) which were a cornerstone of change. Findings discredited the view of childbirth as pathology, asserting that childbirth is a normal physiological process for the majority of the women. The proposals in these reports sought to shift the provision and delivery of maternity services from 'technological childbirth' towards 'natural childbirth', redressing the power balance between the medical profession, women, and midwives. The CCR made far-reaching recommendations, placing the woman at the centre of care, proposing continuity and choice of care, making place of birth and women's right to unbiased information central tenants of maternity services (DH 1993a). For the first time, women's views and accounts were taken into consideration; their preferences and wishes were to play a part in the planning and delivery of services, serving to break "*the mould of silent subservience*" (Kirkham and Perkins 1997: xiii).

Whilst the CCR has been an influential directive, it made limited attempts to address issues of inequalities specifically concerning women from the BME communities. Although the detrimental effects of language, poor communication, and stereotyping were acknowledged, there were few recommendations; implementation has also been variable. The issues of choice, control and continuity have been the subject of much debate, but the recommendations advocated in the CCR have in fact only played lip-service to the needs of women using the maternity services (Kirkham and Stapleton 2001). Inadequate national

financial structure and lack of information for women about their choices have meant the concept of choice, control and continuity remaining a rhetoric for some women (Hunt and Symonds 1995; Kirkham and Stapleton 2001; Stapleton, Kirkham and Thomas 2002). The vision and aspirations of professionals and women have not been realised because the introduction of the proposed changes was to be 'cost neutral': there was no long-term funding attached to the proposals. The plurality of providers of midwifery and obstetrics[28] necessary to meet the recommendations of CCR did not materialise. Once the pump-priming financial funding was used, many of the innovations were terminated, leading to a reduction in practising midwifery units. There was a growth in large obstetric led units primarily "*to save money and improve patient safety*" (Bosanquet et al 2005: 12), and maintenance of the 'status quo' by powerful medical professional interests (Currell 1996) promoted centralisation of maternity services.

The juncture of twentieth and twenty-first century has seen a number of government directives to modernise the NHS (DH 1997, 1999, 2000), calling for major systems reforms (DH 2006a, 2006b), and proposing the shift of services from hospitals into the community, thereby giving patients a voice, with more choice and more control. Central to these reforms is the commitment to place patients at the heart of the way the NHS is organised (DH 2000, 2004b), but, it is unclear how the move toward centralisation will offer this 'expanding choice' for women and their families.

### 3.4. The culture of the NHS

Midwives have harnessed the above changes and capitalised on the opportunities, expanding and extending their new roles in providing care for women in medicalised and technological environments, but this has been at the expense of eroding their competence in normality (Robinson et al 1983; Donnison 1988) and their well-being[29] (Sandall 1995; 1997). Midwives are now increasingly working in an environment influenced by policies and guidelines to deliver maternity services in a safe and evidence-based environment. The

[28] Some of the examples of plurality of providers are midwifery-led units, obstetric-led units, team midwifery schemes and models of care for normality.

[29] The implementation of modernised care models such as working in teams has meant different working patterns, involving midwives often working longer hours that are likely to cause stress.

impact of many policy directives[30] has been to control clinical practice through a number of organisations[31], so risk management, clinical governance, quality assurance, and transparency have now become the new lexicon of the operating environment, leading to uniformity of provision which is often paradoxical to individualised care. As a result, many midwives working in the hospital and community setting experience organisational and cultural pressures, providing care for women and their families in an oppressive and defensive environment (Stapleton et al 1998; Kirkham 1999; Ball et al 2002; Deery 2003; Kirkham and Stapleton 2004; Kirkham et al 2006), and subsequently develop "*obedient behaviours*" resulting from either "*an obligation to follow hospital policies*" or "*fear of consequences from challenging senior staff*" (Hollins Martin and Bull 2006: 5).

The culture of midwifery has developed in gendered institutions with gender shaping the behaviours, attitudes, roles and distribution of power within hierarchically structured organisations (Davis 1995) and patriarchal systems (Doyal 1995; Ehrenreich and English 1979; Oakley 1976; 1980; 1984; 1993; Witz 1992). Midwives, predominantly women, have been culturally excluded from "*exercising of authority*" (Hunt and Symonds 1995: 35), employed in hierarchical systems of masculine domination occupying relatively low hierarchical positions against the backdrop of their struggles of professionalisation (Kirkham 1996; Heagerty 1996; Hearn 1982). This operating culture limited midwives' ability to exercise their power and authority only to the private sphere of their work (Hunt and Symonds 1995; Kirkham 1999). They were expected to conform to organisational needs where there was a lack of both support and good role models (Kirkham 1999). The masculinised organisational culture, coupled with the medical model of obstetrics has been oppressive; in fact midwives' behaviour patterns mimic those of oppressed groups (Freire 1970; Roberts 1983; 2000; Stapleton et al 1998; Kirkham 1999; Kirkham and Stapleton 2001; Deery 2003). They internalise the values and behaviours of their oppressors and in turn use them to oppress and bully their subordinates, peers, or clients (Freire 1970; Roberts 1983, 2000; Ball et al 2002) - a form of 'horizontal violence' (Leap 1997).

[30] Some of the examples of such policies are the NHS Plan (DH 2000), the Kennedy Report (Bristol Royal Infirmary 2001) and The Victoria Climbié Inquiry - the Laming Report (DH 2003).
[31] Examples of such organizations are the National Institute for Clinical Excellence, the NHS Litigation Authority, the National Patient Safety Agency and the Healthcare Commission.

The overall impact of the above changes is that midwives have been working for some time within a complex and demanding environment (Mackin and Sinclair 1998; Sandall 1997; 1999). They are working under great pressure, having to juggle a number of competing priorities, and are constantly racing against time (Kirkham and Stapleton 2001; Deery 2003; 2005). Midwives, like street level bureaucrats, "*often spend their work lives in a corrupted world of service*" (Lipsky 1980: xiii) and "*are constantly torn by the demands of service recipients to improve effectiveness and responsiveness and by the demands of citizen groups to improve the efficacy and efficiency of government services*" (Lipsky 1980: 4). The context in which midwives work is polarised; the way in which they wish to work is inhibited by the organisational culture. The policy directed by the government is thus in conflict with reality.

Despite this, midwives embrace a number of "*coping mechanisms*" (Lipsky 1980: 19) to manage pressures which inevitably affect service delivery. Midwives manage their clients on a "*mass basis since work requirements prohibit individualised service* [....] *at best* [....] *permits them to deal with public fairly, appropriately, and successfully. At worst, they give favoritism, stereotyping, and routinising...*" (Lipsky 1980: xii). Care delivery is routinised and often rationed: antenatal services are centralised and women are required to attend antenatal clinics instead providing home visits; communication of information often depends on assumed knowledge and understanding, or is dependant on the time available (Kirkham, Stapleton, O'Cathain and Curtis 2001). This culture can affect the midwife-woman relationship by controlling or silencing women and achieving compliant behaviour through managed consent. In addition, to negotiate work pressures, street-level bureaucrats also modify their own expectations, values, attitudes and behaviours. There are many midwives who are becoming frustrated with working within the constraints of the organisations and workloads, and those who are unable to give women the best care in the way advocated by the government proposals are either leaving the profession or working independently (Ball et al 2002). Those midwives who continue to work within the environment where there is conflict between ideals and practice are likely to experience stress and/or burnout (Lipsky 1980, Sandall 1995; 1997).

### 3.5. Seeking women's views

Recognition of the importance of consumers' views as part of the evaluation and planning of health services is not new (Locker and Dunt 1978)[32], however it has gained greater prominence over the last two decades. Consequently there is an extensive body of literature, seeking views of women who have experienced midwifery services. Many studies and surveys focus on the views of White women (Cartwright 1979; Oakley 1979; Reid and Garcia 1989; Audit Commission 1997; Proctor and Wright 1998; Gibbins and Thomson 2001; Green et al 2003). There are some that seek views of SA women[33] (Woollett and Dosanjh-Matwala 1990a; 1990b; Bowler 1993a; Bowes and Domokos 1993a; 1996a; Katbamna 2000; Dartnall et al 2005), some that focus on women from East-Asia, or those seeking asylum, and some that focus on those from black African and African-Caribbean communities (Larbie 1985; Harper - Bulman and McCourt 2002; Mcleish 2002; Neile 2003); a few have made attempts to compare views of White women with those from BME backgrounds (Rudat et al 1993; Woollett et al 1995; Hirst and Hewison 2001; 2002). Additionally, women's views have been ascertained by studies evaluating new ways of organising maternity care, for example evaluation of care models (Flint and Poulengeris 1987; Farquhar et al 1996; Morgan et al 1998; Hundley et al 1994; McCourt et al 1998; McCourt and Pearce 2000; Boulton et al 2003), effectiveness studies such as evidence based leaflets (Kirkham and Stapleton 2001), or initiatives to improve access to maternity services for women from the BME backgrounds, such as an evaluation of the AMBC (Rocheron et al 1989) and of linkworker and advocacy schemes (Parsons and Day 1992; Warrier and Goodman 1996).

Views of some women, including those from Pakistani backgrounds, are underrepresented and often inappropriately researched (Ahmad 1993; Douglas 1994; Baxter 1996; Bowes and Domokos 1996a). Where research has sought the views and experiences of these women, it has not informed midwifery practice in any significant manner, muting their

[32] Patients' views of nursing care and their experience with hospitals were explored as early as 1960s, for example see McGhee (1961) and Cartwright (1964; 1967).

[33] I have intentionally not cited studies conducted in the early 1980s for example Homans (1980) and Currer (1986), the assumption being that the new ways of organising maternity services as well as the preparation of midwives should have enhanced service provision and delivery. However it is disturbing that little appears to have changed in the way women from SA backgrounds experience services. The findings of the above studies demonstrate that many of the issues persist.

voices (Ardener 1975). Often the study designs exclude women from the BME communities, perhaps, women whose spoken and written English skills are less developed are unlikely to participate in postal surveys[34] that utilise self-completion questionnaires. Based on this assumption, it is also possible that researchers actively exclude the women from surveys (see van Teijlingen et al 2003: 77). Similarly, in studies utilising interviews for data collection, some researchers exclude consumers whose first language is not English, on the basis that they may not provide a rich account or may cite reasons such as lack interpretation resources or concerns about the accuracy of interpretation and translation (Newell 2004). In many studies the response rate from women from the BME communities forms a small percentage of the larger sample, and it is impossible to make any meaningful conclusions, hence their 'voice' remains unheard. It is unclear whether the practice of obtaining views of women from the BME communities is likely to change[35].

Given that women's views are used as measures for the evaluation of maternity services (DH 1998a), commissioners and provider units are unlikely to have a full picture when views of some groups are under-represented. If NHS organisations do not effectively identify the views of women from diverse backgrounds then it is unlikely that maternity services will respond adequately and appropriately to the needs of all its consumers.

Findings of large-scale studies suggest that the majority of women express satisfaction with maternity services (Audit Commission 1997; Green et al 1990). However, this is not the case in more specific studies, where women's testimonies of their experiences make disturbing reading. Some, however, are sceptical about the findings, particularly with the overwhelming satisfaction levels against a background of variability of quality of services, and suggest that it is possible that the satisfaction surveys are measuring other concepts rather than satisfaction (Baker and Whitfield 1992; Fitzpatrick 1993). It is possible that

[34] The exception here is a national postal survey by Jacoby (1988) to explore views of women regarding information and advice they receive during pregnancy and childbirth. The sample size in this study was 1508 and of this 43 percent of the responses were from white women, 24 percent from Asian women and 31 percent from other ethnic groups.

[35] Currently the National Perinatal Epidemiology Unit is conducting a postal National Survey of Women's Experience of Maternity Care which is funded by the Department of Health and Healthcare Commission; the report is expected in early 2007. Personal communication confirmed that the overall sample size for the survey is 4,800, a return rate of 62 percent (2,966 completed returns) and women from the BME communities make up 13 percent of the respondents (Rowe 2006). In absence of published material from this survey, it is difficult to make any comments but it is unclear whether any meaningful analysis can be drawn.

patients do not describe their encounters with health services in terms of dissatisfaction as they may be grateful for the service and reluctant to criticise the NHS (Fitzpatrick and Hopkins 1983). Although studies of satisfaction have raised important issues, they have posed many methodological challenges in terms of sampling, and data collection and analysis (Shearer 1983; Lumley 1985; Bramadat and Driedger 1993). Of those who have examined dissatisfaction (Mulcahy and Tritter 1994; 1998; Annadale and Hunt 1998; Coyle 1999), some found that participants were far more exact about the sources of dissatisfaction than satisfaction (Mulcahy and Tritter 1998). Studying dissatisfaction in midwifery would be timely, however, this idea may not be acceptable, as the NHS organisations do not want negative publicity. Notwithstanding this, to assess the quality of services both positive and negative dimensions of women's views are important, as targeting areas where specific aspects of care were poor, enables commissioners and provider units to improve maternity services.

The findings on ethnic differences in maternity experiences are variable among studies. A possible explanation for this may be that women are not a homogenous group; they are differentiated by ethnicity as well as other factors such as socio-economic, education and poverty, so the variability of their experiences and concerns should not be surprising. Often studies, group together responses from women from the BME backgrounds, owing to small numbers of responses, concealing the variations amongst the different ethnic groups (McCourt and Pearce 2000; Singh and Newburn 2000). Where studies have made an attempt to compare women's views of maternity services between White and other ethnicities, they have reported that SA women's views are not just different from those of White, African-Caribbean, and Black African women but there are also a number of variations between Pakistani, Indian and Bengali women (Rudat et al 1993; Katbamna 2000). It is apparent that women tend to answer questions about what they want based on what they have experienced, therefore maternity service providers must consider this when using such findings in making decisions about service/care models. For example van Teijlingen et al (2003) report that women are more likely to favour the care that they have received, and if their opinion is sought on a care model that they have not experienced, they are likely to respond to it less favourably. Others assert that health service users are "*fairly uncritical and assume that whatever system of care they are receiving has been well thought out and is probably the best*

*one. The women tend to accept and be satisfied with whatever care arrangements they experienced and to prefer them to alternative possibilities. They were conservative in the sense of saying that 'what is, must be best'"* (Porter and Macintyre 1984:1198).

Whilst many SA women are satisfied with the maternity services, there are others who are not (DH 1992; 1993a; Audit Commission 1997; Garcia et al 1998; Singh and Newburn 2000). Many of the criticisms of maternity services are common to all women. Lack of involvement in decision making, lack of adequate information to make informed choice, inability to carry out their and their partners' wishes and poor attitude of the staff are cited as problematic by women from all ethnicities (Rudat et al 1993; Kirkham and Stapleton 2001). However, it is the persistence of wide variation in the quality of service provision among different community groups that is of concern. Some women, particularly those from diverse backgrounds such as the BME communities, express greatest dissatisfaction with the care they have received throughout childbirth, proposing that they are more likely to receive less favourable treatment because services fail to take account of their linguistic, faith and cultural needs, and furthermore they are more likely to experience additional difficulties owing to stereotypes and discrimination (Phoenix 1990; Woollett and Dosanjh-Matwala 1990a; 1990b; Bowler 1993b; Bowes and Domokos 1993; 1996a; 1996b; Katbamna 2000; Dartnall et al 2005).

The consequence of this variation in the experience of maternity services is quite serious, particularly in terms of maternal and perinatal mortality and morbidity. The variation of these rates between women from the BME communities and their white counterparts has not declined despite overall improvement in the rates of maternal and perinatal mortality and morbidity, suggesting that many women from the BME communities do not enjoy equality of access to the same care (Parsons et al 1993; Acheson 1998; Lewis 2004). It is possible that amongst many other factors "*the availability of good medical care tends to vary inversely with the need for it, in the population served*" (Tudor-Hart 1971: 405).

## 3.6. South Asian women's experiences of maternity services

### ..... Communication .....

Whilst not all SA women make negative comments about communication (Hirst and Hewison 2001; 2002), it is perceived as one of the most common barriers, which denies SA women effective access to equitable maternity services (DH 1993a; 1993b; Bowler 1993a; Bowes and Domokos 1993; 1996a; Gerrish et al 1996; Garcia et al 1998; Katbamna 2000; Lewis 2001; Dartnall et al 2005). Many organisations have attempted to overcome difficulties through employing interpreters, advocates, and link workers, but the models of provision are variable (Rocheron et al 1989; Mason 1990; Parsons and Day 1992; Hoare et al 1994). Such initiatives have proved invaluable in organisations that have ensured maternity services are more accessible to SA women, but maternity services continue to struggle to meet the communication needs of women. However, there are still some organisations and midwives who believe the problem of communication lies with the women and, worse, that this problem is associated with culture: women are 'not willing to learn to speak English' or 'men do not want their women folk to learn English'[36], thereby pathologising SA cultures (Brah 1992).

Midwives acknowledge that caring for women who are unable to speak English fluently is problematic (Reynolds and Shams 2005), and often these women are left feeling frustrated and angry (Bowler 1993b; Sivagnanam 2004). Midwives fail to develop 'good relationships' with women, particularly when there is lack of feedback, possibly compromising the quality of care (Sivagnanam 2004). It is likely that midwives project these attitudes when providing care to SA women; women's testimonies acknowledge that poor attitudes of midwives and poor relationships prevented them from making any real choices and decisions and marred their experience of childbirth (Bowler 1993b; Bowes and Domokos 1993; 1996a; Katbamna 2000; Singh and Newburn 2000; Dartnall et al 2005). It is likely that because of communication difficulties midwives are unable to provide holistic

[36] In chapter 2, section 2.3, reference was made to the way Pakistani women have been constructed as dependents of men – wives, daughters and mothers, and not as waged workers, unlike many African Caribbean women and some Indian women who had entered Britain in their own right as a result of recruitment drives. Similarly Asian family structures have been pathologised, projecting Asian family life as a problem (Parmar 1981). Asian women, including Muslim women, are perceived to be 'docile', 'passive' and oppressed, and controlled by the long standing 'traditional customs and practices and 'domineering' men (Brah 1992: 64).

care; they are only able to provide the physical aspects of care, and women's emotional and psychological needs are less likely to be addressed. It is possible that when communication and language is ineffective both the midwives and the women are left frustrated, resulting in negative experiences and a potentially poorer quality of service. It is therefore possible that such negative experiences 'put women off' accessing maternity services.

**..... Information needs .....**

All women need information that is evidence-based, enabling them to make informed decisions about their care. Whilst many women are satisfied with the information provided during childbirth experiences, many are not (Singh and Newburn 2000; Kirkham and Stapleton 2001; Kirkham 2004). Many SA women profess that they have difficulty in obtaining information and making their wishes understood (Bowes and Domokos 1996a; Katbamna 2000; Singh and Newburn 2000; Richens 2003; Sivagnanam 2004). It is possible that these issues, together with factors such as discrimination, contribute towards SA women being less successful in accessing health care and maternity services than the white indigenous population.

Those women who experience language and communication difficulties have a tendency to be less confident and less familiar with the maternity services, remaining unaware of the range of maternity services and choices available to them (Woollett and Dosanjh-Matwala 1990a; 1990b; Bowes and Domokos 1993; 1996a). They not only encounter difficulty in finding information in the appropriate language and format, but often they are offered little or no information regarding options of care during pregnancy and labour (Turner 2002; Sivagnanam 2004). Lack of appropriate information has meant that the women have not been adequately prepared for their pregnancies and labours, affecting their decision making and sense of personal control (Hemingway et al 1994; Narang and Murphy 1994).

**..... Appropriate and sensitive maternity services .....**

Many SA women report that midwives and maternity services respond to their needs for privacy and dignity, however there are others who claim that the quality of maternity

services offered to them is often inappropriate and insensitive (DH 1993b; Ullah 1994; Bowes and Domokos 1996a; 1996b; Katbamna 2000). Some of the experiences cited are refusal of the option to see a female doctor (Ullah 1994; Sivagnanam 2004), lack of rest and recuperation from birth (Woollett and Dosanjh-Matwala 1990b). Women postulate that services are not appropriate, with advice based on traditional British norms. For example, dietary advice, health education and parenthood education is often cited as culturally insensitive (Katbamna 2000). Indeed midwives often claim that their lack of knowledge and understanding of cultures, lifestyles and faith requirements of the women they serve is a barrier to effective care. Unless midwives are equipped with basic information relating to faith and cultural practices, it makes it easier for them to make assumptions based on inaccurate generalisations and stereotypes (Gerrish et al 1996). Whilst there is a plethora of information on diverse cultures, customs and religions these 'tool kits' and 'cook book recipes', unless critically consumed, can serve to perpetuate stereotypes and provision of generalization service.

In many studies SA women have stated that maternity services are inadequate because there is a lack of bilingual staff who can assist with communication, denouncing maternity services for being insensitive, particularly when relatives or friends are used as interpreters during sensitive consultations (Ullah 1994; Bowes and Domokos 1996a; 1996b; Katbamna 2000; Sivagnanam 2004). Whilst most SA women prefer to be seen by a female practitioner, some accepted being seen by a male practitioner. However many Muslim women, particularly those who observed purdah, were likely to be distressed in circumstances when they were examined by male practitioners (Ullah 1994; Katbamna 2000; Sivagnanam 2004).

Some women have reported that services respond inappropriately to their cultural and faith prescriptions (Bowes and Domokos 1996a; 1996b; Katbamna 2000; Sivagnanam 2004), citing unacceptable examples such as parent education sessions where women and their partners are positively encouraged to attend jointly (Katbamna 2000). This is a form of institutional racism[37] when the practices and policies of an institution unintentionally produce

[37] Institutional racism is "when a requirement or a condition which applies to everyone has the effect of excluding a significantly greater proportion of people from a particular racial group than others, because they cannot comply with the

disadvantage or a poor outcome for some of the service users (CRE 1994). On the whole, the needs of the majority of women from the SA communities are met less effectively and the services fail to take into account the needs, desires and lifestyles of women from diverse backgrounds.

### ..... Stereotyping and discriminatory services .....

Stereotypes[38], prejudice[39], discrimination, and racism can effectively serve as a barrier in the provision of equitable service provision. The corollary of prejudice can be quite serious, which could effectively deny the individual or the group equal access to services. For example, a midwife may hold an inaccurate assumption that Asian women cannot read English or their own language; based on this belief, the midwife may make a decision to withhold distribution of informational leaflets to Asian women, so that Asian women are not aware of the services available to them.

Stereotyping is a basic sense-making process where use of labelling and typification is commonly made during first interaction. Stereotypes assist individuals to make sense of a dearth of information quickly so that appropriate behaviour is adopted to facilitate interaction (Macintyre 1978; Green et al 1990). Midwives are therefore likely to make use of stereotypes to help them make decisions about the kind of care a particular woman is likely to want (Macintyre 1978; Green et al 1990). Whilst there is some sympathy with this view, midwives' continued lack of knowledge - which contributes to the formation of stereotypes - is concerning (Gerrish et al 1996; Neile 1997) particularly where stereotypes shape the type and quality of care delivered to the women. For example, providing care based on the

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rule" (CRE 1994: 22). However in 'The Stephen Lawrence Inquiry, Sir William Macpherson develops this definition and asserts that institutional racism is "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantages minority ethnic people" (Macpherson 1999: 28). If the rule cannot be objectively justified and it is disadvantageous to the excluded person or group then it is unlawful.

[38] A stereotype on the other hand is "an exaggerated belief associated with a category. Its function is to justify (rationalize) our conduct in relation to that category" (Allport 1954:187). The use of categories is to assist the separation of humans into groups, who are then described in terms of the characteristics they share.

[39] Prejudice is "a hostile attitude towards a person who belongs to a group simply because he belongs to that group, and it therefore presumed to have objectionable qualities ascribed to that group" (Allport 1954:8), often an unfavourable opinion or feeling about another individual is formed without knowledge, thought or reason. More than often these opinions or assumptions are based on personal beliefs, where stereotypes are operating at an unconscious level, and can be destructive (Allport 1954).

assumption that SA women have low pain threshold led to a disturbing consequence in that midwives often withheld pain relief from SA women whom they considered were neither in real need nor deserving of such care (Bowler 1993a); because of the belief that SA women live in extended families, healthcare professionals assume that they do not need support for parent education, bereavement and counselling (Woollett and Dosanjh-Matwala 1990a). SA women perceive these stereotypes in practice and report that midwives are dismissive of their needs and women were seen to be making a fuss about 'little things' and are treated as if they have "*Asian woman syndrome*" (Sivagnanam 2004: 20). Such encounters with health services negatively affect the women and, coupled with stories from within the community, women have a tendency to develop preconceived fear and apprehension towards maternity services and healthcare professionals (Dartnall et al 2005). They become fearful of being "*labelled or judged*", of being "*disapproved by healthcare professionals*", seen as "*baby-making machines*" and of "*discrimination*" (Dartnall et al 2005: 23-25).

Typification and labelling of health service users are key components in health settings and a feature of street-level bureaucrats, however "*the particular difficulty with labels* [....] *is the characteristics on which they are based...*" (Lipsky 1980: 69). Kelly and May (1982) have provided an extensive literature review of 'good' and 'bad' patients. Much of the work isolates traits, behaviours or qualities that form the basis on which a patient is categorised as 'good' or 'bad'. Johnson (1997) however argues that "*social evaluations are not in any clear way tied to traits or variables which patients do or do not possess. Rather, evaluations of people* [....] *are socially constructed in relation to a complex web of powerful social influences*" (page 92). "*The term social judgment* [that is, judgement of the social worth of one person by another (page 92)] *is preferable because it has within it the possibility of variation and change ..... Good and bad are useful descriptors, but betray any notion of subtle variation in an individual's label and in variability between individuals*" (Johnson 1997: 93).

Prejudice and stereotype are linked with the concept of ethnocentrism[40]; although the term is neither positive nor negative, in healthcare it is often used to ascribe a negative

[40] Ethnocentrism is defined as "the view of things in which one's own group is the centre of everything and all others are scaled and rated from it" (Sumner 1906: 13).

connotation. Ethnocentrism is frequently seen as a belief or a feeling that one's way of life and worldview is superior to others (Leininger 1978; Thiederman 1986). Ethnocentric tendencies affect nurse-patient relationships where healthcare practitioners view and evaluate others from their own worldview (Leininger and McFarland 2002). When healthcare practitioners value their own culture more highly than that of other ethnic groups, perceiving their cultural ways to be the best, they devalue and belittle other ethnic groups and perceive others' cultures as bizarre and strange. Ethnocentric behaviours could in fact lead midwives to ignore or dismiss cultural requirements of women from the SA groups as being unimportant, hindering the delivery of responsive and sensitive care. This would serve very little to meet the tenets of woman centred care.

### 3.7. South Asian women: as the 'Othered'

In many of the above studies the use of terms such as 'them' and 'us' was cited, demonstrating a form of marginalisation known as 'Othering', serving "*to mark and name those thought to be different from oneself*" (Weis 1995: 17). Othering is a process through which people construct their own identities in reference to others in a way 'us' is superior and 'them' is constructed as of inferior status (Said 1985). Within the discourses of gender, a woman is seen as Other and it is the black person as the Other in 'race'. SAs have been constructed as the 'Other' over time (Ahmad 1993); they were seen to have a culture that was different from 'us'. They "*represented the epitome of the outsider[s]... constituting an antithesis of the 'British way of life*" (Brah 1996b: 23), undesirables who 'smelled of curry' ..... wore 'funny clothes', lived 'packed like sardines in a room' ... [and] practised 'strange religions', and recently Muslim people in particular are seen as the 'Other', the terrorists[41]. These, as well as the external physical characteristics, are markers that form the basis of Otherness, and the tendency is to focus on the differences between 'them' and 'us', ignoring individuality. So, SA women's inability to access maternity services, overcome communication and language barriers and their failure to comply with care is the result of their customs and traditions conflicting with those of the British maternity services. There is a possibility that 'Othering' practices may reinforce and reproduce positions of dominance and

[41] Please see footnote 19 on Islamophobia in Chapter 2.

subordination (Fine 1994) when the individual who is being treated as the 'Other' experiences marginalisation and is excluded from enjoying the opportunities.

Racial discrimination in the maternity services is well documented and plays a key role in the way maternity services are provided and delivered (Phoenix 1990; Johnson 1993; Stubbs 1993). However, reference to racial discrimination here serves to remind of the presence of institutional racism, which leads to the embodiment of discriminatory practices and differential access to aspects of health care for people from SA backgrounds. Phoenix (1990) examines how discrimination is institutionalised in maternity services with particular reference to issues of reproduction, where attempts to reduce the fertility rate of women from the BME communities can be seen as a form of covert discrimination. She demonstrates how negative stereotypes about women from diverse communities such as they 'have too many children', 'breed like rabbits', 'drain the resources' and 'swamp British culture' feed into institutions' practices and policies and disadvantage certain sectors of the community.

Findings of many studies involving women from a wide range of BME communities cite that women often provide testimonies about some form of discrimination when accessing maternity services (Phoenix 1990; Woollett and Dosanjh-Matwala 1990a; 1990b; Douglas 1992; Bowler 1993a; Bowes and Domokos 1993; 1996a; 1996b; Ullah 1994; Katbamna 2000; Neile 1997; 2003; Ellis 2004). Whilst some forms of discrimination are subtle and difficult to identify, others such as discriminatory attitudes, racist and derogatory comments and hostility, are not[42]. Midwifery care based on such beliefs and values is most likely to affect the standard of care and support which SA women receive, and together with poor reception and handling of some of the women, is likely to leave them humiliated. This experience together with the inflexibility of the maternity services may potentially hinder SA women from making full and confident use of NHS provision. Where women are left feeling marginalized and humiliated they are unlikely to exercise control and choice over the care they receive.

[42] This is a form of direct discrimination, which is racism at an individual level. Direct discrimination is a process whereby one person is treated less favourably than others on racial grounds. A hypothetical example of this is that the ward manager informs only white women on the ward of extending the visiting hours and not the SA women as she does not want too many visitors. Another example of individual racism is where a health care practitioner does not provide translating or interpreting services because she/he believes that whilst in England everyone should speak English. This will in fact lead to poorer quality of service.

## 3.8. Gaps in the literature

Expressed satisfaction and maternal and infant clinical outcomes for many SA women are poorer than their white counterparts. In Chapter 2 an outline has been provided of policy response to the health needs of the BME communities. However, despite policy initiatives and guidance, Britain's maternity services continue to be denounced for being insensitive and for failing to adequately take account of the linguistic, faith, and cultural needs of many of its SA women. The government proposals and the NHS reforms advocate maternity services to respond appropriately, and 'markers of good practice' (DH 2004a) can be achieved by empowering women, enabling them to work in partnership with midwives, make informed decisions, and be in control of the care they are to receive. However against the limited progress made over the last two decades and in light of continuing communication and language difficulties, lack of information, and experiences of discrimination and racism, it is possible that issues of informed choices, control and empowerment will remain a myth for many SA women.

Identifying literature that examined experiences and views of Pakistani women concerning maternity services was difficult because many studies made the use of the term 'South Asian'[43] or 'Asian'. Where studies did state the ethnic composition of their sample, they have not reflected ethnicity when reporting findings (Woollett and Dosanjh-Matwala 1990a; 1990b). Of the studies that examined maternity experiences of SA women, the majority focused on either antenatal of postnatal experience (Woollett and Dosanjh-Matwala 1990a; 1990b; Katbamna 2000; Singh and Newburn 2000), the exception being Bowler (1993a; 1993b). Given the number of people from Pakistani[44] background residing in Yorkshire and the Humber, then it makes business sense - as well as being a matter of social justice - to elicit the positive and negative maternity experiences of Pakistani women so that maternity services may respond to their needs.

[43] Footnote 19, in this Chapter, provides a rationale for the use of generic term South Asian.

[44] The proportion of the non-White population of the UK residing in Yorkshire and the Humber is approximately 7 percent. The largest BME group in the region is Pakistani, accounting for nearly 3 percent of people, which is twice the proportion across England as a whole (1.4 percent). There is, however, inter-regional variation - for example local authorities such as Kirklees and Bradford have a higher proportion of minority ethnic groups when compared to that of the whole country.

## 3.9. Summary

In this chapter contextual background has been provided, specifically outlining the provision of contemporary maternity services, focusing on the recent developments within maternity services that have resulted in response to social, political, economic and technological factors. Finally, I have explored the maternity experiences of SA women; it would have been relevant to explore maternity experiences of Pakistani women, however, there is a lack of literature that looks at specific minority ethnic groups. Where studies attempt to investigate Pakistani women, much of the literature focuses on other SA groups as well.

Women's experiences are shaped by the social context of organizations in which they birth. The current midwifery context is a kaleidoscope of complexities, for example there are recruitment and retention challenges, midwives are constrained by organisations' demands and as such are unable to provide the best care that women deserve, or even have time to provide women with adequate information so that they can make informed choices. Midwives experience work-based stresses that emerge from conflicts between ideals and reality, resulting in 'burnout' and loss of experienced and committed staff.

Although many women from both white and the BME backgrounds are satisfied with maternity services, many are not. Usually, it is women from the middle classes who are able to take full advantage of the facilities offered by the NHS because they can articulate their preferences (Beech 1991). For many, in particular SA women, accessing and utilising services is a challenge mainly because many are less confident, and experience communication and language difficulties. For women whose first language is not English, asserting their wishes, and exercising choice and control over their care becomes difficult, if not impossible.

The government's quest for the provision of high quality, individualised care requires women to be involved in the planning of their care and to work in partnership with the professionals in choosing the care they receive, as well as being in control of what is happening to them (DH 1993a; 2000; 2004a). Achieving this is a complex issue, particularly in a multiethnic society where consumers of midwifery have diverse health needs. Women are not a

homogenous group; they are from a wide range of diverse backgrounds that differ from each other in terms of culture and ethnicity. NHS organisations need to ensure that their services are flexible in order to respond to individual needs of the women and their families; they need to listen to women's views, respect their ethnic, cultural, social and family backgrounds, and communicate effectively with them, above all treating them as equal partners in planning, delivering and evaluating services.

# Chapter 4

## Journey through research design: moving from methodology to method

> "....And so we look for the pieces of the story, the way of telling it, and the elements that will make it whole, but it hasn't come to us yet. So we are now the ultimate bricoleurs, trying to cobble together a story that we suspect will never enjoy the unity, the smoothness, the wholeness that the Old story has. As we assemble different pieces of the Story, our bricolage begins to take not one, but many shapes".
>
> **Lincoln and Denzin (1994:584)**

### 4.1. Introduction

In this chapter, I illuminate the research methodology and design. Central to the discussion are four key elements: philosophical assumptions, theoretical framework, methodology and methods that have shaped the study's design. The philosophical assumptions of this thesis are aligned with the constructivist paradigm; it both draws on this discourse and to some extent critiques it. The theoretical framework is symbolic interactionism, and I engage with Critical Inquiry and Feminism. These philosophical and theoretical frameworks have informed the methodology of interpretive ethnography, and I engage with qualitative methods for data collection, namely those of participant observations and interviews. First, I will consider the philosophical and theoretical framework of the study and then discuss how this approach underpinned the selected methodology.

### 4.2. Research paradigms

A paradigm is a conceptual model used to guide research, deeply embedded in the socialisation of adherents and practitioners', telling them what is important, legitimate and reasonable (Guba and Lincoln 1994). Researchers' philosophical beliefs and principles guide and influence their actions in terms of how they should see the world and how it should be understood, including how it should be studied. Researchers

therefore approach their studies with certain beliefs or a 'worldview' that guides their research, including guiding the choice of research question, approaches to data collection, and interpretation. As these sets of rules play a central part in the research design, researchers must actively engage with philosophy, theory and methods in the planning and conducting research (Mason 2002; Crotty 1998).

## 4.3. Philosophical assumptions

Methodology refers to the way in which qualitative researchers conceptualise the nature and reality of the social world, and deliberate over the way in which it can be known (Strauss and Corbin 1998); methodology is underpinned by the philosophical assumptions guiding the research study. The three key assumptions are ontology, epistemology and methodology (Guba 1990); Table 4.1 summarises the philosophical assumptions of the researcher and their impact on the practice of research.

The constructivist paradigm was chosen as the philosophical base for this study as it proposes a relativist view of reality (Greene 1990; Guba and Lincoln 1994). My ontological assumption in this thesis was underpinned by a relativist viewpoint, asserting the belief that there are many realities where assumptions, meanings and actions are interpreted and constructed by individuals (Guba and Lincoln 1994). Within this study there are the different realities constructed by women, service providers (midwives and interpreters), the researcher, and subsequently the realities of my audience. Indeed, the construction of realities is likely to change according to context for each woman, being influenced by social, political and economic factors. There are no absolute truths, but constructions are built and interpreted by individuals in their social context (Guba and Lincoln 1994). However, there may be many aspects that are shared between individuals and often between cultures (Guba and Lincoln 1994). In order to gain understanding and attach meaning to the situation or reality as seen by the participants, the researcher is required to enter into the participants' world. Based on these beliefs, I rejected other approaches such as positivism, where the ontological assumption is one of a 'realist', reductionist view of reality, a perspective suggesting there is a real world 'out there', driven by indisputable laws which can be studied and understood independently of time and context (Guba and Lincoln 1994).

**Table 4.1: Philosophical assumptions and their implications for practice of research**

| Assumption | Explanation | Question | Characteristics | Implications for Research Practice |
|---|---|---|---|---|
| Ontological | Concerned with the nature of reality or the nature of the knowable. It is concerned with existence and the nature of those things that exist (Williams and May 1996). | What is the nature of the phenomenon or entities or social reality under investigation? | Reality is subjective and multiple, as seen by participants in the study, and is constructed by those who are involved in the research situation. | Researcher uses quotes and themes in words of participants and provides evidence of different perspectives. Reporting the realities. |
| Epistemological | Concerned with the relationship between the researcher and what is being researched. Is either objective or subjective, and is dependent on the ontological stance. | What is the nature of evidence of the subject of investigation? | Researchers attempt to lessen distance between themselves and that being researched. | Researcher collaborates, spends time in field with participants and becomes an "insider"[45]. |
| Methodological | Gives consideration to how the researcher can find out or gain further knowledge. | What is the process of research? | Researcher uses inductive logic, studies the topic within its context, and uses an emerging design. | Researcher works with particulars (details) before generalising, and describes in detail the context of the study, continually revising questions from experiences in the field. |
| Axiological | Concerned with the role of values within the research. | What is the role of values? | Researcher acknowledges that researcher is value laden and that biases are present. | Researcher openly discusses values that shape the narrative and includes own interpretations in conjunction with interpretation of participants. |
| Rhetorical | Concerned about the manner in which the language of research is going to be used. | What is the language of research? | Researcher writes in a literary, informal style using the personal voice, with qualitative terms and limited definitions. | Researcher uses an engaging style of narrative, may use first-person pronoun, and employs the language of qualitative research. |

Source: amended from Creswell (1998:75)

[45] Whilst development of relationships between the researchers and the participants is important for data gathering, close relationships with the participants may lead to participation impacting on data collection and similarly over familiarity may lead to bias in data collection.

The epistemological assumption underpinning this thesis aligns with social construction, adopting a transactional and subjective stance, arguing that knowledge would be created through interactions between the researcher and the participants during the process of inquiry, and not through discovery. Women participants are seen as knowledgeable experts of their own lives and it is this knowledge that I wanted to explore. While I reduced the distance between myself and the participants, I recognised that there were implications for axiological assumptions (see Table 4.1), linked with subjective aspects in terms of researcher knowledge, experience and beliefs. Throughout, in keeping with good research governance, I openly discuss the values that have influenced the narrative, as well as my own interpretations and those of the participants to explicate issues likely to impact on this study.

My methodological assumption, upon which the overall research process was conceptualised, was to work inductively by generating categories from the information gained from the participants. Categories emerging from participants offer rich 'context-bound' information that leads to patterns or theories of explanation. I worked with details before suggesting any generalisations, described in detail the context of the study, and continually followed hunches arising from experiences in the field. When entering the field I acknowledge that I was a pseudo insider; on the one hand I had professional knowledge of midwifery by virtue of being a qualified midwife and midwifery educationalist, although I was not employed within the study settings. On the other hand, I was a woman from the Asian subcontinent and a mother of two children, a user of maternity services. I consciously bracketed[46] these experiences' when entering the field because I wanted to obtain an "*emic*" (Patton 2002:267) perspective of the women's experiences. Emic perspective is about getting an insider voice on the phenomena being investigated; it is about understanding its "*language, beliefs and experiences*" (Streubert and Carpenter 1999:148). In contrast "*etic*" perspective is getting the outsiders view, focusing on knowledge and making use of pre-established categories for organising and interpreting data (Patton 2002:267). As I wanted to seek women's maternity experiences, I entered into a dialogue with the women to compare and contrast the information gained, identifying their constructs. It is the emic, woman centred account that is the driving force for the emerging categories and themes in the analysis.

[46] Bracketing is where the researchers are required to set aside their personal knowledge, beliefs and values concerning the phenomenon being examined, ensuring that data is not influenced by the researchers (Streubert and Carpenter 1999).

## 4.4. Theoretical framework

Theoretical frameworks are "*philosophical stances*" (Crotty 1998: 66) or assumptions that inform the methodology and research process, providing *"an explanation of what is going on in the situation, phenomenon or whatever we are investigating"* (Robson 2002: 61). In this section I provide the theoretical assumptions underpinning this study.

### 4.4. (i) Symbolic Interactionism

Symbolic Interactionism focuses on the nature of social interaction (Crotty 1998; Pidgeon 1996). Blumer (1969), advancing Mead's work, asserts there are three interactionist assumptions. First, human beings act towards others in terms of the meaning they ascribe to that individual; second, meanings are seen "*as social products, as creations that are formed in and through the defining activities of people as they interact*" (Blumer 1969: 5). Thirdly, meanings are a consequence of social interaction, where individuals develop meanings through an interpretive process.

Central to symbolic interaction is the principle that people act in relation to one another, taking each other's behaviour into account; understanding the social world requires interpreting human behaviour and social meanings. Meanings are expressed in terms of symbols such as language, religious objects and clothing, and are the basis for actions and interactions (Burns and Grove 2005). This suggests that social meanings are constructed and reshaped by individuals during the process of interaction, involving a two stage process of 'interpretation'. The individual first perceives that an object has a meaning then, through the process of internalisation, organises and makes sense of that meaning in order to respond (Blumer 1969). However, these interpretations are constantly under revision, so the same situation can mean different things at different times. The world of a particular individual or culture is socially constructed, and each person's action within it is inextricably linked to the meaning that person attaches to the situation (Hammersley et al 1995). This school of thought claims that human behaviour is based upon experience of the world, interpretation of this experience, and the development of social meanings that inform actions; experiences are then reviewed in the light of behaviour, and behaviour may be revised, "*.... human behaviour is constantly constructed, and reconstructed, on the basis of people's interpretations of situations they are in*" (Hammersley et al 1995:8). This suggests that meanings and

interpretations of behaviours are generated through social interaction and may therefore change.

Given that humans construct their reality, a key element in this thesis is acknowledging that Pakistani women interpret their experiences of childbirth in terms of their own social meanings, and it is this interpretation that guides their behaviour. The interactions between women and midwives takes place in a social context where both are guided by group-specific rules and behaviours; the women and the midwives are both influenced by social and cultural issues, but the midwives are also influenced by professional cultures and codes of conduct. Furthermore, there are issues of power, gender, and ethnicity that impact on the way midwives and Pakistani women interact with each other.

Here I attempted to understand the behaviour of Pakistani women through the meanings they attached to their experiences; this did not mean giving reasons for the behaviour of Pakistani women or the midwives, but rather making sense of how they interpreted the world and interacted with each other. It is essential to study the situation from the women's perspective, a standpoint that lends itself to guidance of the research by the constructivist paradigm.

### 4.4. (ii) Critical Inquiry

This theory is commonly associated with the Frankfurt school of Critical Inquiry, influenced by a number of theorists aligned to Marxist persuasion (Kincheloe and McLaren 1994). A researcher embracing the criticalist stance is one:

> *"who attempts to use her or his work as a form of social or cultural criticism and who accepts certain basic assumptions: that all thought is fundamentally mediated by power relations that are socially and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; that the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of the capitalist production and consumption; that language is central to the formation of subjectivity (conscious and unconscious awareness); that certain groups in any society are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterises contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable; that oppression has many faces* [ ...]".
>
> Kincheloe and McLaren (1994: 139-140).

At the heart of critical theory is the notion of 'production' and the 'social relationships' arising from it and these are dynamic forces that evolve within historical, cultural and social contexts (Crotty 1998). As such, this approach focuses on how subjugation and injustice shape an individual's experience and understanding of the world. The role of oppression and power is acknowledged as being fundamental to this thesis, for this reason I aligned with critical inquiry. Though symbolic interactionism is essential, I believe critical theory would encapsulate concepts of power and oppression, seeking to complement and move beyond understanding to empowering and "*confronting social justice*" (Kincheloe and McLaren (1994: 140). In this way critical research endeavours to become transformational.

**..... Power .....**

The concept of power is fundamental to the understanding of society and social relationships. Power is a complex phenomenon with multiple and diverse meanings, with no shared element apart from the name (Lukes 2005). As disparate notions are applicable to different situations, different perspectives are not analysed in this section, although they will be threaded into the fabric of this thesis. I engage with a post-structuralism Foucauldian explanation of power as it is encapsulated by the critical theory perspective (Kincheloe and McLaren 1994). Foucault (1977; 1980; 1989) offers a much more radical perspective on power, but he has resisted providing a definitive definition. He asserts that power, is not vertically transmitted through the political-economic system, with powerful individuals/groups oppressing and dominating those in less powerful situations, instead believing it "*is exercised rather than possessed; it is not a 'privilege', acquired or preserved, of the dominant class* [of which 'some have it' and 'others do not have it'], *but the overall effect of its strategic positions – an effect that is manifested and sometimes extended by the positions of those who are dominated*"[47] (Foucault 1977:26-27). Power is therefore a facet of all human interactions and all social relationships; it is everywhere with everyone caught up in the machinery, apparatus and mechanism of Power.

[47] Here Foucault rejects the Weberian and Marxist perspectives. Weber explains that power is "*the chance of man* [sic] *or a number of men to realise their own will in a communal action against the resistance of others who are participating in the action*" (Weber 1978: 926). This explanation suggests that everyone has some chance of getting their own way; however some individuals or groups have more chance of achieving this than others. In social relationships those who hold 'more of this' (power) will utilise it to achieve their personal goals despite resistance by those who have 'less of this' (power). By implication, within this perspective there exists an element of open conflict where those who hold power achieve their own goals at the expense of others through the use of personal power.

In contrast, Lukes (1974; 2005), drawing parallels with the Marxist persuasion, rejects power as a generalised social resource based on legitimate authority for the benefits of the society as a whole. The argument posed is within the political economy basis that power is considered to be held by those in society who occupy upper echelons of a social system that is normally stratified and hierarchical, and this dominant group uses the power for its own benefit at the expense of other groups. There are a number of social groups that have more power (men, rich, and white people for example) than others in society (such as women, the poor, and black people). The more powerful groups are seen to be dominant, exercising power over the less dominant and as such the "*interests of the dominant groups are in direct conflict with the interests of those subject to its power*" (Haralambos 1980: 101). Marxists therefore focus on the structure and influence of the social system, suggesting that the source of power is embedded in the economic infrastructure, a system based on ownership and production. The dominant group makes use of this power to exploit and oppress the subordinate group. Here power creates a situation of conflict. Similarly Freire (1970) draws upon the Marxist persuasion, offers a model of oppressed group behaviour, which has been referred to in chapter 3.

Although Foucault rejects the suggestion that power is negative, he accepts there is resistance to power by those on whom it is exerted. This resistance, however, remains contained within the machinery of power and causes little dissonance within the system. This is owing to the fact that the bodies are docile and obedient and as a result accommodating. Power or the effects of power are more exhibited by "*those who are dominated; power is not exercised simply as an obligation or a prohibition on those who 'do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them*" (Foucault 1977:27).

Power is in a diffuse conjoint relationship with knowledge that is fundamental to the maintenance of power. Foucault therefore claims that power is productive; it is creative rather than oppressive in the sense that it is the means whereby development of knowledge and science happens. Power, he argues, is a force that "*is exercised only over free subjects, and only in so far as they are free*" (Foucault 1892: 220), and it is the relationship of power with knowledge that is an intrinsic part of the production of truth (Foucault 1980).

Foucault draws upon prison and Panopticism[48] to develop his thesis of disciplinary society. The Panopticon facilitates surveillance and control, enabling one-way surveillance where those in authority can observe those under surveillance. The Panopticon would be "*the perfect disciplinary apparatus* [which] *would make it possible for a single gaze to see everything constantly*" (Foucault 1977: 173). However, those who are subject to this surveillance are unable to determine whether they are being observed or not. So those who are being observed are in "*a state of conscious and permanent visibility that assures the automatic functioning of power.... this architectural apparatus should be a machine for creating and sustaining a power relation independent of the person who exercises it*" (Foucault 1977: 201).

Foucault stresses the role of disciplinary power in defining different bodies and individuals on which it is exerted and it is this that influences and normalises social behaviour. Foucault goes on to argue that individuals constantly scrutinise other individuals and examine what they are doing. This scrutiny, he argues, is the 'gaze'; "*it is normalising gaze, a surveillance that makes it possible to qualify, to classify and to punish. It is through 'gaze' or 'surveillance' that information is collected about those who are to be dominated and controlled. Gaze establishes over individuals a visibility through which one differentiates them and judges them*" (Foucault 1977:184). Gaze or surveillance becomes an essential component of disciplinary power. It is when this compulsory visibility, this compulsory surveillance, is exercised on those individuals who have to be observed through invisibility that disciplinary power is operationalised (Foucault 1977). It is through such surveillance, he argues, that "*disciplinary power*" becomes "*an integrated system*" and functions through "*a network of relations from top to bottom, but also to a certain extent from bottom to top and laterally...*" (Foucault 1977:176).

[48] Foucault places a great focus on the building, the 'Panopticon', based on Bentham's design (Foucault 1977: 195-228). The Panopticon, he states is a circular building with a central tower with the prisoners' cells at its periphery. Whilst the central tower has windows opening on the inside of the building, the prison cells has two windows - one situated on the inside corresponding to the central tower and the other on the outside to permit light into the cell. Each prison cell is separated from the other by a wall, ensuring the prisoners were unable to come into contact with their fellow inmates. The net impact of this type of building is that it permits the supervisor, who is based in the central tower in good light, to observe continually each and every prisoner in the building. The Panopticon, by means of its architectural design, facilitates surveillance of inmates. Buildings based on similar designs have been used in other institutions where there exist disciplinary regimes, for example hospitals, factories, and schools.

According to this perspective medical practitioners are in a position to observe and investigate the bodies of the women, utilising power relations under the pretext of furthering knowledge. It is here that the interface of power and knowledge is evident, creating a network of power relations through and between institutions and sciences, and thus power is immersed in all social domains, being present in the "*fine texture of organisations*" (Handy 1993: 123). Within obstetrics and midwifery there are many practices that arguably are the apparatus of disciplinary power. Clinical examination of the woman, for example, brings the woman's body into visibility where it becomes an object of knowledge and is under surveillance and under the gaze of healthcare professionals.

### 4.4. (iii) Feminism

Essentially, women are at the heart of this thesis. Firstly, this study is about women who experience marginalisation at every stage of life, commencing at conception. Secondly my personal values and beliefs have been developed from feminist principles: I value women and try to understand their world and experiences and strive to work with them to place their issues on local and national agendas. It is predominantly these factors that propel me to engage with the feminist theoretical perspective. Whilst I would not claim this study is wholly underpinned by a feminist perspective, it does draw upon a number of feminist philosophies.

Although there is a range of competing theoretical explanations (Reinharz 1992; Stanley and Wise 1993), essentially feminist theoretical perspectives provide "*some kind of analysis and explanation of how and why women have less power than men and how this imbalance could be challenged and transformed*" (Stacey 1993: 50). Many have attempted to redress this imbalance of invisibility by creating a platform to raise women's voices (Belenky et al 1986) and bring about change in their subordinate position in society through "*consciousness-raising activities*" (Stanley and Wise 1993: 64).

In the 1960s there was much talk of 'sisterhood' and 'black and white' 'together, we shall overcome'. The notion of sisterhood talked of equality and common oppressions experienced by all women through the system of patriarchy. Whilst use of slogan sisterhood portrayed a sense of solidarity amongst women, there was also a sense of conflict. Black feminists have challenged much of feminist theory on the basis that it is

based on the position of white women in society and effectively ignores the heterogeneity of the women (Carby 1982; Parmar 1982; hooks 1982; 1984; Brah 1996). Parmar (1982: 237) argues that "*.... to speak of women, all women categorically, is to perpetuate white supremacy – white female supremacy – because it is white women to whom the comments are addressed and to whom the comments are most appropriate*".

However, despite black women taking an active role in the formation and function of the feminist movement, they continue to feel marginalised from their white 'sisters'. One possible explanation for differences in black women's experiences could be that they face a 'triple' form of oppression that is different from that of black men, white women and white men or indeed from that of people from the working class, in terms of sexism, racism and classism. Of course, this is not to say there is a hierarchical form of oppression, whereby one group can be more oppressed than another, but that black women are subjugated to various forms of oppression, from different levels, determined by their gender, class and 'race': "*We believe that sexual politics under patriarchy is as pervasive in Black women's lives as are the politics of class and race. We also often find it difficult to separate race from class from sex oppression because in our lives they are most often experienced simultaneously*" (Carby 1982: 213). Where black men have written about the historical context of racism, the gender dimension has been absent from their studies (see Freire 1970), so the black women are marginalized because their experiences are constructed through the experiences of others such as black men or white women, who in turn use their own experiences as a starting point. bell hooks best illustrates this in her analysis asserting that "*much feminist theory emerges from privileged women who live at the center, whose perspectives on reality rarely include knowledge and awareness of the lives of women who live in the margin ... .:. Although feminist theorists encompass a larger number of experiences, that serves to unify rather than polarize, such theory is complex and slow in formation. At its most visionary, it will emerge from individuals who have knowledge of both margin and center*" (hooks 1984: x).

Thus as white women have objected to a patriarchal account of herstories, so are black women unwilling to accept either sexist or racist accounts of their herstories. Whilst white women are willing to write their herstories in defiance against patriarchy, they failed to do so from an anti-racist viewpoint. Not only does this demonstrate white women's failure of accountability towards black women, but it also demonstrates the limited outlook they have in terms of history and the oppressive nature of white women (hooks 1984; Amos

and Parmar 1997). Although white feminists have attempted to bridge the gap in relation to class, little has been done in reference to race and racism, reflecting "*the way in which black women have been either made invisible or marginalized in the theoretical and political spheres*" (Parmar 1982: 236). White feminists have failed to realize that racism is as important for black women as patriarchy is for all women. This is not to say that there should be exclusion of white experiences, rather there must be inclusion of black experiences within contemporary feminist discourses.

## 4.5. Methodology

In this section, I chart my journey of making choices about the research methodology. Initially, I selected conventional ethnography approaches for this study to enable me to see and hear what was happening, and to obtain an in-depth understanding of the culture in which Pakistani women birthed because I surmised I could not have achieved this from simply conducting interviews with women. I also provide a rationale for digressing from my original intent to that of interpretive ethnography as events unfolded in the research setting.

The most appropriate approach identified for this study was that of interpretive ethnography because, the methodological position adopted for the research is consistent with the philosophical assumptions associated with interpretive ethnography and also because this paradigm facilitates a holistic perspective centred on the women's knowledge, experiences and feelings. Interpretive ethnography enabled me to examine the social context in which birth took place, and to explore the feelings, opinions and experiences of participants - including emerging issues - through field study. The research questions lend themselves to a qualitative approach, seeking woman-centred data and permitting me to capture and understand women's personal experiences within their social context (Denzin and Lincoln 1994; Hammersley et al 1995; Morse and Field 1998; Mason 2002; Robson 2002). Within the qualitative paradigm, researchers are able to "*explore a wide array of dimensions of social world, including the texture and weave of everyday life, understandings, experiences and imaginings of research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate*" (Mason 2002: 1). It involves studying "*things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them*" (Denzin et al

1994:2). However, knowledge is relative for humans as they use a variety of strategies to make sense of their everyday life in their search for meaning. Therefore, their reality from a qualitative perspective is considered to be subjective and not fixed and as such is open to many, often simultaneous interpretations. There are a number of dominant philosophical assumptions in qualitative research that can be used to guide the research design; these approaches are 'ethnographic', 'interpretivist', 'biographical, life history and humanist', 'conversation analysis and discourse analysis' and 'psychoanalytic' (Mason 2002).

At the beginning of my research journey it was the ethnography assumption that guided the research process, but during field work I also aligned it with the interpretive-naturalistic paradigm[49] that allowed women to be retained as the central focus of the account, bringing their muted voices from the margin to centre. This change led to my method of data collection changing from participant observations which is closely associated with ethnographic research (Denzin et al 1994; Hammersley et al 1995; Robson 2002) to that of ethnographic interviews –an approach more in keeping with that of "interpretive ethnography" (Mason 2002: 56).

However, the emphasis remained on generating thick, rich descriptions to illuminate the plurality of Pakistani women's social lives, their meanings and characteristics in three ways: by demonstrating experiences, comparing and contrasting experiences, and combining experiences as a component of describing and interpreting data (Noblitt and Engel 1991). The empirical phase drew upon the interpretive ethnographic account of qualitative research to understand and discover lived experiences of the women's encounters with the maternity services. The principal reason why Pakistani women's experiences and accounts are important to this research is that it avoids reducing or interpreting their experiences in order to fit them into the context of prevailing Western or European theories. It allows for interpretation of the data in the context in which it was collected (Woodhouse 1992), so that the reader is permitted to experience vicariously and to understand the meanings Pakistani women attach to the negotiation of their care.

[49] In order to obtain cultural knowledge, and informed by work of Mavis Kirkham and Sheila Hunt, I wanted to observe [Pakistani women's] behaviour in labour and "*inquire the meaning of that behaviour*" (Spradley 1980:7). However as I shall discuss in Chapter 5, owing to challenges of participant recruitment I changed the method of data gathering from 'participant observation' to 'qualitative interviews'.

### 4.5. (i) Ethnography: epistemology and ontology

I was attracted to the ethnographic tradition for two reasons. First, it would enable me to explore social relations and contemporary practices of organisations within which childbirth took place. Second, most importantly, an ethnographic approach would permit me to get close to Pakistani women and get 'immersed' in their culture. I believed that it would provide me with the opportunity to understand, an emic (insider's) view of participants learned behaviour in coping with labour, including their beliefs about labour and labour pain, because ethnography is "*grounded in the culture concept and seeks to understand the native's (or human carrier's) view of a cultural system*" (Aamodt 1989:40).

Ethnographic research embraces naturalistic epistemology, where the researchers attempt to lessen the distance between them and what is being researched. The findings emerge as a result of an interactive process between participants and the researchers and are grounded in participant's experience (Grove et al 1993; Robson 2002). In contrast to positivist ontology, reality is subjective and multiple as seen and constructed by those who are involved in the research situation, that is, participants and researchers. These assumptions further convinced me that ethnographical approaches would be best suited for this study so that voices of the Pakistani women remain central to this study.

It is noteworthy, however, that there is considerable debate around what ethnography is or is not. "*For some it refers to a philosophical paradigm to which one makes a total commitment, for others it designates a method that one uses as and when appropriate*" and many determine a position anywhere along this spectrum (Atkinson et al 1994: 248). Some writers assert that 'ethnography' is one and the same as fieldwork (Brewer 2000, for example), others have argued that ethnography is often used "*interchangeably*" with participant observation (see Savage 2000: 326); whilst others suggest that it is an overall tradition within qualitative research (Baszanger and Dodier 1997).

Ethnography derives from the field of social anthropology which focused on studying small communities thought to share similar cultural beliefs and practices (see Atkinson et al 1994: 249-50), and since has been widely used by a variety of disciplines, for example education and nursing. Ethnographic researchers set out to study people's

lives, describing "*ways of life of humankind*" (Vidich and Lyman 1994: 25), "*ways of life*" (Denzin 1997: xi) and "*human activities*" (Baszanger and Dodier 1997: 8). It is a form of social science research: a study of the social life, social world and other aspects of the culture of a particular group or naturally occurring social setting where participant observation and ethnographic interviews are central to research fieldwork (Hammersley et al 1995). At the heart of ethnography is that the researchers participate "*overtly and covertly, in peoples daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research*" (Hammersley et al 1995:1). The researchers gather first hand knowledge of the social processes in the 'natural', ordinary settings by examining people's behaviour and their language (Spradley 1980).

The epistemological assumption of the ethnographic methods is influenced by a naturalistic stance (Schatzman and Strauss 1973; Lofland and Lofland 1995; Skeggs 2001). The philosophical belief is that the social world has social meanings resulting from interactions and people's interpretations of those interactions, asserting that human behaviour is linked with the meaning that situation has for them; human beings' understanding and subsequent behaviour changes as they interact with others; each situation may have many perspectives and behaviours and beliefs can be fully understood within the broader context of culture and the organisational culture. Ethnographic researchers are therefore concerned with understanding the phenomena through the understanding of the people being studied and they immerse in a cultural setting to learn from people (Spradley 1979; 1980), gaining an understanding about the topic from participants' perspective (Fetterman 1998). The researchers immerse themselves in the day to day activities of the people whom they are attempting to understand, utilizing a systematic process of observing, detailing, describing, documenting and analysing the particular patterns of a culture in order to grasp the life ways of people in that culture. Subsequent to this they develop ideas from the data collected, enabling the researchers to view the "*emic perspective*" (Fetterman 1998: 20), that is, the 'insiders world'. This requires the researchers to spend considerable time in the field "*to learn what knowledge people use to interpret experience and mold their behaviour within the context of their culturally constituted environment*" (Aamodt 1989: 41); they do not take the outsider's perspective as a conventional scientist would. It is

against this background that ethnographic approach is central for gaining cultural knowledge and understanding (Dobson 1991).

Although an exact set of rules and procedures for conducting fieldwork is absent, the purpose of the study, the nature of the setting and the ontological and epistemological stance of the researcher determines the design of the study. Notwithstanding this, Atkinson et al (1994) ethnographic research is characterised by some key features. First, there is "*a strong emphasis on exploring the nature of particular social phenomena, rather than setting out to test hypotheses about them*". For example people's behaviour is studied in their natural, every day settings instead of experimental conditions. Second, there is "*a tendency to work primarily with "unstructured" data, that is, data that have not been coded at the point of data collection in terms of a closed set of analytic categories.*" This is not to say that the research is unsystematic but rather there are no pre-determined categories that are used to interpret the data. Third, the focus of the "*investigation* [is on] *a small number of cases, perhaps just one case, in detail*" and finally the "*analysis of data [that] involves explicit interpretation of the meaning and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most*" (Atkinson et al 1994: 248).

Methodological assumptions that are unique to ethnographic research have received considerable attention (Hammersley 1992; 1998). Its principle, 'naturalism', subscribes to the premise that the purpose of social research is to encapsulate social reality of the people in 'naturally' occurring settings. The 'communities' or 'settings' should not be created artificially for the research purposes and that researchers can only study social reality of people by first-hand contact with it (Hammersley et al 1995). This view is in conflict with that of positivism; naturalists argue that social reality can not be achieved by studying people in controlled environments that may be created by quantitative research, for example experiments or from data collected by quantitative instruments because what people say they do is not always compatible with what they do (Agar 1980).

Researchers adopting naturalism, like positivism, seek to minimise their effects on the actions and behaviour of the people being studied. In the naturalist perspective the researcher is the main instrument of investigation gathering data through watching,

listening, talking, experiencing and taking notes in its natural settings as it occurs and collecting accounts of situations in the participants' own words. However ethnographic researchers are viewed as a likely source of bias that must be minimised in order to safeguard objectivity. Whilst the researchers attempt to lessen the distance between themselves and what is being researched in order to obtain an emic view, they must maintain a marginal position to minimise any bias (Hammersley et al 1995; Gerrish 1997).

## 4.6. Justifying an 'interpretive ethnographic' approach

Ethnographic approaches, comprise of diverse "*perspectives and activities*" (Mason 2002: 55) mainly influenced by epistemological and ontological stances (Hammersley et al 1995) with different types of 'ethnography' located within modern, post-modern, post-structuralist and feminist explanations (Skeggs 2001). My intention here is not to discuss these but to provide a justification for selecting an interpretive ethnography approach for this study.

Consideration was given to critical methodologies such as critical ethnography and feminist ethnography as their primary intention is to change existing social structures as well as being "*concerned with bringing about human emancipation*" (Hammersley 1992: 96; Grbich 1999; Marshall and Rossman 2006). In healthcare critical ethnography as a research methodology has been used by many to understand the origins of the power structures that exist within institutions or social groups (see Dykes 2005 for example). Critical ethnography refers to "*ethnographic studies that engage in cultural critique by examining larger political, social and economic issues that focus on oppression, conflict, struggle, power, and praxis*" (Schwandt 1997: 22). Whilst traditional ethnography tends to describe groups or participants it studies and speaks for them, critical ethnography speaks on their behalf (Foley and Valenzuela 2005). It shifts the research focus from individual or group pathology to an analysis of cultural dominance and minorities. Critical ethnography focuses on power and how it is distributed within a cultural setting (Carspecken 1996; Grbich 1999) and it is based on the assumptions that "*false consciousness exists among people regarding the hierarchies of power. Society is in a state of crisis and people are dissatisfied. Society is inequitably structured and dominated by powerful hegemonic practices that create and maintain the continuance of a particular world view*" (Grbich 1999: 159). Critical

ethnography aspires to challenge the status quo and the dominant powers in society; it challenges oppression and confronts the embedded structures that overtly or covertly bring about racism, sexism, and classism as a way to speak on issues of power and equity. Whilst a critical ethnographical approach would have been appropriate for this study particularly in terms of the position people from the BME communities[50] find themselves in Britain, I rejected it mainly because the method of data collection changed from participant observation to ethnographic interviews during the course of the study. I remained mindful of a standpoint that a study of a "*culturally distinct population does not, in itself, make the research an ethnography* [...] *it is the use of participant observation within a culturally and socially defined context that is the signature of ethnography*" (Bink and Edgecombe 2003: 1029)

As the chosen data collection method changed from participant observation[51] to ethnographic interviews, the approach I adopted was that of "*interpretive ethnography*" (Mason 2002: 56). This approach "*sees people and their interpretations, perceptions, meanings and understandings as the primary data sources*" (Mason 2002: 56). The distinction between the ethnographic approach and the interpretive approach is that whilst ethnographic researchers have to be "*fully immersed in the day-to-day lives of the people being studied*" (Robson 2002: 187), interpretive researchers do not "*have to rely on total immersion in a setting*" (Mason 2002: 56). The latter explore people's view of the social world through these people rather than through observation. The interpretive approach can be used to justify interviews as a method for data collection "*where the aim is to explore people's individual and collective understandings, reasoning processes, social norms, and so on*" (Mason 2002:56).

The knowledge that findings of seminal ethnographic research by Mavis Kirkham (1983a, 1989) and Sheila Hunt (Hunt and Symonds 1995), (examination of childbirth through analysing the culture of midwifery care in the context in which it occurs) has been critical to the provision of woman-centred care, further persuaded me that this approach was most suitable for this study. It would therefore enable me to gain an insight into the Pakistani Muslim women's worldview of childbirth and have potential

[50] See Chapter 2, section 2.4. on 'Race relations' in Britain which traces the experiences of people from the BME communities in Britain.
[51] Participant observation method is closely associated with ethnographic research (Atkinson et al 1994; Hammersley et al 1995; Robson 2002).

for contributing to responsive provision and delivery of maternity service for them. Although I have adopted the interpretive approach, I remain influenced by ethnography.

In summary, the above discussion details the decisions made at the beginning of the study and the justification to modify the research approach which remains within the body of ethnography. It is a finessed version more suited to the investigation of the topic and the research setting.

## 4.7. Methods of data collection

I employed 'qualitative interview' as the main method of data collection for this study, however I did plan for and conduct three observations as an 'observer- participant'.

### 4.7. (i) Participant Observation

Researchers employ participant observation[52] methods to study the meanings that participants attach to social situations because it provides them with the opportunity to immerse themselves in the day-to-day activities of the participants and understand their social reality (Becker 1958; Bryman 1988). In contrast to methods that tend to test theories, this method is used to generate data from which theories can be developed. Within this perspective the researcher is the main instrument of investigation, where data is gathered through watching, listening, talking, experiencing and taking notes in natural settings. More importantly, accounts of situations are collected in the participants' own words. Both these aspects assist the researcher to construct the social situation based on available versions of the events.

Some of the advantages associated with this method are: a) researchers are less likely to impose their own reality on the phenomena they are attempting to understand; b) it assists with understanding the process of action including why and how participants behave in particular social situations; and c) researchers are able to record their subjective experiences during the observational period and subsequently use these when explaining their data.

[52] The research studies utilising this method flourished in the field of crime and deviance, race relations and cultural understanding (Willis 1977; Bhasker 1989; Pryce 1986; Porter 1993), including the feminist field (Kay 1990; Webb 1990; Hey 1997) and midwifery (Kirkham 1989; Hunt and Symonds 1995; Dykes 2005).

Gold (1969) and Junker (1960) have provided researchers with four[53] typologies of field roles: 'complete observer', 'observer-as-participant', 'participant-as-observer' and 'complete participant'. There appear to be two clear role distinctions at opposite ends of the spectrum: one of a complete participant and the other of a complete observer. However, the distinction between the two other roles of participant-as-observer and observer-as-participant is not as clear cut, and some question the value of such fine demarcation (Hammersley et al 1995). The choice of the role will be dependent on the research question and the researcher (Hammersley et al 1995).

Spradley (1980: 58) links the four roles with four levels of participation. The first level is "*passive participation*" where the ethnographic researcher is present in the social setting but does not participate or interact with any of the actors. The second is that of "*moderate participation*" where the researcher maintains a balance between participation and observation. The third level is referred to as "*active participation*" which involves engaging in similar activities to those of the actors in the social setting in order to acquire greater knowledge of the cultural codes and behaviours of the social setting. The final level is that of "*complete participation*" where the ethnographer engages in all the activities of the actors and the social setting.

With participant observations, development of relationships is important so the researcher can get close to the participants and access their perspectives. However, a balance needs to be achieved with regard to 'close relationships' and 'over-familiarity' between the researchers and the participants; if not managed well these are likely to affect data collection (Hammersley et al 1995).

[53]In the 'complete observer' role researchers have no contact with those who are being observed, normally adopting the use of a one-way mirror (Corsaro 1981), or observed from windows or public places (Lofland 1973, Karp 1980). In the 'observer-as-participant' role, contact with the participants is brief and formal and is that of observation only. As a 'participant-as-observer', the researcher carries out functions of both participation and observation. 'Complete participant', a covert observation where researchers conduct studies without informing the group of their intention, and without obtaining consent from individuals/ groups they are studying. Whilst there are some advantages in adopting this type of role, it violates ethical principles and would come under criticism.

### 4.7. (ii) Qualitative interview

In addition to participant observations, semi-structured interview was selected as another principal method of data collection because it offered greater potential to obtain in-depth data from participants. Semi-structured interviews provide an opportunity to engage in a purposeful way with the participants, gaining insight to their views, perceptions and thoughts. This facilitates understanding of their interpretations of the social context in which they birthed their babies, enabling the women's voices to be distinct and discernible (Ribbens and Edwards 1998). Semi-structured interviews -sometimes referred to as qualitative interviews - are "*modifications or extensions of ordinary conversations*" (Mason 2002: 62). Qualitative researchers are keen to obtain participants' "*understanding, knowledge and ... their ... insights*" and "*the content of the interview, as well as the flow and choice of topics, changes to match what the individual interviewee knows and feels*" (Rubin and Rubin 1995: 6). Qualitative interviewing, although it is similar to 'ordinary' conversations, is distinctive, being "*conversations with a purpose*" (Burgess 1984: 102). They are guided conversations that explore issues in depth. Qualitative interviewing is consistent with the interpretive ontological position that seeks both to describe in detail, and to develop understanding of the social world of the participants (Rubin and Rubin 1995).

It is essential that qualitative researchers become concerned with the types of relationships they want to develop with the participants (Ribbens 1989). Fostering a warm and trusting relationship with the women was important to glean richer information, and I was very much influenced by Oakley's (1981) views about reciprocity during the interview process. Oakley rejects the hierarchical relationship and unequal power between the interviewer and the 'subordinate' interviewee. Feminist interviewers, she argues, should be in a non-hierarchical relationship with the interviewees and should "*invest their own personal identity in the relationship*" by answering interviewees' questions, and sharing knowledge when requested (Oakley 1981: 41), without "*los[ing] their distance and objectivity*" (Fontana and Frey 1994: 367). However, it is important that the researcher learns to develop conversational partnerships, to listen to and hear what is being said. They need to be in tune with their own behaviour and thoughts and need to develop skills of flexibility to respond with ease and speed to the respondents (Rubin and Rubin 1995). They argue that researchers cannot be objective and neutral in an interview situation, because they bring to the setting personal ontological and epistemological viewpoints that affect what they hear

in an interview, which issues they choose to follow, and how they interpret and analyse the data. However, self awareness and reflexivity as personal tools may enable the researcher to recognise the likely impact of their values, beliefs and experience on the way they 'see and hear' the data.

## 4.8. Reflexivity: the researcher and the researched

The concept of reflexivity, that is the influence of the interactions between the researcher and the participants, occupies a central place in many of the qualitative approaches to research. It is "*....a self awareness of the relationship between the investigator and the research environment*" (Lamb and Huttlinger 1989: 766). Reflexivity emphasises the importance of critical self-awareness where qualitative researchers clarify personal values and beliefs and examine how these may impact on the relationship between them and the participants. Some supporting this notion assert that qualitative researchers must engage in critical reflexive practice if their arguments are to be taken seriously (Mason 2002).

Qualitative research, which seeks to view the world from the individual's perspective, is complex; it is affected by issues of language, gender, social class, race and ethnicity. It is therefore of paramount importance that a positive relationship is developed between the researcher and the participants, in order to gain as full an account of the situation as possible. The researchers should work to develop a relationship of trust with their participants, thereby promoting equality in the power relations between them. The issues of power and trust between the researcher and the participants, referred to as relationality, could enhance the validity of the findings (Hall and Callery 2001).

Where the researchers and the participants are of a similar ethnic and cultural background it is likely to promote trust and reduce inequalities in power relationships. Matching for ethnicity is important but it is an extremely complex issue. For example, Blauner and Wellman (1973) argue, "*There are certain aspects of racial phenomena, however, that are particularly difficult, if not impossible, for a member of the oppressing group to grasp empirically and formulate conceptually. These barriers are existential and methodological as well as political and ethical*" (1973:329). Whilst matching for ethnicity encourages the processes to be more equal between the researched and the researcher, there are other issues concerning class and socialisation that should

be taken into account. My assumption is that being of a similar cultural background to that of the participants can be an advantage in promoting a conducive environment for the women to share their feelings about sensitive issues. However, it has been argued that when researchers do not share the same cultural background as participants, informants may be more likely to be forthcoming about their views (Rhodes 1994).

Matching ethnicity is not achievable in all studies, and efforts should be made to ensure that the principles of antiracist research are upheld. Many, for example Papadopoulos and Lees (2002) offer framework to develop researchers who are competence to undertake ethnically sensitive research. Due consideration should be given to issues of racism, coupled with interpersonal, organisational/institutional and structural/societal issues. Researchers need to examine their own assumptions about their ethnicity and have a clear understanding regarding ethnicity, race, and socio-economic circumstances. They should be clear about the research questions. When both the researcher and the participants share the same culture the informants may not make some of the information explicit as they feel the researcher already knows this information or the researcher ascribes a shared understanding of the concepts. In some instances ascertaining certain views may cause offence, particularly when examining sensitive issues. For example, a Muslim researcher asked a Muslim participant "*Do you believe in God*?" The participant replied "*A Muslim should not ask such a question of a fellow Muslim*" (Rehman and Walker 1995: 497). In these circumstances a researcher who is not ethnically matched would be able to ask such a question.

Others, for example Phoenix (1994) feel that matching is extremely important and goes further than just broadly looking at white or black; issues of language, religion and cultural aspect need to be looked at. Other issues such as shared experiences, age, gender and class also play a key role. Most importantly it depends on the research question. For example, to investigate a sensitive issue it may be important to match gender rather than ethnicity; what is more important is that all researchers have adequate education and training to conduct research effectively. It is likely that it is more important to match for language than for ethnicity because a significant number of people from BME communities do not speak English.

The relationship of the researcher and the participants is of fundamental importance and impacts on each stage of the research process. "*The researcher is the instrument of the*

*research, and the research relationship is the means by which the research gets done*" (Maxwell 1996:66). Maxwell, supporting the notion that the relationship between researcher and researched is important, goes on to suggest that this relationship affects the participants in the study, the researcher and consequently other aspects of the research design such as data collection. I believe it was essential for me to establish a relationship with the women well before labour commences, so chose to meet participants in the antenatal period. As this was an exploratory study of women in labour, which is a sensitive and emotional time in a woman's life, a positive relationship with the women would enhance the quality of discussion as well as allowing for 'rich' data. My chosen method of data collection was initially that of observation during the intrapartum period, and meeting the women in the antenatal period provided me with an opportunity to develop a rapport with them at an early stage. Being of a similar cultural background to the participants I was able to promote a conducive environment for them to share their feelings about sensitive issues.

I acknowledged that my presence would have an effect on the women and the midwives from a number of perspectives. It is inevitable that I would bring my own experiences, values and beliefs into play during collection and interpretation of data. Also the notion of being a "naïve inquirer" within the ethnographic framework presented a challenge for a number of reasons. I am a mother of two British born children, and I have used British maternity services; I also believe that because I was known as a midwifery educator to the midwifery staff of that maternity unit, my experience is likely to have been different from that of other women. Furthermore, my thirty years' experience of midwifery practice and education gives me an 'insider's' knowledge of the way maternity services are planned and delivered, and this may influence the way I interpret data. It is possible that my social class, my dress and my language impacted on the research process. However I shared the same language as the women and wore my Indian clothes when in the field.

Clearly there are differences in the positions occupied by the researchers and the way in which they interact with the participants and with the data. However by incorporating reflexivity and relationality into qualitative research it is possible to reconcile these differences in position (Hall and Callery 2001).

### 4.8. (i) Being 'Myself'

Subjectivity, "*normative and emotive*" (Schwandt 1997: 147) that is, the researcher's individual values, opinions and feelings can affect the study at every stage of the research process. Merely identifying the 'subjective' self does not ensure that the biases or their impact is reduced but that it has to be accounted for in a meaningful manner (Peshkin 1988). As the main instrument of research (see for example Denzin et al 1994: 2; Robson 2002: 167), the researcher engages with the study from its development to completion; from "*devising and refining a thematic framework* [...] *to making judgements as to the meaning and significance of the data*" (Ritchie and Spencer 1994: 180-182). Qualitative research is an "*interactive process shaped by the* [researcher's] *personal history, biography, gender, social class, race and ethnicity and those people in the setting*" (Denzin et al 1994: 3). For trustworthiness of this study to 'stand up' to external scrutiny, it was essential that the distinction between the "*experiences of the respondents and the researcher's representation of them*" was explicit (Bradbury-Jones 2007) and that the representation was credible. For these reasons, I have threaded reflexivity throughout the thesis to demonstrate rigour and trustworthiness. I constantly reminded myself how 'me' may affect the research process and outcomes; articulating to the readers of this thesis accounts when I brought 'me' to the fore so that 'me' did not intentionally influence the research.

I construct my (auto)biography through the use of my multiple realities and in this sense I align myself with the philosophical perspective of social constructivism and indeed its epistemology and ontology - its attendant subjectivity and reflexivity. As a Punjabi woman, I have several self-constructed identities embracing my ethnicity, citizenship; professional and social roles, for example I define myself as 'Punjabi' or 'Indian' or 'Asian' or 'Black' or 'British'. These multiple identities have been constructed as a result of not just my birthplace and migration history but also how others see me. I was born and brought up in Kenya, East Africa to Sikh parents who originate from Punjab, North India. I migrated to Bradford, England in 1967 where I completed my secondary education. Subsequently I undertook general nurse training (1971-1974) and in 1975 commenced midwifery training, a field that I have remained in both as a practitioner (1975-1980) and as an educationist (since 1980). As a student of doctoral programme, I construct myself as a researcher moving from novice (in the beginning) to a competent "*bricoleur*" (Denzin and Lincoln 1994: 2) as I journeyed on the research pathway. I am

the author and raconteur of my thesis and as a midwifery educationalist I regularly contribute to professional communities of healthcare. Through multi-faceted social networks, I am an observer and participant of social and organisational life. In this self construction, I acknowledge 'me' as a health services user; I am a mother of two children. In most 'traditional' writing, multiple self constructions, such as these are 'silenced', however, I have quite transparently brought these multiple constructions of 'me' to the fore.

This thesis has emerged, essentially from the accounts of twenty-seven women (thirteen women as users of maternity services, nine interpreters and five midwives). They shared their journeys with me, however they were in control of the information; they decided what they wanted to share and what they wanted to withhold. They were given the opportunity to view their transcripts although not all women capitalised on this opportunity despite the offer of assistance with translation (all the transcripts were in English). The findings transpired as a result of 'making sense of the data', through reviewing and personally engaging with pages and pages of text (typed transcripts and hand written field notes). The process of data management is described in chapter 5 including the steps taken to ensure trustworthiness of the study findings. Due care was taken when summarising the data and identifying the themes which finally culminated in the study findings. Whilst the findings were a result of 'me' (I essentially determined the themes), I ensured that checks and balances were built in the process to ensure that these findings were women's voices and not my views and prejudices. It is most likely that the outcomes of this thesis would be different depending on the participants, research settings, use of different literature and/or a different research paradigm. However, I remain convinced that some of the key issues that women reported around their experiences of maternity services, the importance of relationship with their midwives and the need for support and information would still be discernible. In fact some of the findings reported in this thesis are virtually identical to findings reported by other researchers over the last two decades (for example, see Dosanjh-Matwala 1990a; 1990b; Leeds Family Health Services Authority 1992; Woollett and Bowler 1993a; Bowes and Domokos 1996a). It is from this interactive process that the study findings have emerged, a process which involved women's accounts and my knowledge and experience; whilst these two components are not readily distinguishable, I strongly believe that I did everything to ensure that women's voices were brought from the margin to the centre.

## 4.9. Summary

In this chapter I have detailed the interpretive ethnographical research design and its methods, which will underpin the study of experiences and context of Pakistani Muslim women's birthing in northern England. My thesis is located within the constructivist paradigm and I have outlined the methodological approach chosen to address the research objectives and questions. I have provided the philosophical and theoretical framework of the study as well as discussing the way in which they have influenced the methods that were chosen.

In the next chapter I shall demonstrate the execution of the methods and discuss some of the issues concerning the reliability and validity of translated materials and qualitative data, and provide a description of the transcription and analytic approaches that I adopted. I shall also present a description of the social and demographic characteristics of the women who participated in this study.

# Chapter 5

## Methods: mapping the journey of the research process

**To Understand the World**

And the children said unto Halcolm,
"We want to understand the world. Tell us, O Sage, what must we do to know the world?"
"Then, my children, you must go out into the world. Live among the peoples of the world as they live. Learn their language. Participate in their rituals and routines. Taste the world. Smell it. Watch and listen. Touch and be touched. Write down what you see and hear, how they think and how you feel.
"Enter into the world. Observe and wonder. Experience and reflect. To understand a world you must become part of that world while at the same time remaining separate, a part of and apart from.
"Go then, and return to tell me what you see and hear, what you learn, and what you come to understand."

**Patton (2002:259)**

### 5.1. Introduction

This chapter explicates the principal data collection methods for this study, including sampling and recruitment strategies, and the social and demographic characteristics of the participants. Discussion focuses on the transcription and data analysis before addressing reliability and validity of qualitative data.

### 5.2. Research design

Data collection extended from April 1999 to December 2003. Whilst this thesis provides an emic account on the social discourse of midwifery practice, it draws on published literature to underpin interpretation, thereby adding to knowledge about midwifery practice. The accounts of women's maternity experiences are presented first, followed by my analysis and interpretation of meaning within the social discourse. Figure 1 provides an overview of the research process.

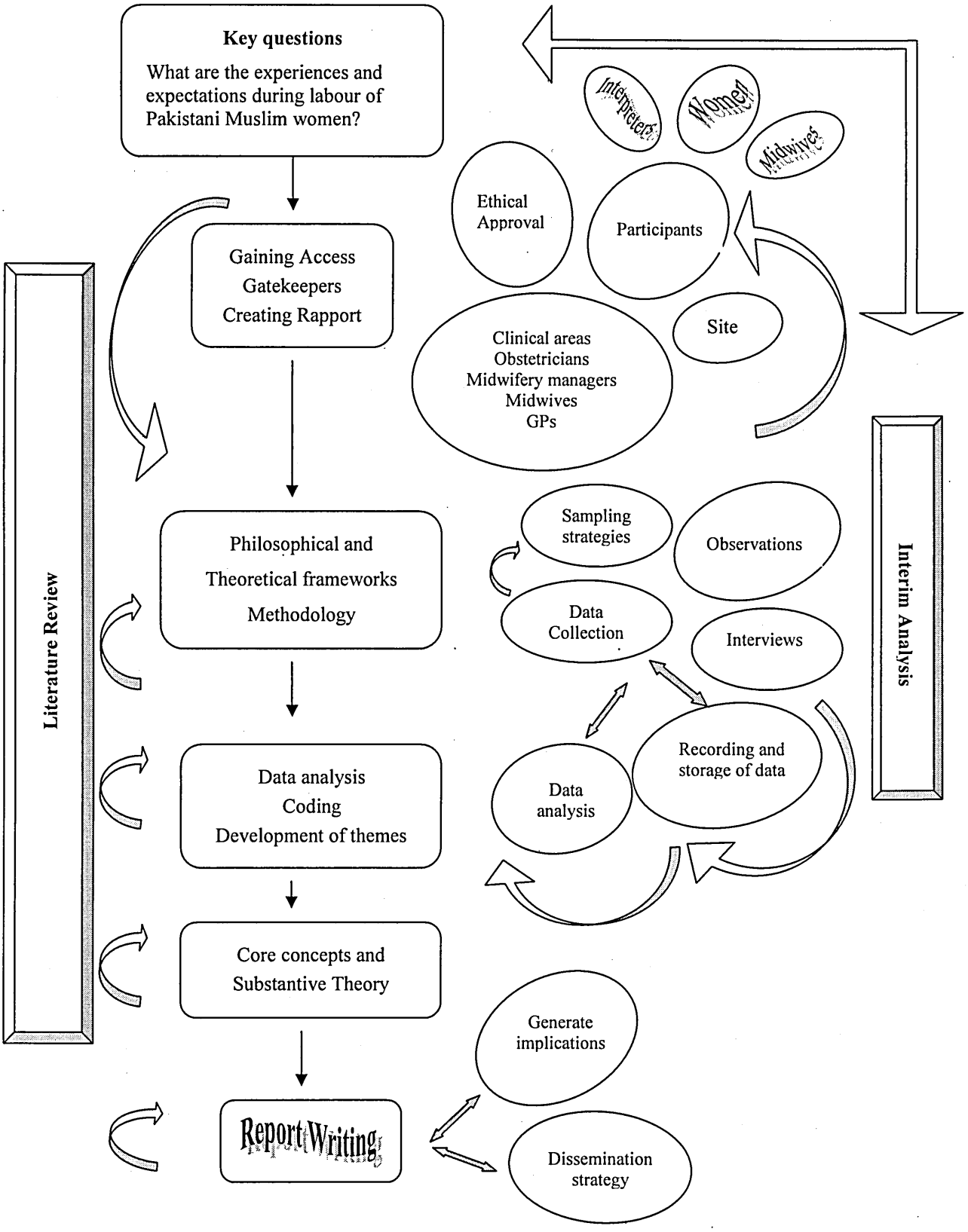


**Figure 1: Mapping the Research Process**

Source: adapted from Miles and Huberman (1994) page 308.

## 5.3. Gaining access: treading on egg-shells

The study was conducted in a maternity unit in northern England with a high percentage of Pakistani women; the unit was accessible from my home[54]. As I was unfamiliar with the Unit, my first task was to develop relationships with the gatekeepers[55] to negotiate access. Following ethical approval from the local Research Ethics committee[56], the senior midwifery managers and senior consultants of the Unit were approached to discuss the intentions of the study.

In essence the senior midwifery managers were the principal gatekeepers[57] to the study site, so I held meetings with them to i) develop a rapport; ii) discuss details of operationalising the study and iii) agree a process to identify participants. These 'gatekeepers' supported study proposals and offered suggestions for sampling and recruitment strategies. Access at ward level was negotiated with senior midwives by attending their meetings to share information about the study. They were provided with written information about the research, including methods of data collection, issues of confidentiality and anonymity, and my professional and academic background.

Access granted by key gatekeepers at senior level did not permit entry in practice setting; transaction of negotiating access at ward level was sensitive. The midwives in the antenatal clinic were receptive to the study; this was not the case on the delivery suite because they probably considered my presence during the birthing process to be intrusive. The atmosphere of the meeting with the delivery suite midwives was 'cold', initially with little engagement in discussion but they were interested in my rationale, and asked some challenging[58] questions.

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[54] This was an important factor to inform my decision because I was aware that I could be involved in data collection during evenings and nights. At the time of making decisions about the sites, my daughter was fifteen years of age and my son nine and my partner worked on nights. So it was important that the site where field work was to be undertaken was within easy reach.

[55] The term 'gatekeepers' as a plural is intentionally because there were many gatekeepers with whom access was negotiated, for example the consultants, ethics committee, midwifery managers and practitioners, women and their husbands.

[56] The transaction of gaining ethical approval will be outlined in a later section. The practice of gaining ethical approval was less challenging because I gained support from key actors before the Committee meeting, for example the Head of Midwifery. She also gave me the insider information regarding which senior obstetrician to approach to seek support. We agreed that she would inform this consultant obstetrician of my study and of her consent prior to my meeting him.

[57] Here the gatekeepers are Team leaders and midwifery practitioners.

[58] For example, one of the midwives asked "*do you think that these women do not get good care*?" Another asked "*these women get a good deal and they don't do badly, you know*".

## 5.4. The research setting

The research site is a large consultant-led unit in an Acute Trust serving a multiethnic population in City A with an annual birth rate of over four thousand births per annum: approximately five percent of women are from BME communities. To get an insight into the macro and micro culture of the Unit, I spent four days shadowing midwives in the antenatal clinic, delivery suite and community setting. Women attended the hospital antenatal clinic for their first antenatal visit, where their obstetric and medical history was taken and their place of care was determined. Women who were categorised as 'low risk' were cared for in the community setting, attending the hospital antenatal clinic at eighteen weeks for their dating scan. If there were no complications the women would carry on accessing antenatal care in the community setting for the remainder of their pregnancy, or until forty weeks of gestation. For women who were categorised as 'high risk', antenatal care was in a hospital setting. This model of service delivery is typical of British maternity services.

On admission to the delivery suite, women were usually admitted in the assessment room. If they were assessed to be in early stage of labour, they were transferred to an antenatal ward until established in labour when they would be transferred back to the delivery suite. However if they were considered to be in established labour then they would be transferred to the labouring rooms on the suite.

The interpreters who participated in this study were recruited from three cities (City A, B and C) in northern England using a snowballing approach.

## 5.5. Sampling strategies

The sampling decisions began with the development of initial ideas about the research methods and then modified. As this study was located in an interpretive ethnographic paradigm, it uses a purposive sampling strategy where the researcher focuses on participants' "*context and studies it in depth*" (Miles and Huberman 1994: 27; Burgess 1984; May 1997; Robson 2002). I adopted criterion-based purposive sampling (Denzin and Lincoln 1994; Miles and Huberman 1994) deliberately seeking out individuals, groups and settings where the social processes under scrutiny could be studied (Glaser

1978; Bogdan and Biklen 1982). However, owing to recruitment challenges convenience sampling was utilised.

The sampling criteria were informed by the research questions and theoretical logic, ensuring that the data gathered were able to contribute to the development, refinement and testing of theoretical explanations (Mason 2002). Theoretical sampling, however is not simply a process that occurs at the beginning of a study but "*evolves during the process*" (Strauss and Corbin 1998: 202), occurring as part of the interplay between data generation and data analysis to identify what further data should be collected and what the focus of this data should be (Glaser and Strauss 1967). Thus the purpose of theoretical sampling is specifically to generate data to develop the emerging theory and is essentially "*directed by the evolving theory*" (Strauss and Corbin 1998: 203).

## 5.6. Study participants and their characteristics

### 5.6. (i) Pakistani Muslim women

#### ..... Inclusion and exclusion considerations .....

Primigravidae Pakistani women with no history of either medical or obstetrical complexities were invited to participate in the study to identify sources which assisted in constructing their knowledge of childbirth, underpinning their behaviour and expectations. Multigravidae women were excluded because previous maternity encounters would significantly influence their knowledge and behaviours. Women with complicated pregnancy and labours were also excluded on the basis that they were more likely to have additional anxiety that could affect their experience. Women identified as having healthy babies were included in the study, based on the premise that my presence during labour or subsequent postnatal interviews would be less intrusive. Where women experienced loss it would be inappropriate for them to participate, although having developed relationships with the women I might not be able to withdraw from their experiences[59].

[59] And in practice this did happen; for example Samira, (one of the women who had agreed to participate in the study) who had experienced a preterm birth, still insisted that I go and visit her. I contacted Samira at thirty seven weeks of her pregnancy to remind her about the study when she informed me that she had already given birth at thirty-four weeks of pregnancy. Whilst I did not include her in the study, I did go and visit her and she openly shared her experiences, which understandably were related to anxiety and fear around the wellbeing of her baby son.

I anticipated that the sample size would be around fifteen to twenty women to allow me to answer the study questions. Recruitment and data gathering continued until the interim analysis indicated that no new data was being generated about the phenomena under investigation (Glaser and Strauss 1967; Strauss and Corbin 1998; Mason 2002).

I attended nine antenatal clinics[60] in the Unit over a period of three months (January to March 1999) to recruit women; I approached women in their early pregnancy[61] who fulfilled the inclusion criteria, and once they consented to speaking to me, I gave them verbal and written explanations of the study's purpose. The women were encouraged to take the written information and consent form home to discuss the study requirements with their husbands before confirming their consent. Information shared with potential participants was standardised by compiling a list of items for discussion[62].

Following up these women was a challenge because their subsequent antenatal care was in the community setting and not in the Unit. During the nine week period of recruiting from the antenatal clinic, eight women fulfilling the inclusion criteria were identified. Of these, two declined to participate; three verbally consented but were uncontactable[63] and three consented to participate; two were excluded subsequently as they developed hypertensive complications.

Although the access rates by 'Asian' women were high in the antenatal clinics in the Unit, recruitment was slow because (a) not all were of Pakistani origin, and (b) the majority of the Pakistani women attending these clinics were experiencing medical and obstetric complications, therefore did not meet the inclusion criteria.

In view of the slow recruitment, a second strategy involving antenatal clinics in the community setting was adopted for recruiting women. I met with three community teams with a high case load of Pakistani women to appraise them of the study. Whilst some

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[60] One of the obstetricians in this unit was an Asian female and the majority of her case load was of women from the BME communities; I had been advised to attend this antenatal clinic as it included a higher percentage of Asian women.

[61] Normally, in accordance with the unit's practice, antenatal care was provided in the community setting for women with uncomplicated pregnancies, attending the hospital setting at eighteen weeks of gestation for a 'dating' scan.

[62] 1. Explain the reason for contacting potential participants was to invite them to participate in the study; 2. Outline the topic of the research, purpose of the study including issues of confidentiality and anonymity; 3. Explain the participant's contribution towards the study in terms of data collection (participant observation and interviews) and the timeframe; 4. Give details of who I am, professional background, research supervisors; 5. Explain issues related to consent and its withdrawal and 6. Provide written information and ascertain future contact details.

[63] Two women provided their mobile telephone numbers to confirm their consent however these numbers were unobtainable when I contacted them. The woman who agreed to contact me via her midwife did not confirm her consent.

midwives in these teams were receptive to the study's intentions, others were hostile to the issue of researching ethnicity. This group posed challenging questions such as: *'Why are you doing this study? Do you think that these women do not get good care? Does anybody think of what other women want from the service? These women get good care and there is no need for this type of research. Do you think we do not give them good care? Why is so much money being wasted on researching these women? I can tell you what these women want and you can spend your time doing better things than this research'*. However a few midwives were helpful and wanted to assist me with the recruitment. Inevitably I was drawn to midwives who demonstrated interest in the study and were willing to assist. Once the settings and the clinics from where study participants could be recruited were identified, I attended the relevant clinics, where I identified potential participants.

From this setting, I identified twenty-eight eligible women: fifteen declined to participate and thirteen agreed. Of this group, I managed to observe just two labours (in 1999 and 2000 respectively), because three women had instrumental deliveries and were excluded; the midwives failed to inform me about the admission of seven recruits, and on one occasion when I was alerted I could not attend. In accordance with study protocol, women were only included if they agreed to observations of their labours; it is not clear how many women would have consented to just be interviewed.

Negotiating access with the women was challenging, despite a number of modifications to the recruitment strategy. At the time of this study there were three externally-funded studies being conducted in the City, all exploring issues of ethnicity in maternity services, making the research pool very competitive. For example, full time researchers engaged with the funded studies had the advantage over my part time research. It would be intrusive if more than one observer was to be present at delivery. Given these difficulties, in consultation with my research supervisor, I changed the data collection strategy from observation to semi-structured interview in the postnatal period, with the caveat that I would undertake observations of labour where the women consented. Whilst I acknowledge that the data set would have been very different had I observed a larger number of labouring women, in-depth interviews are a source of rich data.

The third strategy was to recruit from the community setting (from January 2002 to December 2003). Fifty-nine eligible women were identified (see Table 5.1): of these, ten

participated in the study, nineteen[64] were uncontactable, eleven had instrumental deliveries, and nineteen declined to participate.

All the women who met the inclusion criteria were invited to participate in the study when they were approximately thirty weeks of gestation. Once the women had given their consent to participate in the study, a label was attached on their hand-held maternity notes requesting delivery suite midwives to inform me of the woman's arrival. Normally I contacted the women at least a week before their due date to check if they were progressing as expected with their pregnancy; this call also served as a reminder about the study.

**Table 5.1: Eligible participants**

| Criterion | Number 1999 January-March | Number November 1999 to December 2000 | Number January 2002 to December 2003 | Total |
|---|---|---|---|---|
| Women eligible and invited to participate in the study. | 8 | 28 | 59 | 95 |
| Women declined to participate in the study. | 2 | 15 | 19 | 36 |
| Women developed medical/obstetrical complications or birthing assisted by instrumental delivery. | 2 | 3 | 11 | 16 |
| Women consented to participation but were lost to the study. | 3 | 8 | 19 | 30 |
| Women participated in the study. | 1 | 2 | 10 | 13 |

Of the eligible women, over thirty percent of the women declined to participate. Whilst some women did not give a reason, many reported that birthing was a private task and their "*religion does not permit any other person to be present during this time*" (Field notes: Tuesday 26 January 1999). Others declined because of the unknown and did not want to make a nuisance of themselves in front of me; a few said that their husband was intending to be present at birth and that both of them would be uncomfortable if I was present. It is likely that, as other researchers have reported, Pakistani women are reluctant to talk in

[64] Women were either not available for interviews or had gone to recuperate from childbirth to their maternal homes.

detail about their labours (Woollett and Dosanjh-Matwala 1990a; 1990b; Bowes and Domokos 1996a).

In total thirteen Pakistani women participated in this study; three women permitted me to be present during their birthing period. Although I had requested the midwives to alert me when the women were admitted, the midwives called me when these women were in advanced stages of labour, a pattern that continued for all three labours despite being reminded.

Characteristics of the Pakistani women who participated in this study are presented in Table 5.2. Of the thirteen women, eight were born in England and five in Pakistan. Their age range was from seventeen to twenty-five: four of the women were between the ages of seventeen to nineteen and nine were between the ages of twenty and twenty-five. Seven of the thirteen women had received their compulsory education in England: three women left without formal school leaving qualifications, three had studied to GSCE level, and had accessed further education. The seven women who had received their compulsory education in England were fluent and literate in both Urdu and English. Three of the thirteen women had received their education in both Pakistan and England and, whilst they could speak both Urdu and English, they were more fluent in Urdu. Women who had received all their education in Pakistan were fluent in Urdu/Mirpuri and were neither literate nor fluent in English.

**Table 5.2: Characteristics of Pakistani women**

| Interview number | Woman's pseudo name | Woman's place of birth | Age | Education | Occupation | Spoken language | Interview language |
|---|---|---|---|---|---|---|---|
| 1 | Alisha | England | 21 | England until 16; clerical course at college | Financial Clerk | Urdu and English | Mainly English |
| 2 | Bilqis | Pakistan | 25 | Pakistan - primary | Housewife | Mirpuri | Mirpuri |
| 3 | Deeba | England | 20 | England until 16 | Housewife | Urdu and English | Mainly English |
| 4 | Camillah | England | 18 | England until 10, then Pakistan | Housewife | Urdu, some English | Urdu, some English |
| 5 | Eiliyah | England | 21 | England until 16 | Part time receptionist | Urdu and English | Mainly English |
| 6 | Farzana | Pakistan | 20 | Pakistan until 14 England final 2 years until the age of 16 | Housewife | Urdu | Urdu |
| 7 | Ghazala | England | 21 | England – GCSE level | Assistant teacher | Mirpuri and English | English |
| 8 | Husna | England | 20 | England until 16 | Housewife | Urdu and English | English and Urdu |
| 9 | Inayat | England | 20 | England - GCSE level | Shop - sales assistant | Urdu and English | English |
| 10 | Jariyah | Pakistan | 17 | Education in Pakistan | Housewife | Urdu | Urdu |
| 11 | Khatiza | Pakistan | 22 | Education in Pakistan | Housewife | Mirpuri | Mirpuri |
| 12 | Lateefa | Pakistan | 17 | Education – early in Pakistan and later 3-4 years in England | Housewife | Urdu, some English | Urdu, English |
| 13 | Maheera | England | 19 | England to GCSE level | Supermarket Sales assistant | Urdu and English | English |

### 5.6. (ii) Interpreters

Interpreters, liaison officers, and advocacy workers (hereafter, collectively 'interpreters') were selected as informants for this study because they worked closely with the Pakistani women; they were more likely to have grassroots knowledge of issues encountered by women accessing maternity services.

Interpreters were recruited using a purposive sampling technique based on snowball sampling strategy. Snowball sampling is a non-probability sampling method and does not accord 'units comprising the sample population' an equal chance of being selected (Robson 2002). Snowball sampling allows for identification of like by like. Qualified interpreters with experience of at least one year working within the maternity services were

included, to ensure they would be able to answer the questions set out in the study; the only exclusion criterion was experience of less than a year of working with Pakistani women during childbirth. A total of nine interpreters participated in this study during September to December 2002. See Table 5.3 for the characteristics of the interpreters. It is likely that these nine interpreters were not involved in delivering interpreting services to the women included in this study. The data set emerging from these participants was analysed separately however were integrated at the reporting stage.

**Table 5.3: Characteristics of interpreters**

| Interview number | Pseudo name | Title | City | Place of work | Length of experience: childbirth period (years) |
|---|---|---|---|---|---|
| 1 | Nafisa | Interpreter | A | Maternity services | 4 |
| 2 | Ojala | Liaison Officer | B | Maternity services | 9 |
| 3 | Pakeezah | Interpreter | C | Maternity and Gynaecological services | 7 |
| 4 | Qirat | Liaison Officer | B | Maternity and Gynaecological services | 7 |
| 5 | Rabbiya | Advocacy | A | Maternity services | 10 |
| 6 | Shabana | Interpreter | A | All areas of health services including maternity | 3 |
| 7 | Tahira | Interpreter | A | All areas of health services including maternity | 5 |
| 8 | Uroosa | Interpreter | C | Maternity and Gynaecological services | 6 |
| 9 | Vardah | Liaison Officer | B | Maternity and Gynaecological services | 4 |

Each interpreter was invited to suggest another individual who would be willing to participate in the study. With snowball sampling there is, however, a risk of bias, with a possibility that other informants who are not part of the network are deliberately omitted. However, as the sample was drawn from three different cities where the maternity service models were different, such biases were likely to be minimal. Although not planned, all interpreters were of Pakistani origin. To preserve the privacy of interpreters, the nominator approached the nominee and with her consent, contact details were passed on to me. The first contact in all situations was via telephone, followed by written information.

### 5.6. (iii) Midwives

Five midwives contributed to this study. Three of the midwives provided care for the women whose birthing I observed; they predominantly worked in the hospital setting. The other two midwives worked in the community setting, providing care for the women in the antenatal and postnatal periods. As only five midwives have contributed to this study, for confidentiality their ethnicity[65] is not disclosed in Table 5.4.

**Table 5.4: Characteristics of midwives**

| Pseudo name | Place of work | Length of service in midwifery (approximate years) | Experience of working with Pakistani women including those from other BME groups |
|---|---|---|---|
| Abigail | Hospital setting | 3 | 2 years |
| Bernice | Hospital setting | 21 | Most of midwifery career |
| Celina | Hospital setting | 4 | 3 years |
| Dorothy | Community setting | 25+ | High case load of women from the BME groups |
| Faith | Community setting | 10+ | High case load of women from the BME groups |

## 5.7. Entering the field

### 5.7. (i) Ethical considerations

Ethical issues, with particular reference to responsibilities toward participants, the integrity of the researcher, transparency, and robust research governance, were an integral component of the research process (Stanley and Wise 1993; Fontana and Frey 1994; Green-Powell 1996; Mason 2002; British Sociological Association (BSA) 1993; Royal College of Nursing (RCN) 1998).

### 5.7. (ii) Ethical approval for the research

The sensitive nature of this study led many practitioners to be suspicious of its focus, therefore key gatekeepers were consulted during preparation of the submission. The

[65] It is noteworthy that four midwives were White and one was of African-Caribbean origin.

proposal included full information about the intended research design, and proposed information sheets and consent forms for participants. Following discussion, the local Research Ethics Committee approved the study proposal in February 1998 subject to minor revisions[66].

### 5.7. (iii) Obtaining informed consent

All participants were fully informed about the study and their role. They were provided with written material and offered the opportunity to review the information collected.

The women were initially provided with an information sheet and consent form (in Urdu and English). Information was also given verbally in the women's preferred language. Assurances were given about confidentiality and anonymity. Women were advised that the interviews would be audio taped with transcriptions made available to them to confirm accuracy of the content. The right of withdrawal was clarified, with assurance that this would not influence their care.

Consent from the women was obtained at every phase of the study because it is difficult to predict the issues that may arise (Knight 2002). Once verbal consent was obtained, arrangements for the interview were made. Interpreters were contacted by telephone; study purpose was explained and following consent arrangements were made for the interview. All nine interpreters who were approached agreed to participate.

Local midwives were informed of the study and their role within it through verbal and written information, but consent for the observed labours was reaffirmed on arrival on delivery suite.

### 5.7. (iv) Confidentiality and anonymity

The process of recording and storage of data was communicated to the women verbally and in writing. Anonymity was assured; pseudonyms were adopted as I felt that the

[66] The Ethics committee required that the title of the study was entered on top of the information sheet and clarifying wording on information sheet to read: 'an invitation to take part in research study' instead of 'I do hope you will be able to participate in the study'.

participants should retain the respect of being cited by a name. All participants were informed that data would be utilised for the development of this thesis, presentation at seminars, and for publication, without their privacy, confidentiality and anonymity be breached.

### 5.7. (v) The ethical journey

As a Kenyan-Indian female with specific interest in equality in midwifery practice, researching experiences of Pakistani women raised ethical concerns for me that went beyond issues of individuals' rights to dignity and privacy, informed consent, protection from exploitation, and consequences included in a variety of Codes of Conduct for Research (BSA 1993; RCN 1998; ASA 1999). Such codes are concerned with avoidance of certain actions and aspirations for a level of professional conduct to ensure that the rights of others are respected, obligations fulfilled and no harm done (Robson 2002; Mason 2002). They do not, however, protect the researcher from self-discovery. In addition to these were ethical concerns relevant to my work, namely how I would handle personal bias and research relationships, and the best epistemology to address the ethical issues of research involving minority groups.

Observations and interviews are intrusive (Ersser 1996), and the well-being of the women came before the interests of the study. However, I accepted it was possible that some women might experience a degree of pain or might express frustrations and anger with themselves, their situation or maternity services. As I explained the study to potential participants, I became aware I was alerting them to some of the emotions experienced by previous respondents: "*am I acting as an honest broker, or am I channelling the women to a certain way of thinking?*" (Field notes: 18 October 2002). During the research, as I heard more and more women's stories I started to see similarities with my own challenges, such as fighting for my rights, but I was aware of the risk of seeing racial connotations when there were none. I was traumatised on many occasions by the degree of racism experienced by some of the women when listening to their aspirations and life chances. During the process of exploring interview transcripts I also saw contradictions, for example, I encouraged participants to reveal their stories, and in one interview a woman was so distressed because her husband was in Pakistan, that I had to steer her back to discussions about her experience of maternity care.

## 5.8. Data gathering

Data collection, interpretation and transcription of interviews occurred concurrently during the study. Thorough exploration of transcripts was fundamental in understanding women's perspectives, highlighting new leads to be followed in subsequent interviews; understanding social relations and social discourses extended the participants' perspectives. The two strategies for data collection were observation-participation of labours and interviews.

### ..... Initial data .....

A file was created for each participant, and, using a conversational interview style, a sheet with participants' contact details, obstetric details, period of gestation and expected date of delivery was completed; socio-demographic information was included, showing age, education, language spoken, length of stay in England, marital status, and ethnic origin. As Pakistani women are more likely to be married, a more general proxy question was used to ascertain marital status.

### 5.8. (i) Becoming 'observer-as-participant'

Before commencing data collection, consideration was given to the extent to which I wanted to be a participant, and how to perform the observations; one's presence changes the way actors in the setting behave and interact (Spradley 1980). I adopted the role of 'observer-as-participant', acknowledging my presence would possibly impact on the interaction between the midwives and the women. I chose to 'observe' and 'listen' without intending to involve myself in the provision of direct physical care - thus minimising impact

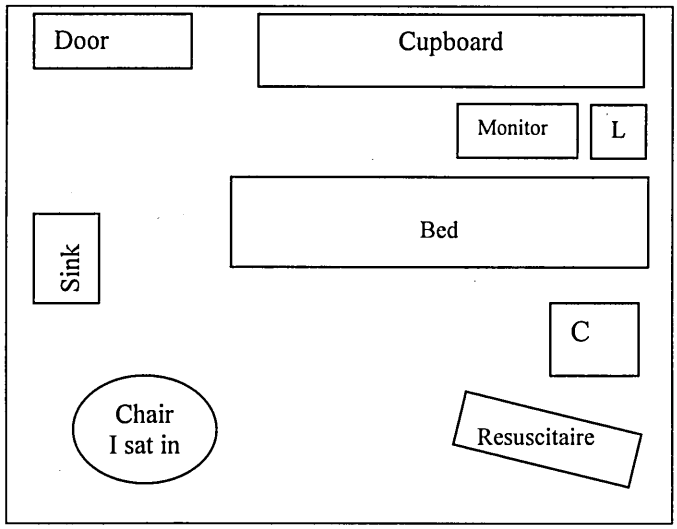
Studies by other ethnographers (Kirkham 1983b, 1989; Hunt and Symonds 1995) indicate that the degree of participation and observation oscillates during the course of data-gathering episodes depending on the conditions and need. As an 'observer-as-participant', I accepted that whilst I would observe the actors within the Unit, allowing them to *"follow the flow .... uninterrupted by intrusion"* (Adler and Adler 1984: 378). This would not prevent me from interacting with the actors, but would specifically mean not asking research questions or introducing new concepts into the setting. Indeed, I

entered into dialogue with the actors about general issues in order to develop relationships and elicit information.

**….. Being 'observer-as-participant' …..**

My experience of being 'observer-as-participant' is limited to observing only three labouring women[67]; therefore I cannot claim sophistication of the method or the development that other ethnographic researchers experienced (Burgess 1984; Hammersley and Atkinson 1995; May 1997). However, I shall describe my learning from this process and include the analysis of the data collected.

Alisha, Bilqis and Deeba were cared for in single delivery rooms where there was not much room once the delivery trolley was brought in. All three delivery rooms in which these women birthed were of similar set up and layout; I took up the seat at the bottom of the bed as indicated in Figure 2.




Key: L = locker; C= chair

**Figure 2: Diagrammatic Impression of Delivery Room**

No-one took up the offer to see my fieldnotes, although one midwife did ask what was being written. Whilst I wanted to capture events unfolding, and intended to be open

[67] The first observation involved Alisha and the total time I observed her was one hour and two minutes – I arrived when Alisha was in the second stage of labour. The second observation of labour was with Bilqis and the total time I spent with her was four hours and thirty-seven minutes. I did have the opportunity to observe just over three hours of her first stage of labour. Deeba was the third woman whose labour I observed, for about two and half hours in total, approximately one hour and forty-five minutes of which were during first stage of labour.

and transparent, I was careful in what I documented; this was not to deceive anyone but to safeguard against individuals being offended by my notations.

The women I observed were advanced in labour and stayed in bed; I sat, observed and made continuous notes. My intention was to observe the social interaction between the midwife and the woman as well as interaction between the woman and her birth partner in the midwife's absence. There were times during my observation of the interaction between the women and the midwives that one of them would look at me, or appeared to invite my comments; I resisted involvement.

Although I observed rather than participated, there were instances when I was directly asked questions, that it would have been disrespectful to ignore.

On another occasion I acted as interpreter at the request of the midwife to inform Bilqis that an episiotomy had been performed during her delivery which required suturing. I recognise this communication represents direct care, but had I refused to interpret I would have jeopardised my relationship with the midwife; more importantly it would have denied Bilqis informed care.

I got involved with the delivery of care that at the time I judged to be ethically appropriate. One such incident occurred when Alisha asked the midwife if she could put her newborn son to her breast. The midwife informed Alisha that this would be possible as soon as the delivery work was completed. (Field notes 10th April 1999) Over forty minutes later the midwife informed Alisha she needed to "*just complete some paper work and then I shall be back*". At this point I asked the midwife if she had any objection to me assisting Alisha with breast feeding. The midwife said "*just go ahead*". My concerns here were two-fold: provision of evidence-based care and concern that Alisha's needs were not being met. Although I had the midwife's permission to support Alisha with breastfeeding, my theoretical notes question whether this intervention would affect my relationship with the midwife (Field notes: 10th April 1999).

At the follow-up interviews both Alisha and Bilqis confirmed that they found my presence valuable, thanking me for being with them – Bilqis found that to some extend I fulfilled her needs for information whereas Alisha found my assistance with breastfeeding invaluable.

I did not intervene in every incident; there were some occasions when I intentionally remained an observer. However there is clear demarcation between suboptimal care and misconduct, and had there been instances that I perceived to be potentially harmful, I would have intervened regardless of the impact it had on the research.

### 5.8. (ii) Recording data

To understand the social setting in which the Pakistani women birthed, I wanted to understand the culture of the maternity services by observing labouring women wherever they chose to go during labour. I used Spradley's (1980) typology of descriptive, focused and selective observations as a framework. In terms of data collection and recording a nine-dimensional template was devised (Spradley, 1980) (see Figure 3). On the cover sheet, I recorded the social demographic details for example the name of the woman, her age, her place of birth, her occupation, and a summary of her birthing history - details were taken from the woman's maternity notes.

| Time | Goal | Actors | Event | Acts | Description of activity | Physical space and objects | Feelings |
|---|---|---|---|---|---|---|---|
| The sequence that takes place over time for example 1st stage of labour. | The purpose of the action i.e. what is going to be achieved, for example to confirm fetal wellbeing in labour and to exclude fetal complexity. | Description of social actors involved in the activity including their roles, for example midwife, woman, family members. | This involved a set of related activities that social actors carry out, for example assessment of fetal heart in labour. | Single actions that were taken, for example listening to the fetal heart by the midwife, and woman watching the midwife. | Specific activity involving a set of related acts, for example what the midwife did and how the woman responded. | Description of physical place(s) where care was delivered, for example delivery room, and things such as furniture and room layout. | This involved recording emotions expressed. |

**Figure 3: Nine dimensional template used for data collection during observation.**

My fieldnotes consist of data from the observations of labour and the social settings; I regard them as a fundamental part of data collection. They are descriptive and involve observational, theoretical and methodological processes (Schatzman and Strauss 1973; Burgess 1984). Observational notes involve detailed recordings of events within the social setting, they are descriptive with minimal interpretation. The theoretical notes

(Spradley, 1980) make up the 'feelings' component where I attempt to draw meaning from the observational notes and make conceptual links about what is happening and why. Finally the methodological notes focus on my reflections of the research process and serve as reminders of issues that need to be addressed. These observational, theoretical and methodological notes have served centrally and critically as a cumulative and developmental record of the research process allowing triangulation by bringing three kinds of notes together through a variety of analytic and operational processes (Schatzman and Strauss 1973; Burgess 1984).

### 5.8. (iii) Quality in recording data

I started constructing the text during the observation phase, and wrote field notes contemporaneously during observations. To achieve thick description I made detailed notes at the end of each observation or interview as soon as I returned home. All field notes were added to the participant's file.

Initial analysis of observational field work was inadequate. Conceptual themes in the data were identified through hand coding of concepts and phrases, but sophistication did not develop as I observed only three women during the intranatal period. However, a meeting with my supervisor provided the opportunity to focus and select lines of inquiry within a complex social situation; throughout the study supervision was central in maintaining focus.

## 5.9. Reflexivity: observer-as-participant

### 5.9. (i) Being one of them

Being aware that presentation of self (Finch 1984) was an important factor in facilitating respondent recruitment, I wore shalwar and kameez[68] during the recruitment and data collection phases. When considering issues of dress, the Head of Midwifery had suggested that I wear 'theatre uniform' – pale blue tunic and trousers, but this may have led both women and staff to see me as a staff member. . . It is "*sometimes .... necessary for the*

[68] All except one woman who participated in this study wore shalwar and kameez. Mothers and mothers-in-law of all the women I met wore shalwar and kameez. None of the women wore a hijab, veil or a burqah – dress code was not discussed in this sense but some of the women increased their privacy and dignity during their experiences in labour. Similarly all of the interpreters wore shalwar and kameez.

*researcher to dress in a way that is very similar to the people to be studied*" (Hammersley and Atkinson 1995: 83), and I did this out of respect for cultural prescriptions; it was important for the women to have trust and belief in me.

By wearing shalwar and kameez I felt I was 'myself', rather than a midwife or an educationalist. I felt that I was more approachable for the women and not a threat to the midwives.

### 5.9. (ii) Observations: moving from general to specific

Spradley (1980) and Jorgenson (1989) suggest that the focus of the observation shifts during the course of data collection from being very general and unfocused at the beginning becoming very specific towards the later stages. Initially the observation is descriptive and serves to provide background to the social context, however as one develops an in-depth understanding, it is the questions that emerge that direct the observation, lending it to examine particular settings and actors (Burgess 1984). The "*fieldwork is a continual process of reflection and alteration of the focus of observations in accordance with analytic developments*" (May 1997: 143). Whilst the value of observing Alisha, Bilqis and Camillah during their intranatal period cannot be underestimated, the focus of the observations remained very general. Nonetheless they served the purpose of describing context, assisting me to understand the issues raised by women in the subsequent interviews. However, having analysed the limited observation and interview data there are many emerging questions where observations of labouring women would have been more appropriately answered by "*watching what people do and listening to what they say*" (Robson 2002: 310).

### 5.9. (iii) Observer affects the observed

One of the advantages of direct observation is that data are collected from natural settings. Observation is about understanding actions rather than controlling or altering the setting (Adler and Adler 1984: 378). It is a given that by becoming part of the social context under observation, the observer is likely to influence the context (Hammersley and Atkinson 1995; Patton 2002); for example the staff may be on "*best behaviour*" (Kirkham 1983a: 86; 1989: 119).

Staff contact with Alisha and Bilqis was intermittent during the first stage of their labours and continuous with all three women during the second stage of labour. The quality of the interaction and care was variable, suggesting that observation did not influence the staff to be on 'best behaviour'.

### 5.9. (iv) Observer-participation: being 'myself'

Being a midwife was most useful in gaining access and developing good relationships with staff and participants. Equally, being a midwife brings familiarity and could have contributed to my overlooking relevant concepts (Kirkham 1989; Field 1991). Although I had substantive midwifery experience, I had not been in the delivery suite for at least five years. Moreover, I did not personally know staff members or how the art and science of midwifery was practised in this Unit. I experienced that "*the linguistic variables that carry social information are network-specific*" (Aamodt 1981), therefore I made efforts to observe and record everything, and did not attempt to interpret any action during the observation period. I learnt the art of recording situations and events by observing and listening

Much has been written about the conflict between the roles of clinician and researcher when clinicians conduct research (Aamodt 1981; Lipson 1984; Burgess 1984; Kirkham 1983a; 1989; Field 1991; Gerrish 1997; 2003). Although I set out not to participate actively in the care of the women during labour I did not achieve this, and I did participate[69] in the delivery of care to all three.

### 5.10. Interviews

Although interviews had been intended as complementary to observational data, a decision was taken whereby interviews became a principle instrument because of limited opportunity to observe births. The interviews were loosely structured around critical incidences identified during observations initially; however, subsequently interview guides were used.

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[69] However I recognise that had I been involved in more observations, emergency situations might have arisen where I might have been 'pulled' to act as a midwife, for example postpartum haemorrhage and neonatal asphyxia. Not to act would have been unethical.

A semi-structured style was chosen because it offers the potential to obtain in-depth data, and would facilitate movement from general to specific issues. It provided an opportunity to engage in a purposeful way with the participants, gaining their views, perceptions and thoughts, understanding their interpretations of the social context in which they birthed their babies. This would enable the women's voices to be distinct and discernible (Ribbens and Edwards 1998).

As the qualitative interviews with the women and interpreters were exploratory in nature, I devised an interview guide of a few general questions covering similar grounds for each different group of participants so as to triangulate the data generated. For the women the broad questions related to their birthing process, pain relief in labour, expectations and attitudes based on the observed behaviour. For interpreters and midwives, the questions were around maternity services and their perception of the service needs of the women

### 5.10. (i) The interview agenda: reflective learning

A prototype interview guide (see Table 5.5) was devised with the intention of exploring experience and perceptions of the women participants.

**Table 5.5: Prototype interview guide used with the women participants**

| Questions | Topics of interest |
|---|---|
| 1. What do you think about the services you received in labour? | Attitudes toward intrapartum services in general. |
| 2. What do you think about the care you received during labour? | Attitudes toward labour. |
| 3. What do you think about methods you received for relieving pain in labour? | Methods of pain relief. |
| 4. What changes, if any, would you make to the way in which pregnant women are cared for in labour? | Aspect of the services that women would prefer to change. |

This guide was piloted with Zarina, a Pakistani woman who had recently had a baby. As a novice 'qualitative' researcher, I was surprised by how anxious I was conducting this interview. On reflection, I had focused on obtaining answers to the questions, and had overlooked exploring related avenues of interest proffered by the woman. For example, Zarina talked about her sister's maternity experience in Pakistan and her own role as a birthing partner.

The interview guide was revised (see Table 5.6) by refining questions, but ensuring that the tool remained broad enough to permit flexibility in responses. The broad questions became narrow and more focused as the interview progressed.

**Table 5.6: Interview guide for interviews with the women participants**

| Questions | Prompts |
|---|---|
| 1. Can you tell me about your labour? | What do you think of your labour?<br>What was your labour like? |
| 2. Did you know what was going to happen in labour? | Is it how you expected it to be?<br>What did you know about labour before you had the baby?<br>How did you know about it?<br>What type of information did you have? Why? |
| 3. Can you tell me about the labour pain? | What was your labour pain like?<br>How did you manage the pain?<br>What did you know about the pain? What sort of methods of pain relief did you know about?<br>How did you know about these?<br>Did you attend any antenatal preparation sessions? |
| 4. What did you think about the care that you received during labour? | What factors made the care good?<br>What would you have liked to make your care better? |

The interview guides used with interpreters and the midwives were not piloted (see Tables 5.7 and 5.8). Their design was very similar to those used for the women as they focused on four topics to facilitate discussion.

**Table 5.7: Interview guide used for interviews with the interpreters**

| Questions | Prompts |
|---|---|
| 1. From your experience of working with Pakistani women can you tell me what they want from maternity services during labour? | What are the cultural/faith needs?<br>What are their general needs? |
| 2. Can you tell me how well their needs are met? | Are there sufficient resources?<br>Are women involved in the decision making?<br>Do women know what to expect in labour?<br>Where do they get their information? |
| 3. What did you think about the care that they received during labour? | How do they manage their labour pain?<br>What factors made the care good? |
| 4. What is it like to work as an interpreter? | What support do you get? |

**Table 5.8: Interview guide used for interviews with the midwives.**

| Questions | Prompts |
|---|---|
| 1. What do Pakistani Muslim women expect from maternity services during labour? | What is their expectation?<br>Do the women specify any needs? |
| 2. Do maternity services meet the needs of Pakistani women? | Do women know what to expect in labour?<br>How well are the women prepared for labour and pain relief?<br>Are there sufficient resources?<br>Are women involved in the decision-making? |
| 3. What is it like to care for Pakistani women? | What works?<br>What are the barriers?<br>Are you prepared for this? |
| 4. What would you like to change? | What support do you get? |

## 5.11. Interviewing

### 5.11. (i) Interviewing women participants

All thirteen participants gave consent for the interviews to be audio-taped[70] . Antenatal contact enabled me to establish relationships with the women, making interviewing more easy. As I did not want to interview the women too soon after delivery I decided to interview them in their homes within the first three weeks postnatally. As I had met all the women at least once in the antenatal period, I knew their preferred spoken language and interviewed them in that language. As indicated in Table 5.2 six interviews were mainly in English, three were a mixture of English and Urdu, two were in Urdu and two in Mirpuri.

The interviews were conducted in a conversational style so I could develop an understanding of the meaning the women attached to events, actions and setting. I did not rigidly control the interviews, but facilitated the generation of the rich data and detailed descriptions necessary to develop theoretical explanations; I asked probing questions, sought clarity and checked assumptions. The women talked freely about their labour as well as their antenatal and postnatal experiences. The majority of the women were very keen to tell me their stories and as Khatiza (interview 11) said "*this*

[70] The interviews were between an hour and a quarter and two and a half hours long, with the majority of the interviews lasting for approximately one and a half hours.

*has been very good to talk about my experience and have time to myself*" (Field note: Monday 15th December 2003). Occasionally other family members participated in the interview. The interview with Khatiza (interview 11) and her husband was two and a half hours long.

After the ninth interview I felt there were no new insights, but I continued until after the eleventh interview when I was certain that no new data was forthcoming. All participants were mailed a transcript[71] of the interview within three weeks of their interviews

### 5.11. (ii) Interviewing interpreters

All nine interviews were conducted in the interpreters' homes, and lasted one and a quarter to two and a half hours. Although these interviews were conducted primarily in English, the conversation often slipped into Urdu, which is typical of conversations between bilingual people.

These exploratory interviews solicited a full account of interpreters' experience of the provision of maternity services to Pakistani women. The interview guide (see Table 5.7) served to ensure that the four topic areas were addressed. I found that all except one interpreter did not need further prompting once I posed the opening question - '*can you tell me what Pakistani women want from maternity services during labour?*'

I ceased to recruit interpreters for the interviews after conducting nine interviews, because after the seventh interview I felt there no new insights.

### 5.11. (iii) Interviewing midwives

Five midwives were interviewed; of these, three were conducted on the delivery suite soon after completion of the women's birthing, and two were conducted in the Health Centres where the community midwives were based. The five interviews were variable in length: those conducted in the delivery suited lasted fifteen minutes, twenty minutes

[71] The transcripts were translated copies from the audio-tapes and these were in English. I provided the women with an opportunity to discuss the transcripts with me or to arrange a meeting where I could translate for them.

and thirty-five minutes[72] and were not audio-taped; two interviews of forty-five minutes each were conducted with community midwives and taped.

## 5.12. Data management

All recorded interviews were transcribed[73] as soon after the interview as possible so that theoretical notes, observation commentary and my reflections could be captured when the information was 'fresh'; Interviews conducted in English were easily transcribed whereas those conducted in Urdu/Punjabi/Mirpuri required both translation and transcription. The process of translation and transcription was extremely lengthy: on average an hour long English interview tape took four hours to transcribe, taking twice as long if translated. I considered employing an official translator to undertake transcription but rejected this idea due to the sensitive nature of the data, a wish to preserve respondent anonymity and the importance of listening to respondent stories to enhance the analysis. Though transcribing was time-consuming, it brought me closer to the women's experiences and their words. Transcribing also provided me with an opportunity where "*structuring the material into texts facilitates an overview and is itself a beginning analysis*" (Kvale 1996: 168).

Having to transcribe interviews is a complex task involving "*translating from an oral language, with its own set of rules, to a written language with another set of rules*" (Kvale 1996: 165). I did not attempt to 'clean' any data as I did not want to risk changing meaning by making corrections to improve grammar.

## 5.13. Translation: issues of reliability and validity

Vulliamy (1990) notes that the quality of translation is likely to depend on the skill of the translators, their knowledge of the language and the culture of the people participating in the study, and the translator's position in relation to the researcher. As just over half the interviews were conducted in Urdu or a mixture of Urdu and English, it is important to trace the steps to ensure reliability and validity of data.

---

[72] I accompanied Celina when she went on her lunch break.
[73] Transcription (and translation) of all interviews was conducted by me.

Being multi-lingual, my thought processes draw upon different languages to develop my understanding. I used English to develop the interview guides and it was translated verbally into Urdu if women preferred. To ensure 'measurement equivalence', a form of validity that refers to measuring the same construct using a measure in different languages (Chang et al 1999). I piloted the questions with two Pakistani women and found this highlighted the consideration needed for issues related to content, semantics and grammar (Twinn 1997). In order to enhance equivalence in back-translation of the interview transcripts, I utilised the expertise of a female Pakistani professional translator in education to validate accuracy. I adopted this process of collaboration advocated by Birbili (2000) with all but two transcripts for which I had not obtained consent from the participants. I also consulted a professional advocate specifically to discuss the use of the most appropriate words where direct translation was not possible, and of verbal back translation where there seemed to be ambiguity.

One of the issues that arose during translation from English to Urdu is that many words and phrases do not have equivalents in Urdu, and where equivalents exist they are not commonly understood. For example for the English word '*pregnancy*', translates into '*haamla*', a word that many lay Urdu-speaking people would not know. A lay term for pregnancy that women tend to use is '*mein bemaar hu*' meaning '*I am ill*', or women may use '*mere peyat may kuch hai*' which translates '*I have something in my tummy*'. I felt the onus was on me to ensure that conceptual equivalence was achieved rather than relating individual words or phrases to that of Urdu (Temple 1997).

As part of the analysis of the interview data a close examination of the interview transcripts was required to obtain participants' perspective. It is possible that the reliability of the analysis might be affected by the quality of the transcripts when translating from Urdu into English. Twinn (1997) established that when different translators were used to translate the same transcript from Chinese into English there were differences between the translations, and proposes that to minimize any threats to the validity and reliability in the data analysis and achieve "*consistency in translation*", use should be made of "*one translator for all the interviews carried out in a study*" (Twinn 1997: 421).

I attended to the issues of validity and reliability and of accuracy of translation by being the sole transcriber; I asked participants to edit transcripts as necessary, and sought assistance from a professional translator to check accuracy of the translations.

Throughout translation of recordings into English, I was aware that the meaning of women's words should not be lost. My challenge was whether to use "*literal - translating word-by-word*" or "*free*" translation (Birbili 2000: issue 31). Literal translation of participants' data, whilst it might more accurately convey what participants have said, could "*reduce readability of the text*" and subsequent comprehension (Birbili 2000: issue 31). Free translation, where the researcher attempts to translate and write in one's own language, may improve readability, but carries the risk of "*misrepresenting the meaning of the conversational partner*" (Rubin and Rubin 1995:273) and "*of losing information*" (Birbili 2000: issue 31). I used both literal and free translation: where possible I used literal translation, but consideration was given to improving grammatical inconsistencies, and these were checked for accuracy by the professional translator. This was not an easy task, but where there were problems I wrote the original words in the transcripts to remind me of the context during analysis. Likewise, difficulty was encountered when trying to translate words expressing emotions when there was no English equivalent. Some of the women used the word '*pareshaan*' to describe their feelings, but this could be translated into many different words[74], for example 'anxious', 'distracted', 'distressed', 'jittery', 'teased', 'tortured', 'troubled', 'scattered', 'worried', depending on context.

## 5.14. Data analysis

Informal analysis was undertaken concomitantly with the data collection phase, culminating in a seminar presentation with peers; formal analysis took place at the end of data collection. Preliminary analysis consisted of reading the transcripts of the interviews, field notes and records of observations of labours and recognising broad themes.

This preliminary analysis facilitated induction, that is, the production of facts to confirm general statement and inference of general law from particular instances. I wanted to provide space to hear women's intrapartum experiences rather than shape or manipulate

[74] Please see 'Urdu - English Dictionary' accessed on http://www.geocities.com/urdudict/p/par.htm

what they tell me. It is asserted that "*interview content* [.....] *is a joint production*" (Mauthner and Doucet 1998: 124); the interviewer actively listens to the stories of the participants, and the conversations are guided by the research agenda and by the interviewer's analytical thinking.

Having completed the data collection, I was faced with the challenge of making sense of this massive amount of data from different groups of participants. There is much guidance to assist qualitative analysis but few rules (Bryman and Burgess 1994; Miles and Huberman 1994; Wolcott 1994; Coffey and Atkinson 1996; Strauss and Corbin 1998; Mason 2002; Robson 2002). Like Mauthner and Doucet (1998: 120) I "*found few detailed presentations of the step-by-step processes of how transcripts are analysed*"; there was no template I could use in its entirety. So, acknowledging that the responsibility in qualitative research lies with the researcher "*to monitor and report their own analytical procedures and processes as fully as possible*" (Patton 2002: 434), I have endeavoured to demonstrate rigour and integrity in the process of analysis I undertook, enabling readers of this thesis to judge its trustworthiness (see section 5.16).

I was aware that "*the issue of listening to women, and understanding their lives 'in and on their own terms', has been a long-standing and pivotal concern amongst feminist researchers*" (Mauthner and Doucet 1998: 120). The discourses of methods of data analysis were important to me because I wanted to ensure that whatever method I chose would provide an opportunity for the women's voices to be heard. I wanted to present their experiences accurately without losing meaning. Central to these issues were the challenges of "*seeking to explore such privately based knowledge and personal understandings and then reconstitute them within publicly based disciplinary knowledge*" (Edwards and Ribbens 1998: 13). So the balance was to be achieved between voicing and silencing socially invisible private knowledge. "*If we cling to .... authoritative ways of knowing, we run the risk of silencing, or shaping in particular ways, private, domestic and intimate ways of knowing, meaning and experience*" (Edwards and Ribbens 1998: 16). On the other hand, if there are no actions, then these private knowledges and personal understandings will continue to remain invisible and hidden. Thus, I saw my role to "*translate between the private world of women and the public world of academia, politics and policy*", but with caution that I do not perpetuate "*the stereotypes and cultural constructions*" (Standing 1998: 193).

### 5.14. (i) Data analysis: the framework approach

It is against this background that my choice of approach to interpreting data is rather eclectic; I draw upon feminist principles so that I can keep the women's voices alive in the data, while ensuring a transparent systematic process. Data analysis focused upon constructing key themes through content analysis, and the method for this was the 'framework' technique (Ritchie and Spencer 1994: 173). Whilst the 'framework' would facilitate systematic analysis of the textual information, its staged approach would enable women's voices to be kept alive.

In Table 5.9, I summarise content analysis undertaken within this study. I have drawn upon the ladder of analytical abstraction (Carney 1990) to display the decisions made during analysis, thereby forming an audit trail. The analysis, and constructions arising from it, are contestable. Its role here is a summary or template of the detailed discussion that follows.

The framework approach consists of a number of discrete though highly interconnected stages. Whilst this approach is systematic and closely controlled, it relies on the "*creative and conceptual ability of the analyst to determine meaning, salience and connections*" (Ritchie and Spencer 1994: 177). The central focus is on the original accounts and observations of the people it is about, and is open to change, additions and amendment throughout the analysis process. This approach consists of "*shifting, charting and sorting material according to key issues and themes*" (Ritchie and Spencer 1994: 177). This model was particularly useful in this study because it highlighted associations between women's experiences, attitudes and behaviours. There are five stages involved in this framework and these are familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation. Although these stages should be accomplished systematically, in practice I found these processes were not linear but rather cyclical, whereby I moved forwards and backwards within the stages.

**Table 5.9: Process of analysis based upon Carney's ladder of abstraction**

| Levels in Carney's ladder of abstraction (1990) | Analytical activity | Activities undertaken to trace decisions that shape inductive analysis |
|---|---|---|
| **Level one**<br><br>Involves summarising and packaging the data. | 1. Create a text to work on<br><br>2. Try out concepts to find a set that fits. | 1. **Familiarisation** with data - text and research diary.<br>2. Text conventions used in constructing observational and analytical notes.<br>3. Develop **a thematic framework** and use throughout fieldwork; using constant comparison to elucidate conditions, interaction, strategy and consequences. |
| **Level two**<br><br>Repackaging and aggregating the data. | 1. Identify themes and trends in the data overall, recombining and selecting categories, the analysis of which reveal key phenomena in the culture. | 1. Apply **indexing** system to the data in search for relationships in the data and write analytical memos; finding out where the emphasis and gaps in the data are.<br>2. **Charts** of data used in displays.<br>3. Visual displays of relationships.<br>4. **Process of mapping and interpretation** used to develop categories and concepts. |
| **Level three**<br><br>Developing and testing propositions to construct an explanatory framework. | 1. Explore thematic interpretation through member checking.<br><br>2. Delineate the deep structure. | 1. Member check to discuss analytical themes in displays.<br>2. Written accounts sent to member checkers for approval/verification. |

Source: adapted from Carney (1990)

### ..... Familiarisation: the first stage .....

I drew upon the principles of Mauthner and Doucet's (1998: 124-125) "*voice-centred relational method*" of analysis where they advocate three to four readings of interview texts. During the first reading of the interview transcripts I was better able to understand women's maternity experiences and tried to understand their personal birth stories. I looked for key recurrent words and phrases.

The second reading of the transcripts was concerned with listening to how the women related their experiences and feelings about themselves the midwives, and the maternity services. In accordance with Mauthner and Doucet's model (1998), I highlighted pronouns 'I', 'we' and 'you' in the women's narratives, giving attention to their stories. I was able to build a picture of where the women saw themselves, whether they were struggling with words, and how they perceived and experienced themselves. With

having to focus on 'I', 'we', 'you' and 'they', I was able to listen to the women as they spoke about the world in which they experience childbirth. I became conscious of the struggles of the women in negotiating with maternity services and the midwives. 'I', 'me' and 'we' was more about the women as service users, who were in a vulnerable and marginalised position and 'they' were the midwives, general practitioners, and the organisation. This reading enabled me to develop a sense of the structures and processes that affect quality of service delivery.

Although a set of three to four readings is advocated, I undertook only three. In the final reading, I focused on relationships and the wider social context of women's birthing. I listened to how the women spoke of their "*interpersonal relationships*" (Mauthner and Doucet 1998: 131) with the midwives, and in particular to how these relationships affected the women. As I was interested in the social context of women's experience, I also explored women's relationships with their husbands and families. In addition to this I listened to the ways in which women experienced the "*broader social, political, cultural and structural contexts*" (Mauthner and Doucet 1998: 132) of birth. I concentrated on women's narratives, exploring the factors that acted as facilitators and inhibitors in accessing their maternity services. I examined these concepts to see whether they reflected current theoretical explanations, and what sorts of links existed between women's words and the contemporary theories.

**..... Identifying a thematic framework: the second stage .....**

During the familiarisation stage I also began the process of "*abstraction and conceptualization*" (Ritchie and Spencer 1994: 179). In my first reading of the texts I highlighted key words, phrases and sentences that were related to the research questions, and noting these in the margin of each transcript. These were frequently readjusted during subsequent readings and further developed when greater understanding was gained in terms of interpersonal relationships and women's social context. In the familiarisation phase, analytical notes were made on transcripts, and these extended to a range of notes pertaining to issues requiring clarification, similarities and differences with the literature, questions being asked of the data, key words or concepts, and any exceptions.

I then grouped key words and phrases into key issues and concepts; similar words and phrases were clustered together to form categories. These concepts were then grouped together into themes and each theme was named. Descriptions assigned to the categories enabled me to identify thematic similarities in order to group different concepts. The thematic framework was constructed by drawing upon a priori issues identified in the research aims and interview topics and, more importantly, issues that were raised by the women.

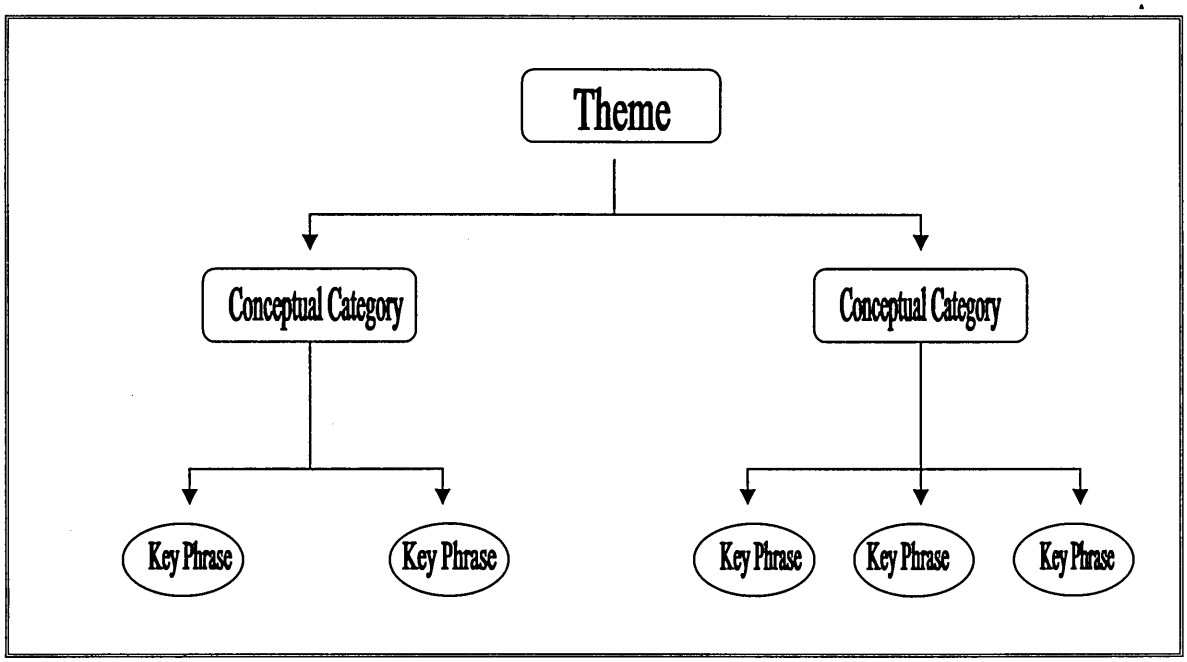


**Figure 4: A thematic framework: from key words and phrases to themes**

Initially the framework in Figure 4 was descriptive, but as it was applied to transcripts, the categories were refined and verified in light of the emerging issues and concepts. In practice, I found that there reached a point when there were no new issues emerging, and as a result there was no further movement of the concepts and themes.

I continued to explore the literature to develop a body of broad theoretical and conceptual knowledge in order to stimulate questions during analysis. It is essential that the researcher read in a range of fields to prevent being dominated by one specialist discipline, and should read more in depth in the substantive and theoretical area under study during the final stages of analysis (Glaser 1978). I had developed extensive

knowledge of the literature, before designing the study; I extended this to include literature on phenomena identified from interviews.

**….. Indexing: the third stage …..**

The third stage involves indexing, where "*the thematic framework* [...] *is systematically applied to the data in its textual form*" (Ritchie and Spencer 1994: 180). The indexing system was underpinned by themes that emerged from the interviews. I applied this index system systematically to the interview data, data collected during observations, and to field notes. Judgements were made about the meaning and significance of the data both in the excerpts and within the overall context. Single excerpts of interaction often contained a number of different themes and each was referenced; this process highlighted patterns of association. Employing an indexing system made the process of analysis explicit during member-checks and was a marker for trustworthiness; having to revisit the transcripts several times also ensured that important issues would not be missed.

**….. Charting: the fourth stage …..**

'Charting' involves building "*up a picture of the data as a whole, by considering the range of attitudes and experience for each theme*" (Ritchie and Spencer 1994: 182). I created a two-way grid with index categories column headings and participants as rows. A chart was created for each theme and each group of participants.

Although Ritchie and Spencer (1994: 184) advocate the process of "*abstraction and synthesis* [where] *each passage of the text, which has been annotated with a particular reference is studied and a distilled summary of the respondent's view or experience is entered on the chart*", I chose to select the components of transcripts which had been annotated and paste them verbatim on the chart. I felt these quotes were powerful in themselves in illustrating women's feelings and experiences of maternity services and midwifery care. The comments made by the women were helpful during the final stages of analysis as ensured that context remained central; these comments were also used as 'quotes' in the discussion of findings.

The process of charting served two purposes; one was the creation of a picture where I could see key issues emerging, and the second was enabling me to compare the data between participants

**….. Mapping and interpretation: the fifth stage …..**

The final stage is 'mapping and interpretation', where the researcher examines the whole dataset and starts to define concepts. During this phase the researcher sets out to determine patterns as well as understand ranges and provide explanations. All the charts and field notes are reviewed and the researcher arranges the data in a useable form and "*compares and contrasts the perceptions, accounts or experiences* [and] *searches for patterns and connections and seeks explanations*" (Ritchie and Spencer 1994: 186). Thus, it is by "*weighing up the salience and dynamics of issues*" and "*searching for structure*" that a picture is created.

During this final stage of data management I searched for emergent patterns and concepts pointing to interpretations of experience, for example racial experiences, personal agency, and explanations and understanding of events, providing insights to the structures and processes the participants were encountering. The emergent themes were formalised and returned for checking to four randomly selected participants who I refer to as 'scrutineers'. These themes subsequently formed the basis of this thesis.

## 5.15. Reflexivity

Whilst I contacted the women participants directly at three points, the indirect interface continued through the processes of data management, analysis, and writing up.

In the majority of cases my relationship with participants was respectful and warm. I suggest this is because I tried to be on the women's side as they ultimately had the power to allow me into their world. However, the success of the relationship was more importantly in adopting the feminist principles of research during the whole interface; I was able to celebrate the woman-to-woman interview (Oakley 1981). I was also able to share the subordinate structural position of women by the very nature of my gender, enabling me to identify with the women and form strong bonds through the interview situation (Finch 1984).

Reading transcriptions and listening to the audio-tapes was sometimes emotionally distressing, owing to the degree of discrimination and racism experienced by some participants. On reflection, my distress was related to the impact the discrimination had on the women - their anger, their pain, and their bitterness towards the systems or midwives. On two occasions, I wanted to report the issues of racism to the Head of Midwifery, but I did not, as it could have had a disastrous effect on my integrity as a researcher. Nevertheless, these shared experiences of powerlessness among minority ethnic researchers and participants could possibly be a basis for fostering feelings of mutual trust. According to Oakley (1981: 55) "*where both* [interviewer and interviewee] *share the same gender socialisation and critical life experiences, social distance can be minimal. Where both interviewer and interviewee share membership of the same minority group, the basis for equality may impress itself even more urgently on the interviewer's consciousness*". As a researcher from a SA background, I felt that I was able to maintain a good rapport with the participants. The fact that we shared a common cultural background and were able to draw upon similar experiences contributed to the relationship.

## 5.16. Trustworthiness

The issue of trustworthiness is central to the whole research process and is primarily concerned with bias (Burgess 1984; Robson 2002) and the assessment of the "*quality, rigour and wider potential of research*" (Mason 2002: 38). Trustworthiness refers to the way in which the findings of a qualitative study represent reality; the study's rigour can be demonstrated by an audit trail running from selection of research design to presentation of findings (Guba and Lincoln 1994). There are alternative approaches to demonstrating trustworthiness in qualitative research (Miles and Huberman 1994; Lincoln and Guba 1985), with some suggesting credibility instead of internal validity, confirmability instead of objectivity, dependability instead of reliability, and transferability instead of external validity.

The criterion of credibility refers to the truth and accuracy of the data (Miles and Huberman 1994), being "*built into the research process with continual checks on the credibility, plausibility, and trustworthiness of the findings*" (Kvale 1996: 242). At all stages of this study I endeavoured to examine the influences on data collection and the authenticity of findings by attending to questions such as potential for researcher bias, ensuring that member checks were made to assess representativeness of the data analysis

and findings, and that the categories selected for discussion grasped the essence of the phenomena under description. Hammersley (1992) asserts that an account is valid or true if it represents accurately those features of the phenomena that it is intended to describe.

**Table 5.10: Trustworthiness: Summary of modus operandi**

| Criterion | Concerned with | Modus operandi |
|---|---|---|
| **Credibility (internal validity)** | Truth of the data and its believability. | Constant comparative analysis.<br>Saturation of categories. |
| **Confirmability (objectivity)** | Degree to which the analysis reflects the truth. | Translation and back translation.<br><br>All women participating in the study were offered the transcripts to check.<br><br>Member checks<br>3 Pakistani Muslim women participants each checked the findings, interpretations and conclusions of their own transcript and that of one other woman.<br><br>External audits<br>2 external educationalists/researchers scrutinised data analysis and my conclusions from the observations of labour and interviews involving the Pakistani Muslim women.<br>1 external professional interpreter involved in scrutinising the data analysis and the conclusions derived from interviews with the interpreters.<br><br>Regular discussions with the supervisor.<br><br>Seminar/workshop presentations.<br><br>Keeping a reflective diary. |
| **Transferability (external validity)** | Potential application of theory to other situations. | The framework presented to a group of Pakistani Muslim women and to a group of midwives studying post-registration midwifery programme.<br><br>The findings in the main were accepted as most likely to be their personal experiences. |
| **Dependability (reliability)** | Accuracy in the research methods and research practice. | Transparency in research design and in collection and analysis of data.<br><br>Seminar/workshop presentations - peer scrutiny.<br><br>Regular discussions with the supervisor. |

Adapted from Miles and Huberman (1994: 277 - 279)

There were a number of approaches I adopted "*whereby the naturalist's alternative trustworthiness criteria may be operationalised*" (Lincoln and Guba 1985: 301; Glesne and Peshkin 1992); these are summarised in Table 5.10. The credibility of my research was improved through persistent engagement with the research topic over a prolonged period.

This enabled me to recruit suitable participants as well as providing internal and external checks. I participated in semi-formal presentations at workshops and seminars, which encouraged peer review where other researchers and supervisors critically engaged in debate and discussion. In addition triangulation of data collection methods, data sources and theory provided corroborating evidence on the emerging themes and perspectives; member checks were seen as "*the most critical technique for establishing credibility*" (Lincoln and Guba 1985: 314), involving taking the data analysis, interpretations and conclusions back to the participants for scrutiny.

Spradley (1979), Lofland and Lofland (1995), Rubin and Rubin (1995) and Kvale (1996) and many others assert that the credibility and trustworthiness of findings are dependent on the researcher remaining true to the data and presenting findings in a way that captures and reflects participants' stories, ensuring that participants can recognise their own realities. Where, as here, research is conducted by a single individual, the research is at risk of being interpreted from a narrow perspective either because the researcher is not open to the breadth of data or because s/he approaches the data from a particular perspective.

Whilst I did not employ grounded theory for data analysis, I did utilise some of its procedures, such as constant comparative analysis and saturation to substantiate credibility of the data. Constant comparative analysis is where "*empirical indicators from the data ..... are looked at for similarities and differences*" (Schwandt 1997: 60), revealing that many of the codes and themes identified originated from the data. The comparison of data sets revealed that the majority of information given was balanced and insightful, and there was similarity with that described by other participants.

I became acutely aware that "*.... power relations continue in our analysis and writing*" (Standing 1998: 198) and "*however equal the methods of access and interviewing, we, as researchers ....hold the real power of which data, which parts of the interviews, to use, how to interpret the women's words, what to use the research for, and how to represent the women's voices....*" (Standing 1998: 188). So I took great care when extrapolating quotes from the transcripts, ensuring that the quotes from the participants reflected their experience(s), supported by theoretical triangulation, and that quotes did not just come from the women who were most articulate, but also represented the 'less powerful' (Standing 1998). The language and the wording of the quotes therefore remain unaltered.

A number of strategies were adopted to assure confirmability, that is, the degree to which my analysis reflected the truth constructed by the participants. As recommended by Lincoln and Guba (1985), a system of cross-checking my interpretation of data and findings were established within the research design. Three of the women who had participated in the study verified the accuracy of their transcripts, together with another anonymised script each, against my analytical and theoretical notes and tentative conclusions. The process of checking and comparing interview data sets enabled me to assess if the participant was exaggerating her experience of maternity services or giving me information she perceived I wanted.

In addition, the data were subjected to external audits (Lincoln and Guba 1985; Miles and Huberman 1994). This was over and above the external scrutiny of the data during translation stages. Three independent experts examined the process and accuracy of data collection and analysis, including verification of the interpretations of data. The two experts (a midwife and a health visitor) who examined the data from the women participants were academics/researchers with interests in the field of ethnicity. Both indicated that the interpretations and conclusions were underpinned by the data, which was confirmed to be accurate. Data analysis and subsequent findings from the interpreters and midwives were subjected to similar external scrutiny.

The third expert was a professional interpreter who audited the research process including data analysis, findings, interpretations and conclusions derived from the interviews involving interpreters.

Transferability, also referred to as "*fittingness*" of the research concerns the possibility of the theory being applied to other contexts (Miles and Huberman, 1994: 279). The frameworks were presented to a group of Pakistani women and to two groups of midwives studying a post-registration midwifery programme. The findings in the main were accepted as most likely to be their personal experiences. The findings of the study can be applied to other Pakistani women either on a population or case-to-case basis.

Dependability concerns itself with "*how reliable, accurate and precise the research tools or instruments are, and this in turn is being judged by the consistency with which known instruments produce certain 'measurements'*" (Mason 2002: 187). This means that in qualitative research the researcher is often the main data generation instrument,

and methods are not standardised but are appropriate means of generating data (Miles and Huberman 1994; Mason 2002). As the main researcher I recognised the study's arbitrariness and subjective nature, given that my view of it was coloured by my own experiences. An effort has been made throughout this study to make explicit my own ontological and epistemological assumptions, and through logging my feelings and reactions in a research diary.

## 5.17. Summary

In this chapter I have described the strategies for recruitment, sampling, data collection and analysis, including those for assessing the trustworthiness of the data and findings. In doing so I have highlighted some of the challenges in conducting interpretive ethnographic research and I have provided details of my research to demonstrate reflexivity and ethical conduct. The next four chapters will focus on the findings of the study, and have been structured around the three main themes that emerged from the data gathered from the participants.

Chapter 6 focuses on Pakistani women's **Knowledge of labour and its process including pain relief.** Chapter 7 will address the emerging theme of **social support during labour,** and chapter 8 will focus on the theme of women's **relationship with midwives.** Chapter 9, the final chapter, reports the findings from the interpreters.

# Chapter 6

# Transition into the unknown: women's ways of 'knowing'

**Excerpt from an interview**

"[.....] it is frightening to be in a situation when you do not know what is going on and maybe you are new to the country and this is a totally new procedure and you have not seen much of this [childbirth] in Pakistan as well because there, the married women keep you away from it and so it is quite frightening. So just being able to be reassured and to be told at every stage no matter how trivial it just gives the person that confidence and makes them relax a little bit. Women then know that they [midwives] will tell me everything and they will not do something to me that I am not aware of that they will not let me know.

**Alisha (Interview 1)**

## 6.1. Introduction

This chapter focuses on the theme of 'knowing'. All women frequently talked about their knowledge of labour and pain relief and, the range of sources from which they gained information to construct their knowledge of childbirth. I shall explore women's experience of labour pain and explore how they developed their knowledge about methods of pain relief. The findings revealed that women's knowledge and understanding of process of birthing was low. They had little knowledge of what happened in labour, available methods of pain relief and common interventions.

## 6.2. Uncharted journey

### ..... Fear of pain .....

Many women in this study expressed fear of childbirth. They talked about being frightened of "*not knowing what was going to happen during labour*" (Farzana – interview 6). They were "[.....] *kind of scared of birth and labour* [.....] *sort of didn't know what it would be like and* [were] *really scared* [....]" (Eiliyah). These women expressed concerns about the wellbeing of their baby, and whether they would be

"*treated normally*[75]" in hospital (Ghazala); they were worried about not making a nuisance of themselves; they were afraid of labour pain and whether they would survive childbirth. Similar concerns have been voiced by women worldwide (Jeffery et al 1989; Katbamna 2000; Melender 2002; Saisto and Halmesmaki 2003). Fear and anxiety in pregnancy and childbirth is not uncommon in both primigravidae and multigravidae women (Katbamna 2000; Hofberg and Brockington 2000), though some studies report that anxiety is more intense in pregnant primigravidae women (Melender et al 1999; Alehagen et al 2001). Possible explanations might be that childbirth is painful and the women go through great change and uncertainty during pregnancy and labour (Raphael-Leff 1991; Paradice 2002). Other factors noted are psychological, where previous negative life experiences may affect the women's ability to cope, and social factors where women are concerned about economic factors or lack of support (Katbamna 2000; Melender 2002; Saisto and Halmesmaki 2003).

There appears to be no clear definition of 'fear of childbirth', nor at what point anxiety and fear turns from a physiological (Raphael-Leff 1991) to a pathological state (Saisto and Halmesmaki 2003). Fear is multidimensional, consisting of three components, that is, subjective experience of fear that the woman herself defines, objective indicators such as psychophysiological changes resulting from fear, and finally where a woman may attempt to avoid certain situations (Rachman 1990). Some degree of worry and anxiety during pregnancy and labour is inevitable and is regarded as 'natural'; the majority of women overcome these concerns. However, a few do go on to develop extreme fear of childbirth with adverse consequences (Ryding et al 1998; 2003; Hofberg and Brockington 2000; Saisto and Halmesmaki 2003), and some women report that fear of childbirth has been a key determinant for them in delaying or avoiding pregnancy (Hofberg and Brockington 2000). Such extreme cases, where women actually develop a phobia of pregnancy, are referred to as 'tokophobia' (Hofberg and Brockington 2000). In this study 'labour pain' was one of the most frequently cited reasons for being 'scared':

[75] When this issue was further probed Ghazala reported that she had heard that "*some women had told her that sometimes that nurses treat Asians differently* [....] *they do not treat us the same as their own*".

"[.....] *I knew about pains in labour, you know my auntie had told me. But I did not know what sort of pain ..... I thought I will have pain ... yeh... yeh. She told me you'll be alright well every time the pain comes just breathe in and the pain goes just breathe in and out and that was it. What made it worse was that I didn't know that the pain will come and go and when the pain came I just kind of jumped and I got kind of really scared. I just did not know what was happening*".

Khatiza

**..... Going through hell .....**

Almost all thirteen women talked about labour pains during the antenatal period and in the postnatal period. Although the main purpose of the antenatal meeting was to confirm women's consent to participate in this study, nine out of the thirteen women initiated discussion about labour pain. Many women were concerned about its nature and about options for pain relief. All antenatal visits took place in women's homes, lasting about half an hour each. The conversations at these meetings were not recorded, but field notes were made after the meeting. I found these discussions very difficult because I was aware that giving any advice would contravene research ethics. However the women knew I am a midwife and would have expected me to know about methods of pain relief; at a professional level I felt I was letting the women down. I provided them with the opportunity to articulate their concerns and advised them to discuss the issue of labour and pain relief with their midwives.

During the postnatal interviews, the majority of women focused their discussion on labour pains and the methods used to relieve it. These finding are echoed by other researchers suggesting that all women, regardless of ethnicity, find experiences of labour pain an important part of their journey. Bowes and Domokos (2003) also reported that labour pain was a central part of women's experiences in their study of Pakistani and White women, and other studies have reported that fear of labour pain is the most common reason for fear of childbirth (Hofberg and Brockington 2000; Waldenström et al 1996; Searle 1996; Areskog et al 1981; Melender 2002; Saisto and Halmesmaki 2003). Whilst some women in my study found they could tolerate pain and it was "*not as bad as* [they] *had first thought*" (Deeba), a few were distressed about their experience of pain: for them it was like "*going through hell*" (Farzana).

*"The pain nearly killed me. It was really, really bad and I just could not cope. They* [midwives] *kept telling me that it was early labour and they could not give me anything for the pain. But it was bad just in my back ....".*

Jariyah

The experience of labour pains for one woman carried on in the postnatal period. She recounted:

*"One thing I didn't like it when they put me in a ward where all pregnant women were. I was the only one there with a baby and every one else were waiting for their babies – some were early and some were late – and they had the baby's heart beats on* [cardiac monitors] *and it felt like that I was in labour room and every time I heard* [sounds of fetal heart] *I thought oh no; I felt that I was in labour again and it was like I felt contractions again. But you know after that my contractions never came and when I was like lying in my bed* [postnatal period at home] *at the back of my head I felt that I was still in the same room and I was still in labour and having pain and I just could not get over it and now when I go to bed I just don't think of it. In a way the labour has really put me off. The pain has really put me off and I didn't know, that it would be really that bad,* [.....] *I don't think I will have another one* [baby], *this has put me off really".*

Inayat

The findings of this study suggest that like many other women (Green et al 1998; Green et al 2003), Pakistani women are worried about labour pain and for some it is associated with fear of childbirth. Although the majority of women talked about labour pain, all except three looked at the experience positively. They were pleased with the outcome of having a healthy baby and possibly these feelings of joy supersede their concerns for pain. However, Inayat appeared to have been emotionally affected by her experience and yet she did not discuss her experience with her midwife at any point. Inayat revealed that she had discussed the emotional distress caused by labour pain with her mother-in-law and her mother:

*"My mother-in-law was saying that don't worry about it, it will get better next time and my mum was saying that well that's how it is. Don't worry about it and don't let that put you off. Next time you have a baby it will be easier but I don't know* [.....]."

Inayat

Given the association between labour pain and fear of childbirth, as well as the correlation of extreme fear of childbirth with intervention and adverse mental health, it

is important that midwives ask women about their feelings during pregnancy, labour and the postnatal period. In circumstances where undue anxiety is identified this should be discussed in more detail and strategies to overcome these should be explored. It appeared that Inayat's needs to overcome the distress caused by labour pain have not been met, and this might affect her future pregnancy and childbirth. Many women in this study, however, used the interviews as an opportunity to talk about their experiences, and some acknowledged they found this beneficial.

## 6.3. Ways of knowing

Modern day structured childbirth preparation has been established throughout the UK since the mid 1900s (Murphy-Black 1990), informed by the traditions of public health (Williams and Booth 1974) and control of childbirth pain (Kitzinger 1974; Skelton 1985). Currently it is based on the model that emerged in the early 1950s and 1960s which involves a range of programmes, primarily aiming to "*use psychological or physical, non-pharmaceutical modalities for the prevention of pain in the childbirth*" (Enkin et al 2000:24). Where this study was conducted, the programmes of preparation for childbirth and parenthood are provided by the NHS Trust in both the community and hospital settings; voluntary organisations such as the NCT also provide private sessions. Childbirth preparation sessions are also provided specifically for SA women who are not proficient in English, where the healthcare professionals are accompanied by an interpreter employed by the Trust. The programmes cover a broad range of topics to facilitate women's knowledge of childbirth, promoting their confidence and ability to develop strategies to manage labour, as well as developing greater knowledge of infant caring skills. These weekly education sessions are normally provided over five or six weeks when the women are about thirty weeks pregnant.

Pakistani women in this study reported a number of sources from which they gained information to construct their knowledge about labour and methods of pain relief. However, many reported low levels of knowledge of labour process and believed they did not have enough information on which to base decisions; they dismissed their own knowledge and put their trust in the midwives' knowledge.

### 6.3. (i) Structured childbirth preparation

Of the thirteen women who participated in this study, eight were unaware of antenatal provision of childbirth preparation sessions. Five women reported that their midwives had informed them of these sessions but only three had attended. The other two women reported that their personal circumstances prevented them from attending. Farzana reported that her mother was ill and she could not leave her on her own. Not attending childbirth preparation sessions, in her opinion, did not disadvantage her unduly because she got the information about labour from her mother and her friend. However, later on in her interview Farzana talked about needing more information about methods of pain relief. When asked if she would have benefited from going to the childbirth preparation classes she affirmed:

> "*I don't know hm.... not really. I don't think ..... because mum never went to classes and they* [babies] *came out all right, didn't they. I mean it's different with Asian people. I mean if it's English people, they obviously go to the classes, they go through the whole book and everything*".
>
> Farzana

> *"I don't know, you don't really get a lot of Asian people going to classes and stuff do you. I mean I would have gone because I have studied in this country, I go about the English way. I would have gone, but I was working when the classes were on".*
>
> Ghazala

Farzana's comments raise a number of issues. For example, like Ghazala her perception was that the childbirth preparation classes are for 'English' women. It could be inferred that they saw their way of constructing knowledge about childbirth different from their White counterparts; English women attend classes and Asian women don't. Alternatively it is possible that the Pakistani women perceive that the information provision at the childbirth sessions is ethnocentric and does not meet their needs. Ghazala, who was proficient in English, explained that she "*goes about in an English way*", possibly meaning that she is Westernised, but still she did not perceive these sessions were for her. Conversely, it is possible that like Farzana, some Pakistani women see their mothers or mothers-in-law as role models, and believe they can follow that example.

**….. Attendance …..**

Low attendance at childbirth preparation sessions is a topic of much investigation (O'Brien and Smith 1981; McIntosh 1988; Jacoby 1988) as is their effectiveness (Gagnon 2000). Many factors identified that prevent women attending are not wanting to go, not knowing about the classes, feeling it wasn't worthwhile, concern that exercises might harm the baby, time of classes, and difficulties with physical access (Rees 1996). Other research evidence suggests that women from lower socio-economic classes, young, single women, and some women from the BME groups are less likely to attend than women from middle classes (Boswell 1979; Milner 1990; Cliffe and Deery 1997). Some reasons given for low attendance at preparation sessions by women from the BME background are lack of interpreters, lack of written information in languages other then English, perceived differences in childcare practices, domestic commitments, and that the style of class is too formal (Combes and Schonueld 1992). Other reasons given for the low uptake of the preparation programmes is that the content is not sensitive to the cultural needs of the women. For example one of the women in Katbamna's (2000) study reported that:

> *"The lady in the class was talking about how the baby will be delivered in hospital. I felt very embarrassed because in Bangladesh we do not talk about such things. I had gone to parentcraft classes because I thought I had to go ….. I didn't know what it was all about but after I found out I did not want to go anymore".*
>
> Bangladeshi mother, first pregnancy (Katbamna 2000: 65)

Woollett et al (1995) commenting on attendance rates stated that whilst the uptake of antenatal classes was low by SA women, rates were similar to those identified in some studies (Husband 1983; Jones and Doughtery 1984) and higher than ones reported in others (Dobson 1988; Watson 1984). It appears that factors such as proficiency in English remain a barrier to access. However, a lack of recent literature on antenatal education makes it difficult to judge the current situation regarding attendance.

Of the eight women who were unaware of the preparation sessions, three expressed disappointment at not being informed. Of the remaining women a few women felt they would not have gone because they knew how to look after the baby and would be getting support from their family. It was also apparent that they were unclear about the

purpose of the classes. Khatiza was in agreement that antenatal preparation was important but was of the opinion that it would not be of value to her, asserting that:

> *"I didn't go to any antenatal classes but I had read a lot about birth and felt I was okay and plus I could speak English and didn't have any problems. But for women who do not speak English that is an issue in our Asian culture you know interpreting is an issue".*
>
> Khatiza

Some of the women stated that apart from childbirth sessions there are other sources where knowledge about labour could be gained, for example through reading, videos and talking to other people; not all women felt this was an appropriate way to prepare. Some of the women felt too much information was frightening, and they would have preferred not to know. However, retrospectively they did feel they benefited from knowing; not knowing did compromise them in labour.

> *"I bought a book for labour which had picture of baby being born but I didn't look at it. It was all disgusting. I wish I had read it then but I didn't. It looked disgusting* [.....] *When I had to read it I had to cover the pictures like that* [demonstrates how she covered the information] *but I just didn't read the book I just shut the book and thought forget it. And I just learn when the baby comes home and stuff like that. I think if I had looked at the pictures and read a lot I would have been even more scared and I'd rather take it as it comes and see how it goes. I rather not see what it is like in a book."*
>
> **Inayat**

Literature strongly suggests that White married women from middle to upper socio-economic groups are typical attendees at childbirth preparation sessions (O'Meara 1993; Lumley and Brown 1993; Gagnon 2000). Historically the organised sessions for childbirth education were aimed at the middleclass, and it is of no surprise that the uptake of this service is low among working class women. Uptake of preventative services continues to be an issue among groups such as very young women, those from lower socio economic groups, and those from the BME communities. It appears that the women who would benefit most from the sessions are less likely to access these opportunities. There is also a prevailing view held by many midwives that SA women do not attend the antenatal childbirth sessions, but if SA women do not know about the antenatal sessions then they cannot attend.

**….. Usefulness…..**

Midwives in the Unit (research setting) are expected to inform all primigravidae women of these preparations session at the booking visit. Interestingly some women did not know about these sessions. Given all women had attended antenatal clinic in early pregnancy, it is unlikely they would have missed this information. It is possible that women were informed but because the information was provided during early pregnancy the women forgot. However, all three women who had attended the antenatal preparation sessions found them extremely helpful, for example:

> *"They* [antenatal classes] *like taught me the feeding, like breast-feeding and stuff that really helped* [….]. *Before, like, I didn't know what drugs were really and what we can use* [for pain relief]. *And when you go to the classes, they* [midwives] *tell you what drugs you can use, what disadvantages and advantages they give, so I knew what I wanted, put it on paper* (birth plan). *I think it's best to put it down on paper, then the midwives know what you want them to do".*
>
> Alisha

Of the three women who attended the childbirth preparation sessions, two women were not proficient in English and they attended the sessions where the Trust interpreter was present. They all found these sessions very informative and were able to provide accounts of many aspects of care they found helpful:

> *"I went to the preparation classes and I knew a bit from there. The video that was given told me what would be happening* [in labour]. *I knew that the pains would start and stay for so many minutes and then subside and then start again after some time. They also told us about the drugs to reduce your pain during labour…. that was good. But* [woman laughs] *I didn't need any well when I went into hospital I had her* [baby girl] *soon after getting there".*
>
> Lateefa

Two of these women commented that they were encouraged to take their mother-in-laws with them and this was helpful. Although this was not a common practice, one of the three women who attended antenatal classes developed a birthplan which she found helpful. Many women who did not attend the antenatal sessions reported they did not know what was happening during labour. They found labour very frightening and as Inayat reported "*gosh I didn't know that pains would be intermittent. When they started and stopped I thought this is it, I am going to die*". It could be inferred that women entered childbirth with limited knowledge of the processes.

Although some of the women received information about labour from the midwives at their antenatal clinics, they would have preferred to attend structured education sessions. During my antenatal meeting with Jariyah, she raised the issue of labour pain. I was mindful that I did not 'step out' of my boundaries of a 'researcher' by giving her information, but at the same time Jariyah had expressed a need to know. I enquired if she had been to the childbirth education sessions. She reported that she was not aware of such provision and expressed disappointment. I agreed to accompany her to the midwife's clinic where she could get some information. At the clinic, midwife Dorothy was dismissive of Jariyah's need for information about pain relief. She said:

> "*you do not need to worry about these things* [laughs], *come and sit down. Here have these leaflets and you can read about pain relief methods. Love, you are going to be alright and it will be okay*"
>
> Midwife Dorothy

Midwife Dorothy then proceeded to inform me that "*these women do not have many problems and I just don't tell them much as this will frighten them even more*". It appears that midwives are gatekeepers of information. They make decisions regarding who should be given information and from whom they should withhold it. They are likely to base their opinions on the values and beliefs they hold about different women. Similar findings were reported by others, for example Kirkham and Stapleton (2001) found that midwives control the flow of information by withholding it from women. They were influenced by their own values and beliefs, and by organisational constraints, as well as holding views that certain women would not find the information appropriate.

The findings revealed that women who did attend the childbirth education sessions were more aware of childbirth practices. Where NHS organisations provide service models to address language and communication issues, a low level of proficiency in English is not a barrier to accessing childbirth classes. The reasons for low utilisation levels of health promotion activities are complex and extend beyond proficiency in speaking English. The commissioners and providers of services need to explore ways that are responsive to meet the information needs of Pakistani women, for example through written material or audio-video tapes. Many have evaluated and redesigned services to improve access to and utilisation of childbirth education (Walker and Pollard 1995).

### 6.3. (ii) Social networks

Historically education for childbirth has always been available to the women in the antenatal period through the women's social network (Jeffery et al 1989; Vincent-Priya 1992; Nolan 1997). Women developed knowledge through sharing their experiences of childbirth as well as being involved with caring for pregnant/labouring women and infants within their communities - learning through experience. The Industrial Revolution and medicalisation of childbirth are probably the main reasons for the collapse of the women's network, and mainly impacted on middle class families. The women became isolated from their female relatives and friends and no longer engaged in the activities where they shared oral histories of childbirth. The situation for the working class families was different because community collectiveness continued to operate, and the female networks remained an important source of knowledge. Although with hospitalisation and medicalisation of childbirth, much of the management of pregnancy and childbirth has been relocated from the hands of lay women to medical professionals, affecting all women.

Although similar changes have occurred in the Indian Subcontinent, particularly with regards to medicalisation of childbirth, the pace has been slower than in Britain. Traditional birth attendants, dais and female relatives still play a pivotal role in childbirth (Chesney 2004; Chawla 2007). It appears that this system where female relatives play a central role exists to some extent in Britain in many SA communities. For example it has been noted that SA women receive information about pregnancy, childbirth and postnatal care from other family members (Thomas and Avery 1997; Katbamna 2000; Ingram et al 2002; 2003; Jayaweera et al 2005).

The majority of women in this study, regardless of their attendance at preparation sessions, gather information from their networks. Almost all of them discussed labour and pain relief with other female relatives or friends at some point during pregnancy. When discussing their sources of information, they identified key informants as friends who had had babies, other family members such as aunties, and their mothers or mothers-in-law.

Friends: *"I have a friend who has had her baby last month and she was also telling me about her labour. We are both from the same village in Pakistan. This was her first baby as well so she was able to tell me what happens in labour and what to expect".*

Jariyah

Family:

*"My auntie told me a few things; you know like that they are going to do this* [vaginal examination]. *When you go into labour you lose your privacy and they are going to see everything and she told me a bit about that. She told me that they will take your clothes off and about the pains and what will happen".*

**Eiliyah**

Other females:

*"I was kind of scared of an epidural as all these women talk about it and this and that. You get so many side effects of it but ... and backache ...backache gets bad".*

***Husna***

Many women found talking to others from their social networks helpful, but others did not. For example, Husna had heard stories about the negative side effects of the epidural and was very anxious and was *"scared and frightened of having epidurals".* However, during labour further information was given to her by the midwife and the anaesthetist, as she recalled: *"The doctor ... told me that I am just gonna get headaches later on and you don't get backache from that"* (Husna). Social networks are good in terms of providing women with information about childbirth, but the quality of the information and the level to which it prepared the women is not clear. Some women appeared confused by the advice given and relied on the midwife and other healthcare professionals to give further advice. It is possible that the quality of advice was good but the women did not have confidence in this way of knowing, perceiving the authoritative knowledge to be superior. Conversely it could be that lay knowledge was not based on current evidence and NHS practices and women needed further information.

Whilst women cited social networks as a source of information it appeared that these networks were variable – some women had strong networks and others did not. Advice was detailed for some topics, such as infant caring skills and women's physical

wellbeing, but for others - particularly emotional support - it was scant. Although the quality of the input could be challenged apropos its fullness it is nevertheless an important source from which the women develop knowledge about childbirth. It is worthy to note Alisha's comments that some women may be "*new to the country*", as would be the case for recent migrants who may not have strong networks. Furthermore, some women in this study concurred with Alisha and reported that childbirth is a married woman's business, where both in Britain and Pakistan young and single women are normally excluded from the practice of childbirth.

### 6.3. (iii) Literature

> *"I bought magazines and read about birth of baby and all these things and I didn't have a problem. Midwives don't always give information you see they are just so busy they have other things. When I used to ask my midwife for information she just didn't have time to discuss other things so I goes to my husband I shall get magazines from the supermarket* [.....] *so I just read*".
>
> Maheera

A few of the women who were proficient in reading and speaking English gained information from published literature. They cited leaflets as one of the common sources of information. In addition to this one woman cited magazines and another cited a childbirth book as a source of information. However, it is not clear how effective these sources were in terms of increasing women's knowledge.

## 6.4. Women as recipients

When I first commenced data analysis and heard women's words, two key issues started to emerge.

#### ... Passive Recipients...

First, the women appeared to be 'passive recipients'; the majority of the women accepted the care that was given to them. In some instances women were given an explanation for the care delivery, but not in others; the majority of the women did not challenge any aspect of care. Some perceived midwives to be busy. This concept of passivity has been echoed by findings of other studies. For example Stapleton, Kirkham, Curtis and Thomas (2002) attested that many women who seek maternity care

are silent because they are not given 'time and voice' by midwives who tend to be working in a 'pressured environment' where there are many competing priorities. They observed that midwives give clear messages that they are 'busy', they look 'stressed out' or 'too frazzled' and it is these messages that deter women from engaging with the midwives. Furthermore, Stapleton et al observed that many women, in particular those from poorer backgrounds, those who were young or where there was a mismatch of language, were more likely to be silent during their consultations with the midwives.

**….. Compliant women …..**

Second, the findings suggested that the majority of women had very low expectations of their care in labour. They were grateful for the care and were easily satisfied. The interpreters in this study also reported that the Pakistani women were more compliant than their White counterparts. Some of the interpreters cited situations where they found the quality of communication between the midwives and many Pakistani women was not adequate, and at times the information exchange was less than satisfactory; they reported that compared to White service users, many Pakistani women were reluctant to ask for information or 'ask questions' during episodes of care or during investigative examinations. This possibly resulted in Pakistani women being less well informed about their individual circumstances. Nafisa, one of the interpreters, whilst explaining her experience of interpreting for Pakistani women during a number of situations, gave the example of when she accompanies women during obstetric ultrasound examinations.

> *"The Asian women do not ask the questions and some of them …… I have done so many scans now* [.....] *Sometimes they'd* [ultrasonographer] *do it* [explain to Pakistani women]. *It depends on who you get sometimes they'll explain it is .... this is the spine ... this is the head we are looking at. Some of them don't and the women are looking at the monitor but they don't ask any questions ……..*[....] *the English woman would be asking what's that bit that you're looking at now. And I think the Pakistani women may think I shall look silly asking that question. They do not have the confidence to ask the question".*
>
> Interpreter Nafisa

Nafisa alluded to a possible explanation for this difference between White and South Asian women, stating that it is possible that those Pakistani women who either lack confidence or language ability are unable to effectively engage in conversation with the healthcare professionals. However, it is not clear whether this is the case only for

women who are not proficient in English, or if this behaviour is adopted by other Pakistani women regardless of their ability to speak English. Given that the interpreters would not be accompanying women who were fluent in English, it is difficult to reach a view. However, most of the interpreters highlighted that Pakistani women *"just go in, they just sort of think, they* [midwives] *are the professionals and they know the best and they must be right"* (Interpreter Tahira).

If lack of ability to speak English prevents Pakistani women from engaging in conversation where information exchange occurs, and if this is coupled with a lack of ability to read information leaflets, then this will inevitably affect the capacity of these women to have a fuller knowledge of the services available to them. Consequently they are less likely to work together with the practitioners in making decisions about the nature and type of care they wish to receive. The corollary of this situation is that Pakistani women will neither be able to make informed choices nor gain the benefits available from maternity services.

> *"I think my main concern with the Pakistani women has been their lack of knowledge of what their rights are. The lady who had her IVF baby she hadn't ever had a normal delivery* [woman having second baby with a previous caesarean section]. *They* [medical professionals] *wanted her to have a normal delivery and she was having a difficult time* [....] *She did use me to get what she wanted across. She was saying that 'I am tired, I can't push anymore, I had a baby with operation before, can you just ask them to just operate. I was able to say that on her behalf and they* [medical professionals] *just didn't listen.* [.....]. *They* [Pakistani women] *don't question like what an English lady....she would have asked for an explanation and held the doctors or midwives accountable.... whereas this Pakistani woman didn't. She was extremely grateful and thankful to the staff for caring for her so well".*
>
> Interpreter Nafisa

Nafisa, as did some other interpreters, perceived Pakistani women to be passive and accepting of care; they were critical of Pakistani women's 'lack of knowledge', lack of knowledge of 'their rights' and being passive recipients of health services. However in the above incident, although the woman was able to articulate her wishes through Nafisa, these were apparently not taken into account when making decisions about her care. It is possible that Nafisa did not have knowledge of the obstetrical/medical history and without further information about this incident it is difficult to draw any conclusions. However, it could be that cultural and ethnic stereotypes that exclude

Pakistani women are feeding into healthcare professionals' decision making processes. Nafisa also stated the woman "*was extremely grateful and thankful to the staff for caring for her*", having had a successful in vitro fertilisation, the woman is possibly grateful to have a live baby and may not see her own experience as important; if women believe that 'medical professionals know best' then complaining about the care and their choices would not be seen as acceptable.

Clearly efforts should be made to overcome language barriers by making use of interpreters so that women receive a full explanation of their care. Interestingly some women in this study who did not speak English fluently, and did not receive support from interpreters, commented that "*the midwife was really nice..... she ... 'ohus ney mere bisther par badh ker, mera hath narmee say pakhar ker, muja kagez pay lekh ker bathaya"* [the midwife sat on my bed, held my hand gently and explained (epidural) by drawing it on paper] (Farzana). However this was not the experience of all the women, suggesting that there are other operating factors that play a role during interactions between the women and the practitioners.

However, on analysis of the data it emerged that the Pakistani women had expectations of some aspects of care but were hesitant in articulating their preferences. Many women spoke of their needs and expectations, expressing overall satisfaction with the maternity services, despite the services failing to meet some of their expectations. This is probably because women's needs and wishes are a by- product of the existing systems (DeVries et al 2001) and midwives and other health care professionals are seen as experts with authoritative knowledge and women perceive that 'they know best', and must be right (Porter and Macintyre 1984; Bluff and Holloway 1994).

## 6.5. Women's knowledge

Drawing upon Belenky et al's (1986) framework of women's '*ways of knowing*'[76] it appears that Pakistani women in this study utilised three approaches of knowing in constructing their knowledge of childbirth, but that levels of knowledge were variable.

[76] For an explanation of Belenky et al's framework see Chapter 3, Section 3.3.

**..... Silence or absence of voice .....**

Some of the women developed strategies to cope with childbirth through 'silence'. This does not mean they did not speak and did not have other types of knowledge but that they were intellectually voiceless. For example when discussing method of pain relief, Ghazala alleged:

> *"You know when I went into labour I didn't know what to expect. I didn't have any information. Didn't know what pain relief there is. What epidural is? If you don't have any information then you don't know any thing and your mind is blank. You don't know anything you just have pain that's it".*
>
> Ghazala

Yet as the interview progressed, Ghazala stated *"I did not know what I wanted. Epidural* [.....] *you see I have heard so many people say that it is not good and I did not want the epidural".* It was evident that Ghazala had some information related to epidural analgesia, though she did not see this as the knowledge upon which to base her decision. Ghazala had gathered information from other sources and formed a view that epidural analgesia was "*not good.* However, she went on to say *"My pain was just bad and midwife said I should have epidural ..... I agreed. They said epidural and I said yes. And I signed it* [consent form] *but I was really glad afterwards that I had epidural. Normally pain was very difficult".* Although Ghazala confirmed that she did not know much about the way epidural worked or what it was. However, when the midwife suggested epidural analgesia for pain relief she accepted it without any discussion, suggesting she was intellectually voiceless; she did not discuss with the midwife what she already knew about epidural analgesia. This is despite the fact that Ghazala is fluent in speaking English and was educated to GCSE level in England. As Belenky et al (1986) state, if women see authorities as all-powerful, they will obey words that are not meaningful to them. Although many women who participated in this study had heard poor reports about epidural analgesia from non-professional sources, they went on to have this mode of pain relief. Ghazala confirmed her satisfaction with epidural analgesia, saying her opinion about it had changed; she stated that she would not hesitate to recommend it to others.

The findings suggest that the majority of the women in this study were dependent upon the midwives' knowledge and took little part in the decision making process where they

could have discussed their pre-existing knowledge. Arguably these women were passive partners and were therefore subject to the control of those around them. Many women were aware of the negativity of the epidural analgesia, however their own personal positive experience would change the stories they subsequently tell their 'networks'.

**….. Received knowledge …..**

The majority of the women in this study had "received knowledge", having developed their knowledge from information gained from a raft of different sources. The women accepted that the literature, midwives and doctors were always right. The tendency was to listen to others and have little confidence in their own understanding. There were many occasions in the antenatal period when the women asked me for information about pain relief. In addition to referring them to the midwives, I encouraged them to tell me what they already knew; an approach which allowed me to retain my researcher objectiveness and permitted me to support the women. Although the women used to begin with "*I do not know much about….*" when I encouraged them to talk, they demonstrated knowledge of three methods: "*the injection*" (intramuscular injection of Pethidine), "*gas and air*" (entonox) and "*injection in the back*" (epidural analgesia). Some of the women talked about the choice of pain relief in relation to the intensity of the pain:

> *"There were the gas and air, epidural and there were that other one, Pethidine…… I could have all three of them and take them step by step but I had to jump it and I said that I can't take it* [pain]. *I jumped the Pethidine and I said that I can't take it. Pethidine was not good for me and epidural was good for me and I had it* [epidural]*".*
>
> Inayat

This suggests that Inayat was able to make a judgement about the method of pain relief based upon her knowledge. However, it is not clear if there was any input from the midwife during this decision making. Similarly Farzana stated that she did not want "*strong pain relief straight away"* because her aunt had informed her that labour gets progressively painful, and she may wish to have a stronger method as labour progresses. Some of the women talked about knowledge gained from social networks about pain relief, but despite having knowledge, many of these women wanted midwives to give them more information:

*"So then one of the nurses* [midwives] *explained to me what an epidural is. I knew bits and bats but she explained thoroughly. She asked me what I thought about it. Then I talked about it with my husband and then I said I'll go ahead with it, as I could not take the pain* [....]. *I had to approach them* [midwives] *several times and my husband, he said about pain relief and that how come that they are not explaining it to you and I was thinking that like they would give leaflets or something. But they did not do anything like that".*

Husna

*"I had heard about the pain but didn't know what to expect. I had only read the things for pain relief but when I was in pain I couldn't remember anything and that's where I thought they* [midwives] *would have been able to help. But they didn't sort of do that they said that it was my choice and I would have thought that they would have given me more advice on this* [pain relief] *as they know the best".*

Jariyah

Some of the women reported their frustration about having to seek information. Having the information assisted them to have some sense of control in making decisions. Many women were unable to make choices to manage their pain effectively. They relied on medical methods of pain relief; use of non-pharmacological methods was absent, but this could be owing to women's lack of knowledge of 'natural' methods of managing pain. Some of the women felt helpless, particularly in early labour when pain relief was refused:

*"I asked for pain relief as I were in a lot of pain but the midwife said that she was not able to give any pain relief* [when asked if Bilqis was utilising natural methods such as mobility to manage pain] *No as the midwife was unable to give me anything I did nothing else. I asked for tablets or as I didn't want an injection* (epidural analgesia) *but the midwife was unable to give me anything else".*

Bilqis

According to Belenky et al (1986), 'received knowers' are dualists. They see things in terms of black and white, and one view is always regarded as superior to the other. The majority of the women were accepting of the midwife's decisions, and arguably believed that midwives were 'right' and 'they knew it'; the midwives' wisdom of methods of pain relief is central to the knowing process. It is evident that in attempting to comprehend new information, women's own knowledge is discounted. These

women look outside themselves and their friends for guidance about the 'right' way to do things.

**..... Subjective knowledge .....**

Some women realized their ability to develop their knowledge for themselves, and relied on a strong inner voice with which to develop their thoughts. A woman who constructs knowledge in this way is much more likely to work in partnership with the midwives and other healthcare professionals. As "subjective knowers" begin to hear their inner voice and begin to listen and act on what they hear inside them, they move from passive to action based understanding. However, in midwifery practice this may not always be a reality for Pakistani women. There are two reasons for this. First is that Pakistani women are in an unequal position because of their ethnicity and cultural differences. Second is the concept of 'power', which renders the women ineffectual. Women in this study were not readily able to cite their intuitive feelings about pain relief, but were able to do so in other areas:

> *"Well they just ignored me and said that they couldn't give me anything, as I was not in labour. You see they said that I wasn't open enough you know the cervix was not yet open for me to be in labour. They just told me to go to sleep. But I couldn't, as my pain was bad. I knew that this were labour. I think that was the worst time for me was lying in the dark and with nobody there and my pain was just getting bad and bad".*
>
> Jariyah

If Pakistani women are to be equal partners in making decisions about their care then their subjective knowledge has to be valued. Subjective knowing can be used to develop confidence, encouraging Pakistani women to trust their own instincts about such knowledge. However, one of the dilemmas with subjective knowing, is that because of its subjective nature, which for some lacks facts and associated sciences, it holds a lower place within the hierarchy of knowledge. Although midwives may use experiential knowledge they also subjugate women's knowledge through professional authority.

Many women in this study appeared to be of the opinion that their knowledge was less important; their trust was much more in the authority. Consequently not all women

move onto either developing 'procedural' or 'constructed' knowledge stages. They did not integrate knowledge they felt intuitively was personally important with the knowledge they had learned from others. The women appreciated the 'experts – authorities' and they obeyed them; they did not decide for themselves the validity of that knowledge.

### 6.6. Issues of choice and control

The findings of this study indicate that the majority of Pakistani women in this study were compliant with the care and they were not forth coming in asserting their needs. They 'did not make a fuss' during their encounters with maternity services and in the main they were silent recipients of maternity care. Lack of sufficient and timely information about labour and its processes, lack of confidence or limited ability to speak English may explain the way in which Pakistani women in this study negotiated their journeys of labour. If women lack information and do not feel confident in accessing maternity service, it is then questionable whether they can exercise choice and control as proposed in the government directive (see chapter 3) over the care they receive.

Having information is essential in assisting women to develop knowledge of childbirth and related issues, enabling them to make informed decisions about the care they want and prefer. However, it is questionable how much of this choice is a 'real choice' and how much is an 'illusion'. Kirkham argues that most of the options that are offered are within the "*rules of the game*" determined by the professionals (Kirkham 2004: 272), and it is these 'rules' that prevent women from choosing the type of care they wish. Many organisations offer various types of care that women can choose from - as midwifery led, G.P. led, obstetrician led or shared care - but there are rigid obstetric and medical selection criteria which women have to fulfil. In addition to this many organisations provide information about the available options of care in English and are selective which information is translated (as well as into which language), because of constrained budgets. So for many women who cannot read English the options from which they choose are reduced.

For choice to become a reality women should have access to unbiased evidence-based information. This information should be in appropriate formats and should meet the needs of women from all social and cultural backgrounds. Lack of choice is heavily

debated and there remains a great variation in women's experiences (Hunt and Symonds 1995, Neile 1997, Stapleton 1997). It is clear that some women have more choice than others as they are able to access more information, are able to articulate their choices and wishes, and in general are better placed in social and cultural contexts.

For women to be in control during childbirth they need to work in partnership with the healthcare professionals, introducing factors such as access to adequate and appropriate information, redistribution of power from professionals to women, and "*relationships* [that] *are more egalitarian and less hierarchical*" (Kirkham 2000: 221). Midwives in such relationship are more likely to share their power base by giving clear, balanced, and sound information to the women. The women are more likely to communicate effectively, with better quality of information exchange that should play a major role in promoting choice and control. However not all women are confident in articulating their needs and preferences, and in actively participating in the decision making process. Women's experience of having control is varied and is dependent on the organisational culture and the competence of the healthcare professionals as well as their own expectations (Hunt and Symonds 1995).

## 6.7. Women's experiences of knowing: reaching conclusions

The findings reveal that Pakistani women, like many other women, have a desire for accurate and timely information about childbirth in the format they can understand, enabling them to exercise their right to choose their care. However, in practice, opportunities where information could be accessed were variable, and many women in this study voiced their concern about lack of available information. Such concerns have been echoed by numerous women in other studies, for example Singh and Newburn (2001), Kirkham and Stapleton (2001) and Mander (2001). Women developed their knowledge from a number of sources, and had heard of common methods of pain relief and some procedures. However, the women knew little about the process of labour and the interventions used in labour, and they lacked detailed understanding.

The findings suggest that those women who had received formal education, were proficient in English, and had resided in the UK longer, were more likely to know about different methods of pain relief and care options. Similar findings have been reported by others who claim that healthcare users' knowledge of services correlates positively with

education, language and medical understanding (Firdous and Bhopal 1989); Woollett and Dosanjh-Matwala 1990a). In practice it is those women who are most in need of information who get the least.

The findings from the interpreters' data in this study suggest that not all Pakistani women are given the '*whole story*'. Some of the interpreters reported clear differences between information given to Pakistani women and White women by the midwives and other healthcare professionals. Pakistani women got less information than their White counterparts, and those who were more proficient in English were advantaged. Although it appears that there is continued struggle for maternity services to provide all women with adequate information, better informed Pakistani women still did not have knowledge of all options available to them. In those circumstances where women had limited awareness of options of pain relief and care, they were restricted in the choices they were able to make. Consequently, women entered the most sensitive period of their lives with limited information, not knowing what to expect.

Possible explanation for this situation may be that it is likely that the midwives did not provide the information and in fact controlled 'information giving' or it is possible that midwives did provide the information but the women did not understand it. Conversely it could be that information was provided, women did understand it, but chose not to retain it because it was not orientated to their needs.

**..... Midwives: controlling information .....**

Findings suggest that midwives are the "*gatekeepers*" of information (Levy 2004: 61); thus midwives are selective and have control of both the amount of information that is be given and who receives it. As Lipsky argues (1980: 90) "*Giving or withholding information is another way in which services may be rationed. Clients experience the giving and withholding of information in two ways. They experience the favoritism of street-level bureaucrats* [in this case the midwives] *who provide some clients with privileged information, permitting them to manipulate the system better than others. And they experience it as confusing jargon, elaborate procedures and arcane practices that act as barriers to understanding how to operate effectively within the system*". The implications of giving or withholding information are that they determine women's ability to make choices and access services.

An alternative explanation for midwives' selective distribution of information may be part of their strategy to maintain professional dominance. Midwives and other healthcare professionals perceive they have greater 'expert' knowledge than the women and they retain this status by not fully informing the women. Thus by maintaining the status quo, they remain in a more powerful situation and the women continue to be dependent on them. Alternatively midwives may be acting as "*protective gatekeepers*" (Levy 2004: 61), in that they recognise the women need the information, but they perceive that if women are provided with "*too much information there is a danger that the women would not successfully assimilate it, misunderstand or inappropriately personalise it with consequent worry or fright*" (Levy 2004: 63; Kirkham and Stapleton 2001). Therefore, it is possible that the midwives determine women's ability to assimilate information, and it is likely they use the women's ability to communicate in English as a basis for this judgement. It is likely that midwives may categorise Pakistani women as being less likely to benefit from information, and view their non-attendance at childbirth preparation sessions negatively; as a result they withhold information.

By determining the information needs of Pakistani women based on favouritism or on perceived assimilation ability midwives can effectively perpetuate the 'inverse care law'. There are many examples in midwifery where "*the greatest need for healthcare is associated with the poorest provision*" (Kirkham, Stapleton, Curtis and Thomas 2002a: 510); disturbingly this continues to persist (Brown and Lumley 1993; Cliff and Deery 1997, Nolan 1999; Kirkham et al 2002b). One of the midwives in this study with a high case load for caring for women from the South Asian communities reported "*I like caring for Asian women; they are not a problem* [.....]. *It is those who are living in those big houses that I do not like to work with*" (Midwife Dorothy). Dorothy explained that the women who were White and predominantly belonging to upper social classes were too demanding and challenging. They asked too many questions "*you have to be on your toes all the time* [.....]. *The antenatal clinics take twice as long whereas these Asian women don't ask much and they are really quiet souls .... they are no trouble at all and they just get on ..... they do not need much information*". It is possible that when time is rationed, and midwives have to meet a number of demands, the midwives give information to those women who are 'demanding' and restrict information for quieter women.

Equally, when midwives are under time pressure to deliver "complex information", they are more likely to "*restrict information*" (Stapleton, Kirkham, Curtis and Thomas (2002: 198). Or it may be that midwives adopt communication patterns that tend to have a 'one-way' mode: the midwives give the information but do not check whether the women have understood it. These strategies to manage the time in antenatal clinics unintentionally discriminate against those women who do not ask for information.

It is possible that the midwives stereotyped Pakistani women as undemanding and assumed they have fewer information needs. Such findings are borne out by other studies where midwives stereotype women and make judgements about the kind of care they deserve or want (Green, Kitzinger and Coupland 1990; Bowler 1993a). It is possible that Pakistani women who do not speak fluent English may have been categorised by midwives as uneducated, ignorant and unintelligent (Bowler 1993a), resulting in displays of negative attitudes towards them (Neile 1997; Richens 2003; Ellis 2004; Sivagnanam 2004 and Hindley 2005).

## 6.8. Summary

This chapter has focused on the major theme of 'knowing'. The findings reveal that nearly all Pakistani women in this study expressed their desire for accurate and timely information about childbirth, and nearly all of them reported needing more information during labour to make decisions about pain management. In order to construct their knowledge and understanding the women obtained information from a number of sources, with social networks featuring most predominantly. However, reference was made less frequently to the midwives or other healthcare professionals as a source of knowledge of childbirth.

Only three women attended childbirth preparation sessions, with various reasons given by others for non-attendance. Those who attended were aware of some common medical methods of pain relief and of a limited number of procedures undertaken during labour; their knowledge of natural methods of pain managements was limited. However, the women knew little about the process of labour and interventions used in labour, and they lacked detailed understanding about the practices. They were less confident in using the knowledge they had constructed themselves, discounted it within the social discourse of midwifery practice. They complied with medical and

professional knowledge. Most of the women were passive recipients and complied with care; they did not articulate their choices and wishes.

# Chapter 7

## Availability of support: option or a necessity

**Excerpt from an interview**

"No I don't think that they [Pakistani women] get a good deal out of maternity services that's a lot to do with them. The fact that they are not complainers historically and traditionally they don't complain they don't know what they should expect and what they get they are extremely grateful for. They do not have anything to balance it against. To compare it against and I think, you know, may be that the professionals actually realise that and because of that might be giving a .. hum.. second-hand service. They [midwives] are probably not as alert in their service delivery as with someone [woman] who is more aware of what their rights are and what kind of care they should expect.

**Interpreter Nafisa**

### 7.1. Introduction

Universally, nearly all women give birth with the assistance of others (Jeffery et al 1989; Oakley 1992; Jordan 1993; Vincent Priya 1992; van Hollen 2003). *"It is a rare and usually accidental occurrence that a woman gives birth entirely unaided. Since the proper course of birth almost always includes the participation of others, birth attendants must be seen as an integral part of the event ..... it is clear that the process of birth is significantly and essentially shaped by social interaction"* (Jordan 1993:60). Pakistani women in the UK, unlike in Pakistan[77], are dependent on the midwife for social support because childbirth is hospitalised and it is a legal requirement for a midwife to be present.

This chapter focuses on the major theme of social support. Concept of social support is discussed in relation to the Pakistani women's experiences vis-à-vis its manifestation. Pakistani women's accounts will be utilised to discuss the structure of social support, its sources and its accessibility.

[77] Childbirth predominantly remains in the hands of women. Although in hospitals childbirth is attended by trained midwives, in many rural parts dais and traditional birth attendants play a significant role.

## 7.2. Social support: definitions

Whilst there is an abundance of literature and studies on social support, there does not appear to be agreement on the definition of the term. Different authors adopted different definitions and some acknowledge that social support is "*an extremely complex and elusive concept*" (Hupcey 1998: 1239) and is "*difficult to define*" (McCourt 2003:187). However, implicit within various definitions[78] is some sort of positive interaction between the provider and the recipient, as well as behavioural actions by the provider towards the recipient and vice versa. It is this interactive nature, and the reciprocity, that makes the concept more complex given there is no uniformity between providers and recipients. Variations exist between the 'type of support provided', 'recipients', 'perceptions of support', 'intentions or behaviours of the provider', 'reciprocal support', and 'social networks' (Hupcey 1998). Thus social support is a multidimensional concept that means different things to different people.

Nevertheless, social support in not a new phenomenon; it has been studied extensively, gaining currency since the early 1970s (Oakley 1992). It's health benefits and importance in women's experience of labour is well recognised (Hodnett et al 2004). The literature links social support with positive physical and psychological health outcomes, confirming that women who receive continuous one-to-one support from midwives, doulas, or childbirth educators during labour are more likely to give birth without the use of analgesia or anaesthesia, are less likely to have a caesarean or instrumental vaginal birth, are less likely to report dissatisfaction with their childbirth experiences, and develop a stronger relationship with their midwives (Oakley 1992; Madi et al 1999; Hodnett et al 2004). Claims have also been made that women's perception of the quality of the support which meets their emotional, informational and physical needs during labour can promote their confidence and their coping ability, instilling positive feelings about their labour experience (Tarkka and Paunonen 1996).

The majority of the above studies that examine clinical outcomes of social support do not report on the ethnicity of the study participants and where they do, because of the small numbers of participants, do not undertake comparative analysis. Therefore

[78] Christine McCourt (McCourt 2003; McCourt & Percival 2000) draws upon Schumaker's and Brownell's (1984:13) definition "*an exchange of resources between at least two individuals perceived by the provider or recipient to be intended to enhance the well-being of the recipient*"; Oakley (1992: 144) defines social support as the "*provision of a non-judgemental listening ear, discussing with women their pregnancy needs, giving information when asked to, and carrying out referrals when appropriate to other health and welfare professional and voluntary and statutory agencies*".

neither the support structures during childbirth, nor the implication of social support, are known for Pakistani women in the UK. Literature from the Indian Subcontinent suggests that female relatives, dais and traditional birth attendants are the main providers of social support in childbirth (van Hollen 2003; Chesney 2004; Chawla 2007), providing *"mechanisms that effectively prevent the labouring woman from turning hysterical or even losing her calm"* (Patel 1994: 117). Those women who have their babies in large city hospitals often have such support restricted because of space, and medical staff do not want to be bothered by relatives (van Hollen 2003).

## 7.3. Social support: the threads

It is not the mere presence of the supporters that affects the positive clinical outcomes, but the specific activities they carry out. These activities, though, are dependent on interactions between provider and recipient, where the support provider in the first instance should recognise the woman's needs and then respond accordingly. In labour, social support has three dimensions: emotional, informational and physical (Mander 2001; McCourt 2003). As informational need has been discussed in Chapter 6, I shall focus on emotional and physical needs.

### ..... Emotional support .....

Many women in this study expressed the need for emotional support, which according to Mander[79] (2001) involves listening to the women and demonstrating concern and intimacy; recipients should feel that they are being cared for and get a sense of esteem, belonging and security. Not all women who expressed the need, received emotional support. For example, Khatiza reported:

> "[.....] *I thought that it would be easier in the hospital as there are people around, you know, but it wasn't like that. I would have preferred to stay at home until the last minute you know, because I didn't find it easier there* [in hospital]. *At least at home you are in your own place and it is your own surroundings you know* [.....] *I would have preferred at least somebody there to at least to talk to. I was left no my own. There was just no-one and I would have preferred somebody to be there to talk to*".
>
> Khatiza

[79] Mander (2001) draws upon the work of Gottlieb (1978) and Miller and Ray (1994) in defining emotional support.

When Khatiza's labour commenced she decided to go into hospital as she wanted to be in an environment where she would feel secure in the presence of medical staff. As Khatiza's husband had recently arrived from Pakistan, he was unable to take time off from his recently secured employment. There were no social or family networks upon which Khatiza could call; her assumption was that presence of staff would be continuous, providing opportunity for social interaction. However this was not the case; in the absence of support from the staff, she felt that she would have preferred to remain in her familiar surroundings at home instead of being in a strange and alien environment that increased her fear and feelings of isolation.

There is a commonly held believe amongst some staff that SA people live in extended families and they look after their own. Bernice, when sharing her experience of caring for Bilqis and other women who lacked fluency in speaking English, claimed "*these people live in large families and bring their sisters or mother-in-laws with them, so communication is not really a problem*". However, this is not always the case, and a minority of the women in this study lived in a nuclear family system, often with weak social networks.

**….. Practical support …..**

Practical or tangible support in labour is about physical care, and women find comfort from activities such as back massage, being assisted to walk around to manage pain of labour, and being assisted in finding the most comfortable position in labour. Many women in this study highlighted the benefits of birth companions who assisted them during labour, citing a number of activities.

> "*Well I had actually my auntie with me ……. and she was quite helpful as well. She massaged my back and everything. I had all the pain in my back and that was really bad and she kept on massaging me and that was very nice of her*"
>
> Maheera

In the UK, formal support is normally provided by the midwives, and to some extent doctors, and informal support is provided by the women's partners, family members, and friends (Garcia et al 1998; Singh and Newburn 2000; Enkin et al 2000). Support in labour by women for women was once continuous (Leap and Hunter 1993) however

currently it is an "*exception rather than the routine*" (Hodnett et al 2004:1), and many women and their companions are *"left without professional support at some time during labour"* (Garcia et al 1998: 60). Although continuous support is advocated, in practice many maternity units find it difficult to provide one-to-one care. In the Unit where this research was conducted, labouring women were normally allocated a midwife for continuity of carer, but one-to-one was not a model of care provision.

The midwives were allocated a case-load at the beginning of a shift, dependent on the number of women requiring intrapartum care, the number of staff available on the shift, and the other demands on the midwives' time, Midwives normally cared for about three to four women at a time but this was dependant on the complexities of women's labours. Of the three labours I observed, midwives Abigail and Bernice used to come into the room every half an hour during the first stage of labour, and almost always carried out the observations and then left the room (Observation of labour notes 10 April 1999 and 16 December 1999). They both stayed with Alisha and Bilqis during the second stage of labour, although Bernice used to leave the room with the health care assistant in charge of the woman's care. Celina's practice was slightly different, and she appeared to have a stronger relationship with Deeba, staying with her for longer periods during observations and continuously during the second stage of labour (Observation of labour notes 20 January 2000).

In addition to receiving formal support, ten women in this study were supported either by their husbands or by female members of the family; three of the women were unaccompanied and were totally dependent on the midwives and other healthcare professionals for social support (See Table 7.1). Two women whose husbands were in Pakistan did not have access to informal support either because their extended family did not live in the city; they did not have strong social networks or where they did have female relatives, they were unavailable because of childcare commitments. Despite having formal[80] and informal support not all the women in this study were able to access these structures continuously. Many of the women, in accordance with the Unit practice, were transferred to the antenatal ward during early stages of labour: they were

[80] In present day midwifery, social support for women in labour is provided by a variety of formal and informal sources. Formal sources of support normally include the healthcare professionals, who also provide clinical care to the women during labour, as well as those professionals who are specifically employed to provide support in labour, such as the healthcare assistants. The woman's partner, family members or friends are considered informal sources of support in labour.

not allowed any informal support until they were transferred to the delivery suite when labour was established.

**Table 7.1: Sources of social support**

| Name | Husband | Females | None | Midwives and other healthcare professionals |
|---|---|---|---|---|
| Alisha | ✓ | | | ✓ |
| Bilqis | | Mother in law | | ✓ |
| Deeba | | Sisters | | ✓ |
| Camillah | | | ✓ | ✓ |
| Eiliyah | | | ✓ | ✓ |
| Farzana | | Auntie | | ✓ |
| Ghazala | ✓ | | | ✓ |
| Husna | ✓ | Mother in law | | ✓ |
| Inayat | ✓ | Mother in law | | ✓ |
| Jariyah | ✓ | | | ✓ |
| Khatiza | ✓ | | | ✓ |
| Lateefa | ✓ | Mother in law | | ✓ |
| Maheera | ✓ | Auntie | | ✓ |

## 7.4. Availability of formal social support

In this study, midwives were central to the provision of formal support, and the women highlighted midwives' behaviours that impacted on their experience (See Table 7.2). These findings are confirmed by other cross-cultural studies (Mackey and Stepans 1993; Bryanton et al 1994), and like other women, Pakistani women greatly appreciate the technical and clinical skills of the midwives as well as provision of emotional support (Hillian 1992; McNiver et al 1992). However, women's experiences of the quality and accessibility of support are variable.

**Table 7.2: Social support – behaviours of midwives**

| Emotional Support | Practical support | Information Support |
|---|---|---|
| • simply by being there<br>• talking to me<br>• showing interest<br>• displaying positive body language<br>• soothing voice<br>• maintaining eye contact<br>• praising<br>• assisting with breathing exercises<br>• supporting me as I would her<br>• touching me | • providing physical comfort<br>• assisting with position<br>• repositioning pillows<br>• mopping the brow<br>• giving iced water<br>• putting on the fan<br>• giving me an injection<br>• rubbing my back<br>• holding my hand | • giving information about the baby<br>• giving information of progress of labour<br>• giving information in understandable terms<br>• answering questions |

**..... "Midwives come when you buzz" .....**

Celina, reflecting on Deeba's birthing experience, emphasised the importance of social support. She perceived that whilst "*it is important to have women's husband and other relatives supporting them, they complemented the midwives' role*". Midwives and other healthcare professionals do recognise that provision of social support is central to their role, although there are great variations in the quality of support. Some women in this study, whilst appreciating informal support structures, reported that support by midwives was important in meeting their emotional, informational and physical needs:

> *"They* [midwives] *just in general they were okay.... and they were just there. So I knew that, there were help there, if I need it. When my pains got very bad and I was scared, I thought ... they'll help me, calm me down and change my position this way and that way and it would not be as painful if I did this and that ... the general advice they gave..... That's what you need"*
>
> Khatiza

> *"The main thing is that everyone's* [midwives and doctors] *around you, it's good to have that. The midwife...yeh...she didn't say much but she knows baby is okay, she used to come in and check the baby and tell me that baby is okay, and they know it if something is going wrong"*
>
> Camillah

Some women in this study stated that although support from the midwives could be better, they valued having midwives around; it was knowing they were in capable hands. They expressed disappointment when support from midwives was inadequate, but they were able to justify this by saying "*well they* [midwives] *are busy and have other things to do*" (Ghazala) but the women viewed it as important to have the expertise of midwives' clinical knowledge and "*know that everything is okay with the baby*" (Eiliyah).

Conversely there were some women who voiced concerns about the support they received. They did not feel that they received the level of support they expected and deserved. This was particularly the case when they were in early labour and were transferred to the antenatal ward instead being cared on the delivery suite. For example, Bilqis stated that she went to the maternity hospital when her labour pains started and following examination the midwife sent her home because the midwife confirmed that she "*was not in labour*"[81]. However Bilqis returned to hospital the next evening as she was experiencing labour pains. Following examination[82], and in accordance with the hospital practice, she was admitted on the antenatal ward until the labour got established.

> "*I went to hospital in the evening and they* [midwives] *checked me and said that I was not in labour and they sent me to the ward. They would not let my mother-in-law stay and said that she had to go home. I could not speak English and I was on my own. I was very scared and when the pains were coming more frequent and were painful, I buzzed for the nurses* [midwives] *to ring my mother-in-law but they said they couldn't and told me to go to sleep. I couldn't go to sleep, I was so scared on my own*".
>
> Bilqis

On one hand Bilqis was supported, because once her fear and anxiety was recognised she was admitted to hospital instead of being sent home, but on the other, because she was sent to the antenatal ward without a companion, her support needs were not met. However, those women who were left on their own during labour reported that the midwives did come when the women summoned help:

> "*The midwives didn't do much to help me or even be with me all they kept saying was go to sleep I am sure there would be more they could have done for me by being there and saying things or* [....] *And how could I go to sleep I was just so upset. But at last when the pain got*

[81] Records of the examination at 16.45 hours indicate: "tightening and cervix posterior and 1 cm dilated".
[82] Records indicate that at 18.00 hours – there were mild contracts and the "cervix posterior and 1-2 cm dilated".

*really bad and I could not cope with it I buzzed hard and then they* [midwives] *came and said they will check me and said that I was in labour and they will send me to delivery suite and then give me something for the pain..... Well when my pain got really worse I then went downstairs* [delivery suite] *at about half one*"

Jariyah

Some of the women in this study, highlighted that they did not feel adequately supported in labour. Women recalled many instances when they were left on their own for long period. Those women who were accompanied were grateful for having support from their companions. However, those who were unaccompanied did not wish to be left alone and revealed that being on their own was a frightening experience. Although the availability of support was not continuous, it appears that women did have some control in how they achieved it. They 'buzzed' the bell when they needed support; the way they buzzed suggests their frustration with lack of expected support. Jariyah was possibly frightened of being left on her own, or because of the pain, and when she was unable to cope she 'buzzed hard'. Conversely, midwives exercised control on women: midwives left the women on their own and only came to attend to them when they 'buzzed the bell'.

Social support is subjective and individual in nature, and "*perceptions about support can be inaccurate and do not reflect the support that is available or what has been provided*" (Hupcey 1998: 1233). Regardless of whether the perceptions are accurate or inaccurate they do influence how the women perceive their labour experience. The childbirth experiences of Pakistani women in this study emphasise lack of support from the midwives, and as continuous one-to-one support positively correlates with clinical outcomes (Hodnett et al 2004), this lack of continuous support is a matter of professional concern. However, women participating in this study who experienced inadequate support did not report any adverse outcomes. This is not surprising as all of these women were selected on the basis that did not have any obstetric or medical complications.

Midwives are acutely aware that whilst one-to-one support is beneficial to the women, to the NHS and to society, it is currently not possible in many British maternity hospitals (DH 1993a, 2004a). First, with midwifery staff shortages (Ball et al 2002) and constrained funding in the NHS (Carvel 2005, British Medical Association 2005), this

situation is unlikely to change. Second, the medicalised model of care, coupled with advances in science and technology, has placed new demands on midwives' role, and they have to juggle many balls within the current NHS climate.

**….. "She approached me" …..**

Whilst all Pakistani women were supported by midwives, some reported that support was received spontaneously and others that they had to summon it. However, many women reported that the quality of support was variable and some were left feeling undervalued and marginalised. Husna, speaking favourably of support received from the midwife, identified that it was forthcoming spontaneously and that the midwife responded to her:

Husna "*Hum.... quite effective actually. She* [midwife] *really got on with me and they really tried to fit in with me as if they've been there for ages*"

Kuldip What made you think that they fitted in with you?

Husna "*…… The midwife I had was quite impressive she asked me..... instead of me approaching her all the time she approached me and she was going out of her way…… I agree with that. Rather than me approaching them* [midwife] *they should have approached me, instead of rushing off. Like I do watch a lot in hospitals and they put a lot of hard work into it*"

Many women, like Husna, were observant and appreciated that staff worked hard and were busy. However, when discussing whether her requirements were met in labour Husna responded:

> *"Reasons my requirements were met because I was like quite demanding because whatever I needed whatever kind of information I required I always had to ask wherever I go because I am quite demanding".*
>
> Husna

It appears that Husna was able to articulate her requirements and pursue her needs. However there were other women in this study who expressed dissatisfaction with the availability of social support and were critical of the system:

> *"... You just lie in your bed and no one comes to check you. They* [midwives] *only come when you buzz…… ... they just ignore you and you buzz again .... They came and look at you and are rude to you so you do not say any more...."*
>
> Jariyah

The data from the interpreters confirmed that some Pakistani women "*do not get a good deal out of maternity services*" (Interpreter Nafisa - quote cited at the beginning of this chapter). Some of the interpreters felt that this was "*a lot to do with*" the women themselves, because "*they don't know what they should expect*" (Nafisa). However this does not seem to be the case here. Nearly all women in this study expected social support from the midwives.

Midwives have theoretical knowledge and technical and supporting skills beyond those of lay companions, so are in an ideal position to provide social support to women. However, it is not clear why some midwives are able to provide better support than others. It is likely that individual midwives' practice is variable or the unpredictable workload on delivery suites affects the quality of support. Alternatively, it is possible that the Pakistani women 'do not ask' for support, although women's accounts would suggest otherwise. It is likely that other factors such as age and proficiency in English contribute to this inequality. So the quality of care given to women is dependent on social factors and is a "*second-hand service*" (Interpreter Nafisa).

Many Pakistani women were able to express that their support needs were not being met. Whilst many women cited that they received support from the midwives, for some it was available only when requested, and when it came it was not always sensitive to their needs. However, there were some women who felt that they could not ask for support because either the midwives were "*busy and have other things to do*" (Husna), or they will "*just get annoyed with me*" (Jariyah), or "*she does not like me*" (Farzana). The women in this study wanted midwives' continued presence particularly when they were on their own and frightened of the '*unknown*'. They wanted reassurance that all was well.

The women in this study reported that when they called for assistance by 'buzzing the bell', midwives did attend, however in many circumstances they failed to acknowledge the needs of the women. The midwives were either dismissive of the women's needs or trivialised them. Whilst it was evident that the women attempted to access support it was not always forthcoming or of a quality that the women expected. This could possibly be owing to midwives stereotyping the women as "*attention seekers*" (Bowler 1993b: 13). Many women recalled their thoughts during labour: they were excited that at the end of their labour there is going to be a new person, their baby is going to be born. However,

concomitant with these thoughts women experienced fear for example "*is the baby going to be alright"* (Camillah), "*will she/he live"* (Eiliyah), "*am I* [the woman] *going to die"* (Inayat), "*will I live through this"* (Bilqis) and "*what is happening*?" (Khatiza). With lack of support, these questions remained unanswered and women negotiated their uncharted journey of labour in the culture of fear of the unknown.

**….. Checking or supporting …..**

The majority of the women valued the midwifery and obstetric care and the reassurance their 'baby was alright'. At no point did any of the women criticise or challenge technical aspects of their care. When those women who had had interventions were asked about their views on being induced, having artificial rupture of membranes, intravenous infusions, or electronic fetal heart monitoring, all women spoke positively. They saw that these procedures were an important part of British midwifery and that the doctors and midwives know best.

> *"yeh logho kho in chezo ka patha yeh, mujeh kaya malum bus joeh eh logh karthey hae sub thekeh hae* [these people (midwives and doctors) know about these things (medical interventions), I do not know about them and whatever they do is good]"
>
> Camillah

They viewed regular monitoring as an important aspect of their care and essential in confirming the wellbeing of the baby. For example, Ghazala commented that *"At that time in labour …… yes care was good …… The midwives kept on checking you. They see you are okay and baby's heart is okay"*. However, not all midwives told them the findings from their assessment or, when they did, the language used was not informative. For example, following assessment of the maternal and fetal health, midwife Abigail informed Alisha that the "*baby's okay*", (observation notes 10 April 1999) and midwife Bernice told Bilqis *"you are doing alright kid", "you're cracking on, won't be long"* (observation notes 16 May 1999). Nevertheless, the women were reassured by the knowledge that an assessment had been conducted regardless of whether or not they knew the findings; they trusted the midwives, who they perceived would act on their behalf and intervene if necessary:

*"they* [midwives] *kept on coming in ... taking blood pressure and that, and checking, you know, baby's heart - Manhey samajhi nah sakni par joh karnhe sah thekeh sah* [although I did not understand what they were doing but whatever they were doing was acceptable] *I am unable to speak English so I didn't ask her* [midwife] *anything, but she knew what she was doing and ensure that everything was alright [.....] She used to check me and that was it"*

Bilqis

Although verbal communication between Bilqis, her mother-in-law and the midwife was minimal during episodes of care, their behaviours were of interest. Midwife Bernice maintained little eye contact with either Bilqis or her mother-in-law. Bilqis normally closed her eyes when the midwife entered the room, possibly giving the message that she did not wish to interact with Bernice, and the mother-in-law, although she did not ask for any information, used to watch the midwife when undertaking the examination making the record. When exploring this behaviour in the interview, both Bilqis and her mother-in-law voiced that their needs were not met to the level they expected. They found that midwifery staff were not always considerate of their needs and they would carry out their duties regardless of women's concerns.

*"No, that's the thing I couldn't fall asleep, as soon as I shut my eyes and felt a bit comfortable someone* [midwifery staff] *would come in and open the door then I would get scared thinking you know has labour started or something, because I didn't know what was going on because I had my epidural ..... I hadn't slept in two days, as soon as I shut my eyes the door opened and they'd want to check my blood pressure, shut my eyes again, and they come in again. I thought you know has labour started, I got really scared".*

Ghazala

It appeared that Ghazala did not have a similar understanding of labour to that of the midwives: her maternity records illustrated she was in labour, and yet she was not aware of it. Also, her needs were for sleep and rest but she was unable to get these. It is possible that if a midwife could have stayed with her during this period then she would not have been startled when staff entered her room.

Some of the interventions caused distress to the women, and whilst midwives are required by hospital policies to undertake these interventions, some midwives did not respond to women's distress. This led the women to perceive that midwives were not supportive and women's needs were not taken into account. For example some of the

women in this study found vaginal examinations distressing. Inayat when discussing her care in labour gave a detailed account of her vaginal examination and the distress it caused her:

> *"I didn't like what they* [midwives] *were doing to me. I didn't like that at all..... to have that test you know when they put the finger up in you.* [.....] *That's one thing that put me off* [.....] *It was awful, it was uncomfortable, I didn't like it. I didn't like what they did. It was just disgusting"* [When asked if she had informed the midwife that she did not like this examination, Inayat said] *Yeh but they* [midwives] *just said that they had to do it and there was nothing else that they could do and I had to put up with it. She* [midwife] *said that that's the only way they find out how far on I am. You know they just don't listen to you. They just do what they want to and they don't take into consideration if you like something or not. Oh it was just disgusting and that's the only thing that put me off. I mean the contractions were also really, really bad and that put me off as well but that* [pulls her face and shakes her head from side to side] *that* [vaginal examination] *was really, really disgusting and I didn't like it. If it were not for that it was brilliant".*
>
> Inayat

Some women complained about experiencing pain during vaginal examination, feeling embarrassed, ashamed and helpless, asserting that they *"felt really ashamed that everyone could see me down there.....it was just awful"* (Camillah). Some women complained about the frequency of vaginal examinations, stating that "*they* [midwives] *do it* so *often. They don't need to do this ....they are touching you all the time there, it is just embarrassing*" (Ghazala).

Although some women questioned the practices that they found distressing, many women appeared to be accepting of 'what was done to them' and did not question those practices they perceived as normal. For example, a male doctor performed a vaginal examination on Khatiza and then the couple complained about it. When asked if they had requested a female doctor, they replied *"no we could not do anything and the hospital staff should know".* They readily accepted health professional explanations. Whilst their expectations were shaped by what was previously described to them by healthcare professionals, and accounts of relatives and friends giving birth, they accepted that the procedures had to be done.

The women in this study cited several such examples suggesting that when women's concerns or requests were not responded to, they saw this as a lack of respect and did not feel supported. There appears to be a mismatch between the midwives' agenda and women's. Whilst the midwives are required to undertake certain procedures it is possible that some midwives' work within the hospital practices without considering alternative means of meeting the women's needs. For example, in Inayat's case the midwife could have used other signs to assess progress of labour. Overlooking women's wishes, and dismissing their requests, leaves women feeling frustrated and humiliated 'stripping them of their dignity' (Inayat).

Women in this study highlighted that formal support during labour was ad hoc and piecemeal. This is of concern given that midwives recognise the need to provide continuous support in labour, and that policy initiatives recommend one-to-one midwifery care (DH 1993a).

## 7.5. Availability of informal social support

### ..... Support from husbands: availability and appropriateness .....

The presence of husbands[83] during labour and birth is a recent phenomenon, gaining currency in the 1970s, mainly owing to the change in the social context of birth. With the hospitalisation of birth and an increase in technological interventions, the midwife's role has become more technocratic, encouraging husbands to assume active roles in caring for their wives (Bedford and Johnson 1988; Burgess 1997; Enkin et al 2000). Whilst many women have found the presence of their husbands a positive experience (Smith 1999a; 1999b; Somers-Smith 1999), others raise possible adverse effects (Odent 1984; 1999; Kitzinger 2002). Although husbands are increasingly in attendance during childbirth (Singh and Newburn 2000), patterns of attendance by ethnicity are not known.

In this study eight women were accompanied by their husbands during labour; the women's views about their husbands' presence were varied. Many women commented

[83] The term 'husband' is used here because all the women who participated in this study were married. However where it is not related to the study it includes male partners who are babies' fathers.

favourably about having their husbands present in terms of the tasks they undertook, being advocates, providing safety and provision of emotional support.

> *"[.....] My husband was there and he knew what I wanted and what pain relief I wanted and every thing and so he was able to make sure that I get what I wanted. Even if I was unable to tell them what I wanted having him was a help as he could tell them what I wanted..... When the epidural was not working he was able to get the midwives and ask them to come and help and top up"*
>
> Khatiza

> *"Because I heard other women saying that some of them* [midwives] *don't come round for a while, but my husband was there and it did not bother me if the midwife was not there"*
>
> Alisha

Some were just grateful for the mere presence of their husbands. Jariyah had been labouring on the antenatal ward from 20.00 hours to 01.30 hours without any support. Her repeated requests to summon her husband to join her were refused until 01.30 hours when she was transferred to the delivery suite. She comments:

> *"They* [staff] *were better there* [delivery suite]. *When I went there and asked the staff to ring for my husband they said they will. So my husband came and I was so pleased to see him and I started to cry because I had been so scared. It was so helpful to have him there....."*.
>
> Jariyah

Whilst many women found the presence of their husbands of benefit, some women found support by midwives more satisfying. However, it is not clear whether this was owing to midwives' technical knowledge or because of the shared experience of labour pain. Where women were accompanied by husbands and female relatives, it was the female companions who tended to carry out practical tasks:

Husna

> *"They* [midwives] *did meet my requirements you know satisfactorily and I was very impressed and they met my requirements. Like when I was in labour quite simply what I had expected they were all met.* [Discussing support from her husband, she reported] *he did support me throughout. Like without the midwife's support ..... the midwife was... she knew what was going on and generally she was more helpful than my*

*husband, because, like, if they like ... nice to me, because they were generally good with me, I could not have ever done it without them"*

Kuldip Why did you think midwives were more helpful than your husband?

Husna *"Hm ... women are more understanding like say for instance I was like having bad experience. They will say I did this I did that* [.....] *Well my mother-in-law was with me as well along with my thingy* [husband] *and she was very helpful... She massaged my back and every thing. I had all the pain in my back and that was really bad and she kept on massaging me, wiped my face... I felt good"*

Whilst many women in this present study accepted support from their husbands, not all felt that it was appropriate. Many women reported feeling embarrassed when they were accompanied by their husbands and other female relatives. The embarrassment may possibly be because of the nature of their relationship with their husbands prior to marriage[84] or the possibly son-mother relationship. Alternatively it is likely to be the presence of a man in a women's domain. In almost all cases where the women were accompanied by their husbands and female relatives, husbands were excluded from the actual birth.

*"It was because, it was like [woman laughs] you have got your legs wide open and then like sisters and brothers and it is quite like embarrassing..... She* [mother-in-law] *was quite helpful but thing is that it should have been different if was just my husband* [.....]. *It was a bit embarrassing. Like with both of them, when I was pushing he actually went out* [of the room]*"*

Husna

*"...I didn't want him* [husband] *to be there when they were doing the tests* [vaginal examinations] *and I didn't want him to see things like that and I felt uncomfortable as well. And I had to ask him to leave the room and I had his family around as well and I told him look I don't want nobody here until I have had the baby. Because I don't want ... you see... it is not nice for them ..... As a Muslim girl it is not nice for others to see things like that* [vulva] *so I said I don't want nobody in there only females. I don't mind only females and only ladies but no males I don't want any males ..... When I was having the baby I had to ask him* [husband] *to leave".*

Inayat

[84] Although I did not seek this information during the interviews it was evident that many of the women were in consanguineous marriages.

A minority of the women explained that, unlike British maternity services, the presence of husbands would be unacceptable in Pakistan.

> *"If I was having the baby in Pakistan then I certainly would feel a bit strange* [to be accompanied by her husband in labour]. *Pakistan 'mey ous time per mere mard kho waaha aana manah hey'* [in Pakistan my husband would not be permitted to be present during labour] *In Pakistan majority of the childbirths are attended by the dais and very few births take place in the hospitals. They* [women] *only go in if they have excessive pain or other difficulty or are going to have an operation....."*
>
> Lateefa

Traditionally Pakistani women perceive childbirth as 'women's business' and prefer the presence of female companions. However, for many in Britain this is not the case. Other studies show that Asian women were as likely as non-Asian women to have husbands present at birth suggesting that Asian women are much more accepting of Western practices, and that there are changes in the social context in which birth occurs (Woollett et al 1995). Thus many women, including Asian women, wish their husbands to accompany them. However it is not clear whether it is all SA women's views or only some ethnic groups, notwithstanding the fact that women from different ethnic groups are not homogenous either. For instance, Katbamna (2000) confirms this change in traditional practice for Gujarati groups. She noted that the majority of the Gujarati women in her study were accompanied by their husbands in most parts of childbirth, but this was not always the case for Bangladeshi women. Although Bangladeshi husbands accompanied their wives into hospital they tended to wait outside the labour ward. A likely explanation for this is that Bengali people are more recently migrated than Gujaratis, therefore it is possible that they still reflect 'back home values and behaviours'.

**.... Childbirth: women's domain ....**

For some in this study the presence of any man was unacceptable. This was cited as an area that caused the women and the interpreters some concern. Whilst observance of modesty was one of the reasons given for exclusion of men during labour and birthing, some women and interpreters perceived that childbirth was women's domain and that the presence of men was not culturally acceptable.

*"I think there has been quite a big change now that in the Pakistani women [...] on the whole they do not like their husbands to be there. They see having a baby is a covered thing ... something that is done in private not for men it is a woman's thing. They do not mind their mothers or their sisters in law being with them in labour and this has to be acknowledged when providing service and there has been some change in this".*

Interpreter Uroosa

Birth "*in most places is a private event* [.... and] *an additional male observer might be accepted in medicalized systems, that is hardly ever the case in areas of the world where birth remains within the domain of family or the women's community*" (Jordan 1993: 119). It has been noted that in Southeast Asia women are often segregated from the rest of the community during labour, either by taking them to another part of the village or to a special hut where only women are permitted (Vincent Priya 1992). However, this view of childbirth as a woman's domain is changing: "*older generation do not like their husbands to be there, but younger ones they are taking their husbands with them"* (Interpreter Pakeezah).

This comment was interesting given that all except one of the Pakistani Muslim woman who participated in this study were aged twenty-one or under. The average age of the women was twenty, with an age range of seventeen to twenty-five. So there were some young women who did not perceive the presence of men (including their husbands) to be appropriate during the intrapartum period. It is possible that the interpreter is referring to primigravidae and multigravidae women who use maternity services. It is likely that the multigravidae women are on average older than the primigravidae. It is difficult to draw any firm conclusions from this data regarding the changing view in the younger generation about the presence of men during labour given that some of the women in this study were accompanied by their husbands and others were not. However, it is possible that those women who were accompanied by their husbands accepted it only because this was one of the most reliable sources of physical and emotional support as well as a conduit of informational support.

When talking about the presence of husbands and the gender of healthcare professionals, some women and interpreters talked about modesty. Although modesty is a global issue, they reported that preservation of modesty was central to women's self-esteem and they prefer that the intimate parts of their bodies be 'covered up'. Some

of the women in this study reported that midwives "*kept them covered up* [....]", (Camillah, Eiliyah, Lateefa and Maheera); midwives respected not only women's faith and culture but their privacy, and as a result women stated that they had a sense of control over their body and their care.

**..... Gender of the health care practitioners .....**

There is a popular conception that Pakistani women prefer a female doctor, but issues of modesty and the gender of the practitioner are not confined to Pakistani women; women from White and other ethnic backgrounds have raised similar concerns, emphasising a preference for female practitioners "*to discuss what they refer to as 'women's problems*' (Ali et al 2003: 32). However, for Pakistani women this requirement appears to be more critical. As Nazroo (1997) highlighted that all women preferred to see a female doctor, but inconsistent patterns emerged when responses were compared. Seventy-five percent of Pakistani women and eighty-three percent of Bangladeshi women preferred to be seen by a female doctor, compared with nineteen percent of White women.

The majority of the interpreters in this study stated that almost all women who access maternity services have a desire to be examined and treated by female healthcare practitioners. However, they did say that Pakistani women are pragmatic about this requirement and accept that in case of emergency, when no female doctors are available, they would not mind being examined by male doctors provided there is a female member of staff present; in such circumstances cultural and faith prescriptions are secondary to medical/obstetrical management.

> *"Pakistani women will all of them say that we would like a female doctor, we would like female staff and we would like least amount of people involved during this process"*
>
> (Interpreter Nafisa)

There is some suggestion from the findings of this study that Pakistani women have a preference for a female doctor in labour, but they readily accepted interventions by male doctors that did not concern intimate examinations. It appears that the gender of healthcare practitioners was important to women from two aspects; one of 'acceptability' in terms of cultural prescription, and the other from the perception that female staff had deeper understanding. Many women in this study stated "[....] *as long*

*as it's a woman"* (Camillah), suggesting that healthcare practitioners were only acceptable if they were female, irrespective of their profession, and some women commented that they would feel less embarrassed with a female carer. However, some women commented that *"women know it in themselves"* (Jariyah), *"understand it from a woman's side"* (Inayat). The possible suggestion is that for some women, a female carer has, by default, insight and understanding into pregnancy, childbirth and womanhood which professional training and experience cannot provide.

In fact the Pakistani women in this study, who made reference to issues of modesty, stated that they preferred to be examined and cared for by female doctors. This was a cause of much concern for some of the women but not all of these women specified this need prior to being admitted to the delivery suite:

> *"I thought ..., they would have male doctors and that's one thing that I was worried about. But the only time that I saw the male doctors was when I had the epidural and he just put the epidural in my back and that's it and that was one good thing about it. That's the one thing I was worried about....* [When asked if Inayat had informed the midwife during pregnancy of this requirement] *No to be honest I hadn't thought about this before. I just thought that they would know that as Muslims you do not want men to be around you at that time. It is not just nice for them to be seeing you like that you know those things* [vaginal examination and birthing of the baby] *are just private and no other men should see you like that and I don't know what I would have done if there was a male doctor and I would have asked for a female but I don't know, this didn't happen and I am just thankful to Allah.*
>
> Inayat

Although some women in this study were 'worried' about being seen by the doctor, they did not seem to be unduly concerned when the doctors were involved in delivering services such as epidural analgesia. They do not appear to be concerned if male doctors attend the upper half of their bodies but they appeared to be more worried if the doctors were to be involved during intimate examinations. All of the women included in this study had uncomplicated births and this is most likely because women who participated in this study were included only if there were no predicted complications either in the antenatal or the intranatal period. Apart from citing of epidural analgesia by the anaesthetists, the other interventions women experienced, for example rupture of membranes and attaching of fetal scalp-electrode, were carried out by the midwives. So there was little need for involvement of medical professionals. If all efforts were made

to normalise birth, as has been recommended by current maternity policy (DH 2004a), and if midwives, who are predominantly female, were in control then there would be less concern that Pakistani women would encounter male healthcare practitioners.

Given that Britain has been a multiethnic country for some time, some of the interpreters and the Pakistani women expected that maternity services and the midwifery profession would be familiar with Pakistani women's requirements or preference for gender of the practitioners. Of the thirteen women only one woman had discussed this requirement of practitioner gender with the midwife. It is possible that the other women either expected maternity services to know of the need and respond to it accordingly, or could not articulate it owing to communication barriers.

Midwives recognise that the majority of women, particularly Pakistani women, prefer female practitioners. All five midwives who participated in this study acknowledged that Pakistani women have a preference for a female doctor, however nearly all of them reported that meeting this need was beyond their control.

> *"They* [Pakistani women] *want a female doctor and mind you some even ask for a female doctor. But if there are no female doctors on duty we try and explain that there are no female doctors and they're generally okay about it..."*
>
> Midwife Bernice

It is good practice to attempt to respond to women's faith and cultural requirements, however where maternity services are unable to respond to such requirements then the approach should be to discuss the situation with the woman concerned and reach an acceptable solution. One of the midwives was dismissive of the women's requirement of a female doctor:

> *".....well I know that they* [Pakistani women] *have special needs, you know, like wanting a female doctor and hmm...., but they just have to accept that they just can't dictate everything..."*
>
> Midwife Dorothy

Given that only five midwives participated in this study it is difficult to draw any firm conclusions concerning midwives' views on choice of gender of the practitioner. Many

Pakistani women find physical contact with males upsetting, even in a medical setting. They find examinations of a gynaecological nature very traumatic and distressing, and feel humiliated and spiritually unclean, violating their *hiya*[85] and *purdah*. Whilst women in this study talked about *hiya* in the context of faith and culture they associated it with embarrassment, particularly exposure of the lower half of their bodies to 'strange' medical men.

The findings of this study suggest that there is a complex set of ideological assumptions by which women determine their informal support structure in labour. All women prefer formal midwifery support. Concerning informal support, some women preferred to be accompanied both by their husbands and their female relatives, recognising that each provides different support. A minority of women reported they were discouraged by the midwives from having two or three people present during childbirth, as only one companion was allowed with the woman according to hospital policy. Such policies may be detrimental given that women received different support from different companions. However, women found the presence of both husband and relative uncomfortable, particularly during established labour, intimate procedures, and delivery. Some women, regardless of whether they were accompanied by another female relative or not, excluded their husbands during the birth of the baby. It appears that women have individual preferences influenced by their faith and cultural beliefs regarding the presence of men during childbirth. It is possible that Pakistani women's preferences are dependent on their acculturation to British childbirth practices, or that the availability of female relatives or social networks determines who could accompany them during childbirth. It appears there is diversity in Pakistani women's preferences in the type and nature of social support, therefore women should be offered choice in determining their companions.

### 7.6. Allah as a source of support: total availability of social support

Some of the women in this study claimed that they were sustained by their Islamic faith system and their belief in Allah:

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[85] All Muslim people should observe in addition to the 'Five Pillars of Islam' prescriptions of 'modesty' referred to as '*hiya*' and 'seclusion', which is '*purdah*' (Roald 2001). The ideas of modesty or hiya encompass issues of "humility, restraint in manner and conduct, avoiding excess, and presenting an unpretentious appearance" (Patel 1997:56).

> "*They* [midwives] *just gave me a pain killer you know a tablet and I just had the pain I could not do much about it well there was nothing I could do about it. I kept wishing that the 'Allah' would release me from all this pain safely.....*".
>
> Maheera

> "*.... just read and pray to god, read the Quran and stuff and pray that everything goes well, that you actually give birth to your baby and it actually comes out alive, and just pray really. Pray namaaz and read the Quran and all that kind of stuff* [with reference to the antenatal period]".
>
> Farzana

Lateefa spent most of her first stage of labour at home. She recounted her "*nightmare*" stating that because there were no beds on delivery suite she was advised several times by the midwives to stay at home until beds were available. At the final phone call Lateefa's husband informed the midwife that Lateefa was very distressed and they could no longer wait. When asked how she managed herself at home, Lateefa stated:

> "*Well I was fasting and I had to say my five prayers and when I was reading the 'namaaz' then I did not feel the pain very much..... I was reading "Quran Shareef" and I got the internal peace and internal strength to cope with the pain. This is recitation of verses from prayers to help her* [woman] *use as part of coping mechanisms*".
>
> Lateefa

The women suggested that faith beliefs were an important constitution of emotional support. Those women who had a stronger belief in Allah were able to recite verbal prayers to derive emotional and spiritual support. Although Ellis (2004) reported that, SA Muslim women found vaginal examination polluting, and without appropriate ablutions[86] they were prevented from praying through which they "*gained great strength during labour*" (Ellis 2004:245). Pakistani women in this present study asserted that they are forbidden from saying formal prayers after rupture of their membranes and following vaginal bleeding, but they could, however recite verses in labour; liquor amnii and vaginal bleeding are the polluting agents that rendered them unclean. However, they did suggest that having a dedicated place for prayers would be valued particularly for their visitors.

[86] Ablutions also referred to as 'woo zoo', 'wudzû' or 'wudu', is ritual washing with clean water of mouth, nostrils, face, hands and forearms, the wiping of the head and ears, and washing of the feet (Winter 2000: 20). This practice is normally performed prior to saying formal prayers.

> *".... you can't really pray* [when labouring]. *I started to bleed and my waters had been broken and you are not allowed to pray. There are certain things* [reciting verbal prayers] *you can say but there are other things* [reading 'Quran Sharif' and saying formal prayers] *that you can't do. That is you can say the words from the Quran in silence but you can not say the prayers* [.....] *you are not allowed.... But there should be a praying place. If not for the patient itself you know your partner or whoever is there they need a place ... it helps"*
>
> Khatiza

In Pakistani as in other cultures, childbirth is seen as a highly contagious and polluting situation. The women are perceived to be in a state of pollution during this period, mainly owing to loss of blood and remains of parturient products through the vagina. It is during this time that prohibitions and taboos to prevent the dangers of this impurity are observed. It was reported that some women may perceive that they have been defiled by midwives.

> *"..... I need to be clean I need to be ... they* [midwives] *should not be touching me, they have not had a 'woo zoo', they don't clean themselves when they have been to toilet or whatever, they might not have a bath every time whatever ..... Oh they* [midwives] *just delivered a baby and they got a 'shetta'* [splash of blood] *on them .... on their ..... they are not 'paleth'* [clean] *enough and then they are sort of touching me and touching my tummy and now ..... I am not 'paleth', I have to have a bath now....."*
>
> Interpreter Pakeezah

The two main issues which lead to defilement of women are their birth attenders who are predominantly midwives and the blood. When this category was followed during interviews with other women and the interpreters, sufficient data emerged to support this category. However there was sufficient published literature which suggests that for SA women there are two main events that are seen as polluting. One is menstruation and the second is childbirth. For further details see Bharj (2007).

One of the many faith beliefs that Muslims have is that everything is in Allah's hands: all events are destined to happen and people are powerless. If people become ill or are suffering it is in Allah's will (Zahr and Hattar-Pollara 1998). Quite often Muslims will respond to any news or any hope with the words 'In sha-allah' which means 'if Allah wills'. Many women in this study, when discussing labour pain, were resigned to the

fact that they will be relieved of the pain when Allah wishes, and they persevered with patience and prayers.

## 7.7. Summary

The findings suggest that Pakistani women expect and want social support. They have identified multiple sources, formal and informal, from where they received support. They placed great importance on the presence of the midwife, valuing her support, despite the variability in the quality of care, its availability and accessibility. The majority of women had lay companions during childbirth. Whilst they valued support received during labour from their husbands and female family members, they perceived this to be less useful than support from the midwives. Although social support in childbirth was variable, they found it was a necessity and not an option.

Experiences of women in this study confirmed that many midwives focused on technical aspects of care. The women perceived technical care to be very important in terms of reassuring them but some missed out on other dimensions of social support. Women's accounts suggest that some midwives were able to package 'checking' and 'supporting' (Keirse et al 1989), however others were not. Their focus was more on 'checking' and in these situations women missed out on support. However, the findings of this study are no closer to understanding why some midwives are able to do both and others fail to do so, thus warranting further investigation on the way midwives support Pakistani women on the delivery suite. Given that evidence confirms that continuous support in labour reduces the risk of operative delivery and the need for analgesia, and improves women's experiences of childbirth (Hodnett et al 2004), then arguably women in this study were more likely to experience medicalised birth.

Overall the findings suggest that the Pakistani women in this study were very cooperative with the midwives and other medical staff during childbirth. The majority of the women were accepting of and grateful for the care they received. Whilst many were critical of the care and the level of support during the interviews, they did not express their concerns and worries about the support they received at the time. This is possibly owing to the fact that women in Pakistani culture are polite: they are either culturally programmed that it is 'not good to challenge' or it is possible that they do not have the competence to challenge, particularly when they are in a vulnerable situation.

Alternatively it is possible that they consider by challenging they could jeopardise the care they receive, and as a result they just accept the care they receive.

The accounts of most of the women, interpreters and midwives in this study highlight that overall Pakistani women are passive and silent recipients of care. However, the same could not be said of their stance during the course of the interviews. The findings of this study are echoed by others confirming that women are often silent during medical consultations (Kirkham and Stapleton 2001). Therefore silence and compliance is not peculiar to Pakistani women. Women in this study did not engage with the midwives or other medical staff in making any decisions about the type of care they want and deserve. Often many women had little control over what was happening to them.

# Chapter 8

## Women and midwives: the ways they respond

> "The voice of those less socially powerful is muted, even though they give birth and deliver the babies, and their dependence upon those who control the 'right way' to give birth is considerable. Those who are excluded from independent clinical practice or from receiving maternity care appropriate to their needs, still continue to provide care and to give birth. Issues of exclusion and dependency are therefore intertwined and mutually sustaining"
>
> **Kirkham 1999: 79**

### 8.1. Introduction

This chapter contributes to the understanding of the Pakistani women's relationship with the midwives within social discourses of maternity services. The 'woman and midwife' relationship was perceived to be central to the experiences of the Pakistani women during childbirth. Women's and the interpreters' accounts provided insights into the midwives' attitudes and behaviours that were instrumental in shaping relationships between the women and the midwives. However, data from the midwives who provided care to three women in this study provide a brief insight into the challenge of communicating with Pakistani women.

Pakistani women's words suggest that overall, the majority of women were unable to develop deep and meaningful relationships with their midwives during labour. Whilst the women identified the factors that influenced the development of relationships with their midwives, they were unable to suggest how the negative aspects could be overcome to ensure that care is responsive and sensitive to their needs. With further critical insights of the women's words, it appears there are many other issues within the maternity services which play a significant role in service delivery to Pakistani women.

## 8.2. Women's and midwives' relationships

Pakistani women, the interpreters' and the midwives all asserted that midwives play a crucial role in developing relationships with the women during childbirth; this sense is echoed by others (Halldorsdottir and Karsldottir 1996; Walsh 1999; Kirkham 2000; Pairman 2000). The women and the interpreters identified some aspects that influence the woman-midwife relationship.

### 8.2. (i) Midwives: a friend

Pakistani women gave insights into their *emic* worldview of their relationships with midwives. They spoke of their relationship with the midwives being either close or distant including characteristics of the midwives that shaped these relationships. They cited dimensions of the midwives that they most valued, attaching worth to the interpersonal interactions. Whilst women experienced continuity of carer on the delivery suite, the length of their labours and the stage of their labour at the time of admission determined the number of midwives they encountered. Although none of the women could name the midwife who cared for them, they all encountered two or more midwives during their labours. This enabled them to compare the positive and negative qualities of the midwives.

Pakistani women readily identified those midwives with whom they developed rapport with ease: they were friendly, sociable and approachable. The majority of the women valued midwives' continuing presence, particularly those who "*showed interest*" in and interacted with them.

> "*They* [midwives] *were very nice* [....] *they were friendly and they were there. They stayed with me until my husband came and were explaining what was happening to me. They stayed with me and talked to me and showed interest.* [.....] *they* [midwives] *asked about me and asked whether I wanted a boy* [....]."
>
> Jariyah

The women appreciated when midwives made attempts to get to know them. Characteristics of midwives which enabled women to manage their labours were: listening and talking to them, spending time with them, using language that women understood, making use of touch and gaze. These activities assisted the development of

a closer relationship and the women felt connected with the midwives. The two factors, 'friendliness' and 'showing an interest' appear to be connected in providing an atmosphere in which the women could relax and enjoy their birth experience.

Conversely, there were situations where women were unable to develop relationships because the midwives did not show interest in them as people and did not spend time with them. Some women reported that midwives were unkind and showed no concern for them.

> *"The midwife I had, at first she was a bit stubborn, I don't know.... She came did the checking and didn't say much...she just was not interested, I don't know.... I just did not feel I could talk to her....."*
>
> Ghazala

### 8.3. Women's views of Midwives

#### 8.3. (i) 'Good' midwives

All Pakistani women readily identified the attributes of the midwives that impacted on their childbirth experience, categorising midwives as either "*good*" or "*bad*" (See Table 8.1). The women contested that 'good' midwives treated them with respect: they were approachable, understanding, and supportive, findings that concur with other studies (Walker et al 1995; Oakley et al 1996; Holroyd et al 1997; Fleming 1998; Churchill and Benbow 2000). Midwives were able to form a rapport and engaged in 'ordinary' conversation; women felt the relationship was of a social nature: "*they* [midwife] *were more of a friend*" (Maheera) as opposed to a "*professional*" (Farzana). Non-verbal and verbal aspects of social interaction were seen as helpful.

> *"The way they* [midwives] *spoke to me, the way they explained .... and very warm and welcoming and you know they would say we are here anytime you want us. Making you feel that you are safe, and don't be afraid of asking of anything you want. Just giving this feeling to the patient is just very helpful for a patient and I guess they did a good job of that and I guess that made me feel me more at home environment and don't hesitate to ask anything*"
>
> Eiliyah

**Table 8.1: Summary of attributes of the midwives which contributed towards the woman-midwife relationship**

| | Good midwife: positive attributes | Bad midwife: negative attributes |
|---|---|---|
| **Affective domain** | • close relationship<br>• showed interest<br>• friendship<br>• demonstrated kindness and concern<br>• open behaviour<br>• nice<br>• acceptance<br>• warm<br>• approachable<br>• open communication<br>• smiling<br>• listening<br>• talking<br>• humour | • distant relationship<br>• uninterested<br>• professional*<br>• demonstrates little kindness and concern<br>• closed behaviour<br>• rude<br>• limited communication<br>• not speaking nicely<br>• ignorant<br>• did not engage in any communication |
| **Psychomotor domain** | • available and accessible support<br>• supportive<br>• helpful<br>• spend time<br>• facilitator of information | • limited support<br>• not responsive<br>• did not spend time<br>• blocks information exchange |
| **Cognitive domain** | • knowledge<br>• professional experience | |

* A minority of women described midwives as 'professionals', categorising them as 'bad' implying that whilst these midwives performed their duties, their demeanour was cold and lacking connection with them. It is suggested that when 'professionalisation' is accompanied with increased authority there is a greater distance between the care giver and service user (Isherwood 1992). It is possible that with the constraints of professionalisation, hierarchy and current NHS culture the midwives' encounters with the women are brief and midwives may appear to be aloof (Davis 1995; 1996) such that the midwives are unable to develop relationships with women in a meaningful manner and fail to be "*with women*" (Isherwood 1992: 14) or may be "*absently present*" (Berg et al 1996).

### 8.3. (ii) 'Bad' midwives

Conversely, some midwives were labelled as "*bad*", because they were *"ignorant"* (Ghazala), *"not responsive"* and *"rude"* (Khatiza). Some women professed that some midwives were "*butmeez*"[87] (Bilqis), lacking knowledge of the women's needs. 'Bad' midwives failed to respond to women's support needs and they behaved disrespectfully.

[87] '*butmeez*' means 'ignorant'.

*"Not speaking nicely and being ignorant. You know, when you call for them* [midwives], *they take time coming. Fair enough, there are plenty of patients there, but there are plenty of staff there, at the same time. And when they do come, they look at you and speak to you in the way, as if to say why are you calling me again, sort of thing. You know they just don't want to know and they just don't want to help"*

Khatiza

Midwives who did not engage in conversation were perceived as uninterested. Women who had negative encounters with the midwives did not feel part of the birthing process. They felt "*undermined, marginalised, and angry"* (Ghazala) and "*less confident*" (Bilqis). Whilst these midwives provided physical care, the women did not get to know them. These finding concurred with those of other studies (Anderson 2000a). The Pakistani women were able to compare the differences between their relationships with different midwives, particularly when they had been cared for by more than one midwife.

*"..... She* [midwife on night-duty] *was okay, I was a bit scared to talk to her because she was answering and then full stop and not explaining things .... They* [midwife and the student midwife on day-duty] *were bubbly and nicer than the other lady* [midwife on night-duty]. *They just come in* [delivery room] *and talk to you. You asked her* [midwife on night-duty] *a question, she would just answer and walk back out again. It was just .... She was not friendly and nice* [....] *They make you feel at home and stuff. The first lady was not like that, she was not horrible or anything, but she wasn't nice either. But the other ladies you could tell as soon as they came, they smiled at me, they were asking me how I am, joking about with me, being lovely and that was the difference, totally different, I could tell straight away* [....]"

Farzana

Pakistani women in this study developed a typology of the midwives as being either '*achiy auratay*' (good women) or '*kharab auratay*' (bad women), and identified the characteristics that underpinned the way in which they reached their decisions. Similarly in other studies, women have described midwives as 'caring and empowering' as opposed to 'uncaring and discouraging' (Halldorsdottir and Karsldottir 1996) or 'warm professional' versus 'cold professional' (McCrea et al 1998).

The women were able to connect with the midwives through verbal dialogue on different levels, for example fuller explanations, joking, non-verbal communications signalling warmth, receptiveness, acceptance, and perceptions about willingness to engage professionally with the woman. Very few women, however, spoke of the professional knowledge of the midwives; it is likely that the women had confidence in the midwives' competence and did not feel that the quality of care would be affected from a professional perspective. On the other hand it is likely that women were more accepting of the care and its quality and it did not occur to them to question that aspect. Many of the women, whilst they found some of the midwives disrespectful, felt *"they knew their job it was just the way they responded"* (Khatiza). Women found midwives' poor communication techniques offensive.

The women had varied experiences of childbirth, some 'good' and some 'less good', but these were insightful. Similar findings have been echoed by other studies where it is reported that women have either profoundly good or profoundly poor experiences (Hirst and Hewison 2002; Hirst, Green, Khan, et al 2002). It was evident that their experiences were influenced by the quality of the relationship they had with their midwives. Those women who did describe their relationship with their midwives as not being 'good' did, however, value and appreciate the care they received from them:

> *"In hospital .... It was brilliant. It was really good. It was all new to me and I couldn't believe all the things they* [midwives] *did – running around, cleaning you up - that was new to me as well. They were brilliant and they* [midwives] *are doing an excellent job..... It was really good yeh. They were brilliant. Yeh"*
>
> Inayat

The majority of the women in this study appreciated the work of the midwives. All three midwives working on the delivery suite acknowledged the importance of developing a professional relationship with women for whom they care. They identified "*listening and respecting the women*" (Celina) and *"getting to know them*" (Abigail) as important in developing relationships. However, Bernice felt that the women were not on the delivery suite for "*long enough to develop a relationship*".

## 8.4. Interpreters' views of midwives

Similarly, interpreters in this study identified positive and negative attributes of the midwives, suggesting that there were some midwives who were 'good' and some who were 'bad' (see Table 8.2).

**Table 8.2: Positive and negative attributes of the midwife from the perspective of interpreters**

| | Positive Attributes | Negative Attributes |
|---|---|---|
| **Affective domain** | • sensitive<br>• caring<br>• non-judgemental<br>• interpersonal interaction<br>• friendly<br>• pleasant<br>• approachable<br>• kind<br>• respectful<br>• smiles<br>• interpersonal communication (verbal and non-verbal)<br>• provide explanation in simple terms<br>• listening<br>• attentive<br>• woman-friendly | • insensitive<br>• not paying attention<br>• abrupt<br>• rude<br>• lacks understanding<br>• not taking initiative<br>• does not explain<br>• does not listen<br>• dismissive<br>• body language<br>• tone of voice<br>• dangerous* |
| **Psychomotor domain** | • skilfully doing things | |
| **Cognitive domain** | • knowledge<br>• professional experience | |

*For further explanation of the term dangerous, please see section 8.4. (ii) 'Bad' midwives, page 182.

### 8.4. (i) 'Good' midwives

The interpreters identified characteristics and behaviours of the midwives that they perceived were essential in facilitating "*sensitive and woman-centred care*" (Interpreter Rukiah), and categorised these as positive. The majority of the interpreters suggested that midwives who provided woman-centred care were "*keen to overcome barriers*" (Interpreter Rukiah); strived to develop "*relationship with the women*" (Interpreter Shabana); were "*approachable*" (Interpreter Qirat); communicated at the "*same level as that of the women*" (Interpreter Shabana); displayed "*body language which was open,*

*non-verbal communication was inviting in particular their 'tone' and 'facial expression'*" (Interpreter Nafisa), and were "*non-judgemental and the best ones are those willing to learn from other people's experiences as well as about other communities and about diversities*" (Interpreter Rukiah). They were able to create an environment of "*familiarity*" (Interpreter Ojala), and provided "*continuity of carer*" (Interpreter Pakeezah).

Midwives were reported to be 'good' if they went "*the extra mile*" to be with the women despite some of the communication and language barriers. These midwives "*held women's hand and smiled at them a lot*" and were "*with them*" (Interpreter Rukiah), and they possessed good communication and interpersonal skills.

> " [.....] *the midwives ... as well as imparting the information in a form that a patient can understand, I think their body language their tone all of that conveys their earnestness in wanting their patients to know what is going on and it is the listening as well asking the right kind of questions to elicit the right responses that tells the patient that my midwife cares about me* [....]".
>
> Interpreter Tahira

Some of the interpreters suggested that when women have a better understanding of maternity services as well as of investigations, the women are likely to comply with the service delivery which should potentially influence clinical outcomes. There is much literature suggesting that the way clients respond and act upon healthcare is dependent on the interaction they have with the healthcare professionals (Blaxter 1990; Oakley 1992, 1993, 1995). The majority of the interpreters commented that most of the women who had a positive experience of childbirth spoke favourably reporting that "*the midwife was friendly or kind or treating me with respect*" (Interpreter Rukiah). Some of the interpreters highlighted that when there is continuity of carer, the midwives are more likely to develop a relationship with the women.

> "[....] *especially this special clinic - diabetic clinic which I said when they* [Pakistani women] *come regularly and they become ..... you know, it is like for nine months they will be seeing the same midwives .... They* [midwives] *know women by their name without looking at their books. They* [midwives] *will say hello Shaheen, hello Shamim, hello ... and now you have come, how are you? And the patients, they feel really happy that she* [midwife] *has remembered my name. By calling them their first name and that gives the patients reassurance that I have been cared for that she* [midwife] *remembered my name and they do take time*".
>
> Interpreter Ojala

The findings that many Pakistani women prefer to be seen by a 'friendly' face is concurred by other studies reporting that women prefer to be cared for by midwives who are known to them (McCourt and Pearce 2000). The majority of the interpreters, however, confirmed that the feedback received from the many women suggests *"they are very happy with the midwives and nurses and they appreciate ..... they* [midwives] *look after us very well"* (Interpreter Nafisa)

### 8.4. (ii) 'Bad' midwives

> *"They* [Pakistani women] *don't get a listening ear. They* [midwives] *do not go to length to explain the whole thing. They say it once and that's it.* [....] *You can't have this blah, blah, blah...* [...]. *And they* [midwives] *don't really pay much attention and one can tell, you know from their body language; from their facial expression, that they are angry and they are not paying attention".*
>
> Interpreter Ojala

Conversely, the interpreters perceived that some midwives delivered *"rudimentary service"* (Interpreter Rukiah), they gave *"mono-syllable instructions"* (Interpreter Nafisa), *"they don't explain what they are doing"* (Interpreter Pakeezah). The majority of the attributes perceived as negative by the interpreters were within the affective domain.

> *"They say, "They didn't like her" that "she wasn't friendly", "she was abrupt", they didn't like her manner.* [....] *Many of the women* [...], *especially the women who did not speak English their opinion of that particular midwife was it was to do with her being of certain community background and it is their prejudice that they expected her to behave negative towards them."*
>
> Interpreter Rukiah

Most of the interpreters elicited several accounts where they saw midwives exercising power over women by *"ignoring them"* (Interpreter Pakeezah), displaying racial prejudices and racist midwifery practices.

> *"*[...] *with Asian women there is a language barrier, they* [midwives] *do have to go to length; they have to spend twice as much time with Asian women than with English women or European women – those who speak English. So there is a little bit of anger there, so they'll* [midwives] *say we are spending so much time with them* [Pakistani women], *we don't get paid for it. So we are explaining just once and that's it. You can do the rest"*
>
> Interpreter Vardah

Communicating with women who are not proficient in English can be frustrating; using non-verbal strategies such as drawings is ineffective in some situations. Some interpreters reported that often, when midwives are unable to communicate fluently with the women, they deny them services.

> *"Midwives themselves have said to me 'oh I have been in situations where I've spoken to colleagues who have said we weren't gonna give it* [Pethidine to relieve pain during labour] *because they didn't want anybody suing them for giving summat without consent. And yet there are other things they* [midwives] *might do without consent like give the Syntometrine and I am not convinced that they ask women. They tell women".*
>
> Interpreter Rukiah

Those midwives who withhold treatment because of fear of litigation, do so intentionally. It would be more appropriate for midwives to make use of interpreting services to obtain informed consent than to withhold treatment, but if midwives carry out certain procedures without consent and not others, it is likely that they intentionally withhold some treatment based on the prejudices they hold (see Bowler's 1993a, b study). It is also possible that communicating with women who are not proficient in English is time-consuming, and midwives who are already under pressure manage the task as quickly as possible (Menzies 1970).

A minority of the interpreters categorised midwives as "*dangerous*" (Interpreter Rukiah). They used the term not to imply that the midwives provided 'unsafe' or 'harmful' service but that they were more likely to collude with stereotypical held viewpoints about social and cultural norms that apply to a given BME group, exercise control, patronise and negatively label women. I cite an excerpt from Interpreter Rukiah's transcript:

> *"The ones that come to mind are often the ones who have had an experience of working in a predominant Asian community that they suddenly become experts about that community. So what they can often do is reinforce negative stereotypes or* [....] *they will label people – tie them to the same brush or they will hold this thing because they are seeing this thing on regular basis that it must be true that this does exist in this community.....*

*An example would be when I was having my second child and my marriage had just split up and I was two months pregnant so it was time of my first appointment. So the midwife was saying .... she was making assumptions about my situation. So when she got to the box of divorce – separated, married. She said "oh you will be married won't you". Because she knew that I was a Muslim woman, she knew I was Pakistani, she knew I was brown. So I paused and said actually no I am separated. And this midwife she looked up at me, suddenly her head popped up from the where she was looking at the page. She put the pen down on the desk and she crossed her arms and sat very straight up and she looked at me very tensely for the first time she really gave me eye contact and she said 'that's very unusual from somebody from your community in't it, 'what happened?' And I looked up at her and I said well it does happen but I am not prepared to give you the details. So she looked at me again very astonished and her facial expression changed and became quite angry. She wasn't angry, she was cross and she said okay then. She was abrupt after that she was very abrupt after that because she obviously used to ..... she had a very patronising manner actually. She was patronising - that's what makes a bad midwife. She was patronising. She thought because she was being smiley, smiley, soft voice ..... I should do everything her way and I think there are midwives who mistakenly think that Asian women don't know this. And some Asian women will follow this because they see this smiling, pleasantly talking midwife and they think she must be nice because she talks to me nicely and so they don't check what their instincts are telling them sometimes and they will go with the flow. And when you challenge them or question it or refuse to participate, those midwives become quiet aggressive actually. Or abrupt with you and they make it very clear that you are not one of them, you are a trouble causer. Those are the ones who I see are bad midwives. The one's that ... those to me are the most dangerous midwives; they're not necessarily bad but most dangerous midwives. As long as they are in control, you get a reasonably good service as good as she's gonna give you [....] But if you do anything to rock the boat, she's gonna label you. She's gonna do things and you won't know about it necessarily. She will tell her colleagues about you – watch out for that one.*

Interpreter Rukiah

## 8.5. Midwives: Able to tell her my needs

In situations where the women were able to relate to the midwives, they were able to inform the midwives when their uterine contractions were getting painful and thus either receive pain relief or practical support to manage their childbirth pain.

*"You see I had a good relationship with the midwife..... in fact a good relationship and she was so nice that I felt comfortable talking to her and this was really good .... It is good to have an understanding midwife .... I was so relaxed with her and was able to tell her when the pain was getting bad and ask for stronger pain relief... and things..."*

Deeba

Not all women enjoy the same relationship with their midwives. Some women were hesitant in articulating their health needs; in some circumstances intentionally deciding not to communicate with the midwife. When observing Bilqis' labour, 'there was limited interaction between Bilqis and the midwife' (observation notes 16 May 1999). Other entries made were 'Bernice has entered the room and looked at Bilqis, then at mother-in-law and smiled; Bernice then looked at me and said "*still here it won't be long now*" and then went to read the notes'; 'Bilqis has her eyes closed, she is lying on her back and she turns her face towards her mother-in-law and groans and has pulled her face'. She communicated her distress from uterine contractions through non-verbal communication - through grimacing or through groaning. In response to this Bernice looked at the mother-in-law and asked her "*oh she is having pain?*" and then left the room. The possible reasons for this limited interaction between Bernice and Bilqis are a) Bilqis did not speak any English so verbal communication is limited. b) Bernice has other commitments and is not able to spend much time in the room. c) Bilqis depends on her mother-in-law for support. Both Bilqis and her mother-in-law had hoped that the midwife would identify these cues and respond accordingly to their call for assistance with managing the pain.

It is noted in the field notes that during established labour there was minimal verbal communication between the women and the midwives. When observing interactions between the women and the midwives it was evident that all three midwives picked up women's non-verbal cues, however their responses to these cues were variable. Abigail's and Celina's practices were very similar. They responded to Alisha's and Deeba's cues by asking "*is the pain coming?*", or responded by rubbing the women's backs, mopping their brows or holding their hands (field notes of observed labour 1 and 3). Their support of the women embraced and incorporated emotional care, physical touch, and 'actual doings things to the woman', seeking verification of their assessment and their presence by remaining in the room with the women.

On the other hand, Bernice responded to Bilqis' cues differently. She provided care according to the midwifery practices and protocols such as recording Bilqis' pulse, and listened to the fetal heart, but she did not stay in the room with Bilqis. It is difficult to judge why Bernice did not stay in the room with Bilqis; it is possible that she had other duties to undertake or did not perceive the need to stay with Bilqis, or it could be that she opted out of providing emotional care. Bernice appeared in this instance to be 'task orientated', and she was not 'with' Bilqis. Bilqis verbalised her discomfort and her needs to her mother-in-law who was supporting her. There was, however, an instance when Bernice did not respond to Bilqis' non-verbal cues about having labour pains, and Bilqis' mother-in-law asked me to "*do something for the pain*".

Bilqis had made several attempts to communicate her needs for pain relief to Bernice; these were recognised but not responded to. When Bilqis perceived that Bernice was ignoring her needs, she turned to her mother-in-law and expected her to act on her behalf and communicate her needs. When recollecting her experience of labour, Bilqis described the care by the Bernice in terms of the midwife coming in to 'check the baby' and then going out:

> *"Well it was difficult at times because the midwife only came in to the room to check the baby – she would do this quickly and leave me on my own ... she didn't say anything to me. She didn't ask me if I was in pain or if I needed anything. I couldn't tell her because I don't speak English when the pain was bad.... I desperately wanted you* [the researcher] *and 'Amma ji' [*mother-in-law] *to come soon so that you could ask the midwife for something stronger for the pain. I asked the midwife to phone you to come into the hospital ... she refused to do and said it was too early"*
>
> Bilqis

It is evident that the midwife was in control in this situation and would be able to make the decision when to summon the woman's companions. It could be perceived that either the midwife was 'obstructing' the woman's needs or the midwife was making a decision based on clinical judgement. Women did not doubt midwives' expertise in provision of physical and technical care, however some women were left feeling angry and frustrated by the lack of interpersonal skills of some of the midwives.

## 8.6. Going along with the midwife

> *"I think if you haven't got the language you feel isolated and you feel lost and you don't know who to turn to and you just see these midwives coming and you sort of think, you just go yes, yes you don't even know whatever they're saying that's the only thing you know, nod their head or whatever and in that point of view I think ... ".*
>
> Lateefa

Findings suggest that the attitudes and behaviours of the midwives were of central importance in influencing the quality of women's childbirth. Because of its uniqueness, Jariyah provides an explicit account of her response to the midwife and adds to the knowledge of how women may construct their understandings of maternity services. Jariyah's experience is a powerful account that illuminates a number of issues worthy of discussion. As with all interviews, I asked her my single opening question: "tell me the story of your labour from the beginning":

> *"I started with backache during the night and in the morning* [8th October 2003] *just felt unwell and I did not know whether this was labour or not so in the morning I rang my sister to ask her about it..... She* [sister] *told me that it could be the start of labour and just to rest and watch out for the pains to start. But when I had seen the midwife at the* [antenatal] *clinic, she had also told me a bit about labour starting and to watch out for the watery type of blood which can come. But I didn't have that. But later on in the morning, I started to have some pains and I decided to go to hospital and also my husband was going to go to work at 5 o'clock and I did not want to be on my own, as I would not know what to do..... It was at about 8 o'clock at night the nurse* [midwife] *checked me and said that I was not in labour and I was sent to the ward* [it is 'normal' practice of this unit to send those women who are not in established labour to the antenatal ward. Recording in the woman's hospital notes is made that the cervical dilatation is of 2cm].
>
> *I got a bit scared and I asked if I can call my husband or my mother and the nurse* [midwife] *said no I couldn't and I had to go to sleep and they would check me in the morning. But I couldn't go to sleep I was scared..... I was just scared. I suppose I was frightened of the pains and labour and not knowing what was going to come next and I was on my own and nobody to talk to. I had heard a lot about the pain and that it gets really bad pain..... You see I have a friend who has had her baby last month and she was also telling me about her labour. My sister had also told me about the pains and I have also read a lot of magazines and I knew about labour and pain relief and all that.... I didn't know of the classes but my midwife told me a bit about labour and what to look for but she didn't tell me about any classes.*

*I was scared of the pain and I were on my own and not knowing what was happening .... Well when my pain got really worse I then went on to delivery suite at about half one* [01.30 hours]. *On delivery suite it was better but the nurses on the ward do not take notice of you. I just didn't like being on the ward and I did ask the nurse* [midwife] *if my husband could come but they* [night staff] *said no and I should get to sleep and then ring him in the morning. You see how could I go to sleep when I am in pain. They just did not believe me when I keep saying that I was in pain and they kept saying to me that I was not in labour and my pain was not bad and I should go to sleep. But I know my pain was worse..... Well they just ignored me and said that they couldn't give me anything* [for the pain], *as I was not in labour. You see they said that I wasn't open enough you know the cervix was not yet open for me to be in labour. They just told me to go to sleep. But I couldn't* [go to sleep], *as my pain was bad. I knew that this were labour. I think that was the worst time for me was lying in the dark and with nobody there and my pain was just getting bad and bad.....*

*I was well annoyed with the nurse* [midwife] *for not believing me and not giving me anything for the pain. I wanted to tell her that I am having the baby and I know what is happening to me so don't tell me that I am not in labour. But they just ignore you and it is at this time I wished my husband or my mum was with me. I just got very annoyed with them.*

*I just didn't want to talk to them and I just didn't say much mind you not that I saw much of them. You just lie in your bed and no one comes to check you. They only come when you buzz. But I have heard that some nurses* [midwives] *treat Asians like that so I was very scared. I hope I never have to stay on that ward again well next time I shall be staying at home until I am ready to have the baby.* [I used probing techniques and asked Jariyah if she had told the midwife that she was annoyed and that she knew that she was in labour?] *Well no you can't say anything to them* [staff]. *They will take it out on you then. You know they will not give you good care and tell you off and all that... They just don't care* [Jariyah's tone of voice at this point has changed and is very low] *but it was not like that on delivery suite the midwives there took notice of you there but mind you my husband had come by then so it was lot better having him there.*

*..... the nurse* [midwife] *said that ... that I was in labour and to go to delivery suite to have my baby.* [It is recorded that cervical dilatation at 00.45 hours was 5 cm]. *I was just so glad that they were going to do something and I were going to be out of this ward. On delivery suite, they* [staff] *were better there. When I went there and asked the staff to ring for my husband they said they will. So my husband came and I was so pleased to see him and I started to cry because I had been so scared. It was so helpful to have him there..... And when I went to delivery suite I could have gas and air and this was good and it helped me with the pain and also when they checked me and broke baby's waters and put me on the monitor to check the baby and also gave me the drip to speed up the labour.*

*..... I knew from the magazines that there was gas and air and injections and there is also one in the back - I think it is epidural but I wasn't given any advice which to use I thought that the nurse* [midwife] *would be able to tell me. It was my first baby so I didn't know what it would be like mind you I had heard about the pain but didn't know what to expect. I had only read the things for pain relief but when I was in pain I couldn't remember anything and that's where I thought they would have been able to help. Well I was just not sure and I thought that nurse* [midwife] *would tell me. But they didn't sort of do that they said that it was my choice and I would have thought that they would have given me more advice on this as they know the best.*

*There were a few nurses* [midwives] *who looked after me but some were good and some were okay but the nurse on the ward were not good. There was one nurse* [midwife] *..... you see when my pain got unbearable and the 'gas and air' was not working I asked one nurse* [midwife] *what other type of pain relief was there and she asked if I had been to parentcraft classes. And I said no and she got annoyed and said well you should have gone and then you wouldn't waste my time. I do not have time for all this now. She was a bit frightening but you can't say much and you just go along with them but that made me a bit frightened but my husband helped here by speaking to the other nurse* [midwife*] and told her that the gas and air was not working. Then this other nurse* [midwife] *came who was nicer than the first one and explained the injection I could have and said it was strong and better than the gas and air and would help with the pain. So I then had the injection* [Pethidine].

Jariyah became distressed when she relived her experience.

Jariyah's account of her labour highlights a number of issues relating to midwives' attitudes and behaviours which had a powerful impact on this woman's birthing experience. It also demonstrates the strategies which midwives bring into play to silence the women.

Her early experience of labour was filled with fear that arose from the unknown, labour pain and being alone. For nearly three hours Jariyah was on her own, her needs for support and pain management were ignored and dismissed. She became angry and responded by not communicating. She did not feel in a position to challenge the midwife because of her fear of racism and being blamed for not attending antenatal education classes. Jariyah's experience on the antenatal ward is not an isolated event; a minority of other women recounted similar experiences. It is possible that some

midwives adopted behaviours such as 'ignoring women' and 'dismissing women's concerns thereby silencing the women.

### 8.7. Midwives: silencing Pakistani women

Midwives, like other healthcare workers, utilise coping strategies to process their work (Menzies 1970).

**….. Isolating strategy …...**

It is likely that by choosing the antenatal ward as the place of care in early labour, women are isolated. This gives midwives more time to spend with women on the delivery suite. Admission to the antenatal ward puts women in a 'holding' situation which is focused around midwives, and it is possible that the staffing levels may be minimal. However, by sending women to the antenatal ward, the midwives absent themselves from women's care and arguably prevent delivery of services.

**…..Ignoring/obstructing strategy…..**

Midwives ignore the women by not believing them. Women recognise that they are in labour and they are then told by midwives that they are "*not in labour and* [they are] *sent to the ward*". It is possible that women are confused – based on their knowledge they perceive that labour has commenced, and yet the midwives confirm that they are not in labour. Some of the women who were on the antenatal ward in early labour, have possibly received discriminatory care where midwives have been dismissive of their needs, failing to recognise the women's fear and isolation. *"mujeh asey lagtha tha kye mujeh jail mey bundh khar deya hey"* [being on the ward was as if I had been locked in the prison (Khatiza)]. Some women were subjected to long hours of fear in early labour. Their requests for pain management or a companion were disregarded. By not meeting the needs of the women the midwives are in fact obstructing provision of support, and by not meeting their needs for labour management they are providing inhumane treatment and going against her wishes. Some of the women described how midwives ignored them and did not respond to their health needs.

*"I buzzed the bell as I was having a lot of pain. The nurse* [night staff] *said that she could not give me anything yet and to go to sleep. She told me I was not in labour and there was a long time for the baby to come yet ..... I was in a lot of pain ....I was so scared on my own"*

Bilqis

*"They* [midwives] *could give me nothing for the pain ..... Nothing ..... Apart from the painkillers that's all. There was nothing else they could give me. They* [midwives] *said that there was nothing else they could give me.....I don't know ..... I don't know. I think they were just ignorant I think in a lot of ways .... Maybe because they ..... I don't know if they were racist or what but ..."*

Khatiza

Some women's testimonies show they were ignored by the midwives and their needs were dismissed. Many of these women were hesitant in giving full accounts and explicitly stating what they believed were key issues. This is evident in the above quote where Khatiza was reluctant to suggest that the midwifery staff were racist. In addition to this, whilst Jariyah did not categorically state that there was any form of racism, she did infer that there is a perception of organisational racism: *"I have heard that some nurses* [midwives] *treat Asians like that so I was very scared"* (Jariyah). This would suggest that Pakistani women hold the view that midwives treat Asian women differently from White women. When recalling her experience in hospital Ghazala felt she was treated differently; *"I don't ..... it is the way they* [...] *they look at you and they make their face you know like that* [acts out the way she was treated – she places the napkin on the table whilst imitates the facial expression and looks away]" (Ghazala).

The way Ghazala acted out the midwife's non-verbal behaviour would suggest that she was treated with disgust. At the initial interviews I made attempts to explore these issues further, but this was neither easy nor successful. My rationale for not pursuing this was that the women who did recall their experiences became distressed. Nevertheless, women referred to both the verbal communication and the body language of the midwives which they described as different. Women who experienced prejudiced attitudes expressed them in varying degrees. Some were very forceful in expressing that they were treated differently because they were Asians, whilst others were less conclusive. It seems that responding to women's needs in an inappropriate manner is a form of discrimination, and can be construed as racist behaviour. Experiences such as that of Jariyah can leave the women believing that midwives do not care for them.

**….. Victimisation strategy…..**

A minority of women perceived that their pain management needs were not met. Midwives had the tendency to link the women's lack of knowledge about pain relief methods in labour with non-attendance at antenatal classes, and blamed the women for not attending the antenatal classes; the midwives did this without considering whether or not necessary information about the ante-natal classes had been disseminated or if the women had knowingly chosen not to attend.

There are numerous examples of the manifestation of institutional racism where writers such as Anionwu and Atkin (2001), suggest that frontline practitioners hold racist attitudes. These attitudes can hinder people from minority ethnic communities in their attempts to access services. For example, midwives may perceive Pakistani women as problematic, which arises from cultural practices, and blame them for their own problems. One example would be that midwives believed attendance at antenatal sessions would have adequately prepared the women for managing their labour pains; where Pakistani women do not attend antenatal classes they are therefore not informed about methods of pain relief. When women subsequently request the information they are seen to be wasting midwives' time.

**…… Silencing the women …..**

Where women encountered negative attitudes, they had mixed responses. Although some women were scared and others got annoyed, in both cases they were compliant with the care the midwives provided: "*They just do not believe you* [...] *they ignore you and well I just did not talk to the midwife*" (Camillah). Some of the women did not verbally communicate their displeasure, but chose not to communicate with the midwives.

Women did not challenge the midwives. One of the reasons for this was fear of victimisation where they would be treated less favourably by the staff. Another reason could be fear of being labelled as trouble makers (Bowes and Domokos 1996b; Stapleton and Thomas 2001). It was evident that the women were dependent on the midwives for care during labour, and they actively took the decision not to challenge; they refrained from engaging in any conflict.

Women were not readily forthcoming with criticisms of midwives and of the maternity services as a whole. Concurring with Bowes and Domokos (1996b), there were many examples where women appreciated the services provided by the midwives. The women on the whole were compliant with their care and wanted to maintain and develop their relationship with the midwives. However, it does not mean that they agreed with the way in which they were treated, it is just that they did not want to damage their relationship with the midwives.

### 8.8. Communication: Muddling along

It is a truism that communication is a central element in developing a fulfilling woman-midwife relationship (Davies 2000), and a key determinant of satisfaction levels of women's experiences of maternity services (National Childbirth Trust 1995; Garcia et al 1998). Those Pakistani women who were unable to speak fluent English felt that they were compromised in provision of information, and were unable to interact with midwives in a meaningful manner. They perceived not being able to speak English was a challenge, so instead of articulating their needs, they just 'went along' with the midwife and complied with the midwives' decisions. The findings of this study concur with those identified by others (Gerrish et al 1996; Katbamana 2000; Hart et al 2001) that issues of language and communication are a major barrier to accessing health care. However, despite this knowledge, none of the women who participated in this study was given access to an interpreter during labour.

> *".... if you have a midwife who is keen on overcoming the communication barrier* [she] *will book an interpreter to explain pain relief. But if you have got a midwife who is not too much inclined* [to overcome communication and language barrier] *then the women who are served by that particular midwife will have a minimal service and the midwife will give the rudimentary service".*
>
> Interpreter Tahira

Many interpreters stressed that the communication and language challenges were not insurmountable; many of the challenges could be overcome by adequate and effective provision of professional interpreting services. Freelance interpreters, or those employed by an interpreting agency, voiced greater disquiet about the NHS trusts and midwives' commitment to overcome communication and language difficulties.

The majority of the interpreters perceived effective communication[88] was midwives' responsibility. They conceded that the majority of midwives in the community setting utilised interpreting services however, use of interpreting services in the hospital setting was limited, particularly in the delivery suite. Even when the delivery suite staff had been informed by the community staff in advance, the interpreting needs of women were not met.

> *"The thing that I have noticed* [is] *that any interpreting that I have done has been initiated by the midwife looking after that patient. She* [midwife] *will have rung the delivery suite to tell them that this woman needs the interpreter. The hospital or the delivery suite is not proactive in getting the interpreter".*
>
> Interpreter Nafisa

Experiences of the liaison officers were different. They were employed by the Trust, providing cover for all practice areas within the maternity services. The freelance interpreters highlighted that those midwives who were committed to communicating effectively with the women, and who wanted them to make decisions about their pregnancies and labours, were more proactive in *"organising interpreting support"* (Interpreter Tahira). Conversely there were some midwives who *"just muddle along"* (Interpreter Nafisa), and did not request interpreters for their clinics or when they visit women who are not proficient in speaking English. Meeting women's communication and language needs was more like a lottery where *"some lucky ones* [Pakistani Women] *get it* [interpreting support] *some don't"* (Interpreters Ojala and Rukiah).

### 8.8. (i) Midwives as gatekeepers

The freelance interpreters highlighted that there were some midwives who did not make arrangements for interpreters to be present during episodes when they delivered care *"....even* [in areas with] *higher Asian population ...."* (Interpreters Nafisa, Tahira and Shabana). They were critical of those midwives who did not utilise interpreting services to communicate with the women who were unable to speak English fluently, suggesting that these midwives were in fact denying women the opportunity of having full information and making decisions about their care.

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[88] It is likely that the interpreters may be aware but midwives do have a professional duty in respect of the commitment that "*all patients and clients have a right to receive information* [.... which is] *easily understood*" (NMC 2004: 5).

> *"... Oh well her husband kept popping in* [and was able to translate for me]. *And it was total laziness* [on the part of the midwife] *and inconsideration of the fact* [that the woman may have some needs]. *Because their* [midwives'] *agenda was met when her husband came in, they got to know what they needed to know. It is total inability* [on midwives' part] *to see that communication is a two way process; they were denying that woman the opportunity to express her views; denied her the opportunity to say what she wanted to say or to ask the questions that she wanted to ask".*
>
> Interpreter Rukiah

Midwives were seen as the "*gate keepers*" of the interpreting services, confirming findings echoed by others (Gerrish et al 2004). Midwives were seen to have power to organise such services and were of the opinion that as long as the "*midwife's agenda was met*" (interpreter Rukiah), they were dismissive of the women's rights to communicate their needs to the midwife.

Research continues to highlight that the British Pakistani population is one of the most disadvantaged communities in terms of health and healthcare (Modood et al 1997; Acheson 1998). Where service users and healthcare professionals do not share the same language, there are adverse outcomes in terms of lack of awareness of services such as antenatal screening (Sandall et al 2001; Rowe and Garcia 2003), low uptake and utilisation of services (Gerrish et al 1996; Gerrish 2001; Petrou et al 2001), poor quality of care, patient dissatisfaction and poor health outcomes (Nazroo 1997; Acheson 1998; Lewis 2004). Maternity services have acknowledged the continued concerns about the negative correlation between communication difficulties and health outcomes, placing communication and language on its agenda (DH 2000a). Many organisations, in their quest to redress this inequity, have introduced initiatives to overcome communication barriers when delivering services to women from SA backgrounds (D'Souza et al 2001-2002). However, what is of concern is that despite such efforts, inequalities in patterns of access and utilisation of maternity services as well in clinical outcomes continue to persist (Firdous and Bhopal 1989; Petrou et al 2001; Kupek et al 2002).

A plausible explanation for this situation is that implementation of successful initiatives is sporadic and often policy is not translated uniformly, with cost driving provision. Despite evidence confirming the effectiveness of linkworkers and advocates (Rocheron, Dickenson and Khan 1989; Mason 1990; Parsons and Day 1992; Robinson 2002) such

services are not available in many Trusts with high SA service users, and if they are, the policy initiatives are only partially implemented (D'Souza et al 2001-2002).

### 8.8. (ii) Overcoming communication difficulties

#### .....Midwives making do ....

All five midwives identified that communication and language was a challenge when caring for Pakistani women. Midwives Abigail, Bernice and Celina who worked in the hospital setting acknowledged that at times communication and language was problematic, but as the women were on the delivery suite for a short duration they could "*manage the situation if it is straightforward*" (Midwife Abigail). They acknowledge the use of strategies to overcome these difficulties for instance use of 'husbands and relatives', 'non-verbal communication', 'drawing on paper', and 'sign language' to communicate information to the women during their intrapartum period. All three midwives, however, revealed that normally SA women "*are not a problem* [....] *these women are quieter and just get on with it* [labour]" (Midwife Celina) and they are of "*no trouble*" (Midwife Bernice) and more than often there is not enough time to get an interpreter when "*these women come in*" (Midwife Bernice). These three midwives did however say that if communication was a real problem, particularly if there was an emergency, then they would try to get an interpreter.

### 8.9. Accessing interpreters

Midwives in this study talked about some of the complexities they experienced when accessing interpreter services, for example negotiating with the interpreting agency, not being able to get interpreters at short notice, and the limited availability of the service from Monday to Friday between 09.00 - 17.00 hours. They asserted that the delivery suite is a "*twenty-four/seven service*" (Midwife Bernice), and women who are not proficient in speaking English "*access services during the night time as well*" (Midwife Bernice). As they have to manage without interpreting services between the hours of 17.00 and 09.00 hours. they saw no reason why they could not manage at other times and they are able to "*make do*" (Midwife Abigail).

Midwives explained that it was not possible to pre-book the interpreter in advance because they cannot predict when the women are going to be admitted. Whilst community midwives are able to pre-book interpreters, this is not possible on the delivery suite. They do not request interpreters in advance because often women are not in labour or in established labour when they arrive in the delivery suite, so to get an interpreter in such circumstances would not be cost effective.

> *"there is the interpreter service but to be honest for us in the delivery suite it doesn't work. We can't pre book them* [interpreters] *'cause we don't know when they* [Pakistani women not proficient in English] *are going to come in. They* [women] *can come in and then can't be in labour and if we have already requested the interpreters we have to pay them even when we do not use them. We are wasting hospital money and interpreters' time".*
>
> Midwife Bernice

It is not clear why the interpreters are only needed if the women are in established labour; women's assessment when they are first admitted to the delivery suite is also an important time. With proper interpretation services, midwives could obtain a full obstetric history, allay the woman's fears, and develop a relationship with her. Then again it is not surprising that the interpreters perceive midwives' behaviour to mean that they do not see "*communication to be a two way process*" and that as long as midwives' get "*to know what they needed to know*" (Interpreter Rukiah) they do not call upon interpreting services.

Interestingly, none of these three midwives identified the Trust's advocacy service as an option for enhancing communication and language when caring for Pakistani women. Midwives working in the hospital setting did acknowledge the availability of Language Line, although they pointed out that this mode of communication was not as effective as face to face communication. Whilst one of them had used this service for caring for women seeking asylum, none of them had experience of using this service when caring for Pakistani women.

Conversely Faith, a community midwife working in an area with a high case load of Pakistani and Bangladeshi women, stated that she always made arrangements for the interpreters to be present when caring for women who were not proficient in speaking English. She acknowledged that being able to communicate with women successfully was an essential feature of delivering care:

> *"These women have a real need to get information and we need to speak to them in a way they can understand and to give this information. Language is a real issue and managers do not know what we have to put up with day in and day out"*
>
> Midwife Faith

Faith discussed some of the challenges she faced negotiating financial budgets for interpreting services with her managers, and she was most disapproving of the services. *"Some of them speak no English at all.... they are nice an' all.... But we sometimes just fail them. At our team meeting we are told this is your budget for interpreters and that's it..."* (Midwife Faith). She was critical of the interpreting services asserting that they were not adequate to meet demands: *"Of course midwives want to use interpreters"* especially when the woman *"speaks no English, it can be very frustrating you know"* (Midwife Faith), and often it was the financial pressures that constrained midwives' use of interpreting services. The number of times I have been *"pulled up by my manager"* because of the overspend in the interpreting services budget.

In contrast Dorothy, whose case load also consisted predominantly of SA women but in another part of the city, did not view communication and language as a major issue. She reported that *"having babies for these women is second nature"* and that she *"gets by"* without difficulty. She stated that she did not *"use the interpreter service"* because having *"worked in the area for so long"* she has become *"known to the families"* and the families know that if they *"can't speak English that they have to bring someone with them"*.

Gerrish et al (2004) reported that healthcare practitioners who have control over the timing of client visits are more likely to use interpreting services. Midwives who have control over the organisation of their work in settings apart from the delivery suite are more likely to arrange interpreting services. Yet the practice of both of the community midwives who participated in this study was different. Faith arranged interpreters to be present when delivering care to women who were not proficient in English, and Dorothy did not. Similarly it should be possible to make arrangements in the antenatal and postnatal wards, and yet use of this service was not made.

Those women who were offered interpreting[89] services claimed that the services were good and cited their benefits, though it was available on an ad hoc basis. However, not many women knew about the interpreting service nor did they know they could request it. These findings were supported by the data from the interpreters and the midwives. All midwives in this study had variable level of knowledge about the services and their use, but they were all aware of the cost. The financial implications of the service caused the midwives to question the need for the service, relying instead on the women's relatives to act as interpreters.

It is apparent from the findings in this study that there are a number of factors which influence midwives' use of interpreting services, although it is difficult to draw any firm conclusions because of the small number of midwives who participated in the study. However there is some triangulation of the categories derived from the data from the interviews with the interpreters.

### 8.9. (i) Midwives: trusting the interpreters

Three of the five midwives expressed concern about the quality and standard of interpretation by the interpreters. They were concerned about the accuracy of the content and not knowing what was communicated. Although they were unable to confirm this, they based these assumptions on the non-verbal cues, body language, and lengthy communication between the woman and the interpreter that preceded only short feedback. Other studies have reported similar concerns among healthcare professionals (Pharoah 1995; Gerrish et al 1996; Gerrish 2001). Another explanation may be that when using interpreting services, the midwives do not remain in 'control' of the communication, and feel 'alienated' and 'marginalised', leading midwives to mistrust the communication process (Chesney 2000). Clearly in a three-way communication, the midwives are not holding the same power base as in two-way communication with the women. It is likely that most of the midwives preferred 'word-for-word' translations and did not orientate on the content of the consultation. However, word-for-word translation is difficult and sometimes unachievable because of differences in the languages. Interestingly Faith, who used the same interpreters as other midwives, spoke favourably of the quality of interpretation and the relationship she had developed with them.

[89] Some women reported the use of interpreting services during their pregnancies.

**..... Confidentiality.....**

Midwives in this study highlighted that because many of the interpreters were from similar community groups to the women, the women were reluctant to make use of the interpreters to protect the confidentiality of their families, and were more in favour of using family members. All of the interpreters in this study, however, were trained and were aware of issues of confidentiality, although a minority of them did confirm that they were coming across situations where women were concerned about this:

> *"But I do not know why they* [women] *have got in their brain that when somebody from outside will interpret then they will talk about us. That's why mother-in-law and sister-in-law come with them and this has never happened".*
>
> Interpreter Tahira

Some international studies suggest that patients consider interpreters were not truthful in communicating the message (Scheppers et al 2006), and some people prefer to use family members as interpreters "*because they trusted them*" (Edwards et al 2005: 90). This was not the case in the present study; the women who accessed the interpreting service were grateful to the interpreters. Concerns about the use of formal interpreters were mainly raised by the midwives, and to a lesser extent by the interpreters.

For most of the midwives in this study, trusting the interpreters was based upon whether the interpreter was competent and discreet. The midwives and the interpreters need to develop trust and reduce these uncertainties, as they may potentially exclude women from working in partnership with the midwives and participating in decisions about their care.

### 8.9. (ii) Family and friends interpreting

In this study all midwives, except Faith, confirmed that the majority of women are accompanied by female members of their family, friends, or their husbands when coming to hospital. In the absence of formal interpretation services, this approach is appreciated by the midwives, however they provided small indications that use of family members and friends could prove inappropriate at times. In contrast, the interpreters expressed strong concerns about the use of family members for interpreting.

They argued that using friends and family members to overcome communication difficulties, whilst convenient and possibly cheaper, can be a major barrier during the consultation process, especially when discussing sensitive and personal issues.

> *"....use family members who give mixed messages and lack of clear information...using family members is not a trouble to anybody. They can censor or edit whatever they want. They do not have to interpret to best of their ability and they can decide how much they want to tell .... I do not think they do this intentionally, I think they decide themselves that.... that is not really important or that does not apply to her or.... my wife, or ....my sister ... or ...my cousin. Whether they interpret information correctly or not but they may not communicate all the information intentionally or sometimes not intentionally".*
>
> Interpreter Nafisa

Whilst there are perceived advantages of using relatives or friends who are known to the women, such as gaining more knowledge about the women's condition, and the reassurance of their presence to the women (Waxler-Morrison et al 1990; Phelan and Parkman 1995; Edwards et al 2005), many of the interpreters highlighted a number of drawbacks. Relatives' or friends' own perceptions may affect the quality of translation, and it is possible that voluntary interpreters or relatives are likely to control the information flow by withholding it from the women or the midwife (Bradby 2001). This may take the form of making judgements about what is best and/or screening what is important for the woman, or by answering on the woman's behalf. They may protect the woman from bad news (Phelan et al 1995) or in circumstances when husbands are involved they may be embarrassed to relay messages about sensitive parts of the women's bodies.

Voluntary interpreters or relatives and friends are often untrained in the art of interpreting, have little or no knowledge of the NHS and are often themselves confused by medical terminology; their proficiency in English may be variable and in sensitive situations they have to deal with their own emotions, making them prone to interpreter errors (Wright 1981, 1983; Farooq et al 1997). It is likely that many women during their labours may be accompanied by female relatives who themselves may not be proficient in English, and this would affect the quality of the information exchange. For example, during observation of Bilqis' labour there were a number of episodes when the midwife had communicated with Bilqis through her mother-in-law, who herself was not very

proficient in English, and they had to clarify the message with me. For these reasons the quality of care is likely to be poor. There is limited literature on the impact of interpreter services on quality and availability of health care within maternity services.

Clearly most of the midwives in this study continue to use family and friends despite some of the disadvantages of this practice (Lewis 2001). The reasons for limited use of interpreting services are not clear; it may be because of staff dissatisfaction with the quality of interpreting service, a shortage of qualified interpreters, or possibly obstacles encountered when accessing interpreting services.

### 8.9.(iii) Interpreting services: issues of supply and demand

**….. Need for bilingual services ……**

The Pakistani women's competence in speaking and reading English varies considerably and is dependent on socio-economic background, education and length of settlement in Britain. The data in this study suggest there are still some young Pakistani women who are unable to speak and read English fluently. Similar findings have been echoed by others, for example some of the Bangladeshi women who contributed to the findings of Jayaweera et al's study (2005) were unable to understand or speak fluent English as they had recently arrived in the UK. Although the majority of the interpreters acknowledged the benefits of the interpreting services, they all reported that not all women who needed the service received it.

The findings of this study indicate that the demand outstrips the supply; this is confirmed in findings from other studies (Gerrish et al 1996; Bhakta et al 2000; Gerrish 2001). The interpreting services are not adequate to meet the communication and linguistic needs of maternity services, and this is further compounded by an increase in recent influxes of refugees. In an NHS already strapped for cash, unless there is adequate service provision to meet the demand, the ability to avoid the use of family members, children and friends will remain a myth. The NHS organisations have a complex 'double whammy' situation; on one hand an increase in provision of interpreting services to meet the demands is likely to exert further financial pressure, and on the other hand NHS trusts are under considerable pressure to meet interpreting demands if they do not wish to breach the requirements of the Race Relations Act

(2000). It is possible that with the political discourses around speaking English, and the financial constraints on the NHS, the provision of adequate levels of interpreting services will remain impossible. NHS organisations need to accurately assess the communication and language needs of their local population and explore innovative ways to respond to them.

The interpreters and midwives discussed initiatives to overcome communication and language barriers, for example, providing interpreter or liaison officer services, producing multilingual audio and video tapes, and making attempts to employ staff with multi-language skills. However, there was some disagreement on the level of availability and adequacy of interpreter/liaison services. Interestingly, four midwives (three from the hospital setting and one in the community) considered the present arrangement for interpreter/liaison services were adequate. But then again I did not observe them making use of interpreting services, even in situations where I felt they needed to communicate essential messages. In these situations the mother-in-law, husband, and on some occasions, the researcher, was used. For example on one occasion Bernice wanted to inform Bilqis that an episiotomy had been performed and that her perineum would require suturing: Bernice asked me to interpret. In contrast, the interpreters reported that these services were severely inadequate for meeting the needs of all SA women.

**..... Ethnic monitoring .....**

When interpreting services were discussed with the midwives, most of them referred to their own assessment of the need for interpreter services based on women's level of proficiency. Taking into account the above evidence, if practitioners have to make decisions about the use of interpreting services based on financial drivers, then it is difficult to assess the true need for interpreters. Midwives and the interpreters can only report the information on when the services were used and did not appear to have full knowledge of instances when interpreter services were requested but were not available, or when they should have requested the service but did not.

## 8.12. Summary

In this chapter the theme of women's and midwives' relationships has been discussed. The women told their journeys during childbirth, the interpreters shared their experiences, and midwives' contributions - whilst limited - were centred on the challenges of communication and language barriers. Women's birth experiences were grounded in the relationships that they developed with their midwives. These relationships were built on respect, and women's voices corroborated that it was the midwife, together with her qualities and behaviours, her continuing concern, the manner in which she cared, and her respect for the woman that were the underpinning ingredients to how the women viewed their birth experiences.

# Chapter 9

# Facing challenges: being an interpreter

**Excerpt from an interview**

"...we work in partnership with the doctors and the midwives. We are not midwives but we have a responsible role and we make sure the woman has understood what the doctor is telling them .... That they are going to have a caesarean section and all that stuff. Doctors do explain it but they are rushed and can't spend time with them [women]. We are professionals really but what is upsetting that there is no career progression within the Trust. They just do not recognise us as a part of their team.

**Interpreter Ojala**

## 9.1. Introduction

In areas where the take up of maternity services from women from the BME communities has been high, NHS organisations have employed a range of bilingual health workers (Eng and Young 1992). Broadly speaking they fall into three categories. First there are the interpreters, who translate 'word for word' what the health professionals say to the service users and vice versa; second is the linkworkers (also known as liaison officers), who in addition to interpretation also acts as cultural advisor and health promoter (Baxter 1997). The third role is that of advocates who in addition to interpretation, mediate between the service users and healthcare professionals, making sure that the service users are able to make an informed choice of healthcare, and they also negotiate clinical or cultural issues on the behalf of the service users (Parsons and Day 1992).

In the mid 1960s translators and interpreters were introduced by organisations to overcome communication and language barriers, followed by 'Teachers of English as a Second Language' in around the 1970s and it was not until the 1980s and 1990s that the linkworkers, bilingual healthcare assistants and advocacy schemes developed (Parsons and Day 1992). Interventions such as linkworkers and advocates developed as a direct result of AMBC (Bahl 1988) to overcome communication and language and cultural

barriers that existed between the Asian families and the health service. Following the evaluations confirming the effectiveness of linkworkers and advocacy schemes (Rocheron et al 1989; Mason 1990; Parsons and Day 1992; Market and Opinion Research International 1994), many organisations appointed linkworkers and advocates to improve communication between the women, healthcare professionals and maternity services.

Much of the current research has examined the effectiveness of interpreters in promoting access to services (Alexander et al 2004) or effective use of interpreters or interpreting services in overcoming language and communication barriers (Gerrish et al 2004), there is little published work that has explored the interpreters or link workers experiences of their role. This chapter focuses on the data which provides an insight into some of the challenges faced by being an interpreter, linkworker or an advocate.

## 9.2. Interpreters as professionals

> *"My job is demanding and yes I translate the message between the doctors and nurses and the ladies .... But you see my role is much broader..... It is hard to describe it is like that. I suppose I give the ladies health advice....hmm...give them more information and at times tell the doctors and nurses what the ladies want"*
>
> Interpreter Ojala

The majority of the interpreters in this study perceived their roles to be central in supporting midwives and doctors in the delivery of maternity services which was responsive to the needs of Pakistani women. Whilst some interpreters, particularly freelance interpreters, saw their role primarily to translate information accurately between the healthcare professionals and the women, the liaison officers and the advocacy worker viewed their role to be much broader. They reported that their role was much more than interpreting and was much more a link between women and doctors and midwives. They believed that they played a key role in promoting a two-way communication, ensuring that women obtain adequate information about their treatment and care as well as ensuring that the healthcare practitioners understood the needs of the women. Thus they perceived that they minimised the potential for misunderstanding and they assisted the midwives and doctors to provide appropriate care and support to women at all key points. They considered that they played a key

role in informing communities about the available maternity services, so that women could exercise choice and control over the care they receive.

> *"That's where we come in. They* [women] *need information,* [interpreters] *to go through very slowly because first there is a lot of anxiety then especially when somebody comes to the hospital they are a bit vulnerable. Especially with pregnant women their hormone levels are all over and then they have small kids at home and they are thinking of so many other things.* [...]. *Doctor has explained quickly and which hasn't sunk in and then that's where we come in. And then we have time to go through and they ask many questions to us. They ask all sorts of questions - what will be happen, what... ".*
>
> Interpreter Tahira

Similar findings are reported by Baxter (1997) and Gerrish et al (2004) reporting that freelance interpreters viewed their role simply in terms of translation whereas the link workers perceived their role extending it into "*cultural broker*" and "*patient advocator*" (Gerrish et al 2004: 411).

However, unlike Hsieh's (2006) study findings where the interpreters wanted to be invisible, majority of the interpreters in this study viewed themselves as part of the healthcare professional's team and considered themselves to be "*emerging professionals*" (Interpreter Vardah) and a minority even discussed the struggles they experienced with wanting to change their title from '*interpreter*' to '*interpreter officer*' (Interpreter Nafisa).

> *"My role is just so important especially if they* [women] *don't speak English. They* [women] *think that I have more than just an interpreting role to play that if there is something going wrong that I will highlight it and in a way we are really health professionals"*
>
> Interpreter Uroosa

> *".. They* [Pakistani women] *want to ask but they don't get a chance or they don't feel that it is the right time to ask...my job is to explain to the patients fully and to satisfy them till they say yes we understand .... As professional I feel, I myself feel, we are caring profession, we work in a caring profession"*
>
> Interpreter Qirat

Recognising that they play a vital role in the delivery of maternity services, some of the interpreters questioned the reason for not "*universally providing services of interpreters, linkworkers and advocacy workers*" (Interpreters Nafisa, Pakeezah and Tahira). They

spoke about having to develop business cases in different organisations regarding employing interpreters, linkworkers and advocates, questioning the need for such practices when there was ample evidence on the effectiveness of these interventions. They argued that given Britain has been a multiethnic country from sometime, that such interventions should be mainstreamed.

### 9.3. Pressure of time

Many interpreters identified that having enough time for effective communication was often a problem. They reported that there were many occasions when there was not enough time to provide adequate explanation to the women during consultation because a) the doctors and the midwives were busy b) the interpreters also felt that healthcare professionals applied pressure on them to complete the consultation and c) healthcare professionals did not take into account that a three-way communication would take longer. Some of the interpreters believed it was their responsibility to explain the situation fully as well as ensuring that women had understood the messages communicated to them. They highlighted situations when they suspected that the women did not fully understand the message during their interaction with the healthcare professionals; they often sought further opportunities, outside the interpreting episode, to communicate with the women to ensure that they fully understand the health message. Some of the interpreters spoke of feeling "*helpless*" (Interpreter Shabana) and "*dissatisfied*" (Interpreter Pakeezah) particularly when they had translated the message but perceived that the women had not understood the message. They felt pressurised by the healthcare professionals to complete the interaction "*quickly*" (Interpreter Vardah) and reported that such situations were out of their control

> *"Sometimes the doctors and nurses are so busy their time is so short. If suppose the woman has come for induction and she needs to know what she is going to go through and the doctors explain quickly once and then that's it.* [....] *we just explain the whole thing and go some where else and* [....] *they* [women] *grab hold of us when ever they see me going past please will you explain to me again and this is what they have said - I did not understand properly although I do understand but ... anxiety is there ... you see they want reassurance somebody to explain ..... To go to greater length, because they have many questions to ask, what is going to happen? What will I do? There is ... doctors do answer some questions but they can't go in length with them".*
>
> Interpreter Ojala

However, Ojala was keen to explain that doctors and midwives are often unable to spend adequate time with the women not because they don't want to but "*because the clinics are so big and they* [doctors and midwives] *are so busy. There have about 10 or 20 women waiting, 40 women are waiting and if they start spending..... they do spend time but they don't have time when others are waiting*". It is possible that the midwives and doctors adopted 'ways of being' with the women which served to maintain emotional distance (Menzies 1970; Lipsky 1980) by utilisation of appointments and allocating specific time to see each woman with greater emphasis on getting the job done, thus serving to control the women.

Some of the interpreters gave accounts of situations when they supported women who were distressed. They reported incidents when the midwives were busy with clinics and did not have time to spend with the women who were "*really distressed*". So they would call upon the services of interpreters to "*spend some time with them*" (Interpreter Rukiah). Some interpreters reported, often they were doing midwives work of listening and supporting the women, particularly when doctors and the midwives wanted to "*hurry up the conversations because they were pressed by time*" (Interpreter Shabana).

> *"They sometimes ask the ladies how are you? And they* [women] *start to tell them their other problems they are having. The midwife just looks at me to say I haven't got time for all this and that.... I then have to tell the lady to just answer the question"*
>
> Interpreter Ojala

Many interpreters believed that they filled a vital gap by ensuring that the women fully understood the care delivery; they were able to provide reassurance to the women and believed that as a result of their interventions women were better informed.

### 9.4. Three-way conversation is time consuming

Interpretation is a complex process which involves more than word for word translation. It requires decoding of linguistic codes where each language has its own rules and the time this involves is further complicated by the three-way relationship. The process of interpretation in any consultation takes longer than normal and often this has been a source of pressure for the interpreters. The interpreters reported that interpretation "*is not about translating word for word, in some cases it is not possible to just translate*

*words because there are no words in Urdu for an English word*" (Interpreter Shabana). Often during the interpretation the interpreter may have to elaborate and adapt the message (Kaufert and Putch 1997). To ensure that the women fully understood the message and the progress of their pregnancy or labour they sometimes had to explain the context. The interpreters believed it was important that the women understood all the implications and had all the necessary information to make an informed decision about consent, care and treatment. They ensured that communication is genuinely two-way and the midwives take on board what is important to the women. However many interpreters found that many midwives and doctors were uncomfortable with the process of interpretation. In particular it was those circumstances where the healthcare professional had asked one question and the interpreters had to enter into a dialogue with the women, explaining in detail the issue to the women that the healthcare professionals were casting doubts on the interaction and appeared to be mistrusting of them. For example:

> *"We are also being watched by the professionals wondering why you are using more words then necessary or why you are engaging in a conversation with patient when you have to wait for the professional to say everything".*
>
> Interpreter Nafisa

Some of the interpreters gave an account of the non-verbal behaviour of the healthcare professionals which they perceived was disapproving of their conversation with the women. Some of them reported that not all healthcare professionals appeared to understand their role and often lacked training of using the interpreters in three-way conversations.

> *"Sometimes a midwife will look at me a bit sharpish especially if the conversation is taking longer. They think 'I have asked a question and I just want an answer'. They can't understand why it should take longer"*
>
> Interpreter Rukiah

### 9.5. Midwives and doctors are sceptical of us

The majority of the interpreters highlighted that despite playing an essential role in achieving organisational goals many midwives and doctors did not view them to be part of the team. "*I work in partnership with them* [midwives and doctors] *and yet they do*

*not recognise what I do, basically they ignore us*" (Interpreter Vardah). Many interpreters stated that they were rarely if at all invited to join in team activities, for example, having coffee with the team or team meetings. The majority of the interpreters felt that they were a valuable resource and the maternity services rarely used them to develop services which respond to the needs of the women from the BME communities, where they thought they had a lot to contribute. They believed their bilingual skills as well as bicultural experience would contribute to a greater understanding of NHS organisations' strategies to develop services which are more patient focused.

> *"It feels sometimes that you don't feel part of the team. They* [midwives and doctors] *will... many of them have team meetings and I am not invited to go. You see they talk about making services good for the Asian women but they never ask me, I work with these ladies and I could add a lot of cultural stuff and what the ladies say they want"*
>
> Interpreter Qirat

Many of the interpreters expressed concern about the way in which they were treated and they did not believe they were always respected by the healthcare professionals; often they had no place of their own where they could go and sit down. The freelance interpreters had to make do with standing in the corridors or sitting in the waiting rooms with the women. In contrast the liaison officers did have an office where they could go for coffee breaks.

> *"Well we sometimes don't feel welcomed by some of the doctors and midwives. It is as if they don't want you there. They don't trust you and sometimes don't believe you. First they* [midwives] *will say.... Oh they are like threatened in a way then I say we work here as a team; It's not like I am undermining anybody's ability. You are a midwife and you know what to do with this patient and I am a liaison interpreter* [....] *when I go to the hospital, I have my professional hat on my job is to go and given them a listening ear or to listen to them and to listen to their problems".*
>
> Interpreter Vardah

All interpreters in this study believed that their role was central to maternity services. They believed that in addition to providing extra support to the women they influenced the quality of service delivery.

*"[....] the women feel that they have somebody who knows the system. Being there with them would ensure that they would have perhaps had better service delivery. That people would be more mindful of what they were doing".*

Interpreter Tahira

*"If there is something going wrong ... I will highlight it and being there with them* [women] *would ensure that they would have perhaps have better service delivery*"

Interpreter Vardah

*"I feel that I give them a bit more but I am constrained through my professional boundaries* [....] *What the patients like is that they just think that because I am there or another interpreter it will just mean that the people will watch their 'p's' and 'q's' and will be less sloppy that there is an impartial observer to observe what they are doing".*

Interpreter Nafisa

When attempting to ascertain the evidence on which these statements were based, some of the interpreters reported that there have been occasions when the women have acknowledged their support and stated that:

*".... they* [women] *have said things like "when you are here they* [midwives] *talk to us differently". I have had that comment said to me quite a bit. Meaning that we* [women] *are given more respect. We* [women] *are given more importance and they* [midwives] *tend to do their job better and it is not slap dash and this what they have said. That is not just from delivery suite it is from many other aspects of interpreting that I have found that people have said to me."*

Interpreter Nafisa

### 9.6. Support structures for us are missing

Many interpreters talked candidly of many stressful and distressing situations in which they had acted as an interpreter. For example, when women had experienced abortions and stillbirths, had birthed babies with congenital disabilities which on some occasions were life threatening or experienced difficult births. Nafisa cites an example when she was called to interpret for a woman on delivery suite. The woman had been in labour for a long time and was getting distressed. Nafisa reported that the woman had her previous baby delivered by a caesarean section and because she was exhausted in her

present labour, she wanted to have a caesarean section. However, the obstetric team intended to achieve a vaginal delivery. Nafisa gives the following account:

> *"The lady who had her IVF baby she hadn't ever had a normal delivery. She* [woman] *was saying that 'I am tired, I can't push any more, I had a baby with operation before, can you just ask them to just operate.* [....] *They* [medical staff] *ended up after spending a full night trying to get her pushing, she was exhausted they took... she had an epidural... they took her in for a caesarean and when they went in for a caesarean, I went with her. The doctor decided that she wanted to have a go at forceps delivery and ... hum .... and because she had a first one by caesarean, underneath the lady was intact so the doctor tried forceps but nothing happened except for a lot of blood and the lady was cut so she was stitched up below and then do a caesarean. The baby was delivered and I held him and what had happened the forceps had pressed on one side of his face and that created a type of paralysis so only one side of his face was moving when he was crying but the other wasn't which made him look quite distorted and this was quite worrying for the mum. It was very worrying. She was extremely anxious and I also didn't know what to say and I had to wait for the consultant paediatrician to come and look at the baby. Luckily I was there and was able to see because I had seen him* [baby] *at birth and I had held him I could see that there was slight change within those 3–4 hours while we were waiting and it seemed less pronounced and what the consultant paediatrician said that because there has been slight change and improvement it looks like 24 hour thing, and we shall carry on observing. I went the following day to visit* [the woman] *and give my congratulations and the baby was fine.* [....] *She* [woman] *thought that the care was okay because that she had so much input and activity going on but from my perspective I could see that there was some .... that she had unnecessary trauma you know she was intact underneath and she had to have unnecessary stitches. She had a caesarean before she was happy to have caesarean again. They* [medical staff] *thought that it was going to be caesarean, as she was not opening up that she had been pushing for so long and yet it was their own reasoning that they told her that they wanted her to go for a normal delivery. And the woman was exhausted. Handing over from staff I think there is also not full communication doesn't take place from night staff are handing over to morning staff. Sometimes it can be difficult for them* [day staff] *to get a grasp and that this woman had been pushing all night that she is exhausted and to ask her to push away again and I was interpreting but it was the doctor who made that decision. From where I was sitting from I would have been annoyed and I would have wanted answers as to why they gave me the forceps? The tear? The anxiety? That something that might not have righted itself. If his* [baby] *face had not righted itself I would have wanted to know why. What are you going to take responsibility?*
>
> Interpreter Nafisa

There is ample literature around the interpreting process, however there is limited literature which examines interpreters' experiences of interpreting (Gerrish et al 2004; Fatahi et al 2005; Hsieh 2006). Of these one is from England and the other two are from Europe and America. There were however many similarities in the experiences of interpreters in this study when compared to international literature regarding some of the dilemmas they face as outlined by Nafisa. Interestingly, Hsieh (2006) highlighted incidents when some of the interpreters were much more challenging towards the practitioners and institutional practices, interestingly many of the cited excerpts highlighting challenging behaviours are mainly from male interpreters. This was not the case in the findings of this study. It was not my intention to seek interpreters' day-to-day dilemmas but they did emerge as a strong theme. And had I examined interpreters strategies to overcome some of the challenges then it is possible that I may have found some similarities. Based on this limitation, my assumption is that the interpreters in this study "*did not wish to upset the system*" (Interpreter Rukiah) and wanted to "*keep on the midwives' side*" (Interpreter Tahira) because many of them were reliant on the midwives to call them. All the interpreters were Pakistani Muslim women and if maternity healthcare professionals hold stereotypical views of Pakistani people based on cultural and ethnic factors then female Pakistani interpreters are no exception.

Nafisa was clearly still disturbed about this incident because she got distressed and angry when providing this testimony. She did, however, acknowledge afterwards that she found talking about this incident helpful. I personally found it difficult not to say very much or probe her about the incident. Like Nafisa, some of the other interpreters were distressed about other stressful incidents. Many of them, however, were critical of maternity services, reporting that there is often no counselling or similar support available for them when they have been involved in distressing situations. They stated that they were not able to talk about the situations with other colleagues and were often left traumatised. Many of the interpreters suggested that there should be support systems to assist them to deal with distressing situations.

> *"They* [healthcare professionals] *just have no clue about what we go through. They just call us to interpreter and that's it. Sometimes we don't know what's gonna be there..... Once we have translated for them that's it they don't ask us how are you? Do you feel okay....."*
>
> Interpreter Ojala

These findings raise some interesting points and NHS organisations need to consider effective infrastructure to support healthcare professionals including interpreters to ensure the maternity services are accessible and equitable to Pakistani women. Interpreters have identified some key issues for their own development and these should be taken forward proactively by individual NHS organisations. However it is essential that, in absence of national guidelines, individual NHS Trusts should develop Codes of Practice to provide training and development programmes for interpreters; and where interpreters are employed by the NHS organisations then employment practices should be extended to them, for example 'personal development plans' and annual development reviews, and the possibility of clinical supervision should be explored.

Ideally having midwives and doctors from the Pakistani background would be most advantageous situation as it would address both of these requirements. Indeed many of the government policies and reforms are aimed at recruiting health staff who share the same cultural and linguistic characteristics as the populations they serve, thus reducing the inequalities in access to health services (King Edward's Hospital Fund for London 1990; DH 1993b; 1998b). This belief is underpinned by the philosophy that such a workforce is better equipped with the knowledge and skills necessary to facilitate the generation of culturally sensitive and appropriate healthcare to Britain's multi-ethnic society. To this end the profile of the midwives should reflect that of the local communities, as they have the most direct contact with the women and have a major influence on the quality of care provided.

Currently however, despite a number of initiatives, increase in the recruitment of midwives from the BME communities is slow. There is growing evidence highlighting that at present people from Pakistani communities experience inequality with regard to accessing nursing and midwifery education, promotion and continuing education opportunities in comparison to their white counterparts (Gerrish et al 1996; Beishon et al 1995; Iganski et al 1998). Given this context the make-up of the maternity workforce may change, but it is not achievable in the near future nor at the speed which is required to make demonstrable impact.

## 9.7. Summary

In this chapter, the theme of interpreters' challenges of executing their role has been discussed. Some of the interpreters acknowledged the difficulties and limitations which often arose out of less than satisfactory communication between the Pakistani women and the healthcare practitioners. They cited issues of language proficiency, midwives' and doctors' ability to speak and/or understand Urdu and women's ability to understand English and to speak it fluently, are of significant importance. In addition, understanding the social structure and cultures of Pakistani Muslim communities and their beliefs and values was also cited as being vital.

The majority of the interpreters who participated in this study saw themselves as 'professionals'. They argued that they played a major role in health needs assessment and information gathering, developing women's knowledge about their health and ill health including playing a key role in providing quality services. They were, however, critical of organisations in that much of their work went unacknowledged and very little of it was seen. They perceived their contribution to the services was invisible and indeed they raised a number of pertinent questions. For example they wanted to know the reasons for not providing services such as interpreters, link workers and advocates as part of normal service. The liaison officers and the advocacy workers in particular stated that the need for employing interpreters was not new; such roles were first introduced in the 1980s through the AMBC (Bahl 1988). Further, they questioned a need for a business case in different organisations about employing interpreters, link workers and advocates when there was evidence on the effectiveness of these services.

They expressed disquiet regarding their career progression, emphasising that there were few career progression opportunities for the interpreters despite their receiving appropriate training. They perceived a lack of adequate recognition of their role, despite making a vital contribution to maternity services. They voiced concern about the organisation's failure to recognise the emotional impact of interpreting, particularly when they were engaged in sensitive issues: there was no emotional and psychological care for the carer. They affirmed that the majority of them worked in partnership with midwives and doctors in achieving organisational goals and felt that their role was marginalised, and they questioned the reasons for failure to mainstream their role. Whilst many such initiatives to overcome communication and language difficulties have

assisted the growth of knowledge amongst consumers of maternity services, these initiatives are ad hoc, under-funded and are not mainstreamed, and until these issues are addressed it is likely that interpreters will continue to feel undervalued and marginalised.

# Chapter 10

## Endings: discussion and recommendations

**Equality**

You declare you see me dimly
through a glass which will not shine,
though I stand before you boldly,
trim in rank and making time.
You do own to hear me faintly
as a whisper out of range,
while my drums beat out the message
and the rhythms never change.
Equality, and I will be free.
Equality, and I will be free.

You announce my ways are wanton,
that I fly from man to man,
but if I'm just a shadow to you,
could you ever understand?
We have lived a painful history,
we know the shameful past,
but I keep on marching forward,
and you keep on coming last.
Equality, and I will be free.
Equality, and I will be free.

Take the blinders from your vision,
take the padding from your ears,
and confess you've heard me crying,
and admit you've seen my tears.
Hear the tempo so compelling,
hear the blood throb through my veins.
Yes, my drums are beating nightly,
and the rhythms never change.
Equality, and I will be free.
Equality, and I will be free.

**Maya Angelou**

### 10.1. Introduction

The main focus of my thesis was to understand the birthing experiences of Pakistani Muslim women in England against the organisational culture of the NHS. I set out to understand Pakistani women's relationships with midwives, and to understand the factors that shape their experiences of labour. At a broader level, the study was designed to contribute to debates about the provision of maternity services to women from vulnerable groups. The study was conducted in northern England, and involved thirteen women, nine interpreters and five midwives. The women shared their birthing

experiences, the interpreters[90] shared their views about the maternity services for Pakistani women, and the midwives provided brief insights into their experiences of caring for Pakistani women. Of the thirteen women, three permitted me to be present during their birthing period and I felt very privileged to be given this opportunity. I also conducted brief interviews with the midwives who cared for these three women; two other midwives working in the community setting were also interviewed. It is through the data analysis from these interviews, and the observations of labour, that these findings have emerged.

In this final chapter I shall focus on two main areas: first, I shall proffer a summary of the findings discussed in earlier chapters, and discuss the key findings. In doing this I shall answer the research questions posed in Chapter 1, which were formulated to address the gap in research about the childbirth experiences of Pakistani women, and to identify opportunities to overcome barriers to accessing intrapartum services. Second, I shall focus on the implications of the findings for midwifery practice, education and future research.

## 10.2. Summary of findings

The findings of this study reveal that many Pakistani women report a broadly positive experience during their encounters with maternity services. None of the women reported having either an entirely positive, or an entirely negative experience during childbirth; they had a mixture of both. They valued Western maternity services and believed that the midwives and doctors know best, citing attributes of the midwives that contributed to their experience. Many women were passive and silent partners, some were informed but compliant, and some did not engage with the midwives to determine their care.

The expectations of the Pakistani women were to have adequate and timely information about the available options of care, a constructive relationship with the midwives, and continuous support during their intrapartum period. Whilst some women expressed satisfaction in these areas, many voiced concerns about the inconsistency in the availability of information, and consequently women laboured with lack of knowledge

[90] The use of term 'interpreters' was made throughout the thesis to refer to the interpreters, liaison officers and advocacy worker who participated in this study; this was to preserve anonymity of the participants.

about the available methods of pain relief and of processes of care. Support in labour was available, often on request, but was of inconsistent quality. The women perceived that their ability to speak English played a part in the development of their relationship with the midwives, but they were of the opinion that a lot also depended on the attitudes and behaviours of the midwives. Other central findings were that there was low level of utilisation of interpreting services, and evidence of stereotyping and racism that shaped the context in which women birthed their babies.

Midwives, not surprisingly, were the orchestrators of women's childbirth experiences; midwives, are in position of relative power, were 'serving' women who were in a relatively powerless position. The midwives manifested 'power' (Lukes 1974) in terms of influencing or controlling the women, the birthing events, processes and resources. Midwives directed the stage controlling the giving of information, determining the level and nature of support for women and the types of response the women received. Midwives' working practices were shaped by the cultural dimensions and financial imperatives of the NHS, and this impacted on the way midwives either promoted equality or perpetuated inequality.

### 10.3. Women's information needs

The study findings confirmed that Pakistani women, like other women, have the desire for accurate and timely information about maternity services, so that they can exercise their right to choose the kind of care they want. Nearly all the women, irrespective of their proficiency in English, expressed their desire for information. However, in practice, opportunities where information could be accessed were variable and many voiced their concern about inaccessibility of information during childbirth. The study findings suggest that those women who had received formal education, been to the childbirth preparation sessions, were proficient in English, and had resided for some time in UK, were more likely to know about different methods of pain relief and options of care. Similar findings have been reported by others, suggesting that healthcare users' knowledge of services correlates positively with education, language and medical knowledge (Firdous and Bhopal 1989; Woollett and Dosanjh-Matwala 1990a). This suggests, among other things, that there is a greater need to provide appropriate and relevant information to those women who are less proficient in English. The findings

from the interpreters' data suggested that not all Pakistani women are given the '*whole story*'; the Pakistani women got less information than their White counterparts.

**….. Midwives: controlling information …..**

One possible explanation for the lack of women's knowledge is that the midwives controlled 'information giving' or perhaps midwives did provide the information but the women did not understand or remember it. Findings from this study suggest that the midwives were key players in deciding the appropriateness of giving information to the women. One of the possible explanations for withholding information could be that midwives are the "*gatekeepers*" of information (Levy 2004: 61). They are in control of both the amount of information that should be given and who should receive it.

Selective *"giving"* and *"withholding"* of information by midwives may be part of a strategy to maintain professional dominance through retaining informational power (Lipsky 1980: 90). Midwives perceive they have greater 'expert' knowledge than the women, and they retain this knowledge by not fully informing the women. Thus by maintaining the status quo, they remain in a more powerful situation and the women remain dependent on the midwives. Alternatively, midwives may be acting as "*protective gatekeepers*" (Levy 2004: 61), in that they do recognise that women need information to make informed choices, but they perceive that if women are provided with "*too much information there is a danger that the women would not successfully assimilate it, misunderstand or inappropriately personalise it with consequent worry*" (Levy 2004: 63). It is possible that the midwives base their view of Pakistani women's ability to assimilate information on ability to communicate in English, categorising them negatively as less likely to benefit from information. Or the women may be viewed negatively for not attending childbirth preparation sessions, and as a result midwives withhold information, or 'titrate information giving' accordingly (Kirkham and Stapleton 2001).

The findings suggest that women who were most in need of information got the least, perpetuating 'inverse care law' (Tudor Hart 1971). Similar findings are echoed by others, where "*the greatest need for healthcare is associated with the poorest provision*" (Kirkham, Stapleton, Curtis and Thomas 2002a: 510). One of the midwives in this study with a high case load for SA women reported "*I like caring for Asian women, they*

*are not a problem ..... It is those who are living in those big houses that I do not like to work with*" (Midwife Dorothy). The midwife explained that the women who were White and predominantly belonging to upper middle classes were too demanding and challenging. They asked too many questions "*you have to be on your toes all the time* [.....]. *The antenatal clinics take twice as long whereas these Asian women don't ask much and they are really quiet souls .... they are no trouble at all and they just get on ..... they do not need much information*". It is possible that when time is rationed, and midwives are under pressure to achieve all their duties, they give information to those women who are 'demanding' and restrict information for those women who they judge will '*get on*' and '*do not need much information*'. Or when midwives are under pressure of time to deliver "*complex information*", they are more likely to "*restrict information*" (Stapleton, Kirkham, Curtis and Thomas 2002: 198).

Or it may be that midwives adopt communication patterns that have a 'one-way' mode: the midwives give the information however they do not check whether the women have understood it. These strategies for managing the time in antenatal clinics unintentionally discriminates against those women who do not ask for information. It is possible that Pakistani women who did not speak fluent English may have been categorised by midwives as uneducated, ignorant and unintelligent (Bowler 1993a), and therefore display negative attitudes towards them (Bowler 1993a; 1993b; Neile 1997; Ellis 2004; Sivagnanam 2004; Hindley 2005).

### 10.4. Meeting women's support needs

The findings of this study suggest that it was mainly the women who determined when they needed support. Given that the women in this study did not demonstrate overt active participation or assertiveness in their care, it is likely they were not forthcoming in *'buzzing' the bell'*. Women may have been reluctant in summoning help and when they did get assistance, support was either not forthcoming or did not fully meet women's needs, leaving some of the women feeling helpless and vulnerable.

The findings of this study indicate that some midwives '*went out of their way*' to develop relationships with the women and meet their support needs. However, there were others who utilised behaviours and language that silenced the women, thus preventing them from further engagement in decision-making. Whilst both the women

and the interpreters found some of the behaviours adopted by midwives offensive, often it was '*the way in which they* [midwives] *responded'* which was unpleasant. Whilst it is true that "*an inability to share a common language obviously presents a major obstacle*" (Gerrish et al 1996: 38), "*there is much more to effective communication than mere linguistic skill; intonation and body posture may say very much more than a health care service provider may wish to acknowledge*" (Gerrish, et al 1996: 40).

It is likely that the women perceive midwives to be oppressive for two reasons. First the midwives are in a more powerful and authoritarian position than the women, and it is through their body language and verbal communication that they remind women of their power. In addition, midwives, in their struggles for power within the hierarchical structures, maintain the power differentials with the women, ensuring that the women remain dependent on the midwives. The second reason may be that midwives demonstrate hostility towards women because of women's ethnicity and faith. This may be perceived as midwives acting discriminatorily, which is unlawful. This could be interpreted as a case of direct discrimination where the midwives are providing '*less favourable treatment'* based on women's ethnicity and faith markers (CRE 1994). In addition, it is possible that through discriminatory attitudes and behaviours midwives effectively withhold information and support, leading to poorer quality of service delivery. It is also questionable whether midwives can develop a trusting relationship with Pakistani women when they hold stereotypical views of them.

### 10.5. Women and Midwives developing relationships

The women in this study highlighted the importance of the relationship with midwives and the impact of this on their childbirth experiences. Women identified the characteristics of midwives that they valued most. The women stated that midwives who demonstrated 'acceptance', and were 'supportive' and 'helpful' were 'nice'. The midwives with whom they were able to develop a positive rapport and a close relationship were defined as 'friendly'; women valued characteristics of being social and approachable.

The women described the midwives as being either '*achiy auratay*' (good women) or '*kharab auratay*' (bad women). They made these judgements based on the attributes displayed by the midwives. For example they reported good midwives '*smiled*', '*had a*

*laugh with them', were 'warm', 'approachable', 'midwives listened and talked with the women'.* On the other hand, those midwives who were perceived as '*butmeez*[91]', '*insolent', 'not responsive'* and *'rude'* were reported as being '*bad'*. At no point did the women in this study question professional care: they trusted midwives' knowledge and competence. The facet with which they took issue was the way in which midwives responded to them. The findings of this study highlighted that the attitudes and behaviour of midwives play a pivotal role in influencing women's childbirth experiences.

### 10.6. Communication and Language: a central concern

Communication and language was a strong theme in this investigation. The focus was on language difference, use of and availability of interpreting services, and effectiveness of interpreting. All participants echoed previous findings: that communication and linguistic issues are one of the main factors which either facilitates or hinders the provision of effective services (Woollett and Dosanjh-Matwala 1990a, 1990b; Gerrish et al 1996; Garcia et al 1998; Jayaweera et al 2005). Midwives acknowledge that it is difficult to communicate information and develop relationships with the Pakistani women, especially those who are not proficient in English (Reynolds and Shams 2005). Midwives are able to giving information, but they are unable to check whether the women have understood it or not. If this is the case then it is not surprising that Pakistani women, particularly those who do not speak fluent English, do not have full information upon which to make decisions. It is possible that as long as midwives can fulfil their statutory responsibilities as specified in the 'Code of professional conduct' (NMC 2004), they are under little pressure to identify - let alone meet - Pakistani women's needs or preferences.

Many women in this study, felt they were not involved in decisions, and felt their needs were not identified. They perceived this was mainly owing to their inability to communicate effectively with the healthcare professionals. They did, however, state that there was a lack of well-developed systems for organisations from which to elicit information. For women who are not proficient in speaking English, the midwives' inability to enable effective communication can greatly affect experiences of maternity

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[91] Meaning ignorant

services. With women unable to access appropriate and timely information it is likely they may be left feeling vulnerable and less confident in making decisions; they may also be left feeling isolated during the hospitalisation period.

### 10.7. Interpreters: an invisible resource for the women

The interpreting services were not commonly utilised by the delivery suite midwives. One possible explanation for this is that some midwives see that women are on the delivery suite for only a short period and that midwives can '*make do*' with other strategies such as non-verbal skills, signing or use women's labour companions. It is likely that midwives, like those in Hunt and Symonds' (1995) study, place more emphasis on physical and technical care than on emotional and psychological care. Indeed, some of the women in this study reported that some midwives would come into the room to '*check and listen to the baby's heart*' and then go out (see chapter 7). It is possible the midwives use stereotyping and labelling to control the way they interact with the women, possibly adopting the strategy of time keeping and 'processing' the women, with emphasis on 'getting the job done' as an organisational defence against stress and anxiety (Menzies 1970). Further, communicating through the use of an interpreter - a three way communication - is time consuming. It is therefore not surprising that in a culture where midwives are pressurised to manage their time in order to 'process' their work, they may chose not to utilise interpreting services. Nonetheless this approach cannot be condoned as it may lead to delivery of an inferior quality of care to Pakistani women.

The midwives in this study indicated that accessing interpreters was an obstacle. On one hand financial considerations affected their ability to access interpreting services, and on the other there was the need to book interpreters in advance. Booking interpreters in advance was problematic because it was difficult to predict the interpreting needs of women prior to admission. However, the community setting, where the midwives have control of timing of home visits and antenatal clinics, would be an ideal place in which to book interpreters to overcome communication and linguistic barriers. The findings of this study, however, suggest that in practice this was not the case, although because of the small sample size generalisations cannot be made. The data from the midwives and interpreters suggest that the use of interpreting services

was very much dependent on the midwives' practices. The interpreters thus perceived midwives as the 'gatekeepers' of interpreting services.

The findings of the study confirmed that the availability of interpreting services within the participating NHS Trusts was variable, and there were different models of service to overcome the language and communication issues. It was reported by the women and the interpreters that interpreting services were poor and often not available when needed. It is disturbing to note that communication and linguistic issues continue to act as a major barrier for Pakistani women in accessing and utilising maternity services, particularly when evidence confirms that lack of ability to communicate in English has a positive relationship with poor clinical outcomes "*across a range of conditions and types of treatment*" (Audit Commission 1993:3; Lewis 2001; 2004). This is a serious issue given that evidence continues to suggest that those women from the BME communities who speak little English are more likely to die (Lewis 2001; 2004), particularly where interpreting services were inadequate and healthcare professionals were unable to get appropriate and relevant information on which to base care.

Despite initiatives to overcome language and communication barriers, findings from this study show that services in parts of northern England continue to fail to meet the communication needs of Pakistani women. A possible explanation for this is that the 'supply does not meet the demand' and there are insufficient qualified interpreters within the NHS. This could be because the NHS is not developing the service of interpreters and as such is maintaining the status quo (Baxter 1997). On the other hand, it could be that the NHS is attempting to develop and improve the service, but demand grows much faster than supply owing to demographic changes resulting from immigration and influx of asylum-seekers. Nevertheless, organisations and individual practitioners have a legal and ethical obligation to provide linguistically appropriate maternity services (Race Relations (Amendment) Act 2000), and they need to develop strategies to ensure that women and their families are not unduly disadvantaged in accessing and utilising the services because of communication barriers.

### 10.8. Women as compliant partners

The women in this study said the use of machines in labour was reassuring. Whilst they could not explain exactly what was being monitored, they reported that the machines

were for '*checking the baby*' and that regular check-ups during labour were essential for the health of their baby; they wanted to know if everything was '*okay*' and there was '*nothing wrong with the baby*'. This possibly suggests that Pakistani women are strongly committed to Western maternity care (Woollett et al 1995). SA women are also reported to be accepting of the medicalisation of childbirth (Watson 1984; Bahl 1987), and examples were seen in this study where the women did not question interventions such as continuous monitoring of the fetus, acceleration or induction of labour. The findings of this study suggest that the majority of the women accepted the care that was provided. First they did not want to challenge the status quo, and second they viewed Western maternity care as being superior to that of Pakistan. They were grateful for the care they received.

The findings highlight that Pakistani women did not actively engage with midwives to determine the type of care they received. They appeared to be passive recipients of care, demonstrating compliant behaviour by accepting care and interventions. According to Weiten and Lloyd (2000: 175) "*compliance occurs when people yield to social pressure in their public behaviour, even though their private beliefs have not changed*". However within health discourses it is asserted that "*compliance .... implies varying degrees of coercion, placing a patient in a passive role and discouraging personal control*" (Walker et al 2004: 174) and as such is a dysfunctional concept (Anderson and Funnell 2000), given the current emphasis on involving the users of health services in developing a shared understanding of treatment and care. None of the women in this study worked together with the midwives to plan their care. However, it was evident that whilst many women were passive and compliant, there were some who became "*informed compliant*" (Kirkham, Stapleton, O'Cathain and Curtis 2001:155).

A possible explanation for the Pakistani women being compliant is cultural 'social norms', those explicit or unspoken rules that govern how individuals should behave in particular situation (Taylor et al 1995). Whilst there are many types of norms, the two that are particularly relevant to the findings of this study are 'descriptive norms' and 'prescriptive norms'. Descriptive norms specify how the majority of people behave in a given situation, for example, 'everyone has to lie in bed during labour'; prescriptive norms denote the way individuals *should* behave in any particular situation, for example, 'staff would get annoyed if I asked for any further explanation'. In healthcare

institutions individuals adopt certain prescribed norms akin to that of a '*sick role*' (Parsons 1951) or a '*patient role*' (Turner 1995), and indeed professionals' behaviours often teach women to be patients (Kirkham 1983b; Hunt and Symonds 1995). It is possible that the midwives and other healthcare staff pressurised the women to conform to usual practices, thereby maintaining the status quo. On the other hand it is likely that the women "*went along with the wishes of the dominant authority* [midwives in this case]" (Johnson 1997:141), in order to toe the line (Waterworth and Luker 1990), so that they would not be rejected or criticised. The findings of this study suggest that women adopted the strategy of compliance in order to manage some of the difficulties they faced in terms of linguistic barriers and staff attitudes. They were '*docile*' (Foucault 1977), accepting what is offered so that they can '*fit in*' with the midwives, and not resist the power the midwives or other healthcare professionals have over them.

Conversely, when social norms are not conformed to then the behaviour can be interpreted as deviant. It is possible that the women in this present study demonstrated compliant behaviour by accepting care during labour, because they wanted to be liked by midwives, and to be perceived as 'good patients'. On the other hand it is likely that the women felt they were dependent upon midwives and other health professionals for ensuring a healthy and safe delivery of their baby, as some of the women expressed they were scared during labour and thought "*they were going to die*". It is likely the women thought that should they question the care or interrupt the midwives, they would be perceived as '*deviants*'.

Hence some of the women in this study were reluctant to challenge midwives' behaviour as it could put them at risk of receiving poor care or ill treatment from the midwives. It is possible that the women thought that should they challenge behaviours or request for further explanation, they could be labelled as '*troublemakers*' or '*difficult*' and the midwives "*will take it out on them*". This in turn could be perceived by women as jeopardising the quality of care provided by the midwife. Indeed, such concerns are upheld by finding from other studies (though the participants were mainly White women), suggesting that women are unable to question midwives' action because of the different positions of power held by the women and the midwives (Stapleton and Thomas 2001). However, Stapleton and Thomas found that there are occasions, albeit rare, when women did ask questions, though this was only when women had established a trusting relationship with their midwife.

The findings of this study indicate that not all Pakistani women were able to establish a positive relationship where there was reciprocity or trust. It may be that women's inability to speak fluent English, or their ethnicity, influenced midwives' attitudes and behaviours, thereby hindering development of the woman-midwife relationship. Where Pakistani women developed positive relationships, they were able to seek further information, nevertheless, they remained 'informed compliant', accepting care that was provided to them by the midwives (Stapleton, Kirkham, and Thomas 2002). Some women were not on the delivery suite for long and as a result did not have enough time during labour to develop such relationships. Women succeeded in developing good relationships with their midwives in the antenatal period, highlighting benefits of continuity of carer.

Another explanation for women's non-engagement in decisions about their care, and accepting what was offered, is that they were seeking reassurance that the labour was '*going well*' and the '*baby was okay*'. The majority of women in this study believed that monitoring and interventions were carried out to make sure their babies were all right and did not question the medical interference with the care. They did not feel the need or ability to question why their membranes were ruptured and why labour was being accelerated, not even when the care they received was contrary to their views. For example, almost all the women in the study perceived epidural analgesia negatively, but when it was offered to them during labour they accepted it. One of the explanations for this could be that they placed trust in the midwife's knowledge. It is possible that the women complied with the superior knowledge of the midwives, placing them in a position of authority, and allowing them to make decisions about health care including methods of managing pain (Bluff and Holloway 1994).

It is also possible that the midwives framed information (Stapleton, Kirkham, Curtis and Thomas 2002) in such a manner as to steer (Levy 1999) women to make decisions that fitted in with the midwives' views. Or indeed it is likely that when the labour pain became unmanageable for the women they accepted what was offered to relieve it even if it went against their view. The women stated that delivering care in labour was part of midwives' job, and some of the women said that it was important to allow midwives to carry out interventions, suggesting that intrusion in healthcare professionals' domain would not be appropriate. Furthermore, the findings from the interviews with the interpreters suggested that the women saw use of technology as reassuring.

The Pakistani women in this study were uncritical of maternity care and services; they assumed that the care provided in labour is the best, as it has been 'well thought out', therefore, 'what is, must be best' (Porter and Macintyre 1984: 1198). The explanation for compliant behaviour is likely to be a result of conservatism, respect or politeness.

### 10.9. Stereotyping: a vicious cycle

One of the many 'veins' running through this thesis is the use of stereotyping and the subsequent effect this has on the quality of the relationship between the midwives and the women, as well as on the quality of care and communication. Indeed, the literature from cognitive psychology describes the role of '*typification*', or in sociology the role of '*labelling*', in managing the vast amount of sensory information people encounter in their everyday lives. Typification or labelling helps people to assign characteristics to an individual based on their group membership. Whilst the processes of typification or labelling assist the development of broad categories, it is a crude mechanism, that does little to develop specific information about particular individuals. The concerns are, however, that when the typifications become rigid and inflexible they become either negative or positive stereotypes and it is this that can lead to prejudice and discrimination.

"*Stereotyping thus may be thought of as a form of simplification,* [...] *mental shortcuts* [...] *that summarize and come to stand for a more complex phenomena* [....], *yet they are prejudicial and inaccurate as a summary characteristics for groups of people with nominally similar attributes*" (Lipsky 1980: 142). According to Lipsky, the use of stereotypes may be a coping strategy used by midwives to manage their occupational stress by minimising the development of relationships and saving time by 'mass-processing'. In light of this the use of stereotypes might therefore be useful in many situations (Green et al 1998), although they become dangerous if the group labelling takes precedence over individual needs when planning and delivering care. In practice, however, when ethnic and cultural stereotypes are used to explain different patterns of health and social care needs, healthcare professionals are most likely to make value judgements and inappropriate assumptions about the needs of service users from diverse backgrounds.

The findings of this study suggested that some midwives categorised Pakistani women on the basis of their ethnicity and culture and this influenced the way in which they were treated. In these situations stereotypes acted as a vehicle for developing an oppressive culture of care. One of the beliefs held by the midwives working on the delivery suite was that women should be informed about labour, options of care and methods of pain relief prior to going into labour. Their belief was that labour is not the time to orient women with this information and that the women should obtain and familiarise themselves with such information during the antenatal period by attending the preparation sessions. They held this belief regardless of whether information at these sessions would meet the needs of the women or not.

The findings from this study illustrate that not many women asked for information during childbirth; they believed lack of communication was a problem created because they could not speak English, and therefore did not expect or demand information about methods of pain relief or procedures in labour. Pakistani women who were less proficient in English may have refrained from requesting information in a different language. One reason is that assertiveness in a medical context is culturally perceived as inappropriate, and Pakistani women did not want to be seen as lacking confidence in their midwife/doctor, or seen as questioning their authority by asking for information. This was very evident during the interviews, when most of the women were reluctant to articulate information that might have been seen as a criticism of the midwives or maternity services. In fact some women defended the midwifery care they had received. They, like the participants in Bowes' and Domokos' study, "*were genuinely appreciative of the* [maternity service and midwifery care] *available to them, to the extent that they did not feel that they had the right to hold, let alone state, their individual preferences*" (Bowes and Domokos 1996a: 58).

Then again when some women did attempt to seek further information, the midwives silenced them by '*getting annoyed*' and telling the women that if they had '*been to parentcraft classes*' they would '*not to wasting* [midwives'] *time*'. Midwives refrained from providing relevant information that would have assisted the women in making decisions about the methods of pain relief. Regardless of their antenatal knowledge almost all women expressed the need for more specific information during labour to make decisions related to labour and labour pain.

Interestingly, midwives adopted a 'victim-blaming' philosophy towards the women for not attending the antenatal classes. These findings are not new and are borne out by studies where midwives display negative attitudes towards Asian women based on assumptions such as being '*attention seeking*', '*making too much noise during labour*' and '*having low pain threshold*' (Bowler 1993a; 1993b). Holding these assumptions often led to disturbing consequence where midwives often withheld care and treatment from Asian women whom they considered were neither in real need nor deserving of such care (Bowler 1993a; 1993b; Neile 1997; Ellis 2004; Sivagnanam 2004). However, it is disappointing that the status quo has been maintained and there is little in the way of encouragement that progress being made to overcome this inequity.

It may have been acceptable at one time for midwives to rely on stereotypes to provide care for Asian women, however, given that midwives have now been caring for SA women since the 1960s, they should have developed knowledge and competence to eradicate such stereotypes. Furthermore, the assumption that attendance at the childbirth preparation sessions would prevent women seeking further information in labour may not be true given that there is a body of knowledge that confirms women need information that is timely so that they can orientate themselves to their labours (Kirkham 1983a; Kirkham and Stapleton 2001).

This practice of categorising and stereotyping is a "*professional defence mechanism*" (Kirkham, Stapleton, Curtis and Thomas 2002b: 549); utilised by midwives to protect themselves from any 'interference' from the women. It is possible that midwives adopt this strategy to manage their work. If this is the case then for Pakistani women it means that being informed and being able to make choices is a lottery - a matter of chance. One consequence of this action is that some women lacked information about the range of maternity services and choices available to them in labour. It is therefore not surprising that Pakistani women had the tendency to be over-dependent on the midwives for information about the services during labour. However, it is possible that the midwives perceive Pakistani women to be over-dependent, and possibly negatively assess them as 'bad' or 'unpopular', making it likely that they will withhold information and compromise their care (Kelly and May 1982).

It is likely that the over-dependency of women adds to the already pressured time of the midwives. The midwives become angry and frustrated, and display negative attitudes

towards Pakistani women during their interactions by getting annoyed and adopting abrupt responses. The women perceive these cues that the midwives give out during their verbal and non-verbal communication. These actions may perpetuate some of the stereotypes that are held by women about the midwives and other healthcare professionals. For example some of the women said "*yeh lohk humarrha say farhk karthe hay*" ['these people treat us (Asians) differently'] (Jariyah), and '*yeh lohk hum mein or guro may alag alag saluk karte hein*' ['these people treat us less favourably than the Whites'] (Khatiza). The women perceive some midwives to be hostile towards them and as a result become reluctant to engage with those midwives.

It is possible that this is a case of self-fulfilling prophecy (Rosenthal and Jacobson 1968). The midwives, based on their experience of caring for the SA women and on their assumptions, have developed a view of how women from these backgrounds will behave in labour. Midwives behave according to these expectations, influenced by the stereotypes they hold about the Pakistani women; these stereotypes could be that the women are 'unpopular' (Stockwell 1972) based on their 'ethnicity' (Kelly and May 1982) and/or 'social worth or value' (Johnson and Webb 1995). Likewise, the Pakistani women possibly enter into the relationship with preconceived ideas and behave according to expectations based on what they have 'heard' about health services, their experience of midwifery services during the antenatal period, and their experience of other institutions. The negative stereotypes held by the midwives and the women of each other are likely to prevent the development of a trusting relationship.

Indeed, both the women and the interpreters in this study categorised midwives into two types, those who were 'good' and those who were 'bad'. Whereas the women[92] categorised the midwives as 'good' and 'bad' based on their attributes in the way midwives behaved with them, the interpreters[93] perceived those midwives who provided humane care to be 'good' and those midwives who provided discriminatory services as 'bad'. The women want to fit in with the midwives so they do not want to ask for information. However, when some women have attempted to ask for information, the midwives have silenced them. It is possible that the women were unable to ask for further information because of their inability to speak fluent English,

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[92] Table 8.1, provides a summary of attributes of the midwives which contributed towards the woman-midwife relationship.

[93] Table 8.2, provides a summary of positive and negative attributes of the midwife from the interpreters' perspectives.

or for the fear of being labelled trouble-makers (Bowes and Domokos 1996a; Stapleton and Thomas 2001). Women may feel that they are dependent on health professionals for antenatal care, childbirth, and postnatal care, and are likely to want to avoid being labelled as troublemakers by refraining from asking for information in a different language. In addition, women may not want to be seen as 'special needs cases', or as creating extra work for their midwife, thus perpetuating the vicious cycle of stereotyping.

The findings of this study indicated that even when there were no linguistic or communication barriers between the women and the midwives, other differences, in particular ethnicity, continued to negatively affect the way in which midwives responded to the women. The study findings suggest that discriminatory attitudes and hostility affect the woman-midwife relationship and the standard of care and social support which Pakistani women receive. In some of the situations, poor reception and handling of the women left them with feelings of humiliation and disgrace. It is possible that this experience, together with the inflexibility of the maternity services, does little to encourage Pakistani women to make full and confident use of NHS provision. Notwithstanding this, the Race Relations (Amendment) Act 2000 places a duty upon provider units to ensure that discrimination does not take place in service provision and to promote race equality. Street-level bureaucracies are required to maintain a culture where the concept of equity is an integral part of its philosophy, developing and implementing policies which take into account consumers' race, gender, ethnicity, disability, sexual orientation, culture or religion. However an unexpected though unsurprising finding of this study shows that this is not the case. Whilst women were hesitant to use the term 'racism' they described many situations where racist stereotypes were used by midwives to provide care, leaving them feeling demoralized and marginalised. Those women who developed a good relationship with their midwives, reported that the midwives '*fitted in with them*', '*met their needs*' (Husna), and that midwives '*got to know them*' (Inayat); they reported their labour experiences to be positive. The women expressed satisfaction with their experiences where the midwives '*go out of their way*' (Eiliyah) and get to know the women at a personal level and provide personal care.

## 10.10. Institutional racism

The findings of this study highlight a number of gaps in the provision of maternity services for Pakistani Muslim women. A notable example in this study was the inability of the services to adequately meet the communication and language needs of the women. It is likely that institutional racism may explain why provision and delivery of maternity services continue to fail to meet the needs of Pakistani women. Institutional racism, whilst it has been brought to the forefront in the health service by the Stephen Lawrence inquiry (Macpherson 1999), is not a new concept. It has been an issue for over twenty years (Glasgow 1980), and a number of writers have examined how discrimination is institutionalised in maternity services. For example Ann Phoenix (1990) examined the concept by making particular reference to issues of reproduction where attempts to reduce fertility rate for women from the BME communities may be seen as a form of covert discrimination.

Others suggest that the inability of service providers to recognise the structural barriers to provision of services facing minority ethnic people presents a fundamental form of institutional racism (Anionwu and Atkin 2001), where "*health and health care is structured systematically in terms of pervasive racial inequality, discrimination and disadvantage*" (Stubbs 1993: 37). Institutional racism operates where organisations claim, based on the assumptions, that they treat everyone the same and 'race' makes no difference. This belief in a 'colour blind' approach, where 'same service to all' means 'equal services to all', and can lead to service provision based on the majority norm that fails to recognise diverse needs.

'Othering' practices were evident in women's accounts of their encounters with maternity services, interpreters' accounts of their experiences and midwives discussions about Pakistani women. All participants made use of Othering terms such as 'them' and 'us', '*humarrha lohk*' (us people) and '*guroh lohk*' (White or English). Pakistani women mainly used Othering language when describing situations when they perceived that they were being treated differently; likewise the interpreters made use of such language when, in their opinion, midwives behaved differently in providing services to White women as opposed to Pakistani women. Midwives used terms such as 'they' and 'these women', particularly alluding to situations which were complex and demanding. For example Bernice explained "*all SA women get the same care that every woman gets on this*

*delivery suite but they do not go to the parent-classes and they tend to learn from their mothers-in-law* [....]". It appeared that Othering conversations were used more often in terms of cultural explanations, as Bernice did or in racialised terms mainly by women or the interpreters. For example "*when I was on postnatal ward they just ignored me and would not help and when they come and speak to the other English women you can tell"* (Ghazala).

A possible explanation for Pakistani women to be perceived as the 'other' is within the theory of 'pollution' (Douglas 1966). In Douglas' thesis the concepts of 'ritual pollution' and 'secular defilement' are defined as a state of uncleanliness brought about by contact with a 'dirty' or 'polluting' person, object or activity, and are concerned with ideologies within society about how the environment is reordered so it can fit with the ideology. 'Dirt' is not about being clean, it is simply a matter of being out of place and 'there is no such thing as absolute dirt: it exists in the eye of the beholder'; dirt is thus 'essentially disorder' (Douglas 2002: 2). This means that it is not the quality of things that is considered dirty, but where they stand in the order of things as determined by that society's system of symbols. Within this perspective the 'white' English culture is 'pure' and 'clean' which is being disrupted by the 'others', the 'Pakistanis'. As Pakistani women are 'out of order', 'out of place' and 'do not fit', they become 'filth', 'dirt', and 'pollution' and have 'spoiled the picture'.

Overall, the present findings support previous literature on institutional racism, indicating that health professionals' prejudiced attitudes and assumptions can lead to Pakistani women being deprived of services. However, in practice it is difficult to argue that all gaps in the provision of maternity services are a result of racism. For example, the findings also show efforts were made to address the communication and language needs, such as employing interpreters, however the issue is that this service was either inadequate or midwives failed to make use of it.

### 10.11. Midwives: being in the middle

Midwives are subjected to NHS demands and constraints, and these shape the way in which they interact and spend time with the women. Midwives are working in 'pressurised working conditions', dancing to the tune of many masters; "*midwives are in the middle*" (Stapleton, Kirkham, Thomas and Curtis 2002: 607). On one side are the

demands placed upon them by medical colleagues, who maintain a far higher position within the medical hierarchy, as well as those of their managers, employers, professional and statutory agencies, and partner organisations. On the other side are the Pakistani women, in a far lower position than the midwives within the hierarchy. The midwives have to manage "*professional conflicts over responsibilities for the patient, negotiate struggles over power with the physicians and contend with sexism and paternalism on the part of both doctors and patients* [as well as] *bureaucratic rules and the imposition of medical authority*" (Lupton 1994: 118).

Pakistani women are possibly another source of stress for the midwives. Having to meeting informational needs and communicate with women who are not proficient in English needs more time, placing extra demands on the midwives. Midwives are possibly pressurised into 'doing it to the women' and 'getting the job done' rather than 'being with the women' and meeting their needs. Midwives therefore employ coping strategies of looking 'busy', employing 'routines and rituals' and becoming 'task-oriented', which all lead to controlling women and reducing direct contact with them (Menzies 1970). It is possible that when midwives have to prioritise all the demands placed upon them, the needs of those in a more powerful position take precedence over those in a lower hierarchical position. Thus the individual needs of women do not remain central to the care provision (Levy 1997; Kirkham and Stapleton 2001). It is therefore likely that, having to work within the culture of managing competing demands compounded by current recruitment and retention issues, the midwives may have little time to spend attending to the women's needs.

Whilst "*the management of time is of utmost importance*" (Lupton 1994: 118) for the midwives, who are having to "*juggling priorities*" (Kirkham and Stapleton 2001: 156), time "*is also used as a strategy of maintaining authority*" (Lupton 1994: 118). It is possible that the midwives leak non-verbal messages, which women pick up, perceiving midwives to be 'very busy'. Findings of many studies have reported that when women sense that midwives are busy they do not want to "*bother*" or "*trouble*" them or "*like to ask*" the midwives for any information (Kirkham and Stapleton 2004: 132). This corresponded with the findings of this study where some of the women were reluctant to keep ringing the bell as they did not want to "*put additional pressure on the midwives*" because they were seen to be "*busy as they have to look after so many other patients*".

### 10.12. Midwives: Liberators or oppressors

The women in this study reported that there were many occasions when they were left on their own in labour. Of course, the midwives did come to attend to them but it was just to '*check the baby*' and then they would go. However, the women go on to state that the midwives would come when they '*buzzed*' the bell. Overall midwives are in a powerful position where they "*control the content, timing and pace of the interactions*" (Lipsky 1980: 120). Whilst it is true in many cases that the midwives are able to control the time they spend with the women when providing care in labour, they are often under considerable organisational pressure. Midwives work in an environment where structures are "*hierarchical, reinforced by economic imperatives and an NHS management culture of 'getting it right'*" (Kirkham and Stapleton 2004: 118). In addition to this midwives' "*practice is constantly visible and tightly controlled*" (Kirkham 1999: 733). It is then not surprising that the midwives working on the delivery suite report that "*some of the sources of 'occupational' stress come from medical and auxiliary staff but a sizable proportion of stress is caused by midwifery colleagues*" (Mackin and Sinclair 1998: 991).

The midwifery profession is in the unfortunate position of receiving an oppressive 'double-whammy'. First the midwifery profession is oppressed by male, medical men who are historically guilty of maintaining 'power over'. Second, midwives, as women within society, are oppressed by western patriarchy. Thus, midwives are an oppressed group largely because of their lack of control over their profession. Such oppression is reflected in midwives' lack of confidence, feelings of being undervalued and low self-esteem. It is therefore possible that the midwives working in an oppressive midwifery culture adopt characteristics of oppressed group (Roberts 1983; 2000), and in internalising the values of the most powerful group (Freire 1972) become oppressors. They demonstrate oppressive behaviours towards those who are in less powerful positions than them and in this case it is likely to be the women.

On the other hand it is possible that the midwives are having to juggle many balls at the same time and are concerned with 'getting the job done' given the number of tasks that have to be completed when on duty, and this governs the way in which they function. In their study of 'Informed Choice in Maternity Care', Kirkham et al cite many situations where clients were categorised into types, arguing that such categorising could possibly

assist midwives to "*organise care in stressful and hurried situations*" (Kirkham, Stapleton, Curtis and Thomas 2002a: 549). It is likely that midwives develop techniques of "*processing clients*" thus affecting the length of their interactions with the women, although "*conceptualisation of time ..... contributes to disempowering of procreating women*" (Simonds 2003: 39). It is possible that Pakistani women, owing to their communication and linguistic needs, require longer periods of interaction that add to midwives' pressures. This may be perceived by the midwives as an 'abnormal' behaviour hence their responding by "*reprimanding or otherwise sanctioning deviance from acceptable standards of client behaviour*" (Lipsky 1980: 58). It is noteworthy that there is limited data in this study that explored midwives views of caring for Pakistani women, and therefore conclusions cannot be drawn about how midwives organised their care for this particular group of women.

## 10.13. What does this study contribute to the understanding of Pakistani women and their ability to access maternity services?

Challenges posed by the findings of this study are for both individual professional practice and organisational responsibility, and I locate these in the current philosophy of the NHS and its reality for Pakistani Muslim women. Contemporary issues of patient-centredness and partnership working lie at the heart of NHS reforms (DH 1990; 1993a; 2000; 2004a). The proposals within these policy documents recommend that maternity services must be woman-centred and must be flexible and responsive to the individual needs of the women and their families. Service providers should listen to women's views, respecting their ethnic, cultural, social and family backgrounds. Thus maternity services must be planned and provided with the needs and wishes of women, their babies and families at the centre; care should encompass the concepts of choice, continuity and control (DH 1993a; 2004a). To strengthen service users' and carers' contribution in the way the services are provided and delivered they are given "*new rights and new roles within the health services*" (DH 2000: 88). There are calls for healthcare providers and the women and their families to work in partnership to develop and implement service models that ensure services meet the needs of the local population. The premise is that through working together with the midwives and healthcare professionals the women would actively participate in the decision-making processes about the care they receive as well as being in control of what is happening to them (DH 1993a; 2000a; 2004).

Midwives acknowledge that they can provide 'woman-centred care' by utilising the principles of control, choice and continuity, and in good faith treat all women as individuals. This involves showing respect for them, identifying and meeting needs as far as possible, communicating effectively, and above all treating them as equal partners in planning, delivering and evaluating services.

Whilst there has been a slight shift towards the sociological model, the findings of this study suggest that in reality this was not the case for many Pakistani women. Many women in this study voiced the concerns echoed by wider literature that Pakistani women do not enjoy these benefits. I have argued above that the Pakistani women are passive recipients of maternity services and many remain at the informed compliant stage where often their needs remain unmet. The women were unable to exercise choice and control over the care they received let alone work in partnership with the service providers. The women in this study did not believe they were able to work in partnership with the midwives, nor were they able to determine the care they received; they had little information on which to make their choices. Lack of information, notably because of communication and language difficulties and racism, prevented women from getting adequate support and building a trusting relationship with the midwives. Unless these inadequacies are urgently addressed the status quo is likely to be maintained, and issues of choice, control and continuity will remain rhetoric and a myth for Pakistani women.

**..... Originality and contribution to knowledge .....**

Before I bring the writing my thesis to a close by making recommendation, I assert its uniqueness and its contribution to the development of midwifery knowledge.

This study has predominantly documented childbirth experiences of Pakistani Muslim women; It has explored the worldview of Pakistani Muslim women during their journeys through childbirth. It is clear from the women's accounts in this study that Pakistani Muslim women do not have unique needs during childbirth; however their needs continue to be unmet. Like many women in the UK (see chapter 3), Pakistani women in this study, expressed a need for adequate and timely information, emotional support and a constructive relationship with their midwives, calling for trust and respect. In the absence of information concerning labour, not all Pakistani women in

this study were able to make an informed choice or full use of the services during the intrapartum period. Consequently, many laboured "*in the dark*"[94]. This finding is disturbing, particularly because it is well over twenty years when women's need for such information was recognised. Maternity services appear to be in inertia in that they have been unable or reluctant to respond appropriately to women's need for information. Likewise, published literature suggests that women have a need for physical and emotional support during labour (see chapter 7); women in this study expressed a similar need. Pakistani women called for constructive relationships with the midwives; furthermore, communication and linguistic barriers, and the role of perceived stereotypes and discrimination were identified as key determinants affecting their childbirth experiences. These findings as indicated above are not new; South Asian women have reported similar issues elsewhere over a decade ago (see chapter 3). Evidence from this study suggests that for Pakistani Muslim women little has changed, despite many attempts to modernise maternity services. This is regrettable.

Evidence from this study and from other national studies (see chapter 8) reveal that many women have similar encounters ..... good and bad ..... with maternity services however findings of this study suggest that ethnicity is an important marker in that experiences of women from a Pakistani Muslim background are marginally worse than their 'White' counterparts. It is possible that communication and linguistic barriers compounded areas of dissatisfaction. Disappointingly, however, limited use was made of professional interpreters to overcome these challenges. Whist there is significant amount of evidence related to use of interpreters in health setting (see chapter 8 and 9), this study is unique in exploring the experiences of interpreters in maternity services. The majority of the interpreters in this study expressed dissatisfaction with the NHS; they reported that their skills were under-utilised and more importantly they were invisible in that much of their work went unacknowledged.

Interestingly the majority of the women in this study reported that their cultural and faith needs were met and due regard was given to their privacy and dignity requirements. This suggests that at one level the NHS has responded to the cultural aspects but it is the oppressive patriarchal structures, which render women to

[94] The term 'labouring in the dark' was first coined by Professor Kirkham in early 1980s (1983a). In her study of communication of women and midwives in labour she reported that women had limited information and as a result they were unable to orientate themselves to the events during labour; I borrow this term unreservedly, at this juncture of my thesis, to capture what many women in this present study reported: they laboured with a lack of information.

vulnerability and passivity, which have been slow to respond to maternity needs of Pakistani women. Childbirth is the most powerful event in a woman's life; the midwife is one of the main conduits in this journey to enable Pakistani Muslim women to birth their babies in an anti-oppressive environment which makes informed choice, control and continuity a reality. This, midwives can achieve by their ability to '*be with the Pakistani Muslim women*'

> *"We never think entirely alone: we think in company, in a vast collaboration; we work with the workers of the past and of the present. [In] the whole intellectual world ..... each one finds in those about him [or her] the initiation, help, verification, information, encouragement, that he [or she] needs".*
>
> Sertillanges 1958: 272

## 10.14. Recommendations

A major issue emerging from the findings of this study is the tension between meeting women's expectations and midwives' modus operandi. The potential of poor clinical outcomes happening, for example maternal deaths, maternal or fetal complications, still births or birth injuries, when women cannot participate fully in their care is quite high. However no adverse effects were experienced by any of the women in this study; they all had relatively uncomplicated pregnancies and childbirth. The findings suggest that women do not have the scope to be active partners in the care they receive, owing to lack of ethnically sensitive provision of services, and engagement with the midwives.

The findings of this study have identified that despite the NHS directives there are some deficits in the provision and delivery of maternity services to Pakistani Muslim women. Not all Pakistani women have enjoyed their experiences of childbirth; they identified many areas of concern which have been articulated in the findings of this thesis. Their voices should be heard by the practitioners, educationalists and the researchers and I proffer the recommendations for them to facilitate ethnically sensitive and appropriate maternity services, ensuring that they are responsive and accessible to the needs of all women.

### 10.14. (i) Implications for practice

The findings of this study identify the Pakistani women's perceptions of the maternity services in northern England. These need serious consideration if there is a real commitment to a 'woman centred' approach to service provision, and to eradicate racism and discrimination in midwifery. Otherwise, the philosophy of woman-centred maternity services where women exercise choice and control over the care they receive will continue to be rhetoric. The responsibility for this change must lie with organisations including midwives and other healthcare professionals. This in a way places this study in the current health policy and 'race equality' framework of a patient focused NHS (DH 1997; 2000; 2004a; 2005).

#### a) Improving access to information

Organisations must develop effective strategies to ensure that the information needs of Pakistani women are met, and the strategies should be targeted at local needs. Women in this study wanted written information but did not have it, and whilst all women wanted information, they differed in their preferences for the amount and type of information. One way forward could be for midwives to assess information needs on an individual basis and provide information accordingly. This is difficult to achieve because of the time constraints on midwives. So information should be translated taking into account local language and language format needs. It is likely that when information is provided in written form, the women can extract information according to their own needs. The translated material should be in simple language and most importantly translators who are experienced in the appropriate field, and who are familiar with medical terminology, should be used. Care should be taken to ensure that the information is sensitive to cultural and faith beliefs and any publicity or information materials should project positive images of the Pakistani women.

Information leaflets will only be useful if women can read them, but not all women may be able to read either English or their own spoken language. Therefore consideration needs to be given to alternative media such as audio and video tapes or illustrations, so that women can extract information according to their own needs.

Leaflets on informed choice are available, which have been developed by MIDRIS and by individual health authorities, often in different languages. However, there is a need for such leaflets to be evaluated to indicate what their content is and how accessible they are for lay people. Although some health education and promotion leaflets have been evaluated (Kirkham and Stapleton 2001), there is little work around their use and effectiveness for Pakistani women (Turner 1996). Many organisations are deterred from developing diverse communication strategies because of the cost implications, although it is worth acknowledging that effective communication strategies will not only deliver an efficient and quality service but will also save both the organisation and midwives time.

Information should be disseminated through various channels for Pakistani women, for example, local ethnic press, radio, television, local community road shows.

**b) Engaging with Pakistani women**

Organisations should consider engaging Pakistani women on a regular basis and particularly when developing service models. Organisations should identify the needs of the local Pakistani women so that services are targeted to meet their needs. They need to engage and consult local Pakistani women in assessing issues that affect them, and listen to the views of Pakistani women through focus groups or surveys. Pakistani women need to be involved in management committees or steering groups, working in partnership with other statutory, voluntary and community organisations to develop care pathways.

**c) Midwives from the Pakistani Muslim background**

By acknowledging that the NHS is not meeting the needs of many communities, the Government is responding to the health needs of its BME communities through various policies and reforms. It advocates that some of the inequalities in access to health services may be reduced by employing health staff who share the cultural and linguistic characteristics of the populations they serve (King Edward's Hospital Fund for London 1990; DH 1993c). This belief is underpinned by the philosophy that such a workforce is better equipped with the knowledge and skills necessary to facilitate the generation of culturally sensitive and appropriate health care to Britain's multi-ethnic society. It would

therefore be appropriate to encourage more people from the Pakistani Muslim background to enter midwifery. However, this is not so simple given that the NHS has being trying hard for some time to attract and retain nurses and midwives from the BME (Gerrish et al 1995; Beishon et al 1995; Iganski et al 1998). There has been an increase in nurses and midwives, however, these have been in the main as a result of many NHS Trusts having to look to recruit from abroad to fill vacancies (Porter 1996). Whilst this response overcomes the immediate problems of staff shortages, it does little for the Department of Health's aim (DH 1993; 1998) to recruit a culturally diverse workforce to reflect the local community profile, particularly as these nurses are from Europe and other international countries. This may increase the cultural gap between the midwives and women, reducing the quality of care. Attempts to achieve a workforce that reflects local community profiles may never be successful. This under-representation of staff from the Pakistani Muslim background in midwifery has serious implications as it compromises the NHS in both delivery of equitable health care and in social justice and business efficiency.

Nonetheless, I am cautious to advocate that midwives from Pakistani Muslim background should care for women from Pakistani backgrounds as this may perpetuate ghettoisation. Should a situation arise where midwives from Pakistani background care for Pakistani women, it is likely that midwives from other ethnic backgrounds will not be able to develop transcultural competence. Having a similar ethnic background is advantageous, however it should not be assumed that this alone will facilitate transcultural competence; it is a learnt activity. There are many midwives from 'white' ethnic backgrounds who provide excellent ethnically sensitive maternity care. The qualities these midwives possess have been highlighted by both the women and the interpreters. It therefore may be appropriate that midwives who are committed to addressing issues of inequality of access, have similar philosophies and should be grouped together to provide care to women from diverse backgrounds within the primary care setting.

### d) Interpreters/liaison officers/advocates

In the absence of midwives with the relevant communication and language skills, organisations may wish to engage the services of interpreters, liaison officers, and advocates who can play a major role in overcoming communication barriers. Efforts should be made to ensure that supply meets demand. The interpreters, liaison officers

and advocates can be prepared to deliver information to the women. The case is often made for the interpreters, however these workers need to develop social and political knowledge, for example of racism and policies and practices that can lead to inequalities, and this knowledge can only be gained through experience and education.

The findings of this study show a gap in the knowledge of a number of issues concerning interpreting services in maternity. Organisations, through ethnic monitoring, need to identify the level of need and uptake for the service, the quality of interpreting services, and the experiences and preferences of women and their families as well as midwives' and interpreters' experiences. Maintaining the status quo is not an option. Where interpreting services are introduced these should be based on evidence, local needs and preferences, and evaluated to assess productivity and value for money.

There should be an effective infra-structure to support and acknowledge the services provided by these staff. Consideration should be given to the possibility of developing a pathway that might provide an opportunity for these staff to enter into midwifery education, or into a midwife assistant role.

**e) Partnership models**

The **Expert Patient Programme** could be extended into midwifery. Women who have recently had babies could be prepared to develop systematic programmes to work with Pakistani women during pregnancy and childbirth in order to empower them with appropriate information.

Use could be made of **peer support** to complement midwives in providing detailed information. Whilst the women did not talk about continuity of carer during labour, they did report that being left on their own in labour was frightening, and it is here that support workers who are able to relate to the women should be considered. Other support structures that have been evaluated, such as **doulas,** should also be considered. The NHS organisations should collaborate with other community and voluntary organisations to strengthen **social networks; this would also enable empowerment of women as future users of maternity services.**

### f) Promotion of equality of access to maternity services

The findings of this study highlight that women and interpreters expressed inequity in the provision and delivery of services. Many organisations, including the one in which this study was conducted, are committed to the provision of equitable services, but these are not found in practice. The Race Relations (Amendment) Act 2000 has placed the duty on organisations to develop Race equality schemes (RES) with clear recommendations to eradicate discrimination and racism. Whilst the majority of organisations have complied with the requirement, they need to review how they can utilise this tool to ensure that the rhetoric of equality and policy becomes a reality for midwifery and for Pakistani women. The RESs compel organisations to:

(i) Assess whether their functions and policies are relevant to 'race' equality
(ii) Monitor and evaluate their policies to assess the effect on 'race' equality
(iii) Engage in consultation with women from Pakistani backgrounds in developing policies
(iv) Involve Pakistani women in monitoring policies
(v) Publish the results of consultations, monitoring, and assessment activities
(vi) Ensure that information about all services is accessible to Pakistani women
(vii) Provide education and training to all staff working in maternity services on the new duties

Effective use of **ethnic monitoring** should be made through RES where services can be planned in response to needs.

### g) Culture of midwifery

Whilst this study did not intend to explore the realities of midwives caring for women from diverse backgrounds, there is a growing body of evidence that suggests midwives are currently working in complex and often challenging situations. They respond to various demands placed upon them by the organisations and the women. Issues of human justice, rather than duties of care, dictate that midwives need to be effectively supported in delivering maternity services that are ethnically sensitive and women-centred. Indeed, there is emerging work examining these issues in detail (Deery 2003)

and subsequently offering innovative support structures for midwives. These proposals require serious consideration.

### h) Midwifery care pathways and maternity care networks

Midwives must not lose the opportunity to make use of care pathways and managed maternity care networks (DH 2004); these will help ensure that women work together with multi-professional teams in determining the care they receive is of a high standard. Most of the women who access maternity services are relatively healthy; they have uncomplicated childbirth processes and as such less complex health and social care needs. Midwives are in an ideal position to support and care for such women. However, there are few women who have complex health and social care needs, who require specialised care either for the whole of the pregnancy, the labour and peripartum period, or part of these. Women with complex needs may then be cared for by the obstetrician and the midwife.

A variety of service models should be considered. For example, midwives may work in small group practices, based on social enterprise models, providing diverse and innovative care models (see RCN Policy briefing on nurse led social enterprise). Such diversity would create a raft of opportunities for midwives, and they would not be confined to working only in hospital or community settings. In addition, midwives might explore how they can work in the primary care settings with the general practitioners, as such getting engaged in practice-based commissioning. This type of diversification and competition may possibly dismantle the monolithic ideology of the NHS as a health and social care provider offering real choice to women.

## 10.14. (ii) Implications for education

The policy implications from this study for education are three-fold: (a) to address issues of education and training about racism and equality; (b) to proactively challenge inequalities and discrimination in order to improve service provision and service delivery; (c) to develop strategies to promote inclusiveness of diversity. In order to develop an effective approach to education and training about racism, the goal should be combating racism at institutional, professional and individual levels. The process of combating racism must be seen as a shared responsibility that requires each employee,

be they practitioner, student or manager to "*recognise his or her agency in producing, reproducing and or challenging racism*" (Bhavnani 2001: 113). Ethnicity, otherness, or difference should not be constructed as the problem in order to explain differences in outcomes or experiences for Pakistani women. As long as ethnicity is constructed as a problem, then the approach to service delivery, education and training, and indeed employment practices, remains one of approaching it from the perspective of unique needs, perpetuating differences as problematic. The processes for challenging inequalities and discrimination should not be about 'punishing wrong-doing', but about discovering what is not working, then remedying it with the intention of doing greater good for many.

In order to deliver sensitive services, organisations require culturally competent practitioners who can deliver anti-discriminatory, culturally sensitive care. Midwives and other healthcare professionals need to be equipped with appropriate levels of competence to work in a multi-ethnic environment and assist in the provision of anti-discriminatory care, thereby developing improved relationships between the women and the midwives. Aspects of interpersonal skills required to communicate with women who are not proficient in English warrant consideration, as does the development of competence of working with and through interpreters. Although it is appropriate to have the additional services of the interpreters to assist women whose first language is not English, the midwives may never acquire the necessary competence, meaning the standard of care for Pakistani women will continue to differ.

**a) Diverse education methods**

Educational institutions need to find diverse education methods to facilitate learning. Midwifery education needs to be flexible in developing students' professional knowledge, driven by the sociological model, and effective in developing an in-depth understanding of society, including the legal and professional frameworks. Education also needs to reflect the recognition that most stereotypes and assumptions are based on prejudice and lack of awareness, and this can lead to ineffective care. The recommendation is that midwives need to understand race equality and discrimination. It is not acceptable to process people based on stereotypes despite the arguments that it is a normal way of making sense of data.

Practitioners should make use of interactive learning to develop transcultural competence. For example, this might be reflective practice in which a practitioner engages in a "reflective conversation with the situation" (Schon 1983: 163), integrating theory and practice through the process of reflection-in-action. Non-reflective approaches to education are likely to rely on ideological assumptions whereas reflective conversation allows for greater sensitivity to issues relating to power, inequality and disadvantage. With reflective learning, midwives are encouraged to make use of reflection to chart what they normally do and identify key needs and differences. By making use of the experiences of Pakistani women for whom they have provided care, they could compare this with their other practices and identify learning opportunities. Midwives are in an ideal position to develop further understanding as they can use their Supervisors of Midwives for some of the reflective learning.

Other methods of learning recommended are use of drama and involvement of women in learning and teaching, as well as in assessment. Midwives should get feedback on their performance by facilitating focus group sessions with recently delivered Pakistani women to talk through with them what was good and what was not.

Midwives and other healthcare professionals who care for Pakistani women may be encouraged to utilise repertory grids, where they may use specific constructs relevant to working with diversity. For example, 'develop competence in transcultural communication', 'recognise ways to avoid behaviours that might be offensive', and 'recognise behaviour which could be seen as prejudicial and racist'.

### 10.14. (iii) Implications for research

There is a substantive potential for future research in this field. At a pragmatic level, research could further develop areas from this study and extend the focus to users and carers of other minority ethnic groups, including those who have recently arrived in the UK. In addition, it could adopt a multi-agency approach to examine issues relating to diversity and equal opportunities in accessing services.

### a) Developing this research

This research has highlighted some of the key issues that impact on the Pakistani women accessing maternity services. Pakistani women's needs and preferences need further exploration through observational study of labours, but such research needs to be effectively resourced.

This thesis begins to explain women's experiences of labour. However, there is a need for further research into such understandings, and this should include observation of the information provided during antenatal period. Such observations could enable examination of the information, to establish which types of information lead to understanding. In turn, this could allow for suggestions on how the provision of information could be improved to enhance women's understanding, enabling them to work in true partnership with the midwives to plan and assess their care.

### b) Multi-agency approach to examining issues related to diversity

The NHS is committed to multi-agency working and sharing and promoting good practice. In many instances, the voluntary and local government sectors have a broader experience of caring and working with diversity. One example is the advocacy services developed for asylum and refugee seekers. I am proposing that a multi-agency approach would enable a more holistic focus on how the statutory, voluntary and independent sectors manage with issues of race, ethnicity and diversity.

### c) Transcultural midwifery Unit

There is a need for such a centre to develop a stronger body of knowledge, to further explore the needs and preferences of women from diverse backgrounds. Whilst midwives would be in favour of such an institution, in reality it would be difficult given that funding bodies may not value such work – another example of institutional racism.

### d) Action research

There are some excellent examples of good practice, albeit on a small scale, and it would be appropriate for these to be collated, put into practice, and evaluated as an exemplar of 'ideal' maternity care for women from Pakistani Muslim background.

### e) Midwives experiences of caring for women from BME backgrounds

Little is known about the experiences of midwives and other healthcare professionals working in maternity service serving Pakistani women and women from other ethnic minority groups. There is need for further research to understand midwives' perspectives and experiences in terms of providing care for women from the minority ethnic communities.

### f) Interpreting services

This research has identified that interpreting services are inadequate and there is a lack of evidence about how midwives utilise interpreters to overcome communication and language difficulties. The evaluation of interpreting services in maternity services is not up-to-date, and where evaluations exist these are mainly conducted from the service providers' perspective; information is needed from the service users' perspective, to clarify needs and preferences.

# .....Epilogue.....

This enquiry has been in the context of an increasing interest in maternal health, which recognises correlation with socio-economic factors (Acheson 1998), ethnicity, and social exclusion, as well as the pivotal role played by equality (DH 2005). This thesis has predominantly documented primigravidae Pakistani Muslim women's experiences of their labours.

I am in debt to my supervisor, Mavis Kirkham who, when reading the draft chapters of this thesis, raised important issues which extended and strengthened my understanding. However most poignant was her 'appreciative engagement' with my text. The way she communicated informed me that she was 'with me' in trying to understand the development of my ideas. Warmth and connection was created by her comments. For example:

- *This is very clear! ...Go for it!*
- *A very important and telling point*
- *I know the feeling!*
- *I like the way you are beginning to link the threads – this is appropriate!*

By trying to understand the stance I was coming from, and through questioning, she used encouragement and connection to focus on what I was trying to say, rather than concentrating on identifying inconsistencies between my account and her own preconceptions. I felt competent in my effort to communicate and ready to hear her critique. Equally, she reduced the power bestowed by her academic seniority and created an alongside collaboration in which *she* was learning from my enquiry whilst extending it:

- *I think you need to explain this further.*
- *I don't understand what you are getting at.*
- *Yes! ha!*
- *I would take issue with this .... But explain.*
- *You cannot say this!*
- *Wow... as an examiner I would take issue with this.... Either reword or reference this!*

Through theorising of women's words, from sources beyond myself, I show that women wanted information about labour and methods of pain relief, as well as emotional and practical support during labour. They wanted a trusting relationship with their midwives. Overall, women knew little about labour process and methods of pain relief, and believed that midwives would provide information when they needed it. Many Pakistani Muslim women believed that British maternity services are the best, where care is based on scientific and technological advances. They felt safe when care was within highly technical surroundings. They generally accepted care and interventions because they wanted the best for their babies' health, as well as a healthy outcome for themselves. They also thought the midwives and other healthcare professionals 'knew best'.

This thesis adds to the growing body of knowledge that exposes the realities of women during their labour and should assist individuals and organisations that are attempting to address issues of race equality in service provision and delivery. It begins to address the issue of the information needs of the women and how these may be met to improve maternity services for Pakistani women. Through this thesis I revealed much about the way in which midwifery care is actually delivered during labour, and the implications that this has for women. This thesis shows that in addition to communication and linguistic differences, and the women: midwives relationship, discrimination and racism were key factors affecting women's childbirth experiences. Furthermore, the findings in this thesis are very timely in view of the National Service Framework's (DH 2004) commitment to deliver culturally sensitive care.

Through the study findings, I have highlighted the fact that women's experiences of maternity services in labour are shaped by a set of complex factors. Central to these experiences are the midwives and the constraints placed on them by the institutional structures and professional power. It is therefore not sufficient to aim the subsequent implications for practice only at midwives. The organisations need to take responsibility to readdress the structural issues that lead to inequalities in accessing maternity services, and above all support midwives to be 'with the Pakistani Muslim women'.

The findings of this thesis are very timely in the wake of equality, choice and woman focused services. However it was sad and disappointing to learn that despite many efforts by individuals and organizations, many women still get a 'raw deal' from some aspects of maternity services. This is not to say that this is the case for all, and there were many women who enjoyed several aspects of the maternity service. Nevertheless, I call to all international leaders of midwifery to place issues of inequality of access high on the international agenda.

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