

The Midwife-Woman Relationship in a South Wales Community: A Focused Ethnography of the Experiences of Midwives and Migrant Pakistani Women in Early Pregnancy

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Summary

Background

In 2014, 27.0% of births in England and Wales were to mothers born outside of the UK. Compared to their white British peers, minority ethnic and migrant women are at a significantly higher risk of maternal and perinatal mortality, along with lower maternity care satisfaction. Although existing literature highlights the importance of midwife-woman relationships in care satisfaction and pregnancy outcomes health professionals report difficulty in providing services to minority ethnic and migrant women. However little research has explored the factors contributing to the midwife-woman relationship for migrant and minority ethnic women.

Research Aims

To explore relationships between migrant Pakistani women and midwives in South Wales; focusing on the factors contributing to these relationships, and the ways in which these factors might affect women's experiences of care.

Method

A focused ethnography in South Wales; semi-structured interviews with 10 migrant Pakistani participants (eight pregnant women, one husband and one mother) and 11 practising midwives, fieldwork in the local migrant Pakistani community and local maternity services, observations of antenatal booking appointments, and longitudinal reviewing of relevant media outputs, such as UK news reports of issues relating to migrant people. Data were analysed concurrently with collection using thematic analysis.

Findings

The midwife-woman relationship was important for participants' experiences of care. A number of social and ecological factors influenced this relationship; including family relationships, culture and religion, differing healthcare systems, authoritative knowledge, and communication of information. However, differences were seen between midwives and women in the perceived importance of these themes. Findings therefore suggest that in order to understand how midwife-woman relationships are created and maintained, more needs to be done to recognise and address these differences. Due to the complexity of the relationships between themes a social ecological model of relationships is forwarded as a means of visually capturing the complexity of the findings, as well as potentially shaping midwifery education and clinical midwifery practices.

Conclusions and Implications

Findings from this study provide new theoretical insights into the complex social and ecological factors at play during maternity care for migrant Pakistani women. These findings can therefore be used to create meaningful dialogue between women and midwives, encourage collaborative learning and knowledge production, and facilitate future midwifery education and research.

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Dedication

I dedicate this thesis to my beautiful, amazing, inspiring, witty and wonderful Nan; Dorothy Studden. Her kindness, acceptance and strength in the face of adversity could humble almost anyone. She was a ray of light to many, and is sorely missed by all that knew her. She always had the utmost faith in me, and I know she would have been extremely proud of everything I have achieved.

'Round The World And Back Again...

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Chapter One: Introduction

1.1 Setting the Scene

In 2014, 27.0% of births in England and Wales were to mothers born outside of the UK. This number has steadily increased over the last decade, and projections suggest that this rate is likely to continue to rise. Recent UK mortality reports indicate significantly higher maternal and perinatal mortality rates for minority ethnic and migrant women compared to their white British counterparts. Minority ethnic and migrant women also report lower maternity care satisfaction, and UK health professionals report more difficulty in providing services to these clients.

Previous research into the existing ethnic and migrant inequalities in pregnancy outcome suggests a number of influencing factors, for example the role of genetics, socioeconomic status, and language barriers. However such factors have been shown to be insufficient in explaining the extent to the observed ethnic and citizenship inequalities. An existing body of literature highlights the importance of midwife-woman relationships in care satisfaction and pregnancy outcomes, however little research has explored the ways in which these relationships are established for migrant and minority ethnic women.

As there are documented difficulties in midwife-woman relationships for migrant and minority ethnic women, a major priority is to further explore the ways in which this relationship might be enhanced. This thesis addresses this issue by conducting a focused ethnography to explore relationships between first generation migrant Pakistani women and midwives in the South Wales region; focusing on the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care.

Through interviews and observations, a number of themes were identified as being important for the relationship between migrant Pakistani women and midwives in South Wales. These included three 'main' themes (Family Relationships, Culture and Religion, and Healthcare System), two 'weaving' themes (Communication of Information and Authoritative Knowledge), and a 'meta-theme' (Otherness). Due to the complexity of the relationships between these themes, a graphic was developed from the data to provide visual representation of the interconnectedness of themes; named the social ecological model of relationships.

This thesis adds to the body of knowledge about ethnic and migrant inequalities in pregnancy outcomes in the UK, and provides new theoretical insights into the complex factors at play during maternity care for migrant Pakistani women. The newly developed social ecological model of relationships allows for visualisation of the complexities of this particular midwife-woman relationship, and provides a window into possible reasons for tension and disconnect. The findings from this study, in addition to future work to further test and refine the model, has the potential to facilitate future discussion on cultural issues, encourage collaborative learning and knowledge production, and provide a framework for future practice, education and research.

1.2 Personal Reflection

Multiculturalism has been a strong interest of mine for as long as I can remember. From a young age I was exposed to music and dance from a variety of cultures, and I was always interested in learning as much as I could about the different ways in which people lived their lives. As I got older, I slowly became aware of the barriers to multicultural integration, and discovered a number of inequalities based on ethnicity and country of origin. The injustice I felt when learning about such inequalities created a personal desire to enhance the lives of vulnerable, or unfairly treated, individuals. Consequently, on completion of a 4-year Applied Psychology BSc., I had already undertaken a number of research projects involving inequality and vulnerable populations. Following my graduation, I took on a position at a residential school for children with Autism, where I was once again immersed in a world of inequality and vulnerability.

During my time at the residential school I developed a keen interest in midwifery, and although I romanticised about a career as a midwife, I was hesitant to abandon the strong research background I had built. After reading a number of papers and reports on current midwifery practice I was shocked to learn that significant ethnic inequalities existed in pregnancy outcomes for women in the UK. As I delved further into this research, I realised that the evidence behind these inequalities was still lacking. Indeed, whilst previous research had considered the influence of a number of genetic and socioeconomic factors, findings seemed to suggest that such explanations could not sufficiently explain these differences. It was clear that an alternative approach was necessary, and I immediately knew that this was something which I wanted to explore. Indeed, I instinctively knew that I had found my calling in the form of a midwifery-related

PhD; allowing me to combine my existing research skills and interests with a newfound passion for midwifery.

As my original career plan had never involved the undertaking of a PhD, I felt secure in my knowledge that any proposal I developed would never encompass research for research's sake; this journey was born purely from a desire to further knowledge in the field of ethnic inequalities. My dedication to this cause was tested numerous times throughout the process; as will be seen in a later chapter, many hurdles had to be navigated during data collection. However, my newly acquired sense of purpose allowed me to use these events productively by incorporating them into the study as data, and using this 'spare' time to write a paper, which was published in an international journal in March 2015 (Appendix One).

I hope that this thesis will be the first of many contributions I make to the field of maternity research, and I look forward to a future where maternal mortality rates are so low that any type of inequality is impossible.

1.3 Organisation of the Thesis

This thesis is divided into nine chapters. Following this introduction, Chapter Two reviews the literature that explores minority ethnic and migrant women's experiences of maternity care and inequalities in pregnancy outcomes. Potential factors behind ethnic inequalities in pregnancy outcomes are discussed, and the importance of these inequalities in the current social and political climate is discussed. The focus of this chapter then turns to the importance of midwife-woman relationships in determining care satisfaction and pregnancy outcomes.

Chapter Three discusses the methodological approach taken to this research, and how this approach was chosen. The chapter commences with the debate between qualitative and quantitative approaches to research. Following this, an overview of the various philosophies underpinning qualitative research is presented, and the decision to choose ethnography over the others is justified. The concept of naturalism is introduced, and the reasons given as to why a naturalist focused ethnography is the most appropriate approach by which to explore the midwife-woman relationships for migrant Pakistani women in South Wales.

Chapter Four discusses the research design and conduct of this study. The criteria by which participants were included and the procedure used to recruit them are described. The data collection methods are discussed, including the rationale for the use of semi-structured interviews and observations. Detailed descriptions of data collection are given, and the use of language services is discussed. Ethical issues are highlighted, and the problems of achieving quality and rigour in qualitative research are discussed, including the steps taken to attenuate these issues.

Chapter Five, the first findings chapter, places the findings in the social and political context in which data were collected; providing detailed demographics of participants, and describing public perception towards immigration and NHS maternity services. This chapter also introduces a broad overview of themes from the data, and describes the data-driven development of a social ecological model of relationships.

Chapter Six, the second of the findings chapters, describes data relating to the experiences of migrant Pakistani women. Observation and interview data are discussed, and three main themes are highlighted. These include 'Family Relationships', 'Religion and Culture', and 'Healthcare Systems'.

Chapter Seven, the third findings chapter, describes data relating to the experiences of midwives. Here, as with the previous chapter, observation and interview data are discussed, and key themes are highlighted. The three main themes identified within data on midwives' experiences mirror those found in data for migrant Pakistani women's experiences.

Chapter Eight discusses the similarities and differences between the experiences of midwives and women, and relates the overall findings of the study to existing literature. Themes are discussed in line with the social ecological model of relationships developed from the data.

The final chapter, Chapter Nine, articulates the study's original contributions to the body of literature in this field; including new theoretical insights into the complex social and ecological factors at play during maternity care for migrant Pakistani women. The strengths and limitations of this research are discussed, and recommendations are made for practice, education, and future research. The thesis concludes with the recommendation that the findings from this study be used to create meaningful dialogue between women and midwives, encourage collaborative learning and knowledge production, and facilitate future midwifery education and research.

Chapter Two: Literature Review

2.1 Chapter Aims

As outlined in the previous chapter, my PhD journey began with the surprise I experienced when reading about the ethnic and migrant inequalities in UK pregnancy outcomes recorded by the 2011 maternal mortality report (Cantwell et al. 2011). The first half of this chapter, therefore, mirrors this review process; beginning where I began, with a discussion of the literature relating to ethnic and migrant inequalities in pregnancy outcomes. This first part of the chapter also considers research relating to general health inequalities in the UK. The focus is then narrowed to critically appraise the literature on pregnancy outcomes for UK minority ethnic and migrant groups specifically, with a view to determining the potential factors behind inequalities in outcome.

The second half of this chapter proposes that existing explanations for ethnic and migrant inequalities in pregnancy outcomes in the UK are insufficient, and a refocus of this area of research is proposed. Literature highlighting the importance of client-provider relationships on health outcome is discussed, and it is proposed that further research is needed to understand differences in midwife-woman relationships between minority ethnic/migrant women, and their white British counterparts. It is argued that such research may lead to credible explanations for the observed ethnic and migrant variation in pregnancy outcomes for women in the UK.

2.2 Literature Review Method

Two approaches to literature review were considered for the current thesis; a systematic literature review, and a narrative review. Each approach is summarised below, and the section 2.2.1 provides a brief rationale for the chosen approach.

Narrative literature reviews describe the history or development of a research area by reviewing a broad scope of relevant literature and providing a qualitative summary of this research (Green et al. 2006). As such, narrative reviews provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of new research (Cronin et al. 2008; Paré et al. 2015). These types of review can inspire research ideas by identifying gaps or

inconsistencies in a body of knowledge, thus helping the researcher to determine or refine specific research questions or aims (Whittemore et al. 2014).

A systematic review, on the other hand, involves a detailed search of the literature based upon a focused pre-defined question, which is usually clinical in nature (Cronin et al. 2008; Paré et al. 2015). This approach dictates that the researcher develops quantifiable criteria which determine if a research publication should be included or excluded in the final synthesis (Green et al. 2006).

2.2.1 The Narrative Approach

The narrative approach to reviewing existing literature was chosen above a systematic review approach. In line with the ethnographic approach I took to this study, I wanted to take a broad rather than narrow approach to reviewing the literature. In this way I could review literature from a range of disciplines (i.e. sociology, health services research, midwifery research, and psychology), and weave these together to give a comprehensive background of the existing literature relating to the pregnancy experiences and outcomes of minority ethnic and migrant women. Consequently, this approach was inclusive rather than exclusive, and helped to identify existing gaps in knowledge and facilitate the development of focused research question.

2.2.2 Search and Analysis Strategies

The approach taken to the narrative literature review was rigorous but was not intended to be a systematic review. Detailed accounts of the search strategy and analysis of literature (including keywords and inclusion/exclusion criteria) can be found in Appendix Two.

Keywords were generated through background reading and refined over multiple drafts, and research databases were selected based on their relevance to the field. Searches were saved in each of the databases used, and email alerts were added in order to keep up-to-date with newly published work.

Searches were run in full in 2013 and again prior to submission of the thesis in 2016. Results from all searches are included in Appendix Two. Great consideration was given as to the best way to incorporate this new literature into the existing literature review written at the beginning of the PhD process. After discussions with my PhD supervisors, and in fitting with the narrative approach to reviewing the literature, I decided that the best option would be to weave updated literature into the existing review.

Articles were assessed on their quality, rigour, and relevance to the current research, with the assistance of the evaluation tool created by Long and Godfrey (2004), described in Appendix Two.

2.3 Ethnic Inequalities in UK Pregnancy Experiences and Outcomes

In the UK, minority ethnic women consistently report lower maternity care satisfaction (Singh and Newburn 2000; Bowes and Domokos 2003; Richens 2003; Redshaw et al. 2007), and less choice in their maternity care (Redshaw et al. 2007; Redshaw and Heikkila 2011) than their white British counterparts. Similar findings are shown globally; with minority ethnic and migrant women reporting less positivity about their maternity care (Small et al. 2014).

In addition to poor *experiences* of maternity care in the UK, a wealth of research details poor pregnancy outcomes for minority ethnic women; including an increased risk of complications during pregnancy (Nair et al. 2015), unplanned caesarean section (Essex et al. 2013), and having their baby cared for in a neonatal unit (Raleigh et al., 2010). Furthermore, despite a significant decrease in maternal mortality rates since the 1930s (Chamberlain 2006); (Ibison et al. 1996); (Knight et al. 2015), substantial differences in mortality rates can be observed between ethnic groups (Knight et al. 2015). For example, between 2011 and 2013, the estimated mortality rate for white women in England was 7.8 deaths per 100,000 maternities (Knight et al. 2015); for black African women this rate was more than tripled at 28.3 (Knight et al. 2015), and was also significantly higher for both Pakistani and Bangladeshi women; 15.9 and 14.7 respectively (Knight et al. 2015). Overall 39% of all direct maternal deaths occurred in women from black and ethnic minority groups (Knight et al. 2015), an extremely worrying statistic given that data from the Office for National Statistics (ONS) suggest that individuals from these ethnic groups accounted for less than 20% of residents in England and Wales during the same time period (Office for National Statistics 2013a).

Over-representation in maternal mortality rates is not only seen for minority ethnic populations but also, more specifically, for foreign-born women (Knight et al. 2015). Indeed, the most recent report on maternal mortality in England suggests that a quarter of women who died in 2011-13 were born outside of the UK (Knight et al. 2015); with 70% of these women being born in either Asia or Africa (Knight et al. 2015). Although the overall relative risk of maternal mortality for non

UK-born women slightly decreased between 2011-13 (Knight et al. 2015), in-depth study of the data shows that this risk actually increased for certain groups of migrant women over this time period. For example, the relative risk of maternal mortality for Pakistan-born women living in the UK increased from 1.53 to 1.8 (Knight et al. 2015) – suggesting almost twice the risk of mortality for these women compared to their UK-born counterparts. This increase was reflected in ethnicity data; the relative risk of maternal mortality for Pakistani women rose from 1.29 to 2.12 in the same time period (Knight et al. 2015). The authors therefore acknowledged that the observed decrease in maternal mortality rates for migrant women was largely driven by the large number of EU migrants included in the second report (Knight et al. 2015), and had potentially masked increases in risk for non-EU migrant women.

Along with increased risk of maternal mortality, data consistently suggest that minority ethnic women are at an increased risk of *perinatal* mortality. For example, in 2013 mothers of black ethnic origin were twice as likely to have a stillbirth than mothers of white ethnic origin (Draper et al. 2015), and babies of Asian or Asian British ethnic origin were also at significantly increased risk, with up to 64% higher stillbirth rates than their white counterparts (Manktelow et al. 2015).

Similar ethnic inequalities are seen in cases of maternal and infant morbidity. A national cohort study of data from the UK Obstetric Surveillance System (UKOSS) found that severe maternal morbidity significantly differed between white and non-white women in the UK; cases of maternal morbidity stood at 80 cases per 100,000 maternities for white women, compared to 126 cases for non-white women (Knight et al. 2009). A recent analysis of updated UKOSS data (2005-2013) suggests continuation of these ethnic inequalities; compared to white European women, odds of severe maternal morbidity in the UK were found to be 83% higher for black African women, 80% higher for black Caribbean women, 74% higher for Bangladeshi women, and 43% higher for Pakistani women. International data show similar risks for migrant populations; research conducted in Germany found a higher risk of severe maternal morbidity for women from Asia, Africa, Latin America and the Middle East, compared to native women (Reime et al. 2012), whilst a study from the Netherlands found that their ‘non-western’ immigrant population had a risk of severe maternal morbidity almost a one and a half times higher than women born in western countries (Zwart et al. 2011).

Despite government policy aimed at reducing health inequalities in the UK¹ (NHS England et al. 2015; NHS Wales 2015) recent statistics on maternal and perinatal mortality rates in England and Wales suggest that maternity services are not doing enough to provide equitable or effective care to vulnerable women. For example, ethnic inequalities in UK maternal mortality rates did, in fact, increase between the 2014 and 2015 reports (Knight et al. 2015). In order to resolve this issue, it is first necessary to establish why these inequalities exist. However, difficulties arise when interpreting the literature on health inequalities due to an overlap between ethnicity, nationality, race, and migration status (Hayes et al. 2011). For example, whilst the majority of previous research has focused on inequalities between groups defined by self-reported ethnicity (Hayes et al. 2011), inequalities in outcome also exist between first and second generation immigrants (Dhawan 1995; Bakken et al. 2015), and some research suggests that health risks may even vary linearly with length of residency (Smith and Grundy 2011; Sorbye et al. 2014).

In order to understand the relationship between ethnicity, migrant status and pregnancy outcomes, it is first necessary to consider the background to this field of research; reviewing literature on ethnic inequalities in general health, in order to provide insight into these associations.

2.4 Ethnic Inequalities in Health: An Overview

2.4.1 General Health Inequality

Health 'inequality' is the term used to describe the variation in health outcomes for distinct populations; including mortality/morbidity rates, disease prevalence, and treatment outcomes. The scale of health inequality varies greatly across countries (Crombie et al. 2005), with cross-global comparisons showing the United Kingdom to have one of the largest gaps in health status between high and low income groups when compared to countries of similar economic and social background (OECD 2015). Data from 2013 suggests that whilst 88% of the top 20% of earners report good or very good health, only 68% of the bottom 20% of earners report this same positive health status (OECD 2015). Despite the subjective nature of self-reported health, such measures

¹ These will be discussed in the following section

have been found to be a good predictor of people's future health care use, and are therefore seen as a good indicator of health status (OECD 2015).

In response to persisting health inequalities, the United Kingdom has become a world leader in policy development and practical action to tackle these inequalities (Health Inequalities Unit 2008). In November 2008, Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010 (Marmot et al. 2010). The final report, 'Fair Society Healthy Lives' concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

(Marmot et al. 2010)

Since 2012 health bodies in England have had legal duties to address health inequalities (NHS England et al. 2015) and are assessed on their performance of these duties on an annual basis by the Secretary of State for Health (NHS England et al. 2015). Furthermore, the British government holds full and continuing engagement with the social determinants and health inequalities agenda of the World Health Organisation and European Union (Health Inequalities Unit 2008).

Similar legislation and guidelines are present in other parts of the United Kingdom. For example, in 2008, the Scottish government created a Ministerial Task Force on Health Inequalities to review new evidence and highlight areas for attention (Beeston et al. 2014). Likewise, Northern Ireland relies on a Health and Social Care Inequalities Monitoring System to track differences in mortality and morbidity, and access to health and social care services (Stewart et al. 2012). In Wales, 2011 saw the creation of the 'Together for Health' five-year plan, which aimed to work with partners to improve services for the most vulnerable groups, provide better information on health and health care services, and do more to help people understand health issues (NHS Wales and Welsh

Government 2011). As part of this initiative, progress was monitored and reports published regularly. However, in its strategic plan for 2015-2018, Public Health Wales (a department of NHS Wales) suggested that the efforts made to reduce health inequalities for people living in Wales had not had the needed impact (NHS Wales 2015). Consequently, new strategies were introduced, including the creation of The Social Services and Wellbeing (Wales) Act (NHS Wales 2015). This Act places a duty on local authorities and partners to gain a better understanding of the needs and characteristics of their local populations, in order to ensure organisations are targeting support in the right areas of need (NHS Wales 2015). As part of this new legislation, a framework for evaluation was created to measure progress and enable early decisions to be made about whether initiatives should be continued or stopped, and whether such initiatives are likely to succeed in reducing health inequalities in Wales (NHS Wales 2015).

As touched upon earlier, a large body of research suggests that health outcomes are most variable across groups when based on their socioeconomic backgrounds; individuals with a higher degree of social deprivation show significantly worse health outcomes than peers with higher socioeconomic status (Pearson et al. 2010; NHS Wales 2015; Public Health England 2015). The majority of UK government policies have, therefore, focused on reducing gaps in socioeconomic status and local area deprivation in order to tackle these observed health inequalities (Goodwin et al. 2015). However, as described in the recent strategic plan from Public Health Wales, such policies have had limited success in narrowing the gap (Goodwin et al. 2015; NHS Wales 2015), and many health researchers argue that the relationship between socioeconomic status and health outcome may be mediated through other factors such as ethnicity and migration status (Bhopal 2007; Pearson et al. 2010). The following section reviews the literature to support this claim, exploring associations between minority ethnic/migrant status and poorer health outcomes.

2.4.2 Inequality in Health: Minority Ethnic and Migrant Risk

A number of health outcomes show inequality based on ethnicity and migrant status. Cause-specific mortality for example, has been seen to vary by country of birth; while mortality from coronary heart disease is higher than average for people born in South Asia it is lower than average for those born in the Caribbean and West Africa (Gill et al. 2007). Circulatory diseases also show ethnic variation. Ischaemic heart disease, for example, is 30–50% more common in Indians compared to the population as a whole (Gill et al. 2007). Variation is also found in mortality rates of diabetic patients in the UK; mortality rates are distinctly high for those born in Bangladesh,

whilst China-born individuals show much lower rates - a significant gap between the two (Gill et al. 2007).

Ethnic inequalities in health are also seen in reports of *morbidity* prevalence in the UK (Bhopal 2007). For example, significantly higher rates of life-limiting long-term illnesses are found in Pakistani, Bangladeshi and black Caribbean populations compared to their white British counterparts (Nazroo 1997; Becares 2015), whilst research from the United States suggest significantly higher rates of cardiovascular death in black populations compared with all other ethnic groups (Meadows et al. 2011). Similarly, an exploration into the health characteristics of black and white individuals in London found a higher risk of stroke in black compared to white participants (Heuschmann et al. 2008). The authors also discovered group differences in patterns of risk reduction; while stroke incidence and risk factors decreased for white participants over a period of 10 years, this decrease was not mirrored in black participants (Heuschmann et al. 2008). Research by Misra and Khurana (2011) also shows ethnic variation in hypertension prevalence, with South Asians showing higher risk than UK-based white Europeans.

As demonstrated above, ethnic inequalities exist across a variety of health outcomes, including the variation in pregnancy outcomes discussed at the outset of this chapter. A number of explanations have been put forward, in previous literature, to account for these ethnic variations in health outcomes. The following section critically reviews this existing literature in order to determine the legitimacy of these explanations.

2.5 Ethnic Inequalities in Pregnancy Outcomes: Possible Explanations

This section critically discusses literature relating to factors contributing towards ethnic inequalities in health, and more specifically in pregnancy outcomes. Factors discussed in extant literature include the role of socioeconomic status, genetics and language barriers. Gaps in the literature are then highlighted, alongside an argument for the need to explore alternative factors contributing to the ethnic inequalities in pregnancy outcome. This argument is then used to build the rationale for my own research.

2.5.1 Genetic Differences

The role of genetic differences in health inequalities is often viewed as a controversial research area (Bhopal 2007). However, health research suggests that genetic predispositions *do* exist for some health risks - for example the physiological susceptibilities for obesity, diabetes and cardiovascular disease found in the South Asian population (Abate et al. 2003; Naran et al. 2008; Misra and Khurana 2011). Although US researchers often link pre-existing medical conditions, such as hypertension and diabetes, to ethnic disparities in severe maternal morbidity (Fiscella 1996; Varner and Esplin 2005; French et al. 2006; Puthussery 2016) these links have not been identified in UK data (Knight et al. 2009; Puthussery 2016). Indeed, evidence on the role of biological factors in ethnic inequalities in neonatal and infant outcomes in the UK is restricted to a limited number of conditions and outcomes.

One example of genetic-based risk for infant outcomes in the UK is the association between infant death and congenital anomalies in some minority ethnic groups (Bakeo 2004; Gray et al. 2009; Kurinczuk et al. 2009). Fatal congenital anomalies are around four times higher for babies born to mothers of Pakistani origin than those born to white British mothers (Kurinczuk et al. 2009), and are usually the result of consanguineous (close blood-relation) domestic partnerships (Bundey and Alam 1993; Sheridan et al. 2013). When close family members procreate, the risk of infant and perinatal mortality increases, due to the increased likelihood of harmful recessive gene expression (Bittles and Makov 1988). This risk increases further when families marry within close relatives over successive generations, resulting from a clustering of rare gene variants (Woods et al. 2006; Bittles 2008). As first cousin marriages are still common amongst Pakistani families in the UK (Shaw 2009; Bakken et al. 2015; Bittles 2015), such congenital anomalies may therefore be responsible for a proportion of the perinatal and infant mortalities seen in this population (Kurinczuk et al. 2009; Sheridan et al. 2013). Furthermore, the religious and cultural beliefs of Pakistani women suggest that pregnancies are unlikely to be terminated, even if congenital anomalies are identified early on in the pregnancy (Alsulaiman et al. 2012). Hence, these deaths will add to mortality statistics, and potentially contribute to the observed ethnic inequalities in perinatal mortality (Ajaz et al. 2015).

Genetic susceptibility has also been suggested as a factor contributing towards the ethnic inequalities seen in incidence rates of perineal tears and obstetric anal sphincter injuries in the UK (Balchandra and Ramage 2011; Shah et al. 2011). For example, a study by Shah et al. (2011) found

that immigrant Chinese women were significantly more likely to experience perineal tears from childbirth, when compared to white British women. Similar findings were found by Balchandra and Ramage (2011) when comparing women of Indian and African origin to their white counterparts. As perineal tears often lead to health complications extending further than the immediate physical birth outcomes (Williams et al. 2007) it has been suggested that these physiological risks may play a part in explaining inequalities in other pregnancy outcomes (Williams et al. 2007).

Despite these findings, many authors acknowledge that the underlying genetic mechanisms of susceptibility are often poorly understood (Cantwell et al. 2011) and should therefore be interpreted with caution. Indeed, such genetic differences are unable to explain the differences in outcome observed between UK- and foreign-born women of the same ethnicity. Furthermore, delivery factors such as slowing down the delivery of the head by instructing women to not push at this point (thus relying solely on the uterine expulsive efforts) has been shown to decrease the incidence of perineal tears by 50% to 70% (Harvey et al. 2015). Such findings suggest that incidents of tearing may, in fact, be largely influenced by communication between woman and health providers at this stage of labour.

In summary, the reviewed literature would suggest that genetic susceptibility to poor health is insufficient to explain the large ethnic inequalities seen in pregnancy outcomes. It is therefore necessary to consider alternative explanations for these inequalities.

2.5.2 Socioeconomic Status

As previously discussed, one of the most common explanations of ethnic inequalities in health is the increased risk of social and economic deprivation found for minority ethnic individuals (Pearson et al. 2010; Public Health England 2015). Indeed, a number of healthcare researchers believe that socioeconomic factors (such as educational attainment, household income, or occupational status) can also explain the observed ethnic differences in pregnancy outcomes such as preterm birth rates (Butler and Behrman 2007). In support of this concept, findings from the United States suggest that women on lower socioeconomic levels have a significantly higher risk of preterm delivery, even when controlling for other known risk factors such as pre-pregnancy weight, weight gain, alcohol and tobacco consumption and ethnicity (Berkowitz 1981; Collins Jr and David 1990). Socioeconomic status has also been linked to observed ethnic inequality in *maternal* outcome; in an analysis of the risk factors for progression from severe maternal

morbidity to mortality Kayem et al. (2011) found that maternal death was significantly associated with women's employment status; women most likely to die were those who were unemployed, or in routine or manual occupations.

A number of differing factors have been proposed to explain this association, including links between lower socioeconomic status and both negative health behaviours, and poorer uptake of antenatal care (Hummer et al. 1998; Kington and Nickens 2001; Seeman and Crimmins 2001). Uptake of antenatal care is particularly relevant to pregnancy outcomes, as a recent report suggests that women who experience inadequate usage of antenatal care services hold twice the risk of developing severe maternal morbidity compared to those who access this care regularly (Nair et al. 2014). This risk is mirrored in maternal mortality rates; the most recent report of maternal deaths in the UK and Ireland suggests that only a third of women who died received the nationally recommended level of antenatal care (Knight et al. 2015). As a significant relationship is found to exist between socioeconomic status and uptake of antenatal care (Kayem et al. 2011); it is possible to suggest that the association between ethnicity and pregnancy outcomes may be mediated through lower socioeconomic status and uptake of antenatal care. This mediating effect may be especially relevant when considering data from countries such as the USA, where individuals have to pay for healthcare, and financial barriers can affect timely access to maternal care (Comfort et al. 2013) and health services in general (Ward et al. 2015). Indeed, women of childbearing age appear most vulnerable to this situation; in the most recent US National Health Interview Survey, females aged 18-64 were the demographic group least likely to have obtained needed medical care during the past 12 months, due to the cost of this care (Ward et al. 2015). In fact, 8.1% of the female 18-64 population in the US were estimated to have experienced cost as a barrier to care, compared to 5.3% of US citizens on average.

Despite strong associations between minority ethnicity, socioeconomic status and health outcomes, a large body of research exists to suggest that this association cannot sufficiently explain the observed ethnic differences in pregnancy outcomes. For example, a national cohort study in the UK found that elevated risks of poor pregnancy outcomes existed for minority ethnic populations even after adjustments were made for differences in age, socioeconomic status, smoking status, and body mass index (Knight et al. 2009). This is supported by research from Jayaweera and Quigley (2010) who examined indicators of health status among a cohort of UK mothers in relation to their individual ethnic grouping, migrant status (born abroad or in the UK),

and length of UK residence. These authors found an important relationship between ethnicity and most health indicators, which was independent of country of birth, length of residence and socio-demographic circumstances (Jayaweera and Quigley 2010). Similar results were found more recently by Nair et al. (2014) whose case-control study of severe maternal morbidity found an increased risk for minority ethnic women which could not be accounted for by other known risk factors, including socioeconomic status.

Taken together, these findings suggest that low socioeconomic status may sometimes contribute towards poorer pregnancy outcomes for minority ethnic women. However, it is important not to conflate correlation with causation, therefore it is acknowledged that existing studies cannot fully explain the observed inequalities in pregnancy outcomes and that additional risk factors for poor maternity outcomes exist for minority ethnic women, independent of social situation (Zwart et al. 2011). Indeed, improving socioeconomic circumstances for mothers in some ethnic groups is not always associated with better health outcomes (Jayaweera and Quigley 2010), therefore alternative factors must be considered in order to account for these inequalities. The following section reviews the existing literature on language barriers in maternity care, and discusses the potential impact of these barriers on ethnic minority women's pregnancy outcomes.

2.5.3 Language Barriers

Poor client-provider communication is often cited as a contributing factor to ethnic inequalities in pregnancy outcome (Lyons et al. 2008; Raine et al. 2010; Bennett and Scammell 2014), with the main barrier to communication resulting from differences in first language (Binder et al. 2012; Korkodilos et al. 2013; Esscher et al. 2014). Indeed, previous research suggests that language barriers present risks for a variety of health outcomes as a result of miscommunication and confusion between client and provider (Roberts et al. 2005; Jonkers et al. 2011). Observations at a London GP surgery, for example, found that major and extended misunderstandings frequently occurred when consultations took place with patients who were not native English speakers (Roberts et al. 2005). Similar findings are shown in maternity care research, sometimes with grave outcomes (Jonkers et al. 2011). For example, an investigation into ethnicity-related factors contributing to severe maternal morbidity among immigrant women in the Netherlands found that language barriers frequently prevented women from presenting medical complications and concerns to health professionals, which led to a number of avoidable complications during pregnancy and birth (Jonkers et al. 2011). In one such case, a migrant woman was unable to

communicate important information about a pre-existing diagnosis of epilepsy, and healthcare providers were therefore unprepared for the epileptic fit she suffered during birth, and the woman's health was compromised (Jonkers et al. 2011).

When speaking to migrant women about interactions with healthcare professionals, authors of existing literature report women's concerns about communicating important health information (Harper Bulman and McCourt, 2002). For example, during interviews with Somali refugee women, participants expressed concerns that language barriers often meant that they were unable to put forward important questions and concerns to healthcare staff and that this language barrier left them feeling unsupported, frightened and anxious, especially if complications developed during pregnancy (Harper Bulman and McCourt 2002). Such findings are supported by data covered by the 2011 maternal mortality report (Cantwell et al. 2011), which reported that midwives experienced difficulties in communicating important information to women, when language barriers existed. In fact, in such cases, midwives reported an inability to obtain a full and comprehensive booking history, which consequently limited their ability to provide effective care to these women (Cantwell et al. 2011).

Despite the clear dangers of miscommunication in health care, mounting research exists to suggest that interpretation services are still not consistently used in UK maternity care (Cantwell et al. 2011; Knight et al. 2015). In fact, the most recent UK maternal mortality report suggests that a common theme across maternal deaths was the failure to use professional interpreters (Knight et al. 2015). In some cases outlined by the report, no attempt was made to seek interpretation by healthcare staff, despite a clear language barrier (Knight et al. 2015), and one woman was reportedly seen four times before her antenatal assessment was completed adequately (Knight et al. 2015); a task that would have been completed easily with the use of an interpreter.

Similar findings emerge when speaking with minority ethnic women about their experiences of maternity care; for example authors Harper Bulman and McCourt (2002) found that only a quarter of the Somali women they interviewed were provided with interpreters during their maternity care, and many of these women did not know that interpretation services existed. Indeed, in one study, Somali women claimed that they were often asked to wait until an English-speaking Somali person came in for an appointment (Threadgold et al. 2007), or were encouraged to use friends or

family members (including young children) to interpret for them (Harper Bulman and McCourt 2002; Threadgold et al. 2007).

Such findings are worrying, as guidelines from the National Institute for Health and Care Excellence (NICE) state that when there are language barriers, women should be provided with an interpreter who “should not be a member of the woman's family, her legal guardian or her partner” (NICE 2010, p. 17). Indeed, numerous mortality reports also warn against this practice (Cantwell et al. 2011; Knight et al. 2015), as the sensitive nature of pregnancy often involves the sharing of intimate personal details which are unsuitable for young children to translate. Domestic partners are also deemed inappropriate candidates for interpretation, as such practice would arguably prevent women from disclosing important issues such as domestic abuse (Cantwell et al. 2011).

Alongside concerns about the visibility of domestic abuse, the emotional investment of family members in the woman's health is also seen as a barrier to their suitability to interpret; authors of the 2011 maternal mortality report raised concerns that such investment might prevent family members from relaying the seriousness of symptoms to women in order to ‘protect’ them (Cantwell et al. 2011). As will be seen in the findings chapters, there was some support for this notion from migrant Pakistani participants when talking about the involvement of family members in women's pregnancies. Despite these numerous recommendations, recent reports suggest that the use of family member interpretation is still common in UK healthcare (Knight et al. 2015).

In addition to issues of miscommunication, existing literature on the healthcare experiences of minority ethnic women suggests that language barriers are also likely to reduce minority ethnic women's uptake of/continued attendance at antenatal care (Harper Bulman and McCourt 2002; Jayaweera et al. 2005). For example, Somali women in the UK have reported missing hospital appointments as a result of being unable to find an interpreter (Harper Bulman and McCourt 2002), and feeling as though they could not seek medical help and advice due to their lack of English language (Threadgold et al. 2007); some even reported being turned away from GP surgeries due to a lack of interpretation services (Threadgold et al. 2007). Recent research by Cresswell et al. (2013) suggests that late initiation of antenatal care is still an issue for minority ethnic women, and authors cited communication barriers as a significant cause of non-attendance.

Considering the existing literature on language barriers in maternity care, it appears that lack of effective communication between midwife and woman may result in lower standards of care, and limited access to health services. It could be argued that language barriers, therefore, are responsible for the increased risk of adverse pregnancy outcomes for ethnic and migrant groups (Cantwell et al. 2011; Draper et al. 2015; Knight et al. 2015). However, research by Ellis (2000) suggests that substandard maternity care and communication issues are experienced by minority ethnic women, even when language barriers do not exist. During interviews with the researchers, South Asian women described problems in communicating with their midwives, despite being UK-educated and fluent in English; many recounted situations where they felt “muted” (Ellis 2000, p. 250), were not actively listened to, and were not given the opportunity to express themselves (Ellis 2000) by the midwives caring for them. Such issues imply communication problems between minority ethnic women and midwives that extend further than language barriers (Ellis 2000). As will be seen in the findings chapters of this thesis, communication was a recurring theme in relationships for migrant women and midwives, and issues with communication were often expressed separately to, or in the absence of, concerns regarding language barriers.

2.5.4 Racism and Stereotyping

The impact of stereotyping, discrimination and racism on health outcomes is a well-researched field in the health inequality literature (Bollini et al. 2009), and the majority of such research suggests an association between discrimination and poor health. For example Brondolo et al. (2011) examined the relationship between perceived discrimination and self-reported health amongst Asian, black, and Latino populations in the US, and found a significant, independent, association between perceived discrimination and poor self-reported health which was consistent across all ethnic groups (Brondolo et al. 2011). Similar links between experience of race-based discrimination and poor health are longstanding; research from 2004 suggests that, independent of the effects of age, gender, and household social class, individuals who worried about being racially harassed were 61% more likely to report poor health, than those who were not (Karlsen and Nazroo 2004).

In addition to the risk to general health, previous research suggests an association between experiences of racism and poor pregnancy outcomes; including infant mortality, preterm delivery, and low birth weight (Dominguez 2008; Earnshaw et al. 2012). Research by Mustillo et al. (2004), for example, found that 50% of black women with preterm deliveries, and 61% of black women

with low-birthweight infants, reported experiences of racial discrimination in at least three different contexts (e.g. at school/work, on the street, from the police). Similarly, a review from the United States found a consistent positive relationship between African American women's experiences of racial discrimination and risk of preterm birth and low birth weight (Giurgescu et al. 2011). Consequently, authors in this field of research argue that the chronic stress of experiencing racism or discrimination may be an underlying social determinant of persistent ethnic disparities in pregnancy outcomes (Dominguez 2008; Giurgescu et al. 2011). Lending weight to this argument, an international review conducted by Bollini et al. (2009) found that countries with policies promoting the integration of migrant populations had significantly reduced inequalities in obstetric risk, based on migration status, compared to those with weaker policies. The authors argued that these effects were likely mediated by the increased nurturing of social participation and equity of immigrants in countries with strong integration policies (Bollini et al. 2009); leading to decreased discrimination of immigrants, and consequently better health outcomes for this population (Bollini et al. 2009).

While the above research suggests a direct association between discrimination and health outcomes, a number of studies claim a looser connection between the two. Recent maternity research by Slaughter-Acey et al. (2016), for example, found that that perceived racism was only associated with preterm birth for women who reported mild to moderate depressive symptoms; this association was not found for women with severe depressive symptoms. Furthermore, research by Kelaheer et al. (2008) found that although racial discrimination was significantly associated with higher levels of anxiety, worry and depression in UK adults, there was no direct association between discrimination and health (Kelaheer et al. 2008). Such findings suggest that discrimination and racism may have a more complex relationship with health outcomes than previously assumed (Slaughter-Acey et al. 2016). In fact, some authors argue that chronic stress caused by discrimination is not the cause of ethnic inequalities in health, but instead such inequalities are caused by unfair treatment by healthcare providers, based on negative stereotypes of some ethnic groups.

Indeed, the impact of stereotyping on healthcare provision is a widely studied area of health research (Bowler 1993; McFadden et al. 2012). Existing literature highlights a tendency for health professionals to create stereotypes of minority ethnic client groups, often viewing women as part of a homogenous group with homogenous needs (Harper Bulman and McCourt 2002; McFadden

et al. 2012). One of the ways in which these stereotypes are thought to be created and maintained, is through the decreased ability to communicate with these service users (Bowler 1993), and the resulting frustration experienced by both service user and health professional (Bowler 1993; Harper Bulman and McCourt 2002; Roberts et al. 2005; McFadden et al. 2012; Bennett and Scammell 2014). For example, Bowler (1993), who explored midwives' perceptions of South Asian women accessing maternity care in the UK, found that low levels of English language fluency resulted in women being characterised by midwives as rude, unresponsive and unintelligent (Bowler 1993), and that these language barriers meant that women were unable to challenge the assumptions made about them, or to build a relationship with the midwife which might disconfirm some of these negative beliefs (Bowler 1993). Furthermore, there was a tendency for midwives to express negative attitudes towards South Asian women based purely on their language fluency – voicing their frustration that these women (especially those with longer history of residency) had not made more effort to learn English (Bowler 1993)².

Alongside attitudes towards language fluency, health professionals have been reported to form stereotypes of minority ethnic women based on their expression of pain (Bowler 1993; Puthussery et al. 2008). For example, health professionals in Puthussery et al. (2008)'s research claimed that South Asian women had lower pain thresholds, and expressed pain in a more extreme manner, than women of other ethnic origins. Similar stereotyping of pain expression is seen in research from almost ten years previously; during interviews with Bowler (1993), midwives described South Asian women as having a tendency to “make a fuss about nothing” (Bowler 1993, p. 166). However, when the author conducted observations of the labour wards these midwives worked on, similar noise levels were recorded between Asian and British women (Bowler 1993). When challenged on inaccurate stereotypes, midwives suggested that incompatible cases were an exception to the rule (Bowler 1993) and seemed unwilling to allow this stereotype to be challenged or modified.

Research from the Netherlands suggests similar cases of stereotyping; immigrant women reported feeling that healthcare providers had underestimated their complaints, and that this had led to the development and aggravation of complications (Jonkers et al. 2011). In a couple of cases extreme

² Similar attitudes were found in my own research, and will be discussed in the findings chapters.

and abnormal pain was interpreted by healthcare professionals as normal birth pain when, in fact, these women had actually sustained uterine rupture (Jonkers et al., 2011).

South Asian women are not the only ethnic group to be stereotyped by healthcare providers by their expression of pain, however; during interviews with Puthussery et al. (2008) healthcare professionals suggested that African women viewed childbirth as a natural process and were therefore unlikely to use pain relief during labour (Puthussery et al. 2008). Such findings raise concerns about the type of care provided to women who are stereotyped by their expression of pain (Puthussery et al. 2008; Raleigh et al. 2010). For example, research by Raleigh et al. (2010) found that minority ethnic women were less likely to report adequate pain relief during labour and birth than their white British counterparts, and research by Harper Bulman and McCourt (2002) found that pain relief had not been discussed with Somali refugee women at all antenatally. The midwives caring for these refugee women suggested that discussion of pain relief was often unnecessary with this client group, as Somali women were more 'natural' and unlikely to use pain relief stronger than 'gas and air' (Entonox) (Harper Bulman and McCourt 2002).

Stereotype-based assumptions are also found when speaking to midwives about minority ethnic women's birth preferences. For example, health professionals in Puthussery et al. (2008)'s research claimed that minority ethnic women had a strong group preference for hospital birth. The ramifications of this assumption are made clear by research which shows that minority ethnic women report less choice about place of birth than their white British counterparts (Raleigh et al. 2010), arguably denying the opportunity for individualised care.

Lack of individualised care is often seen as a risk factor for poor pregnancy outcomes. Indeed, reliance on inaccurate ethnicity-based associations can have serious implications for women's maternity experiences and outcomes. Midwives in Bowler (1993)'s research, for example, appeared to base women's estimated length of labour on ethnicity, and neglected to account for additional factors such as parity. This led to a number of cases where midwives were unprepared for complications in South Asian women's birth experiences (Bowler 1993). For example, one midwife informed the researcher that a South Asian woman would "be back in an hour, they're always quick" (Bowler 1993, p. 168); basing this assumption on the woman's ethnicity, and ignoring the fact that this woman was primiparous; a factor which would suggest a longer labour time (Bowler 1993). The author concluded that ethnic stereotyping of this sort had clear potential

for mistaken expectations of labour, and that this was likely to influence the level of care provided by the midwife (Bowler 1993). Indeed, research from the United States found that the ethnicity of patients influenced the diagnosis and treatments given by doctors (van Ryn 2002; van Ryn and Fu 2003; Burgess et al. 2006).

Although existing literature suggests clear negative consequences of inaccurate stereotyping of minority ethnic women, some authors argue that some stereotypes may serve a positive purpose in the provision of tailored care. For example, it is argued that categorisation of women allows for quicker decision making based on what that woman is likely to want or need in emergency situations (Green et al. 1990). Indeed, in the context of midwifery, Macintyre (1978) argues that stereotypes are used by midwives to help pitch their interactions with women appropriately. However this view is now rather dated; whilst there remains some support for the usefulness of stereotypes in day-to-day life (McFarlane 2014), all recently published literature on the effect of stereotypes in the healthcare setting support the notion that stereotyping of patients is likely to have negative effects on health outcome (Aronson et al. 2013). In fact the most recent discussion of the usefulness of ethnicity-based stereotypes seems to be that of Bowler (1993), who suggests that the usefulness of stereotypes in providing care depends on the accuracy of these assumptions. Indeed, the researcher found that negative stereotypes of black and minority ethnic patients were often used by midwives to make incorrect judgements about the kind of care different women wanted, needed and deserved (Bowler 1993). Consequently, Bowler (1993) claimed that such stereotyping was likely to be a major factor in the creation of the inequality in health experiences of black and minority ethnic patients. This concept is supported by authors of newer research in this field, who argue that the inhibition of individualised care, due to pre-existing assumptions about women, may contribute towards the ethnic inequalities seen in pregnancy outcomes (Raleigh et al. 2010).

Despite these assumptions, a number of studies challenge the role of stereotyping and discrimination in poor maternity care and pregnancy outcomes. For example, during discussions of their maternity care experiences with McCourt and Pearce (2000), minority ethnic women attributed poor care to systemic factors, and rejected any suggestions of racism and/or discrimination. Similar findings were shown by Cross-Sudworth et al. (2011), who found that maternity care experiences for Pakistani women seemed to be influenced by their level of education and social support, rather than perceived racism or discrimination from healthcare

professionals. Such findings suggest the existence of factors contributing to poor outcomes for minority ethnic women which are over and above that of racism and discrimination.

2.5.5 Section Summary

As seen in this section, existing literature lends support to associations between poor pregnancy outcomes and factors such as genetic risk, differences in socioeconomic status, language barriers and stereotyping/racism. However, such research also suggests that ethnic inequality in these outcomes remain even once these contributing factors have been accounted for. Consequently, it would seem that additional, as yet unexplored, explanations may exist for the observed differences in pregnancy outcomes. The importance of this knowledge gap is discussed in the subsequent section, which considers the relevance of ethnic and migrant inequality in pregnancy outcomes to current affairs.

2.6 Current Affairs of Relevance within the UK

Net migration for the United Kingdom has substantially risen in the past 3 years (Office for National Statistics 2016), and in the year ending September 2015, 323,000 more individuals entered the UK than left (Office for National Statistics 2016). As a result, non UK-born communities continue to grow within the United Kingdom, increasing the ethnic diversity of the general population. Indeed, a recent report from the migration observatory suggests that one in seven (13.1%) of the UK population in 2014 were born abroad (Rienzo and Vargas-Silva 2016). In areas such as London, this population percentage increases, with data from 2013 suggesting that 39% of inner London's population were born abroad (Rienzo and Vargas-Silva 2016).

High numbers of UK resident foreign-born women have a visible impact on UK maternity services; in 2014 over a quarter of births (27.0%) in England and Wales were to mothers born outside of the UK (Office for National Statistics 2015). Furthermore, during 2014, the number of births to non-UK born women in England and Wales *increased* by 1.4% from the previous year, whilst births to UK-born women *decreased* by 1.1% (Office for National Statistics 2015). Such statistics suggest an increasing use of UK maternity services by foreign-born women, a concept further supported by differences in estimated fertility rates. For example, in 2011 the estimated fertility rate for UK-born women was 1.9 children, in comparison to an estimated 2.29 children for each foreign-born

woman (Office for National Statistics 2012b). These figures suggest that foreign-born women, on average, will access maternity services twice as often as their UK-born counterparts (Office for National Statistics 2012b). In fact, when considering estimated fertility rates for separate minority ethnic populations, these differences are significantly higher; for example Pakistan- and Bangladesh-born women have estimated fertility rates of 4.7 and 5.3 children per woman respectively (Office for National Statistics 2012b), suggesting an even higher frequency of service use by these women.

Given the continued ethnic and migrant inequalities in pregnancy outcomes, the growing use of UK maternity services by migrant populations is worrying unless there are improvements in quality of care. In fact, recent maternal mortality lend weight to this concern; not only are migrant populations growing, but their risk of maternal mortality is also growing (Knight et al. 2015). Whilst the 2015 report suggests a decreased risk of maternal mortality for white British women, when compared to the previous report, this risk has actually *increased* for some minority ethnic and migrant groups (Knight et al. 2015).

Considering the growing migrant population in the UK, and the related risk factors for inequalities in pregnancy outcomes, the UK healthcare system needs to develop policies and interventions to narrow these inequalities. This is particularly so given that in 2007, the Confidential Enquiry into Maternal and Child Health (Lewis 2007) set out recommendations for monitoring the health status and access to care of pregnant migrant women, which, given the lack of improvement, now need to be further developed into proactive steps to narrow these inequalities and make improvements in patient safety.

As discussed, previous policies for tackling ethnic inequalities in health have focused almost solely on the issue of socioeconomic status (Health Inequalities Unit 2008). As such, the majority of policy implementation to tackle these inequalities has been based on reducing broader social inequalities in health (Health Inequalities Unit 2008), including strategies and interventions focused on improving determinants of socioeconomic status and deprivation, such as early years support for children and families, social housing, educational attainment and skills development, and reductions in unemployment (Health Inequalities Unit 2008). However, such strategies have had limited success (Infant Mortality National Support Team 2010; Korkodilos et al. 2013), and it is

therefore necessary to consider other ways in which pregnancy outcomes for migrant and minority ethnic populations might be improved (Goodwin et al. 2015).

The next section of this chapter considers a potential alternative factor in influencing pregnancy outcomes for this client group; the midwife-woman relationship. Literature supporting the association between this relationship and pregnancy outcome will be discussed, and findings will be used to build a rationale for this PhD research.

2.7 Time to Re-explore the Midwife-Woman Relationship?

There is a growing body of qualitative research which emphasises the importance of midwife-woman relationships on inequalities in pregnancy outcomes (Wilkins 1993, 2010; Cantwell et al. 2011; Jonkers et al. 2011). Indeed, research conducted over 20 years ago found that women valued personal, emotional and biographical experiences from their midwives (Wilkins 1993); stressing the importance of a confiding, trusting, close relationship which had their emotions, experiences and concerns at heart (Tinkler and Quinney 1998). Similar findings have been repeated more recently - for example, during interviews with second generation ethnic minority women in the UK, Puthussery et al. (2010) found that satisfaction with maternity care was consistently linked to women's relationship with healthcare professionals; women valued warmth and support, which then led to trust and confidence in the care they received, and in those providing it (Puthussery et al. 2010). Exploring this issue from the opposite angle, qualitative research in the Netherlands found that migrant women attributed substandard maternity care to poor relationships with their healthcare providers (Jonkers et al. 2011). These findings are supported by a systematic review of women's experiences of birth, which found that the quality of the client-provider relationship was a key factor of a positive birth experience, outweighing variables such as birth environment, and even pain and medical intervention (Hodnett 2002).

As seen, a number of previous studies highlight the importance of good quality midwife-woman relationships on women's experiences of pregnancy and birth. However, research also exists to suggest that the importance of this relationship extends further than opinions and emotional assessments of this care. In fact, a number of authors suggest an association between the quality of midwife-woman relationships, and women's health outcomes (Berg 2005; Ólofsdóttir 2006;

Boyle 2013). This association is acknowledged in a number of enquiries into maternal mortality in the UK; in the 2007 report, poor quality of midwife-woman relationship was reported as a key factor for substandard maternity outcome (Lewis 2007), and in the 2011 report authors suggested that emotional support and effective communication were important for the prevention of maternal mortality (Cantwell et al. 2011). Indeed, support for the association between client-provider relationships and pregnancy outcomes has increased during the course of this PhD. A Cochrane review, published in the UK in 2016 highlights the benefits of the midwife-led continuity model of care, naming the establishment of a relationship between the care provider and pregnant women as one of its main differences to other models of care (Sandall et al. 2016b). Women receiving this midwife-led continuity model of care (where the same midwife or same members of a small midwifery team are seen at every appointment) have been shown to be at less risk of preterm birth before 37 weeks, less risk of fetal loss before and after 24 weeks, less risk of neonatal death, and less risk of instrumental delivery, compared to women receiving other models of care (Sandall et al. 2016b). A following report from the Sheila Kitzinger symposium group suggested that relational continuity should be scaled up, as there is “compelling evidence that ongoing supportive relationships between women and their maternity care provider improves outcomes and experiences of care” (Sandall et al. 2016a, p. 8). In fact, the members of this research group suggest that supportive midwife-woman relationships improve outcomes for women at both low and high risk of medical and obstetric complications, women with complex social problems, longstanding histories of mental illness, socio-economic deprivation and those from black and minority ethnic backgrounds (Sandall et al. 2016a).

Despite such evidence, in-depth studies of the relational issues between midwife and woman are relatively rare in the history of maternity research (Hunter 2010). This lack of exploration is concerning, as models of client-provider relationships provide credible explanations for the association between good midwife-woman relationships and positive pregnancy outcomes. The concept of “reciprocity” identified in Hunter (2006)’s research, for example, suggests that balanced exchanges (equal give and take between midwife and woman) increase happiness in the midwife-woman relationship, which then improves the quality of midwifery care, midwives become more authentically empathetic towards, and emotionally connected, with women - which in turn facilitates open communication and the provision of enhanced emotional support (Hunter 2006; McCourt and Stevens 2009). This concept is supported by claims from midwives that the development of meaningful client-provider relationships increases their ability to perform

“genuine caring” (Berg 2005) and allows them to become safer practitioners (Ólofsdóttir 2006). Indeed, during interviews conducted in Iceland, midwives reported that they connected to women by forming relationships based in reciprocity and trust (Ólofsdóttir 2006), and that these enhanced relationships resulted in safer midwifery practice by encouraging continuous one-on-one interaction with women during labour and birth (Ólofsdóttir 2006). Alongside the increased likelihood of continuous care, midwives suggest that good client-provider relationships are key to addressing stress, frustration and burnout, consequently allowing them to provide more effective, and therefore safer, care to these women (O'Mahony and Donnelly 2007; Degni et al. 2012).

Further support for the association between the quality of client-provider relationship and pregnancy outcomes is provided by research into help-seeking and health behaviours. Whilst it is widely accepted that poor relationships with healthcare providers often results in less help-seeking in populations such as those suffering with mental health issues (O'Mahony and Donnelly 2007), it is less commonly publicised that these findings are mirrored in the field of maternity care. However such research does exist; for example, in a literature published in the late 1990s, Pairman (1998) reported that sensitive issues were more likely to be disclosed in a trusting midwife–woman relationship. Later UK-based research by Lynch (2011) showed similar findings; women who had a close and trusting relationship with their midwife were more likely to seek help, independent of other factors such as immigration status and ethnicity (Lynch, 2011). Alongside the impact of relationships on help-seeking behaviours, previous literature suggests that the quality of the relationship between client and provider predicts the quality of communication between them (Boyle 2013). For example, a study by Edge (2011) found that UK-born Black Caribbean women reported a lack of compassion from healthcare providers, resulting in a lack of trust and reluctance to continue their maternity care with these health professionals (Edge 2011). Similarly, research from the same year found that minority ethnic women felt as though they had been treated in a disrespectful way due to their ethnicity, and that they consequently felt uncomfortable asking midwives questions about their care (Lynch 2011). The author acknowledged that this denial of a trusting and caring relationship caused a lack of vital information sharing, which could have serious implications for the health of women and their babies (Lynch 2011). As seen in the earlier section on language barriers, effective client-provider communication is essential for safe practice and positive outcomes in maternity care (Lewis 2007; Cantwell et al. 2011; Sandall et al. 2016a; Sandall et al. 2016b).

A better understanding of women's relationships with their midwives is especially relevant for the UK healthcare system, where maternity care is construed as a partnership between the woman and service provider (Department of Health 2007; Cross-Sudworth et al. 2011). It is therefore suggested that more targeted investigation is needed into the relationship between care providers and vulnerable women; allowing for an exploration into the ways in which maternity services can be adapted to provide effective care for an increasingly diverse client group (Lynch 2011; Goodwin et al. 2015).

2.8 Chapter Conclusion

Literature discussed throughout this chapter suggests continued ethnic and migrant inequalities in pregnancy outcomes exist in the United Kingdom. Previous government policies to reduce these inequalities have had little impact – in fact recent maternal mortality rates suggest increasing risks for some minority ethnic and migrant populations. However, these policies have been based on improving factors such as socioeconomic status and language barriers, whilst research reviewed in this chapter suggests that these factors alone cannot fully explain the relationship between ethnicity/migrant status and poor pregnancy outcomes (Goffman et al. 2007; Knight et al. 2009). Indeed, an international review of studies on perinatal outcomes and migration found that migrant women had significantly worse outcomes than women born in their country of residence, even when adjusted for biological, medical, demographic and socioeconomic backgrounds (Gissler et al. 2009). In fact, these adjustments only explained a small part of the statistically significantly higher mortality risk among migrant populations (Gissler et al. 2009), suggesting the existence of alternative contributing factors.

As discussed, existing literature lends support to an association between midwife-woman relationships and pregnancy outcomes. Such literature suggests that the relationship between women and their midwives not only impacts on uptake of antenatal care, but also influences the quality of care received once services have been accessed. Consequently, such research suggests that a poor relationship is likely to result in poor outcomes. Differences in the quality of these relationships for minority ethnic and white British women may, therefore, present an alternative contributing factor towards ethnic inequalities in outcome, unaccounted for by previous research. The extent of research exploring midwife-woman relationships seems inarguably limited,

especially when considering the importance placed on this relationship by both women and midwives in previous research. As discussed, there is potential for this client-provider relationship to be more difficult, and imbalanced for ethnic minority and immigrant women. Therefore, this chapter summarises by suggesting that research exploring midwife-woman relationships for migrant and/or ethnic minority women would have the potential to provide credible explanations for the observed ethnic and migrant inequalities in UK pregnancy outcomes.

Chapter Three: Research Aims and Methodology

3.1 Chapter Aims

The first half of this chapter begins with a discussion of further rationale for undertaking the study, with reference to the literature reviewed in the previous chapter. A case is made for focussing the study on migrant Pakistani women receiving maternity care in South Wales. From this, a primary research aim is established, alongside an additional number of areas of interest to be explored.

The second half of this chapter discusses the methodological considerations of the research; including a consideration of the philosophical worldview aligned with the research aims and acknowledgment of the different methodological approaches available for adoption. This includes a detailed discussion of qualitative, quantitative and mixed method approaches, concluding in an argument for the use of a qualitative research design. The final section of the chapter considers two methodological approaches to qualitative research; grounded theory and ethnography. Justification for the choice of an ethnographic approach is provided, along with a brief discussion of the naturalist-positivist debate and how this applies to my research aims.

Part One: Rationale and Research Aims

3.2 Rationale for Research Topic

As discussed in the previous chapter, minority ethnic and migrant women in the UK show poorer pregnancy outcomes than their white British counterparts, and report experiencing poorer quality relationships with their midwives. Despite the evidence suggesting a strong association between midwife-woman relationship quality and pregnancy outcomes, no research so far has directly and exclusively looked at this relationship for minority ethnic and migrant women. I therefore decided that this was something I wanted to investigate further. The first step in designing my research was to decide on a participant group to study.

As previously discussed, previous research in the area of ethnic inequalities in maternity outcomes has varied in its participant characteristics. While some studies have used populations based solely on ethnicity (Puthussery et al. 2008; Rowe et al. 2008; Twamley et al. 2009; Puthussery et al. 2010; Raleigh et al. 2010; Edge 2011; Ravelli et al. 2011; Zwart et al. 2011), others have recruited based on migration status (Hoang et al. 2009; Hayes et al. 2011; Zanconato et al. 2011; Balaam et al. 2013; Hoban and Liamputtong 2013). This is an issue which caused notable limitations in recent research exploring the maternity care experiences of UK-born minority ethnic women (Puthussery et al. 2010). The authors noted a potential over-representation of older, better educated women; over half of participants were 30-39, and almost half were educated to degree level or above (Puthussery et al. 2010). While allowing greater confidence in the findings for this specific population group, such samples make it near impossible to generalise findings to the wider population (Puthussery et al. 2010).

At the other end of the spectrum, participant populations with a range of ethnicities have been included in a number of studies in this field, in an attempt to give a minority ethnic 'overview'. For example Puthussery et al. (2010) used a mix of black Caribbean, black African, Indian, Pakistani, Bangladeshi and Irish women in their exploration of the maternity care experiences and expectations of UK-born minority ethnic women. A similar approach was undertaken by Redshaw and Heikkila (2011), who described their participants as BME (black and minority ethnic). These authors acknowledge that findings from studies with such diverse participant characteristics make it near impossible to disentangle views of participants based on their ethnic background (Redshaw and Heikkila 2011), especially with the small numbers found in these studies. This creates problems with generalisation of findings, as individuals with different ethnic backgrounds may have cultural-specific needs (Redshaw and Heikkila 2011) and may also be treated differently by health providers (Redshaw and Heikkila 2011); as discussed - different stereotypes exist for women from different ethnic backgrounds (Puthussery et al. 2008). Redshaw and Heikkila (2011) recognise these limitations; noting that their combination of views from participants from a number of different ethnic backgrounds may have blurred over differences in opinion between groups.

Despite my enthusiasm to explore midwife-woman relationships for women from a broad range of ethnicities the limitations discussed above, alongside the time constraints of a PhD, meant that in order to create credible knowledge on ethnic inequalities in maternity care, it was necessary to

narrow my focus to a specific client group. After a thorough review of the literature on ethnic and migrant inequalities in pregnancy outcome I decided that the most appropriate client group to study would be first generation migrant Pakistani women receiving maternity care in South Wales. This decision was based on a number of factors, briefly summarised below.

3.2.1 First Generation Migrant Pakistani Women in South Wales: Residency and Risk

At the time of study design, ONS statistics showed that 25.5% of births in England and Wales were to mothers born outside of the UK (Office for National Statistics 2012b). This rate steadily increased over the 3 years in which this PhD was undertaken, and by the time of submission births to non-UK born women represented 27% of UK births (Office for National Statistics 2015).

In addition to the increasing rate of births to migrant women in the UK (Office for National Statistics 2015), maternal and perinatal mortality reports suggested that these individuals were at increased risk of poor pregnancy outcomes; between 2011 and 2013 a quarter of UK maternal mortalities were women born outside of the UK (Knight et al. 2015), and babies born to non UK-born women accounted for 24% of all UK stillbirths in 2014 (Manktelow et al. 2016). Consequently, I decided that first generation migrants (those born outside of the UK) were an important population with whom to conduct my research.

In order to determine the specific population to study, I first needed to decide on an area in which to conduct the research. South Wales was chosen as the geographical location for this research for two main reasons. Firstly, previous research into the pregnancy experiences of migrant and minority ethnic women in the UK has focused mainly on areas in England, for example London and Bradford (Harper Bulman and McCourt 2002; Binder et al. 2012; Kanthasamy et al. 2013; Sheridan et al. 2013; Lephard and Haith-Cooper 2016). Comparatively little research has been done in this field in Wales. As Wales has a devolved health policy, maternity care guidelines differ to those in England. Therefore, my PhD studentship seemed like a good opportunity to explore maternity experiences of migrant and minority ethnic women in the Welsh context.

Secondly, as my PhD was based at a university in South Wales, there were also practical reasons for this decision – for example minimising the travel costs for myself and participants, along with the benefits of having existing contacts within local health boards.

A single health board within South Wales was chosen as the research site, and participants were recruited from the maternity services linked to this health board³. This decision was in keeping with the ethnographic approach taken by this research; focusing on one research site allows for the conduct of an in-depth study that takes into account contextual factors such as local characteristics (Marcus 1998).

At the time of study design, the three largest minority ethnic groups in the recruitment area were 'white: other', 'Indian', and 'Pakistani' (Office for National Statistics 2012a). When considering rates of maternities in the UK, the top three countries of birth for non-UK born mothers were Poland, Pakistan and India (Office for National Statistics 2015). In terms of pregnancy outcome, the most vulnerable of these minority ethnic groups appeared to be the Pakistani population. Indeed, mortality reports published during the design phase of this research suggested that Pakistani women were second most at risk of both infant mortality (Office for National Statistics 2013c), and maternal mortality (Cantwell et al. 2011), when compared to all other ethnic groups in the UK.

These findings appear to have remained consistent throughout the course of this PhD. A recent report from the Office for National Statistics shows that Pakistan remained the second most common country of birth for non UK-born mothers between 2010 and 2014 (Office for National Statistics 2015), and the newest report from MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) shows that Pakistani women remained the second most at risk of maternal mortality between 2011-2013 (Knight et al. 2015).

3.2.2 The Inclusion of Midwives

Once I had established the migrant status and ethnicity of women to be included in my research, it was necessary to make a decision on the inclusion/exclusion of the views of midwives. Although the majority of research on maternity care for minority ethnic women focuses on the experiences of the women themselves, a number of studies have also included interviews with healthcare professionals (Harper Bulman and McCourt 2002; Puthussery et al. 2008; McFadden et al. 2012). As my research interest focused on the relationship between midwife and woman, I decided to include data from midwives; acknowledging that this inclusion would allow for a holistic

³ Characteristics of the study site are detailed in Chapter Five (page 92)

exploration of relationships from both perspectives, and an increased understanding of the impact of these relationships on care.

3.3 Research Aims

The main aim of the research was to explore relationships between first generation migrant Pakistani women and midwives in the South Wales region; focusing on the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. The underpinning purpose of the study was to add to the body of knowledge about ethnic and migrant inequalities in pregnancy experiences in the UK.

A number of potential themes were identified from the existing literature, discussed in the previous chapter. These informed the construction of specific research questions, as follows:

- Theme: Cultural expectations of maternity care and the midwife role
 - *How might family dynamics and cultural practices amongst migrant Pakistani families affect women's pregnancy and maternity care experience?*
 - *What are migrant Pakistani women's expectations and understandings of maternity and midwifery services in UK/Pakistan? What influences these expectations?*
- Theme: Social support networks
 - *How might migrant Pakistani women's social support networks affect their midwifery care experience?*
 - *How might migrant Pakistani women's social support networks affect their relationship with their midwife?*
- Theme: Stereotyping and prejudice
 - *How do British midwives in Wales view their relationships with migrant Pakistani women?*
 - *Do migrant Pakistani women report experiences of stereotyping and prejudice, and if so, how do they describe these experiences?*

- Theme: Links between relationship and care
 - *What do migrant Pakistani women and British midwives perceive as the barriers/facilitators to establishing a client-provider relationship?*
 - *How do these relationships affect the level of care midwives are able to provide/clients feel they have received?*
- Theme: Language Barriers
 - *How useful are interpreter/translation services from the perspective of women and midwives?*

3.4 Working Terms

Throughout the remainder of this thesis, migrant Pakistani ‘clients’ or ‘service users’ (women receiving maternity care) will be described as migrant Pakistani ‘women’ or ‘woman’. This term is reflective of the language used by midwives to describe their clients, and is important in discarding any connotations of illness or of women paying privately for these services.

Similarly, a ‘good’ midwife-woman relationship will be used to describe relationships which provide positive experiences to both woman and midwife, and is reflective of the way in which midwives talk about the quality of their relationships with women.

Mirroring terminology found in previous literature in this field of research, women who reside in their country of birth are sometimes referred to, in this thesis, as ‘native’ women.

For the purpose of this thesis, the term ‘pregnancy outcomes’ is used to describe any outcome that occurs as a result of a pregnancy. For example, this term would include both maternal and perinatal morbidity and mortality.

In order to protect the identity of the participants involved in this research, the recruitment city and health board in which research took place have been anonymised. These are referred to simply as ‘the health board’ and ‘the recruitment city’.

Part Two: Methodology

The second part of this chapter outlines the decisions made regarding the methodological approaches to my research. This includes discussion of the philosophical 'worldview' in which this research is situated, and a debate on the best methodological approaches for this research.

3.5 A Philosophical Worldview: Constructivism

During development of my research aims, it became clear that the philosophical worldview most relevant to my research interests was Constructivism. Constructivism is described in Berger and Luckmann's (1967) 'The Social Construction of Reality', and Lincoln and Guba's (1985) 'Naturalistic Inquiry', and suggests that individuals seek understanding of the world in which they live and work (Crotty 1998; Lincoln et al. 2011). In order to do so, individuals develop subjective meanings of their experiences, which are directed toward certain objects or people (Crotty 1998). As these meanings are varied and multiple, the Constructivist view proposes that researchers acknowledge and embrace the complexity of views rather than narrowing meanings into a few strict categories or ideas (Crotty 1998). Indeed, the Constructivist researcher's intent is to interpret the meanings others have about the world, rather than attempting to categorise this experience merely according to the researchers meaning (Crotty 1998). Such views fit well with my current research aims; attempting to understand the potentially complex relationships between midwives and migrant Pakistani women. Furthermore, Constructivist researchers believe that subjective meanings are created through interaction with others and through the historical and cultural norms that operate in individuals' lives (Creswell 2013). Thus, Constructivist researchers often explore interaction among individuals, and focus on the specific contexts in which people enact these interactions (Creswell 2013). Once again, such ideologies parallel the aims of my research; attempting to understand interactions between individuals in the context of a South Wales maternity care setting.


Furthermore, the Constructivist worldview aligns with my research in that investigators are encouraged to inductively develop a theory through data, rather than starting with a specific research question which deductively addresses a pre-defined theory or hypothesis. In setting out to broadly explore a relationship, rather than seeking to answer narrower questions about this relationship, my research aims parallel this approach to data collection. Cultural and historical contexts are also often explored in Constructivism, in order to understand the way in which individuals might shape their subjective meanings in relation to their experiences (Creswell 2013). This seems especially relevant for my research, which considers relationships between individuals from different cultural backgrounds.

3.6 Choosing a Methodological Approach

Given the adoption of the Constructivist worldview, I decided that a qualitative approach would be most appropriate to address my research aims. The following section discusses this approach in relation to the other methodological approaches available; the quantitative approach, and the mixed methods approach (Holloway and Wheeler 1996).

3.6.1 The Different Approaches

Qualitative research is a form of social inquiry that centres on the way people make sense of their experiences and the world in which they live (Holloway and Wheeler 2010). The main aim of qualitative research is to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures (Holloway and Wheeler 2010), however it may also be used to uncover trends in thought and opinions, and dive deeper into a given problem. The extract below is taken from pages 3 and 4 of Holloway and Wheeler's (2010) 'Qualitative Research in Nursing and Healthcare', and describes the common elements of qualitative research.

- 
- The data have primacy (priority); the theoretical framework is not predetermined but derives directly from the data.
 - Qualitative research is context-bound and researchers must be context sensitive.
 - Researchers immerse themselves in the natural setting of the people whose behaviour and thoughts they wish to explore.
 - Qualitative researchers focus on the 'emic' perspective, the views of the people involved in the research and their perceptions, meanings and interpretations.
 - Qualitative researchers use 'thick description': they describe, analyse and interpret but also go beyond the constructions of the participants.
 - The relationship between the researcher and the researched is close and based on a position of equality as human beings.
 - Reflexivity in the research makes explicit the stance of the researcher, who is the main research tool.

(Holloway and Wheeler 2010, pp. 3-4)

In contrast to qualitative research, which mostly results in written data such as interview transcripts and field notes, quantitative research is used to generate numerical data or data that can be transformed into statistics (Bryman and Cramer 1994). In this way, quantitative data can be used to measure a phenomenon and its characteristics, to disprove hypotheses, and to uncover statistically significant patterns in research.

Researchers have fiercely debated the relative strengths of quantitative versus qualitative approaches to research (Holloway and Wheeler, 2002), and these approaches are traditionally seen as dichotomous (Brown 1996). However, some authors suggest that certain research projects might benefit from mixing the two approaches (Gillies 2002). This approach is argued to allow for the generation of quantifiable data, while at the same time probing deeper with a qualitative approach to make sense of the possible explanations for the quantitative results (Gillies 2002).

There appears to be an even mix of qualitative and quantitative research in the field of ethnic and migrant inequalities in pregnancy experiences/outcomes. However, obvious differences appear when considering the research aims of studies encompassed by these approaches. For example, whilst the majority of quantitative research focuses on differences in incident rates such as obstetric complications and maternal and perinatal morbidity/mortality (Knight et al. 2009; Shah

et al. 2011; Knight et al. 2015; Manktelow et al. 2015), qualitative research tends to explore differences in the thoughts and feelings surrounding experiences of maternity care (McFadden et al. 2012; Balaam et al. 2013; Small et al. 2014).

Despite this general divide in research aims, a number of quantitative studies have attempted to answer questions not only about the physical but also the emotional processes involved in maternity care for migrant and minority ethnic women. For example Redshaw and Heikkila (2011) designed a questionnaire checklist to determine women's concerns about labour and birth. Although some important ethnic differences were noted, the authors acknowledged that the use of quantitative methods significantly limited the information that they could gain (Redshaw and Heikkila 2011); noting that some of the issues left off the checklist may have been of concern for some groups but not others (Redshaw and Heikkila 2011). Consequently the authors suggested that further research in this field, with the use of qualitative methods, was necessary in order for key differences to be discovered (Redshaw and Heikkila 2011). A similar approach to data collection was taken by Raleigh et al., (2010) who used a survey to examine ethnic and social inequalities in women's experience of maternity care in England. However, these authors did not recognise the quantitative nature of their research to be a limiting factor; highlighting that the questionnaire used in this research was based on that used by an earlier national survey and was developed with specialised professional input and extensive field testing with recent mothers (Raleigh et al. 2010). Regardless of the potential limitations of this approach, quantitative research has proven essential in highlighting and confirming the existence of ethnic inequalities in pregnancy outcome, and, as discussed the previous chapter, has been crucial to discredit explanations of these inequalities centring solely on factors such as socioeconomic status and genetic risk (Zwart et al. 2011; Nair et al. 2014).

As suggested, qualitative research in the field of ethnic inequalities in pregnancy outcomes has been successful in gaining insight into the reality of maternity care and pregnancy outcome, as understood and experienced by migrant and minority ethnic women (Richens 2003; Puthussery et al. 2010; Jomeen and Redshaw 2013). Qualitative methods such as interviews and focus groups are especially well suited to these aims, as participants are encouraged to use their own words and ideas to create a holistic picture of the issue being explored (Richens and Smith 2011). In fact, qualitative researchers argue that this approach is best way to examine why certain groups of people are at risk for certain adverse health outcomes, as they allow new ideas to be brought

forward and explored (Gillies 2002; Holloway and Wheeler 2010; Richens and Smith 2011). Indeed, authors such as Holloway and Wheeler (1996) argue that explorations of relationships need always to be qualitative in nature. This argument is made additionally relevant to the current research by authors such as Cross-Sudworth, Williams and Herron-Marx (2011), who suggest that qualitative methods provide an excellent framework for exploring women's experiences of maternity care. In fact, Lundgren and Berg (2007) claim that "when complex phenomenon, such as the midwife-woman relationship in human life has to be understood, qualitative methods are the primary choice" (Lundgren and Berg 2007, p. 220).

As noted earlier, some authors promote the use of mixed methods to enhance study design. This approach was taken by Cross-Sudworth et al. (2011) in order to explore migrant Pakistani women's experiences of maternity care in Britain. For the qualitative part of the research, authors interviewed participants to gain rich data and discover unexpected themes (Cross-Sudworth et al. 2011). This data was then analysed and turned into a set of statements (Cross-Sudworth et al. 2011). Participants then used these statements to report which views most corresponded to their own thinking; producing quantitative data which could then be statistically analysed (Cross-Sudworth et al. 2011). It is argued that this combination approach therefore allows for the power of statistical analysis to support subjective views put forward independently by participants (Cross 2005). Consequently, as suggested earlier, a number of authors argue that a mixed method approach gets the most thorough use of information by increasing the breadth and depth of understanding of data (i.e. triangulation), while offsetting the weaknesses inherent to using each approach by itself (Brown 1996; Cross 2005; Cross-Sudworth et al. 2011). However, a number of criticisms have been raised about the reliability of this approach (Cross 2005); including the discovery of inconsistent results when repeating this process on the same participants (Cross 2005). Other researchers argue that this approach is also significantly more time consuming than other methods (Watts and Stenner 2012), and that the complexity involved in implementing mixed method designs often results in the need for clear, comprehensive instructions (Watts and Stenner 2012).

3.6.2 The Chosen Approach: Qualitative

There appear to be a number of benefits and limitations to each methodological approach presented in this section. However, given the exploratory nature of my research aims, along with the focus on building an understanding of interpersonal relationships through collecting and

analysing data from people who were, at the time, experiencing this relationship, I decided that qualitative methods were the most appropriate choice for this study. Indeed, as will be discussed later, this methodological approach proved to provide rich, in-depth, data on the experiences of both women and midwives, whilst also allowing for the emergence of potentially unconsidered themes.

3.7 Ethnography and Grounded Theory

Once I had decided to use a qualitative approach to data collection, it was necessary to select an appropriate approach to analyse and interpret data. The most popular approaches adopted by researchers in the field of ethnic inequalities in pregnancy outcomes are grounded theory (as used by (Lyons et al. 2008; Puthussery et al. 2008; Puthussery et al. 2010)), and ethnography (as used by (Bowler 1993; Mumtaz and Salway 2007; Wikberg et al. 2012; Higginbottom et al. 2013b)). In the following section, each are briefly discussed, and a case is made for the approach most relevant to the research aims defined earlier in the chapter.

3.7.1 Grounded Theory

In *The Discovery of Grounded Theory*, Glaser and Strauss (1967) suggested that graduate students in the social sciences were being trained to confirm the ideas of early theorists rather than being encouraged to generate theory themselves (Glaser and Strauss 1967). This led to the author's creation of the 'grounded theory' approach; whereby a set of multivariate nonstatistical (or quasistatistical) procedures, known as grounded theory methods, were used to facilitate theory construction (Glaser 1992).

The grounded theory approach to qualitative data stresses the importance of the context in which people function (Goulding 1998) and has a basis in 'Symbolic Interactionism' (Mead 1934); the theory that people base their actions on those of others through learning social rules (Goulding 1998). Indeed, Symbolic Interactionism suggests that the social world cannot be understood in terms of simple causal relationships or universal laws of behaviour (Goulding 1998); humans' actions are instead based on intentions, motives, beliefs, rules and values which differ both between culture, and from person to person (Goulding 1998). The aim of the grounded theory approach, therefore, is to investigate the interactions, behaviours and experiences of individuals

(Holloway and Wheeler 1996) and to explore the way in which individuals perceive these interactions and experiences (Holloway and Wheeler 1996). The grounded theory approach dictates that researchers do not enter into the study with a specific hypothesis, instead generating all theory from the data collected (Glaser 1992).

3.7.2 Ethnography

Ethnography is most simply described as "the art and science of describing a group or culture" (Fetterman 1998, p. 1), and has its origins in social anthropology – the study of the norms and values of societies (Atkinson et al. 2001). The ethnographic approach developed as a way to understand the social life of humans within specific cultures (Hammersley and Atkinson 1995) and analyse cultural norms (Holloway and Wheeler 1996); allowing for cross-cultural comparison and providing a better understanding of behavioural differences and inter-group conflicts (Hammersley and Atkinson 1995).

As with grounded theory, ethnography also follows the principles of Symbolic Interactionism; emphasising the diversity in individuals' intentions, motives, and beliefs, and the role which these divergent factors play in shaping human interactions (Holloway and Wheeler 1996). However, in this approach, ethnographers are encouraged to immerse themselves in the culture they are studying as part of the research process (Holloway and Wheeler 1996). Indeed, a defining characteristic of ethnography is:

"a commitment to the first-hand experience and exploration of a particular social or cultural setting"

(Atkinson et al. 2001, p. 4)

In this way, the ethnographer attempts to understand a social organisation or a cultural system in its own terms, from within (Atkinson and Pugsley 2005). This often means committing oneself to sustained engagement with a given culture in order to collect rich and meaningful data, and to learn the relevant cultural knowledge and social norms (Hammersley and Atkinson 1995). As a result, ethnographic research tends to focus on a single research site, as is the case in my study - the more settings studied, the less time can be spent in each.

A number of principles have been developed to guide ethnographic research. These include the following assumptions:

1. Social 'actors' (those individuals in the particular cultural framework being studied) engage with one another and with the world about them in the light of their interpretations and understandings of actions, objects and communications.
2. Social life is not a matter of fixed entities and structures. Identities and meanings are always available to negotiation and redefinition.
3. Phenomena cannot be analysed without considering social and cultural contexts.
4. Social actors are knowledgeable, being thoroughly socialised into their own culture. This is often Tacit knowledge - it is not explicitly taught, and actors may not be consciously aware of the rules, conventions and knowledge that they use and draw on in everyday life.

Adapted from Atkinson and Pugsley (2005)

In ethnographies, specific research questions are rarely finalised before data collection begins (Fetterman 1998). Instead, research aims go through a process of 'progressive focusing', where the research problem is narrowed from general to specific questions over time, as data is analysed and collected (Hammersley and Atkinson 1995).

Although participant observation is a defining feature of ethnography (Atkinson and Pugsley 2005), it is not the only research method used in this approach. Ethnographers will typically include semi-structured or unstructured interviews with key informants, alongside analysis of relevant media such as legislation or documents that may affect the social or political context of the social world under study (Atkinson et al. 2001). This combination of methods allows for triangulation of data, and also allows for situational application of interview questions (i.e. asking a participant to explain a certain behaviour witnessed during observation). Indeed, using more than one data collection approach provides multiple interpretations and achieves fuller understanding of the same phenomenon from different perspectives (Holloway and Wheeler 2010), and helps to achieve the methodological rigor (credibility) of the study (Holloway and Wheeler 2010). As will be seen, the combination of interviews, observations, and document reviewing was used in my research for the reasons noted above.

While there is no specific time frame for conducting an ethnography, some ethnographers suggest that conducting research over a sustained period of time is necessary to get a holistic picture of a

social world under study (Hammersley and Atkinson 1995). For example, the ethnographic approach assumes that actions and behaviour often have a complex chain of events leading to them (Hammersley and Atkinson 1995), which may not be apparent or identifiable when such behaviours or actions are studied only at the time frame in which they occur (Atkinson et al. 2001). Furthermore, the use of repeated interviews and observations at different time periods (as is the case in my research), allows for conclusions to be drawn on the stability of relationships and behaviours (Atkinson et al. 2001).

Focused ethnography, a subcategory of the ethnographic approach, has emerged as a method for applying ethnography to 'focus on a distinct issue or shared experience in cultures or sub-cultures in specific settings.....rather than throughout entire communities' (Cruz and Higginbottom 2013, p. 36). Indeed, focused ethnography is conducted within a discrete community or context, whereby participants have specific knowledge about an identified phenomenon (Higginbottom et al. 2013a). In this way, focused ethnography aims to explore participants' beliefs and practices by viewing them within the context in which they actually occur, rather than aiming to produce findings which can be generalised (Higginbottom et al. 2013a).

3.7.3 Comparison and The Chosen Approach: Focused Ethnography

Grounded theory and ethnography share a number of similarities. For example, both methodologies are used to investigate phenomena in naturalistic settings, both have been derived from Symbolic Interactionism, and participant description and observation are salient in both of them (Pettigrew 2000). Differences in these two traditions exist, however, in the purposes of each one, which in turn, affects data collection and analysis procedures, and the end products (Pettigrew 2000). Whereas a grounded theory researcher ends by reporting a substantive theory that explains the patterns of the phenomenon under study (Annells 1996), an ethnographic researcher ends by reporting a rich description of the cultural meaning of the phenomenon in a particular culture (Guba and Lincoln 1994). In other words, ethnographers attempt to describe and explore a social world, whereas grounded theorists attempt to generate a theory about the interactions within this world.

While each methodology has its own advantages and limitations, Holloway and Wheeler (1996) argue that it is essential to follow the approach which best fits the world view of the researcher/s conducting the study. Due to the research aims of my study; to explore the relationship between

two 'cultures' (the migrant Pakistani woman and the South Wales midwife), it was clear that ethnographic approach fit nicely with this world view. Indeed, as mentioned earlier, ethnography facilitates cross-cultural comparison and understanding of behavioural differences and inter-group conflicts/relationships (Hammersley and Atkinson 1995). Ethnographers therefore believe that ethnographic studies are ideally suited to understand complex cultures, and some claim that this approach is the best method for studying the behaviour of immigrants in their new host society (Aldiabat 2011). This approach has also been identified as a way to assist nurses to identify and to meet the needs of individuals from a certain culture by understanding these behaviours (Liamputtong and Ezzy 2005).

Considering the above points, I decided to take an ethnographic approach to my research. Further reading on ethnography confirmed this decision, as I came to learn of one of the founding concepts of ethnography; 'Schutz's 'stranger'' (Schutz 1944). In his paper, titled 'The Stranger: An Essay in Social Psychology', Schutz (1944) proposes that in the weeks and months after an immigrant arrives in a new country they must learn the new societal rules, which may be very different to the pre-existing knowledge they thought they had about this society. Schutz (1944) suggests that these individuals are therefore forced to adapt in order to survive; areas of ignorance suddenly take on new importance, and things which were previously thought to be important may not be so (Schutz 1944). By being forced to learn about the culture in this way, the stranger acquires a certain objectivity not normally available to members of the culture (Schutz 1944). In ethnography, the researcher similarly adopts the role of the stranger, in order to learn about the culture from an 'inside but objective' viewpoint (Schutz 1944).

The concept of Schutz (1944)'s stranger seemed a perfect parallel to my own research aims. Not only was I attempting to understand the migrant Pakistani culture, but also the maternity care culture in which these midwife-woman relationships were taking place. That is, I was a 'stranger' in both cultures. Both of my participant groups also took on the role of the stranger themselves – attempting to form a relationship with a member of a culture very different to their own.

As discussed earlier, focused ethnography differs slightly to the traditional ethnographic approach, in that it focuses on a specific aspect of a field which is studied with purpose (Cruz and Higginbottom 2013). Proponents of this approach argue that focused ethnography is especially well suited to studying the practice of healthcare as a cultural phenomenon, understanding the

meaning that members of a subculture or group assign to their experiences (Roper and Shapira 1999). Consequently, I decided that a focused ethnographic approach would be the most suitable for meeting my research aims.

Embedded in the ethnographic approach is the naturalism versus positivism debate. Positivists believe that all scientific theories should be open to scientific testing, with the ability to control and manipulate variables to test outcomes (Hammersley and Atkinson 1995). In this approach, theories can be falsified with certainty, and every effort is made to attain undisputable 'facts' (Hammersley and Atkinson 1995). Naturalism, on the other hand, proposes that the world should be studied in its natural state, undisturbed by the researcher (Hammersley and Atkinson 1995). Research must be carried out in ways that are sensitive to the nature of the setting, therefore variables and context are not manipulated or controlled (Hammersley and Atkinson 1995).

The naturalist view was inspired partly by 'Symbolic Interactionism' (Mead 1934); described earlier in terms of its relationship with both the ethnographic and grounded theory approach. In conflict with the positivist model of behaviour as a stimulus-response reaction, the naturalist view suggests that people interpret stimuli in unique ways (Hammersley and Atkinson 1995), and that these personal interpretations result in diverse actions as a result (Hammersley and Atkinson 1995). It is therefore suggested that in order to understand an individual's behaviour, researchers must use an approach which facilitates understanding of the complex social meanings the individual attaches to stimuli (Hammersley and Atkinson 1995).

I therefore decided that the best way to approach my research aims (exploring the relationships between migrant Pakistani women and midwives in South Wales), was to conduct a naturalist focused ethnography. In line with the principles of ethnography, it was my aim to describe and understand the social world of migrant Pakistani women and their experiences with maternity care, along with the experiences of midwives in working with migrant Pakistani women. In order to respect the naturalist approach to ethnography, Phase One of the current study centred around fieldwork in migrant Pakistani communities and antenatal clinics, prior to formal interviews and observations. This allowed me to become embedded in the cultural worlds of both participant groups and to "come to interpret the world in the way they do" (Hammersley and Atkinson 1995, p. 8).

3.7.4 The Importance of Remaining Reflexive

Qualitative data is extremely vulnerable to outside influences such as the motives, feelings, and actions of the researcher or research team (Holloway and Wheeler 1996; Cruz and Higginbottom 2013). As a result, during both data collection and analysis, it is necessary to acknowledge that the researcher is a part of the world which they are studying (Holloway and Wheeler 1996), and that personal motives and experiences will therefore shape interpretations of, and actions in, the social world under study (Holloway and Wheeler 1996; Cruz and Higginbottom 2013).

Although impossible to escape, authors of qualitative research propose that as long as these influences are efficiently acknowledged and explored, such influence does not create a significant limitation to the research (Hammersley and Atkinson 1995). With this in mind, ethnographers, along with other qualitative researchers, adopt a 'reflexive' position during all stages of the research; reflecting on their own feelings and potential influences on their research (Hammersley and Atkinson 1995) and making this explicit and transparent to readers (Cruz and Higginbottom 2013). Consequently, I felt it appropriate to write a number of these reflexive pieces throughout the PhD process, and used these accounts to ensure that all potential personal and interpersonal influences were explored and considered appropriately. Indeed, as seen in the personal reflection in Chapter One (pages 2-3), I recognised my own desire to improve outcomes for a vulnerable group, and so was careful to ensure that this did not impact on my data collection or analysis. It was necessary to regularly remind myself that I must be careful not to actively seek things out from the data, or to over-emphasise issues of personal importance. Extracts from my reflexive pieces are woven throughout the thesis, as to allow for a more holistic understanding of the research process.

3.8 Chapter Conclusion

This chapter concludes with a clear methodological framework in place; the adoption of a focused, naturalist, ethnography to explore relationships between midwives and first generation migrant Pakistani women accessing maternity care in South Wales. The following chapter looks at the practical and ethical issues considered during the design of this study; providing a detailed description of the research methods used, and the rationale for doing so. The process of data collection is described, and the difficulties and challenges faced during this time are discussed.

Chapter Four: Research Design and Conduct

4.1 Chapter Aims

The chapter begins with a discussion of the research methods most commonly used in studies adopting the ethnographic approach, which goes on to form the basis of a rationale for the research methods employed in my study. An outline of the design of the study is then provided, along with a detailed research schedule. Following this, accounts are given on the details of the research conduct of the study, including a discussion of the difficulties encountered in the process of recruitment and data collection. Practical and ethical issues considered during the design of this study are then outlined, including acknowledgement of the challenges faced in gaining funding and ethical approval. A number of reflexive accounts are provided throughout the chapter to increase transparency of the research design and conduct. By the close of this chapter, the reader should have a clear understanding of how the study was carried out, and how existing literature was used to support each decision made.

4.2 Selecting Research Methods

4.2.1 Focus Groups vs. Individual Interviews

In the field of maternity care experiences, qualitative studies have used both individual interviews (Puthussery et al. 2008) and focus group discussions (Richens and Smith 2011) to collect data. A large number of studies have used a combination of the two approaches (Lyons et al. 2008; Cross-Sudworth et al. 2011; Essén et al. 2011; McFadden et al. 2012), either in attempts to triangulate results, or in order to accommodate participants' wishes by offering a choice.

Initial planning considered the use of focus group interviews as a primary means of data collection. Focus group interviews are open-ended group discussions which explore a specific set of issues

associated with a predefined topic and a homogenous group of participants (Kitzinger 1994). The use of focus groups, especially with minority ethnic participants, has been actively encouraged by a number of researchers who claim that this approach is particularly useful for encouraging participation of people who are reluctant to be interviewed on an individual basis (Richens and Smith 2011). As participants hear other individuals' responses, their own views can be clarified and challenged in a way which is not possible in one-to-one interviews (Richens and Smith 2011), providing participants with an opportunity for self-interpretation and adding further depth to responses and comments (Richens and Smith 2011).

Despite the potential benefits of focus group interviews, a number of limitations with this approach meant that individual interviews were deemed more appropriate for data collection from my study's participant group. One of the deciding factors was research suggesting that minority ethnic women are twice as likely to worry about embarrassment during care and childbirth as white women (Redshaw and Heikkila 2011); suggesting that they might also experience high levels of embarrassment when speaking on this subject. For that reason, it was felt that minimising the number of people present during interviews (i.e. just myself, the participant and an interpreter, if needed) might help alleviate this embarrassment. Furthermore, previous research suggests that minority ethnic women often prefer not to receive care from midwives from their own culture, due to issues of confidentiality and embarrassment (Cross-Sudworth et al. 2011). Therefore, it was hypothesised that talking about pregnancy issues with women from their own community might prove especially uncomfortable for participants, and consequently lent support to the individual interview approach to data collection. The potential need for interpretation during interviews provided additional support for the use of individual (rather than focus group) interviews; it was expected that the use of interpreters during a focus group might prove difficult, practically, and may reduce the likelihood of accurate transcription.

4.2.2 Interviews: Structured or Unstructured?

For both individual interviews and focus group discussions, the majority of previous research uses semi-structured interviews with the use of a flexible 'topic guide'. These topic guides are either developed from previous literature (Cross-Sudworth et al. 2011; Edge 2011), or from pilot studies/initial focus groups with participants (Lyons et al. 2008). Topic guides can be altered continuously throughout data collection; adding prompts and questions as new ideas and themes emerge. For example Lyons et al. (2008) revised their original topic guide (created through

consultation with maternity service providers and previous literature) after initial focus groups and interviews; removing and adding a number of topics which became apparently more or less applicable than previously thought (Lyons et al. 2008).

Other researchers, however, prefer a slightly less structured approach to interviewing. For example Harper Bulman and McCourt (2002) developed open prompts relating to each stage of maternity care, and left participants to introduce issues they considered of importance themselves. After a few interactions with mothers, common themes emerged, and the authors used these to create prompts to further explore these issues when brought up in subsequent interviews (Harper Bulman and McCourt 2002). Puthussery et al. (2008) and Edge (2011) took similar approaches; beginning with open questions about general experiences, then using prompts and probes to facilitate deeper understanding and clarification of specific topics addressed by participants. Although leaving questions open allows for more information, as participants may raise issues neglected by researchers (Harper Bulman and McCourt 2002), this interview style creates an extremely large amount of data; a lot of which may be irrelevant to the research question (Holloway and Wheeler 1996). It is therefore important to consider the aims of the research in question; while open questions and a flexible topic guide may be appropriate if exploring overall participant experiences, more structured questions may be needed for more specific research questions.

4.2.3 Interviews: Space and Time

Previous studies with a design similar to my own lasted between 30 – 90 minutes, with an average length of around 45mins; focus group sessions generally lasting longer than individual interviews. When conducting interviews on highly emotional, sensitive or private topics, many authors argue that it is best to conduct the interview in as secluded a place as possible, such as at the home of the participant (Adler and Adler 2002). Indeed, the majority of interviews in previous research on maternity care experience were conducted either at the participants' homes (Puthussery et al. 2010; McFadden et al. 2012) or in a 'private setting', such as an office (Puthussery et al. 2008). Some researchers, however, preferred to conduct interviews at community settings, for example church halls (Edge 2011; McFadden et al. 2012). Although ethical guidelines often restrict researchers in terms of their ability to interview participants at home (Bramhagen et al. 2006) a number of researchers argue that this can often be the best approach (Hämäläinen and Rautio 2015). For example, Eggenberger and Nelms (2007) interviewed families in a hospital

environment, and argued that participants may not have been open in their answers, due to being in a strange environment which included many outsiders. A study by Rautio (2013) supports this concept; when participants were interviewed in a university setting, the author noticed that these interviews were more formal than those held at homes. Bearing in mind the pros and cons of different interview locations, I decided that participants should be offered a range of location for interview, including community settings as well as their homes.

4.2.4 The Use of Observations

As discussed, observations are often used alongside interviews to triangulate and confirm emergent themes within the data (Hammersley and Atkinson 1995), thus increasing credibility of findings (Hammersley and Atkinson 1995). Despite providing rich context-bound data, observational methods have not been commonly used in research considering relationships and experiences in maternity care. Indeed, to this day, one of the most well cited observations of minority ethnic women's maternity care remains that conducted by Bowler (1993), over 20 years ago.

The lack of observational data on maternity care for minority ethnic women is surprising, as it is commonly documented that interviews alone are unlikely to provide completely credible data on attitudes and behaviours (Cross 2005). Indeed, participants are likely to underplay or ignore any stereotypes or negative views which might be seen as socially inappropriate (Cross 2005), a phenomena known as 'social desirability' (Crowne and Marlowe 1960). Observations, however, are much less susceptible to social desirability (Cross 2005), as the natural setting of observations allow researchers to collect data in a context which has less potential to be controlled by the participants' wishes to be seen positively (Cross 2005). Therefore, observational data on the behaviour of participants often indicates personal attitudes or beliefs which differ from those reported by the same participants during interviews (Cross 2005).

As well as increasing the credibility of findings, observations also provide the opportunity for informal interviews. For example Bowler (1993) claims that some of the most valuable data in her research came from comments made by midwives during observations. These came about in a number of 'natural interviews'; asking midwives to expand on passing comments, and questioning them further on these issues (Bowler 1993). Indeed Bowler (1993) argues that these natural style interviews are extremely informative, as midwives' encounters with women are the times at which

stereotypes and perceptions are most often and naturally expressed. It is possible to argue that many health care providers may not even realise their own biases or feelings concerning an issue until they are presented with the situation in question (Bowler 1993). Furthermore, observation allows for contextual information that would be missed if using interview alone – for example conversations between healthcare staff, and body language shown during appointments (Bowler 1993). It was decided, therefore, that observation would play a key part in data collection for the current research; allowing for a more well-rounded exploration of sensitive themes associated with the research question.

4.2.5 Observations: Participant or Non-participant?

In qualitative research, observations can take one of two forms; participant or non-participant (Spradley 2016). During participant observation, the researcher interacts with people in everyday life or specific activities, while collecting data (Jorgensen 1989). Non-participant observation, on the other hand, involves observing participants without actively participating, and is used to understand a phenomenon by entering the community or social system involved, while staying separate from the activities being observed (Ostrower 1998).

Of the two approaches, participant observation is most commonly used in ethnographic research, as it is in keeping with the community immersion promoted by ethnography (Jorgensen 1989); the participant observer becomes known within the social setting, and gets to know the community in a more intimate and detailed way than someone who simply observes (Jorgensen 1989). Indeed, Spradley (2016) argues that the participant observer is consequently given much more detailed information than the non-participant observer. Consequently, I assumed the role of a participant observer when conducting fieldwork in the migrant Pakistani community (seen in Phase One of the research schedule, page 63).

In an ethnographic study, participant observation usually begins with the researcher making broad descriptive observations in an attempt to understand common situations and norms (Spradley 1980). Once these data have been recorded and analysed, the participant observer then uses findings from these data to narrow the research to make focused observations (Spradley 1980). The final stage of this progressive focusing (as described in an earlier section) is to narrow the research further to make selective observations (Spradley 1980). Although a clear focus is usually present by the time observations cease, guidelines for participant observation suggest that

general descriptive observations should be continued throughout this progressive focusing (Spradley 1980). Following these guidelines, initial observational data recorded in the Pakistani community and maternity services in South Wales were general and broad. After a number of observational periods, and analysis of the existing data, the focus of observations was narrowed to consider the community relationships, social norms, and cultural attitudes which may impact the midwife-woman relationship for these community members and midwives.

Although the participant observer approach worked well during Phase One community observation periods, this method didn't seem appropriate for observations of antenatal booking appointments in Phase Two. As I was neither a health professional nor a friend or family member of the service user, there was no opportunity for me to be involved in the appointment itself. The non-participant observation approach was therefore taken for this part of the data collection. This approach has a number of advantages as well as limitations. On the one hand, non-participant observation increases the likelihood of the 'observer effect'; where the presence of a researcher will influence the behaviour of those being studied (LeCompte and Goetz 1982) decreasing the credibility of any data collected (Wilson 1977). On the other hand, however, non-participant observation creates easier opportunities for recording data, as the researcher is not required to take part in the activities (Liu and Maitlis 2010). This approach is also often seen as more objective than participant observation, as it avoids over-familiarity with situational norms (i.e. the way in which midwives would normally interact with women in antenatal booking appointments) and allows the researcher to appear impartial in the situation (Liu and Maitlis 2010). As my research took the form of a focused ethnography, it seemed logical to go straight into focused observations of the midwife-woman relationship during antenatal booking appointments. Broad descriptions and general observational data were recorded in parallel with these focused observations.

4.2.6 Observations: Covert or Overt?

When using either participant or non-participant approaches to observation, researchers need to make a decision on whether this observation should be covert or overt (Bulmer 1982). In overt observations, participants are made aware of the researcher's intentions (Bulmer 1982), whilst covert observations are conducted without the participants' knowledge (Bulmer 1982). I decided that overt observation was the best approach for my research. In addition to the moral and ethical advantage of being honest about intentions, overt observation offers a number of practical advantages. If a researcher can find a community willing to accept an observer, for example, ease

of access to this group is likely to be increased, and researchers can be open about what they are interested in and why (Bulmer 1982). This approach also means it is easier for researchers to record data via note-taking or audio/video recordings.

Taking the above issues into consideration, overt observation was the best approach to my research. However, in order to minimise the observer effect mentioned previously, I attempted to 'blend in' with the environment of my research site by mirroring the dress code and body language of others. I also refrained from making any notes during community immersion – instead writing up notes later in the day, or recording voice memos once I had left the area. As will be described later in the chapter, a similar approach was taken to recording observational data for antenatal booking appointments, however some basic notes were taken during these observations in order to record body language during conversations.

4.3 Sample Characteristics

As previously mentioned, it was decided that there would be two participant groups; first generation migrant Pakistani women receiving maternity care in South Wales, and midwives practising in the same geographical area.

The following inclusion criteria were created for participant eligibility:

Migrant Pakistani women

- First generation migrant Pakistani female
- Between 3-6 months pregnant
- Receiving maternity care in the South Wales region
- First pregnancy in South Wales (no experience with maternity care in South Wales previously).
- Aged between 16-45 (increases in maternal risk for individuals above and below this age range)
- No serious illness/conditions which may affect the pregnancy
- No language restrictions

It was decided that no language restrictions would be placed on migrant Pakistani women's inclusion in this research. While the provision of translators comes with unavoidable associated costs (both in terms of finance and time), the exclusion of non-English speaking women ultimately implies a bias towards westernised participants (Harper Bulman and McCourt 2002; Cross-Sudworth et al. 2011). Thus the experiences of those experiencing the most challenges in relation to communication and cultural diversity may be lost. It was therefore decided that there would be no exclusion criteria relating to English language ability; information sheets would be provided in a number of languages common to Pakistan, and interpreters would be arranged for those who required them.

Midwives

- Practising midwife in South Wales
- UK-born
- Experience of providing maternity care to migrant Pakistani women.

No other exclusion criteria were placed on midwives, as I was aware of the risks this would place on creating identifiers for midwife participants. Furthermore, I hoped to include a broad range in the demographics of midwives, in order to be representative of the population.

4.3.1 Sample Size

For qualitative studies, optimum sample size varies with the aims of the research (Holloway and Wheeler 1996). For example, Cross-Sudworth et al. (2011) state that their sample size (15 women) was driven by the availability of participants, the sample sizes of previous research, and the principle of 'theoretical saturation'. Theoretical saturation is a term coined by Strauss and Corbin (1990a) to describe a situation where no new information is obtained from further data collection. There are no fixed sizes or standard tests that can determine the required data for reaching saturation (Strauss and Corbin 1990a), therefore sample sizes are often expanded until saturation has been achieved.

When reviewing the existing literature on minority ethnic and migrant women's experiences of maternity care services, qualitative studies show large variation in the sample sizes used. For example, whilst Harper Bulman and McCourt (2002) and Cross-Sudworth et al. (2011) recruited 12 and 15 participants respectively, Puthussery et al. (2010) recruited 34 black Caribbean, black African, Indian, Pakistani, Bangladeshi and Irish women, Edge (2011) used a population of 42 black

Caribbean women; and McFadden et al. (2012) had samples of 23 Bangladeshi women, 28 health practitioners, and 4 health service managers. One of the largest sample sizes in qualitative research in this area is Essén et al. (2011) who interviewed 39 Somali women and 62 maternal care providers.

Although some qualitative researchers cite small sample sizes as a limitation to the transferability of their findings to other contexts (Harper Bulman and McCourt 2002; Cross-Sudworth et al. 2011), the richness of data produced by the method of theoretical saturation increases the credibility of the findings (Strauss and Corbin 1990b). Small samples are therefore both justified and necessary in qualitative research, as long as the collected data are rich (Cruz and Higginbottom 2013) and data saturation has been reached (Cross-Sudworth et al. 2011; Cruz and Higginbottom 2013). Bearing this in mind, I decided to keep flexible estimates of sample size in mind during the research process, which were based on the richness of data collected, data saturation, and the time limits imposed by the PhD process. My initial estimate for sample size was 20 migrant Pakistani women and 10 practising midwives. As will be seen, recruitment of migrant Pakistani women was harder than anticipated, therefore sample size was much smaller than first estimated. Nevertheless, data saturation was reached during interviews with women, and richness of data was further enhanced through the use of observational data and narrative reviews of relevant media such as government policy and current affairs.

4.4 Recruitment Methods: Migrant Pakistani Women

Difficulties are often reported in recruiting minority ethnic participants for health research (Levkoff and Sanchez 2003; Sheldon et al. 2007). Amongst the explanations for poor recruitment of minority ethnic individuals are mistrust of academic institutions (Giuliano et al. 2000; Levkoff and Sanchez 2003) concerns over confidentiality (Levkoff et al. 2000), and practical issues in accessing the research site – for example travel costs and/or childcare (Sinclair et al. 2000; Levkoff and Sanchez 2003; Rugkasa and Canvin 2011). Additionally, barriers to recruitment can exist when community gatekeepers are unconvinced of the benefit of research to their community (Rugkasa and Canvin 2011), or when undocumented individuals fear that interview information might lead to deportation (Levkoff et al. 2000). Consequently, recruitment of individuals from ‘seldom heard’ populations often leads to more expenditure in terms of time, effort and finance (McCormick et al.

1999). Furthermore, underestimating the potential difficulties in recruiting a population can lead to the utilisation of inappropriate methods of recruitment, resulting in low numbers of participants (Twamley et al. 2009). This often leads to a change in recruitment methods during the course of the research (Twamley et al. 2009), further increasing the cost and consumption of time.

It became clear that careful planning was needed in order to optimise the recruitment of migrant Pakistani women. In order to do so, it was necessary to follow the advice of Richens and Smith (2011), who suggest that “researchers must understand the cultural and environmental needs of their target group and use this knowledge to constantly evaluate the success of their recruitment strategy and data collection method” (Richens and Smith 2011, p. 34). My preliminary fieldwork in the Pakistani community was therefore invaluable for this stage of planning, as was the involvement of my Project Support Group. Representatives for each participant group were able to give advice and support on recruitment methods, and how best to engage with these populations.

During a meeting with this support group, a number of recommendations were made to enhance recruitment. It was agreed that I should:

- Take part in Pakistani community activities and highlight my interest in improving outcomes for migrant women
- Speak to gatekeepers about the potential benefits of my research
- Offer to conduct interviews in participants’ homes

A number of recruitment methods were considered, including snowballing and purposive sampling. An overview of each approach is given below, along with the benefits and limitations of each, in regards to the research aims of my research.

4.4.1 Snowballing

The snowballing technique is one of the most common methods used in research with seldom heard populations, and involves initial participants recommending other eligible participants (Harper Bulman and McCourt 2002). If participants are particularly hard to reach, researchers can begin this approach through the involvement of ‘culture brokers’; individuals who are well known within the community or who are familiar with the culture/habits of the population (Essén et al. 2011). These culture brokers can be used to contact potentially eligible participants, set up initial interviews, assist on follow up interviews, and facilitate further snowballing from this point (Essén

et al. 2011). Whilst Harper Bulman and McCourt (2002) suggest that the snowball sampling method is “invaluable for gaining understanding of cultural norms and building a trusting relationship” (Harper Bulman and McCourt 2002, p. 368), other authors argue that this type of sampling increases the likelihood of homogeneity bias (Twamley et al. 2009); if participants are all connected in some way then it is arguably likely that they will share similar traits such as age and socioeconomic status. This technique is also likely to exclude socially isolated people (Twamley et al. 2009), who often hold the most valuable information.

4.4.2 Purposive sampling

Purposive sampling is an alternative method of recruitment, commonly used in research with minority ethnic populations (Redshaw and Heikkila 2011; Jomeen and Redshaw 2013). Purposive sampling involves the selection of participants based on the purpose of the research; selecting individuals who are expected to have the most knowledge on/experience with this issue (Richens and Smith 2011).

In terms of maternity care research, purposive sampling of women is often performed by midwives during antenatal clinics (Puthussery et al. 2010; McFadden et al. 2012); often using community midwives as ‘gatekeepers’ (i.e. culture brokers) to access vulnerable or hard to reach groups such as minority ethnic women (Richens and Smith 2011). Although Twamley et al. (2009) reported that recruiting women through hospital based antenatal and postnatal clinics proved most effective in terms of participant numbers and demographic diversity, midwives discussed the burden of this recruitment on their already high workload (Twamley et al. 2009).

The use of health professionals in recruiting for research is a frequently debated subject and many researchers stress the care which should be taken to ensure that recruitment does not demand too much of the health professional’s attention (Twamley et al. 2009). In addition to the ethical concerns concerning increased workload, midwives also suggest that this added time pressure results in them prioritising recruitment for studies which they feel are important (Twamley et al. 2009).

Considering the limitations and benefits of the methods above, purposive sampling, through midwife gatekeepers, was selected for initial recruitment for pregnant migrant Pakistani women. Once a few women had been recruited through this method, attempts were made to utilise the snowballing approach. However, none of the migrant Pakistani women involved in my research

reported knowing anyone else who might be eligible for the study at the time, and so recruitment continued to be driven by midwife gatekeepers.

4.5 Recruitment Methods: Midwives

The recruitment plan for midwives was identical to that of migrant Pakistani women. Purposive sampling was conducted by sending out emails to all midwives working with migrant women in South Wales. Snowballing was then used to recruit other midwives eligible for participation. The snowballing approach was much more successful with midwives than migrant Pakistani women – after taking part in the research themselves, a number of midwives passed on my contact details to colleagues and encouraged them to take part.

4.6 Creating a Data Collection Schedule

4.6.1 Cultural Considerations

As discussed, special consideration was made when approaching recruitment of migrant Pakistani women. Along with the previously mentioned recommendations, the Project Support Group member representing the Pakistani community also advised that most (if not all) migrant Pakistani women I recruited were likely to be Muslim, and that I should therefore be mindful of religious holidays and festivals which might affect participants' availability to take part in research. Being aware of religious events is something which is echoed by other researchers working with culturally diverse populations (Lazear et al. 2008; Gater et al. 2010). In terms of the current study this involved taking into consideration the religious practices surrounding Eid and Ramadan.

Ramadan

Ramadan is the ninth month of the Islamic calendar, and is observed by Muslims across the world by a combination of fasting, prayers and charity (BBC 2011). Many will also attend special services in Mosques during which the Qur'an is read (BBC 2011). It is common to have one meal (known as the Suhoor), just before sunrise and another (known as the Iftar), directly after sunset (BBC 2011). As Ramadan is seen as a time to spend with friends and family, the fast will often be broken by different Muslim families coming together to share in an evening meal (BBC 2011). Children,

pregnant women, and those with severe illnesses are not obliged to fast (BBC 2011), however it is common for them to do so.

Eid ul Fitr

The end of Ramadan is marked by a big celebration called 'Eid-ul-Fitr' (also known as 'Eid') – translated into English as the 'Festival of the Breaking of the Fast' (BBC 2011). Muslims are not only celebrating the end of fasting, but thanking Allah for the help and strength that he gave them throughout the previous month to help them practise self-control (BBC 2011).

A number of celebrations occur during Eid, including special services in Mosques, street processions, and celebratory daytime meals (BBC 2011). It is also common, during these celebrations, for Muslims to give gifts to children and spend time with their friends and family (BBC 2011).

In 2015, when I collected data, the dates of Ramadan fell between the 18th June – 17th July, and Eid took place on 18th July (although these celebrations can often continue for a number of days). Interviews with women were originally planned to begin during the first week of July. However, it was anticipated that, due to the festivals of Ramadan and Eid, Pakistani women may be less available to speak with me; many rest during daylight hours of Ramadan, or are busy with family events. Data collection schedules were therefore rearranged to reflect these dates; postponing recruitment and interviews with women until the beginning of August.

4.6.2 Research Methods: Temporal Considerations

When combining the use of interviews and observations in qualitative research, there is debate within the literature as to the correct temporal order of these methods (Hammersley and Atkinson 1995). The current study followed the suggestion put forward by Hammersley and Atkinson (1995); that there is no right or wrong order, but that these methods should be used in accordance with the “best fit” for the research questions in hand (Hammersley and Atkinson 1995, p. 133). Consequently, the research schedule was designed so that antenatal booking appointment observations would be conducted alongside interviews with participants, in order to inform revisions to interview topic guides. As will be seen, observations continued throughout all phases of the study, as access to antenatal appointments became easier once I had existing connections with participants through contact at interview.

Migrant Pakistani women were interviewed at two time-points; once around the time of booking (10-15 weeks pregnant), and then again after their next antenatal appointment (at around 17-18 weeks pregnant). This was designed to capture any change in perceptions of maternity care, or relationship with midwives, as women's pregnancies progressed. As interviews with midwives focused on their general experiences in working with migrant Pakistani women, rather than focusing on a specific temporal relationship, midwives were interviewed at one time-point only.

4.6.3 Research Schedule

Based on the methodological approach of ethnography, along with the aforementioned cultural considerations, the following interview schedule was developed:

- **Phase One (Months 1-3): becoming immersed in the culture(s)**
 - Fieldwork in the migrant Pakistani community (*i.e. attending local focus group/women's group meetings, informal conversations with community elders, volunteering for community-based projects*)
 - Fieldwork in the local health board's maternity services (*i.e. attending refugee and asylum seeker antenatal clinics, attending midwifery team meetings, attending midwifery conferences/educational days*)
 - Reviewing relevant media (*i.e. government policy, reports on public perceptions/attitudes, newspaper reports on current affairs*)
- **Phase Two (Months 4-6): entering the maternity care system**
 - Recruitment of migrant Pakistani women
 - First interviews with migrant Pakistani women (between 10-15 weeks pregnant)
 - Observations of antenatal booking appointments
 - Update topic guides alongside data collection and analysis
- **Phase Three (Months 7-9): midwives' and women's experiences - perceptions and reflections**
 - Second interviews with women, using updated topic guides (between 17-18 weeks pregnant)

- Recruitment of midwives
- Interviews with midwives

Actual data collection differed slightly from this schedule due to issues with recruitment of migrant Pakistani women. Therefore, some midwives were interviewed during Phase Two (recruitment proved easier for this participant group). In practice, this adaptation of the research schedule actually increased recruitment of migrant Pakistani women; midwives became more invested in the research, and seemed to experience more personal accountability for recruiting women. Furthermore, one-to-one contact with midwives, during interviews, gave me the opportunity to explain the study aims in more detail, and to provide midwives with additional participant information packs (many had misplaced theirs since the initial study briefing).

Despite some overlap in the timing of interviews with midwives and migrant Pakistani women, research was conducted closely in-line with the original research schedule. The details of this research conduct are therefore presented below in line with each of the three main phases.

4.7 Phase One: Becoming Immersed in the Culture(s)

In line with the ethnographic approach, Phase One of the research involved immersing myself in the social cultures under study. Becoming familiar with each social culture allowed me to better understand the social worlds of my participants, and gave me insight into the potential recruitment and communication issues I was likely to face.

4.7.1 Becoming Immersed in the Migrant Pakistani Community

In terms of the migrant Pakistani community, part of this immersion was achieved through volunteering for a number of charities providing support and advice to minority ethnic and migrant individuals (BAWSO, Race Equality First, The Mentor Ring). As a result of working with these charities, I was invited to a number of community events to raise awareness for BME and migrant health issues, which led to around 30 hours of working and socialising with members of the Pakistani community. This provided me with opportunities to familiarise myself with the Pakistani culture, provided invaluable information for the design and early stages of my research, and facilitated the involvement of stakeholders.

4.7.2 Becoming Immersed in the South Wales' Maternity Services

In order to familiarise myself with the social world of maternity services in South Wales, I was given permission to complete informal observations of antenatal appointments for asylum seekers and refugees, attended midwifery conferences, and spent some time with midwives to learn about the day-to-day practice of midwifery.

4.7.3 User Involvement

In addition to this fieldwork, a Project Support Group was created. Along with myself, this group consisted of a member of Race Equality First, both PhD supervisors, and an NHS Consultant Midwife. This Group met a number of times throughout the 3 years of the research process, and was involved in discussions regarding ethical/cultural/social issues, recruitment methods, and the creation of participant information materials. Group members were also contacted on an ad hoc basis as needed throughout the study, and provided essential information on topics such as maternity care processes, ways to engage participants in research, and information about Pakistani cultural holidays and traditions.

4.7.4 Reviewing Relevant Media

The collection of media relevant to midwives and migrant Pakistani women began during Phase One, and continued until thesis submission. This involved searching for news stories, healthcare policies, social media posts and government legislation relating to immigration, maternity care, ethnic inequalities and healthcare provision. Searches were carried out under the 'news' and 'scholar' advanced options of an internet search engine, using the key words found in Appendix Three. Additionally, hardcopies of local papers were skimmed for relevant stories on a daily basis, and government and health board websites were searched for relevant policies every six months. Social media posts were also scanned on a frequent basis. A discussion of this media is summarised in the 'Introduction to Findings' chapter.

4.8 Phase Two: Entering the Maternity Care System

As midwives were asked to recruit migrant Pakistani women, I felt it necessary to justify the use of their time by highlighting the importance of the research aims and practical implications of the study. I therefore presented this information to midwives during a monthly team meeting for each

of the midwifery teams covered by the local health board. A short presentation was given, along with time for midwives to ask questions about both the practical and theoretical aspects of the research. Midwives were then invited to take part in the research by recruiting women, giving interviews themselves, and/or giving permission for observations of their antenatal appointments. During these presentations, the role of the midwives in recruitment was clarified, and midwives were reassured that they would not be required to take consent from women, or to provide in-depth explanations of the research.

4.8.1 Recruiting Migrant Pakistani Women

Midwives identified potential participants through antenatal clinic booking records, and provided these women with participant information packs (Appendices Three to Five) on their next appointment. As defined by the sample characteristics, it was necessary to cater to women's potential diversity in language ability when providing study information. During discussions with the Project Support Group, and other members of the Pakistani community, I was advised that literacy in Pakistan was limited to Urdu and English. Therefore written information was made available in these languages only. However, I was advised that a number of languages were commonly *spoken* in Pakistan; the most popular of these being Pashto, Punjabi and Urdu. Study information was therefore made available in these languages in the form of audio tracks on a CD and YouTube videos online; female interpreters⁴ recorded the translated information sheets in Pashto, Punjabi and Urdu, and I recorded an English version myself. During these recordings, the interpreters advised me of slight alterations to wording of the information in order to fit better with language/cultural norms.

Participant information packs therefore included:

- Hard copy documents of the participant information sheet
 - English version (Appendix Four)
 - Urdu version (Appendix Five)
- A CD with audio tracks of the information in English, Urdu, Pashto and Punjabi
- Website addresses for the YouTube videos of the audio tracks above. (Appendix Six)

⁴ See page 70 for a discussion on the use of interpreters in this research

- Website address for the study's dedicated page (containing downloadable versions of the information sheets and the embedded YouTube videos). (Appendix Six)

These packs were provided to all eligible women (through identification from antenatal booking records), in order to reduce the possibility of bias in participant selection by midwives; ensuring that a variety of midwife-woman relationships were explored. In order to minimise workload, midwives were asked only to provide women with these packs, and ask them to fill out a contact form if they expressed interest in the research; no detailed explanation of the study, or consent taking, was performed by the midwife. While inclusion and exclusion criteria were made clear to midwives, it remained my responsibility as chief investigator to confirm eligibility prior to consent.

Due to issues with recruitment, and time constraints caused by hold ups in ethical approval⁵, the final sample size was eight migrant Pakistani women. However, data was also used from one participant's mother, and another's husband, who joined interviews with women. For the purpose of the thesis, these individuals are described as 'migrant Pakistani representatives'. One woman was unable to complete the second interview, as she moved away during data collection. All other participants were interviewed at two time points, as detailed in the research schedule described in section 4.6.3.

Language interpreters were offered to all women at all points of engagement with the study. Despite a wish to include migrant Pakistani women with a range of language ability, and the considerable time and effort put into providing information in a number of languages, the majority of migrant Pakistani women preferred to conduct interviews in English, without the presence of an interpreter. Although one woman who did not speak any English expressed interest in taking part in the research, follow-up calls and texts from the interpreter went unanswered. This lack of diversity in language ability, despite considerable effort being made, reinforces the assumption that there exist seldom-heard women who have limited contact with healthcare services, and more specifically with health research.

⁵ Discussed later in this chapter

4.8.2 Interviews with Migrant Pakistani Women

Preparation

In preparation for interviews with migrant Pakistani women, it was necessary to consider how personal characteristics such as my image and personality might influence interactions with participants and affect data collection. It became clear that there were a number of characteristics which I could change or manipulate (for example I could change my style of dress, or adapt my style of communication to the situation), however there were also a number of characteristics I could not change; namely my gender, age, experience, and race. Due to an inability to change certain personal characteristics, it was necessary to take time to reflect on each of these characteristics separately, and to consider how they might affect my interactions with, and therefore data collection from, migrant Pakistani women.

As suggested, one of the personal characteristics all researchers are unable to change is their gender. Fortunately, it appeared that my gender was likely to be a beneficial personal characteristic for working with migrant Pakistani women, as participants informed me that the Muslim religion dictates that women should not interact with men outside of the family. Although some of my participants complied with this more than others, it was made clear by participants that negotiating access would have been much harder if I were a male researcher. The benefits of being female were especially relevant in terms of the research topic, as many participants voiced their view of pregnancy and childbirth as a sensitive and embarrassing topic to discuss with strangers. A number also claimed that pregnancy was not commonly spoken about amongst Pakistani family members, and especially not with male members of the family. Indeed – as will be seen in the findings chapters, one participant suggested that male members of the family sometimes did not know that Pakistani women were pregnant until the baby arrived.

There were, however, two personal characteristics I felt may be limiting to data collection; namely my age and lack of clinical experience. As will be seen later in the thesis, cultures guided by the Muslim religion tend to favour the knowledge of elders; often respecting experience over formal education. Therefore, I was concerned that some women may feel that it was not appropriate for me to ask them personal questions about pregnancy and childbirth, as I was not a trained doctor or midwife and was in my early 20s with no children of my own. However, in practice, this concern seemed unfounded; women and their male partners frequently expressed respect for the fact that I was doing a PhD, and seemed very interested in, and support of, my research topic. Indeed –

many participants even expressed thanks that this was something that I deemed important to research. Although a couple of women asked about my qualification background (was I a midwife? How did I get into this type of research?), all questions were posed with warmth and genuine interest, rather than a challenge to my position or qualification to carry out the research.

My ethnicity, white British, was another personal characteristic I reflected on before (and during) interviews with migrant women. Initially I was unsure about how my ethnicity might affect my relationship with women, however I assumed that I might get less information from women than if I had been of Pakistani ethnicity myself; I was worried that women may be afraid of being judged, or may think there were issues in existence that I would not understand. However, surprisingly, the opposite seemed true. In fact – women suggested that they preferred discussing private issues with individuals from a different culture, as they felt there was less chance of confidentiality being broken (the Pakistani community in South Wales is tight-knit and it turned out that two of my participants were actually cousins). Participants also suggested that they might be inclined to give less liberal views to a Pakistani researcher, due to fears of being criticised for not following strict cultural or religious traditions.

As mentioned, there were some personal characteristics that were possible to modify for the situation of speaking to migrant women; for example the way in which I interacted with participants. In studies researching depression in culturally and linguistically diverse communities, a number of investigator qualities have been found to be useful for engaging participants (Cardemil et al. 2005; Gater et al. 2010). These include warmth and empathy (Gater et al. 2010), along with cultural sensitivity, multicultural competence, and a familiarity with participants' cultural background (Cardemil et al. 2005). It therefore seemed important, during my interactions with migrant Pakistani participants, to ensure a friendly and open approach, and to demonstrate my respect for the Pakistani culture. This was employed through a number of ways, for example, following cultural traditions such as taking shoes off when entering homes, accepting offers of food and drink, observing prayer time, and learning traditional greetings;

“As-salam-o-alaikum. Mera nam Laura hay”

(Peace be upon you. My name is Laura)

Appropriate clothing was another area in which I made efforts to minimise the researcher effect. It was essential to maintain a professional, yet approachable, appearance - therefore I was conscious

to always wear long sleeved items of clothing (even in the summer), sensible shoes and minimal makeup.

Space and Time

It was important that all participants were made to feel comfortable and relaxed during interviews, therefore both women and midwives were offered their choice of interview location. Previous research suggests that transport and childcare are often inhibiting factors for migrant women's attendance at healthcare appointments (Cantwell et al. 2011), so it was anticipated that the majority of interviews with migrant Pakistani women would take place in the participants' homes. Facilities at Cardiff University, a local hospital and community centres were offered as possible alternatives. As anticipated, all migrant Pakistani women chose to have interviews conducted at their home⁶.

Participants (bar one who moved away) were interviewed at two time-points; once around the time of booking (3 months pregnant), and then again after their next antenatal appointment. Interviews lasted between 20-90 minutes and a flexible topic guide was used to drive the conversation. No notes were written during the interview, although brief reflections were often written or audio recorded immediately after the interview. This allowed me to reflect on aspects of the interview which could not be audio recorded at the time; including explanation of prolonged silences or commentary on body language.

Interview Topics

The aim of the first set of interviews was to explore women's initial expectations of maternity care in South Wales, and how these expectations had or had not been met on their first contact with their midwives. Women were prompted to give detail about their relationship with/perception of their midwife, and expectations about their midwife's role in their pregnancy. Women were also asked their views about the importance of the midwife-woman relationship for their maternity care experiences, and what factors might enhance or inhibit this relationship.

A flexible topic guide (Appendix Seven) was used to lead conversations, however the content of this guide was continuously altered; adding prompts and questions as new ideas and themes emerged from interviews and observations. The original topic guide was developed using the

⁶ As mentioned later in the chapter, lone worker training was completed by the researcher, and lone worker policy was followed at all times.

research aims laid out in section 3.3 (page 35), and question style was influenced by research methods used in previous peer-reviewed literature.

Reflective Account: Obtaining Funding for the Use of Interpreters

During study design, it was expected that many of the women being interviewed may speak little or no English, and so would need interpretation services. Along with practical reasons for the use of interpreters (participants being able to more accurately express their opinions), previous research suggests that interviewees perceive themselves as less confident, less happy and less intelligent when they are required to speak in a second language (Kline et al. 1980; de Zulueta 1990). I decided, therefore, that the use of interpreters might facilitate women in feeling confident and comfortable when expressing their feelings and ideas; women could speak freely in their first language, and this information would be translated back in a culturally relevant way.

However, in order to secure funding for interpretation services, there were a number of barriers that needed to be overcome. Firstly, my initial funding application was rejected by Cardiff University, and it was therefore necessary to explore alternative sources. Although I had been offered these services for free from a number of individuals and organisations (for example the CEO of Race Equality First, a representative from BAWSO, and founders of The Mentor Ring) I was advised, by the ethics committee at Cardiff University, that such practice could hold ethical complications. For example, it would be possible to argue that anyone who was willing to translate for free were likely to have a vested interest in the research, and might therefore be tempted to moderate responses from participants.

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I therefore attempted to seek alternative external funding - a number of sources were contacted however I didn't meet the eligibility criteria for support. Reflecting back on this time, I was close to giving up on the use of interpretation services in my research, and therefore concerned that I might need to make some fundamental changes to my research proposal. Fortunately I managed to appeal the decision on funding from Cardiff University, and I secured the amount necessary to conduct 30 hours of translation through BAWSO.

This experience, however frustrating, was beneficial in that I experienced one of the common issues faced when attempting to conduct research with seldom-heard participants. Indeed, this experience enhanced my empathy for researchers who had undertaken projects with research aims similar to my own, and provided an explanation for the language exclusion criteria, put in place by numerous qualitative studies. Despite the insight provided by my issues with funding, the initial lack of institutional support during this process was extremely worrying to me, as it suggested an indifference towards the equality and inclusion of vulnerable populations.

In practice, only two migrant Pakistani women needed language interpretation during their interviews, and even these women switched between English and Urdu during conversations. As will be touched upon in the discussion chapter, this once again highlights the seldom-heard nature of the most vulnerable migrant populations – despite providing all participant information in a variety of language and media, only those with at least a basic level of English fluency expressed interest in taking part in the research.

Reflective Account: The Practical Issues with Using Interpreters

When using interpreters in any form of qualitative health research, it is important that they have a general understanding of qualitative research (Murray and Wynne 2001), and more specifically a basic understanding of the topic of interest (Murray and Wynne 2001). Consequently I ensured that the commissioned interpreter was thoroughly briefed before data collection began. This briefing also allowed for the exploration any potential cultural differences with regards to accepted interview protocol. As will be seen, this brief evolved into an informal interview with the interpreter, which provided insightful data included in the findings chapters. As this informal interview developed naturally, verbal consent to record data was gained when turning on the Dictaphone, and written consent to use this data was given retrospectively.

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When the interpreter was present, it was necessary to clarify her role in the interview for participants, before the interview began. Women were informed that the interpreter was a registered professional with BAWSO, and that she had signed a confidentiality agreement to protect the woman's anonymity. It was explained that the researcher would ask questions in English, which would then be translated by the interpreter. The participant could then respond in their first language, and the interpreter would translate this back into English for the researcher. All parts of this exchange were recorded by digital Dictaphone, and a small number of extracts were translated by an external interpreter to ensure reliability of translation.

In practice, interviews with the interpreter present proved more difficult than originally expected; judging by women's responses, the interpreter seemed to alter questions slightly, and there were a number of times where the interpreter and participant had conversations in Urdu which were not translated back into English (examples of this are presented as field notes throughout the findings chapters). There was also a tendency for the interpreter to summarise conversations between themselves and the women (sometimes up to five minutes in length) into a short sentence or paragraph when conveying the discussion in English (again – examples are provided in the findings chapters). In fact, it was often necessary for me to press the interpreter for more information, sometimes after guessing at the content of the conversations not translated back to me.

Additionally, the lack of small talk with women, in these interviews, resulted in a more formal and clinical structure of interactions and it sometimes felt as though neither the participant nor I were very comfortable. Indeed, it felt almost impossible to build a good rapport with participants in the presence of the interpreter. It is likely that participants felt the same way, as one woman asked to have her second interview without the interpreter present.

4.8.3 Observations

Focused, non-participant observations of antenatal booking appointments took place in antenatal clinics across the local health board, over a period of 3-6 months. A total of 7 midwives and 15 women were observed during these appointments, which lasted between 20-60 minutes each.

Observations focused on the relationships between midwives and women, and was informed by interview data from Phase One of the research, previous research in the field, and the Supportive Midwifery In Labour Instrument (SMILI) developed by Ross-Davie et al. (2013). The SMILI tool was designed as an objective way to record quality indicators of the midwife-woman relationship; such as demeanour, body language and vocal tone of both the midwife and woman (Ross-Davie et al.

2013). Although I did not utilise SMILI for its primary purpose as a numerical measurement tool, aspects of this instrument (e.g. specific indicators of the client-provider relationship) were used to create a flexible observation guide, which became more focused over time (Appendix Eight).

After antenatal booking appointments, a number of natural interviews arose with midwives. For example, a number of times I asked for clarification of a statement, or an explanation of specific behaviours and/or procedures carried out by midwives during observation periods. Data stemming from these conversations were recorded as field notes immediately after leaving the research site, and allowed for an exploration of feelings as they occurred, therefore providing context for analysis of observation data.

A number of women observed during antenatal booking appointments expressed interest in taking part in other aspects of the research. Consequently, two migrant Pakistani women were recruited to the interview part of the study from these observations.

4.9 Phase Three: Midwives' and Women's Experiences - Perceptions and Reflections

4.9.1 Second Interviews with Migrant Pakistani Women

The second set of interviews with migrant Pakistani women explored how women's initial expectations of maternity care in South Wales were managed throughout their pregnancy, and how women perceived their midwife-woman relationship to have affected the pregnancy so far.

As before, a flexible topic guide (Appendix Nine) was used as a basis of interviews. This guide was based on the topic guide used for initial interviews with women (Appendix Seven), however, as before, the content of this guide was continuously altered; adding prompts and questions as new ideas and themes emerged from data collection and analysis.

4.9.2 Recruiting Midwives

Following ethical and R&D approval from the local Health Board, provisional agreement to use staff in research was sought from the Head of Midwifery of this board. As described above, presentations regarding participation were conducted at midwifery team meetings, in order to

increase understanding of the study, and what participation would involve. Once midwives had been given all necessary information, and approval had been given from the Head of Midwifery, formal email invitations were sent to midwives working in this Health Board. Email addresses were provided by team leaders or midwives themselves. Copies of participant information sheets were sent out with emails, and those who were interested in participating were encouraged to reply to this email, or to contact me via telephone. Midwives proved significantly easier to recruit than women, and the final sample size for midwives was 11.

4.9.3 Interviews with Midwives

Preparation

In order to prepare for interviews with midwives, it was also necessary to consider any researcher characteristics which might affect these interactions. The majority of midwife participants were anticipated to be white British and female, therefore the main areas of concern for this participant group were my age and experience. I considered the possibility that midwives might assume that I would have little experience as I was in my mid-twenties, and I was also aware that my educational background may create scepticism in midwives; coming from a psychology background rather than a clinical registration as a nurse or midwife.

In practice, the perception of my non-clinical background seemed to vary depending on the individual midwife. A minority of midwives, for example, appeared suspicious of my study aims; suggesting that it felt like an accusation of prejudice or racism from midwives. Such feelings of accusation had to be carefully moderated, and I began putting more emphasis on the benefits of the research to both women *and midwives*, and ensuring that the research aims were explained in detail. The majority of midwives, however, seemed to react positively to my non-clinical background – many expressed feeling more comfortable in being honest about their feelings, as there was no fear of being judged by a peer. My lack of clinical registration also seemed to allow midwives to adopt a position of authority on the interview topics, which might not have been possible if speaking to a colleague. This perceived authority seemed to boost midwives' confidence in sharing their opinions and ideas – especially when it came to more controversial topics such as traditional cultural practices and stereotyping.

Time and Space

In terms of arranging interviews with midwives, it was necessary to take into consideration their high workloads and busy schedules. Indeed, the work timetables for midwives added extra challenges for recruitment; many suggested that they did not have time to check emails, reply to text messages, or receive non work-related calls. In order to combat this issue, it was necessary to remain persistent in my approach, and to ensure that every possible step was taken to reduce the time commitment needed for participation. Consequently, regular text reminders were sent to midwives who had agreed to participate, and recruitment emails were re-circulated to midwifery teams every couple of weeks. Awareness of my research amongst midwives was also facilitated by the Consultant Midwife in my Project Support Group. Interview location was also made as flexible as possible – however 10 out of the 11 midwives requested that their interviews be conducted on their lunch break or between clinics.

Interview Topics

Interviews with midwives lasted between 20mins and 60 mins and explored midwives' experiences of working with migrant clients, and with Pakistani women specifically. Midwives were asked about their relationships with these women, and were asked to discuss the barriers and facilitators to establishing these relationships. A flexible topic guide (Appendix Ten) was used to focus interviews and was edited in accordance with data emerging from interviews with migrant Pakistani women, other midwives, and from observations of antenatal appointments. This guide was developed using the research aims laid out in section 3.3 (page 35), and question style was influenced by research methods used in previous peer-reviewed literature.

Questions were sometimes individually tailored to midwives, based on observation data, and their unique responses to questions. As in interviews with women, notes were not taken during the interview, however written reflections were completed once I had parted ways with the participant.

Reflexive Account: Identity as a Non-Clinician

As expressed earlier in this chapter, it was important to acknowledge how my personal experiences and educational background influenced the way in which I collected and analysed data. Specifically, it seemed necessary to consider how my lack of medical training might have affected this process. Despite my initial concerns about researching this topic without a midwifery background, the data collection period allowed me to accept and appreciate the advantages of my own position. For example, the lack of 'insider knowledge' resulted in a lack of bias towards either participant group (midwives or women), and could therefore be classed as a 'true' ethnography as I was immersed in cultures with which I was not originally familiar with.

My impartiality also proved advantageous when it came to the logistics of data collection; a number of medically-trained research colleagues had given accounts of being talked into conducting clinical practice during observations for their research, and had spoken in length about the problems which could occur as a result of both refusing and agreeing to do so. Indeed, through these conversations, it was clear that such instances of clinical involvement often resulted in a change of their status from investigator to health professional, and could influence their relationship with the participant involved. As a result, I often found myself emphasising the fact that I was not a medical practitioner when speaking with participants; assuring women that my role was purely an investigative one (therefore negating any concerns that I might report their views back to their midwife or judge them negatively if they expressed dissatisfaction with the service). At the same time, I reminded midwives that I was unsure of how the maternity care system was supposed to work (therefore providing them with more opportunity to express views or practices which may have been viewed negatively by colleagues).

Despite the benefits of relative independence from both participant groups, there were a number of times where I felt that the recruitment and data collection process may have been easier with a midwifery background. For example, my lack of familiarity with the maternity care system meant that I lacked knowledge such as when might be the best time to observe midwife-woman interactions, at what stage women were likely to have seen their midwives more than once or twice, and how best to promote my research to midwives. I also found myself frequently asking midwives to clarify medical terminology for me; many would forget that I was not medically trained, and would use a variety of medical terms during interviews, with the assumption that I knew what they meant. However, this knowledge deficit was significantly reduced by the fact that both my main PhD supervisor and one of my Project Support Group members are midwives, therefore midwifery information could be sought with ease.

Overall, the benefits of my professional background seemed to outweigh any negatives; allowing me to approach both 'cultures' with the same level of unfamiliarity, and therefore producing an unbiased, impartial lens through which to view data.

4.10 Ethical Considerations

There are a number of ethical issues which have to be taken into consideration when designing and conducting research. The following sections detail how each issue was addressed in this research.

4.10.1 Gaining Ethical Approval

A scientific review of the study protocol was conducted by the School of Nursing and Midwifery Studies (now named the School of Healthcare Sciences) Research Review and Screening Ethics Committee (RRESC) at Cardiff University (Appendix Eleven). The purpose of the RRESC review was to assess the study's scientific merit, and was conducted by an experienced researcher and academic from Cardiff University. Once completed, Cardiff University agreed to act as a sponsor for the research (Appendix Twelve).

Ethical approval was also obtained from the Research Ethics Committee (REC) for Wales (REC reference 14/NW/0145, see Appendices Thirteen and Fourteen), and the study site (Ref 14/CLC/5875, see Appendix Fifteen) through IRAS (ID 120347). The project was accepted on to the local health board's pathway-to-portfolio by the Research and Development lead, and formal support for the study was received in the format of emails from consultant midwives and the Head of Midwifery at the study site.

As touched upon earlier in the chapter, there were severe delays gaining ethical approval from the local health board's Research and Development department, which led to an overall delay of about four months in my PhD process. Despite having been approved by both the School's Research Review and Ethics Screening Committee, and the Research Ethics Committee for Wales, the study was initially denied site-specific ethical approval. Originally it appeared that this was the result of a misunderstanding about the qualitative nature of my research; the reviewer had requested power calculations for my projected sample size. However, despite multiple attempts to explain that a power calculation was not possible to conduct in qualitative research, the decision remained the same, and I was questioned on my ability to act as Chief Investigator for my research. A number of appeals were made against this decision however access was not granted until four months after the original application. As I was determined not to waste time during this four-month appeal process, I authored a paper with my supervisors in the *International Journal of Childbirth* (Appendix One).

Reflecting on this experience, I feel it is important to acknowledge that persevering in my attempt to get site-specific ethical approval for my research was undoubtedly one of the most stressful and disempowering experiences I have ever undergone. As such, I believe that this perseverance is a testament to the belief I have in the importance of my research aims.

4.10.2 Getting Informed Consent

Migrant Pakistani women

All women meeting the study inclusion criteria were given a participant information pack (Appendices Four to Six) by their midwife. Midwives gave a brief verbal overview of what the study involved. If women expressed interest in the research, they were asked to complete a contact detail form (Appendix Sixteen) which was then posted back to me in a postage-paid envelope included with the information packs.

I then contacted these women via telephone, and all questions about the study were answered. Capacity to provide informed consent was assessed through this conversation, then again face-to-face prior to the interview. Individuals were asked about translation requirements, reminded of the study procedure, and an interview date was booked.

Informed consent was discussed with participants at initial contact and then again prior to interview. Participants were reminded of their right to withdraw at any time, and were asked to confirm that they were still happy to take part. If the participant agreed to continue, consent forms (Appendix Seventeen) were signed, and verbal consent was recorded at the beginning of each individual interview.

Midwives

Midwives were emailed a participant information sheet with their invitation to take part in the study. Capacity to provide informed consent was assumed due to their role as a practising midwife, and both verbal and written consent were gained at the start of the interview. Consent forms can be found in Appendix Seventeen. As with the women, midwives were reminded of their right to withdraw at any time.

4.10.3 Maintaining Confidentiality

Participants were fully briefed on all areas of confidentiality, and how this would be met. Details of this are listed below.

- All interviews were recorded using a digital voice recorder. Audio files were transferred to a secure university drive as soon as possible after each interview and the recording was then deleted from the voice recorder. I completed all transcription myself, and was the only person to listen to these audio files (with the exception of a few extracts which were sent to an external interpreter for validation). During transcription, interviewees were allocated identification numbers and all identifiable information was removed from transcripts.
- All personal identifiable data were, and still are, kept in accordance with Cardiff University guidelines; all data, including consent forms, audio recordings and transcripts, are stored securely using a combination of locked cabinets and password protected computer networks. All data will remain stored securely for fifteen years after completion and can be accessed only by myself.
- All interviews were conducted in a location of the participant's choice, and I ensured that this location provided the participant with privacy (unless the participant wished to have another individual present).
- For interviews with women, the interpreter (used for two interviews) was fully briefed about confidentiality and was required to sign a confidentiality agreement prior to engagement in the research. The interpreter's presence in interviews was at the request of the participant only.
- All contact detail forms were destroyed after final interviews with each participant. This was the only place where participants' full name, address and telephone number were recorded. Although this meant that it would not be possible to contact participants for dissemination of the findings, participants were given an approximate completion date for

the study and advised to contact me after that date if they wished to read a summary report.

4.10.4 Participant Withdrawal

Participants were informed of their right to withdraw from the study at any time, and without providing a reason. I reminded participants of this right to withdraw at each point of contact, however none of the recruited participants withdrew from the study. One migrant Pakistani woman only completed one out of two interviews, as she moved away from South Wales.

4.10.5 Benefit and Harm

No reward, financial or otherwise, was offered as an incentive to take part in the study and there was no suggestion of any direct benefit to the participant, other than the therapeutic benefit of participating in an interview (Hutchinson et al. 1994). Nevertheless, I informed participants that they would be contributing to research which aimed to enhance maternity care experience for both migrant women and midwives.

There was no anticipated risk involved for participants of this study. It was acknowledged, however, that some participants could have found some of the questions emotionally provocative. With this in mind, all participants were given an informal verbal debriefing, including ways to access appropriate information (for midwives this referred to details for the NHS staff support systems in place, and migrant Pakistani women were given details of community support organisations, such as Race Equality First, who would be able to assist with services such as counselling and making formal complaints). None of the participants expressed a need to follow up on these services, and no visible distress was detected at any point during interviews or observations.

Prior to observational data collection, it was decided that in the event that I observed poor practice, antenatal clinic managers would be immediately informed, and observation would cease until the matter had been investigated and resolved. No such cases were observed therefore this protocol went unused.

Lone Worker Policy

As I was working alone, and often visiting the homes of participants, it was necessary to put a lone worker policy in place to prevent risk of harm to myself. Guidance and policy statements to

manage the risk of lone working were sought from Cardiff University Security Services. Training in this management of risk was undertaken, and the following steps were carried out to ensure that this guidance was followed:

- A risk assessment was completed and discussed before lone working began; a safe work method was drawn up and agreed upon.
- Regular communication with PhD supervisors was maintained.
- All necessary steps were taken to avoid putting myself at risk, either from the work activity itself or as a consequence of the work environment.

4.10.6 Storing Data

Collection and storage of data followed the eight core principles of the Data Protection Act (1998).

- Interview and observation data were anonymised as soon as possible, using a coding system, so that individuals could not be identified.
- All data, including audio files of interviews, written fieldnotes, and consent forms, were stored in a locked cabinet in a locked room with limited access.
- All computerised data, such as transcripts and fieldnotes, were held on my university computer, which is password protected.
- Computerised data, such as the above, were occasionally stored temporarily on my personal laptop computer, which is also password protected, however these data were deleted as soon as they had been transferred to the university computer.
- Neither the university computer, nor my personal laptop, were left open or unattended at any time whilst working on the data, and passwords to access these computers were changed at regular intervals.

- Stored data are only accessible by my main PhD supervisor and I. In accordance with the guidance from Cardiff University's Research Governance Framework, the data will be retained for a period of no less than 5 years, or at least 2 years post publication.

4.10.7 Quality and Rigour of the Research

It was essential to maintain the quality of the research at all times, in order to justify the time involved in this project; both in terms of the participants and myself and to ensure that the research findings were robust enough to ultimately contribute to knowledge and practice. However, unlike quantitative research, the quality of qualitative research cannot be measured by statistics such as confidence intervals and confounding variables (Noble and Smith 2015). Instead, qualitative researchers aim to design and incorporate methodological strategies to ensure the 'trustworthiness' of the findings (Noble and Smith 2015). This 'trustworthiness' is described in a number of different ways by qualitative researchers, including terms such as 'quality' and 'rigour' (Nakkeeran and Zodepy 2012). Although there exist a number of different criteria available for use in assessing the rigour of qualitative research (Houghton et al. 2013), the most commonly used are those proposed by Lincoln and Guba (1985); Credibility, Dependability, Confirmability and Transferability.

Credibility

Credibility refers to whether or not findings of a study accurately reflect the experiences and feelings of participants (Lincoln and Guba 1985). Indeed, one of the most common issues with qualitative research is the subjective nature of data interpretation (Nakkeeran and Zodepy 2012). Consequently, qualitative researchers attempt to reduce this issue through participant validation (Harper Bulman and McCourt 2002), external validation (Lyons et al. 2008) and a mixture of peer and participant validation (Edge 2011). Participant validation can be done during or after data collection, and involves asking participants to either affirm or reject summaries made by researchers on their views, feelings, and/or experiences (Mays and Pope 1995). External validation, on the other hand, involves an external qualitative researcher analysing the data independently and checking for consistency between findings (Long and Johnson 2000). In my study, both approaches were used. Participants were given a verbal summary of the issues discussed at the end of interviews, and were asked to confirm that these general themes were

representative of their views. Sections of transcripts were also given to both academic supervisors to read, and supervision meetings were held to discuss identified themes.

A reflexive diary was kept throughout the three-year PhD process. This was created in order to maintain self-awareness during the research process by describing and interpreting my experiences as I went along; a process often used by researchers to enhance credibility of findings (Guba and Lincoln 1989). As will be seen, a number of reflexive accounts are included throughout this thesis in order to provide the reader with a better understanding of my actions and decisions.

An additional credibility strategy, employed in my research, was that of transparency of interpretation of data; ensuring that all findings and interpretations were discussed in relation to, and supported by, data extracts throughout. Observational data were also used to assess the credibility of data from interviews.

Transferability

Transferability refers to whether or not the findings of the research could be transferred to other contexts (Lincoln and Guba 1985). As transferability is dependent upon the degree of similarity between two contexts (Guba and Lincoln 1989), qualitative researchers propose that the original context of the study must be described adequately so that a judgement of transferability can be made by readers (Guba and Lincoln 1989). As will be seen in the next chapter, detailed demographics of participants are reported, alongside a description of the study site characteristics and a discussion of the social and political context at the time of data collection. By providing this information, I aim to aid the reader's understanding of the original research context, and facilitate transferability to another setting if applicable.

While it could be argued that findings from my research could not be reliably transferred out of the context of the relationship between migrant Pakistani women and South Wales' midwives, as will be seen in the discussion chapter, I argue that some of the issues experienced by participants may well be experienced by other migrant populations, and therefore may be transferable and provide a good base for future research.

Dependability and Confirmability

The dependability of research is the extent to which the conduct of the study has been carried out according to accepted procedures (Lincoln and Guba 1985), and confirmability considers whether

the researcher has acted on these in good faith or demonstrates bias (Licoln and Guba 1985). Both the dependability and the confirmability of the current study were enhanced by exposing the data, and my interpretation of it, to the scrutiny of other social scientists, namely my PhD supervisors. Both supervisors undertook 'blind' coding of a number of anonymised transcripts, which was then discussed during supervision meetings. Members of the Project Support Group undertook a similar activity – reading a number of extracts and reporting their interpretation of these data. Themes produced by my supervisors and the other members of the Project Support Group matched my own interpretation of the data, therefore suggesting confirmability of results. Data interpretation continued to be discussed with these team members for the duration of the project, in order to maintain this rigour.

The maintenance of a detailed research diary and reflexive accounts also facilitated a critical approach to the study; extracts included in the findings chapters provide a means whereby others are able to audit the process, by providing transparency in terms of the contextual background to idea formation and data analysis (Bryman 2001). The first person account of the study's methodology, provided in this chapter, draws heavily from the contents of these reflexive accounts, in order to enhance this transparency and thus trustworthiness.

As a result of these steps the study demonstrates sufficient quality and rigour and has avoided researcher bias. Indeed, many authors of qualitative research claim that once issues of trustworthiness have been addressed, qualitative methods provide an excellent framework for exploring women's experiences of maternity care (Cross-Sudworth et al. 2011). It is acknowledged, however, that there will always be a number of limitations in research that need to be identified and addressed, and these will be explored further in the discussion chapter.

4.11 Data Analysis: Thematic Analysis

As discussed, data were collected through audio recordings of interviews, written observation notes and general field notes. After many of the interviews, I would drive a short distance from the interview location and record verbal reflections on the dictaphone. Most of these recordings lasted no longer than 5 minutes and there was no set format for these reflections. The aim was to record all of my initial thoughts to refer back to later in conjunction with the transcripts.

Transcripts of interviews were supplemented with these notes, along with brief field notes about the behaviour of the participants (body language, context of interview, etc.). Relevant media was reviewed over the course of the PhD, to provide contextual background to findings.

Data were analysed using the thematic analysis framework described by Braun and Clarke (2006). Thematic analysis involves the searching across a data set to find repeated patterns of meaning (Braun and Clarke 2006) and often follows a data-driven inductive approach; allowing the data to lead the theory, rather than vice versa. Inductive reasoning prevents analysis being driven by the researcher's theoretical interests (Braun and Clarke 2006; Puthussery et al. 2008), and allows for conclusions which are strongly linked to the data (Braun and Clarke 2006)

In contrast to other methods such as IPA, or discourse analysis, thematic analysis is not wed to any pre-existing theoretical framework, and so it can be used flexibly within a number of different theoretical frameworks. The exact form and product of thematic analysis varies between projects, however, and so it is important that researchers give in-depth explanations of the approach taken to analysis in order to provide transparency to the reader (Braun and Clarke 2006). As such, each phase of analysis is described in full in the following sections.

4.11.1 Phase One: Transcription and Familiarisation

Interviews were transcribed in full (including pauses and interruptions) as soon as possible after the interview. All transcription was completed myself, so that continuous updates could be made to the interview topic guide; listening back to interviews allowed for the immediate identification of questions which were similar to each other, unnecessary, or missing. Transcribing all interviews myself also provided me with a deeper understanding of the data; requiring focused attention on the exact words used by participants, and the need to interpret meaning from incomplete sentences using other verbal clues such as intonation, tone and patterns of language.

In addition to personally transcribing all interviews, transcripts were read or listened to in their entirety at least 3-4 times. The first stage was to read the transcript whilst listening to the audio recording in order to ensure accuracy. This was also an opportunity to add additional comments, such as body language or the use of humour. This approach proved invaluable, as repeatedly listening to interviews allowed me to 'hear' participants' voices while conducting computer-aided analysis of transcripts; allowing me to recall the emotion and emphasis attached to specific words or phrases, therefore providing context and enhancing reliability of meaning.

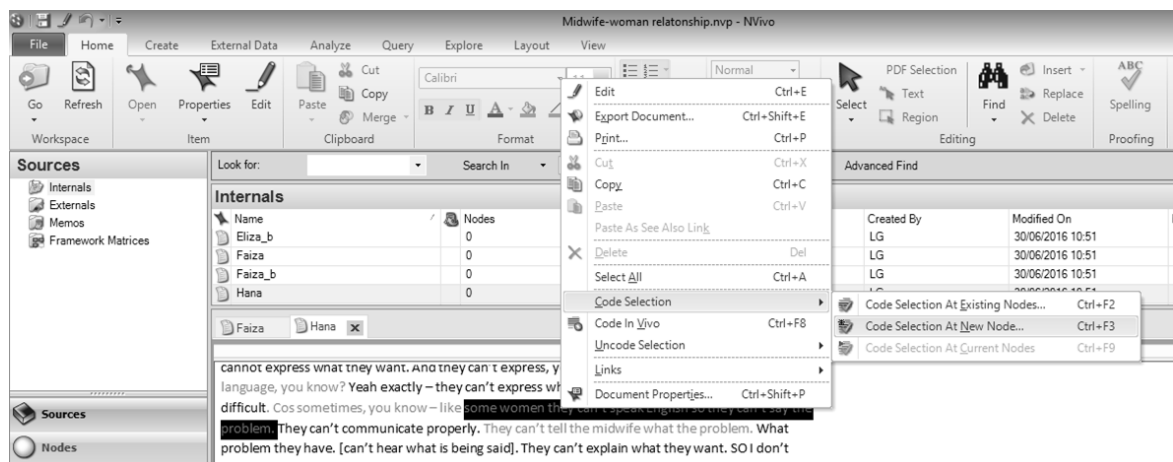
4.11.2 Phase Two: Initial Noting

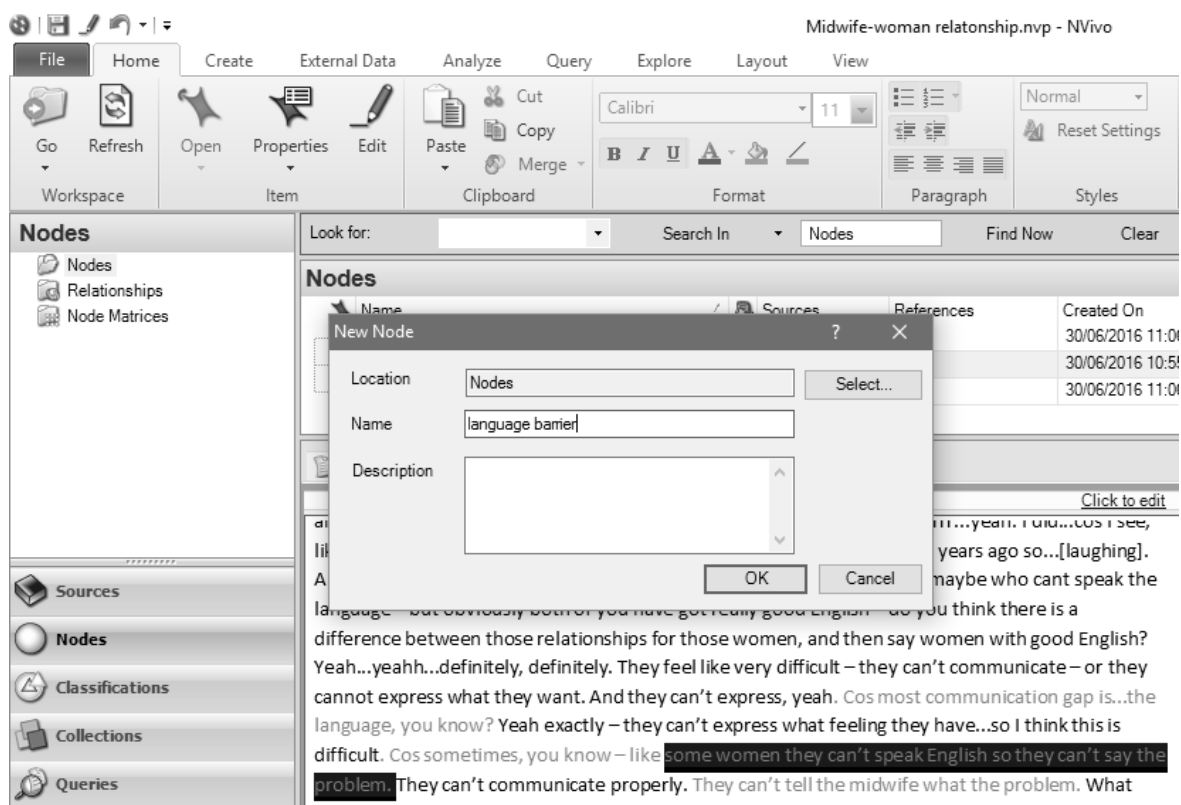
Transcripts and fieldnotes were created and read using Microsoft Word. During the third read-through of participant interview transcripts, common themes and topics which appeared of specific importance to participants were highlighted and comment boxes were used to record corresponding notes. This process allowed me to immerse myself further in the data, and to recognise common themes emerging across transcripts. By the end of this phase, I had created an initial list of ideas about what was in the data and what was interesting about them.

4.11.3 Phase Three: Generating Initial Codes

In thematic analysis, codes are used to identify a feature of the data that appears interesting to the analyst, and refer to “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis 1998, p. 63). The process of coding is the first step in organising data into meaningful groups (Tuckett 2005).

Initial coding was data-driven; codes were formed from the data, rather than approaching the data with specific codes in mind. Transcripts were imported into NVivo 10, and selections of text relating to potential themes/patterns were coded using the ‘node’ function of NVivo (see example below).





Surrounding text was often included in the extract coded in NVivo, in order to provide context when revisiting data. Many extracts were coded under a number of different nodes. For example, the following extract from Faiza was coded under both ‘learning English’ and ‘authority of mother-in-law’

My cousin, like, came from Pakistan. And she want to learn, like, English – so in Birmingham she want to go. And the mother in law...she said “oh – you don’t need to go and learn English - you sit at home and cook” and they really want to go. But yes...some mothers – they don’t want them to go.

Faiza

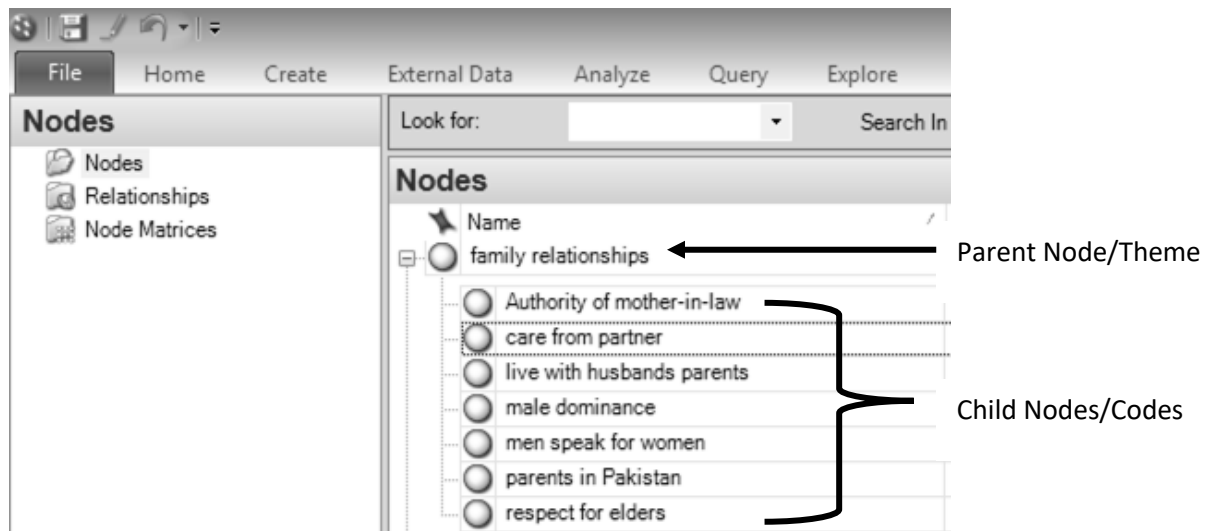
This initial coding resulted in the identification of common codes across interviews; as well as mentally noting the frequency of codes, the number of references and sources relating to each node, displayed in the NVivo programme, gave a good indication of which codes were most common across transcripts.

4.11.4 Phase Four: Searching for Themes

The fourth phase of analysis involved using the identified codes to develop potential themes. In thematic analysis, a 'theme' is described as a concept which captures a response or meaning which holds importance in relation to the research question and is built through repeated and patterned instances of this meaning within the data (Braun and Clarke 2006; Edge 2011). However Braun and Clarke (2006) suggest that researchers must make a personal decision on what qualifies as a theme in terms of their research. For example, whilst some researchers rely on the concept of prevalence (i.e. the amount of data relating to this theme), others assess themes on the relevance of data to the aims of the research (Braun and Clarke 2006).

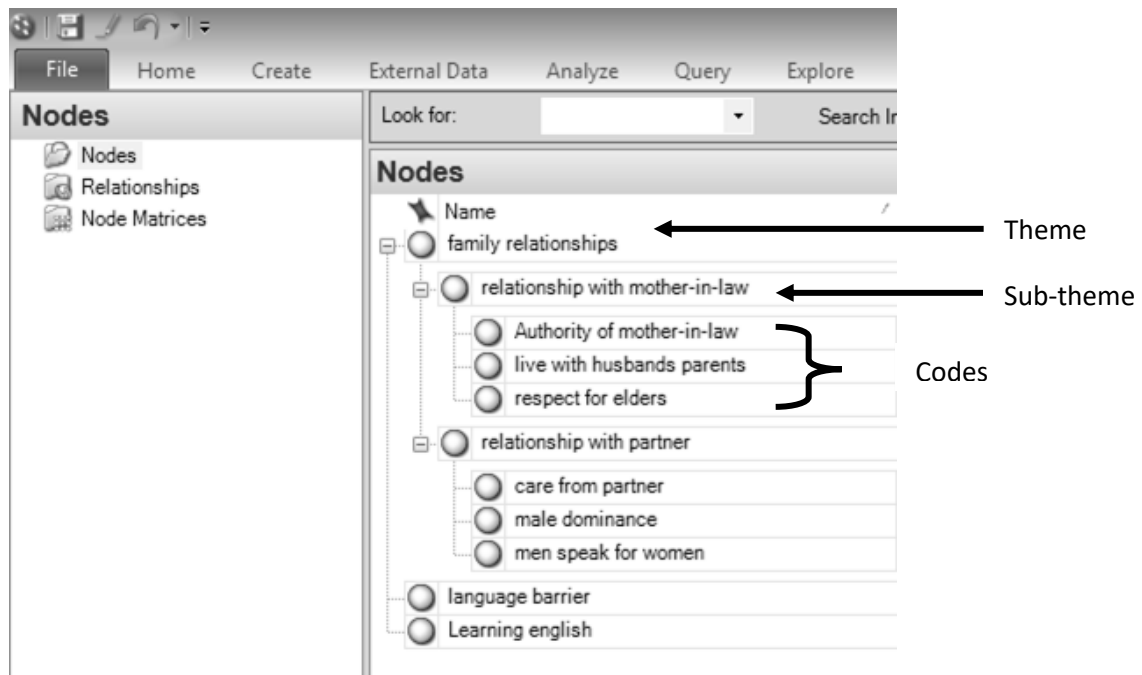
After considering the possible ways to approach the creation of themes, I decided that a flexible guide was most appropriate; themes would be identified based on the prevalence of corresponding codes, the emotional delivery and body language accompanying the corresponding extracts, and consistency across data sets (i.e. interviews and observations).

The codes created in NVivo were reviewed in terms of their relationship to other codes (labelled in NVivo as 'nodes') and many were combined to create themes (labelled in NVivo as 'parent nodes').



As a result, all of the corresponding data extracts within these themes were collated, and could be viewed either under the heading of the theme (parent node) or individual code (child node).

From this stage of analysis, I began to make distinctions between the different levels of themes (e.g., main overarching themes and sub-themes within them). This hierarchy was portrayed in NVivo by the use of node levels, seen below.



A number of codes did not seem to fit within any of the main themes identified during this process and were therefore aggregated into a parent node of “miscellaneous” (later revisited during recoding).

4.11.5 Phase Five: Reviewing, Defining and Naming Themes

During this phase of analysis, themes created using initial codes were reviewed and refined. This meant reading all of the collated extracts for each theme, and considering whether or not they formed a coherent pattern. As a result of this process, a number of themes were combined, some were broken into separate themes, and others were re-conceptualised. Themes were reviewed and refined until data within each theme was coherent and meaningful, and clear and identifiable distinctions existed between themes. Each theme was named, and short summaries of each theme were written to describe the key points in each theme, and how they related back to my initial research aims. At this stage in the analysis I identified a tendency for participants to attribute

views onto others. Data relating to this idea of 'otherness' were therefore collated and are presented as a 'meta-theme' within the findings.

As outlined in the research schedule, data were analysed alongside collection, to identify themes for inclusion into interview topic guides. This progressive, iterative, process of analysis involved repeatedly returning to the original source of the data to ensure that identified themes were truly inductive in nature (Srivastava and Hopwood 2009). In practice this meant a constant process of collecting data, carrying out analysis, and using findings to guide the next piece of data collection (i.e. altering interview topic guides).

As a consequence of this iterative approach to data analysis, complex relationships between existing themes were identified, and I decided to build a visual model in order to better understand the complexities of these data. Following from this, data were revisited and coded through the lens of this model to allow for an assessment of the extent to which data were accurately represented by this visual illustration. A full discussion of the development of this model is provided in section 5.7, page 118.

4.12 Chapter Conclusion

In this chapter I described the design and conduct of the research, along with reflexive passages to provide rationale for the decisions made. In practice, the qualitative nature of my research produced a wealth of rich and fascinating data, which would have been unobtainable through the use of quantitative methods. Indeed, perhaps the most persuasive argument for the value of this qualitative approach, is that the findings differ in many aspects from my initial expectations.

By combining observational and interview methods, I was able to explore the midwife-woman relationship from a number of different angles, and thus examine not only how woman and midwives view these relationships, but also how these interactions play out in real-life settings. Furthermore, by adopting an iterative approach to data collection and analysis, I was able to generate new insights, which will be described fully in the following findings chapters.

4.13 Reminder of the Research Aims

Before discussion of the findings, it seemed appropriate to revisit the specific aims of this research, so that the reader might have these fresh in mind.

As laid out at the start of the chapter, the main aim of this focused ethnography was to explore relationships between migrant Pakistani women and midwives in the South Wales region; focusing on the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. The underpinning purpose of the study was to add to the body of knowledge about ethnic and migrant inequalities in pregnancy experiences in the UK.

The next three chapters of the thesis present findings from this exploration of midwife-woman relationships; beginning with an 'Introduction to Findings' chapter which describes the social and political context in which data were collected. The subsequent chapter focuses on data from migrant Pakistani women, and the final findings chapter explores data from midwives. This thesis ends with a discussion chapter; exploring the similarities and differences between data from women and midwives, and analysing these findings against the existing literature.

Chapter Five: Introduction to Findings

5.1 Chapter Aims

The first part of this chapter introduces the context in which data were analysed. Detailed demographics of the women participants are given, and the relevant social and political issues are discussed. This includes a discussion of the immigration and midwifery issues which arose during the course of my research, along with consideration of the ways in which these issues may have influenced the collected data.

The second part of this introductory chapter provides an overview of key themes from the data, and describes the consequential development of a novel social ecological model of midwife-woman relationships. Although this model of relationships was refined a number of times throughout data analysis and discussion, the final version is presented at the conclusion of this chapter, in order to allow the reader to approach the subsequent findings chapters with this model in mind.

Part One: Placing the Data in Context

5.2 Study Site Characteristics

The study site was a maternity unit within a health board in South Wales, which provides care to around 6,000 women annually. Services include an alongside Midwifery led Unit, and tertiary fetal medicine and neonatal services. The health board employs around 14,000 staff in total, including around 300 midwives (StatsWales, 2015).

The city from which women were recruited is a city in South Wales, with a population of approximately 354,000 (ONS 2015). The largest proportion of individuals are between 20-24 years old, and 51% of the city's population are female (ONS 2015).

5.3 Participant demographics

In order for data to be analysed holistically, it was necessary to note individual characteristics of participants which may have affected the data collected.

5.3.1 Migrant Pakistani Women

As defined by the inclusion criteria, all women recruited to the study were first generation migrant Pakistani, and were accessing Welsh maternity care services for the first time. Social factors varied between women; whilst some participants lived in the affluent areas and had spouses in high-paid jobs, others resided in more deprived areas and tended to have spouses in manual or routine labour. The potential impact of individuals' social factors on findings was taken into account whilst conducting interviews, however emerging data indicated consistency in themes between women from socially and ecologically diverse backgrounds.

Detailed information of each participant, including marital status and parity, is given below (Table 1). Demographics of additional migrant Pakistani individuals who took part in interviews (including one participant's husband, another participant's mother, and the language interpreter) are included in this table. All names are pseudonyms.

Name	Description	Age	Miscellaneous characteristics
Aleena	Pregnant migrant Pakistani woman	32	Married (to Rehan), lived in UK around two years. Aleena's father is a doctor in Pakistan.
Eliza	Pregnant migrant Pakistani woman	17	Newly married (to her cousin). Lived in UK for about 13 years. Live with mother (Rukhsa) and younger siblings. Husband lives in Pakistan – waiting for Visa for him to live in UK.
Faiza	Pregnant migrant Pakistani woman	28	Married – living with husband. Second baby – first born in England six years ago. Previous ectopic pregnancy (in Wales) last year. Lived in UK for about eight years - six years in England, two years in Wales. Husband has lived in UK for one year.
Hana	Pregnant migrant Pakistani woman	26	Married and living with husband. Lived in UK for about seven years.
Liyana	Pregnant migrant Pakistani woman	30	Unmarried - living with partner. Previous child born In England with ex-husband – history of domestic violence. Lived in UK around four years – lived in Wales just over a year.
Nimra	Pregnant migrant Pakistani woman	24	Married – living with husband. Lived in UK around three years.
Zoya	Pregnant migrant Pakistani woman	35	Married – living with husband. Lived in UK around 15 years.
Sara	Female language interpreter	47	Married – husband lives in Pakistan. Lives with two teenage sons (born in Pakistan). Lived in UK around 10 years.
Rukhsa	Mother of Eliza	56	Married. Mother of Eliza. Lives with husband and three children. Lived in UK for about 13 years.
Rehan	Husband of Aleena	35	Married to Aleena. Lived in UK for about 10 years. Rehan's mother is pharmacist, and his father is a doctor (both living in Pakistan).

Table 1: Participant demographics for migrant Pakistani participants

5.3.2 Midwives

All midwife participants were UK-born community midwives. It was decided that further demographics (such as time in practice or seniority) would act as possible identifiers in such a small sample so this information was not collected. The possible limitations of this decision will be explored in the discussion chapter.

5.4 The Context of Immigration

The effect of rising immigration on UK maternity services was a key part of my rationale for undertaking this research. However, the importance of immigration issues further increased as my project progressed. Indeed, a number of events occurred between 2012 (my start date) and 2015 (the end of my data collection), which had a significant negative impact on public perception of immigration, and of Muslim migrants specifically.

It is possible that such public negativity towards migrant populations may have impacted my data collection; influencing the ways in which migrant Pakistani women spoke to me about their experiences, and interacted with their midwives. It is also possible that midwives may have modified their language about immigration and working with migrant populations, due to awareness of current events. It is therefore necessary to outline the context of immigration during the course of my PhD, to afford the reader the same insight I had when analysing my data.

5.4.1 Public Opinion of Immigration in the UK

In the last 20 years the UK, as in the rest of Europe, has witnessed a marked increase in right-wing social movements and political parties which are intensely focused on the perceived ‘threats’ posed by immigration (Hogan and Haltinner 2015). These parties, such as the British National Party (BNP), frame immigration as a multifaceted threat; suggesting that not only is immigration a threat to security (Hogan and Haltinner 2015), but that it also reduces wages and increases the cost of living for UK-born citizens (Hogan and Haltinner 2015). Mainstream political parties have appeared to lend weight to these concerns by adopting more restrictive policies on immigration, and supporting increased monitoring of Islamic groups within Britain (Renton 2005; Pitcher 2006; Richardson 2008). As argued by Hogan and Haltinner (2015), even when mainstream political parties are critical of the more extreme stance taken by parties such as the BNP, media coverage of these criticisms alone helps define the groups as newsworthy. As a result, immigration features highly in current UK media reports, with an overwhelming focus on the perceived need to restrict and reduce population inflow (Clayton, 2014). Public opinion polls clearly reflect this media attention; recent surveys suggested that the majority of respondents felt that there were too many migrants in the UK (Blinder 2015), that fewer migrants should be given UK residency (Blinder 2015), and that legal restrictions on immigration should be tighter (Blinder 2015). In fact, a briefing

released by the Migration Observatory at Oxford University in August 2015 (Blinder 2015) suggested that approximately three quarters of people in Britain favour reducing immigration.

Similar findings are shown when looking at data from Ipsos MORI's 'Issues Index', where members of the public are asked to give their opinion on the 'most important issue to face the nation'. The most recent Index found that immigration/immigrants were most commonly ranked as the most important issue (46%), followed by concerns over the NHS (34%) and the economy (25%)⁷. In fact, as seen in Figure 1, immigration has consistently ranked among the top four 'issues facing Britain' since the early 2000s. Despite some coding error issues, the Ipsos MORI results appear reliable (Jennings and Wlezien 2011), and similar patterns have been found by other polling firms, including Gallup and YouGov (Blinder 2015).

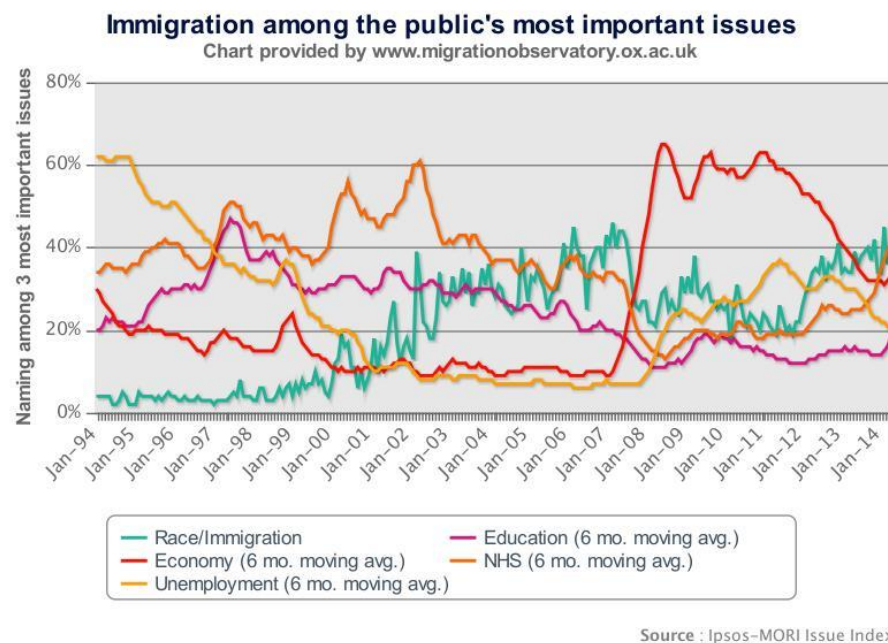


Figure 1. Percentage of respondents naming race relations/immigration as one of the most important issues facing Britain 1994-2015

⁷ [https://www.ipsos-mori.com/researchpublications/researcharchive/3715/Economist-Ipsos-MORI-March-2016-Issues-Index.aspx#gallery\[m\]/0/](https://www.ipsos-mori.com/researchpublications/researcharchive/3715/Economist-Ipsos-MORI-March-2016-Issues-Index.aspx#gallery[m]/0/)

Consistent with the above polls, results from the British Social Attitudes survey in 2013 (Ford and Heath 2013) suggested that large numbers of UK citizens endorsed reducing immigration. Indeed, over 56% chose that they thought immigration to Britain should be 'reduced a lot', while 77% chose either 'reduced a lot' or 'reduced a little' (Figure 2). The same question yielded similar results on the British Social Attitudes survey in 2008, suggesting that these are likely to be reliable estimates.

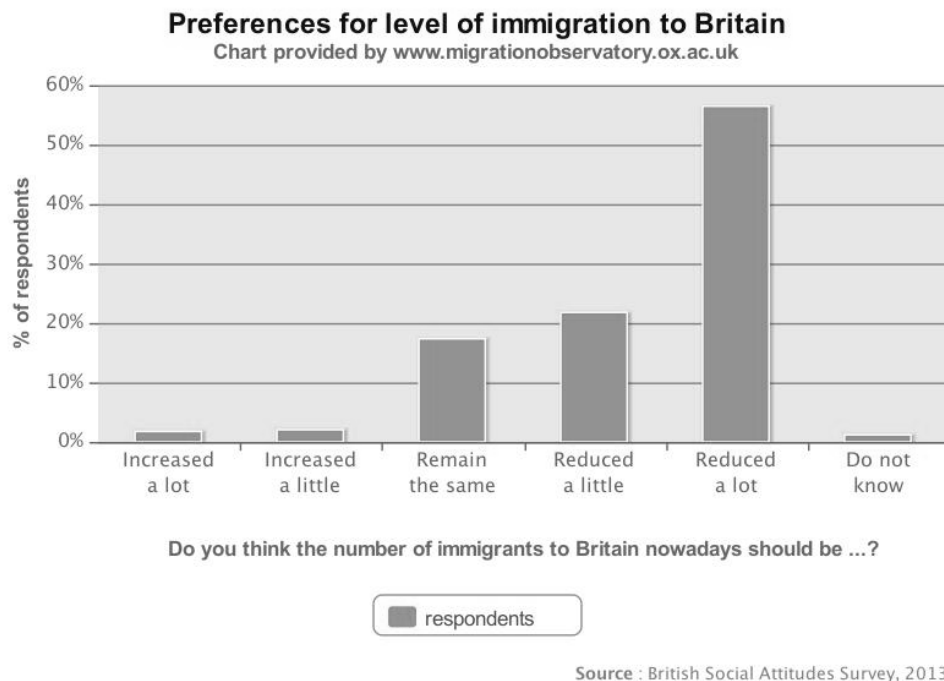


Figure 2. Preferences for level of immigration to Britain.

Although there is general agreement that negative perceptions of immigration are widespread in the UK, there is some debate over the reasons behind this negativity (Hogan and Haltinner 2015). For example, whilst some argue that personal experiences with migrants tend to influence individuals' attitudes (Blinder 2011), it appears that these experiences cannot sufficiently predict an individual's response to questions about immigration. Indeed, in research by Blinder (2011), only 16% of white UK-born respondents reported their neighbourhoods as problematic in terms of race and migration relationships (Blinder 2011). However, results from public opinion polls suggest opposition to migration runs well above 16% (Ipsos MORI 2016) and, as shown by Blinder (2011), even those who viewed their neighbourhood relationships as diverse and cooperative tended to

support reducing immigration 'a lot'. Such findings suggest that an individual's preference to reduce migration is not likely to be based on negative personal experiences with the migrant community (Blinder 2011), therefore other causes must be considered.

One of the alternative causes of negative perception of immigration is inarguably the powerful influence of the media (Allen and Blinder 2013). Indeed, authors on public perception of immigration claim that Britain's national newspapers play a critical role in framing the country's discourse on such issues (Allen and Blinder 2013; Hogan and Haltinner 2015). In order to explore the way in which immigration was being portrayed by British media, Allen and Blinder (2013) conducted a quantitative analysis of the language used in all news stories, letters and other published content dealing with migrants and migration by all twenty of Britain's main national daily and Sunday newspapers, over the period of 2010-2012. With the aid of computational technology, the authors set out to determine which words most often appeared in close proximity to their four key target words; migrants, immigrants, refugees, and asylum seekers. The authors found that throughout the 43 million word corpus, 'illegal' was the most common modifier of 'immigrants' (Allen and Blinder 2013), 'migration' and 'asylum' were linked to words such as 'terrorist' and 'suspected' (Allen and Blinder 2013), and water-related words were used as metaphors for migration; including 'flood', 'influx' and 'wave' (Allen and Blinder 2013). Such terms infer a deluge of dangerous immigrants; inarguably framing the context of immigration in a negative and threatening way. In fact, strikingly similar terminology was found in threat narratives constructed by political parties across the USA, UK and Australia (Hogan and Haltinner 2015), which led authors to propose the emergence of a transnational right-wing 'playbook' of these terms (Hogan and Haltinner 2015). In late October 2014, a term from this 'playbook' was used in a headline from the Daily Mail; reporting claims that migrants were 'swamping' parts of the UK.



Figure 3. Front page of the Daily Mail, 27 October 2014

The above headline referred to statements made by Conservative Government Defence Secretary Michael Fallon, and former Labour Home Secretary David Blunkett, who were quoted as saying that some areas of the UK felt “under siege” and that action was needed “to prevent whole towns and communities being swamped by huge numbers of migrant workers”.

The following month, the UK Independence Party (UKIP) released a statement suggesting that babies born to UK immigrants should be classed as migrants, despite the fact that the party leader’s own two children would be included in that category⁸. Although UKIP did not suggest that the citizenship of those born in Britain was in question, party lead Nigel Farage tweeted his concerns that if children born in the UK were included in the statistics “84 per cent of population growth between 2001 and 2012 – or 3.8 million – was due to migration”⁹.

⁸ <http://www.independent.co.uk/news/uk/politics/ukip-says-babies-born-to-immigrants-in-the-uk-should-be-classed-as-migrants--which-would-include-nigel-farages-own-children-9884841.html>

⁹ As above

A blue decorative graphic consisting of several overlapping, semi-transparent shapes that create a sense of depth and movement, located at the top left of the page.

Reflexive piece

As a result of UKIP's consistent focus on immigration, and the potential "dangers" of this inwards movement to Britain, there appeared to be an increase in discussion surrounding this issue not only in official, but also social, media. As a regular Facebook user, I was constantly exposed to anti-immigration propaganda, and unsupported "facts" about immigration from social media accounts such as "Britain First". A number of my friends are first generation migrants (although I had never thought about them in those terms before), and it was awful to see the way in which this negative media portrayal of immigration could have significant personal impact on them.

When I first began my PhD journey, my main aim was to develop a project which might contribute towards improving outcomes for a vulnerable population. This was the common theme of my previous research; I had completed one study on the living and transfer conditions for adults with learning disabilities, another project which looked at barriers to employment for young adults with learning disabilities, and had written a dissertation on the relationship between false confessions and interrogation style. Most of these projects had, unsurprisingly, met with general support and positivity; it is rare to find negative public opinions regarding individuals with learning difficulties, or those wrongly convicted of a crime. However, although vulnerability in populations usually promotes empathy and support, I began to find that the same response was not elicited by the vulnerability experienced by migrant Pakistani women. In fact, I experienced a number of uncomfortable conversations regarding my research aims.

For example, when I first began my research I was explaining my aims to a couple of acquaintances who had recently had a baby in South Wales. The father (misunderstanding my research completely, it would seem), interrupted me with a comment along the lines of "oh yes, it's awful – there was a Chinese couple in the labour room next to us and the woman just wouldn't stop screaming. It was unnecessarily loud and I felt so awful for the midwives. They couldn't understand a word each other were saying and the midwives were obviously so frustrated with them. If they are going to use our health service, then they should learn the language". I was extremely put out by this comment and quickly changed the subject of conversation.

Since this incident, this misunderstanding of my research has proven increasingly frequent. My reaction depends greatly on my relationship with the individual; friends I will correct, whereas with strangers (for example taxi drivers – an incident which happened recently) I tend to change the subject. Such negativity towards migrants, I feel, has been fuelled by a public acceptance of the negativity towards immigration. Indeed, racist and discriminating posts about immigration have become progressively common on social media, and I myself have 'unfriended' a number of acquaintances on my Facebook account for sharing such posts.

5.4.2 Events affecting perception of immigration

The following section discusses a number of events which occurred during the course of my research (late 2012 until early 2016), and suggests the way in which these events are likely to have contributed towards the increasingly negative public perceptions of UK immigration.

Threats to health; The Ebola 'crisis'

A commonly perceived 'threat' of immigration focuses on the health crises which immigrants are often accused of bringing with them (Hogan and Haltinner 2015). Right-wing political parties across the globe propose links between immigration and increased cases of illnesses such as Tuberculosis, AIDS, aggressive strains of influenza, and Ebola (Hogan and Haltinner 2015).

The claimed link between immigration and increased cases of Ebola was especially relevant during the course of my research, as in early October 2014, UK news reported on the first known case of someone contracting Ebola outside of Africa; raising concerns over spread of this disease to European countries (World Health Organisation 2015). It was quickly publicised that Ebola virus causes an acute, serious illness which is often fatal if untreated (World Health Organisation 2015) and links were made between immigration and the potential spread of this disease (Hogan and Haltinner 2015). Many suggested that it was only a matter of time before fears about immigrants, terrorism, and Ebola were combined into a supercluster of anxiety. Indeed, Robin Wright, a fellow at the Woodrow Wilson International Center and the United States Institute of Peace, claimed that fears over the spread of Ebola were "increasing racial profiling and reviving imagery of the 'Dark Continent'" in both Europe and the United States¹⁰. Similar thoughts were put forward by a writer for a British newspaper, The Guardian, who suggested that the Ebola outbreak was being portrayed as "a new emergency, a new threat, a new reason that black bodies cannot be allowed to infiltrate the borders of nations that our blood and sweat have built...disease and disorder must be contained to preserve health and hierarchy" (Giorgis 2014). Support for this view came from a poll conducted by YouGov in October of 2014¹¹, which suggested that 88% of British people viewed the Ebola outbreak as an important news story.

The perceived link between the Ebola outbreaks and immigration soon resulted in action, as Mitt Romney, two-time presidential candidate, urged the United States to close its borders to nations experiencing Ebola outbreaks (Goodwin and Chemerinsky 2016). Acts of prejudice soon followed across the United States in the following months; Navarro College, a community college in Texas, announced in a letter to an applicant from Nigeria that it would not be admitting any students from countries with known Ebola cases (Goodwin and Chemerinsky 2016), two students from Rwanda (over 2600 miles from the closest affected country) were asked to stay home from school

¹⁰ <http://edition.cnn.com/2014/10/09/opinion/wright-ebola-racism>

¹¹ <https://yougov.co.uk/news/2014/10/09/big-rise-uk-ebola-worries>

for three weeks (Goodwin and Chemerinsky 2016), and a principal who travelled to Zambia, another country with no reported cases, was placed on administrative leave for a week (Goodwin and Chemerinsky 2016). More explicit acts of prejudice were seen in Washington, where it was reported that immigrants from West Africa were being stigmatised, with people moving away from them on public transport, refusing to shake their hands, and being asked to leave work by their employers (Brown and Constable 2014).

Threats to Security: The Rise of ISIS

Along with the perceived threat to health, immigration is often linked to concerns regarding national security in the UK and across the globe (Hogan and Haltinner 2015). This became increasingly common over the 3-year course of my PhD, which coincided with the rise of The Islamic State of Iraq and Syria (ISIS).

ISIS, also known as the Islamic State of Iraq and the Levant (ISIL), were established in April 2013 and initially consisted of members of the terrorist group Al Qaeda (Stern and Berger 2015). The organisation showed a clear drive to establish an Islamic state in the Middle East ruled by strict 'shariah law' - the religious legal system governing the members of the Islamic faith (Glazzard 2015). Strict compliance with this religious system often goes against human rights (especially women's rights), and is therefore highly contested across many nations (Hajjar 2004).

Between study design and write-up of this thesis (2012-2016), ISIS carried out a number of terrorist attacks across the globe. In 2014, James Foley became the first American citizen to be killed by the group; his beheading was filmed and the video released online (Stern and Berger 2015). Later that year a British Aid worker, David Haines, was also beheaded on camera (Stern and Berger 2015), and in September 2014, an ISIS spokesman called on supporters to attack in the West – using whatever tools were at hand (Glazzard 2015).

In September 2015, ISIS laid siege to Kobani, a Kurdish-dominated town in north-central Syria, causing about 130,000 Kurdish refugees to flood into Turkey (Steed 2016). The US launched airstrikes on Kobani in early October, in attempts to prevent ISIS from taking over the town and gaining additional smuggling routes to arm fighters (Fedorov 2016). However, the further influx of refugees to Turkey created a humanitarian crisis, and prompted Turkey to seal the border with Syria (Solomon 2016). Furthermore, despite airstrikes by the US, terrorist actions by ISIS

continued; in October 2015, ISIS members detonated a bomb aboard a plane leaving from Sharm el-Sheikh airport in Egypt, killing all 224 people on board (Fedorov 2016).

In November 2015 The Sun newspaper suggested that British Muslims should publicly denounce the actions of ISIS (Steed 2016). A day later, the Muslim Council of Britain put out a statement in the national press which “unreservedly” condemned these actions (Steed 2016). Despite this action, further calls have since been put out by Western leaders for Muslims, as a whole, to speak out against ISIS (Steed 2016). There has been controversy over these calls, however, as many reporters note that Muslims should not be held responsible for the actions of a minority group (Greenslade 2015), especially as more Muslims have died at the hands of ISIS than non-Muslims (Steed 2016). Indeed, it has been suggested that such demands for a special response from Muslims is in danger of inciting anti-Muslim sentiment amongst Western populations (Greenslade 2015).

Threats to security; The Charlie Hebdo attack

On the 7th January 2015, brothers Cherif and Said Kouachi opened fire in the Paris offices for French satirical magazine Charlie Hebdo, killing 12 of the magazine’s staff. The attack was believed to be an act of revenge; the magazine was known for its derogatory cartoons of the Prophet Muhammad, and witnesses said they had heard the gunmen shouting “We have avenged the Prophet Muhammad” and “God is Great” in Arabic.¹² Following the main attack, a number of police officers and members of the public were killed in related events spanning the next two days.¹³

Threats to Security: Finding Someone to Blame

As seen during the Ebola crisis, population anxieties became clustered; the actions of ISIS and the Charlie Hebdo incident had already been generalised to the Muslim population by many (Greenslade 2015; Steed 2016), and the large number of Muslims amongst Syrian refugees led to these individuals being labelled as potential terrorists (Steed 2016). Adding fuel to these anxieties ‘The Sun’, a daily tabloid newspaper published in the United Kingdom and Ireland, released new ‘data’ from a self-conducted poll in late November 2015 claiming that nearly one in five British Muslims has sympathy for Jihadis (Figure 4).

¹² <http://www.bbc.co.uk/news/world-europe-30708237>

¹³ As above



Figure 4. Front page of the Sun newspaper – 23rd November 2015

This ‘exclusive poll’ was conducted for The Sun by Survation (a UK polling organisation) after the terrorist attacks in Paris by ISIS, and the results were similarly reported by other British newspapers, including The Daily Mail, The Daily Star, and The Times. However, on further reading of the poll results, it became clear that this title was misleading; at no point during the poll were ISIS or Jihadis mentioned, in fact the poll simply asked ‘How do you feel about young Muslims who leave the UK to join fighters in Syria?’ The survey did not distinguish between those who had gone to fight for Islamic State and those who had joined other factions in Syria, such as the Shia militias and Kurds. As a result of this lack of distinction, more than 2,000 complaints were made to the Independent Press Standards Organisation about The Sun’s coverage of this poll; suggesting that it had violated Clause One of the Editors’ Code of Practice (accuracy). Although The Sun refused to make any retractions, the polling organisation Survation quickly distanced itself from the reporting, and other papers released corrections for this information. For example, The Times later stated in its ‘Corrections and Clarifications’ section that its headline was misleading.

While debates continued about the reliability of findings from The Sun’s poll, the effect of the Paris attacks on the Muslim population in the UK was clearly visible; a report to the Government’s

working group on Islamophobia showed a 300 per cent increase in reported hate crimes against Muslims in the UK in the week after the Paris terrorist attack (Wright 2015).

5.4.3 Potential Effects on Migrant Pakistani Participants

As discussed above, negativity towards the migrant Muslim population increased in UK newspapers and social media over the course of my research. Some researchers have even gone so far as to suggest that Muslims in the West have emerged as the new “folk devils of popular and media imagination” (Chakraborti and Garland 2015, p. 115), where Islam is understood as a violent political ideology, religion, and culture (Awan and Zempi 2016), and followers of this faith are seen as disloyal and dangerous citizens, challenging national laws and values and threatening peace and security (Britton 2015).

In an in-depth qualitative study by Choudhury and Fenwick (2011), the authors reported that both Muslim and non-Muslim participants felt that Muslims, as a group, were often viewed as responsible for the actions of terrorists (Choudhury and Fenwick 2011), and that this had led to increased aggression towards Muslim members of their community in the form of verbal and sometimes physical abuse (Choudhury and Fenwick 2011).

Although no research has yet been published on the effect of these specific incidents on public perception of immigration, previous literature shows a consistent association between terrorism and increasing discrimination against Muslims (Åslund and Rooth 2005; Gautier et al. 2009; Goel 2010; Hanes and Machin 2014). In the United Kingdom, for example, there was a rise in Islamophobia and racism immediately following the terrorist attack in London on July 7, 2005 (Baker 2015; Hogan and Haltinner 2015), and increases in anti-Muslim hate crime were reported following the terrorist attacks of 9/11 in the US (Byers and Jones 2007; Hanes and Machin 2014). Similar findings are shown in Europe; researchers Elsayed and de Grip (2013) found that perceived societal integration of migrant Muslims decreased significantly in the Netherlands following a series of fundamentalist Islamic terrorist attacks in Europe, with no evidence for a negative trend in this integration prior to the attacks (Elsayed and de Grip 2013). The geographic segregation of Muslims also increased significantly after these attacks (Elsayed and de Grip 2013). More recently, the activities of Islamic State militants have seemingly legitimised anti-Muslim attacks both in person and online (Dodd and Williams 2014).

Paradoxically, although it seems as though the majority of negativity towards Muslim individuals occurs as a result of terrorist attacks (usually carried out by men), UK data suggests that Muslim *women* suffer most as a consequence of these incidents (Wright 2015). Indeed, of the 115 reported hate crimes towards Muslims in the week following terrorist attacks on Paris, the overwhelming majority of these victims were Muslim girls and women aged between 14 and 45 (Wright 2015). A large number of the reported attacks were in public places, or on public transport, and many of the victims suggested that no one came to their assistance or even consoled them (Wright 2015). Although seemingly illogical to target Muslim women as a reaction to the acts of male terrorists, it is argued that such gender biases result from an ease of identification (Wright 2015); Muslim women are more easily identified than Muslim men due to their adherence to traditional dress and customs. Such findings are extremely relevant to my research, as all of the migrant Pakistani participants wore traditional dress, and adhered to religious norms such as prayer times and minimal socialising with men.

As seen, increasing negativity towards the immigrant Muslim population pre-dates data collection, as does terrorist action by ISIS. It must therefore be acknowledged that migrant Pakistani women in my study may already have been affected by these issues; potentially preventing them from saying anything which could be seen as negative during interviews, or even from volunteering for participation in the research, for fear of repercussions. Indeed, feelings of vulnerability, or concerns regarding negative backlash, may have resulted in women feeling hesitant to voice any complaints or concerns about their care, and may have influenced the way in which they described their relationships with health professionals.

The effects of these issues must also be considered in terms of their potential impact on midwife participants. For example, it is possible to argue that negativity towards working with migrant Pakistani women may have been influenced by midwives' interpretation of the media-proposed links between immigration and crises such as Ebola and acts of terrorism. Alternatively, such media coverage may have made midwives more aware of the political issues surrounding immigration and the Muslim population; therefore resulting in a more careful expression of their opinions during interviews, in order to avoid seeming prejudiced or racist.

5.5 The Context of Midwifery and Healthcare

When considering the social and political environment in which participants were situated whilst taking part in my research, it is also necessary to discuss the changes made to the context of UK maternity care between 2012 and 2015.

5.5.1 Criticisms of UK Maternity Care

At the start of my research process, criticism of UK maternity care was fresh in the minds of healthcare staff; a number of recent reports had highlighted failings in specific units (O'Neill et al. 2008) consequently leading to national investigations of care (Healthcare Commission 2008). Concerns over UK midwifery practice were first raised in 2006 after community involvement led to high-profile uncovering of a number of failures in midwifery units across England (Healthcare Commission 2008; O'Neill et al. 2008). Although the focus was on England, such concerns were seen as relevant across the UK. The most highly publicised of these failings involved the North West London Hospitals NHS Trust, where an investigation was carried out following an abnormal number of maternal deaths (Healthcare Commission 2008). Findings from this investigation identified a number of shortcomings, including inadequate levels of staffing, poor team-working and poor communication by staff with women (Healthcare Commission 2008). Investigations at other sites suggested similar issues, leading the commissioners to believe that there may be a more systemic national problem in maternity care in England (Healthcare Commission 2008).

As a result of these findings, the Healthcare Commission decided to undertake a review of the whole maternity service in England, starting in early 2007 (Healthcare Commission 2008). The resulting report suggested that levels of staffing were well below the average, consultant obstetricians did not spend the time recommended by their professional body on labour wards, doctors and midwives did not attend in-service training courses consistently across trusts, there were too few beds and bathrooms, particularly in labour wards, and there was not adequate continuity of care for women (Healthcare Commission 2008). The report also suggested that women experienced poor communication, and inadequate care and support after their babies were born (Healthcare Commission 2008).

Around the time that the Healthcare Commission report was published, an independent inquiry into England's maternity care services was undertaken by The King's Fund (O'Neill et al. 2008), in order to provide an impartial review of the state of maternity services. Although the authors claimed that findings from the report "should provide some reassurance to prospective mothers and their families" (O'Neill et al. 2008, p. xxiii) they also claimed that there was "much to be done to make maternity care in England as safe as it could be" (O'Neill et al. 2008, p. xxiii). Indeed, as discussed in the literature review chapter, a maternal mortality report, published by the Centre for Maternal and Child Enquiries in 2011, found major differences in mortality rates based on women's socioeconomic status, ethnicity, and migrant status (Cantwell et al. 2011). In the consequent summary report for midwives (also 2011), authors suggested that many cases of maternal mortality could have been avoided if midwives had carried out practices appropriately (Garrod et al. 2011). In terms of minority ethnic and migrant women, authors posited that the provision of appropriate interpreting services could have changed the outcome for a number of cases (Garrod et al. 2011). Recommendations were therefore made, to midwives, to ensure better provision of interpretation services for appointments, alongside written information in a variety of languages (Garrod et al. 2011).

Midwives' knowledge of these ethnic inequalities, and resulting recommendations, is especially relevant to my research, as it suggests a possible sensitivity towards questions about their relationship with these client groups.

The Francis Report

In addition to the direct criticism of UK maternity care, general healthcare services in the UK suffered a heavy blow in 2013, with the publication of what is commonly known as 'The Francis Report' (Francis 2013). This report built on evidence from an inquiry in early 2010 which contained damning criticism of the care provided by the Mid Staffordshire NHS Foundation Trust; suggesting that patients were left in excrement in soiled bed clothes for lengthy periods, assistance was not provided with feeding or toileting, wards and toilet facilities were left in a filthy condition (Francis 2013), and staff treated patients and those close to them with what appeared to be "callous indifference" (Francis 2013, p. 13). The report found that systemic failings had been missed by local scrutiny committees and public involvement groups (Francis 2013), and that these failings were only uncovered through complaints from patients and their family members, alongside concerns over uncommonly high mortality rates. The report concluded that what happened at the

Trust was the result of a system failure, as well as a failure of the NHS organisation as a whole (Francis 2013), and the author concluded by calling for a fundamental change in culture across the NHS.

Although the Francis report did not focus on maternity care specifically, failures were reported to be far-reaching across NHS departments. Such public concern about the state of care in the NHS would therefore arguably spread to all areas of healthcare; impacting on the public opinion of the quality of maternity care that midwives were likely to be providing.

The Morecambe Bay Report

Shortly after the publication of the Francis report, The Morecambe Bay Investigation (Kirkup 2015) was launched by the Secretary of State for Health in 2013, following concerns over serious incidents in the maternity department at Furness General Hospital. Cases between 2004-2013 were reviewed, and findings suggested that serious failures of clinical care had led to the unnecessary deaths of at least one mother and eleven babies (Kirkup 2015). The report suggested that the clinical competence and knowledge of staff fell significantly below the standard for a safe, effective service, and that these staff had often ignored organisational guidelines (Kirkup 2015). Furthermore, when confronted with evidence of poor practice, many of the maternity unit staff denied that there was a problem and rejected criticism in way which, on occasion, turned into hostility (Kirkup 2015). The investigation panel concluded that the maternity staff under investigation had reinforced each other's view that the care they were providing was acceptable (Kirkup 2015), and developed a 'one for all' approach when faced with external criticism from the panel – describing themselves as “the musketeers” (Kirkup 2015, p. 17). This inward-looking culture of midwifery practice was heavily criticised by the panel, who suggested that the needs of women and their families serviced by this unit were being relegated below the needs of the midwifery staff (Kirkup 2015).

Similar to the Francis Report, findings from the Morecambe Bay report suggested that failings in care were missed not only by the Trust itself but also by organisations including the North West Strategic Health Authority, the Care Quality Commission, the Parliamentary and Health Service Ombudsman and the Department of Health (Kirkup 2015). These missed indicators once again indicated a wider-reaching failure of the system (Kirkup 2015), which had clear implications for midwives working in other Trusts across the UK. Indeed, at the 2015 annual meeting of the Royal

College of Midwives, Chief Executive Cathy Warwick suggested that “the terrible truth is right now everything Dr Bill Kirkup found could be happening elsewhere and will continue to happen unless we (midwives), not just others, do something about it” (Royal College of Midwives 2015). Although the findings of the Morecambe Bay report were not published until March 2015, the start of this investigation was made public in 2013, therefore midwives included in my research would have had full knowledge of this.

Increasing Demand on Services

Alongside concerns about the quality of maternity care, reports from 2012 suggested an increasing demand on these services. For example, a report published by the Royal College of Midwives (RCM, 2012) detailed the number of births that took place that year, compared to the number of births for which the midwifery workforce was suited. The report suggested that whilst there were 694,241 babies born in England in 2012, the number of midwives working in the NHS in that year was only suitable for 565,245 births (RCM, 2012); meaning there were 128,996 more births than the service was designed to cope with. Furthermore, an ONS report for the same time period reported that 25.9% of births in England and Wales were to mothers born outside of the UK (Office for National Statistics 2013b), a number which has risen steadily during the course of this PhD (Office for National Statistics 2015). The proportion of ‘complex’ births (i.e. multiple births, women over 40, or women with obesity or pre-existing medical conditions) have also increased in recent years (Morse, 2013), placing additional pressure on midwives and maternity services in general (Morse 2013). Indeed, the latest State of Maternity Services Report (Bonar, 2015) suggests that NHS maternity services in England remain thousands of midwives short.

According to the Birthrate Plus measurement tool¹⁴, midwifery staffing in Wales is reported to be of a good standard. However, it has been argued that the statistics behind this tool does take into account complex births and specialised midwives, so this finding must be viewed with caution.

5.5.2 Changing Guidelines on Interpretation Services

As seen in the literature review, the number of UK births to foreign-born women rose over the course of my research (Office for National Statistics 2015). Consequently, due to the

¹⁴ Current Welsh maternity care guidelines state that all maternity units in Wales now have to be Birthrate Plus compliant; Birthrate Plus looks at the number of women in maternity services, and predicts the number of staff needed for gold standard care (<http://www.birtherateplus.co.uk/>). To be Birthrate Plus compliant, units must fit with these staffing numbers.

recommendations made in the NICE guidelines for care of these women (NICE 2010), it would be logical to assume that the need for interpretation services in maternity care also rose.

However, changes made in local health board guidelines from the research site did not seem to reflect this increased need. Whilst interpretation guidelines from 2010 advised the use of face-to-face services for antenatal care appointments, and the use of telephone services for intrapartum care, later guidelines created in 2013 advised that face-to-face interpretation services should be limited to women with complex pregnancies.

Such changes were introduced due to an increase in cost of interpretation services; in 2013 face-to-face service provision was swapped from 'English for Speakers of Other Languages' to the costlier 'Wales Interpretation and Translation Service'. A 2014 finance review of these new services suggested a significant increase in expenditure, which now stood at between £5-7k a month. In order to alleviate the pressure of these increased costs, face-to-face translation was restricted to those with complex pregnancies.

Despite these new recommendations, at the time of submission of this thesis, such guidelines had not been formally published. Indeed, the most recent guidelines available to midwives were those from 2013; recommending the use of face-to-face interpretation with no restriction on complexity of case. Consequently, as seen in the fieldnote extract from observational data below, there existed inconsistency, confusion, and tension on this topic amongst midwives working at the study site between 2013 and 2015.

Observation – Midwifery team meeting

Has been fed back to midwives that too much money is being spent on interpretation services. Midwives seem very frustrated by this. A number of midwives suggesting they were told that they weren't using this service frequently enough – now being told they are using it too much. Criticised for over-spending. Frustration over the apparent U-turn in guidance. Anxiety and confusion over future use – do they use them or not? One midwife especially upset – suggest they are being reprimanded for following instructions. Says it is unfair. Team leader suggests using services when "necessary". Some debate over when is necessary.

Prolonged discussion on this. Clear tension surrounding this issue. Most appear to feel that interpretation services are difficult to use, costly and unsuitable. Frustration over interpreters turning up to appointments which they had not been booked for (women had asked interpreter directly). Also annoyance at having to pay for an hour of translation when only used for a 10-15 min appointment. Now seen to be causing them further issue as they are being criticised for the cost of using them. One midwife suggests imposing model where women arrange (and pay for) own interpretation services – bring them with them, rather than provision from NHS. This proposal met with general agreement from other midwives in the team.

5.5.3 Potential Effects on Participants

It is possible that the discussed changes in local interpretation service guidelines may have impacted on midwives' views on working with migrant Pakistani women. For example, it is possible that their frustration about the use of interpretation services may have manifested in negative feelings towards the women who need these services. The lack of clear guidelines on the use of interpretation services may have also resulted in inconsistent care for women in South Wales; potentially resulting in poorer midwife-woman relationships for midwives who conformed to new guidelines and did not use face-to-face interpretation during appointments.

General criticisms of UK maternity care have obvious negative implications for the midwives. It is therefore possible that the public criticisms leading up to the period of data collection, discussed above, may have had detrimental effects on midwives' openness to interviews and observations with a non-clinical researcher. Indeed, it is possible that midwives may have been reluctant to say anything negative about their relationships with women, due to concerns about the reputation of UK maternity care services, and NHS care in general. Furthermore, reports on ethnic inequalities in maternal and perinatal mortality, published shortly before data collection began ((CMACE) 2011; Cantwell et al. 2011), may also have influenced the way in which midwives spoke about their

relationships with women. Although some of the midwives I spoke to hinted that these reports had helped to raise their awareness of the ethnic and migrant inequalities in maternity outcomes, others suggested that such reports felt like a criticism of care or accusation of racism. Indeed, when presenting the rationale to my research at academic conferences, I often experienced defensiveness and disapproval from midwives; a number felt that by highlighting these ethnic inequalities in pregnancy outcomes, I was implying poor care or racism by midwives¹⁵. It is therefore possible that some midwives participating in my research may have experienced similar feelings, and consequently modified their responses to my questions about working with migrant Pakistani women. As such, negative experiences of working with this client group may not have been reported by midwives, for fear of an association being made between difficult relationships and poorer provision of care.

Part Two: Overview of Key Themes and Model Creation

In this second part of the chapter, an overview of the broad themes identified during data collection and analysis are presented, in addition to a discussion of the development and refinement of the data-driven model created during early data analysis. This model is described in detail in order to provide the reader with a full understanding of the complex relationships between themes presented in the subsequent findings chapters (Chapter Six and Chapter Seven). In these findings chapters, data are presented in line with the main themes identified during analysis. Chapter Six presents data relating to the experiences of migrant Pakistani women, whilst Chapter Seven presents data relating to the experiences of midwives practising in South Wales. A discussion of these data, in relation to the existing literature, is then presented in Chapter Eight.

In the data extracts presented in the following chapters, pauses are represented by an ellipsis (three evenly spaced dots), whilst omitted words/sections are represented by an ellipsis in square brackets, as such [...]

¹⁵ As a result of these feelings I consequently modified the way in which my research rationale was presented; placing more emphasis on midwives' experiences of care for this client group, rather than a singular focus on mortality and morbidity rates.

5.6 Key Themes

5.6.1 The Importance of the Midwife-Woman Relationship

Both midwives and women expressed the view that a good midwife-woman relationship was important for good maternity care. While women suggested that a good relationship with midwives improved their general experiences of the healthcare system, midwives claimed that good relationships with women improved their job satisfaction and reduced feelings of work-related stress.

The main benefit of having a good relationship with their midwife was claimed, by women, to be the increased feelings of comfort and trust when explaining problems or speaking about personal issues relating to their maternity care.

If you're not feeling comfortable with the midwife you cannot explain a lot of stuff and what you are feeling and all that. And if the doctor's just like rude, and not like making relationship – stuff like that – you won't feel comfortable and all that stuff. I think good relations really matters.

Aleena

Information-sharing was also suggested by women as an important consequence of a good midwife-woman relationship, and many expressed the view that they would get better quality, and higher quantity, of information from midwives who they had a good relationship with.¹⁶

It's really important [to have a good relationship] because, you know, she's the one explaining to you. And especially it's my first [child]. So I should have a really positive [relationship] with her because then she can explain to me, everything – you know, *clearly*.

Eliza

Midwives also suggested that good relationships were essential for the sharing of information, as women's disclosure of information during appointments was seen to be tightly linked to the existing rapport. Whilst the disclosure of things such as domestic abuse and existing health problems were most frequently discussed, midwives also spoke about disclosure in a wider sense – including disclosure of poverty or bad living conditions.

¹⁶ Further examples of this are seen in the following findings chapters, and picked up again in the discussion chapter.

They...they might not necessarily be willing to tell a midwife they *don't* know, things that they will tell us. It's things like *disclosure* of domestic abuse. I've had a couple of cases recently with Pakistani ladies who disclosed. But it hasn't been right till the end of pregnancy! Or even...one of them was as I was discharging her...she came out with it. And I think that's cos she knew it was her last chance to say something. But, if someone *else* had gone to discharge her I don't even know if she would have said it *then* because she knew me...we had a good relationship.

Mary

Along with an increased likelihood of information-sharing, midwives suggested that a good midwife-woman relationship was likely to result in better maternity care in general. It was acknowledged that the quality of this care was likely to impact on women's day to day life and, more specifically, could have an effect on their pregnancy outcomes.

Me: Do you think that has an effect on her pregnancy and her outcomes?

Heather: I think so, yeah. Yeah. Ummm. I think if they know that they've got someone to talk to – and you'd be amazed what they do come in talk about...and the more confidence they've got with you. And you just know, by the time you go to see the end product – it's like, you know, you're their best friend. It's lovely – lovely.

I think they're quite often more...relaxed [if you have a good relationship]. I've never done any statistics or anything on it – but...they tend to have more...I think my women seem to have more normal deliveries than caesarean sections, and that kind of thing.

Mary

In addition to conversations around the *impact* of the midwife-woman relationship, the factors contributing to the nature of this relationship were also discussed with participants. Interview data from both participant groups highlighted a number of important factors which they felt could influence the midwife-woman relationship; whilst women tended to focus on the personality of midwives, midwife participants, on the other hand, spoke more frequently about health care system factors and processes such as continuity of care and time restraints.

5.6.2 Factors Contributing to Good Relationship

Interpersonal Skills

When asked about the factors contributing to a good midwife-woman relationship, women tended to focus on the interpersonal skills of midwives; suggesting that they were able to form good relationships with midwives who were “kind”, “caring”, and good sources of support. Women gave examples of their own experiences as reference to this.

She was really friendly with me, and getting more positive. Like – talking to me more friendly. I’m a really quiet person – but if someone starts talking to me then I will talk, like, a friendly way back. So she was, like, talking really friendly and joking around. And I really liked that.

Eliza

Although interpersonal skills were mainly spoken about by women, midwives also noted the potential for women’s’ interpersonal skills to influence the midwife-woman relationship. For example, a number of midwives cited humour as a contributing factor to a good client-provider relationship.

You know...I think it’s about *personalities*...it’s not about language at all. Because some of the women who don’t speak English...their sense of humour can carry them through. And you can see that...even if they don’t understand – their face *smiles*. And then you can have a native British person...who comes in – and all they want is...just do it and let me get out of here. And... it’s, it’s really hard...to build a relationship with somebody who you think they’re not interested in it – they just come for the sake of coming.

Gail

Gail’s statement “it’s really hard, sort of thing...to build a relationship with somebody who you think they’re not interested in it” was also echoed in her later statement that “No matter what I do...I’ll never be able to build up a relationship [with my Pakistani client] because she just cuts off”. This was supported by other midwives, who suggested that some of their migrant Pakistani clients had “difficult” personalities which prevented them from building a good midwife-woman relationship.

And I’ve come across ethnic...one particular lady who I thought...well...I kinda sussed her out...and so did my colleague. But I think it was due to *her* rather than *myself* – errr...that she said ummm, she couldn’t continue under my care. But it could be because she didn’t like what I told her. And so, therefore, you know – and then she never complied to any medical advice later on anyway.

Claire

In the above statement, Claire recounted a case where one of her minority ethnic clients said she could no longer carry on in her care. Instead of questioning her own contribution towards this event, Claire placed all responsibility of the failure of this relationship on the woman. Indeed, Claire’s assertion that she had “sussed her out” implied that the woman had purposefully been difficult during her care. The mention of a colleague in Claire’s account seems to be used in an attempt to validate her assumptions and was potentially used to deflect blame away from her.

Trust

Both women and midwives suggested that trust was an extremely important factor in the creation of midwife-woman relationships, and for the quality of maternity care in general.

Every lady who sees you for the first time are very nervous – cos they've never met you before...so it's a... you're a *stranger*...so to, to, to relieve the information over to you – to relinquish the information to you – then, they...they need to build some *trust* in you...

Claire

Comfort was also a common theme amongst women, and was tightly linked to the concepts of trust and personality; women felt comfortable with midwives they could trust and who were friendly/used humour when speaking with them.

You need to have the comfort, don't you? ...I think that's best. I felt really comfortable with her.

Eliza

This was an interesting finding, as it suggested a bidirectional relationship between trust and relationship. While Eliza and Claire suggested that trust was important for building a good relationship, as seen at the start of this section, women suggested that a good relationship with their midwife was important for building trust.

Although the common themes, discussed above, were clearly important for the aims of my research, it became clear that this was merely scratching at the surface of the complexities of the midwife-woman relationship. Indeed, there were a number of common, yet seemingly tangential topics on which both midwives and women spoke at length. For example, midwives consistently initiated conversations regarding migrant Pakistani women's cultural beliefs, and women frequently steered discussions towards relationships with family members. As data collection and analysis progressed, it became clear that there existed important social, political and ecological influences on the midwife-woman relationship; in order to fully discuss the midwife-woman relationship, it seemed as though participants needed to place this relationship in the context of factors such as their religious beliefs and family involvement.

Due to the complex interplay between contextual and personal factors influencing the midwife-woman relationship, I decided that I needed to find a way to visualise this interplay. This visualisation eventually developed into the creation of a 'social ecological model' of midwife-woman relationships for migrant Pakistani women, which will be discussed later as an original

contribution to knowledge from my research. The process of model development is described in the following section.

5.7 Creation of a Social Ecological Model of Relationships

The way in which social and political contextual factors appeared to influence the midwife-woman relationship reminded me of a theory of child development by Bronfenbrenner (1979), which I had studied during my undergraduate degree in Applied Psychology (Figure 5). Bronfenbrenner (1979)'s 'Ecological Systems Theory', proposes that child development should be viewed from a social-ecological perspective; placing the child in the centre of a 'layered' system, with all layers of this system interacting and influencing development. As seen below in Figure 5, these systems range from the individual interactions of the child, to the social and political context in which the child is brought up (Bronfenbrenner 1979). In order to correctly study human development, Bronfenbrenner (1979) argued that one had to see within, beyond, and "across" how these systems interact.

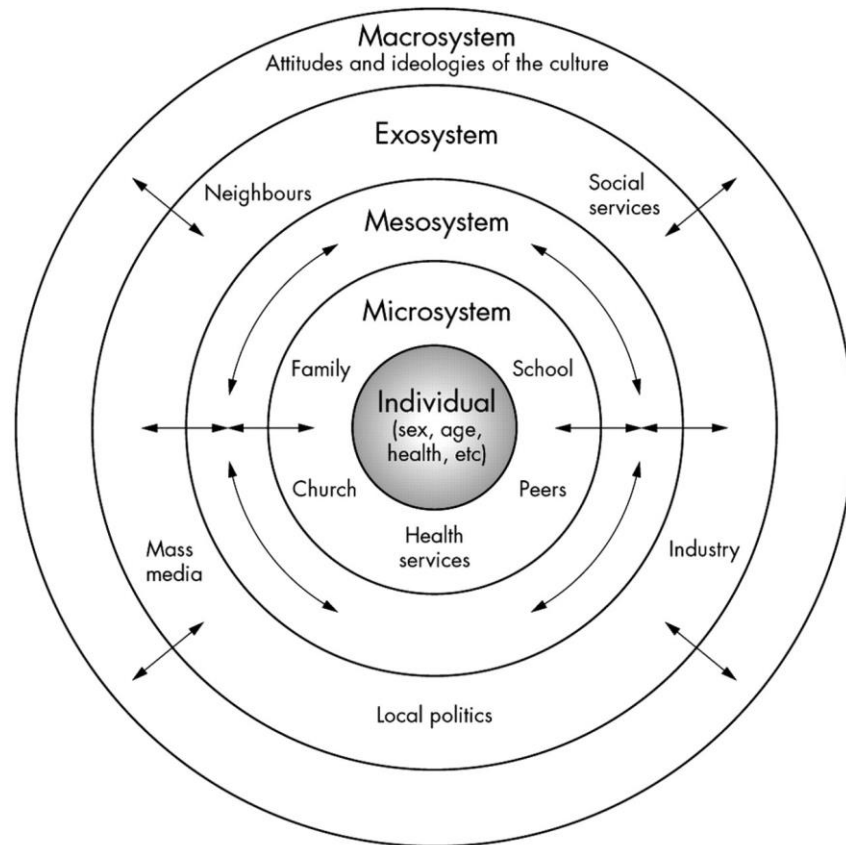


Figure 5. Bronfenbrenner's (1979) Ecological Systems Theory

The more I re-familiarised myself with Bronfenbrenner (1979)'s theory, the more convinced I became that this type of nested, interrelated, model was highly relevant to my own findings. Indeed, the proposed interactions between layers were mirrored by the interactions between themes emerging from my own data. It therefore became apparent that in order to make sense of the complexities of this midwife-woman relationship, it was necessary to view data from the current study through a social-ecological lens.

In order to apply this socio-ecological lens to my data it was first necessary to find a model which was more closely applicable to my research area. There was little evidence of the application of a social ecological model to interpersonal relationships, however I eventually discovered a book chapter by Higgs (2014) which seemed to do just that. The model put forward by Higgs (2014), shown below in Figure 6, posits that each person is a part of multiple relationships, and that people take these personal relationships into their relationships with healthcare professionals.

Furthermore, as seen in my own data, the model acknowledges a multitude of contextual factors which influence these health practice relationships (Higgs 2014).

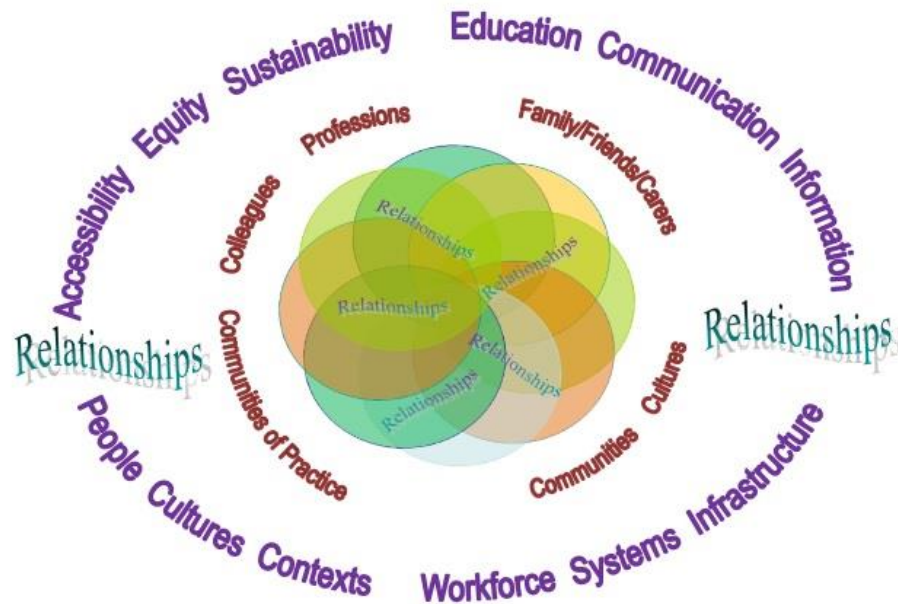


Figure 6. A model of health practice relationships (Higgs 2014)

However, as my data did not directly or fully map onto this model, it was necessary to create a novel social ecological model of relationships that was, instead, developed in an iterative way from my own findings. My first attempt at creating a model overview of the interconnectedness of my themes resulted in a design which adapted elements from each of Bronfenbrenner (1979)'s and Higgs (2014) models, as seen below (Figure 7).

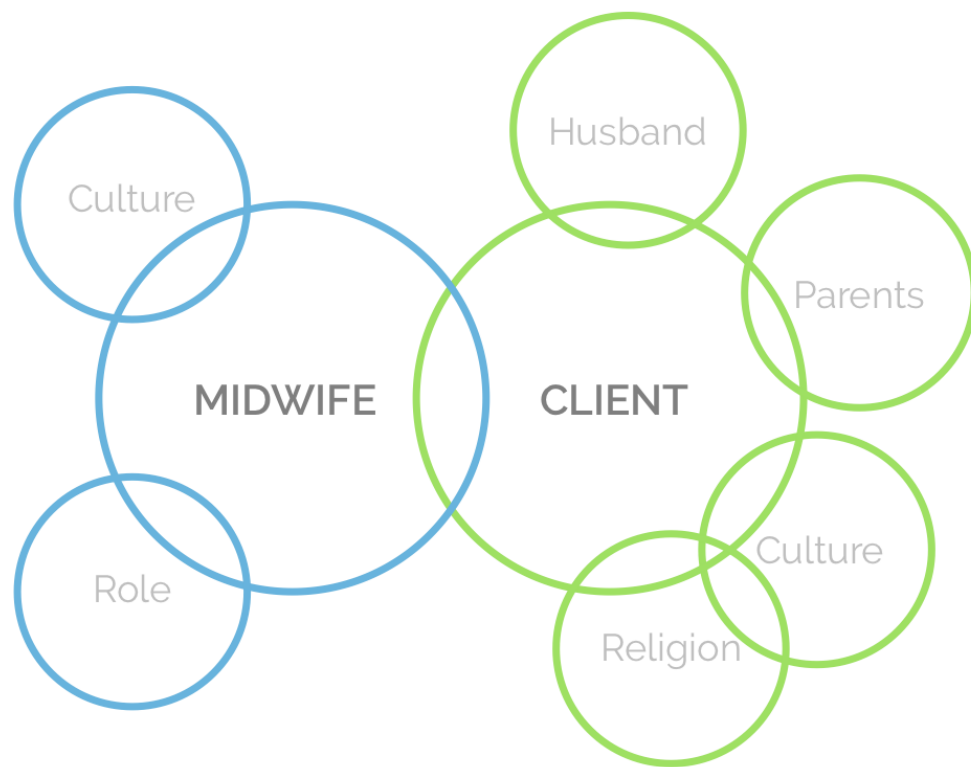


Figure 7. A social ecological model of midwife-client relationships

Although this model initially appeared to represent my data and the emergent interconnected themes, the lack of “nested dimensions” meant that it strayed significantly from the typical social-ecological models, and was unable to represent relationships *between relationships* (for example the relationship between the midwife’s cultural beliefs and the woman’s cultural beliefs).

Whilst considering how I might adapt my model to better represent these inter-relational factors I discovered an alternative theory of health practice relationships developed by Hummell and Gates (2014) which seemed to align with the typical social-ecological framework. Based on Bronfenbrenner (1979)’s work, the model put forward by Hummell and Gates (2014), shown below in Figure 8, suggests that healthcare relationships operate within a series of nested dimensions. Indeed, the authors claim that in order to understand the quality of healthcare relationships, and the impact of these relationships on women’s outcomes, it is crucial to acknowledge the complexities of interacting systems which might influence these relationships

(Hummell and Gates 2014); assumptions that are mirrored in the rationale and research aims for my own research.

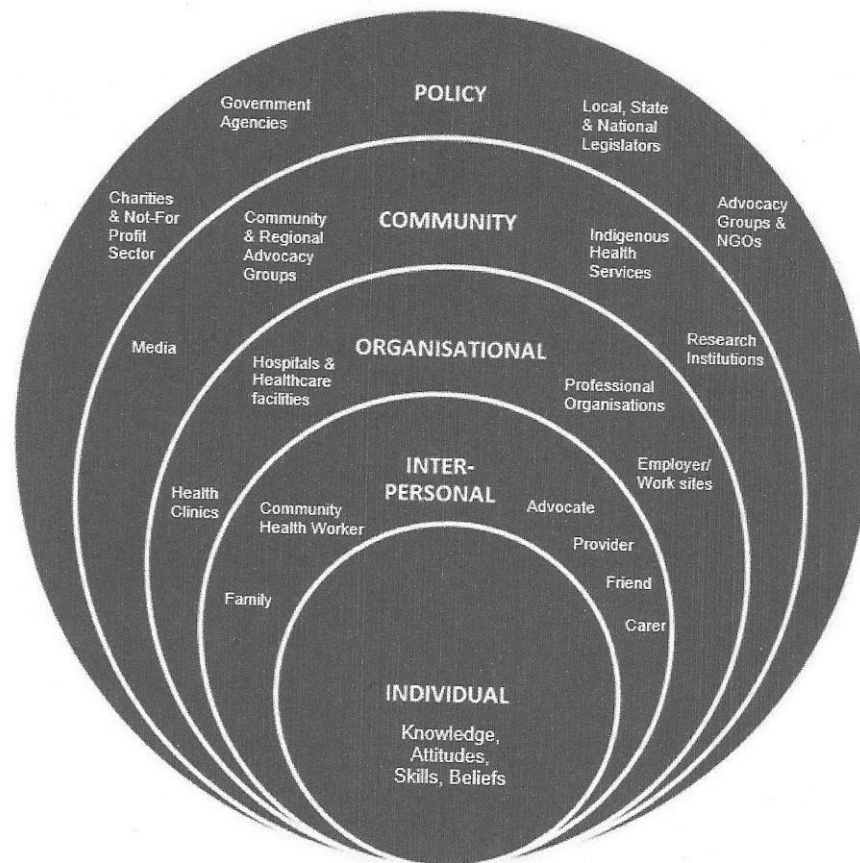


Figure 8. A social-ecological model of health practice relationships (Hummell and Gates 2014).

Although the theory behind this model seemed better placed to represent my data, it was clear that the actual model itself does little to depict the dynamics of relationships between individuals; instead focusing on the factors contributing to the individual *dimensions* of relationships such as knowledge, attitudes and beliefs (Hummell and Gates 2014). It was therefore necessary for me to combine this model with my own; including the nested dimensions of the social-ecological factors, whilst maintaining the representation of the relationships between individuals (Figure 9).

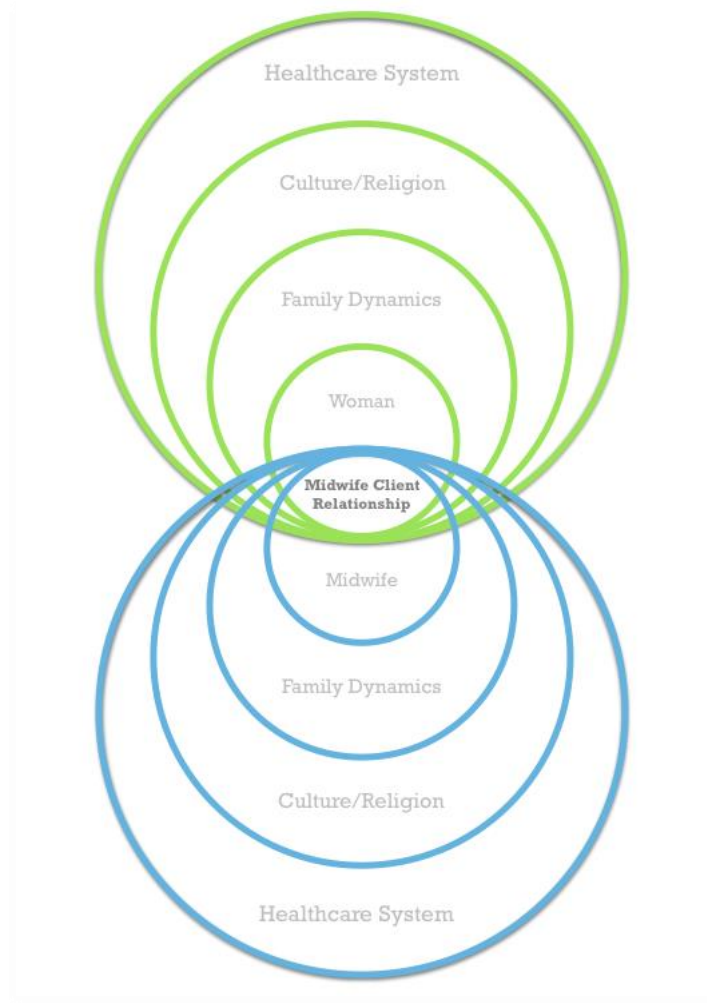


Figure 9. A new social ecological model of midwife-woman relationships

Once happy with this model, it was used as an analytic lens that was deeply rooted in early data through which to view my data; conducting further analysis of transcripts, observations and field notes with this model in mind. As a result, findings were organised by three distinctive social and ecological factors which were intrinsically related to the midwife-woman relationship. These included:

- Family Relationships
- Relationships with Culture and Religion
- Relationships with Healthcare Systems (UK and Pakistan)

As seen throughout the next few chapters, model development closely reflected the iterative approach to analysis taken by this study; enabling flexibility and ongoing changes in response to

new information as it was collected. In practice this meant a constant refining of the social ecological model, extending to the final draft of my discussion chapter. However, in contrast to the chronological format of my thesis until this point, I have decided to present the final social ecological model at the close of this chapter (Figure 10). This has been done in order to allow the reader to approach the subsequent findings chapters with the model in mind, and to enable a deeper understanding of the ways in which themes were interrelated.

5.7.1 The Final Design

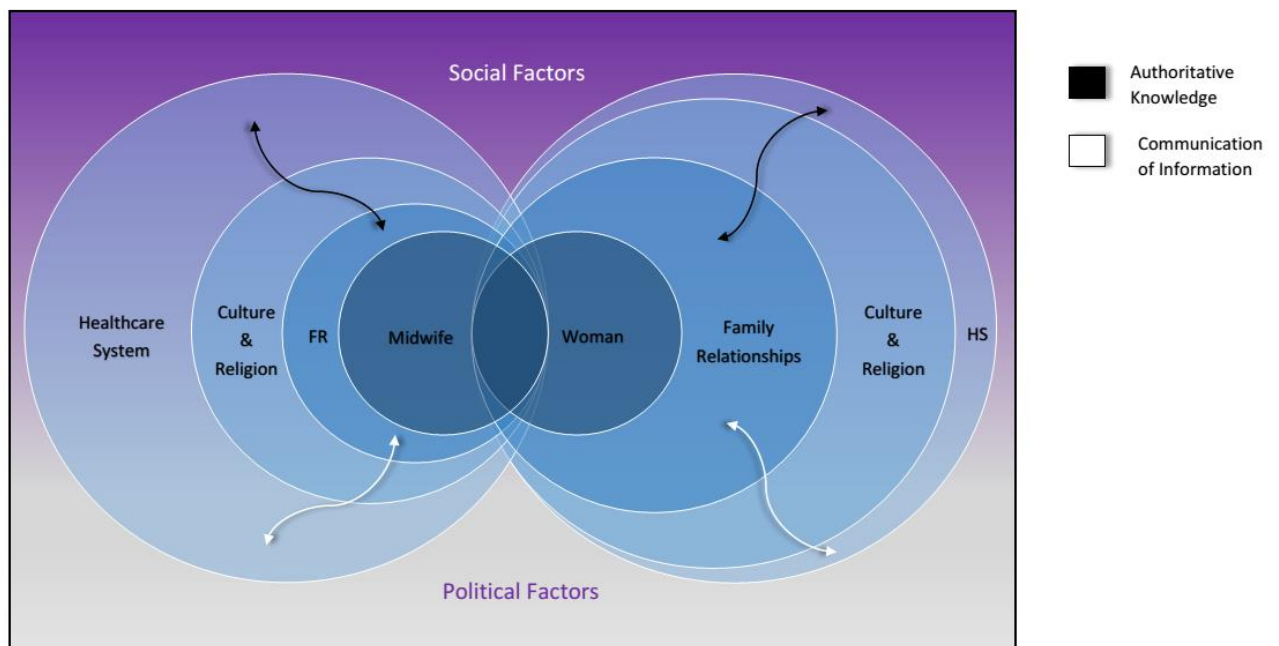


Figure 10. A social ecological model of midwife-woman relationships for migrant Pakistani women. Final version.

HS = Healthcare System

FR = Family Relationships

In the above model, different widths of circles were designed to represent the relative importance of each theme for each participant group. For example, as will be seen, midwives most commonly spoke about the midwife-woman relationship in terms of factors relating to the Healthcare System (therefore the widest gap), whilst the themes of Family Relationships and Culture and Religion were less frequently seen to influence this relationship (narrower gaps). In contrast, women more

commonly discussed Family Relationships and Culture and Religion, and spoke less about Healthcare System influences on their experiences.

The white and black arrows were added to represent two ‘weaving themes’ found in the data; ‘authoritative knowledge’ and ‘communication of information’¹⁷. These weaving themes appeared to feature in data relating to all themes of the social ecological model, and often acted as links between these themes.

The purple and white background to the model was added to represent the influence of contextual factors on the midwife-woman relationship, including those addressed at the beginning of this chapter (for example the social and political issues of public perception of immigration and criticism of UK maternity services). This is seen most clearly in data which suggest an attribution of views on to “others” (by both women and midwives), and is presented as a meta-theme of ‘otherness’ in the discussion chapter. The gradient effect of this background was applied to represent common cross-over between social and political issues, and the outline box was used to symbolise the way in which data relating to the main social ecological relationship themes were situated within this socio-political context.

5.8 Chapter Conclusion

This chapter began by describing the demographics of participants. It then went on to discuss the social and political context in which data were analysed. This included a discussion of the perceived impact of immigration on UK health and security during the past four years, along with an acknowledgement of a number of high-profile reports on the state of UK maternity care in the same time period. The ways in which these events may have influenced data collection were then summarised, in order to provide richness and understanding for the reader.

The second part of this introductory chapter provided an overview of key themes identified within the data, and described the process of developing the social ecological model of midwife-woman relationships for migrant Pakistani women in South Wales. Although presented here in its final form, it is important to remember that this model of relationships was developed concurrently

¹⁷ These themes will be introduced in the following findings chapters as they arise in the data.

during data collection and analysis, and was therefore refined a number of times throughout data analysis and discussion. Indeed, the positioning of this model within the thesis was discussed a number of times with my supervisors (it could equally have been placed at the close of the discussion chapter, which would make the most chronological sense). The decision to present the final version of the data-driven model at this point in the thesis was made so that the reader could approach the next two findings chapters with this model in mind.

In the following chapter, Chapter Six, data relating to the experiences of migrant Pakistani women are presented and discussed. Interview extracts, field notes and observation notes are used to illustrate all findings and establish the rigour of the study.

Chapter Six: The Experiences of Migrant Pakistani Women

6.1 Chapter Aims

This first findings chapter presents data collected from migrant Pakistani women; including extracts from interviews, observations and field notes. At this point, data are discussed with reference to the research aims only – discussion of the findings in relation to previous literature is presented in a subsequent chapter (Chapter Eight). References to, and implications for, the midwife-woman relationship are highlighted, and findings are described in line with themes from the social ecological model, discussed at the close of the previous chapter.

As mentioned in the section on model development, two interweaving themes ‘communication of information’ and ‘authoritative knowledge’ emerged across all levels of the social ecological model, often linking relationships between these levels. References to these themes will be highlighted throughout the first two findings chapters with the use of footnotes. During the course of this chapter any reference to ‘women’ refers to migrant Pakistani clients specifically, unless stated otherwise.

6.2 The Relevance of Family Relationships

It became evident, during data collection and later analysis, that in order to understand midwife-woman relationships, there must be an understanding of social and ecological factors such as women’s relationships with family members and midwives’ perceptions and attitudes towards male authority in Pakistani culture.

During my fieldwork in migrant Pakistani communities, I observed close family relationships; many generations often lived under the same roof, and all members contributed to family life. For example, one family I visited explained that Pakistani women would often ensure relatively large age gaps between children so that the older children could help take care of the younger ones. A

number of participants also spoke about cousins and other close relatives who lived only a few streets or doors away, and were on hand to help with anything the family needed. This was also echoed in my interviews with participants – almost all spoke about the impact and involvement of family members on their pregnancies. In contrast, little was talked about in terms of friendship network support with non-family members, potentially due to the migrant status of the women (only one woman described having UK-based friends outside of her direct family). The main influential relationships, discussed below, were those of mothers (or mothers-in-law) and partners.

6.2.1 Women's relationships with mothers/mothers-in-law

The involvement of mothers and mother-in laws was discussed in generally positive terms, although many participants suggested that high levels of family member influence in pregnancy was expected, due to Pakistani cultural norms. Some participants discussed this influence in terms of their relationships with midwives, suggesting that parental and 'elder' advice would often hold more weight than advice from the midwife¹⁸. Hana, a resident in the UK for the past 7 years, voiced the opinion that most migrant Pakistani women tend to place more value on the knowledge of family elders than health professionals.

I think during pregnancy – and after pregnancy...whether it's in our tradition or is in our culture – whether we are living in UK or any other country – whenever we have baby – we follow our elders. Like – our grandparents...our mother in law...our mothers – we follow them. We don't try to follow what midwife wants to say us – what midwife is saying for safety. We *don't* bother – frankly speaking we *don't* bother. Majority of us we don't bother. We follow our grandparents...our mother in law and our mothers, like that.

Hana

Both women and midwives frequently discussed the existence of differing perspectives on pregnancy and childbirth between family members and healthcare professionals, which was recognised as having the potential to cause tension in the midwife-woman relationship. The influence and advice of family members seemed to be, on the whole, valued by women. However, a number of participants singled out the possible negative influence of mothers-in-law. In the

¹⁸ Link to authoritative knowledge. Here the knowledge of the community/family elders is seen as more valuable than that of the midwife. Other examples of authoritative knowledge will be highlighted throughout the chapter, and explored more fully in the discussion chapter

following passage Faiza, who was experiencing her first South Wales pregnancy, describes a situation experienced by one of her cousins.

Another cousin came from Pakistan. And she want to learn, like, English – so in Birmingham she want to go. And the mother in law...she said “oh – you don’t need to go and learn English - you sit at home and cook” and they really want to go. But yes...some mothers – they don’t want them to go [...] They think – maybe they go out and they make friends [...] She said “no – you just waste of time if you go out and learn English. Better you have to cook something at home and cleaning” ...she said “I feel like I am servant here, I can’t go out...I can’t make friends”. They think, like, if they go out and they learn the English and they make the friends then maybe they all day – maybe they stay out...and maybe mother in law think I have to cook.

Faiza

Faiza’s view was one which was voiced in a number of other interviews. Participants suggested that the domestic role played by women in Pakistani families (cooking, cleaning, etc.) was relieved from elder women by the arrival of their son’s wife into the family. This traditional way of passing on household chores seemed to be challenged by the thought of daughters-in-law going out, for example either to attend antenatal classes or to learn English. Participants suggested that such absences from the family home might cause frustration amongst older women who may be concerned that they would be left to do the chores themselves. Indeed, it appeared that it was not the act of learning English that frustrated mothers-in-law, but the metaphorical doors which were opened to women (in terms of spending time outside of the family home) once they could communicate with others.

Interestingly, none of the women in this research directly spoke about their *own* mother-in-law in negative terms – instead speaking about the mothers-in-law of those close to them (as seen in Faiza’s account), or of Pakistani women in general. A number of potential explanations for this crossed my mind; it was possible that these participants had just been ‘fortunate’ to not have controlling mothers-in-law, alternatively participants may have been careful not to speak ill of their family members as a sign of respect, or fear of having this information relayed back. It might also be possible that the influence of mothers-in-law was less for these participants, as a number had in-laws who still resided in Pakistan. Nonetheless the influence of mothers-in-law was discussed by all participants when speaking on pregnancy and general day-to-day life of migrant Pakistani women, and it appeared that this could impact highly on their experiences of maternity care.

As will be seen in the next chapter, midwives expressed overwhelmingly negative views on mothers-in-law, describing them as controlling and interfering in women's pregnancies.

6.2.2 Women's Relationships with Partners

Despite now living in the UK, and having adopted a number of westernised ideas and behaviours, the majority of participants described how they adhered to the traditional Pakistani family system, at least to a certain degree. Participants talked about the traditional roles of the husband and wife, explaining that women were generally expected to stay at home all day, cook 3-4 meals a day, clean the house, and entertain any family members who might visit.

Faiza: Pakistani women are at home. Like, lots of wives – they have to make food for the man and kids [...] Some English people they make *own* breakfast [laughing] But my husband [...] He can't – even he wake up, like, sometimes 8 o'clock. He wait for me. Like – if I wake up, like, 9 o'clock he wait for me.

Me: So he won't eat until you're up?

Faiza: No... I said he can like, own breakfast, but he doesn't. So I have to make breakfast myself. Then dinner [...] They not eat just cereal. We have to make all bread, egg, some chipati, like...[women] send to school, kids...and they have to pick up from school.

Women's partners varied in their involvement with the research; whilst some were present during interviews, others only appeared to let me in to the house and to say goodbye. It was my impression that there was an air of protectiveness of women from the male partners I encountered; even in situations where partners were in other parts of the house during participant interviews, I was aware of their presence, and often felt as though they were staying close by in case they were needed. An example of this is seen in the following fieldnote extract where one partner, Rehan, even took part in the interviews with his wife Aleena.

Field Note 8

Male partner involvement in research, 14/05/15

Interesting that although only one male partner has been directly involved in the research, other partners have made their presence known during my visits. Some partners have been the primary contact between myself and participants (giving me their telephone number instead of the participant's number). Others have always made sure that they answer the door and that they are the one to invite me into their home (possible that this is with all guests – not just myself). While conducting interviews, only one male partner has left me in the house with the participant alone. Although it has been made clear that partners are welcome to take part in (or be present during) interviews, they seem uninterested in taking part, but interested in my motives for the research. The majority of partners have tended to stay in the kitchen (usually the next room), and although it doesn't seem as though they are interested in listening to the conversation, it feels as though there is a protective nature to this behaviour.

Entwined with traditional domestic roles for Pakistani families, there emerged a theme of male authority and power in Pakistani spousal relationships. This concept appeared consistently across both midwife and woman narratives, as well as during my own observations and fieldwork in the Pakistani community.

Despite a propensity for male authority in Pakistani spousal relationships, it became apparent that there was great variation between families on this issue. Whilst a small number of women suggested that this way of living was outdated and no longer existed in the majority of families, others were living proof that this was not the case.

I say I want to work and he said “no I don't allow you to go to work. I just work – you have to stay at home”. He said “go learn English if you want to, but I'm not allowing you for work” [...] Every time I say “No I want to go to work” he said “no no no, you have to stay at home!”

Faiza

Faiza's submission to her husband's wishes came as a surprise; while Faiza had lived in the UK for the past 8 years, her husband had only joined her from Pakistan within the last year, and Faiza therefore suggested that she took charge in a lot of situations, especially those requiring the use of English. Furthermore, before her husband's arrival, Faiza had been attending college and taking driving lessons with a male instructor; activities which Faiza suggested are rare amongst females in

Pakistani culture. Despite previous freedom in her actions, and her obvious desire to work, Faiza seemed genuinely accepting of her husband's opinion that she should not work, and stated that she would not go against this.

However even in situations where male authority and control was apparent, women often joked about this gender-based power dynamic, and seemed unconcerned by it. For example, Faiza, whose husband would not allow her to work, joked about a situation where she had managed to persuade him to let her continue having driving lessons with a male instructor.

Because I start [driving] before my husband's come here! So...he's just this country one year – I start before. I learning with English instructor – is man! He said "you did not find any woman?" [laughing]. No...I said "I can't now, like, leave him. I can't change now because I learn most of. Cos every instructor they do, like, different differences" I said I can't go change now. He's a good instructor. (So it's ok with him now?) Yeah...not really happy but he said ok. [laughing].

Faiza

Although I had little contact with most male partners Aleena invited her husband, Rehan, to take part in both of my interviews with her. This provided unique insight into their relationship, and the ways in which Rehan was involved in Aleena's maternity care. Although Rehan has been a UK resident for the past 10 years, Aleena only joined him in the UK about 2 years ago. During interviews with the couple Aleena openly teased her husband about the issue of male authority, both in Pakistani culture in general, and in their own relationship specifically.

Rehan: [Men] will go to Pakistan. They will find a girl, which they know like, they will look for 10 – like, you know it's arranged marriage system over there.

Aleena: Same like him – he see 10 girls as well.

Rehan: No I didn't.

Aleena: Yeah, come on.

Rehan: I wanted you when I saw you. [laughing]. It's not like that programme – what you call...err...the take me out? It's not like – you got 50 girls and in front of you and you say "oh yeah I'm gonna marry her" – no it's not like that.

From the variation in views, summarised by extracts in this subsection, it was clear that male authority, and the impact of this power dynamic, varied between families.

During fieldwork and interviews I noticed a propensity for male partners to speak on behalf of women, even when the woman herself appeared to have adequate English language fluency. For

example, the fieldnote extract below is taken from a booking appointment with a migrant Pakistani woman and her husband.

Observation Period Seven
6/01/15

Client seems a little nervous – looking to partner for answers when midwife asks questions (despite good English fluency). Partner answers most questions for client. Partner explains about medical condition of client.... Midwife tries to engage client by directing questions at her – client turns to partner and waits for him to answer. Midwife has started to speak to partner more now – directing questions at him instead of client.

During this observation period, the midwife made numerous attempts to engage the woman in one-to-one conversation. However, more often than not, the woman would turn to her husband and wait for him to answer questions and interact with the midwife.

When asked the reasons behind their lack of direct conversation with the midwife, women gave positive explanations which positioned partners as caring and compassionate – for example stating that their male partners would sometimes take charge of their antenatal appointments out of concern and care. Liyana, a UK resident for the past 4 years, suggested that her partner spoke on her behalf during antenatal appointments as a result of his desire to care for her and ensure her and the baby's health.

Yeah...because he cares for me so that's why he wants to go with me. He wants to know everything ok with me and my baby's health. So he was concerned – so that's why he was with me." [...] I think it's a caring thing. Cos they care about their wives and their children. That's why they do it for their wives or girlfriends [...] he speaks for me and he cares about me so I'm happy about it.

Liyana

Some women suggested that it was purely more practical for the partner to speak on their behalf, as the partners often spoke better English, or that they were too embarrassed to use a second language in front of their partners.

If my husband is sitting with me – sometimes it happens with me as well. Not mostly, but sometimes – I get confused...or I think I am not speaking properly [...] every time when I am sitting with my husband and he says “speak English with me” – I get, like, a bit confused to speak English with him. I don’t know why.

Hana

This admission from Hana, of a wavering confidence, came as a great surprise to me; Hana was one of the participants most fluent in English, and appeared the most self-confident of the participant group. It was therefore extremely interesting that she expressed a lack of confidence when speaking English in front of her husband.

Lack of confidence in language fluency was cited by many women as a reason behind migrant Pakistani women’s potential reluctance to speak English in front of health professionals. Many participants expressed a concern that they would get words or meanings wrong, and therefore suggested a preference for family members to speak on their behalf. Lack of self-confidence amongst Pakistani women arose as an important issue throughout interviews. As will be seen in following sections lack of confidence was, in fact, cited as a barrier for a number of maternity care-related issues.

Confidence is what I’m saying. Like, before I couldn’t talk. Even if I knew English well – my mum would talk. [...] But now that I’ve grown more confidence and stuff...I’ve – after a while I’ve been talking. Like – before my wedding I started talking to doctors, explaining my problems and stuff. But my mum used to still be there. But now – because my mum speaks more, and she can talk to midwives...and she knows the whole process and stuff...I think I’d rather have her talk, than me.

Eliza

Eliza was the youngest of the migrant Pakistani participants at only 17 years old. At the time of meeting Eliza, she had lived in the UK with her parents and siblings for 13 years, and had recently married her cousin, who still resided in Pakistan. Eliza expressed the opinion that she would get more information and better advice if she let her mum (Rukhsa¹⁹) speak on her behalf, as her mum had experience with antenatal care and pregnancy. Support for this view was voiced in interviews with Rehan and Aleena, who proposed that some migrant Pakistani women’s desire for others to

¹⁹ Rukhsa took part in some of Eliza’s interview, and extracts from her are presented later in the chapter

speak on their behalf might be due to differing levels of experience of the system. It was suggested that whoever had lived in the UK the longest would be more likely to ask questions and get more information from health professionals. Midwives, in contrast with this view, expressed a desire to talk to women directly, regardless of experience or language fluency²⁰.

Potential explanations given for women's reluctance to talk to health professionals directly calls into question the desired function of the midwife-woman relationship for these individuals. I came to realise that, for many of the women in my research, the purpose of communication and interaction with their midwives was purely to obtain information and advice or to have tests carried out, rather than to build any kind of therapeutic midwife-woman relationship. If this were the case, women might struggle to understand how allowing (or preferring) a family member or partner to speak on their behalf might affect their maternity care. Here, as in many points throughout the chapter, there are some interesting references to the differences in purpose of communication, and what women perceived as effective communication. This 'weaving theme'²¹ will be explored further in the discussion chapter.

Women's preference for male partners to speak on their behalf initially appeared to be linked to how closely the couple adhered to Pakistani family dynamics; participants who appeared to assume the more traditional gender role and kept to strict religious and cultural practices tended to be those whose partners spoke on their behalf. However, this assumption was challenged during my first interview with Rehan and Aleena; despite being arguably the most 'westernised' couple in the current study (Aleena's work colleagues are all men) Rehan consistently spoke on Aleena's behalf during both antenatal appointments and my own interviews with the couple. Delving into this relationship provided a mass of rich data on this subject, which has been summarised as a mini case study on the next two pages.

²⁰ This will be discussed further in the subsequent chapter.

²¹ Communication of information

Case Study: Rehan and Aleena

Initial contact with the couple was made with Aleena, where she spoke English with fluency and confidence. Indeed during the first 10 minutes of our initial interview, when it was just her and I, she spoke to me openly and at length. As soon as Rehan returned Aleena became quiet and Rehan took over answering questions. Aleena mirrored all of Rehan's points (short agreements and nods), but would always turn to Rehan to answer questions which I had intentionally directed at her. This was an especially surprising case for me as I knew that Aleena was fluent in English, and worked in a customer service role. Indeed, Aleena explained that all of her colleagues were male (a fact which would be frowned upon in traditional Pakistani culture). It became clear that Aleena had come to rely on Rehan as a spokesperson, and Rehan explained that this was the case during most interactions with health professionals, including Aleena's midwife. When pressed on this issue, Aleena and Rehan joked that it was laziness on Aleena's part.

Aleena: One doctor came after 10 minutes and I have to explain everything to him – and then after 10 minutes another doctor came, another doctor came, another doctor came...hundred, two hundred times I explain everything! With all the friends, with all the family in Pakistan as well – on the telephone “ok – that's wrong, that's wrong, this happened now”. So I was just so bad “I'm not telling anyone what's wrong with me now” [laughing]...[“ask him – he knows everything” [laughter] “he already tell two hundred times, so...” ...[I would prefer to have my husband go. So he knows everything what's going on...what she asked...what she said.

Rehan: I know why she would prefer me to go...because every time *she* is gonna ask questions – she wants somebody there to answer it!

Aleena: No – I answer as well...but I prefer that – *he's* the dad – he knows everything what's going on

During interviews with this couple, I started to understand how midwives might feel in similar situations where men spoke on the behalf of their partners. Despite managing to gain some information directly from Aleena whilst Rehan was in the kitchen, as soon as he returned it was clear that Aleena no longer felt she needed (or wanted) to have much input in the conversation. Although I tried to re-engage her, Aleena's preference for Rehan to answer questions made it almost impossible to build any kind of relationship with Aleena herself and I started to give up asking her questions – instead directing my attention to Rehan.

(Continued on next page...)

(...continued from Case Study on previous page)

The less I engaged with Aleena directly, the less input she gave, and the less I felt able to build any kind of connection with her. It was interesting to note that Rehan had never witnessed Aleena speaking with health professionals although, just moments earlier, Aleena and I had been having an interesting and free-flowing conversation about her thoughts and feelings.

Similar situations arose with other participants when transferring between observation and interview settings; women were happy to speak to me directly when their partner was not present, however during antenatal appointments (which partners attended) they said very little. I got the impression that this was very much the choice of the woman; practically nominating their partner to act as a spokesperson. Indeed, during interviews with Aleena and Rehan it became apparent that there was an ongoing domestic debate about this issue. Rehan repeatedly expressed a desire for Aleena to speak for herself, and was constantly telling her to do so during our interviews.

Cos always – I try to force her to tell everything herself. Cos don't ask me to tell. Basically...when *you* will tell...basically you will feel more confident. Also...doctor will understand better. Because it's really awkward...basically when you go to somebody – they ask [Aleena] a question, and *I'm* giving the answers. But I *have* to because she don't answer. I always encourage her to do things herself. Like, you know, it's not like...I said – I'm always here for you. If she...if you're stuck, then fine – I'm here. But at least *try* and do everything yourself.

Rehan

Interestingly, when I spoke with midwives about this finding the main reaction I had was surprise. Very few had experienced a situation where male partners encouraged women to take more control and responsibility, and claimed that this case was probably an exception to the rule. In fact, midwives tended to use this conversation to return to their views of Pakistani culture as one of male dominance and control. These conversations reinforced my assumption that midwives and women had extremely different views on the role of male partners in Pakistan, and that such negative stereotyping by midwives had the potential to cause tension and misunderstanding in the midwife-woman relationship.

It is important to note that Rehan and Aleena's case cannot be generalised to the wider migrant Pakistani community. Firstly, Rehan was the only partner who took part in the interviews (and was present during both interviews with Aleena). Secondly, from what they told me, Rehan and Aleena both came from relatively privileged backgrounds in terms of education and wealth. Finally, they

appeared the most liberal in relation to adherence to Pakistani cultural norms; Rehan had not only encouraged Aleena to take a job, but a job in a company with predominantly male staff.

From data on family relationships, discussed in this section, it is possible to see the potential for high family involvement to limit the rapport built between woman and midwife. Indeed, it appeared that the more family members were involved in the pregnancy, the less women engaged in direct contact with the midwife; potentially limiting the intimacy and quality of the midwife-woman relationship. As seen earlier in the section, strong family influence is also likely to detract from the advice of the midwife, or even directly contradict it, once again causing the potential for tension in this client-provider relationship.

6.3 The Relevance of Pakistani Culture and Religion

Pakistani culture and the Muslim religion were spoken about with warmth and tenderness. Despite this, there seemed to be suggestion of an overwhelming feeling of a change in UK Pakistani culture. Participants talked about how cultural traditions were being left behind or “modernised”, in favour of the western ways of living. In fact, many expressed the feeling that Pakistani individuals were, and *should be* adapting to UK cultural practices and expectations.

The place you live [...] you should *learn* and you should understand *all* the things around that place, isn't it? Then you will be...suitable for that culture and all that things. If you move to another culture and another country [...] you should learn the good things about whatever they are doing. So basically – if you move to UK and you still wanna have your mini country within your home – that's basically wrong.

Rehan

Rehan and Aleena seemed to take a very practical view on the idea of adapting to a new culture; suggesting that it was necessary to enjoy and fully participate in life in the UK. For others the desire to adapt to UK culture seemed to stem from a wish to avoid negativity from UK citizens (authority figures in particular). Nimra, a UK resident for the past 3 years, talked about her willingness to adjust to a new country in order please others.

Nimra: But now I'm here I have to live like the British way. What the midwife wants to me, I'm gonna do that. I wanna make happy to everyone, you know.

[Speaks in Urdu – translator continues]

Translator: That's why she researches a lot because she wants to know what was going on here. Very different both countries. So she says it's not a big issue for me, not big problem for me. I'm ok I adjust very quickly wherever I go.

The adaptation to UK social norms was discussed, by a number of participants, in terms of migrant Pakistani individuals' relationships with healthcare professionals. Many spoke about the need to secure positive relationships with those involved in their healthcare, and acknowledged the existence of some cultural differences that had the potential to complicate this relationship. In the following passage, for example, Eliza talks about how her mum started removing her veil and making eye contact with male doctors in order not to seem rude or disrespectful.

Yeah – so my mum – it was really hard for her then. But now she takes [her veil] off. And she does look up. You have to do it now, because there's no other way [...] We're supposed to look down. But we do...we have to do it. Cos it's important that they have eye contact. It's really important - so that's why we have to change now. But I think mainly now they all do it. They take it off at the doctors, I think.

Eliza

This was something that I had also witnessed during my observations; two participants, who had worn veils in the waiting room of the medical clinic, removed these when entering the midwife's office.

It was clear, however that this adaptation towards a more westernised culture varied greatly between families. During my time working within the Pakistani community, as both a volunteer and a researcher, I realised that migrant Pakistani families were an extremely heterogeneous population in terms of their adherence to cultural traditions and practices; while some women wore full traditional clothing, others tended to “blend” cultural styles – for example continuing to wear the traditional headdress while wearing jeans and trainers. Some of the families I visited would excuse themselves from interviews to take daily prayers, while others did not mention prayer time at all. These differences were also voiced by migrant Pakistani participants, who told me that some families followed strict cultural and religious rules, whilst others maintained only those practices deemed as essential to uphold their religious beliefs. Eliza was a good example of this; whilst her mother kept to strict prayer routines and traditional dress, Eliza had a more westernised appearance, and spoke about herself having a less traditional lifestyle.

Some people do change...like “I’m going to a new country I will change” but some people, like, stay the same. Like our family – my mum...when she came she was – just kind of stayed...like – made the whole house like how we were living in Pakistan, so keep the same thing – culture.

Eliza

Most participants seemed unconcerned about other families' levels of adaptation to the UK culture; explaining that it was personal or familial choice. Rehan and Aleena, however, spent a large proportion of their interview talking about the dangers of people bringing strict cultural and religious beliefs and behaviours into the UK – suggesting that it was likely to end up in confusion.

Some people... they get really strict. But – what I say to them, then, you know – I say “look – you know...if you wanna be like that – like this – you don’t want your family to go out...you wanna have your family’s to be, like, you know...proper, like, exactly Islamic culture and all those things – then don’t *come* to this country! Go back!” And yeah...over there you have, like, you know...the proper culture. Just go back there! Or...ask your family to go back there. Basically it’s very *unfair* with the family...with the wives and kids and all of them - basically you are *confusing* them! Between two cultures, two religions, two countries. [...] You’ve asked them to come from there to UK...now basically you don’t let them go out. If they go out you say “no you have to follow *our* culture” So it’s very confusing...that you’re basically trying to create that culture into another culture...and they get really confused. Like, you know...which things to follow.

Rehan

Throughout my contact with Rehan and Aleena, they expressed strong views about those who they saw as “extremist kind of people” that upheld strict religious behaviours, and it was clear that adaptation to their resident culture was an important concept to them. Rehan suggested that some individuals had been “brainwashed” into following such strict beliefs, and that these people would never comply with advice from health professionals if it conflicted in any way with what they had been taught to believe.

That extremist kind of people... like, we said before – who just don’t *think*...who basically – they haven’t learnt...they haven’t read anything. They just learn the things from other people. Like, for example – if I have told them something – they will just straight away believe, like. Or *this* person told me that this happens like that...so it’s definitely like that. Yeah – those people – they will probably not accept, like, you know, [what health professionals say]. It was *never* a strict religion, in any way. People – they have *made* it in this way. Because they don’t *learn*...basically they just hear what the other people say.

Rehan

Extracts like the above, from Rehan, reaffirmed my understanding of the great diversity between migrant Pakistani families. It also became clear to me that any generalizing or stereotyping of these women could lead to inaccurate assumptions being made by midwives. Data such as this supports the concept of the social ecological model presented in this research; suggesting that in order to understand or enhance the midwife-woman relationship, it is necessary to consider each *individual’s* relationships with factors such as culture, religion, and family members, rather than

viewing these relationships through a lens based on stereotypes of migrant Pakistani women and UK-born midwives. The impact of these individual differences were noted by Rehan, and by Eliza earlier in this section; who suggested that the midwife-woman relationship may be easier for those women who “adapt” to the UK lifestyle. In reference to the social ecological model, it is possible to suggest that poorer relationships for migrant women who do not adapt to UK culture may be due to increased dissonance between midwife and woman in terms of the themes discussed during this chapter.

6.3.1 Education About Pregnancy

The majority of women expressed that they had received little education about pregnancy and childbirth before their own pregnancies. It was explained that due to the private nature of the Muslim religion, pregnancy is not a topic discussed with women until they are married, or sometimes not until they have already become pregnant. One woman even suggested that male members of the family would not know that their relation was pregnant until the birth of the baby, and certain aspects of pregnancy were not discussed even with female family members. Here Nimra talks about the cultural restrictions and its impact on knowledge about pregnancy.

Because unmarried girls in Pakistan, that's our culture - girls not involved. Because, err, before marriage, we're not allowed to get go with a boyfriend, and have a sex and have a baby, you know. So we straight away get married first time, then the first time the guy touches, you know. And then we become pregnant. It's all after marriage. If you were to like 25 and you're still unmarried but you can't go, even you can't talk with any boy, even you can't go out with a boy. That's our cultural thing. And religious thing as well. So that's why the unmarried girl always, we, they don't know what the pregnancy, if they have no boyfriend, no sex, how can they know what the pregnancy thing? [...] Unmarried girls, they don't talk about these type of things.

Nimra

As a result of these Pakistani social norms surrounding pregnancy, not one of the women in my research described having had any real education or experience with pregnancy and childbirth before becoming pregnant themselves. This differs greatly from norms in the UK, where pregnancy is much more public and sex education is taught in schools from age 11 (GOV.UK 2016). I began to consider the possibility that midwives might expect migrant Pakistani women to have some basic knowledge regarding pregnancy before coming to them, therefore give them less information than was needed. Indeed, interview data suggested that, for some participants, this lack of basic knowledge surrounding pregnancy influenced women's confidence in interacting with the midwife. Here Eliza talks about her lack of confidence in getting the correct information

Booking appointment...my mum did that [...] I just have her around because this is my first time so I'm not really sure on any of this. And I've never seen anyone, like, pregnant [...] I'd rather have her talk...she's more *experienced* and stuff...with talking to midwives and doctors [and she knows the whole process...I think I'd rather have *her* talk, than me. [...] If I say something wrong then my mum will be like "no – you say it like this" – that's what I think is important. If I say something wrong then she can, kind of, explain it better. That's why I'm worried – if I just go alone – and some wrong information goes to the midwife.

Eliza

During observations of antenatal clinic appointments, I noted an overwhelming tendency for migrant women to communicate agreement with everything the midwife said, and to ask very few questions. As will be seen in the following chapter, midwives suggested that white British women, on the other hand, were more likely to ask for the reasons behind certain advice, and make their wishes known. One possible explanation for this is hinted at above, by Eliza, suggesting that migrant Pakistani women's lack of engagement in antenatal appointments might be due to a lack of confidence in communicating effectively with the midwife. However, it occurred to me, from data on family relationships, that migrant women with strong family support may feel as though family members could provide all the support and information they needed (and/or *wanted*), therefore nullifying the need to actively engage in maternity care services; instead voicing 'agreement' with the midwife, whilst continuing with advice provided by the family²².

As discussed earlier, the concept of midwife-woman partnership features highly in UK maternity care (Department of Health 2007; Boyle 2013). Therefore, I began to wonder if migrant Pakistani women's lack of engagement with care might influence the way in which both parties interpreted the midwife-woman relationship as a partnership, or not. Whilst UK-born women may have enough personal knowledge and education on pregnancy to create a partnership and joint decision-making approach with midwives, migrant women may rely more heavily on female elders in the family to make such decisions; potentially reducing the value of the advice of the midwife, and disrupting balance and reciprocity in this midwife-woman relationship. Indeed, from observational data, there seemed to be a tendency for midwives to take on a more authoritative role in the relationship if women were reluctant in voicing opinions or communicating issues; further disrupting the reciprocity and partnership style of relationships.

²² Examples of this behaviour is seen in the following section.

6.3.2 Traditional Pakistani Maternity Practices

The impact of culture and religion on the midwife-woman relationship was further demonstrated through women's narratives surrounding cultural practices which took place during pregnancy and childbirth. Practices most frequently discussed were those of shaving the baby's head, putting eyeliner on babies, giving new-borns honey, whispering prayers into the baby's ear and putting glass bracelets and/or necklaces onto the baby. Mixed views on cultural practices emerged from narratives; the majority of women suggested that cultural practices which were deemed as safe should be upheld, whilst those practices of a more controversial nature should be discussed with midwives first. Here, Faiza talks about her ambiguity about adhering to a cultural tradition of putting eyeliner in her daughter's eyes

In Pakistan many of the people think it make the eyes healthy, then they put stuff in eyes, yeah [...] I didn't do her eyes – I was too scared. [Mother and sister ask me "did you put in her eyes?" and I said "no" and she said "why you didn't?" and I said "No – I saw English people...lots of English people...they didn't put anything" ...I said "I don't need to". I told her now – she's fine – her eyes are fine. No point to put, like. We just make in our mind that we have to put, like. She said now – in Pakistan – some women they don't put [eyeliner].

Faiza

This passage from Faiza seemed to suggest that if she had been in Pakistan, or if these relatives had lived in the UK, Faiza would have carried out this cultural practice without a second thought. However, after realising that this is not done in other cultures (and that it seems to make no difference to eye health), she seems relieved that she didn't feel the need to carry out this practice.

The majority of pregnancy and birth-related cultural practices were talked about as being safe and important to Pakistani families; for example, shaving of the babies' hair and making sure that the father was the first voice the baby heard. When talking about these practices, participants explained that they thought midwives should be supportive and understanding of these traditions

Some things related to our religion so it should be ok. For [midwives] as well. Because we have to shave our children head. So it's religious. You have to weigh it. So they will accept this. We have to do circumcision for the boys. It's important in our religion. So they should be ok with it.

Liyana

This extract from Liyana highlights an interesting distinction between cultural and religious practices. In parts of the narrative from Rehan, discussed earlier in this chapter, he suggests that

some maternity practices are falsely carried out in the name of religion, and that such behaviours are actually a result of culture and a misunderstanding of religious codes of conduct. It is possible that this distinction between cultural and religious origins of behavioural practices during pregnancy and childbirth might affect the way in which such behaviours are interpreted by midwives; as will be seen in the next chapter, midwives came to accept some practices by re-labelling them as integral to women's religious beliefs.

Although most women seemed to have experienced midwives' acceptance of cultural practices, many spoke about the potential for conflict in the midwife-woman relationship as a result of differing views on these traditions. In the following extract Eliza suggests how migrant Pakistani mothers might react to being told they should not carry out certain cultural practices.

She would say that – “I've been doing it all my other kids – why can't I do it with them?” She *will* be a bit offended and she'll say, like, she'll kind of go back and *say* that.

Eliza

Sara, an interpreter between English and Urdu/Punjabi, works closely with healthcare staff, and regularly attends number of health visits and antenatal appointments for migrant Pakistani women. During our conversations, Sara offered insights into some of the reactions she had witnessed from mothers who were told that some of their cultural practices were not deemed safe by health professionals.

Other people, they feel uncomfortable...but in our culture, it's ok – it's a normal thing. So that's why the girls come here and when we say “don't do this, don't do that” ... “WHY? We always doing this...why [midwife] keep saying to me, don't do this, don't do that? I *know* – I'm a mum” You know? “She's only a *midwife*, she's very concerned about the baby and I'm the MUM – why not ME? Why they keep always saying to me you're not a responsible mum? You know. You don't look after baby in a safe way. Why they keep saying this to me? This is wrong”. And I have seen these things lots and lots [...] The [migrant girls] feel very weird – “oh what's going on? Why they make this thing very big issue?” If she put the eyeliner – “It's just eyeliner, that's it – why they making so fuss? Why they making so issues with this thing? This normal” You know, like, for you – for me, it's *not* normal thing to put the eyeliner in the 6-month baby eyes – you know. And that thing - when you say to her “don't do this again” - that's not normal for *her*! I think...she say...she told me in my language “I think this health visitor is out of her mind...what is she talking about?”

Sara

This extract from Sara gave an interesting illustration of how normality is constructed culturally; whilst Sara claimed that traditional Pakistani practices made “other people” “feel uncomfortable”, for the Pakistani culture this was seen as “ok – it's a normal thing”.

As evidenced above, Sara's narrative was often filled with strong, emotive language, and her recollection of conversations with migrant Pakistani women often included powerfully negative statements about midwife-woman interactions. For example, in the above extract, Sara claims that many mothers complained to her that midwives and health visitors would question their ability to care for their babies in a safe and responsible way. I was initially sceptical of the extremity in which Sara seemed to describe midwife-woman tensions as none of the women interviewed in this study expressed this view and I did not witness this type of interaction in antenatal appointment observations. However, it is necessary to consider differences in characteristics between Sara's clients and those taking part in this study. Sara described her client group as having extremely limited English language ability, and usually living in the most deprived areas in the recruitment city. In contrast, almost all of the participants in the current study spoke fluent English, and very few lived in areas of deprivation. It is therefore possible to suggest great demographic variation between client groups, and potentially larger space for misunderstanding, miscommunication, and therefore tension over issues such as traditional maternity practices (as seen in the account from Sara).

When discussing the potential for tension over cultural practices, women stated that they would listen to the midwife's advice and wouldn't do anything deemed unsafe or inappropriate by midwives. In fact, a number of women offered this viewpoint before being questioned on it, which suggested that women were aware of issues regarding this adherence. Indeed, women's eagerness to tell me that they would listen to the advice of midwives sometimes felt as though they were saying it only for my benefit. The effect of social desirability was something which I had anticipated, and is described fully in Chapter Four (section 4.2.4, page 52). Throughout interviews it became apparent that feelings on this issue were less clear than initially expressed; over the course of interviews, some participants seemed to swing between a strict following of the midwife's advice, to a more defensive stance of upholding their parental rights. The following passage, from Eliza, is a good example of this. Despite initial claims that she would listen to the midwife's advice, Eliza seems to become confused when talking about the importance of tradition, ending by saying that it should be the parent's choice, and that the midwife should only play an informative role in this decision.

I would listen to the midwife. Cos she's obviously the person who's more experienced in that. And if she's saying it's dangerous, then it's dangerous! You know...because glass things on their hands can obviously cut older people...it can obviously cut a little baby's arm. But then it's tradition....and you

kind of respect tradition as well. I don't know – it's a bit difficult. How would you balance it and everything? Cos if the midwife's like...she can explain it to her. But then I think it's the parent's decision. She can explain it more detailed but I think it's the parent's decision if they want to keep it on or not.

Eliza

This difficulty in balancing tradition with advice is supported by narratives from midwives; discussed in the next chapter. Midwife participants recounted situations where women from other cultural groups agreed not to conduct specific practices, however continued with these practices once the midwife's back was turned. This was supported by a couple of migrant Pakistani women, who told similar stories of their peers secretly continuing practices advised against by the midwife. It became clear that although many women initially thought they would follow the advice of the midwife, conflict between this advice and cultural/religious tradition could easily change their opinion on this matter. As discussed in the section on interpersonal relationships, family influences are also likely to play a strong part in whether or not these practices are continued against the midwife's advice. In the following passage, Hana supports the view that many women will continue to go against the midwife's advice, and suggests that ultimately the knowledge most valued by migrant Pakistani women is that of family 'elders'.

[Pakistani women] – they *do* understand. Definitely they do understand. Those [women] who don't bother...they won't follow you. Frankly speaking they won't follow you. Whatever you will say, they won't follow you. They will say "ok yes we will do" in *front* of you...but when they go back home they won't follow you! They will follow whatever the elders say – they will follow that!

Hana

This claim from Hana, that women will "follow whatever the elders say", suggests that women attribute authoritative knowledge to family members (the advice and knowledge of family members is weighed more heavily than that of midwives²³). However, the suggested "pretence" of compliance with the advice of the midwife makes the power dynamics unclear in this relationship. The fact that women make the effort to hide this behaviour from midwives could, in fact, indicate some degree of power and authority on the part of these health professionals. Alternatively, however, women may just hide this behaviour in order to avoid confrontation or backlash.

Instead of conflict, some participants claimed that their midwife showed little interest in Pakistani cultural practices regarding pregnancy and childbirth. Some women suggested that a lack of

²³ A full description of authoritative knowledge is given in the discussion chapter on pages 213-214

discussion surrounding cultural practice was due to midwives' existing knowledge and acceptance of these practices. Others, however, felt that it would help build a stronger relationship if midwives showed an interest in their culture and traditions; especially if evidence of these practices having taken place were obvious during their maternity appointments (for example the baby's head having already been shaved).

6.3.4 The Role of Religion

All migrant Pakistani women in the current research were of the Muslim faith, and many expressed the view that pregnancy and childbirth were "in the hands of God" or "God's will". For some participants, this seemed to be used as a comfort for when things went wrong (for example miscarriage or foetal abnormalities), however for some participants their religious views influenced behaviour. For example, a number of women refused screening for Downs Syndrome or other abnormalities, as they explained this would not affect their decision to continue a pregnancy.

Yeah – we have our religious beliefs as well – and we...we believe whatever is given to you is yours...you know. You should just thanks to God.

Rehan

During my observations in antenatal clinics I found this to be the norm – only one migrant Pakistani woman I observed even considered having screenings for abnormalities. Whilst women tended to use the concept of God's will as a tool for coping with negative outcomes, as will be seen in the following chapter, midwives interpreted this belief in "God's will" negatively; suggesting that it could act as a barrier to midwifery care.

Once again, there was clear variation in women's acceptance of the will of God during their pregnancy, and the majority appeared to place great importance on both their religious beliefs and the maternity care provided. This variation in view amongst women once more supports the relevance of the social ecological model in understanding midwife-woman relationships; highlighting the importance of considering each individual woman's relationship with religion.

Another religious and social issue which seemed to vary between participants was Pakistani women's avoidance of contact with males outside of their family; whilst some told me they were allowed no interaction with men outside of their family at all, some lived by the view that contact with men was allowed under certain circumstances and when all interactions were conducted in

line with their religious beliefs (for example no close physical contact or being left alone with males one-on-one). Participants acknowledged how these difficulties might affect migrant Pakistani women's access to maternity care²⁴ and how this might, in turn, have an important impact on the midwife-woman relationship.

6.3.5 Language Barriers

When speaking about the impact of language barriers on their relationships with midwives, women consistently referred to the relationship between language and the Pakistani culture. As will be seen later in this section, issues regarding the acquisition of the English language were especially relevant to cultural issues.

English language fluency was talked about at length, by both women and midwives, who saw language issues as the biggest barrier to a good midwife-woman relationship. It was acknowledged by many women that there were a number of migrant Pakistani individuals who struggled with English language, especially in healthcare settings.

They always need a translator, because of the English language. Because loads of people don't understand because another language is their first - English is a second language and they need interpreter or translator for this.

Liyana

I see ladies – they can't even *say* anything [...] My cousins as well...they've been to school here as well but they're not as fluent as *me* cos I've done, like, full education here. They've just – when they came from Pakistan they just got in one of the classes and they just done it till GCSE and then just stopped. But they can *speak* [...] But...umm...like – you still *notice* the English. It's still a bit weak

Eliza

Unsurprisingly technical language used in maternity care was especially challenging for participants. Some participants who I had observed and then later interviewed asked me to clarify terms which they had spoken to the midwife about (and had seemed to understand at the time).

²⁴ For example clients expressed the view that they would not be able to attend sessions offered by midwives such as antenatal classes and English lessons where there were likely to be males present. This will be further explored in subsequent sections in this chapter.

Field Note 4

11/02/15

After the interview Faiza suggested that there were some things she did not quite understand during her appointment, but that she hadn't asked the midwife (she did not give a reason for not asking). Faiza asked me to clarify some things for her, including the procedure of the screening for Downs Syndrome). Faiza seemed nervous about her lack of knowledge on the issues she asked about me, I tried to reassure her that she should not be embarrassed and that it was important to ask her midwife to clarify anything she did not understand.

It became clear that women weren't asking their midwives to explain words or information that they didn't understand, and I could see the potential for this to have quite worryingly negative consequences on women's pregnancy and childbirth.

Confusion over midwifery terminology was not limited to migrant women; I was often aware that I did not know the meaning of some words that were used during antenatal appointments, despite being a native English speaker and having read a number of research papers and books in the field of midwifery. I began to focus part of my observation on taking note of women's reactions to unfamiliar terminology and it soon became clear that very few women asked for clarification of these terms. An amusing situation from my own personal experience supported my assumption that this lack of clarification was likely to be the norm, and so is included as a personal reflection below.

Personal Reflection

One of my closest friends became pregnant during my data collection phase, and shortly after her first antenatal appointment, asked me why the midwife had called her a “primate”. Amused, I explained that what the midwife had almost certainly said was that she was a “primip”; midwifery slang for primiparous - a first time mother. Although my friend and her boyfriend were both native English speakers, and highly self-confident, neither of them had asked the midwife to clarify what she meant by this.

This situation led me to further reflect on the use of medical terminology during antenatal booking appointments, and I arrived at the conclusion that women with limited English language and lower confidence may be even less likely to ask for explanations of misunderstood information regarding their pregnancies.

Women reinforced the view that language issues had the potential to negatively impact on the midwife-woman relationship by giving examples where they had witnessed frustration and tensions between members of their community and UK health professionals. Below, Eliza talks about a situation where she and her mother witnessed an elderly Pakistani lady trying to get a new prescription from the receptionist at their doctor’s surgery. Eliza explained that the elderly patient only knew a few words in English, and that the conversation soon turned into an argument, as the patient could not understand what the receptionist was telling her and was therefore insisting that the receptionist do something to help her.

If the person - like, the patient – doesn’t understand some of what the doctor’s saying, then sometimes doctors will get frustrated as well. [...] The old lady – and I don’t know what that was – that prescription. And she was saying “I wanna get my medicine” but she was in the wrong place. And so...the lady wasn’t getting what the receptionist was saying. So [the receptionist] was getting really harsh on her...and saying in a stern way.

Eliza

As will be discussed in Findings Chapter Two, midwives also gave accounts of situations where language barriers had caused miscommunication and tension between health professionals and migrant women, and many expressed their own frustrations with this issue.

Expression of Feelings and Problems

In addition to causing frustration on a fundamental level between women and health professionals, language barriers were consistently identified as an issue which restricted women's ability to express their concerns and feelings about pregnancy and childbirth.

It's hard, sometimes, to explain your problem with the midwife because of this language thing [...] We trust them a lot - but because of the communication, because of the language, that's the main problem, we can't talk. Sometimes we can't tell them...explain them our problem in a good way, because of the language, because [midwives] just speak English and [Pakistani women] just speak their own language, and it's hard to explain the midwife every single thing.

Liyana

Referring back to the literature review, and my own personal experiences, it is obvious that impaired communication has a negative impact on any relationship (be it personal or professional). It is possible to suggest, furthermore, that this relationship is less likely to be viewed by each party as a partnership. Elements of this were witnessed during antenatal clinic observations – midwives tended not to offer as much information to women who didn't have a good level of English language skills. My experience of this style of information sharing was that interactions became more clinically focused and prescriptive, with little social chat. This type of environment felt less conducive to the creation of a good midwife-woman relationship.

A Desire to Learn English

As discussed, almost all of the women who took part in this research were close to being fluent in English, and most expressed the view that they thought English fluency was becoming increasingly common among migrant Pakistani individuals (especially young women). Participants who did not speak English fluently expressed a desire to improve their language ability

Yeah, because...before when I came this country – that time even they ask [if I needed an interpreter]. That time I said “Yeah I need interpreter” then my interpreter...she told me my language all the time. I just listening. So after, like, I thought I have to speak myself. It's better. Then I can learn English...so slowly slowly I go out – maybe they ask me I need an interpreter I say “No I can speak myself” [...] I've been to like – 1-2 month I've been to like classes. Yeah – last year I started in the college. [Then I had ectopic pregnancy and then I stop. They told me, like, “you can start next year”. I'm thinking that still I will go start English classes again. It's better, like, I want to learn more English.

Faiza

Women suggested that learning English would not only improve their relationship with their midwife, but would also benefit them in their day to day life (for example, integration with British

society, and keeping up with their English-speaking children). Participants not only talked about a *desire* to learn English but the majority also expressed a feeling of *responsibility* to learn the language (especially if they had been in the country a long time). Zoya, a resident in the UK for the past 15 years, even suggested that migrants should be tested on their English before entering the country.

If someone coming from abroad...they should...take some test – English [...] They should have some education if they come here so they can – they don't have any problems speaking. So that's the important thing [...] It should be, like, if you live in this country you should know the language.

Zoya

However, despite acknowledging the existence of language classes, and expressing positivity towards these, the majority of women suggested that migrant Pakistani women would be unlikely to attend such sessions due to practical limitations. Indeed, participants cited lack of opportunity as the most common reason for non-attendance. Most perceived barriers were related to the traditional Pakistani family values previously discussed; women claimed that they were too busy with household chores and cooking for their families to attend classes.

Pakistani women are at home. Like, lots of wives – they have to make food for the man and kids [...] They *want* to learn English...but maybe they haven't time.

Faiza

As touched upon earlier, another barrier to language class attendance, voiced by participants, was family members' desire for women to stay at home. Although some women suggested that their husbands were the main authority on this issue, others claimed that mothers-in-law created the most opposition to pursuing activities outside of the house²⁵.

In addition to a lack of opportunity, or concerns about adhering to religious beliefs, a number of participants suggested that some women may just have no desire to learn English. For Zoya, this lack of motivation to attend courses was illogical, yet common, despite the availability of free services.

I think that mostly there are free courses – just, like, depend on the person if they want to learn [...] And some of women don't bother to take the classes [...] Or...Maybe they don't want to...I don't know. Cos I seen so many people – they go to the classes...but they attend 2-3 classes then big gap – then they come back... I seen so many like that.

²⁵ Examples of this are seen in the section on women's relationships with mothers-in-law on page 129

As discussed in the next chapter, limited English fluency amongst migrant Pakistani women was viewed extremely negatively by midwives. Although many of the women in my research expressed feeling a responsibility (and desire) to learn English, others portrayed a very relaxed attitude towards learning English; instead promoting the use of family members for translation. It is possible that this differing level of importance attributed to language fluency, between participant groups, could contribute to negative midwife-woman relationships.

Although a number of women talked about general language classes available in the UK, there didn't seem to be much education or awareness of the facilities offered focused on pregnancy, or those classes which were just for women. As a result of my fieldwork, I knew of the availability of 'English for Pregnancy' classes for females only, offered at the local hospital. The majority of midwives in my research, however, reported that they either didn't know about the existence of these classes, or did not have access to the details of these. In fact, during my observations of antenatal clinic appointments, language classes were never mentioned by midwives.

Observation Period 12

Asylum seeker antenatal appointment - 18/02/13

Clear that the woman doesn't understand much of what is being said. Midwife tries to give woman information – obvious that woman isn't following most of what is being said. Midwife uses language line – repeats all the questions she tried to ask woman minutes before. Midwife gives woman more information (in English) – woman nods in agreement but it seems clear that she hasn't understood much of what is said. Feel like I am waiting for midwife to mention the language classes I have been told about – midwife doesn't mention anything to woman. I look around room, and surgery – no posters or information about these classes. Midwife finishes appointment – no mention of classes.

As a result of the lack of language class information given by midwives, I quite often found myself doing internet searches for these workshops, at the request of women participants, during my visits for interviews. The seeming lack of knowledge and communication from midwives about available language classes came as a great surprise, especially, as will be seen in the following

chapter, because women's English fluency was a major cause of frustration for midwives and potentially contributed to a more negative relationship with women. It therefore seemed logical that midwives would be providing women with all available tools to improve this English fluency; however it was clear that this was not the case.

In reference to the aim of the current research: exploring midwife-woman relationships for migrant Pakistani women and South Wales midwives, it is necessary to understand that both women and midwives will vary in their expectations of whether English should be learnt by migrant women accessing the UK maternity services. Whilst some migrant women may have expectations of their responsibility to learn English that are similar to those of their midwives, others may not. This concurrence or dissonance in expectations appeared to influence the establishment of good midwife-woman relationships, and must therefore be considered when attempting to understand relationships between midwives and migrant women.

The Use of Interpreters

Women generally discussed the use of interpreters as a way of improving communication with health professionals; a factor already voiced as being important for a positive midwife-woman relationship²⁶. However, there were mixed feelings around the practical effects of using translation services, and the impact this had on the midwife-woman relationship. While women voiced a preference for family members to interpret for them, I knew from reading the CMACE recommendations laid out below (Cantwell et al. 2011), that it was likely that this would be strongly advised against by healthcare professionals.

Recommendation Two: Professional interpretation services

Professional interpretation services should be provided for all pregnant women who do not speak English. These women require access to independent interpretation services, as they continue to be ill-served by the use of close family members or members of their own local community as interpreters. The presence of relatives, or others with whom they interact socially, inhibits the free two-way passage of crucial but sensitive information, particularly about their past medical or reproductive health history, intimate concerns and domestic abuse.

(Cantwell et al. 2011)

²⁶ This subsection poses some important issues for the effectiveness of communication between the midwife and client. This will be further explored in the discussion chapter.

Despite these recommendations, midwives reported that the use of family members as interpreters was still common practice, and that both midwives and women accepted this as standard practice.

Mostly people, what they do - if they don't like any third person – what they do is they have their partners. They know English – they can speak well...they can understand your English – so they can translate for you instead of taking a third party [...] I think that's better. Because both of them have *same* situation – because they are their partners – so definitely they can communicate well – they can tell easily what [problems] they are having.

Hana

Only one migrant Pakistani participant (who had experienced domestic violence during a previous pregnancy with a different partner) independently suggested that external translators were a better idea than using family members. However, when the topic of domestic violence was discussed during interviews, a number of other women acknowledged the benefits of having external interpreters available.

The use of interpreters for antenatal appointments was discussed in depth. Women suggested that the use of any interpreter (including family members) was likely to create distance in the midwife-woman relationship, as one would always be going through a third party.

I think if she interact direct with the midwife it's good, instead of the third person [...] And I think that's quite important for building a good relationship.

Hana

As previously discussed, these difficulties mirrored my own experiences of using interpreters, and during interviews with women I felt that neither myself nor the participant felt very comfortable when the interpreter was present. Ultimately I felt that I was unable to form a rapport with participants whilst the interpreter was there, and it is likely that the participants felt the same; in fact, one of these participants actually asked to have her follow up interview *without* the interpreter. During this second interview I not only found that she was actually much better at speaking English than was initially apparent, but also that she seemed a lot more comfortable, and the conversation flowed more easily. In addition to creating a much more relaxed and comfortable feeling between us, the data gained from this interview was significantly richer than her first interview, where the interpreter was present.

Field note 5

Date – 20/03/15

Liyana asked for her follow-up interview to be conducted without the interpreter present. At first I was a little concerned about this, as I wasn't sure that she would be able to answer my questions, and that there would be a lot of miscommunication. Instead Liyana seemed much more comfortable in my presence than she had previously, and the conversation flowed a lot more smoothly. I, myself, felt more comfortable asking her questions – and also leaving silences to encourage her to continue speaking.

As I experienced during my second interview with Liyana, it was clear that participants preferred to be able to communicate effectively with their midwife, without the need for an interpreter. Here, Eliza suggests that the use of an interpreter might even result in the midwife addressing whoever was interpreting, rather than the woman.

It's not *me* who's talking. I'm not the one really saying, like, I don't know – I'm not really the one talking to her – it's someone else...like barrier...so there's someone else talking. So it would just be...I dunno...the lady wouldn't even be looking – no she *would* be looking at me? ...like, when she's talking – but it would just be weird – I dunno. If I was, like, saying something to that person and that was person was saying it...just – I don't think that relation between us two would be the same. It would just be like – ok that's just. Like...now I can go and I can *relate* to her...talk really, like, be in a nice mood and talk really comfortably with her.

Eliza

Eliza, along with other participants, suggested that the presence of a third person also had the potential to cause embarrassment for women when needing to discuss personal information. As discussed earlier in this chapter, migrant Pakistani women tend to be reluctant to talk about pregnancy, even with close family members. It was therefore easy to understand why women might feel uncomfortable discussing such intimate details with one, let alone two, people they had not previously met. This was especially pertinent as it was likely that the interpreter would be from the Pakistani community. Therefore, due to the closeness of the Pakistani community in the recruitment city, it was possible that this professional would have mutual acquaintances with the woman. Some women even suggested that they would rather not give this information to the

midwife than have to pass it through a third party even if they knew that it was important for the midwife to have this information.

I wouldn't...I wouldn't be able to explain to her more in detail – that's one thing. I don't think I'd be able to. What if, you know, something *personal* – like diarrhoea or something...then the other person's there...she'll feel uncomfortable – maybe that can happen. I would...I would *definitely* feel uncomfortable if I had to talk about my personal stuff. I wouldn't go really in *details*. I would tell...like...yeah – there's something going wrong, but I wouldn't go in details, maybe, because of that person sitting there and listening and stuff. Even if they say "no it's crucial you tell more..." it still feels uncomfortable because there's someone else who knows. That would be difficult for some people.

Eliza

Along with a reluctance to share potentially embarrassing information through a third party, there were also concerns from participants about the efficiency of interpreters. A couple of participants gave examples of their own experiences of miscommunication when using interpreters, whilst others hypothesised that their thoughts and feelings could not be adequately relayed to the midwife if they had to rely on another person.

When *you* speak whatever language you are speaking - it means different. But when she or he will translate for you – definitely he or she will use her own words.

Hana

Either through inefficiency of interpreter or women's reluctance to share embarrassing details, it is clear that lack of information sharing between midwife and woman is a major concern for the women's maternity care. As will be seen in the following chapter, such miscommunication can also prove a cause for frustration on the part of the midwife, as it may become obvious that there is a lot of important information being missed. Indeed, communication issues, as a result of language barriers/poor interpretation, appeared to impact on the midwife-woman relationship by disrupting the balance and reciprocity in these relationships.

To summarise the section on language, it appears that women have a desire and self-identified responsibility to learn English, however many feel restricted by their religious beliefs or time limits due to the demands of their domestic role. For those who therefore rely on the use of interpreters in antenatal appointments, there is often little direct communication with the midwife and a fear that interpreters may not convey information accurately and/or fail to protect the confidentiality of the discussion. In reference to the research question, these factors may result in barriers to the midwife-woman relationship and the effective sharing of information. It is therefore necessary to

consider the impact of these factors on each individual woman and midwife, when exploring ways in which this client-provider relationship can be enhanced.

6.4 Understanding Different Healthcare Systems

Migrant Pakistani women's relationship with the UK healthcare system emerged as a common theme from interview data from both women and midwives. During interviews with women, differences between the UK and Pakistani healthcare systems were highlighted almost immediately.

One of the major differences between systems in each country was the way in which appointments are scheduled. For example, whilst the UK takes a very structured and strict approach to GP appointments (patients will usually not be seen if they are more than 5 minutes late), most services in Pakistan have an "open door" policy; meaning that patients will turn up at the surgery and queue to be seen on a first come first served basis. Women tended to voice preference for the Pakistani appointment system, suggesting that although they might have to sit and wait for a while to see a doctor, it was possible to see a doctor that day.

They just go there, straight away. Take a number and sit. And whenever they call them – they go and tell the doctor what's going on. But if you go in a very good medical centre [in Pakistan] there are [only] a couple of people [waiting] – that's why it's not very busy. So whenever you go – straight away you have a time for the doctor, you know, straight away to the doctor. And that's why people don't know about appointments, you know, to make them.

Sara

As suggested by Sara, waiting times to see the doctor in Pakistan varied between clinics; better (and therefore costlier) medical centres would have shorter queues where patients would be seen quicker. When talking about the UK appointment system, participants expressed great frustration at having to book appointments in advance (sometimes by a few days), and many told me that they could not understand why the system worked this way. Despite the potential for long waiting times at medical centres, most participants suggested a preference for the Pakistani appointment system.

No – it is easier in Pakistan I think. Because we have to book an appointment in GP before 48 hours [in the UK]. So if I am sick *today*...I have to wait the day after tomorrow. So it's very difficult. If my son is sick today...I need a doctor *today*. Right now! [...] If you go hospital – the emergency – we

have to wait 3 or 4 hours. So it's not easy. So I think it should be straight away [...] The NHS system – I think it should be changed. It should. Because I'm sick today so I need a doctor *today*. Not the day after tomorrow!

Liyana

Although most women referred to GP appointments when voicing the issue of immediate access, many also suggested that their frustrations also translated into maternity care, as they could not have access to a midwife whenever they desired.

Yeah you have to take appointment. Before it used to be like every four weeks or three weeks they give another appointment. And they go over there and do all the check-ups – blood pressure, everything. I think after every three weeks or something. But now I think it's quite long – like 4-5 weeks [...] Sometimes, like – you having pain or you having difficulties – but when you call them for the appointment they say “ok it's all full – you have to wait for another day” so the meanwhile you can't do anything – you don't have any tablets to take. That's a bit annoying. Should be an option for emergency midwife as well. Like...if you're having pain – or still they can talk on the phone if they can't come or you can't go. It should be an option, I think.

Zoya

The majority of participants expressed the view that they would like to be able to see their midwife at any time (as in Pakistan). Some also expressed a desire for more frequent scans and check-ups, especially in the first trimester. One participant, Hana, explained that in Pakistani culture the first trimester is seen as the most important, and emphasised the point that she would have liked more contact with her midwife during this time period. In the UK, women's first meeting with the midwife is at a booking appointment, which is conducted around the 10th week of pregnancy. The next appointment with the midwife is then scheduled for around six weeks later; in the 16th week of pregnancy. This system is as per NICE antenatal care guidelines and is recommended from evidence based practice (NICE 2008). However, according to Hana, the timings of these appointments neglect the most critical and sensitive part of pregnancy for Pakistani women.

Because I don't know in *your* culture what is it...but in our culture we think first three months are *critical* or *sensitive* – and after that you will be normal. Our parents – they used to say first three months are critical. You should be *more* sensitive; you should be *more* careful about your pregnancy –during first three months. But we don't have any contact number [for a midwife] ...we don't have anything like that. So we can't contact our midwife, or we can't visit them frequently.... [Pakistani women] would be more happy if they had care or attention in the beginning. Because *that* period is more sensitive and *more* need to care.

Hana

It was also suggested that more contact during these initial months would improve the midwife-woman relationship.

I think instead of...errr...ummm...appointment in 17 week or every 3rd week – they should have *early* appointments – *early* meetings – so they would have good communication and they can express their feelings much better. For *me* – I think it's good to have meeting *early* [...] I think it would be good if you visit your midwife after 2 weeks – every 2 weeks...so you can explain what is happening with you and what you *want*. I think it will make good relationship between you and your midwife.

Hana

From accounts such as these it became clear to see how differences in belief systems around pregnancy might influence the woman's perception of the quality of maternity care received. For example, the UK focus on providing care *after* the first 10 weeks (as recommended by NICE guidelines (NICE 2008)) is unlikely to meet the expectations of women who see this period of time as most important in their pregnancies. Consequently, I began to question whether this mismatch between women's expectations and beliefs, and the way UK maternity care delivery is designed, may leave many Pakistani women feeling ignored by midwives during the time they most desire reassurance and support.

Only one participant seemed unfazed by the NHS system of access to midwives. Aleena told me how she had been experiencing intense stomach pains and had tried to contact her midwife via text. Despite not hearing back from her midwife (two days had passed at this time), Aleena acknowledged potential reasons for the lack of response, and rationalised this by stating that it was a Sunday and that "maybe she was busy or she just didn't receive my text or stuff like that."

Me: Anything else you might have thought of...like anything that could help build a strong relationship between you and your midwife...or anything that could get in the way of that?

Rehan: Yeah – if she replies to a text message! Yeah she didn't reply yet – from the last two days.
[Aleena and Rehan laughing].

Me: She doesn't reply?

[Rehan and Aleena laughing].

Rehan: She was, basically it was Sunday. I think it was Sunday – [Aleena] suddenly had lot of pain in her abdomen and she was very uncomfortable...very very uncomfortable. So, errr, we didn't know what to do.

Aleena: So I would maybe call her...she said I will try and text her and see if it's normal or not.

Rehan: So we sent her a text, and we haven't heard anything back. But she gave us the number – and we thought probably it's a Sunday that's why she not replying. So maybe she could reply Monday I'm sure...

Me: Are you still having pain or are you?

Aleena: No... It's not that bad.

Rehan: But *that* day – it was first time it was very very bad. She was very very worried and all that. But, you know, we called our dad and we spoke to them and he said no it's normal.

Me: So do you think – is that changed your opinion of the midwife at all...the fact that you couldn't get hold of her?

Aleena: No – I thought just maybe she was busy or she just didn't receive my text or stuff like that.

Rehan: Like I said – we don't judge people on one thing.

Although Aleena and Rehan suggested that this incident had not changed their opinion of the midwife, they were responding to a question about what might improve their relationship with the midwife; leading me to believe that the lack of response from the midwife might, in fact, have had more impact on the relationship than the couple were willing to admit. Aleena and Rehan's seeming lack of concern about instant access to midwives during this passage can also be explained, in part, by their ease of access to medical advice from alternative sources (both were the children of doctors and pharmacists). They explained that, as in this situation, they were used to calling on the advice and support of these medically trained family members when UK health professionals were unavailable. It is also plausible to suggest that if the couple hadn't had this access to knowledge, then the midwife's lack of response might have had a more substantial impact on the midwife-woman relationship.

It is clear that women varied in their understanding and awareness of the UK and Pakistani healthcare systems. In reference to the research question, and more specifically the social ecological model, it is clear that these expectations and knowledge must be explored before it is possible to assess the impact of these factors on the midwife-woman relationship; both woman and midwives' individual preferences for, and understanding of, these healthcare systems must be taken into account.

6.4.1 The Role of the Midwife

Another major difference between Pakistani and UK maternity care systems, discussed by women,

was the role of the midwife in their pregnancy and childbirth. Although women reported a higher frequency of antenatal appointments in Pakistan, they explained that these appointments are conducted by doctors or gynaecologists rather than midwives. Most women interviewed in this research were therefore unsure about the role of the midwife. In fact, a number of women suggested that they hadn't encountered the term "midwife" before entering the UK maternity care system. Here, Faiza talks about her surprise at having someone other than a doctor to support her through her pregnancy

We just have doctor [for pregnancy]. You have to go to doctor and then they scan [...] When I come here I don't know [about the midwife]. First time I went to doctors so they told me "now you have to go with midwife" and then I meet with midwife here, and she told me everything. I was surprised...it's really different. Like in Pakistan it's not much look after people, you know. If it's pregnant woman, she has to look after herself. If, she have any problem she go to, like, doctor surgery. No midwife – nothing. She have to ask mum and sister...what I will do. Like...I happen this, like, vomiting or maybe she tell like eat this thing [...] But when I come here they told me midwife – and she check me. And even after baby – health visitor is come to my home. She check, like, her weight. And there is totally different in Pakistan - no health visitor come to your home. No. They check nothing.

Faiza

It became clear through talking to Faiza and a number of other participants that although there was often a higher frequency of doctor appointments for pregnant women in Pakistan, such care was purely medical and usually driven by women's desires for check-ups and worries about the pregnancy. Participants described a service that was absent of ongoing, holistic, care; differing greatly from the partnership model promoted in the UK. It became clear that many participants had no prior experience of an ongoing healthcare relationship which encompassed both their medical needs and their general well-being, and were therefore, as a result, slightly bemused by it.

The need to clarify the role of UK midwives was especially apparent for those women who had had experience with, or heard stories about, 'old style midwives' in Pakistan.

We have midwife which is very, like, *every* midwife is uneducated. Only they have the experience because they *saw* the birth. It's like they are sitting with someone and they know how the baby comes out...how to cut the cord. That's it. Otherwise they don't know. If the patient has any problem...what they have to do – they have no idea. Just like me - I see lots of children born in front of me...I went with my sisters and my niece. But this doesn't mean I am a midwife. But they *do* [say they are midwife]. Which is very high risk in Pakistan. They never look after the human being – they think only of money!

Rukhsa

Rukhsa and others told me that these traditional Pakistani ‘midwives’ were uneducated women who had been present at a number of births but had had no medical training and held no qualifications. Although care from these midwives was suggested to be rapidly reducing in the more urban parts of Pakistan, such care had previously been common for less wealthy individuals. I began to wonder if migrant women, who were used to having doctors involved with their care, might make similar assumptions about the qualifications of UK midwives if this role was not clarified. Hints at support for this assumption came from a number of women who suggested they had no information about the qualification of their UK midwife.

I don’t have any idea about midwife – I mean – what they did, how much qualified they are.
Seriously – at this stage I really don’t know.

Hana

Hana was not the only participant who expressed uncertainty regarding the qualifications and role of UK midwives, even after meeting with these health professionals more than once. This finding was concerning, as it suggested a possible effect on migrant women’s trust in their relationships with midwives in South Wales. It once again became clear that knowledge of, and experiences with, differing healthcare systems were likely to impact on women’s expectations, therefore influencing their attitudes towards care and relationships with health professionals.

The prescription of medication also emerged as a common theme during interviews with women. Women described a prescription culture in Pakistan that significantly contrasted with that of the UK; suggesting a high volume of medication use for illnesses as mild as a headache or common cold.

Because, like, in here – they can’t give us any tablets, any medicine. But in Pakistan if you go see them – if you have, like, vomiting – you go and they give you *lots and lots* of tablets.

Rukhsa

Women suggested that such systemic differences were likely to result in confusion and frustration from new migrants, who would be refused prescriptions from UK doctors. Rukhsa, along with others, acknowledged the issues that this difference in prescription culture may have on individuals’ relationships with health professionals. Many suggested that being refused medication for illnesses could make migrant Pakistani people distrust health professionals, or even interpret it as a personal issue.

Because then people say “*these* doctors are not good because they can’t give us medicine”. But we understand these are good. Now...when we go to the doctor and the doctor say “you don’t need antibiotic every time!” [...] When...like...my child is very sick...ill...and doctor can’t give them

medicine—I don't like it. But if I read about it - why they can't every time give us antibiotics - *now* I understand. When I understand it means it's good for both doctor and patient – relationship is good.

Rukhsa

Mistrust of prescription limitation was also seen in an account by Faiza, who tried to convince her husband that he did not need high strength medication for his headaches. When she suggested that he take paracetamol instead, her husband laughed at her.

My husband, he is come like last year in this country. So I tell him, like, paracetamol if you have headache. And he say no. He eat paracetamol and he said “oh my god – it's better” [...] When he first time came here...when his tablet finished I said “eat paracetamol” he was laughing. He said no.

Faiza

Such reactions highlight the possibility that new migrants will feel that they aren't being taken seriously by health professionals when told to use non-prescription medication like paracetamol for minor illnesses.

From these interviews, it was apparent that informal education surrounding medication use was an important factor in relieving client-professional tensions. As seen in an extract above, Rukhsa expressed an altered perception of medication use, and suggested an over-prescription culture in Pakistan. It was acknowledged, by many, that recent migrants may initially see a lack of prescription as inadequate care, and that this may have the potential to negatively affect client-professional relationships in general. Through conversations on these issues it became clear that how women perceive and understand differences between UK and Pakistani healthcare systems might also dictate their expectations of the UK maternity care system, and of their relationships with midwives.

6.4.2 Women's Expectations of Healthcare

Data in this section demonstrated how expectations of UK maternity care varied greatly between women. While some held high expectations that they sometimes felt were not met, others claimed that it was the best healthcare they had ever received, and talked about how they had boasted about it to their friends and family back home. A small number claimed that they had entered maternity care with very little expectation, and were still unsure as to what to expect.

I don't know. Cos I don't have any friends or anything here. So I don't have any idea. They're all in Pakistan so I don't know.

Liyana

As seen in the above account from Liyana, a number of women claimed that they had very little knowledge of what to expect from their maternity care, and suggested that this was due to a lack of support from people who were familiar with the system.

Nimra: I got so many research maybe online...I don't know anything. [Speaking in Urdu]

Interpreter: She said because her whole family is back home; only in-laws living here in UK. She said, she's got a sister-in-law and she's got kids. But she said we just talk about kids things, we never discuss about the pregnancy, and this system.

I discussed this point with Aleena and Rehan, as they seemed to have a good understanding of the differences in healthcare systems. Rehan supported the view that most understanding and expectations were born from social support and information sharing, by explaining that their information had come from a family member who was already established in South Wales.

One of my...my aunt lives in [South Wales] so she basically told us a lot about this as well. Because my family was from, err...my mum's side, they're in [South Wales]. So my aunt – basically, she's like, helping us as well. You know, the time at every step, what needs to be done.

Rehan

However, it is important to note that the reliance on non-official sources of information could be potentially problematic for women, in that a number of factors may render the information shared as less than useful or accurate. For example, different family members may have different advice which could conflict with that of others²⁷.

Payment for services also emerged as a contributing factor to women's expectations of UK healthcare. Women explained that Pakistan has a number of different types of healthcare system; private GP clinics, private hospitals, and government run hospitals. Free hospitals provided for factory workers were also touched upon although it was suggested that very few people actually used these facilities, preferring to receive no care than bad care. I was interested in how private or non-state provision of medical services and the cost of healthcare in Pakistan affected women's expectations of the state-provided NHS services in the UK. Most suggested that although they understood that the NHS provided good care, new migrants might initially assume that "free" care meant bad care, and might seek out private services.

²⁷ The concept of authoritative knowledge is once again hinted at here, as it is left up to clients to determine which sources of information are most reliable and should be followed.

We got one factory, you know – up to 10,000 people working there in a factory. And the government give free all people there – medical's free for them. They got hospital and everything...but...they not giving any good facilities. Because of free [...] They not giving very good, you know, medical treatment. Cos it's free isn't it? So that's why some people [think] they treat me like an animal, you know? Cos it's *free* – they not giving good services and thing.

Sara

An interesting discussion around expectations surrounding place of birth arose from my conversation with the interpreter, Sara. As echoed in my subsequent conversations with women, Sara suggested that most migrant Pakistani women would expect a hospital birth, and would see this as the “gold standard” of birthing practice. Current midwifery practice in the UK, however, encourages women to at least consider home birth as an option (NICE 2014).

But NOW – I, *one* positive thing – most of girls now, they prefer to go to hospital [to give birth]. That's why loads of girls now – “no no I'm not delivering at home because I'm scared. Because I have seen loads of girls dying like this. So I wanna go to the safe...if I got any complicated – straight away in hospital they have operations – everything they got it - they can help me. But if I come from home to hospital – maybe I can't survive”. So *now*, the girls starting worrying a lot. So loads of girls they go to hospital – my family – they *all* go to hospital.

Sara

What was most interesting to me about this account from Sara was her evaluation of this preference for hospital as a birthing environment as “positive”. Sara's position as female Pakistani interpreter had provided her with a broad experience of working with midwives and health visitors in South Wales therefore I expected her to have a more open-minded opinion of home birth; however, it was clear that this was not the case. When I explained that home births were encouraged for low-risk women, Sara looked shocked and vehemently assured me that Pakistani women would resist that.

Expectations surrounding elective caesarean section by maternal request were also discussed by a small number of participants. As discussed in the literature review earlier the issue of caesarean section is one that frequently emerges in cross cultural comparisons of maternity care, and one which seems to be a major issue in maternity care in general. Here, Zoya suggests differences between countries in their birth ‘culture’; whilst the UK approach tends to encourage normal unassisted birth, caesareans can be requested by women as a preference in Pakistan (without medical reason).

But in Pakistan they do, like, sometimes it's taking too long – they do like C-section, and it's all there. But here, like, the midwife or the doctors they all say like normal delivery is good. Because my sister she is pregnant – but she had regular scanning and they say your baby is very big...bigger than the normal size. But still they waiting for the normal delivery. Like – they said...if it's an emergency it gets more difficulty – so then maybe they will think about a C-section, but she is like, getting much pain. Like 2 cms. But more than a week she is having labour pain. But they won't say. She go to hospital after 2-3 days if she's gonna have labour pain. When she go about it they say no it's not time yet. Like – they won't do anything.

Zoya

Women's expectations of maternity care, and health care in general, were a theme which struck me as extremely important for the midwife-woman relationship. It was apparent that women who expected more frequent access and a more medicalised system (for example more medication and maternally requested elective caesarean) were often disappointed and frustrated with their care, and tended to describe their relationship with their midwife less positively.

6.4.3 Women's Navigation of Care

Both interview and observation data suggest that migrant Pakistani women's understanding of the differences between UK/Pakistani healthcare systems, and their subsequent expectations of UK maternity care affected their ability and willingness to navigate their way through maternity care appropriately.

The major issue with migrant Pakistani women's navigation of the system, both from this research data and the previously discussed literature, appeared to be a lack of attendance at antenatal appointments and classes. This was something I witnessed during data collection; a number of my planned observation periods could not go ahead as women had not turned up for their appointments. Migrant women were also more likely to turn up late, and less likely to make apologies for this lateness. Midwives seemed unsurprised by this and, as will be discussed in the chapter on midwife data, the non-attendance/lateness of migrant Pakistani women at antenatal appointments was viewed negatively and as commonplace.

Observation Period 4

18/12/14

Client is late by 40 mins – Midwife now pressured to do an hour booking in 20mins. Midwife obviously a bit stressed about this but puts on cool, calm face when Client enters. Client doesn't seem concerned that she is late – no apology.

While I am usually cautious about generalising such behaviours to a population, I observed repeated instances of lateness and nonattendance at antenatal booking appointments for migrant women, and very few such instances from UK-born women. Furthermore, a number of migrant Pakistani women were late or were not present at the interviews we had arranged - a number of women later apologised that they had 'forgotten' that they had agreed to meet me; often leaving me standing outside their house unable to get in contact with them.

Field note 6

Date – 07/11/14

Arrive at client's house with interpreter. No answer at door. Try calling client but no answer. Call 2 more times and leave voicemail. Interpreter and I wait half an hour, client eventually calls me back – says she is in Newport and forgot we were meeting. Rearrange appointment for a weeks' time. Little in way of an apology – obvious that she is unconcerned about missing our appointment.

Such experiences reinforced my opinion that attitudes to appointments were in some way culturally influenced, and gave me personal insights into midwives' experiences of these types of situation.

As seen earlier in this section, a number of women expressed confusion over the UK appointment system and claimed that they were still unsure how to use it. However most seemed to project

this misunderstanding onto others and suggested that such confusion was most likely to occur for women who had limited English skills.

When they come this country this is totally different than Pakistan. Then most of ladies, because of their English is not very good, they don't know what actually an appointment is. Sometimes they know a *little bit*...they've told us "people are coming to my house" or "oh I must visit somewhere" because of the appointment...but they don't know is how much it is *important*.

Sara

Despite the tendency to project non-attendance to other women, one participant openly admitted to still not having booked an overdue appointment, and a couple of others disclosed they hadn't seen their midwife since our last interview over 6 weeks previously.

Faiza: Last time when I met midwife – she told me you have to make next appointment, like 17 weeks. Yeah – I didn't meet her.

Me: Ah – you haven't been to see her?

Faiza: Yeah.

Me: Ok.

Faiza: Every day I wake up I say I will do ring her and make appointment but I never did it. Now I think it's like 18 weeks. Yeah – I should go tomorrow, yeah.

When questioned on her reasons for not going to her appointment, Faiza claimed that she was told to take a form for a "healthy start" voucher to her next appointment, and she had not yet acquired this form. Although Faiza's explanation seemed reasonable, her apparent nonchalance about missing this appointment surprised me. Indeed, seeming complacency about appointments was generalised to other migrant Pakistani women by the interpreter, Sara, who claimed that women were unaware of the importance of keeping to these visits.

They think if you don't like to eat now, "oh, ok well I can eat another time". It's similar – they do this with appointments. They're not taking very serious, very important, no. These things are not important because they don't know the system.

Sara

Sara's claim, that women did not take appointments seriously, was important as it suggested a potential cultural dissonance in health priorities. Similar differences in perceived importance were seen when speaking about attendance at antenatal classes; women suggested that such classes were not necessary for women from their culture.

[Pakistani women] know that when the baby's born I've got my mum with me...I've got my dad and stuff...we've got a family. I think that's why. They're mostly dependent on their family [...] And they're more confident in themselves maybe, as well. Like – you know – we can do it [...] We've seen everyone else do it without going to classes and stuff. So they'd be like – “we don't need to do it”.

Eliza

As seen above, Eliza suggested that Pakistani women were less likely to attend classes due to a confidence borne from watching family members raise children without such help. From the way women spoke about this issue, I got the impression that they saw external support (such as classes) as admitting weakness or a lack of ability, and that pregnancy and birth was a normal thing which should be instinctive and kept within families. Indeed, women's narratives indicated that family support and advice was more important than that gained by attending antenatal classes.

Faiza: Women ask mum and sister...what will I do? Like...this vomiting - maybe she tell me to eat this thing...maybe you stop [vomiting]. Eat lemon, or something [...] My sister – last time I eating nuts. I spoke to my sister – she was on phone – she said “what you eating?” I said “nuts” she said “don't eat much nuts, it's not good”. I said “ok...I not eat every day. Some day it's ok”.

Me: Do you speak to a lot of other people about stuff?

Faiza: Yeah...like...my sister and my cousin, they told me. Most of my cousin they live in Birmingham – they are pregnant as well.

Frustration

When speaking about differences between UK and Pakistani healthcare systems, women expressed frustration and annoyance.

It's annoying with the system. It's not [annoyance] with, errr...midwife or doctor. Because it's not in their hands - they have to follow their rules and regulations – they can't do anything. So it's annoying with...it's not personal grudges with doctor and midwife – it's not like that. But you get annoyed with the system.

Hana

Although Hana described annoyance with the maternity care system, she asserted that she did not see this as the fault of individual healthcare professionals. In fact, Hana felt that this was a problem which midwives and doctors were unable to prevent. This was a common theme in narratives; women suggested that frustrations with navigation of maternity care were directed at the system, rather than letting it affect their relationship with individual midwives.

In summary, the data suggested that women varied in their perceptions and understanding of the healthcare system. Level of understanding consequently appeared to influence women's individual expectations of maternity care, and therefore dictated the way in which they navigated the UK system. It was hinted that unsuccessful navigation had the potential to result in frustration, which could impact on women's relationships with midwives. Therefore, in order to fully explore the midwife-woman relationship for migrant Pakistani women, data suggest that it is first necessary to understand each individual's relationships with the UK and Pakistani healthcare systems.

6.5 Chapter Conclusion

The main aim of the research was to explore relationships between first generation migrant Pakistani women and midwives in the South Wales region; focusing on the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. A number of themes were considered when originally planning the current study including; issues around language barriers, cultural expectations of maternity care and the midwife role, social support networks, stereotyping and prejudice, and links between relationship and care. These themes featured significantly in women's narratives and data supported the development of the social ecological model of relationships discussed in the previous chapter. Indeed, as suggested by the model, data appeared to suggest that each woman's individual relationship with social and ecological factors such as their interpersonal relationships with family members, adherence to religious and cultural practices in pregnancy, and their understanding and navigation of the UK healthcare system, were key influencing factors in their relationships with midwives.

In the next chapter, data from midwife interviews and observations are presented. As in this chapter, themes are discussed alongside data extracts such as fieldnotes, transcript extracts and personal reflections.

Chapter Seven: The Experiences of Midwives

7.1 Chapter Aims

This second findings chapter discusses the key themes from midwife data; including extracts from interviews, observations and field notes. In order to set the scene for the following chapter, it is important to remember the social and political context in which data were collected²⁸.

As with the previous chapter, findings are presented in line with the dimensions of the newly created social ecological model of relationships. As before, it is necessary to keep in mind that this model attempts only to simplify understanding of a much more complex set of relationships, and that additional themes must also be taken into account when attempting to fully explore the midwife-woman relationship. Themes covered in this chapter include midwives' perceptions of women's family relationships, relationships with culture and religion, and the understanding of, and approach to, the UK healthcare system. Again, any data relating to the 'weaving themes' of communication of information and authoritative knowledge will be made clear by referencing in footnotes, and any reference to 'women' refers to migrant Pakistani clients specifically, unless stated otherwise.

7.2 The Relevance of Family Relationships

Although it was initially assumed that the exploration of relationships between women and midwives would have a focus on immediate and one-to-one relationships between these individuals exclusively, the data from midwife participants suggested that significant third parties (i.e. family members) were a key dimension within this relationship. In fact, this seemed to be the case even when these family members were not present during antenatal care appointments.

²⁸ At the time of observations and interviews with midwives, public attitudes towards immigration were increasingly negative, maternity services were under pressure to cut the cost of interpretation services, and the National Health Service had recently seen a number of damning reports of healthcare provision. A full discussion of this is presented in Chapter Five.

During interviews, midwives discussed their own relationships with migrant Pakistani women's family members, but more commonly spoke about their experiences with, or assumptions surrounding, the *women's* relationships with their family members.

One example of the role of family relationships and a common theme in midwife narratives was the role of mothers-in-law in women's pregnancies. Midwives tended to describe mothers-in-law in negative terms, and many suggested that they had to make a decided effort to communicate with the woman rather than speaking through her mother-in-law.

They're very young – away from all their family, and with a *dragon* of a mother-in-law...And sometimes, ummm, mothers-in-law *refuse* interpreters. So you're not actually getting to know what that girl really means.

Heather

Susan: They're inclined to talk *for* them as well [...] You're not quite knowing what the lady herself is thinking. I think mothers-in-law *can* be quite, ummm, the *dominant* relative – so they're inclined to – the mother-in-law, if she comes, to sort of *dominate* the consultation.

Me: Do you find that affects your relationship with the client then?

Susan: Well it *does*, really. Because you never really get to *know* them like you do, other ladies. You know...they're keeping them *back*, I think, a little bit really.

Susan's claim that mothers-in-law tended to "dominate the consultation" was a common feeling from midwives, and many suggested that this had the potential to prevent midwives from getting to know the women themselves.

Midwives' concerns regarding the mother-in-law influence in migrant Pakistani women's lives was also seen in their comments regarding the domestic work required from women; suggesting that women were often overworked and controlled by these family members.

I used to find it really difficult when it was young girls who have only just married abroad and then come over. And the mothers-in-law used to...you could *tell* that they just thought "Ah right – she's just here now, to [do housework]..." and they just looked worn down [...] And, ummm...you know – quite often I'd say "she could do with a bit of a rest" because you knew that she's probably cooking and cleaning there [...] But it's surprising how many I've told – "they could do with resting" ... "Oh!" Yeah and you just think "aww bless her". But you can't blame the mother in laws *because ...they* came over – young brides – *they* were worked – and suddenly they think "ahhh – daughters in law at last! I can relax a bit".

Heather

There was often sympathy expressed for women in this situation although, as suggested by Heather, many midwives acknowledged that the mother-in-law had probably been in the same situation herself, and that this was part of the Pakistani family culture. As seen in the previous chapter, women's accounts supported this view - suggesting that daughters-in-law were often expected to take over domestic duties for the household, with limited time for themselves.

Midwives' concerns regarding women's relationships with their mothers-in-law even stretched to day to day living situations; some midwives claimed that women were purposefully kept away from British society by these family members, and suggested that this influence could prevent the creation of a good midwife-woman relationship.

Susan: *personally* I think it's the mothers-in-law again. I think they're inclined *not* to encourage them [to attend things like language and antenatal classes]. Because they want to keep them, don't they? They don't *want* them to take on western attitudes and values.

Me: Do you think this has an impact...

Susan: I don't think they get – it's not such a *close* relationship with me and them, you know?

Although negative views on the woman-mother-in-law relationship were common amongst midwives, a number recounted cases of positive social support from family members in general. Many spoke about the tendency for Pakistani families to live in large houses with up to three generations under one roof, and expressed the view that it must be a great help and comfort to be surrounded by so many family members when dealing with the pressures of becoming a new mother. One midwife told a story about a woman she had supported in labour, detailing the positive impact that the woman's (newly acquainted) family members had on this experience.

You know – I do remember this *gorgeous* young girl. Quite a few years ago actually [...] She was so frightened. She didn't speak a *word* of English. I was working on labour ward, actually. And she had a sister in law and the mother in law – there was three of them, anyway. And [staff] were *really* strict on delivery suite. They were like – “they're allowed, like, two people in the room”. And I just shut the door. *Because* – she was doing *so* well. With all the...like, you know – *girl power*. She was just doing *so* well in labour...because she was *reassured* [...] She *did* have good family support – you could see that she got on really well with the sister in law and the mother in law. So it was – it was wonderful.

Tracy

Thus midwives' views on the quality of family support varied, as did the views of women, suggesting that the influence of mothers-in-law was not culturally consistent, and could vary between families. Whether or not midwives perceived mother-in-law influence to be negative, it

was clear that they felt that mothers-in-law were influential in terms of the “knowledge” being passed down to women.

I mean the ones who have newly come over that haven’t...you know...don’t speak – hardly speak any of the language – all they’re hearing is what the mothers-in-law or the family *tell* them...and they’re taking that as gospel. And of course this was *then*, and things have changed. And you’ve got a real battle to say “just because grandma said it doesn’t mean to say it’s *right!*” [laughing]. Because that’s all they’ve *got*...that’s the only people they can talk to. So ...you know...they’ve given them chapter and verse. So sometimes we’ve got to educate the *grandmothers* so that, ummm, the information they’re passing on at home...is the right information.

Heather

Indeed, it was clear, from the previous chapter, that women often followed pregnancy advice given by mothers-in-law, even if it conflicted with that of the midwife; the practical experience of mothers-in-law appeared to outweigh, and therefore take authority over, the knowledge of midwives. As will be seen throughout the next two chapters, the concept of authoritative knowledge seemed to have important implications for tension in midwife-woman relationships.

7.2.1 The Involvement of Husbands/Domestic Partners

The involvement of women’s male partners in antenatal care was discussed at length by midwives. As will be seen later in this section, although partner involvement was sometimes viewed positively, midwives spent a large amount of time expressing their concerns regarding the involvement of partners in antenatal care; suggesting that this meant that they never met women on their own. Midwives explained that they felt that this not only prevented them from building a good midwife-woman relationship but also hindered their ability to conduct a “routine enquiry” about issues such as domestic violence; local guidelines dictate that such enquiries should only be completed when the woman is alone (All Wales Midwifery & Health Visitors Domestic Abuse Networking Group 2006b).

You get, ummm, women who – they come in and they don’t say a word to you. They’ll come in with another relation – be it their partner or their mother in law. And they literally don’t say a word. And those kind of women – you don’t even get a chance to do routine enquiry with – cos you *never* see them alone – they don’t speak to you – they kind of just nod. Even though some of them *do* speak English – and you can tell that they understand what you’re saying - they’re just nodding in the right places and that kind of thing. And other people are answering for them.

Mary

The tendency for male partners to speak on women's behalf during antenatal appointments was described by women themselves (see Chapter Six). This lack of direct contact with women was seen, by midwives, as one of the biggest barriers to establishing a good midwife-woman relationship. Indeed, women's silence during antenatal appointments often resulted in midwives giving up on interacting directly with women, and instead focusing their attention on male partners²⁹.

I've never really thought about this before. Cos as I said before – I find that I direct most of it at *him* rather than at *her*.

Penny

Penny seemed rather surprised and shocked at her own admission, as she returned to this point a couple of times later in the interview. Penny later acknowledged how this might affect her relationships with women; again suggesting that it was something she had not previously considered. Other midwives expressed similar views and suggested that seeing women on their own, at least once, was necessary to build a good relationship.

You never get a relationship going how you'd like it to be [if there is another person present]. It's all very...official. And that can be...yeah. It's not the same. Even if you've met them once on their own – you kinda get a better idea about who they are and what they can do.

Mary

Mary's account suggested the importance of informality and social chat when getting to know women, in order to "get a relationship going" and indicated that this type of engagement could be disrupted by the presence of others; a feeling which is echoed later in this chapter in reference to the use of interpreters. The negative effect of a third party on the establishment of midwife-woman relationships was commonly noted by midwife participants. Most also acknowledged that it was difficult to speak to migrant Pakistani women alone, as most were always accompanied by partners or relatives. As touched up earlier, midwifery guidelines in Wales posit that midwives should ask some questions whilst women are alone, and therefore need to "ensure lone contact with the woman at least once in pregnancy" (All Wales Midwifery & Health Visitors Domestic Abuse Networking Group 2006a, p. 3). As such, a number of midwives admitted to improvising in an attempt to create even small opportunities for one-to-one contact with women, as Mary describes in the extract below.

²⁹ See observational account of this on page 133

I've followed ladies out to the *toilet* before now. Because I just, literally...you get...is everything alright? She's a bit subdued kinda thing. So followed them out to the toilet – which is kinda a bit stalkerish.

Mary

It became clear that midwives felt that this one-to-one contact was necessary, at least once during the pregnancy, in order to build a good midwife-woman relationship and give good care.

Most midwives suggested that male partners' tendency to talk on behalf of women was the result of a culture of male authority in Pakistan. Male authority was viewed as a characteristic of the Muslim religion, with an inevitable consequence that Pakistani women were culturally conditioned to let their male partner to speak on their behalf.

Isn't it *strange* though? That all the women have developed this habit. And it's almost as if it's the man's place to speak for them.

Gail

In certain cultures – [women] are seen as a minority, aren't they? Females are...like...they should just sit there. They, they look to their partners for approval. It's just the way men have always talked for the woman, you know?

Barbara

However, during discussions on male authority with midwives, I often told the story of Rehan, the husband who wanted his wife, Aleena, to take more responsibility and speak for herself³⁰. All midwives with whom I discussed this expressed great surprise, and suggested that Rehan must be very "forward thinking" and "westernised", suggesting that midwives saw this case as an anomaly.

Me: Yeah – the couple that I was interviewing...the husband...when his wife moved over...he *made* her go into town on her own.

Gail: Did he???

Me: He said "Oh I'm not coming with you" ...and she got lost and she rang him, and he had to go and find her. But he said "No – you go on your own".

Gail: Really?? Oh right!! He's probably very forward-thinking, mind you! [...] He's quite *westernised* in the way that he wants her to go out and do stuff.

Along with other midwives, Gail felt that male authority in Pakistani culture needed to be changed, and many expressed a desire to 'help' women in this situation. This was illustrated clearly by Gail's

³⁰ The anonymity of the couple was ensured at all times.

suggestion (see extract below) that someone needed to “break that cycle” of male authority. It was apparent that very few midwives had considered the possibility that women might, instead, be happy with the gender roles within their domestic relationships. Indeed, it appeared that many of the generalisations made about migrant Pakistani women’s family relationships were based on ethnocentric views held by midwives.

But how can we break that cycle? Because it’s something that we don’t understand! [...] *Again* – it is a *cultural* issue. Cos they feel that...in their culture the *man* is the head of the house. So he makes decisions, he does the talking. He does this. And I think that’s what it is...but we can’t *break* that.

Gail

Nevertheless, other midwives accepted partners’ involvement in antenatal care as a cultural preference or way to negotiate language barriers and made it clear that they did not see it as an indicator of an unhealthy power dynamic.

I don’t know if it’s a respect thing? Or [women] are scared of saying the wrong thing [to me]? ...there isn’t a *wrong* answer – but I think they think there’s a wrong answer. Or...or maybe they’re worried that they haven’t understood what I’ve said – so they’re looking to him to confirm what I’ve said

Mary

In fact, one midwife acknowledged that women may be happy for their male partners to have control during antenatal appointments and suggested that it was not her right to judge or try to change this.

And, you know, who is it for us to, sort of, change that, really? Cos I think that woman...you know, that’s her life, isn’t it? She’s made that life...and she’s obviously quite happy with it. Might not be happy for us – we might not like that life. But, you know, that’s the thing, isn’t it? I think they know that they’ve got choices. But it’s up to them...the choices that they make.

Tracy

Extracts such as those from Tracy and Gail, above, suggested a cultural naivety amongst midwives. There was a tendency for midwife participants to categorise or compartmentalise migrant women, cultures and domestic relationships using their own pre-existing stereotypes. For example, Tracy’s assertion that Pakistani women are “obviously quite happy with it” and that “they’ve got choices” is arguably as naive as Gail’s claims that there is a “need to break the cycle”.

As discussed in previous chapter, the issue of male authority in Pakistani culture is more complex than assumed by midwives, and more multifaceted than I anticipated. Women participants often

teased their partners about gender roles in Pakistani culture, and this was acknowledged by a couple of midwives, who suggested that they could joke with women about their husbands.

And *most* of them have got a fabulous sense of humour as well. I mean you can have a good giggle and things. Usually against men [laughing].

Heather

As demonstrated by the field note extract below, I had experienced similar situations myself, during antenatal observations.

Observation Period Nine

Date - 20/01/15

Midwife asks questions about smoking – client says that partner smokes shisha in the house. Partner says this does not have nicotine in so will not be harmful. Midwife and student midwife suggest it might –client agrees. Information is looked up on internet – shows it does have nicotine. Client teases partner that he will now have to smoke outside as he has been proven wrong. Partner jokingly suggests he has been “ganged up on by women”.

In summary, midwives' views on women's family relationships varied; while some midwives viewed partner and family involvement as positive, others suggested that it could be overbearing. However, all midwife participants acknowledged that constant third party involvement resulted in less one-to-one contact for midwives with women, and therefore restricted their ability to build a good midwife-woman relationship. As briefly touched upon earlier in the section, strong family influence is also likely to detract from the advice of the midwife, or even directly contradict it, once again causing the potential for tension in the midwife-woman relationship. In terms of the research question, these findings suggest that family relationship factors must be taken into account when attempting to understand, or enhance, midwife-woman relationships for migrant Pakistani women.

7.3 The Influence of Pakistani Culture and Religion

Midwives varied in their attitudes towards Pakistani culture. Some spoke about cultural differences in positive terms for example, proposing that working with women from different ethnic groups had broadened their outlook, improved their general knowledge, and made them more open-minded.

It's open...it's widened...I was never judgmental...I'm not a judgmental person [...] I think it's just kind of *broadened* my outlook on it, I guess.

Barbara

Broadening of outlook mainly referred to learning about traditional Pakistani cultural practices carried out during pregnancy and childbirth. However, some practices seemed to divide the opinion of midwives.

7.3.1 Cultural Practices

One practice which seemed to split the opinion of midwives was that of shaving a new-born's head; a practice which is not a cultural norm in the UK. As shown in the following data, some midwives expressed acceptance of this practice, whilst others mentioned concerns about the safety and hygiene of head shaving.

The [hair] *shaving* I don't like, because sometimes they're not very careful so you can have, you know, razor burns and stuff like that. That I don't like at all. But I...I understand why they want to do it. So *usually* I just say to them "just be careful" cos they usually tell you – most of them will tell you before, that they're gonna do it. I mean...I've turned up one time and it was already done. But normally, sort of thing, they tend to say "we need to do this" and then you just explain to them "ok...I know you need to...but just be careful", or "who's gonna do it?" ...because you need to know who's gonna do it, and they just not bothered with hygiene.

Gail

Migrant women being "not bothered with hygiene" was a theme which appeared in a number of midwife participant narratives, however this was largely (although not exclusively) discussed in terms of Chinese women who were understood to have cultural beliefs which prevented them from washing straight after birth³¹. Although many midwives claimed to be understanding of the importance of cultural traditions, there was often a look of disgust or concern on their faces when speaking about these practices.

³¹ An account of this is given later in the chapter.

Midwives' views on most cultural practices were influenced by their understanding of the relative safety of these practices. However, none of the midwife participants referred to any specific evidence or guidelines when speaking on the safety of practices, instead implying that relative risks were common knowledge. A small number of cultural traditions were outright rejected by midwives, and I could sense midwives' annoyance whilst discussing these with me.

Pregnant women shouldn't fast. And I always find that if they *are* fasting then I'm kind of lecturing them "no – you shouldn't be fasting" and that kind of thing...and they do get a bit *funny* about it. Because they...they *want* to do it...and I'm saying no you shouldn't do it. And *that* can cause a bit of...you can see that they're not happy that I'm saying no you shouldn't.

Mary

This annoyance was especially apparent when midwives spoke about the propensity for women to ignore their advice and continue with practices as soon as their midwife was not present³². As suggested by Claire in the following extract, a number of midwives acknowledged that they could not be there at all times to supervise these activities, and that they had little control over what women did when they had left. Although this is arguably true for any women that midwives care for (migrant or otherwise), this was especially worrying for midwives when concerning potentially dangerous traditional practices such as putting necklaces (often made of string) around babies' necks.

They continue to [put string around the baby's neck] because we're not there *all* the time – we're not there *24 hours* – so they may remove it once you've gone...then put it back on after you've gone.

Claire

Although midwives initially suggested that disregard of advice wouldn't affect their relationship with women, a few later admitted that it might influence their attitudes and behaviour.

I hope not! I hope that I'm kinda...it's *hard* because you make opinions all the time and...rightly or wrongly...so I *wanna* say no...but perhaps I do. Perhaps I *do* think "don't be silly...wash, wash that! Otherwise you're gonna be back in hospital" But...that's not my place to say. So yeah – I think it does – it would kind of affect our relationship, I suppose.

Penny

As seen in the above extract, Penny initially expressed hope that her relationship with women would not be affected by their decision not to follow her advice. However, only a few seconds

³² Propensity for clients to carry out traditional practices in secret was also seen in client narratives. Again, this brings up the issue of authoritative knowledge.

later, she admitted that the reluctance of some women to wash following caesarean sections might indeed have affected her relationship with these women.

The hesitant and somewhat confused answer seen in the above extract suggested some dissonance which arose as a result of being questioned about relationships with women whose practices do not always comply with the cultural norms of the midwives. Women's desire to carry out traditional pregnancy and birth practices seemed to put midwives into a difficult position – on the one hand trying to uphold the respectful person-centred approach instilled in healthcare professionals during training and as part of professional regulation, whilst on the other hand being concerned that this approach could result in maternal and infant morbidity/mortality with implications for professional accountability. A need for careful balance on this issue was apparent.

Penny (above) was one of very few midwives who admitted that their personal views on cultural practices may influence their own relationships with women. The majority, instead, tended to project negative attitudes towards cultural practices onto colleagues; suggesting that they could see why 'other' midwives might not accept some practices, and how this might affect midwife-woman relationships for these other midwives³³.

Barbara: It shouldn't impact on the relationship they have with their midwife, no.

Me: Do you think most midwives see it that way?

Barbara: Probably not [laughing]. I think I'm probably kind of an exception, maybe? I dunno...it's difficult, isn't it? I've...I....errr...Yeah. No...no, not every midwife will have the same [view] [...] I'm sure they'll get a bee in their bonnet.

That's just *me*...I'm not, I'm not a kind of *pushy* midwife. I know some people are very much like "this is what you *have* to do...nothing else is acceptable".

Eleanor

Despite claims of being unique in their acceptance of cultural variation, some ambiguity was evident; a number of midwives appeared to be concealing their true feelings on this issue; although some seemed genuine in their acceptance of cultural practices, I felt that some had maybe given me the socially desirable answers that they felt I wanted to hear or would find

³³ This meta-theme of otherness is explored further in the discussion chapter.

acceptable. It is interesting to note, however, that a minority of midwives were quite honest and open about their prejudice and stereotyping of women.

There also appeared to be confusion and anxiety over the midwife's role in the supervision of these traditional practices. "Informed choice"³⁴ was a popular phrase when talking about decision making on this issue - midwives suggested that it was their job to provide women with as much information regarding the safety of these cultural practices as possible, and then to let the women decide for themselves whether or not to carry them out. Despite not approving of some practices, some midwives called on the notion of informed choice to deflect any feelings of responsibility if poor outcomes occurred as a result of decisions made by women.

That's down to *informed choice*. So I think – at the end of the day – you need to inform *why* we recommend they don't put any eyeliner on...and why they need to be mindful of that...let...string around the babies neck. As long as you've informed them...

Claire

However, informed choice seemed to be a tension with midwives' sense of their own professional accountability. In a number of extracts (including the above and below), midwives' concerns about accountability were expressed as a desire to "cover one's back". As shown in the following extract, Mary spoke about her anxieties surrounding a cultural practice which involves putting honey on a new-born's tongue. This was an interesting practice to discuss with midwives, as there was serious disparity on knowledge regarding the dangers of this practice; whilst a number of midwives didn't know there were any risks involved, others appeared extremely concerned about the potentially harmful effects this tradition could have.

I always worry that if I don't say it out loud and document it that I'll be the one midwife who has a baby that goes down with Botulism and then they'll be chasing me "oh you didn't warn them about..." because it *will* come back and bite you on the bum if you don't document it...that you've warned them not to put honey in the baby's mouth for risk of Botulism. If you don't document it and then that baby's taken ill and then the parents say "well we were never told that it wasn't safe". So it's things like *that* that worry me. That could come back and cost me my registration³⁵.

Mary

However, it is interesting to note that in the extract above, Mary's concern is not on whether the baby might actually be harmed, but on the risk of harm to herself of being blamed for this. Where

³⁴ The concept of informed choice will be explored in the discussion chapter.

³⁵ A midwife's registration is what qualifies them to work as a midwife. Losing their registration would mean re-training before they could work.

midwives spoke about practices they deemed as potentially unsafe, they often seemed to be voicing, and then processing, internal conflict on these issues.

I haven't come across anything that's been quite *that* scary, and *that* serious – that I've had to, kind of, refer it – onwards and upwards. It's *bad*, because we *do* have to cover our backs, to protect ourselves, but we have a duty of care to protect our patients, and babies as well. So...it's striking a balance.

Eleanor

Midwives appeared to struggle with this “balance”; acknowledging the need to show respect and sensitivity towards cultural practices, whilst also protecting themselves from possible repercussions³⁶. There emerged competing discourses about informed choice and what that meant for midwives' accountability. As will be seen in the discussion chapter, the balancing of professional accountability with informed choice is made more difficult by a lack of research-based guidelines to inform midwives on best practice surrounding these issues.

General Observation: Cultural practices

When watching and listening to midwives talk about cultural practices in pregnancy, there was a tendency for them to shift around in their seat and look at the ground more than during other parts of the conversation. Although verbally midwives were suggesting that they were accepting of practices, there were often flashes of concern, and even disgust, on the midwife's face during conversations on this topic. Although a couple of midwives were very forthcoming about their opinions on cultural practices, it seemed that the majority of felt uncomfortable speaking about this issue, and lacked confidence in the actions they took when faced with this situation.

Skilful communication was seen to be important for minimising cultural tension, as Heather describes:

³⁶ The concept of balance will be explored in the discussion chapter, with references to the concept of tightrope walking in midwifery.

I don't think it causes problems...it depends how you put it. If you say "right this is the evidence, and I've got to tell you...and this is the evidence we've got on reducing cot death, you know, having different things put around the babies" that we sort of say nothing around the baby – no toys. Ummm – they just accept it I think. If you say it in a nice enough way.

Heather

The nature of midwives' existing relationships with women was also thought likely to affect how cultural practices were perceived and understood.

I think, sometimes...if things make sense to you then you can understand it. If it *doesn't* then you tend to judge. Unfortunately – if you haven't built up a relationship with somebody during pregnancy...you tend to actually be very *hard* on some of the decisions they *make*, and I think we need to be honest about it.

Gail

This assertion from Gail - "if you haven't built up a relationship...you tend to actually be very hard on the decisions they make" implied that an existing positive midwife-woman relationship could help midwives make sense of traditional practices that may seem alien. This suggests a bidirectional nature to the formation the midwife-woman relationship; the level of establishment of midwives' relationships with women seemed to influence their perceptions of their cultural practices, whilst at the same time, midwives' attitudes towards cultural practices influenced the potential for establishing this professional-client relationship.

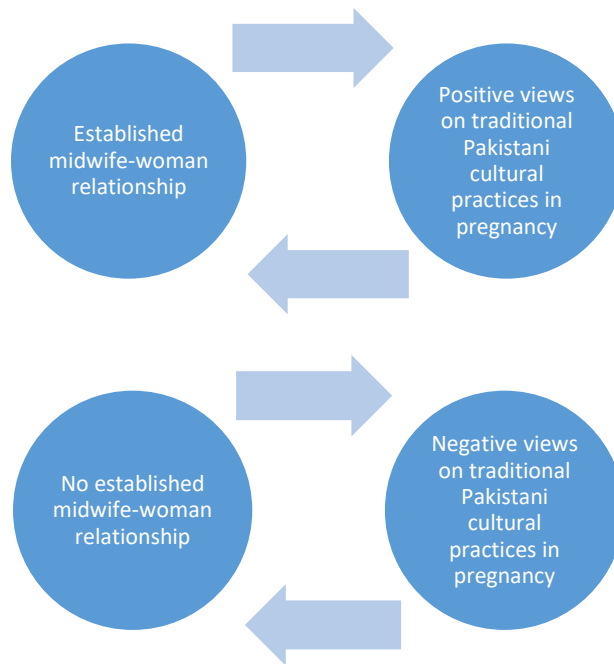


Figure 11. The bi-directional effect between views on cultural pregnancy practices, and establishing a good relationship

Further support for the bi-directional relationship was shown during interviews with other midwives, who suggested that there was a need for health professionals to understand the origins and importance of traditional practices, in order to improve midwife-woman relationships, reduce judgement and safely incorporate such practices into maternity care. As seen in the following extract, Heather spoke about how understanding different cultures could change professional attitudes, and increase empathy, towards women.

I mean – with Chinese women – they’re not to have anything cold. Any cold food or drink. And, of course, in the hospital – when they’re brought a nice jug of iced water – they’re not *allowed* to drink it. And some people get *offended*...” cuhh – they didn’t even want that!” and if only they realised that it’s something as *simple* as...they *don’t* have cold drinks. Then perhaps they could get them something warm, and not get offended by it! I think it’s just a matter of learning as you go along. Learning all the different cultures.

Heather

As Heather infers, learning about cultures was informal, done “as you go along”. None of the midwives who took part in my research had been offered the opportunity to partake in any cultural awareness training, which some thought would have been helpful:

I think it would have been useful. Especially *now* – it's a *need* now! ...for the people coming in. Because when...like I said – when I came in [to midwifery] perhaps the immigration level wasn't as high as it is now.

Nicola

As well as claims about a lack of formal training, midwives suggested that a number of colleagues were hesitant in asking women about their culture.

And it's...not spoken about [...] I go out to somebody's house and I say to them "oh – you've shaved your baby's head" then I'll just ask them about their – about that practice, you know. Just in general conversation I try to. Rather than just *ignoring* it altogether. Because I think there is almost *that* as well – that people don't ask because...out of embarrassment or out of fear of not knowing how the parents are going to react.

Nicola

Interestingly, this was something which was hinted at in an interview with one of the women, who claimed that the midwife 'ignored' the fact that her baby's head had been shaved.

Despite notable concerns from midwives surrounding traditional Pakistani maternity practices, a number of midwives viewed these positively. Heather told me, with delight, how she had learnt that in some cultures the first voice the baby should hear after birth was that of the father. I sensed an air of pride that she had not only respected a cultural tradition of her client, but had also passed on this knowledge to a student midwife who had been present at the birth.

As seen, different levels of understanding and acceptance of Pakistani maternity practices existed between midwives. Furthermore, midwives varied in their concerns over responsibility and accountability for these practices, and it seemed as though that this had the potential to impact the way in which traditional practices were discussed with women. I began to reflect on how this might contribute towards answering the research aim; exploring the relationships between migrant Pakistani women and their midwives. Data seemed to suggest that traditional cultural practices in pregnancy had the potential to cause conflict and tension in midwife-woman relationships, and that this source of conflict was mediated by a number of external factors such as cultural awareness, feelings of accountability, and issues of authoritative knowledge. Therefore, in order to fully explore these midwife-woman relationships, it seemed that these external factors would need to be taken into consideration.

7.3.2 The Muslim Religion

Midwives acknowledged the impact of religious beliefs on women's behaviours, and consequently the potential for these beliefs to impact on their relationships with women. For example, as seen earlier in this section, a desire to fast during Ramadan was seen as unacceptable by midwives, and often resulted in women continuing this practice out of the sight of health professionals.

Two midwife participants spoke about the tendency for migrant Pakistani women to believe that their pregnancy was "in the hands of God" or was part of "God's will". Whilst women's accounts portrayed this concept in positive terms³⁷, midwives described how they often became frustrated and upset by situations where they felt that women put too much trust in Allah, and too little trust in the maternity care system³⁸.

But it's really *sad*, sort of thing. Because what you tend to hear is...when things *do* go wrong – they go "Inshallah" [god's will in Arabic]. But it's *not* [God's will] – you just needed to actually *do* something about it. It's almost as if it's *okay* [that something went wrong]. And you're just thinking – but it's *not*. You could have actually *changed* [the outcome].

Gail

This account, from Gail, suggested that women's reliance on God's will was experienced as a barrier to what she had to offer as a midwife; instead of believing in Gail's professional ability, women rejected the bio-medical model and hence, by extension, an important element of the midwife's knowledge³⁹. Further discussion with Gail on this point led to her claim that women who held this belief were less upset by negative outcomes of their pregnancies, as they believed it was an act of God.

7.4 Communicating in English

Migrant Pakistani women's English language fluency was a common topic of discussion for midwives. Although some midwife participants claimed that English language fluency was rapidly improving for migrant Pakistani women on the whole, the majority suggested that language

³⁷ As seen in the previous chapter

³⁸ Here, lack of trust in the maternity care system refers to non-attendance at antenatal appointments and classes, as discussed in a later section.

³⁹ This situation is an example of 'rejected exchange'; a concept which will be explored in the discussion chapter.

barriers were one of the biggest obstacles in building a “good relationship” with this client group due to its impact on effective communication.

Yeah I think language is the *biggest*...the biggest barrier [...] It's very...*very* difficult. Ummm...because I think that obviously, kind of stunts the relationship as well [...] Essentially you could be seeing this woman over 6 to 8 months...and you would *hope* that by the end of that you've formed a fairly good relationship. But not...I don't always *feel* like that...with women that I'm not able to communicate *effectively* with.

Eleanor

Oh I think that the language is *certainly* a, you know, if you can't *communicate* with them – ummm, that's a *barrier* [...] If I can't sort of talk *easily* with them...it *does*...that does *affect* [the relationship]. So the ladies that I can talk to, you know, *easily* – then I think it's the same. But I do think it is affected if I can't communicate with them.

Susan

It was shown in the previous chapter that women acknowledged the difficulty in expressing feelings and opinions to midwives when English was not their first language. Many midwives also recognised that women often struggled to communicate information and feelings effectively, and suggested that this might have the potential to have impact on pregnancy outcomes. In the following extract Claire describes a commonly experienced situation:

Sometimes – if their English is very poor...you can see the frustration in their face – while they're trying to explain to you *why* it's a problem...or something. You can *see* it...the frustration that they *want* to talk to you about it all

Claire

Where communication was inhibited, it was evident that midwives felt helpless and frustrated on behalf of women, and also became frustrated themselves as they felt that they were unable to do their job effectively. This could lead to resentment:

Having conversations with other midwives – you know – not specifically but may mention “Oh, you know...I had a lady in clinic today – completely did not speak a word of English – I don't know how much she understood of what I was saying” ...and then someone else will say “Oh I have the same...all the time” And it's...it's kind of frustrating for us. And...it...we don't *want* it to be. But because it *is* so difficult – you, you do become a little bit *resentful*...you *do* think – a) I can't do my job properly...and b) you do *question* why women come into this country having not learnt any English. You know – literally not an *ounce*! ... But because there's that lack of communication there – I find myself just being like “cuhh...*why* would you *come* to this country...not knowing how to communicate with people?!”

Eleanor

A small number of midwives were similarly open about such feelings of resentment or frustration. Others, however, tended to project these feelings onto other midwives. This projection onto 'others' was a common theme in both woman and midwife narratives, and is discussed as a meta-theme of 'otherness' in the discussion chapter. Whilst it is possible that midwives overestimated the negative feelings of their colleagues, my own observations and further conversations with midwives suggested otherwise. It became apparent that midwives wanted to acknowledge the 'potential' frustration of working with women with limited English language, however as they did not want to appear judgemental themselves, they therefore projected these feelings onto colleagues.

Susan: No... I don't *judge* people [on not being able to speak English]. You know, I don't think I *do* judge them. Ummm...but it obviously would be much easier if you *could* communicate just one-to-one with them.

Me: Do you think most midwives share your opinion on that one?

Susan: Ummm...I would say *most* midwives do. But I know there *are* midwives that *don't*. Yeah, you know – I can think of a *few* that I've spoken to [that don't share that opinion] – yeah.

It is possible that this projection of feelings has its roots in a lack of training and opportunities to engage in discussions about cross-cultural working. For example, during interviews, many midwives seemed to find it difficult to articulate their frustrations about working with migrant populations.

Some midwives, however, suggested that it was their responsibility to get this information across to women successfully, and gave examples where they used humour and image cards during appointments to improve communication.

I think it's down to the *midwife*; how she is able to communicate that across. You might not *need* an interpreter there to, to do that. But if you make that information very technical, involving, like, *amnio* and *needle go in the tummy* and things like that...you – of course you're gonna scare somebody about it all. But if you're being very, very philosophical about it, and see it in that kind of simple kind of way – put the information across in that way that they *understand* – then they have a much more informed choice about what decision to make.

Claire

Although midwives showed some awareness that women did not always understand important details of antenatal appointments, my own observations suggested that a large amount of

miscommunication went unnoticed⁴⁰. Language barriers limited the attempted information sharing on the midwives' behalf; during observations at antenatal appointments I noted midwives altering the amount of information given to women depending on their English language fluency. In one extreme example of this behaviour, one midwife even started to speak to me over the head of the woman, directing more information at me than at her.

Observation Period 12
18/02/13

Midwife tries to give client information – obvious that client isn't following most of what is being said. Midwife starts directing information to me, instead. Makes me feel very awkward as I feel I am getting much more information than client. Midwife tries to make eye contact with me consistently throughout the appointment, even though I have reminded her before each observation that I am just there to observe and not to interact with me, if possible.

Situations like these suggested that inadequate language support would often leave midwives feeling unable to communicate complex information; consequently, many would stop trying to have detailed conversations with women, and instead provide only basic information and leaflets (all leaflets given to women during my observations were written in English, and there was no mention of alternative language versions, although I knew they existed). This observation was clearly worrying, as some women were not able to access all of the information they needed or were, at least, required to make additional personal effort to acquire this information in a language they could understand. It is logical to suggest that the use of interpreters could go some way to prevent this – however, as will be seen later in the chapter, interpretation services were not always used by midwives, and were often deemed ineffective.

During my observations, I noted that conversational characteristics such as small talk and humour were left out of conversations with women with limited English fluency. When speaking with

⁴⁰ As seen in the previous chapter, one client participant asked for clarification of terms she had not understood during her antenatal appointment.

midwives on this issue, it became apparent that these missing aspects of communication had the potential to influence their relationships with women.

I think the *whole* conversation – the whole hour – isn't *just* about your health and your record. Because sometimes – you know – if they want to talk about how they're *feeling*...yeah – I think it's good to know...to know, really. I mean – not *always* word for word if they're just having, you know, a sort of private conversation. But when you get women who speak English coming in – you're not just talking about, you know, the booking visit. Sometimes they'll have a chat about different things – different worries. And it just helps build up the relationship. So you miss out that side of it [with women who don't speak English]

Heather

Such findings suggest that not only was information sharing seen to be extremely important for the wellbeing of mother and child, but that midwives considered a holistic approach to women's care as an important part of building a good midwife-woman relationship.

7.4.1 Responsibility to Learn English

A theme which midwives discussed with passion was the view that migrant Pakistani women had a responsibility to learn English. As already seen in some of the extracts in the previous section midwives frequently suggested that this was often a cause for frustration when working with women who had limited English language fluency, especially if they were having their second or third baby or had lived in the UK for many years.

I think the women need to take some responsibility for their own...it's fine if you enter the country – in *my* view – if you enter the country and you are here and you're seeking asylum and you're trying to, ummm...get to know where everything is. And you're pregnant. Then for us to provide you with an interpreter – to provide you with the correct service – is the right thing for us to do. But then if you go on to have a *second* or a *third* or a *fourth* or a *fifth* baby...and you still haven't learnt English – and you've been here for 5 or 6 years...then I *do* think you should have *some* responsibility for your own need...to provide yourself with the language of the country that you're living in. I suppose patience runs thin.

Nicola

I think, like – my god! 15 years! That's like.... ridiculous. You've been living in a country and then you still aren't fluent in that language. I think that's *appalling*!

Tracy

A number of reasons were put forward, by midwives, to explain migrant women's lack of improvement in English language fluency. For example, many midwives felt that women were reluctant to attend language classes, or that family members discouraged women from doing so.

Maybe a *reluctance* [to learn English] ...but then I would find that *difficult* to understand...because my opinion would be if I was to go somewhere else, I would make as much effort as I could to, to learn the language, so that I *could* communicate with people. So I don't *know* whether it *is* reluctance...but I would find it difficult to understand, if it was, personally.

Eleanor

Well I think it's this...*personally* I think it's the mother-in-law again. I think they're inclined *not* to encourage them to [learn English], cos they *are*, you know...they want to keep them, don't they? They don't *want* them to take on western attitudes and values. So I think it's just the *family*, you know, the ones that *don't*. It is sort of – they're encouraged by the family *not* to [attend classes]!

Susan

However, despite obvious frustration about women's lack of attendance at language classes, midwives admitted to a lack of knowledge on the details of these available services themselves, and suggested that this information was not readily available to them.

I don't really know that information myself. If I *knew* that there were classes around...but then from my point of view, I suppose I could go out and be fairly proactive in *finding* that information [...] Getting that information across to *us*...let alone *them*...is not happening, I would say. I certainly don't know of any classes that they're doing [...] If it *was* there...I would like to think that I would probably know about it. If it was being made fairly, fairly public...but there's not much that I know of. So I don't feel like I'm equipped to kind of support them with that.

Eleanor

Admissions such as these took me by surprise; the level of negativity surrounding women's 'reluctance' to learn English had suggested to me that midwives were encouraging or facilitating this learning. In fact, midwives were unclear about how to access these classes, and many openly admitted to not informing women about their existence.

Reflection Two: Language barriers

Although I knew about the existence of “English for Pregnancy” classes, from my meetings with a consultant midwife in the practice, only one of the midwives mentioned this to me when talking about women’s language barriers. Most midwives claimed they knew that there were some language classes available but did not have information about these to hand, and admitted that they didn’t give this information to women. Whilst I was waiting to do observations, I took the time to look around the booking clinic environment – mentally taking note of the information provided. From the 5 different locations I visited, none had any information about language classes apart from the basic ESOL classes (and this was only at one location).

Self-contradictions were common throughout midwives’ narratives on women’s language fluency. Indeed, midwives often swung between frustrations towards women’s limited English to sympathy towards their lack of opportunity to attend language classes. Consequently, findings suggested that in order to understand the effect of language on individual midwife-woman relationships it is necessary not only to consider the situation of each individual woman in regards to opportunity and attitude towards learning English, but also to explore the assumptions and expectations of each individual midwife.

7.4.2 The Use of Interpreters

Midwives acknowledged that interpretation services were often needed for appointments with migrant Pakistani women. However, some expressed feelings towards these services that were surprisingly negative. My first encounter of the challenges posed by interpretation services was at a midwifery team meeting which I attended early on in my data collection. From this meeting I learnt that midwives often found official interpreters to be overbearing, and a number of midwives claimed that interpreters would turn up at appointments without being booked. Similar feelings are shown in an account from Eleanor, below.

I do find the interpreters, as well, can be quite overbearing in proceedings. Like I say – they go off on their own conversations. But they’ll also kind of book themselves when we haven’t asked for them to be booked. And they’ll ring up and say “Oh...I gather you’ve got an appointment with this lady at this time...I’ll come along”. And it’s like “No” ...because if we felt like we needed the

interpreter then we would book the interpreter. They can, sometimes, I've had issues with that before – and I have, kind of, taken it to more senior management to be dealt with. Because I don't feel like that's appropriate, really.

Eleanor

The uninvited presence of interpreters seemed to be an area of conflict for midwives. Many expressed feeling as though their authority was being challenged, and that they were being forced to use (and therefore to pay for) services that were not needed. Some midwives even claimed that, as a result of this behaviour, they had started turning interpreters away out of irritation and exasperation. A number of midwives admitted to no longer using face-to-face interpreters for the majority of their appointments, and none were present during any of my observation periods. In addition to turning up to appointments without being invited, midwives claimed that interpreters often tried to assume the midwife's role; asking health related questions and providing advice to women, without translating any of this back to the midwife.

Well I must admit – there...there *were* a few interpreters in the past...that almost *took over* the booking! They were *appropriate* questions but they weren't waiting for *me* to *ask*...and then *they'd* ask. They were just, sort of, taking over.

Susan

As alluded to by Eleanor in the previous extract, Susan suggests that the presence of the interpreter challenged her authority by “taking over” the appointment, and many midwives agreed that they were not able to do their jobs properly in such situations. Not only were interpreters said to make assumptions on behalf of the midwife, examples were also given where interpreters would answer on the woman's behalf without relaying the midwife's question. In fact, Heather gave an account of one particular interpreter who refused to ask women any questions about their mental health; claiming that their culture did not ‘have’ mental health issues.

We had *one* [interpreter] that every time you asked the mental health question... “No, no – we don't have that! We don't have that!” So, you know, a few words had to be said “could you *ask* her the question and could you tell me what her reply is” ... But she didn't believe that, you know, she said “No – we don't have that. We don't *have* mental health problems” And some...you can tell, by looking at them, they very clearly do!

Heather

Accounts such as the above, from Heather, appeared to be examples of ‘atrocities’ stories – where “a straightforward complaint...is transformed into a moral tale inviting [the audience] to testify to the worth of the teller against the failings of the other characters in the story” (Dingwall 1977, p.

393)⁴¹. Indeed, Heather seemed to be using this account as a way to legitimise her negative views on the use of interpreters during antenatal appointment. Similar accounts were put forward by other midwives, who indicated that the involvement of an interpreter could hinder the creation of a good midwife-woman relationship; information was not always communicated correctly, the right questions were not always asked or answered, and the midwife was often required to 'manage' the interpreter – leading to frustration and tension during appointments.

As seen in the previous chapter, women also recognised the potential for the interpreter's presence to have a negative effect on the midwife-woman relationship. Even when the interpreter was not perceived to be overbearing or controlling of the antenatal appointment, both women and midwives felt that speaking through a third party could hinder relationship building:

If you're having to go through a third person you're *never* gonna get that...that same, ummm...the questions are gonna be asked differently to how you'd...how you'd ask...so yeah – it's bound to affect the relationship.

Heather

This was the case even if the 'interpreter' was a family member:

She brought her daughter *out of school* to come and interpret for me. No matter what I do...I'll never be able to build up a relationship with her because she just cuts off.

Gail

Some midwives also suggested that the presence of an interpreter could lead to the woman building a stronger relationship with this third party than with the, because of the social 'chat' that occurs:

That woman will take to the interpreter more than she will take to *me*...because I'm not *involved* in the conversation, as such. I'm just the observer...I do feel like I'm the *observer* sometimes. And ...essentially I *am* getting the information that I'm *asking for*...but if this woman is telling her *other* stuff – I wanna know about that stuff as well. But I do think....*just* the mere fact that you are *able* to talk between yourself – that automatically, you know, forms maybe a stronger bond than I can build with that woman because I can't understand what she's saying...Sometimes I turn up to interpreter calls where I've met the lady, two or three times...and I've had the same interpreter with me the same time...and that woman will, you know, be like, talking to the interpreter *first*...and then turn to me and be like "hello" And I'm just like..."oh" [makes face as in feeling a little hurt]...they form more of a relationship with the interpreter than they do with the midwife who is trying to provide the care.

⁴¹ The importance of these atrocity stories in midwifery practice, and what this might mean for midwife-woman relationships, is picked up in the discussion chapter.

Eleanor

Thus the potential for reciprocity in the midwife-woman relationship may be restricted. Midwives admitted to having felt marginalized by interpreters continuing conversations that they were not a part of, and I had experienced similar feelings during fieldwork, which made it easier to understand their perspective. The following field note relates to one of the first interviews I conducted with a migrant Pakistani participant, during which I felt excluded from conversations with the interpreter.

Field note 3

11/11/14

It was clear that I was missing out a lot of information being relayed between the two, and I had to repeatedly ask the interpreter to give me more detail of what was being said. I started to feel quite excluded from the conversation and felt something close to desperation that I might not be able to get any rich data from participants if this continued....Again, client and the interpreter continued with conversations in Urdu, often involving laughter. This made me feel extremely uncomfortable, and excluded from these conversations.

Interestingly, the possibility of close woman-interpreter relationships was not touched upon at all in women's accounts, suggesting a possible disproportionate weighting being attributed to the woman-interpreter relationship by midwives. Furthermore – as previously discussed – one of my participants asked for her follow up interview to happen without the translator; suggesting that she was more interested in building a relationship with me than with the interpreter.

Even in cases where midwives did not feel excluded from conversations, many felt frustration at the propensity for lost information; acknowledging that a lot of the meaning and feeling of what was being said was often 'lost in translation'. This was especially apparent in situations where interpreters only relayed parts of conversations to midwives.

Sometimes, you know...you *have* to say to the translator, ummm, "what did she just say?" because you will say something, and she'll pass it on...and then you'll get this dialogue going back and forth

like crazy...and then the interpreter will look at you and say “Oh she said no” and you know that she’s said an *awful* lot more than no, so you’ve gotta be able to say “What else did she say? Is she concerned?” – so – yeah...sometimes you’ve got to dig a little bit.

Heather

Again, this was something I had experienced myself; in interviews where an interpreter was present I found myself constantly asking for more information from the interpreter.

Alternative methods of interpretation were only briefly touched upon by midwives, however most acknowledged that these, too, could act as a barrier to midwife-woman relationships. A number of midwife participants claimed that they often had technical or equipment problems with telephone services like Language Line and Big Word, and that they felt that this type of service depersonalised antenatal appointments.

With that in the middle – the telephone – it’s a barrier, isn’t it?

Vanessa

My own observation data seemed to support this assertion; in instances where midwives used telephone services there was much less eye contact between woman and midwife, and small talk was non-existent.

Observation Note: Language Line

Midwife attempts to conduct appointment without use of language line – tries to explain things to woman, however it is clear that woman is not understanding – confused smile on her face and not responding to questions asked (or giving responses which are unrelated to the question). Midwife speaks over woman’s head and tells me that she always tries to do as much as possible without language support first, so that she knows which parts women are most unclear on. Midwife eventually uses language line – repeats most of what has already been said/asked. During this conversation, midwife looks at floor and occasionally looks at me. Almost no eye contact with woman, and no humour/small talk, as in other appointments.

The high cost of interpretation services was highlighted by all midwife participants, and seemed to inhibit midwives' likelihood of using these services. Midwives expressed a feeling of duty to avoid spending this money (possibly due to reports from finance department discussed earlier)⁴². In fact, a number of midwives suggested that the money spent on interpretation would be better spent elsewhere, and many expressed further frustrations at having to pay for interpreters when women did not turn up for their appointments⁴³. Indeed, Gail, along with a few other midwife participants, suggested that she no longer booked interpreters as a result of this cost.

So *usually*, I mean – in my clinic now I very rarely use translators now. It probably isn't *right* but I've had interpreters, on numerous occasions *come* and sat there for the *duration* waiting for somebody to turn up. So the next time I said "well I'm not gonna book you, and we'll have to muddle through". And until somebody can *show* that they're gonna *comply* [with regular attendance] – I don't see why we should be paying it.

Gail

Gail's admission was supported by my observation data; while telephone interpretation was used twice during my observations, face to face interpretation did not occur in any of the antenatal appointments I observed.

Indeed, midwives suggested that the use of family members for interpretation was common in antenatal appointments, despite acknowledgement of the recommendations against this practice, laid out in health practice guidelines (NICE 2010). Many claimed that they often had 'no other choice' than to use family members to interpret and that it was not in their power to override this decision. Midwives described similar challenges for the use of family members to interpret, as with the use of paid interpreters; the presence of a third party had the potential to disrupt midwife-woman rapport building, and replies were often summarised by family members, rather than elaborated upon.

In summary: from the midwives' perspectives, a range of language and communication issues such as miscommunication, attitudes towards learning host-country language, and the use of interpreters appeared to have a multi-faceted impact on the midwife-woman relationship, and

⁴² Chapter Five, page 112

⁴³ Midwives suggested that lack of attendance was common for migrant Pakistani women, as is discussed in depth in the next section of this chapter

form an interweaving theme within the social ecological model presented at the close of Chapter Five.

7.5 Understanding Different Healthcare Systems

Midwives acknowledged and discussed a number of differences between UK and Pakistani healthcare systems, and recognised that such differences might cause migrant Pakistani women difficulty in accessing maternity care in the UK. Indeed, several midwives suggested that women may need extra support in understanding exactly how the UK maternity system works.

The traditions at home are completely different and how many visits they get – some are quite surprised at how *many* they get and some are surprised that they're not getting *more*. So yeah – it is...it is different [...] These are the ones that would benefit more from classes to know *this* is what happens here. Because it *is* different. You know – the whole maternity system at home.

Heather

Furthermore, it was suggested that some migrant women had no understanding of the concept of maternity care, even as a principle, and therefore did not realise the importance of engaging with antenatal care and appointment attendance.

Yeah...and again...in certain cultures...antenatal care – they don't even know what it *is*! So they've never...they don't *understand* the importance...of antenatal care...and if that *hasn't* been communicated to them...

Barbara

Some midwives described situations where women had resisted midwifery care, and felt that such resistance was based on women's views that healthcare was not needed during pregnancy as they were not unwell.

"my baby's moving...I think everything's fine...I'll be alright" kind of thing.

Claire

They not used to it – they always keep saying "it's only *baby* – I'm not *sick*! I'm not unwell, I'm ok. This is a normal thing! Why I go to hospital for? Because I'm pregnant?! That's why I go to hospital? We don't need to go to hospital! Just normal thing"

Sara

Indeed, most midwives felt that migrant women's expectations of care were usually lower than that of UK-born women, and that this was likely to play a part in antenatal care attendance:

I think their expectations are different. I think they're lower than the white British middle-class woman. So when they come, they often seem surprised when we, sort of, keep asking the same questions and insuring that they attend their antenatal classes [...] Sometimes it comes across that they don't really see...not that they don't see the need but it's different. If they've had a baby born in their own country – they've seen a different standard and therefore they might not see it as necessary to come frequently to clinic.

Nicola

In fact, a number of midwives suggested that many migrant women were often happy just to have a problem-free birth.

I think the...mostly the migrant, probably, women, probably happy to have a healthy baby at the end of it...regardless of how that journey is going to happen

Claire

Others suggested that migrant women only attended antenatal care when they wanted signatures and letters for things such as housing, rather than a desire for what midwives viewed as actual *care*.

What I *dislike* is people who come in and they've got a list of demands. "You need to write me a letter for housing. You need to do this – you need to do that" That's *all* they want! And they know *every* single thing [they can get] [...] It can be very one-sided. And it is probably about what they see as *their* needs...and *their* needs are a priority. Care isn't always a priority for them. So what you find is that they default from clinic a lot. And they'll only come when they want something.

Gail

The above view from Gail was echoed in other conversations with midwives, and experiences of feeling used and unappreciated were common. From the midwives' perspective there seemed to be a lack of reciprocity in these interactions, reminiscent of the concept of 'rejected exchange'; midwives attempted to provide holistic care to women, whilst women rejected this approach in favour of a more administrative purpose of the midwife. Although some midwives suggested that helping women access benefits was part of their job, repeated requests for this support caused tension in their relationships with women.

Although midwives acknowledged differences between UK and Pakistani healthcare systems, this was not always enough to prevent frustration when migrant Pakistani women did not navigate their maternity care in the way which midwives expected (for example missing or turning up late

to appointments, forgetting to arrange future appointments). In fact navigation of care was seen, by midwives, as one of the biggest barriers to midwife-woman relationships.

7.5.1 Women's Navigation of Care

Midwives' main concern about navigation of maternity care was lack of attendance at, and continued lateness to, antenatal appointments and classes. As seen in the previous chapter, non-attendance and lateness was something I experienced first-hand during antenatal clinic observations⁴⁴. Although midwives remained professional and friendly in these situations, there was clear frustration at women's attitudes towards timekeeping for these appointments.

I've got to be honest – that, umm, you know – if I look up and think “oh somebody hasn't turned up” – it's nearly *always*, sort of the *ethnic* group – and ladies from Somalia as well. Ummm...one just comes – as long as she's got the day right, she's happy. It doesn't matter about the time!

Heather

Indeed, midwives suggested that the lack of evidence to support their attempts to engage women in care meant that they spent a lot of time chasing women up on appointments. This led to feelings of increased workload and frustration, and midwives suggested that non-attendance was consequently one of the biggest influences on their relationships with migrant women.

Me: What do you think are the kind of factors that help people build those solid relationships?

Nicola: Ummm...pfft. On her part – good attendance! [...] The main issues are not being able to speak English...and... them not engaging in antenatal care

A number of midwives tried, like Heather, to make light of this issue. However it was clear, from tone of voice and body language, that some midwives were extremely annoyed when women were late or did not attend antenatal appointments. A number of midwives suggested that women were often *repeatedly* late to appointments, even after this issue had been discussed with them.

That's one of the...the banes of my clinic. I give them appointments and they just turn up when they like, basically. So my clinic *always* overruns. It never runs to time. And that's across *most* of the cultures apart from the...the British women, who are used to appointment systems. [...] You tell them your appointment is at this time next week – and the receptionist in my clinic – she's really funny...she will tell them off if they're late “you must respect the midwife's time...be on time for your appointment! I'll see if she'll see you...” and she will kind of lecture them. But then they come in kinda smiling “sorry I'm late” and that kind of thing. So they *know* they're late and they've missed their time – but they still do it!

⁴⁴ Observation period 4, page 168

Mary

Midwives' frustrations regarding women's lateness and non-attendance at appointments seemed mainly due to their inability to provide quality maternity care, and many suggested that such behaviour put the wellbeing of these women and their babies at risk. This led to anxiety over professional accountability, and increased workload and stress. For example, in the following extract Mary recounts her initial anxiety after learning that she had been assigned to a caseload which was predominantly migrant women.

When I first came out to community...to this case load...I absolutely hated it. I thought "I'll do my case load and I'll just rotate straight back in" I really thought "oh my god...I can't stand living on the edge"...cos I like to know that all my women have been seen and that everything is tickety boo. And I thought "I can't live like this" I'd be constantly on adrenaline...I'd be on Valium *myself* by the end of 6 months

Mary

Gail's experience of non-attendance had led her to propose creating a "contract" with women in order to assign more responsibility and ownership to women themselves.

I went through a phase when I wanted us to have a contract with women. I don't know why we can't do that. And say in it..."my role is this this this. *Your* role – in *your* pregnancy is that. You come for your appointments. If you do *not* come – if anything goes wrong – it will be *your* responsibility". Cos I think that's what we need. Women need to understand that both of us have got to work together.

Gail

The concepts encompassed by this proposed contract from Gail seemed to reflect the ideals reciprocity; emphasising equal responsibility and effort between midwife and woman. In fact, it appeared that Gail's aims were to limit the potential for rejected exchange by setting out clear responsibilities and guidelines for each party.

Although it was suggested that UK-born women naturally assumed a partnership approach to their care, midwives claimed that migrant women tended to need clarification of the mutual effort and responsibility involved in this approach.

Although a number of midwives suggested that navigation of the system could be improved by providing women with information about the importance of keeping to antenatal care appointments, they explained that there was not enough time to provide this information during their appointments with women. As seen in the introduction to the findings chapter, time

limitations on appointments were a commonly cited barrier to midwife-woman relationships with migrant Pakistani clients. However, the value of education around the importance of appointments was questioned. Some midwives proposed that other factors such as a lack of opportunity or attribution of authoritative knowledge to family members would remain as inhibiting factors.

Midwives tended to make assumptions about women's assessment of care; some suggested that migrant women viewed UK healthcare services as the 'gold standard', whilst others claimed that migrant women had unrealistic expectations which could not be met. Indeed, during a conversation with Gail, she described a situation where a migrant Pakistani woman had asked for information about bereavement services, and had been shocked and surprised when Gail told her that none were available (something which was not, in fact, true)⁴⁵. Gail seemed annoyed at this woman's reaction and told me...

We're telling all these women how brilliant it is, but they can't see it

Gail

In this instance it seemed as though Gail was unwilling to admit failings in the UK system, or on her part more specifically (as these services are indeed available), and therefore interpreted the woman's frustration as a lack of appreciation for the UK healthcare system. A further example of this was shown in another account from Gail, which described an incident where a Pakistani woman had returned to Pakistan for antenatal care, as a result of being told there was no available treatment in the UK for a foetal abnormality picked up in-utero.

They picked up that the baby had [a deformity]. It wasn't just positional. And she came back to my clinic after coming here and she said "what are they going to do about it?" And I said "I can't do anything while the baby's in utero, you've got to wait." And she said "I'm not willing to wait" and she jumped on a plane two weeks later and went back home. But she wouldn't *have* it - that you can't do anything for something like this until the baby's born.

Gail

Further midwife-woman discrepancies over best care were seen in midwife accounts of conversations with women on the topic of home birth. Midwives tended to view home birth as

⁴⁵ A number of bereavement services for pregnant women in the UK are available, and listed on the NHS website. <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/coping-death-pregnant.aspx>

positive, however they claimed that women felt that they were being offered substandard care if home birth was mentioned.

The funny thing *is* it's the one group that when you mention home birth they look at you in shock. Because as far as they're concerned the gold standard, in Britain, is hospital. And probably it was *all* home births for their family. But no – they see that what *we* offer – it's got to be the best...because that's what happens in the UK. Whereas we're trying to encourage it *back*. But *very* rare – they look at you and laugh, most of them. They think you're joking – “No, hospital! Better!”

Heather

Whether due to differences in health care system, cultural priorities, or care expectations, midwives reported that migrant women's approach to maternity services often resulted in tension and negativity in the midwife-woman relationship. In order to avoid this tension, the data suggested a need for increased understanding of healthcare system differences on the part of both midwives and migrant women.

7.5.2 The Role of the Midwife

Midwives tended to describe their professional role as more difficult and demanding when working with migrant Pakistani women, compared to native British women; migrant clients were generalised as having increased care needs, such as the need for language support and extended appointment times. Extracts such as the ones from Tracy and Eleanor, below, suggested how a lack of reciprocity increased stress and disrupted midwives' ability to provide 'proper' midwifery care.

It's exhausting. Cos you're constantly giving your all...yeah it is. It *can* be really draining.

Tracy

It's kind of frustrating for us. And...it...we don't *want* it to be [...] There's...that *sympathy* there but at the same time...it makes our jobs very *difficult* to do...and takes a lot of *time*...a lot of money...like we've already said – for the interpreter services. So it's...it's difficult to kind of remain *objective* about it all...it's, ummm, you know – you have to step back and say “oh – come on – this is just *another* woman who requires your care and your attention” but...it's *hard*. It's very hard.

Eleanor

This increased workload seemed to result in negativity towards working with migrant women, which was apparent during conversations with midwives. Migrant women were deemed more likely to repeatedly move house during their pregnancy, and many midwives expressed frustration

and annoyance at having to 'chase down' these women for antenatal appointments. Although this negativity was openly discussed by a number of midwives, these feelings once again tended to be projected onto colleagues. As seen in the following account, Mary spoke about differences in opinion on moving to a caseload which was mainly migrant women.

Mary: In the space of a year they'd had four midwives in that surgery. Because they didn't like the caseload. Because of the extra work you've got to put in with the women on the caseload. I – when I first took it over – it really did terrify me. [colleagues] said "oh you are going to have a difficult caseload and it *will* take you a few weeks to get used to" and I was like "oh, right, ok" and then the midwife who I took over from, she kind of really tried to scare me and said "oh it's terrible – these women don't come to these appointments" and I was like "ooooh...alright, ok".

Me: So do you think there's quite a lot of stigma amongst the midwives about your kind of caseload?

Mary: Yeah. Definitely. Definitely. Cos we *are* supposed to be non-judgemental. But they do see it as hard work. [There *are* midwives who've got caseloads like mine...and they're not so keen on it...put it that way.

Despite evidence of negative stereotyping of migrant women by some midwives, others suggested that working with migrant women was often challenging but rewarding, and that the extra work was just part of the job of caring for these women.

I'd never worked in a setting like this. Umm...I was pretty much thrown in at the deep end [...] I'm finding it really challenging but I enjoy it at the same time.

Barbara

Some midwives expressed the view that a good the midwife-woman relationship could go some way to ameliorating the challenges of a demanding workload. For example, midwives claimed that when covering shifts for colleagues (and therefore working with women with whom they had not built a relationship), they were more likely to become frustrated with the extra effort needed to put in, and this had a negative impact on their relationship with this woman. Conversely, for women with whom they had a good relationship, this extra workload was not perceived negatively, therefore the relationship was not negatively impacted upon.

And I think...if it's your *own* women...and you know them – and you know what they're like. If you think "Oh well that's just the way she is" you kind of tolerate it. Whereas if I go to do someone else's calls...and they're not there – that really *does* wind me up. "Where *is* this woman?" when you can't get hold of them. And I think it's because they're *your* women, and you feel ownership for them...and responsibility towards them. Just getting to know them [mediates that feeling], I suppose.

Mary

Worryingly, a number of midwife participants suggested that the extra workload and professional anxieties involved in working with migrant women often led them to shut off emotionally and detach from cases, as in the following:

Obviously we're there to *help* people – and we *know* the detrimental effects that some things can *have* on the baby – or their own health, and...err...you know – it can be, like, stressful. But...you have to detach yourself as well. Otherwise you'll just go under, won't you?

Barbara

But I think if you...the only way for me to cope with it...is to just shut off. Is to *shut off* on that. And try not to think about it [...] I think it *can* make your relationship difficult, because...because like I said – you sort of shut yourself *off* from it.

Nicola

Accounts such as the above indicated the high emotional involvement of midwives when working with this client group; resulting in attempts to shut off from these emotions, withdraw from women, and potentially ration the amount of time spent with them⁴⁶. As explained above by Nicola, midwives' ability to form good relationships with women was hindered when they took steps to reduce their emotional involvement.

Once again, and in keeping with the social ecological model, these findings highlighted the complexities of the factors influencing midwife-woman relationships for migrant women. In order to fully explore this relationship, such findings suggest the need to understand individual differences in pairings of woman and their midwives.

7.6 Chapter Conclusion

The primary aim of the research was to explore relationships between migrant Pakistani women and midwives in the South Wales region, in order to better understand the barriers/facilitators of a successful midwife-woman relationship for migrant women in the UK. Data from midwives, presented in this chapter, suggested that in order to understand midwife-woman relationships,

⁴⁶ This is an example of emotion work in midwifery. This concept will be expanded on in the discussion.

individual differences would need to be considered - incorporating not only differences in personality, but also in each midwife's relationship with contextual factors such as their understanding of women's interpersonal relationships, assumptions surrounding Pakistani culture, religion and cultural practices, and their understanding of women's navigation of the UK healthcare system.

Chapter Eight: Discussion

8.1 Chapter Aims

This chapter begins with a reminder of the initial research aims of my study, and a brief reflection on the social ecological model of relationships developed from the data. Next, findings presented in the previous three chapters are discussed in light of existing literature and the study's research aims. This discussion is then summarised, and the social ecological model is presented as a new and original contribution to knowledge. Subsequently, this model is positioned in terms of its potential impacts on the maternity research and practice, and the chapter concludes with acknowledgement of study limitations, and ideas for future work.

8.2 Setting the Scene

The primary aim of this study was to explore relationships between first generation migrant Pakistani women and midwives in the South Wales region; focusing on the factors contributing to these relationships, and the ways in which these relationships might affect women's experiences of care. The underpinning purpose of the study was to add to the body of knowledge about ethnic and migrant inequalities in pregnancy experiences in the UK.

In order to demonstrate the complexities of relationships between migrant Pakistani women and midwives in South Wales in a clear and accessible way, a visual model was created to present data. This model was named a social ecological model of relationships, and is shown below in Figure 12. As described at the close of Chapter Five, the widths of circles are used to represent the relative importance of each theme to each participant group; the wider the circle, the more important the theme. Black and white arrows represent the two weaving themes, and the purple and white background was added to frame these themes within the social and political context and the meta-theme of otherness. It must be remembered that this model is a simplification of a complex set of relationships, and that consequently there may be additional factors at play.

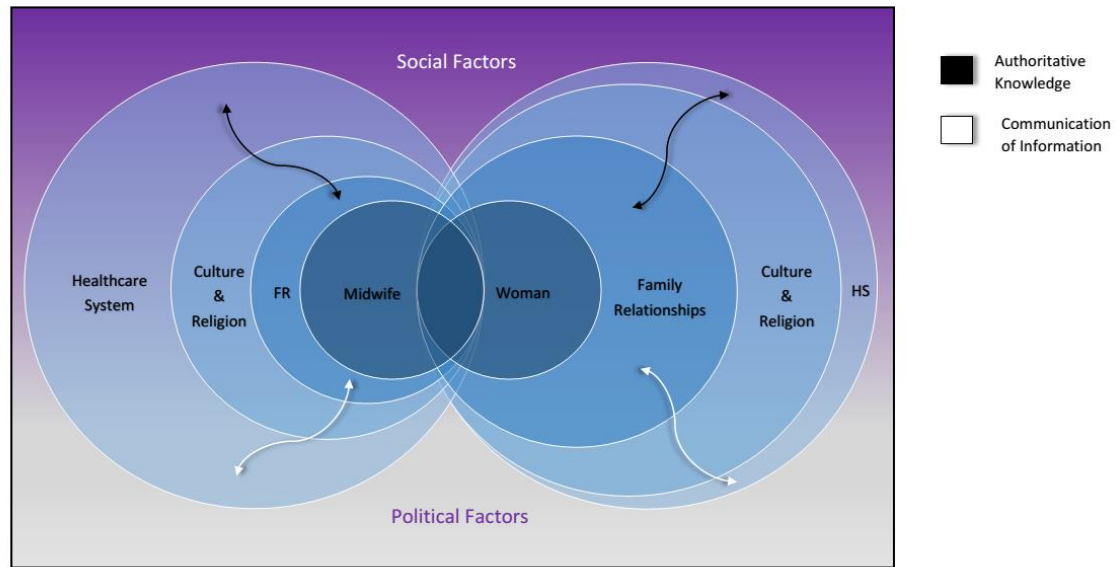


Figure 12: A social ecological model of relationships

In the following sections of this chapter, the elements within this model are discussed with reference to the existing literature in this field.

8.3 Overview of Key Findings

When reviewing the literature on maternity care for migrant women, I initially identified a number of potential themes which might appear in my own research. These were used to inform the research questions and included issues around language barriers, cultural expectations of healthcare, the role of social support, stereotyping and prejudice, and links between relationships and care. All of these themes did, in fact, emerge from the narratives of both women and midwives. However, it was interesting to note that the weight of importance given to these issues was often either much higher, or lower, than I originally assumed, given the existing literature. Take, for example, the theme of social support. Whilst I originally assumed that social support would be extremely important for migrant Pakistani women's experiences of pregnancy, and that this support would come from a wide range of sources (including friends, family members, community), there was little mention of support outside of close family members from participants in this research.

More consistent with my expectations, both women and midwives placed high importance on midwife-woman relationships; a finding which supports the existing literature (Tinkler and Quinney 1998; Puthussery et al. 2010). Indeed, not only was this relationship important to participants, but both women and midwives suggested that difficult relationships could potentially result in higher risk of adverse pregnancy outcomes, through lack of communication and restricted care. Such findings support claims of previous authors that good midwife-woman relationships are an important factor in preventing adverse pregnancy outcomes such as maternal mortality and morbidity (Cantwell et al. 2011). When asked about the factors contributing to a good midwife-woman relationship, women tended to focus on the personalities of midwives; suggesting that they were able to form good relationships with midwives who were “kind”, “caring”, and sources of support. Existing literature supports these findings; similar interpersonal skills were cited as important influences of midwife-woman relationships in a number of previous studies in this field and in the wider literature about women’s experiences of maternity care (Tinkler and Quinney 1998; Wilkins 2010).

Being able to trust midwives was also cited by participants as a predictive factor for good midwife-woman relationships, however little was said about the way in which this trust was built. Again, the importance of trust in midwife-woman relationships is not a new finding in midwifery research; numerous studies have highlighted the importance of this factor for women’s experiences of care (Wilkins 1993; Tinkler and Quinney 1998; Pairman and Mcara-Couper 2006; Wilkins 2010). Although interpersonal skills were mainly spoken about by women, midwives also noted the potential for their clients’ interpersonal skills to influence the midwife-woman relationship. When women seemed disengaged from care, or unresponsive to humour, midwives reported tension in the midwife-woman relationship. Midwives implied that such behaviour was more common in migrant women, and some suggested that migrant Pakistani women had “difficult” personalities which prevented them from building a good relationship with these clients. This finding is supported by the existing literature discussed in Chapter Two; for example, midwives report more difficulty in working with minority ethnic women than their white British counterparts (Bowler 1993; Essén et al. 2011) and have been found to characterise minority ethnic and migrant women as unintelligent, unresponsive and rude (Bowler 1993).

8.4 A Discussion on Family Relationships

Women's relationships with family members (namely mothers-in-law and husbands/partners) were of significant influence during their pregnancies. Although some migrant Pakistani women suggested that the influence of mothers-in-law could sometimes be too extreme or overbearing, most negative views came from midwives, who expressed the view that Pakistani mothers-in-law held authority over their daughters-in-law, which was sometimes expressed as having unreasonable expectations in terms of housework. Midwives also suggested that mothers-in-law tended to "take over" during antenatal clinic appointment discussions, thus preventing midwives from having direct contact with women. These findings are supported by similar research by McFadden et al. (2012) who compared perspectives of maternity care services between Bangladeshi women and health practitioners; health practitioners described the role of mothers and mothers-in-law as problematic and spoke of not wanting to "tackle the grandmother" (McFadden et al. 2012, p. 131). Similar views were expressed by midwives in my own research, who spoke of having to 'go through' mothers-in-law to speak to women.

Furthermore, midwives in my own research suggested that women needed permission from these family members to attend additional care, such as antenatal classes. These descriptions of mothers-in-law as authoritative are supported by literature on Pakistani culture (Zaman et al. 2006; Mumtaz and Salway 2007). Indeed, many authors on this topic suggest that this type of hierarchical family structure is frequently maintained in modern Pakistani families; wisdom is attributed to age, therefore family elders command respect and loyalty (Mumtaz and Salway 2007). In Pakistani culture, older women are considered '*siyarni*' (wise and experienced), and are therefore seen to hold the authority on decisions regarding the pregnancies of family members (Mumtaz and Salway 2007). Traditionally the pregnant woman herself is not supposed to voice her opinion or have any personal desires (Mumtaz and Salway 2007).

Although family member involvement in pregnancy was often viewed negatively by midwives, women claimed that this influence was typically a demonstration of care and love, rather than an exertion of power or control. Such findings might be due to the family-centred, collectivist, approach to decision making for healthcare issues in Pakistani culture (Moazam 2000). This approach emphasises the aim of ensuring that the 'patient' is well taken care of, and protected by the family from any stress or worry caused by treatment and care (Moazam 2000). As a result,

personal identity takes second place to the collective family identity and decisions are made on behalf of the family member (Moazam 2000).

Support for this family-oriented approach to healthcare was found in accounts from migrant Pakistani women during my research, however it seemed as though the midwives in this study lacked insight into this rather more complex and nuanced family-based view of healthcare. It is therefore possible to suggest that a mismatch exists between the midwife-woman partnership model of UK midwifery, and the collectivist, family, approach to healthcare in Pakistani culture. Indeed, Inhorn (2006) suggests that the definition of 'women's health' has been largely forwarded by public health bodies from western countries, and therefore reflects rather narrow western professional definitions. Indeed, (Inhorn 2006) argues that such westernised conceptions may not align with the perspectives and opinions of women from other cultures. As will be seen later in the chapter, differing expectations of maternity care, based on such differences in cultural models of care, may have the potential to influence midwife-woman relationships. However, at this point, it is important to remember that Pakistani culture, like all others, is not homogenous. Indeed, factors such as personal characteristics, socio-economic status and literacy will cause variation in structure between Pakistani families (Zaman et al. 2006), therefore families are likely to differ in their alignment with these westernised ideas.

Although some midwives suggested they had encountered a range of mother-in-law influence on pregnancies, others suggested that *all* mothers-in-law caused barriers to good maternity care, and therefore created issues in midwife-woman relationships. One perceived barrier, caused by mothers-in-law, was the advice that these family members gave to women; midwives reported that this advice often conflicted with their own, with the potential to cause tension in their relationships with the woman and her family. Both participant groups acknowledged the existence of differing (and often incompatible) pregnancy 'knowledge' held by midwives and family elders, and as seen in Chapter Six, women tended to alternate between a desire to follow the advice of the midwife and a desire to follow the advice from family members. This confusion over whose advice to listen to provided interesting insights into women's feelings regarding the legitimacy of knowledge held by midwives and family members. Previous literature suggests that competition between different sources of knowledge is a long-standing issue in birth settings (Irwin and Jordan 1987; Jordan 1987; Hunt et al. 1989a; Hunt et al. 1989b), and is characterised as a struggle for 'authoritative knowledge' (Jordan 1997). Jordan (1997, p. 56) explains authoritative knowledge as:

“for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both...frequently, one kind of knowledge often gains ascendancy and legitimacy. A consequence of the legitimisation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing”

Using this description of authoritative knowledge, it is possible to suggest that migrant Pakistani women may continue to invest in traditional (elder) advice, due to its strong connection with values associated with religion, culture and the respect of family elders. As seen, these factors are all extremely important influences in the Pakistani community (Mumtaz and Salway 2007).

Despite an apparent devaluation of medical knowledge in favour of culture-based knowledge, participant narratives from women suggested feelings of uncertainty as to which knowledge system should be held as authoritative. Indeed, many women expressed the view that *both* ways of knowing were legitimate. However, in a number of accounts, women expressed that they would eventually be forced to align with one way of knowing over the other; a choice between the traditional family knowledge and the new professional, bio-medical knowledge. Whilst mothers and mothers-in-law were traditionally seen as the source of knowledge on pregnancy and childbirth, this way of knowing often became displaced by that of the midwife once the woman had become established as a UK resident. This replacement of old knowledge systems with new appeared regularly in women’s transcripts, and many spoke to me about their willingness to fit in with UK society and to take on UK values and culture. It would appear, therefore, that the issue of authoritative knowledge is of particular relevance for those women who have recently migrated to the UK, as they are most likely to have strong traditional and cultural knowledge systems which may, at least initially, resist being replaced. However, it must be noted that the issue of authoritative knowledge in pregnancy does not apply exclusively to migrant women; previous literature suggests similar tensions between UK midwives and UK grandmothers in terms of the legitimacy of knowledge (Sanders et al. 2015).

Although most women in the current study claimed to follow the advice of the midwife over that of family elders, many suggested that ‘other’ migrant Pakistani women simply pretended to follow the advice of midwives while, in fact, continuing with traditional practices without the midwife’s knowledge; both women and midwives gave personal accounts of women carrying out practices

advised against by the midwife, even as soon as the health professional was out of the room⁴⁷. In fact, contrary to the view of women participants, midwives suggested that very few migrant Pakistani women adapted to the UK professionals' ways of knowing, instead remaining true to their traditional knowledge systems. Whilst some midwives were understanding of this and tried to work around it by assuring women (and their mothers-in-law) of the value of their own experience and knowledge of pregnancy, others seemed unwilling to consider any competing knowledge, and expressed annoyance at having their advice challenged or ignored.

Incompatible ways of knowing about pregnancy and childbirth have clear implications for the midwife-woman relationship. As will be seen in the following sections, differing opinions on issues such as unsafe cultural practices and nonattendance at antenatal classes have the potential to cause tension in this relationship. Furthermore, it is possible that women's belief in the authority of family elders' ways of knowing can lead to devaluation of the midwife's knowledge, disrupting balance and reciprocity in the midwife-woman relationship. This will be picked up in a later section of this chapter: 'Role of the midwife'.

My findings are therefore in broad agreement with the existing literature in clearly demonstrating that women's relationships with their mothers-in-law have an important influence on midwife-woman relationships; either through introducing a competing source of authoritative knowledge, or by being a barrier to the midwife forming one-to-one contact with the woman. It therefore seems that, in order to build a good relationship with women, (and in order to at least provide an alternative source of authoritative knowledge to that promulgated by mothers-in-law), it is necessary for midwives to understand the pregnancy within the context of the woman-mother-in-law relationship for each client, and to acknowledge the influence of this family member.

Both midwives and women also spoke at length about the role of male partners in maternity care. It was clear, both from narratives and my own observations, that there was a high propensity for male partners to speak on behalf of women, even when the woman seemed to have language skills to communicate directly with the midwife. When questioned about this behaviour, midwives and women gave differing interpretations; whilst women tended to give positive explanations (for example that her husband was being caring or protective over her), midwives tended to negatively stereotype this behaviour as an act of male dominance. In fact, midwives tended to interpret this

⁴⁷ This will be discussed further in the next section.

behaviour as an act of power, with some expressing a view that male authority in Pakistani culture was something which needed to be challenged.

Such views from midwives are arguably understandable (although also somewhat naïve as will be discussed later), as Pakistani culture is regarded as a male-dominant culture, where rates of domestic violence are high. For example, a recent systematic review found that the prevalence of physical intimate partner violence perpetrated by a husband against his wife is reported by up to 80% of women in Pakistan (Ali et al. 2015). It is therefore possible that midwives are primed to expect higher rates of domestic abuse in this client group, and may, as a result, inadvertently negatively label or be hostile towards male partners' behaviour.

Furthermore, healthcare providers are expected to play a key role in identifying and intervening in domestic violence (Niaz, 2004), and are trained to recognise victims of violence and refer them to relevant organisations. Indeed, minimum standards for midwifery in Wales posit that:

- All women will be routinely asked about domestic abuse in the antenatal period
- Women should be alone when asked about domestic abuse
- Midwives should ensure lone contact with the woman at least once in pregnancy

(All Wales Midwifery & Health Visitors Domestic Abuse Networking Group 2006a)

Such standards are therefore likely to frame the way in which midwives in Wales view male partner involvement and the resulting lack of opportunity for lone contact with women. Indeed, negative perceptions of family member involvement in women's pregnancies seemed partly to stem from midwives' desire to have direct communication with women. Midwives felt that one-to-one contact was essential not only for creating a good relationship with women, but also in facilitating them to provide effective care. Previous literature suggests that this desire for midwives to ensure one-to-one contact with women is common; in a study by Phillimore and Thornhill (2010) midwives reported a need to ensure women had at least one appointment where they are seen alone. However, the majority of midwives in my research admitted to not being assertive in asking for this one-to-one contact with women. Instead, some described situations where they created opportunity for one-to-one contact with women whilst the male partner was there (for example following women out to the toilet). Evidence of midwives bending the rules to

provide woman-centred care, rather than being assertive, is also seen in previous literature (Hunter 2005).

In contrast to midwives, women seemed unaware of the need for one-to-one contact with their midwife, and suggested that male partners would be happy for them to attend an appointment on their own, if the woman suggested it. Indeed, there was naivety shown by midwives on this topic; tending to generalise male dominance as a culture-wide phenomenon affecting all Pakistani women negatively, and being the root cause of men's attendance at antenatal appointments. In reality, just as with mother-in-law relationships, domestic relationships varied greatly between families.

Variation in domestic relationships, and the influence of those relationships on women's pregnancies, is further evidenced by inconsistencies between my findings and that of previous maternity research in Pakistani culture. Indeed, whilst my results suggested high male partner involvement in women's pregnancies, previous maternity research in Pakistan consistently suggests that male partners are generally unconcerned and uninterested in women's reproductive health issues, dismissing them as an exclusively female matter (Mumtaz and Salway 2007). In addition, such research identifies a cultural belief in Pakistan that men who get involved in pregnancy issues are less masculine and honourable (Mumtaz and Salway 2007). This inconsistency between my findings and existing literature could be explained by differences in the location of the research. For example, whilst this study was carried out in the UK, previous literature such as that of Mumtaz and Salway (2007) was carried out in Pakistan, where there were no language barriers and more social support for the female partner. It may be, therefore, that in contexts where language barriers exist, and women have less social support, it becomes necessary for male partners to become involved and support women through their pregnancies. Alternatively, it is possible that Pakistani men who live in the UK are influenced by UK culture, whereby male involvement in pregnancy is now the cultural norm. Either way, contradictory explanations of male partner's tendency to speak on the woman's behalf suggest that each individual case must be considered separately, and that this behaviour cannot be generalised either as positive or negative.

Despite voicing negative views regarding male partners' tendency to speak for women, midwives often suggested that male partners "looked after" women well. This tendency for midwives to

swing between polarised views of women's relationships with male partners was extremely interesting, as it suggested an internal confusion or dissonance regarding this topic. Indeed, it seemed as though the process of participating in the interview was forcing midwives to form and articulate their thoughts for the first time and not always that clearly. In instances such as this, it was necessary to take a step back from the data in order to consider the potential influences of relevant political and social context. As discussed in Chapter Five, there was increasing negativity in UK public opinion towards immigration at the time of data collection. This, added to public outrage at the terrorist acts organised by ISIS, had resulted in increasing stigmatisation of the migrant Muslim population. It is therefore possible that such stigma may have affected midwives' perceptions of Muslim men and consequently created cognitive dissonance for midwives when male partners were seen to provide comfort and protection to women during their pregnancy.

In summary: data on family relationships highlighted the import cultural and social differences between the UK and Pakistan, and indicated a necessity for such differences to be understood by both women and midwives in order to build a good midwife-woman relationship. As discussed, each participant group appeared to 'weight', or prioritise, each theme differently – represented by the different relative width of circles presented in the social ecological model created from these data (most recently presented in section 8.2). As the theme of family relationships appeared especially important for migrant Pakistani participants, the circle representing the theme of family relationships is therefore relatively large, whilst for midwives it is relatively small (where issues of culture and religion and healthcare system take priority). The difference in weighting, presented visually in the social ecological model, therefore suggests dissonance in the perceived importance of themes between midwives and women; potentially causing misunderstanding and frustration in midwife-woman relationships. Recommendations based on this finding will be discussed in a later section of this chapter

8.5 A Discussion on Pakistani Culture and Religion

All migrant Pakistani women in my research described themselves as Muslim, and stated that their religion was extremely important to their daily life. This was unsurprising, as religion has been consistently reported as a dominant influence in Pakistani culture (Moazam 2000). Although midwives tended to express either positivity or indifference towards the Muslim culture,

conversations regarding traditional Pakistani birthing and pregnancy practices, which were deeply rooted in Muslim culture, suggested that such acceptance did not always extend willingly to these practices⁴⁸. In fact, midwives suggested that traditional practices and beliefs were one of the biggest potentials for tension in the midwife-woman relationship for migrant clients. Furthermore, midwives suggested that migrant women's cultural and religious beliefs, such as "trust in God's will", could result in a lack of adequate engagement in antenatal care and ultimately lead to adverse maternity outcomes.

Previous research has suggested similar tension in midwife-woman relationships as a result of cultural and religious beliefs. For example Essén et al. (2011) found that Somali women's fear and anxiety of caesarean section often resulted in negative stereotyping of these women by health professionals, and a generalisation that Somali women are a "problematic" and sometimes even "traumatising" group to work with (Essén et al. 2011). The authors described situations where Somali women would develop ways to avoid caesarean section; many lying to their midwives about symptoms, denying assessment results, or waiting until the last minute to go into hospital when in labour (Essén et al. 2011). It was acknowledged that, due to the UK healthcare system view of caesarean section as an intervention that may be necessary for maternal and/or foetal wellbeing (NHS Choices 2014), these divergent views were likely to make discussions regarding caesarean section extremely stressful for both the woman and health professional; women became scared, health professionals felt unable to do their jobs properly, and conflict was likely to arise (Essén et al. 2011). Similar to the findings of the current study, healthcare providers in Essén et al. (2011)'s study expressed the view that women's cultural beliefs (often leading to refusal of caesarean section) were frequently the direct cause of adverse maternity outcomes.

Despite midwives' perceived associations between specific cultural beliefs and adverse pregnancy outcomes, none of my participants gave examples where these outcomes had actually occurred as a result of such beliefs. Consequently, I began to wonder about the legitimacy of these fears. It struck me that concerns cited by midwives might, in fact, be similar to 'atrocious stories' found in other nursing and midwifery research (Dingwall 1977; Hunter 2005). Atrocious stories are often

⁴⁸ As seen earlier in this chapter, midwives often struggled to negotiate boundaries between professionalism (non-judgmental and culturally competent care) and their personal opinions (which may be influenced by social and political context of anti-immigration/anti-Islam public opinion explored in the introduction to findings chapter).

fictitious and are used with the purpose of confirming the claims of an individual or professional group (in this case, midwives), to assert their knowledge and status (Dingwall 1977). In my research, for example, midwives spoke of cases where women would continue to put honey on the tongue of a newborn, despite being advised that this practice could cause harm to the baby. Stories such as these were told by midwives in a way which seemed aimed at convincing me of their superiority, whilst positioning the behaviours and knowledge of some migrant women as irrational and flawed. Irrespective of the lack of evidence about whether or not such practices caused babies harm, it was clear that these type of accounts played an important role in midwives' professional talk, identity, and their judgement of cultural practices – both on an individual and group level. Indeed, it appeared that such stories could serve to legitimise midwives' negative attitudes towards certain traditional practices in pregnancy.

Despite a lack of evidence for an association between cultural practices and adverse outcomes, midwives' assumptions regarding this association often resulted in the creation of negative stereotypes of migrant Pakistani women. As seen, a number of midwives claimed that these women were more likely to accept a stillbirth as "God's will", and were therefore less likely to seek medical help for pregnancy concerns.

Similar stereotyping, by midwives, is seen in other sections of the discussion⁴⁹, and has been reported by authors of previous research in the field of maternity care for ethnic minority and migrant women (Bowler 1993; Jomeen and Redshaw 2013). Importantly, and directly relevant to the research aims, these authors suggest that midwives' stereotyping of certain client groups is likely to result in these women being treated differently from the outset of care (Bowler 1993; Jomeen and Redshaw 2013); arguably resulting in an unstable and problematic midwife-woman relationship from the start. In order to break down stereotypes and stigma regarding culture and religion, participants in the current study (both midwives and migrant Pakistani women) suggested that it was necessary to speak openly about these issues, and to have had personal experience of working with people from diverse cultures. Some midwives suggested that acceptance and understanding of traditional cultural practices in pregnancy would facilitate a positive midwife-

⁴⁹ For example when making assumptions about male authority, women's family relationships, and attendance at antenatal appointments.

woman relationship, and many described how knowledge about the background of these cultural practices had helped to broaden their outlook on cultural differences in general.

When speaking about cultural practices which they knew to be negatively viewed by health professionals, women tended to attribute feelings and behaviours to others. For example, whilst they would personally adhere to the midwife's advice on cultural practices in pregnancy, women suggested that 'other' Pakistani women were unlikely to do so - instead agreeing with the midwife superficially, whilst continuing traditional pregnancy practices out of the health professional's sight. This attribution of feelings and behaviours to others emerged a number of times throughout the data, usually around sensitive or controversial topics, and is explored as a meta-theme of the findings in a later section of this chapter⁵⁰.

Continuation of practices, against the advice of midwives, also appeared to be linked to women's views on authoritative knowledge, discussed in an earlier section. Both women and midwives proposed that conflict over cultural pregnancy practices was likely to impact heavily on the midwife-woman relationship; those midwives who felt their knowledge should be seen as authoritative expressed frustration at women's desires to continue with practices that the midwives themselves 'knew' to be unsafe or unsuitable. However, it should be noted that midwives in the current study varied greatly in their knowledge and understanding of Pakistani cultural practices in pregnancy; both in terms of the cultural/religious implications, but also in terms of the safety of these practices⁵¹. It is possible to suggest, therefore, that inconsistencies in midwives' understanding and acceptance of cultural practices could undermine the authority of midwifery advice provided to women. For example, if women receive different advice from each midwife they see, trust in this advice is likely to be low. In fact, women may interpret this variation in midwifery advice as evidence of midwives' lack of knowledge on the implications of carrying out traditional pregnancy practices, and may consequently attribute authority to cultural and religious knowledge of elders.

Throughout midwife narratives on culturally diverse pregnancy practices, there was repeated use of the phrase 'informed choice'. Midwives explained that, for their role in women's pregnancies, informed choice meant educating women on the safety implications of certain practices in

⁵⁰ Section 8.8, page 242

⁵¹ For example, midwives' difference in knowledge over the risk of Botulism from giving infants honey.

pregnancy, and then allowing women to make their own decisions regarding their actions. Indeed, the informed model involves a partnership between healthcare provider and service user that is based on a division of labour (Charles et al. 1999). In this approach, health professionals communicate information on all relevant care options and their benefits and risks, and then it is the responsibility of the service user to deliberate about this information and take the steps required to make the choice (Charles et al. 1999).

Informed choice is recognised and accepted as an important aspect of ethical healthcare (Ballantyne et al. 2006), and has been an important part of maternity care since the partnership approach towards care was introduced (Bekker 2003); placing a mutual responsibility on both parties to engage with care provision and influence outcomes (Department of Health 2007; Cross-Sudworth et al. 2011). As suggested by midwives in the current study, it is therefore often the case that midwives will feel jointly responsible for any decisions made by their client, and may even be found legally accountable for decisions leading to adverse outcomes (Tilley and Watson 2004). Although this is possible for all cases where shared decisions over care are made, midwives may feel more concern about practices they are unfamiliar with, or with women who may not be fully compliant with the ethos of informed choice. Therefore, midwives' sense of tension around accountability for decisions made by migrant women may be increased, compared to their concerns regarding decisions made by UK-born women, who were often perceived as more compliant with informed choice. Subsequently, this may lead to midwives adopting a 'defensive practice' approach when working with migrant women, by going against the principle of objective informed choice and providing women with information and advice which is biased towards professional protection.

This notion of balance between objective and protective information giving is supported by work from (Kirkham et al. 2002); Stapleton et al. (2002), and Levy (1999b); (Levy 1999a), with the latter of these authors referring to this as a process of 'tightrope walking' in midwifery care (Levy 1999b). As seen in my own research, midwives in Levy (1999b)'s study were anxious to meet the wishes of women and to appear unbiased in their advice, but acknowledged their own strong feelings regarding certain issues. As a result, these midwives often felt that they had to strike balances in their information-giving – as, if the correct line was not chosen, highly undesirable outcomes could result (Levy 1999b). Such undesirable outcomes were cited as women feeling patronised, health professionals becoming upset, unrealistic expectations being encouraged, and

the well-being and safety of both parties being compromised (Levy 1999b). Similar dilemmas were described by midwives in the current study, who suggested that they did not want to seem judgmental or patronising when providing advice which went against the wishes of women, but also wanted to ensure that the advice given was safe.

Safety seemed an important issue for midwives in my research, and data suggested that the concept of 'informed choice' could sometimes be used by midwives to reduce their accountability for controversial decisions; midwives could shed some of the responsibility for outcomes by providing the necessary information and then allowing women to make their own decisions regarding the enactment of pregnancy practices. Previous studies reached a similar conclusion (Clarke 1991; Levy 1999b). For example, Clarke (1991) outlined a the tendency for some healthcare professionals to detach themselves when delivering information on pregnancy, and suggested that this was used as a safeguard against becoming legally accountable for the decisions of parents-to-be. Indeed, although not evidenced by all, when discussing traditional pregnancy practices there was a tendency for midwives to focus more on the potential risks to self (both personal and professional) than on the risks to the woman or infant concerned. The tension between the rhetoric of informed choice and the reality of practice is an interesting one, as such findings suggest a possible naivety of the concept of informed choice on the part of midwives.

Interestingly, as seen in the second findings chapter, data from the current study suggested a bidirectional effect between midwives' views on cultural pregnancy practices, and the establishment of the midwife-woman relationship. An established midwife-woman relationship seemed to positively influence midwives' perceptions of the cultural practices carried out by these women, whilst at the same time, midwives' attitude towards cultural practices had the potential to influence the establishment of this professional-client relationship⁵².

Such findings highlight the influence of existing stereotypes and generalisations of Pakistani culture, made by midwives, on their relationships with migrant Pakistani women in their care. The existence of such stereotypes is interesting, as it suggests that some midwives are unaware of the complexities of Pakistani family life and dynamics; despite the large amounts of literature available

⁵² See previous chapter for bi-directional model (page 186).

on this subject, and on cultural competence more specifically (Horvat et al. ; Lecca et al. 2014; Perry et al. 2015).

As previously discussed, negative stereotyping can ultimately result in a vicious cycle of negative effects; negativity and tension will start to form in the midwife-woman relationship, women will be less likely to attend appointments, more work will be needed from the midwife to care for the woman, the midwife will become frustrated at the extra workload required and anxious about perceived risk to the woman, unborn child and the midwife's professional reputation, contributing to a view that these women are harder to care for, and this will eventually reaffirm the midwife's pre-existing stereotype.

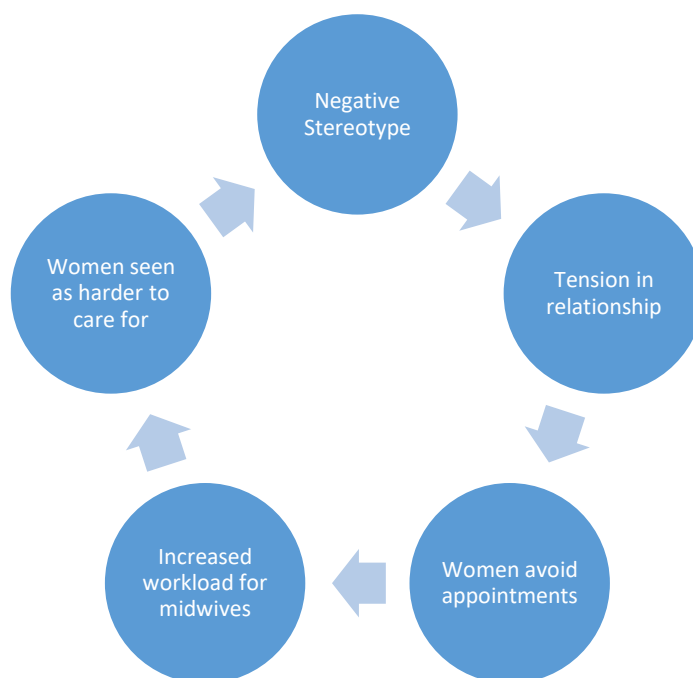


Figure 13. A cycle of negative effects resulting from negative stereotyping of women

Evidence of such an effect was hinted at by Bowler (1993), who found that midwives maintained negative stereotypes of minority ethnic women, even when faced with repeated instances of evidence to the contrary; cases which did not fit with midwives' stereotypes were seen as exceptions to the rule, rather than serving to challenge these generalisations (Bowler 1993). Midwives reported not being able to have a "proper relationship" with minority ethnic women, consequently finding them "unrewarding" to work with (Bowler 1993, p. 161). Combined with the

bi-directional relationship between attitudes towards cultural practice and the midwife-woman relationship, found in the current study, such findings highlight the importance of breaking down negative stereotypes in midwifery care.

Although women in this study spoke briefly about their religious beliefs as a Muslim, they gave little mention of how their religion might impact on their maternity care or their relationships with UK midwives. Midwives, in contrast, expressed overwhelmingly negative views regarding certain religious beliefs – for example the belief in ‘God’s will’ in determining pregnancy outcomes. Midwives claimed that women who held this belief seemed less concerned by problems during their pregnancies, and reported these women as being less inclined to be assertive in seeking care. It was even claimed, by one midwife, that women who believed in the role of ‘God’s will’ in their pregnancies often appeared unaffected by miscarriages or stillbirths. Previous research shows similar attitudes of UK midwives towards the role of religion in women’s pregnancies. For example, healthcare professionals in Essén et al. (2011)’s research suggested that “It doesn’t matter what we tell [Somali women], whatever the consequences are, it’s the work of Allah. We don’t have any influence at all” (Essén et al. 2011, p. 14). Mirroring findings from my own research, these authors also reported that the death of an infant, while considered absolutely tragic and undesirable, was considered by Somali women to be a religious event, and out of the women’s hands (Essén et al. 2011).

In my own research, midwives tended to generalise a reliance on ‘God’s will’ to migrant Pakistani women as a group. However only two migrant Pakistani participants made reference to any religious beliefs in terms of pregnancy outcomes. Furthermore, both of these women suggested that their belief in the will of God was not an alternative to seeking adequate maternity care, or a belief which stopped them from feeling sadness, but instead something which allowed them to rationalise their loss more successfully if adverse outcomes did occur. As only two women discussed this issue, it was difficult to assess whether participants purposefully avoided this topic during interviews as they were conscious of their audience (a white British researcher), or whether midwives were incorrectly generalising these beliefs from their experiences with a small number of women. Either way, it is likely that such negative (and potentially unfounded) attitudes towards Pakistani women’s beliefs would have damaging effects on midwife-woman relationships for this client group.

In addition to viewing women's belief in 'God's will' negatively, midwives also seemed to experience this belief as a barrier to what they had to offer as midwives; disrupting 'proper' midwifery work and causing imbalance in their relationships with these women. In fact, belief in 'God's will' was often perceived by midwives as a fatalistic approach to causation of negative pregnancy outcomes and arguably affected midwives' perception of their agency in the care of women's pregnancies. This perceived denial of midwifery work goes against the partnership model of midwifery promoted in the UK, and has the potential to create friction in midwife-woman relationships. Indeed, as discussed earlier in this chapter, tensions appeared to arise due to a mismatch between cultures of healthcare in the UK and Pakistan. Whilst women viewed their pregnancies from a collectivist standpoint (involving family members and God), midwives identified with the westernised view of maternity care as a partnership based mainly between midwife and woman. It is therefore possible that the perceived belief in 'God's will' in determining pregnancy outcomes provides an example of what Hunter (2006) describes as 'rejected exchange'; midwives attempt to initiate preventative care, whilst women refuse this care in favour of religious beliefs, and reject advice from midwives. Examples of this type of rejected exchange in maternity care of migrant women are found in research pre-dating my own; health professionals in Essén et al. (2011)'s study expressed feeling as though they had very little (or no) influence on Somali women's maternity outcomes. As discussed earlier in this thesis, instances of rejected exchange and denial of a partnership mode of care can cause dissatisfaction in midwife-woman relationships for UK midwives, and consequently result in negative stereotyping of these women (Hunter 2006).

Thus, in reference to the research aims, culture and cultural traditions in pregnancy appear to have an important effect on midwife-woman relationships. How both individuals perceive this issue can lead to tension and negativity in relationships. In order to improve midwife-woman relationships for migrant women, it therefore seems necessary to raise awareness of the competing cultural ideologies of maternity care, and to initiate open discussions on these issues.

8.5.1 The Importance of Communicating in English

As seen in the previous chapters, data suggested an association between language barriers, learning English, and the nature of midwife-woman relationships for migrant Pakistani women. However, this finding proved difficult to align with a specific aspect of the model, as it appeared relevant to a number of the key themes. Numerous read-throughs of the data relating to language barriers, and women's engagement with learning English, led me to realise that both participant

groups attributed a lack of learning English to cultural factors, such as avoiding contact with men and fulfilling domestic duties. It therefore seemed appropriate to place the subtheme of communicating in English within the main theme of culture and religion. Indeed, although language barriers presented a challenge to communication, it was women's perceived reluctance to learn English that, from midwives' perspectives, caused the most negativity in relationships. As a result, this seemed an appropriate placing for this subtheme. However, it is important to remember that data discussed in the following section could equally have been discussed in line with the weaving theme of 'communication of information' (section 8.7, page 239), which considers the perceived purpose of communication, the form this communication took, and what was seen as effective communication by participants.

Inability to communicate effectively was identified by both midwives and women, in this research, as a barrier to the formation of a good midwife-woman relationship. This finding is supported by a number of previous studies; ineffective communication has been cited as a major contributing factor to strained cross-cultural relationships, and for maternity care relationships in general (Binder et al. 2012; Degni et al. 2012; Boyle 2013). Participants in my study identified the potential for language barriers to directly influence maternity outcomes; many expressing fears that miscommunication between woman and midwife could compromise safety and wellbeing. Maternal mortality reports indicate that these concerns might indeed be founded; as seen in the literature review chapter, midwives are especially challenged in that language barriers limit the likelihood of obtaining a detailed booking history, therefore limiting their ability to provide effective and timely care (Cantwell et al. 2011).

Findings from my research also suggested that frustration and tension in midwife-woman relationships were sometimes triggered by language barriers. Previous research supports this finding; both healthcare professionals (Bowler 1993; Binder et al. 2012; Degni et al. 2012) and women (Sargent and Bascope, 1996) report that communication problems in healthcare provision prove both frustrating and concerning.

Although both women and midwives acknowledged the potential for language barriers to negatively affect the midwife-woman relationship, the area of most tension appeared to stem

from midwives' assumptions that migrant women were unwilling to learn the native language⁵³. Midwives' frustration over language fluency seemed linked to the amount of time that the woman had lived in the UK. For example, midwives suggested that whilst they could understand limited English language ability in women who had recently migrated, their patience was lower for 'well-established' migrants; women who had resided in the UK for a substantial amount of years (usually cited around 5+). This lower tolerance of language difficulties was especially apparent towards women who had already had experience with the UK maternity care system and who were returning for a second or third child. Similar findings were presented in Bowler (1993)'s study of UK midwifery care; midwives believed that South Asian women (especially those with longer history of residency) should have better English language ability; many expressing extremely negative attitudes about this lack of fluency (Bowler 1993).

The consistency in these findings, between Bowler in (1993) and my own research (2016), says something interesting about the way in which midwives attribute responsibility to women in terms of engagement in their own care, with an emphasis on longevity of experience. The fact that Bowler (1993)'s study was conducted over two decades ago suggests that this issue has continued to be an extremely important factor in midwives' relationships with migrant/minority ethnic women. Indeed, such findings suggest that language barriers cause tensions in the midwife-woman relationship above and beyond a struggle to communicate effectively. Similar conclusions about the complex effect of language barriers on relationships between midwife and woman were made by Bowler (1993), who suggested that difficulties in communication not only lead to problems accessing healthcare, but also exacerbated the development of stereotypes and racism. The South Asian women in Bowler (1993)'s study had low levels of English, which resulted in midwives characterising them as rude, unresponsive and unintelligent (Bowler, 1993). Lack of English proficiency served to assist in the maintenance of these stereotypes; women had no opportunity to challenge the assumptions made about them, or to build a relationship with the midwife which might disconfirm some of these stereotyped beliefs (Bowler, 1993).

Similar generalisations and stereotyping were observed in my own research. Indeed, it was clear that midwives interpreted 'well-established' migrant women's lack of language fluency as not only

⁵³ Here the native language refers to English. Although Welsh is technically the native language in South Wales, in terms of public service provision and per capita ability to speak the language, English is considered native.

laziness but also disregard for the English language and engagement in UK healthcare services. This appeared to be the source of much annoyance and frustration for midwives, and it was clear that midwives felt this was a barrier to their relationship with women.

Along with assumptions about women's desire to learn English, midwives suggested that Pakistani women were often prevented from learning English by family members (namely mothers-in-law and husbands). This was supported, in part, by women's narratives; women suggested that it was common for mothers-in-law in Pakistani culture to try to keep the daughter-in-law inside of the home in order to carry out domestic duties. Although not explicitly addressed in narratives, I began to wonder whether the tightness of the family unit could also contribute towards women's lack of motivation in attending language classes. Due to the support and help provided by family members in Pakistani culture it seemed plausible that women may feel as though they don't need anyone else to support them; nullifying the point of learning English or attending antenatal classes. This once again may affect the role of the midwife, and structure of the midwife-woman relationship, which will be discussed further in the next section.

Importantly, there seemed to be a surprising (and nonsensical) relationship between midwives' expectations for women to learn English, and their failure to direct women to appropriate resources - for example the locally available 'English for Pregnancy' classes. Despite expressing frustration at women's perceived reluctance to learn English, none of the midwives I observed in antenatal appointments mentioned the availability of language classes. In fact, when I asked midwives about this observation, the majority claimed that they did not know the exact details of these classes, and it was not something they ever broached with women. Therefore, in spite of citing language ability as a source of tension and safety risk, midwives did not seem willing to take the relatively simple step of encouraging women to go to classes. Instead, midwives expressed that they would offer interpretation services to these women.

In terms of interpretation, women in my research stated a preference for using family members to interpret, and midwives reported accepting this decision, despite acknowledging that it was against maternity practice guidelines (Cantwell et al. 2011; Knight et al. 2014). This was a surprising finding, as the reliance on family members for interpretation is frequently cited by midwives in other studies as a cause for concern, many highlighting the inappropriate nature of communicating health care issues through young children (Cantwell et al., 2011). However, as

seen in Chapter Five, midwives in South Wales had recently been briefed about the increasing cost of interpretation, and were therefore experiencing pressure not to use face-to-face interpretation services unless absolutely necessary.

Although midwives acknowledged that professional interpretation services were often needed for the safety of women (and to ensure informed consent had taken place), there was a general sense of negativity, from midwives, around face-to-face translation. As seen in the previous chapter, midwives suggested that the presence of a third person disrupted rapport-building, and that interpreters would often have their own conversations with women which the midwife was not privy to. Previous research on the use of interpreters in healthcare mirrors these findings; suggesting that the use of third party individuals can affect rapport between patient and health professional (Farooq and Fear 2003), and can exclude either the patient or healthcare professional from conversations (Tribe and Morrissey 2004). Such findings suggest that the use of interpreters has the potential to limit reciprocity in the midwife-woman; the interpreter assumes the position of care provider, whilst midwives are used purely for their professional knowledge.

Furthermore, midwives suggested that the interpreters they worked with were often ineffective or had an overbearing presence during antenatal appointments. This is supported by previous qualitative research which found that midwives reported poor quality interpretation as an important challenge for providing maternity care for refugee and asylum seeker women (Bryant 2011). Midwives in my own study suggested that issues with interpretation not only caused misunderstanding and frustration, but also had the potential to negatively impact on their relationship with women. As identified, negativity was also expressed by midwives about the cost of using interpretation services. It seems plausible that such negativity towards using professional interpreters could spill over into the midwife's relationship with the women who need this service.

The uninvited presence of interpreters also seemed to be an area of conflict for midwives. Many expressed feeling as though their authority was being challenged, and that they were being forced to use (and therefore to pay for) services that were not needed. Such findings suggested an interesting sense of hierarchy – midwives appeared to see themselves as gatekeepers to this service, and reacted negatively when women booked interpreters themselves. This attitude towards service provision arguably goes against the woman-centred values of care emphasised in

UK maternity care (NICE 2008); women-centred services should be driven by what women themselves say they need.

As mentioned earlier, midwives often discussed encounters with traditional cultural practices by recounting atrocity stories on the use of interpreters during antenatal appointments. Again, accounts were given by midwives of situations where the other party (in this case the interpreter) was acting in a way which could have caused potential harm to mother or baby, whilst the midwife was portrayed during these accounts as safety-conscious and responsible. For example, as seen on page 195, one midwife told me of an interpreter who claimed that mental health issues did not exist in Pakistan, and therefore prevented the healthcare team from assessing women's mental state during pregnancy; an act that the midwife knew I would view negatively. In this way, it appeared that midwives were attempting to legitimise their negative attitudes towards the use of interpreters by telling me stories which supported the validity of their attitudes.

The majority of data on the use of interpreters came from midwife narratives, as women in the current study had good levels of English and therefore only three of these women had used an interpreter for healthcare appointments. Consequently, it was difficult to assess women's views on the use of interpreters in antenatal appointments. Findings from previous literature, however, suggest overwhelming positivity about the use of interpreters from service users. For example, in Sargent and Bascope (1996)'s study, the authors reported that several participants cried with relief and happiness when they realised that the interviewer spoke Spanish, and expressed their desperation to find someone with whom they could communicate. My own informal conversations with midwives provided similar insights; many suggested that appointments involving interpreters often took much longer, as women were happy to be able to talk to someone in their own language.

Despite these findings, women in my own research acknowledged the potential negative effect of the interpreter on their relationship with their midwife; suggesting that they might not be as open about their health issues if an interpreter was present, or that the midwife could end up talking to the interpreter and not them. Many suggested that they would prefer to speak directly to the midwife, even if it meant speaking in limited English. In fact, this was mirrored in my own interactions with women; one participant, who had initially taken up the offer of an interpreter during our interview, requested that her second interview be conducted without the interpreter

present. Taken together, these findings suggested conflicting perspectives on the use of interpreters in antenatal care; whilst there was agreement on the safety aspect of using these services, participants also noted the potential for a third party to restrict the establishment of a good midwife-woman relationship.

8.6 A Discussion on Differences in Healthcare Systems

Both midwives and women varied in their expectations and understanding of the UK and Pakistani maternity care systems. However, whilst midwives claimed that migrant women “knew” that UK healthcare was the best they were ever going to get women generally expressed views to the contrary; claiming a preference for the Pakistani system. Indeed, midwives felt that they were providing the best care there was, while some women seemed dissatisfied with care which they saw as substandard.

Women’s expectations of UK maternity services were discussed at length, during interviews, and both midwives and women were of the understanding that new migrants were not provided with any information about the UK healthcare system on arrival. Furthermore, midwives admitted that they had very little (if any) knowledge of the maternity services provided in Pakistan for comparison. This is supported by research from Aquino et al. (2015) who conducted semi-structured interviews with NHS midwives in the North West of England over the same time period as my own data collection. Midwives in this research acknowledged that minority ethnic women’s expectations of maternity care, especially those new to the UK, were often vastly different to their own expectations as midwives (Aquino et al. 2015). As in my own research, many of these midwives associated this divergence in expectation with women’s lack of knowledge of the NHS maternity care structure (Aquino et al. 2015), and suggested that women who had limited knowledge of the UK system expected care similar to that provided in the country they originated from (Aquino et al. 2015). One such expectation, which emerged from my findings, was women’s desire for earlier initiation of care. Women in my research suggested that the first trimester of pregnancy is seen as the most important in Pakistani culture, and emphasised the point that they would have liked more contact with a midwife during this time period. The majority of UK maternity care, conversely, begins when women are between 10 to 12 weeks pregnant (NICE 2008) – almost completely missing this first trimester. Such differing understandings of basic

concepts of pregnancy and birth, between UK and Pakistani systems, potentially lay the foundations for frustration and misunderstanding within the midwife-woman relationship. Awareness of this type of non-clinical evidence could have major impact on experiences and clinical outcomes; therefore, as seen in the next chapter, recommendations are made to create opportunity for discussion of these findings.

As seen in Chapter Seven, differences in expectations of care often led to tension or frustration on the part of midwives. This is supported by recent work, which found that when migrant women's expectations were not met, they were likely to become extremely dissatisfied with their care; finding the NHS inflexible to their needs (Aquino et al. 2015). Frustration over unmet expectations were even perceived, by midwives, to be a major contributor to health inequalities, by impeding migrant women's uptake of antenatal care (Aquino et al. 2015).

Previous research suggests that this mismatch of expectations also has the potential to result in negative stereotyping of women. For example, research by McFadden et al. (2012) found that Bangladeshi women's expectations of breastfeeding support were seen by midwives as unreasonably high, and women were consequently stereotyped negatively by these health professionals (McFadden et al. 2012). Mirroring findings from my own research, women in McFadden et al. (2012)'s study based their expectations of care on the Bangladeshi system; in this system new mothers receive extensive practical support with breastfeeding in order to let them rest and recover (McFadden et al. 2012). However, these expectations went unmet by the UK system; in stark contrast to the level of postnatal support given to women in Bangladesh, the majority of UK women are discharged from hospital within the day (Royal College of Midwives 2014b). Indeed, women's length of postnatal stay in UK hospitals has steadily decreased over the last fifteen years with the majority of women now leaving hospital within six hours of the birth (Royal College of Midwives 2014b). In McFadden et al. (2012)'s study, this discrepancy in approach to postnatal care resulted in frustration from midwives at Bangladeshi women's requests for help, and consequently led to negative stereotyping of these women (McFadden et al. 2012).

Such findings suggest that understanding the differences in expectations of maternity services is extremely important in alleviating tension in midwife-woman relationships. During interviews, midwives indicated that they would like to be able to provide migrant women with information about the structure of the UK maternity care system. However, time restrictions on antenatal

appointments was cited as a barrier to providing this basic information. Although I sympathised with midwives' high workloads, this seemed like a rather outdated view of information provision. As seen in Chapter Four, even with a very small budget and the time restrictions of a PhD, I was able to create participant information in a variety of languages and through a range of media. In the current technological climate of apps and websites, it is arguable that such information (which seems key for women's navigation of care) could be easily provided by an organisation as large as the NHS.

8.6.1 Women's Navigation of Antenatal Care

A convergence of views was seen on the subject of maternity care attendance; both women and midwives suggested a tendency for migrant Pakistani women to present at their antenatal appointments late in their pregnancy (therefore missing out on some of their care), late to antenatal appointments, or to miss these appointments altogether. These findings are supported by existing literature which shows that minority ethnic and migrant women consistently receive care less frequently than recommended by the NICE guidelines (NICE 2008; Cantwell et al. 2011; Knight et al. 2015). Such findings are worrying; as seen in the literature review chapter, antenatal care is consistently linked to improvements in maternal and perinatal mortality and morbidity (Knight et al. 2009; Knight et al. 2014; Nair et al. 2015). Indeed, a recent UK national case-control study conducted by Nair et al. (2015) found that inadequate use of antenatal care was significantly, and independently, associated with maternal death from direct pregnancy complications.

Limited involvement with antenatal care not only puts women at higher risk for adverse maternity outcomes, but findings from the current study suggest that it also has the potential to negatively impact the midwife-woman relationship for these clients. In midwife narratives, negative attitudes were seen towards migrant Pakistani women's antenatal care attendance and punctuality. Similar negativity towards women's attendance at antenatal appointments is seen in existing literature from Dublin. For example, in interviews with Lyons et al. (2008) maternity care providers suggested that ethnic minority women did not conform to the 'unwritten' rules of behaviour of the hospital – often presenting late or missing appointments. As a result, women were seen as using a disproportionate amount of staff time and hospital resources, causing frustration amongst healthcare providers (Lyons et al. 2008). The authors concluded that this frustration was an

influential factor in maternity care provider's negative perceptions of working with minority ethnic women (Lyons et al. 2008).

In my own research, frustration was directed not only at women's non-attendance itself, but also at the perceived reasons behind this non-attendance. Indeed, midwives tended to explain this behaviour by stereotyping migrant women as lazy or uninterested in engaging with their care. In contrast to this view, women suggested that non-attendance of migrant Pakistani women was likely due to lack of opportunity, misunderstanding and/or poor knowledge of the healthcare system. For example, it was noted that many the women in my own research were unfamiliar with appointment systems, and a number spoke about an absence of this type of system in Pakistan. A minority of midwives in my research also recognised this issue. Existing literature suggests that midwives are often aware of the navigation issues resulting from a conflict between native and host country healthcare structures (Puthussery et al. 2008; Bryant 2011; Aquino et al. 2015). However, despite awareness of this issue, both midwives and women acknowledged that the functionality of the appointment system had not been discussed at any point during women's engagement with care. Indeed, women expressed continued confusion and frustration about the way in which appointments were made and many suggested that it should be the midwife's responsibility to arrange these on their behalf.

As mentioned, women cited lack of opportunity as another potential barrier to appointment attendance. For example, many participants in my research suggested that childcare and meal provision left them with very little time to arrange or attend antenatal appointments. Thus, women suggested that non-attendance was not a result of lack of interest in engaging with their maternity care, but rather a lack of opportunity to do so. Such findings are supported by Winkvist and Akhtar (1997) who suggest that young women's subordinate position in Pakistani culture is an important factor behind limited uptake of pregnancy-related healthcare. Indeed, my own findings suggested that this subordinate position could deny access to care not only in terms of time restrictions, but also in terms of permission from family elders. For example, women suggested that mothers-in-law were reluctant to approve attendance at non-compulsory healthcare such as antenatal classes, due to fears of breaking cultural norms such as interacting with men, adopting western values, and avoiding domestic duties.

As seen, women's navigation of care was cited as a source of tension in midwife-woman relationships. Whilst midwives generalised this behaviour and created negative stereotypes of women accordingly, women presented reasons for this behaviour which were largely unconsidered by midwives. Such differences in explanations, and the resulting tension created in relationships, highlight the importance of co-operative discussion on such issues. Indeed, these findings suggest that it is essential that midwives do not just accept non-attendance as part of a stereotype, but instead find ways to explore and work around the individual barriers to care. As noted by Tyler (2012), it is responsibility of the service to identify high risk women and to ensure the provision of regular antenatal care.

8.6.2 The Role of the Midwife

Understanding the role of the midwife was also an important element in women's navigation of care. During conversations with women, some uncertainty remained about the role of midwives in UK maternity care, especially for those women who had had experience with, or had heard stories about, 'old style midwives' in Pakistan. Women in my research explained that doctors and gynaecologists were the ones responsible for pregnancy and childbirth in Pakistan, and that the 'midwives' were simply women who had been present at a number of births but had had no medical training and held no healthcare qualifications. Although a number of women suggested that most labour was now overseen by obstetricians in Pakistan, evidence exists for the continued practice unqualified midwives. In fact, an evaluation of traditional home birth attendants in Pakistan found that only 3% were literate, 1% had a formal qualification, 3.8% had more than 1 month of medical training, and only 1% could count a fetal heartbeat with a stethoscope (Garces et al. 2012).

Although the women in my study appeared to trust the quality of the maternity care they were receiving in South Wales, many admitted to being unsure about the qualifications and professional responsibilities of UK midwives. This lack of clarity continued even after women had attended one or two antenatal appointments. Similar findings were recorded in the 2011 Maternity Action Report (Bryant 2011), which found that refugee and asylum seeker women were often unfamiliar with the role of the midwife, and tended to view birth as a medicalised process which required a doctor. Although I found it surprising that the qualifications and professional role of midwives had not been explained to women, it is possible that a certain level of understanding was assumed by midwives, due to the long-established role of midwifery in UK healthcare. This suggestion is

supported by finding from Aquino et al. (2015)'s exploration of midwives' experiences of providing care for BME women. Midwives in their study acknowledged that the depth of their clinical knowledge and experience might have made them less sensitive to women's varied levels of understanding of the NHS maternity care system (Aquino et al. 2015). Consequently, midwives recognised the importance of explaining their role to women to ensure that migrant clients were aware of a midwife's skills and the care that they would be offered (Aquino et al. 2015). The authors claimed that having this conversation with women could help resolve the conflicting expectations that midwives encounter when providing care for minority women (Aquino et al. 2015).

It is not only knowledge and skills that are important for understanding the midwife's role, but also the underpinning approach to care. For example, in UK healthcare, midwives are registered and accountable professionals who work in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period (Royal College of Midwives 2014a). The midwife's role is therefore seen as that of an active partner – providing women with the opportunity to discuss all evidence to help them make the best choices for themselves (Royal College of Midwives 2014a). Indeed, this partnership is commonly seen as integral to midwives' ideal of practice (Downs et al. 1997; Wiggins 2008; Cross-Sudworth et al. 2015). However, as seen from my research, numerous situations occurred which caused midwives to feel as though this partnership did not exist with migrant Pakistani women, and consequently led to frustration and cases of rejected exchange.

Rejection of the partnership approach to care has been seen in previous research with minority ethnic and migrant populations (e.g. Aquino et al. (2015)), and is suggested to result from a different cultural view of maternity care. For example, in interviews with Mumtaz and Salway (2007), Pakistani women expressed the view that pregnancy should not be 'tampered with' as it was a linear process that could only end with the birth of a child. Indeed, antenatal care was viewed by some Pakistani women as interference in a natural process (Mumtaz and Salway 2007). Such findings support the analysis that differing healthcare cultures existed for participant groups in my research; whilst midwives attempted to provide care in line with the partnership model, women seemed to be unaware of, or confused by, this approach. Indeed, a number of women expressed ambivalence towards continuity of carer during their pregnancy, and implicated the role of the midwife as being largely a source of information, rather than an active partner in their

pregnancies. This view is supported by work from Boyle (2013), who suggests that women may not *want* to engage in a partnership relationship with midwives, which may make interactions more complex, causing rejected exchange and resulting in tension in the midwife-woman relationship (Boyle 2013).

Along with negative implications for the balance in midwife-woman relationships, findings from my research seemed to suggest that a lack of partnership with migrant Pakistani women could result in midwives emotionally separating themselves from these clients. This tended to stem from midwives' perceptions of working with migrant women as being more challenging for professional responsibility and accountability. Previous research supports this finding, reporting that midwives describe their job as more demanding and difficult when working with migrant women, and therefore experience higher workload and extra stress (Essén et al. 2011; Aquino et al. 2015). Midwives in my research expressed the need to emotionally detach from their relationships with migrant women in order to protect themselves; using phrases like "shut down" or "switch off" in order to "protect their sanity". This conscious management of emotions in midwifery care is referred to, in previous literature, as 'emotion work' (Hunter 2006), and is said to occur when midwives have to regulate their emotions as a result of care situations which are challenging and emotionally draining. Indeed, the term emotion work (or emotional labour) was originally used by Hochschild (1979, p. 551) to describe situations where an individual "works on inducing or inhibiting feelings so as to render them 'appropriate' to a situation". Similar theories were put forward by Parsons (1951), who suggested that individuals would attempt to maintain 'affective neutrality' - working on controlling emotion to ensure that their emotional reactions remained appropriate for a given context (Parsons 1951).

As suggested by my findings, midwives in previous research have been found to report increased levels of emotion work when working with migrant women (Bowler 1993; McFadden et al. 2012), increasing the likelihood of stress and frustration when working with this client group (Aquino et al. 2015). Furthermore, in my own research, this increased workload seemed to result in negativity towards working with migrant women, which was apparent during conversations with midwife participants; a finding similar to that reported over two decades ago by Bowler (1993).

Taken together, such findings suggest that the role of the midwife remains unclear for migrant women in the UK, and that conflicting models of care have the potential to negatively influence

the midwife-woman relationship for these clients. As will be recommended in the conclusion of this chapter, management of expectations on both sides (midwife and woman) is necessary to reduce misunderstandings and tensions in maternity care, and to encourage partnership and reciprocity in midwife-woman relationships.

8.7 Weaving Theme: Communication of Information

Throughout data analysis, interesting points arose in terms of the communication of information between women and midwives. Although such communication is arguably linked to the acquisition of English, communication issues appeared to reach further than just language barriers between midwives and women. Indeed, data suggested important differences between midwives and women in terms of the perceived purpose of communication, the form this communication should take, and what constituted effective communication.

As suggested, obvious differences existed between participant groups when it came to the perceived aims of midwife-woman communication. For example, midwives placed importance on social aspects of communication such as small talk, humour, and aspects of women's daily lives such as their hobbies and interests, whilst women tended to prioritise the factual information being communicated. Although some mention was given to the social function of communication, by women, conversations with these participants tended to focus more on forms of communication of information relating to scans, physical checks, factual information, and test results. Such findings suggested a difference in the desired outcome of communication of information; whilst midwives expressed a desire to provide holistic, tailored, care and build a good midwife-woman relationship in order to do so, women seemed largely concerned about gaining access to information directly related to their pregnancy. The observed ambivalence from women about one-to-one communication with their midwife further supports this concept by suggesting that women were happy for male partners to speak on their behalf, as long as they knew that these family members would then relay this information to them at a later date. Indeed, the majority of women seemed unaware, or unconcerned, of how lack of one-to-one contact with midwives might affect the midwife-woman relationship.

This finding is somewhat surprising, as previous research suggests that social aspects of talk are highly valued by UK-born women in maternity care (Walsh 1999). For example, conceptualising the midwife as a 'friend' has been seen to have a significant positive impact on UK-born women's experience of childbirth (Wilkins 1993; Walsh 1999), and women have reported wanting a close personal relationship with midwives which extends past the narrow professional context of healthcare (Wilkins 2010), and includes personal, emotional and biographical input (Wilkins 1993). Indeed, the majority of existing literature suggests that a good midwife-woman relationship has an extremely positive impact on women's satisfaction with care (Tinkler and Quinney 1998; Puthussery et al. 2010; Jonkers et al. 2011).

There exist a number of possible explanations for the variation in findings between the current study and previous literature. Firstly, it is possible that due to the family-oriented view of healthcare in Pakistani families (Moazam 2000), women in the current study may have placed less weight on their relationships with midwives; instead relying on family elders for support and advice during their pregnancy. Secondly it is possible that, due to the level of English language ability of participants in the current study, women had no difficulty partaking in social aspects of communication such as small talk and humour, instead struggling with understanding technical aspects of care such as clinical language and test results, and therefore focused on these issues during interviews with me. Alternatively, the relative vulnerability of women in my research, compared to those in previous studies, may have resulted in different priorities in terms of communicating information. For example, first generation migrant women may be more concerned about ensuring they have received all of the necessary information regarding safety and pregnancy outcome, rather than engaging in rapport-building with health professionals. In fact, this notion was suggested by one of the midwives in the current study, who claimed that migrant Pakistani women 'just wanted a healthy baby at the end'. However, it must be noted that women in the current study tended to have more fluent English language ability, and better family and community support than the client group which midwives were referring to, therefore any conclusions about the differences in desired outcome of communication of information must be made with caution.

In contrast to women's ambivalence regarding the establishment of close relationships with health professionals, midwives expressed the need to create and maintain good midwife-woman relationships with clients. However, midwives noted the dissonance between themselves and

women in terms of desired communication outcomes, and acknowledged that this often caused an imbalance in their relationship with women. Indeed, differences in desired outcome of communication often seemed to result in cases of rejected exchange; whilst midwives attempted to build a relationship through one-to-one communication with women, women often rejected these exchanges in favour of gaining the most accurate information (using partners with better language skills and/or knowledge to do so). Midwives reported that this type of exchange led to feelings of frustration, and many felt that they had been 'used' by women in such instances. Similar findings were generated by Hunter (2006), a decade ago, who found that that routine interactions with minimal social communication and a focus on midwifery 'business' were classified by midwives as emotionally difficult.

Interestingly, migrant Pakistani women's desire to receive detailed information from midwives seemed at odds with the information given to them; as highlighted by findings in Chapter Six, midwives were observed giving a reduced amount of information to women who appeared to be less fluent in English than those who spoke English fluently. In instances where this detailed information was restricted, communication appeared more clinical and prescriptive, and seemed unlikely to be conducive to the creation of a good midwife-woman relationship. Such findings present examples of what Hart (1971) termed the 'Inverse Care Law'; the trend that "the availability of good medical care tends to vary inversely with the need for it in the population served" (Hart 1971, p. 405). Examples of the inverse care law are seen in previous maternity care research (Arnold 1987; Brown and Lumley 1993). For example, Kirkham et al. (2002) found that midwives' limited amount of time available for antenatal care was used disproportionately by those most able to access information themselves. Furthermore, materially deprived women were less likely to be made aware of choices available to them and were given fewer information leaflets and less verbal information than more advantaged women (Kirkham et al. 2002).

One explanation behind this variation in information provision, explored in previous literature, is the existence of inaccurate assumptions made by health professionals, as a result of stereotyping. For example, Kirkham et al. (2002) found that midwives limited their provision of information to materially deprived women based on (often incorrect) stereotypical assumptions about these women's literacy levels and desire for information (Kirkham et al. 2002). Similar concepts were found in the data from my own research; women claimed that midwives often made assumptions about their pre-existing knowledge of pregnancy, and therefore neglected to provide them with

basic pregnancy information, including common symptoms such as cessation of periods, and morning sickness. As in Kirkham et al. (2002)'s research, observational data from my own study suggested that written information was not provided to women with limited English. Although I was aware of hardcopy information sheets available in languages other than English, this information was not provided to women during any of my observation periods.

8.8 Meta-theme: Socio-political Context and Otherness

As noted throughout the findings chapters, both women and midwives showed a tendency to invoke a third person during conversations on controversial or sensitive topics; talking more frequently about the feelings and behaviours of 'others', rather than making comment on their own views. This concept of 'otherness' was most evident when speaking on sensitive issues relating to political, cultural or social norms. For example, women referred to the tendency of 'other' women to ignore the advice of midwives, whilst midwives cited 'other' midwives as having a negative perception of working with migrant women.

Although no conclusions can be made with certainty, it appeared that this defensive attribution of views was used, by participants, as a way of deflecting the accountability of their own views onto peers. Tactics such as these are summarised in psychoanalytical texts as 'projection' (Freud 1925); a mechanism by which individuals protect their sense of self-esteem or social desirability when putting forward beliefs which may be sensitive or controversial (Freud 1925). Existing literature proposes a number of factors which predict the likelihood of projection of feelings or beliefs (Gladstone 1959). Firstly, projection is said to occur when the belief or opinion is not acceptable to the individual in terms of their self-conception, and so personalising these feelings would cause discomfort in their view of themselves (Gladstone 1959). Research in social psychology has consistently demonstrated that people strive to maintain a positive self-concept, both publicly and privately (Adler 1927; Allport 1955; Goffman 1978), even when doing so requires a degree of self-deception, pretence, or guile (Schlenker 1980; Tajfel 1982). It is therefore possible that participants in my research used attribution/projection of controversial views onto others as a mechanism to reduce threats to self-worth.

However, projection is also said to occur when social and political norms dictate that an alternative view should be held; for example these beliefs or feelings are socially unacceptable (Gladstone 1959). This concept seems to fit well with my research; as discussed at the start of Chapter Five, data collection commenced in the midst of reports on NHS failings, alongside reports of significant ethnic inequality in maternal mortality rates. It is therefore arguable that participants' awareness of these socio-political issues may have limited their confidence in expressing their true feelings; instead projecting these views onto peers. Certainly, both participant groups resisted being personally or directly associated with any views or comments which could be perceived as politically or socially inappropriate. Indeed, what stood out from participants' references to the feelings of others was how difficult it seemed for them to discuss certain issues; many accounts from midwives hinted that these health professionals may have been trying to negotiate boundaries between personal opinions and political correctness as they spoke.

More recent research on the expression of controversial feelings and beliefs has suggested a distancing response similar to projection, summarised as the 'pot-kettle phenomenon'⁵⁴ (Barkan et al. 2012). Through this response, people are cited to judge the ethically questionable behaviour or feelings of others more harshly and present themselves to others as virtuous and honest in comparison (Barkan et al. 2012). In contrast to the internal regulation of self-perception proposed above, this form of projection is utilised for impression management; the conscious or subconscious process in which people attempt to influence the perceptions of other people about a person, object or event by regulating and controlling information in social interaction (Goffman 1978). Indeed, the 'pot-kettle' form of distancing did not appear to satisfy a desire to be moral but rather the desire to appear moral by using strict ethical standards for moral judgment and self-presentation (Barkan et al. 2012). Similar findings are shown in recent work by Kennedy and Schweitzer (2015) who found that participant's accusations of other's unethical behaviour represented a powerful impression management tool for the self. Based on these findings it is possible that participants in my research used the guise of 'others' to express sensitive feelings or beliefs in a way which maintained a socially acceptable impression.

⁵⁴ The "pot calling the kettle black" is a phrase used to describe a phenomenon whereby people are guilty of the very fault they identify in others. The phrase itself originates from a saying in which the pot mocks the kettle for being black with soot, when the pot itself is also coated in soot.

Data on 'otherness' appeared throughout the main themes of my findings, which suggested the influence of social and political context on all factors contributing towards the relationships between women and midwives. This meta-theme is therefore presented in the social ecological model of relationships (the purple and white background) in order to underline the importance of the political and social context in which midwife-woman relationships were explored.

The many themes identified during data analysis; including the three 'main' themes, the two 'weaving' themes, and this final 'meta-theme', highlight the complexity of midwife-woman relationships for migrant Pakistani women. Such complexity gives emphasis to the difficulty of understanding such relationships, and demonstrates why there is no neat answer or quick fix for improving satisfaction on the part of the woman or midwife. Indeed, if health professionals and women have difficulty expressing and owning their views in a research setting where confidentiality and anonymity are ensured, then tensions are even more likely to continue in practice as a result of unvoiced and unresolved issues. Such findings suggest that a number of complex and sensitive factors must therefore be recognised and confronted when attempting to enhance these healthcare relationships.

8.9 Chapter Conclusion

The main findings from this PhD research are supported in previous literature; including the perceived importance of midwife-woman relationships for both women and midwives. Existing literature reflected the views of midwives in my research by suggesting that this relationship was essential for fulfilling their duties as a midwife and providing good care to women. However, women in my research tended to view relationships with midwives as important for enhancing access to knowledge, rather than a desire to build a professional partnership or to foster trust – a finding which differs from that of previous research.

Findings highlighted the complexity of midwife-woman relationships for migrant women, and suggested a number of social and ecological factors which were important in influencing the nature of these relationships. These included the role of family relationships, participants' relationships with culture and religion, understanding of different healthcare systems, attitudes towards authoritative knowledge and perceived function of communication of information. The

importance of social and political context was also made apparent, including factors such as public opinion towards immigration, and the state of healthcare provision in the UK. The influence of these social and political factors was most commonly seen in data relating to participants' attributions of views to 'others'; described in the discussion as a meta-theme of 'otherness'. In order to demonstrate the complexities of the relationships between these inter-connecting themes, data were used to create a visual model of midwife-woman relationships, presented once more below in Figure 14.

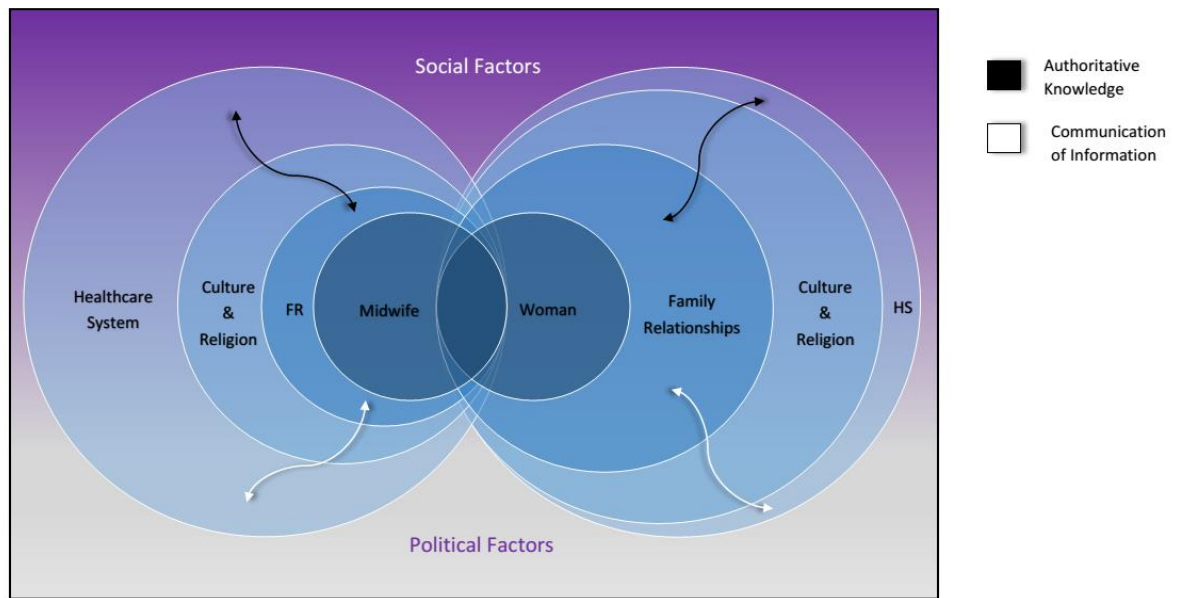


Figure 14. A social ecological model of relationships for migrant Pakistani women and practicing midwives in South Wales

Chapter Nine: Study Conclusion

9.1 Chapter Aims

This final chapter begins by discussing the findings of my research in terms of their contribution to existing literature. Strengths and limitations of the study are then reflected upon, and the chapter concludes with a discussion of the research findings in terms of their application to midwifery practice and education, and implications for future work.

9.2 Contribution to Existing Literature

Findings from this research provide new theoretical insights into the relationship between the complex world of the pregnant migrant woman and the complex professional life of the midwife. The study findings suggest that in order to understand the ways in which this relationship is created and maintained, it is necessary to consider the influence of a number of social, ecological and political factors. These factors were presented visually in the social ecological model at the close of the previous chapter.

This thesis also offers new understanding of maternity care experiences in the Welsh context. As discussed earlier in the thesis, most UK-based research on maternity care experiences has been conducted in England, where there are different midwifery guidelines and health inequality policies. This study therefore expands knowledge in an under-researched area, by exploring the maternity care experiences of midwives and migrant women in South Wales.

Furthermore, the methodological approach taken by this research provides one of the most in-depth ethnographic studies of this topic area since Bowler (1993) and, as a result, delivers an updated insight into the lived experiences of, and relationships between, midwives and migrant women. Indeed, the use of combined methods, as is essential in ethnographic research, provided me with insights which might not have been possible with a different methodology. For example, the inclusion of a second interview with migrant Pakistani women allowed me to compare attitude change across time for these participants, and to speak to women about themes identified during interviews with midwives. Furthermore, this second point of contact with women provided me

with evidence of some behaviour which had been mentioned by midwives – for example the case where Faiza admitted that she had not attended her second antenatal appointment. The inclusion of observational data provided additional support for some of the claims made by midwives during interviews; I observed a tendency for migrant women to turn up late for appointments, and for male partners to talk on the behalf of women. As only one male partner had been included in interviews with participants, this behaviour is something I may have felt that midwives were exaggerating if I hadn't seen it for myself. Consequently, observational data on behaviour guided my adaptation of interview topic guides, which resulted in either confirmation or denial of actions from women themselves.

The ethnographic approach to this research resulted in rich and meaningful data, from which important findings were drawn. As such, this thesis is a timely contribution to the existing literature in the field of maternity care for migrant and minority ethnic women in the UK. As discussed at the start of Chapter Five, immigration has risen, media perception of the migrant Muslim population has become increasingly negative, and the rate of births to women born outside of the UK has risen. Therefore, the need to understand and influence relationships between UK midwives and migrant women is likely to grow.

9.3 Study Strengths and Limitations

While every effort has been made to make this study as robust as possible, there are limitations to the study which must be acknowledged. Some of these are inherent to a small-scale study, carried out with very little funding. Others, with hindsight, could be addressed if the study were to be repeated.

9.3.1 Sample Size

Although some might see a small sample size as a limiting factor, such sampling allows for very rich and in-depth data to be generated with high rigour imposed on analysis, for example, through establishing clear credibility of the findings, all of which suggest the findings are transferable. As the aim of the current study was to conduct an in-depth exploration of midwife-woman relationships, quality and rigour of data was prioritised over quantity (as discussed in the methodology chapter, a number of steps were taken to ensure that principles of quality and rigour

were achieved; for example, the use of observation data alongside interviews, community immersion, analysis of relevant documents, policies and media, and follow-up interviews with women). As no new themes arose in later interviews, data saturation (Strauss and Corbin 1990a) appeared to have been reached during collection, suggesting that the sample size had been adequate and suitable for meeting the research aims.

9.3.2 Reporting of Participant Demographics

Due to the relatively small number of community midwives in South Wales, it was not possible to report demographic characteristics of the midwives involved in this study, as it was decided that this would have led to easy identification of these individuals. This lack of information regarding midwife demographics could be seen to limit the way in which midwife data were interpreted, however all midwives interviewed in the current study were British-born community midwives, and it was these characteristics which the findings suggested were important for the current research. Nevertheless, I remained conscious of the influence of demographics on midwives' narratives, however there were no instances where I felt that reporting this information would make a difference to the way in which data were interpreted.

9.3.3 Sample Characteristics

Arguably the most important limitation to the current study was the difference between demographic characteristics of the migrant Pakistani women who took part in this research, compared to the migrant Pakistani women whom midwives tended to refer to during interviews. Whilst midwives mainly described their experiences in reference to women who had little fluency in English, the majority of migrant Pakistani participants in this research were confident speakers of English (demonstrated by the fact that only two women accepted the offer of having an interpreter present during interviews). Women interviewed in this research, therefore, had little experience with language barriers or the use of interpreters during healthcare and so there was, understandably, limited data from women regarding these issues. Midwives, on the other hand, focused on their relationships with migrant women who lacked English language skills, and who were often facing difficult living conditions.

Although this study was developed with the intention of recruiting women with a range of English language ability (demonstrated by the provision of multi-lingual participant information sheets), these women proved impossible to recruit. As seen in the research design chapter, women with

limited English language are often reported as difficult to recruit into research and these 'seldom-heard' women are once again left unrepresented in findings, albeit not for lack of trying to recruit them.

9.3.4 Selection Bias

The lack of my direct involvement in the recruitment process was a requirement of the ethical review of this research, and removes any suggestion of selection bias in recruitment, or coercion of participants to take part. Nevertheless, without control over the recruitment process it is impossible to say with any certainty that there was no selection bias on the part of midwives recruiting on my behalf. Steps were, however, taken to reduce the likelihood of this bias; in-depth descriptions of the study were provided to all recruiting midwives at team meetings, and the importance of selection bias was flagged up at this point. Midwives were instructed to approach potential participants based only on inclusion criteria. Furthermore, the midwives involved in recruitment for my research had previous experience in recruiting participants for other healthcare studies and were therefore familiar with the methodological issues.

9.3.5 Focus on One Study Site

This research was conducted at a single health board servicing a city and surrounding area in South Wales, with recruitment of participants linked to the services provided by this health board. It is therefore possible that the findings of this research may not be generalisable to other geographical areas; especially those outside of Wales, where different local and national health policies exist. For example, as discussed during Chapter Five, local health board guidelines on interpretation services had been updated not long before data collection began, creating an air of frustration and concern from midwives. It is possible that such context may not apply if this study was to be repeated in England or another location in Wales. Furthermore, it is possible that health boards or local councils in other geographical locations may provide differing levels of support for migrant service users, or be more/less assertive in the provision of information, additionally changing the context in which findings would be interpreted.

However, as discussed earlier in this thesis, the aim of the current research was to explore midwife-woman relationships for a specific client group (migrant Pakistani women) within a specific context (South Wales maternity care). Therefore, in keeping with an ethnographic approach, the richness of data (transferability) was prioritised over generalisability; providing a

nuanced, empirically-rich, holistic account of two specific ‘cultures’, that takes into account contextual factors such as local characteristics (Geertz 1973; Marcus 1998; Falzon 2016). Although multi-sited ethnography is becoming increasingly common (Falzon 2016), this approach has come under considerable criticism from many ethnographers (Falzon 2016) who argue that moving between research sites unavoidably limits the time spent in each site, therefore reducing the depth of data collected (Falzon 2016).

The benefits of conducting a single-site ethnography also exist at a more practical rather than theoretical level. For example, in order to ensure successful recruitment and community engagement, it was necessary to maintain a trusting relationship with gatekeepers and participants. Recruiting from a single health board in a specific city therefore allowed more time to build these relationships, and to conduct fieldwork in the local community and healthcare services.

9.3.6 Focus on Antenatal Care

Interviews and observations with migrant Pakistani women were conducted prenatally. This focus on antenatal care experiences therefore limits the findings of this research to relationships with midwives during this stage of care. It is possible that there may be important differences between women’s experiences of prenatal and postnatal care. With this in mind, the original design of this research encompassed postnatal ward observations and follow-up interviews with migrant women 6 weeks after birth. However, the discussed delays in ethical approval and language service funding put time restrictions on data collection, therefore follow-up of this length was not possible. Furthermore, as discussed in the literature review, the majority of women in the UK are discharged within six hours after birth, therefore observations of this postnatal period would have been logistically difficult to achieve.

In addition to the practical reasons behind a lack of data collection in the postnatal period, I would argue that this additional data collection would have been unlikely to add anything extra to the findings. For example, in the last national survey of women’s experiences of maternity care in England (2010), only 25% of women reported having previously met any of the staff who cared for them during their labour and birth (Care Quality Commission 2010). Therefore, it is likely that the majority of women would have been cared for by a new midwife postnatally, and consequently

would be starting a new relationship rather than showing any change in, or influence of, an existing relationship.

Although interviews with women were conducted during the antenatal period only, interviews with midwives focused on their experiences with migrant women as a whole, rather than focusing on a specific woman or time period. Indeed, midwives often referred to experiences of caring for migrant women in labour and birth. The themes identified during these interviews are therefore likely to apply to all stages of care. Furthermore, both the congruence between themes identified in women's first and second interviews, and the similarity in themes identified between data from midwives and women, suggests continuity of experiences and factors effecting relationships throughout different stages of care. Also, as seen in the rationale for using a single study site, the focus on antenatal care enhanced the richness of data by allowing more time to be focused on this data collection.

9.4 Implications for Practice and Education

9.4.1 Implications for Practice

As seen in the previous discussion chapter, midwives and women differed in the importance they placed on factors contributing to their experiences of care. In the data-driven model iteratively developed during the course of my research, these different weightings of themes are represented by differing widths in the corresponding circles (the bigger the circle, the more influence that factor appeared to have for that participant group). Such findings have the potential to be adapted into a culturally appropriate 'option grid'; a decision support tool designed to aid shared decision making in healthcare (Elwyn et al. 2013), by presenting common patient-generated questions (e.g. what are the chances of miscarriage from an amniocentesis test) against concise evidence-based answers (Beattie et al. 2013). The grid format provides a one-page, easy to read, simple comparison of options (Elwyn et al. 2013) which allows service users to work through key questions and answers, comparing their options across the grid, highlighting which questions or issues matter most to them, and discussing these key questions in more detail with their healthcare provider (Elwyn et al. 2013). In terms of my own findings, option grids could be developed in order to aid decisions during the pregnancies of migrant women. For example, such

grids could display information about traditional cultural practices during pregnancy - providing evidence for the safety of these practices alongside women's thoughts regarding the value of carrying out these traditions.

The popularity of option grids appears to be growing, as they hand power to the service user and demonstrate respect for their views, whilst also going some way to negate accountability for healthcare practitioners (Seal et al. 2013). Indeed, documented use of these grids provides evidence of midwives sharing safety advice regarding these decisions. As discussed in the previous chapter, tension over traditional pregnancy practices showed potential for negative impact on the midwife-woman relationship. The option grid approach to this issue would provide midwives with an objective way of approaching safety concerns, therefore reducing the potential for tension and feelings of judgement.

The graphic representation of my findings, presented as the social ecological model of relationships, may also have practical application in midwifery care in itself, by providing an opportunity for women and midwives to reflect on how their beliefs, assumptions and values fit with this model and how this may influence the midwife-woman relationship. In addition to self-reflection, it may be possible to initiate conversations between midwives and women on these issues, by getting each party to personalise the social ecological model according to their own values and beliefs; creating visual representations of differences or similarities in values for individual pairings of women and midwives. Discussions regarding the differences in values and beliefs may help to reduce stereotyping, and facilitate a better understanding of the complex factors which come into play during antenatal care.

For example, a useful discussion to have might be based around family involvement, and the resulting lack of one-to-one contact with women (which appeared to be a common barrier to establishing midwife-woman relationships in my research). This model could be used to open up discourse with women and their partners regarding the need for direct contact between midwife and woman (whether it be attending sessions alone, or simply encouraging the woman to speak to the midwife directly). Discussion using this model might also be helpful to help midwives understand their own feelings on how domestic relationships may be constructed in Muslim culture, through self-reflection and opportunity for dialogue on these issues. Furthermore, the

practice of midwives and women working together to personalise these models would create opportunity for one-to-one contact and encourage a feeling of partnership.

There were a number of findings from this research which could have immediate implications for midwifery practice in South Wales. For example, the dissonance between midwives' expectations of women to learn English and the reality of midwives' promotion of language classes. This finding suggests that more needs to be done to enhance both midwives' and women's knowledge of local language classes, and to encourage attendance at these sessions. Another important finding was the difference in how women and midwives viewed pregnancy; whilst women saw pregnancy as a family-oriented event which was most vulnerable (and therefore needed most care) in the first trimester, midwives viewed this phenomenon as something which was to be approached from a midwife-woman partnership perspective, and where regular antenatal care should begin after 10 weeks of pregnancy. These findings provide a knowledge base for the differences in meanings of pregnancy and birth between UK midwives and migrant Pakistani women, and suggest that more work should be done to understand these differences, if maternity care is to be truly woman-centred.

9.4.2 Implications for Education

Although midwives suggested that training in cultural awareness would have been useful for negotiating some of the issues discussed, Higgs (2014) suggests that learning in academic settings is not sufficient to sustain these understandings and capabilities, and claims that alternative methods of learning are needed.

Such alternative methods are beginning to appear in the form of a multimedia approaches to cultural learning (Horvat et al. 2011), which accommodates multiple learning styles. The social ecological model developed in this research could therefore as a teaching resource that is founded on the realities of clinical practice; fostering awareness of the complexities of midwife-woman relationships for student midwives and nurses. For example, healthcare students could personalise and reflect on their own models; indicating how they personally sit within each socio-ecological dimension, and how they think specific client groups or individual women might fit into this model. Pregnant women from different ethnicities and cultures could undertake the same task – creating opportunity for experiential learning and co-production of knowledge. As a result of its use by educators, students, clinicians and women the social ecological model will be further tested,

refined and enhanced. As I already have experience in teaching midwifery students, this is something which I hope to pilot at one of the universities I am associated with in the near future.

9.5 Future Work

Although findings were interpreted from a social-ecological standpoint, there were some interesting allusions to gender in many of the accounts in Chapter Seven, which seemed to suggest that midwives perceived shared gender as a positive ingredient for establishing relationships with women. Indeed, midwives often used light-hearted teasing of the male partner to create humour and build rapport with women, and this behaviour was often reciprocated by women themselves. On a more serious note, negativity towards male partners (and their involvement in women's pregnancies) was a consistent theme in midwife narratives, and seemed to indicate the view of pregnancy as largely female domain. In fact, one midwife explicitly referred to the concept of "girl power" during her account of labour. In the absence of time limitations, it would have been interesting to analyse the data from a feminist standpoint, in order to explore the possible existence of a gender-based relationship which transcends ethnicity. Further study could expand on this area of research.

An idea for an alternative area of future work came from the identification of the meta-theme of 'otherness'. As discussed in the corresponding section of the discussion chapter, a minority of recent studies have considered similar findings in qualitative research; suggesting the use of projection and attribution of views in order to achieve impression management in sensitive or controversial situations (Barkan et al. 2012; Kennedy and Schweitzer 2015). However, relatively little research has been conducted in this field, and findings from the current research suggest that projection of feelings may in fact reduce the likelihood of issues being resolved. Although it cannot be said with certainty that this was what participants in my research were doing, further exploration of this would be extremely interesting, and could add to the body of knowledge around midwives' relationships with migrant women. Indeed, it would be fascinating to conduct a discourse or conversation analysis of my data in light of this meta-theme, incorporating the relevant political and social context.

Another possible area for research to emerge from my research findings is the difference in maternity outcomes between migrant women and UK-born minority ethnic women. As seen in Chapter Two, existing literature has come up against great difficulty when attempting to differentiate between minority ethnic and migrant women, due to the ways in which ethnicity data is recorded in healthcare systems (Hayes et al. 2011). However, during observations of booking appointments, I noted that midwives routinely asked women for their country of origin, and how long they had been a resident in the UK. Such information could therefore be used to explore differences in outcomes for migrant women versus their UK-born minority ethnic counterparts. The importance of this is highlighted by a number of authors who suggest that blurring of ethnicity and migration status may be the cause of conflicting evidence for ethnic inequalities in health outcomes (Hayes et al. 2011). Information gained from research using this routinely collected data could be used to enhance understanding of where the highest risks lie, and therefore inform policies aiming to reduce inequalities in pregnancy outcome.

9.6 Chapter Conclusion

As set out by a number of health bodies across the UK, current healthcare policies aim to maximise the health of the population and reduce inequalities in outcome (Welsh Government 2011; Stewart et al. 2012; Beeston et al. 2014; Department of Health 2014). However, recent reports suggest that ethnic and migrant inequalities in maternal mortality are actually *increasing* (Knight et al. 2015). Such findings are worrying, especially given the growing number of babies born to non-UK born women in the UK (Office for National Statistics 2015). As such, recommendations from the recent MBRRACE report (Knight et al. 2015) suggest a need to focus on ensuring appropriate antenatal care is provided in order to reduce maternal and perinatal mortality.

Findings presented in this thesis provide new theoretical insights into the relationship between migrant Pakistani women receiving maternity care in South Wales, and the midwives providing that care. The newly developed social ecological model of relationships allows for visualisation of the complexities of this particular midwife-woman relationship, and provides a window into possible reasons for tension and disconnect. The findings from this study, in addition to future work to further test and refine the iteratively developed social ecological model, have the

potential to facilitate future discussion on cultural issues, encourage collaborative learning and knowledge production, and provide a framework for future midwifery practice, education and research.

9.7 Thesis Summary

In 2014, 27.0% of births in England and Wales were to mothers born outside of the UK. Compared to their white British peers, minority ethnic and migrant women are at a significantly higher risk of maternal and perinatal mortality, along with experiencing lower maternity care satisfaction.

Furthermore, health professionals report difficulty in providing services to minority ethnic and migrant women. Although existing literature highlights the importance of midwife-woman relationships for both pregnancy outcomes and care satisfaction, little research has explored the factors contributing to the midwife-woman relationship for migrant and minority ethnic women.

Research described in this thesis used a focused ethnographic approach to explore relationships between migrant Pakistani women and midwives in South Wales; focusing on the factors contributing to these relationships in early pregnancy, and the ways in which these factors might affect women's experiences of care. Semi-structured interviews were conducted with 10 migrant Pakistani participants (eight pregnant women, one husband and one mother), one interpreter, and 11 practicing midwives. Additional data collection included fieldwork in the local migrant Pakistani community and local maternity services, observations of antenatal booking appointments, and longitudinal reviewing of relevant media outputs, such as UK news reports of issues relating to migrant individuals. Data were analysed concurrently with collection, using thematic analysis.

Findings from this research supported previous literature in that the midwife-woman relationship was seen as important for participants' experiences of care and midwives' job satisfaction. A number of social and ecological factors were identified as influencing this relationship; including family relationships, culture and religion, differing healthcare systems, authoritative knowledge, and communication of information. However, differences were seen between midwives and women in the perceived importance of these themes, suggesting that in order to understand how midwife-woman relationships are created and maintained, more needs to be done to recognise and address these differences.

Findings from this study provide new theoretical insights into the complex social and ecological factors at play during maternity care for migrant Pakistani women as well as the relationships

between these factors. A social ecological model of relationships is proposed as a means of visually capturing the complexity of the findings, as well as providing a tool which could be used to inform midwifery education and clinical midwifery practices. This model could be used to create meaningful dialogue between women and midwives, encourage collaborative learning and knowledge production, and facilitate future midwifery education and research. For example, I aim to pilot this model during an upcoming presentation to both student and practicing midwives at Oxford Brookes University in December, as well as during a session at the University of Birmingham the following week. Following these presentations, feedback will be invited from the audience regarding the accessibility and usefulness of the model, to ensure its application potential.

Aspects of this study will be written up in a number of different publications, and the findings open up various avenues for further research. Indeed, I am already working on a Fellowship proposal which would build on findings from my research. I am also in the process of writing up the findings of this research with plans to submit a paper to the BMC Pregnancy and Childbirth. Additional papers would be submitted to the international academic journal 'Midwifery', and to a professional journal widely read by clinical midwives such as MIDIRS, and would include lessons learnt about recruitment of seldom-heard populations, the use of interpreters in research and practice, and a practice paper for midwives (summarising my findings in a succinct and accessible way). Furthermore, I intend to submit abstracts for a number of conference in 2017, and to continue raising the profile of my research through networking, and teaching opportunities at my current position at the University of Birmingham.

References

(CMACE), C. f. M. a. C. E. 2011. *Perinatal Mortality 2009: United Kingdom*. London:

Abate, N. et al. 2003. Genetic polymorphism PC-1 K121Q and ethnic susceptibility to insulin resistance. *J Clin Endocrinol Metab* 88(12), pp. 5927-5934.

Adler, A. 1927. Individual psychology. *The Journal of Abnormal and Social Psychology* 22(2), p. 116.

Adler, P. A. and Adler, P. 2002. The reluctant respondent. In: Gubrium, J.A. and Holstein, J.F. eds. *Handbook of interview research*. Thousand Oaks, London: Sage, pp. 515-536.

Ajaz, M. et al. 2015. UK Pakistani views on the adverse health risks associated with consanguineous marriages. *Journal of community genetics* 6(4), pp. 331-342.

Aldiabat, K. 2011. Clarification of the blurred boundaries between grounded theory and ethnography: Differences and similarities. *Turkish online journal of qualitative inquiry* 2(3), pp. 1-13.

Ali, P. A. et al. 2015. Intimate Partner Violence in Pakistan: A Systematic Review. *Trauma Violence Abuse* 16(3), pp. 299-315.

All Wales Midwifery & Health Visitors Domestic Abuse Networking Group. 2006a. All Wales Pathway. Antenatal Routine Enquiry into Domestic Abuse: Minimum Standards. Welsh Assembly Government.

All Wales Midwifery & Health Visitors Domestic Abuse Networking Group. 2006b. Antenatal Routine Enquiry - Domestic Abuse. Welsh Assembly Government.

Allen, W. and Blinder, S. 2013. *Migration in the News: Portrayals of Immigrants, Migrants, Asylum Seekers and Refugees in National British Newspapers, 2010 to 2012*. UK: University of Oxford.

Allport, G. W. 1955. *Becoming; basic considerations for a psychology of personality*. Yale University Press.

Alsulaiman, A. et al. 2012. Attitudes to prenatal diagnosis and termination of pregnancy for 30 conditions among women in Saudi Arabia and the UK. *Prenat Diagn* 32(11), pp. 1109-1113.

- Annells, M. 1996. Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research* 6(3), pp. 379-393.
- Aquino, M. R. J. V. et al. 2015. Pregnancy as an ideal time for intervention to address the complex needs of black and minority ethnic women: Views of British midwives. *Midwifery* 31(3), pp. 373-379.
- Arnold, M. 1987. The cycle of maternal deprivation. *Midwife Health Visit Community Nurse* 23(12), pp. 539-542.
- Aronson, J. et al. 2013. Unhealthy interactions: the role of stereotype threat in health disparities. *American journal of public health* 103(1), pp. 50-56.
- Åslund, O. and Rooth, D.-O. 2005. Shifts in attitudes and labor market discrimination: Swedish experiences after 9-11. *Journal of Population Economics* 18(4), pp. 603-629.
- Atkinson, P. et al. 2001. *Handbook of ethnography*. SAGE Publications.
- Atkinson, P. and Pugsley, L. 2005. Making sense of ethnography and medical education. *Medical Education* 39(2), pp. 228-234.
- Awan, I. and Zempi, I. 2016. The affinity between online and offline anti-Muslim hate crime: Dynamics and impacts. *Aggression and violent behavior* 27, pp. 1-8.
- Bakeo, A. C. 2004. Trends in live births by mother's country of birth and other factors affecting low birthweight in England and Wales, 1983-2001. *Health Statistics Quarterly* (23), pp. 25-33.
- Baker, C. 2015. *Shades of intolerance*. Rutgers University.
- Bakken, K. S. et al. 2015. Obstetric Outcomes of First- and Second-Generation Pakistani Immigrants: A Comparison Study at a Low-Risk Maternity Ward in Norway. *J Immigr Minor Health*.
- Balaam, M.-C. et al. 2013. A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. *Journal of Advanced Nursing* 69(9), pp. 1919-1930.
- Balchandra, P. and Ramage, C. 2011. Ethnic variation in obstetric anal sphincter injury. *The Online Journal of Clinical Audits* 3(3).

Ballantyne, A. et al. 2006. Medical genetic services in developing countries: the ethical, legal and social implications of genetic testing and screening.

Barkan, R. et al. 2012. The pot calling the kettle black: distancing response to ethical dissonance. *J Exp Psychol Gen* 141(4), pp. 757-773.

BBC. 2011. *Religions - Islam: Ramadan* [Online]. Available at: http://www.bbc.co.uk/religion/religions/islam/practices/ramadan_1.shtml [Accessed: 07/01/2016].

Beattie, B. et al. 2013. Helping parents decide about Down syndrome screening: Using an option grid as a facilitation tool. *BJOG-an International Journal of Obstetrics and Gynaecology*.

Becares, L. 2015. Which ethnic groups have the poorest health. *Ethnic Identity and Inequalities in Britain: The Dynamics of Diversity* 123.

Beeston, C. et al. 2014. *Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities*. Edinburgh: NHS Health Scotland.

Bekker, H. L. 2003. Genetic Screening: Facilitating Informed Choices. *eLS*. John Wiley & Sons, Ltd.

Bennett, S. and Scammell, J. 2014. Midwives caring for asylum-seeking women: research findings. *The Practising Midwife* 17(1), pp. 9-12.

Berg, M. 2005. A midwifery model of care for childbearing women at high risk: genuine caring in caring for the genuine. *J Perinat Educ* 14(1), pp. 9-21.

Berger, P. L. and Luckmann, T. 1967. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Anchor books.

Berkowitz, G. S. 1981. An epidemiologic study of preterm delivery. *American journal of epidemiology* 113(1), p. 81.

Bhopal, R. S. 2007. *Ethnicity, Race, and Health in Multicultural Societies: Foundations for Better Epidemiology, Public Health, and Health Care*. OUP Oxford.

Binder, P. et al. 2012. Shared language is essential: communication in a multiethnic obstetric care setting. *J Health Commun* 17(10), pp. 1171-1186.

Bittles, A. H. 2008. A community genetics perspective on consanguineous marriage. *Community Genet* 11(6), pp. 324-330.

Bittles, A. H. 2015. The Prevalence and Outcomes of Consanguineous Marriage in Contemporary Societies. In: Shaw, A. and Raz, A. eds. *Cousin Marriages: Between Tradition, Genetic Risk and Cultural Change*. New York and Oxford: Berghahn Books, pp. 33-45.

Bittles, A. H. and Makov, E. 1988. Inbreeding in human populations: An assessment of the costs. *Human mating patterns* 28, p. 153.

Blinder, S. 2011. *UK Public Opinion toward Migration: Determinants of Attitudes*. UK: University of Oxford.

Blinder, S. 2015. *UK Public Opinion toward Immigration: Overall Attitudes and Level of Concern*. University of Oxford.

Bollini, P. et al. 2009. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. *Soc Sci Med* 68(3), pp. 452-461.

Bowes, A. and Domokos, T. M. 2003. Your Dignity is Hung Up at the Door: Pakistani and White Women's Experiences of Childbirth. In: Earle, S. and Letherby, G. eds. *Gender, Identity & Reproduction: Social Perspectives*. London: Palgrave Macmillan UK, pp. 87-102.

Bowler, I. 1993. 'They're not the same as us': midwives' stereotypes of South Asian descent maternity patients. *Sociology of Health & Illness* 15(2), pp. 157-178.

Boyatzis, R. E. 1998. *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Boyle, S. 2013. *Women's views on partnership working with midwives during pregnancy and childbirth*. University of Hertfordshire.

Bramhagen, A. C. et al. 2006. Mothers' experiences of feeding situations - an interview study. *J Clin Nurs* 15(1), pp. 29-34.

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), pp. 77-101.

Britton, J. 2015. Muslims, Racism and Violence After the Paris Attacks. *Sociological Research Online* 20(3), p. 1.

Brondolo, E. et al. 2011. Dimensions of Perceived Racism and Self-Reported Health: Examination of Racial/Ethnic Differences and Potential Mediators. *Annals of Behavioral Medicine* 42(1), pp. 14-28.

Bronfenbrenner, U. 1979. *The ecology of human development: Experiments in nature and design*. Cambridge, MA: Harvard University Press.

Brown, D. and Constable, P. 2014. *West Africans in Washington say they are being stigmatized because of Ebola Fear*. [Online]. The Washington Post. Available at: https://www.washingtonpost.com/local/west-africans-in-washington-say-they-are-being-stigmatized-because-of-ebola-fear/2014/10/16/39442d18-54c6-11e4-892e-602188e70e9c_story.html [Accessed: 01/03/2015].

Brown, S. and Lumley, J. 1993. Antenatal care: a case of the inverse care law? *Aust J Public Health* 17(2), pp. 95-103.

Brown, S. R. 1996. Q Methodology and Qualitative Research. *Qualitative Health Research* 6(4), pp. 561-567.

Bryant, H. B. 2011. *Improving Care for Refugees and Asylum Seekers: The Experiences of Midwives*. Maternity Action.

Bryman, A. and Cramer, D. 1994. *Quantitative data analysis for social scientists*. New York: Taylor & Frances/Routledge.

Bulmer, M. 1982. When is disguise justified? Alternatives to covert participant observation. *Qualitative Sociology* 5(4), pp. 251-264.

Bundey, S. and Alam, H. 1993. A five-year prospective study of the health of children in different ethnic groups, with particular reference to the effect of inbreeding. *Eur J Hum Genet* 1(3), pp. 206-219.

Burgess, D. J. et al. 2006. Understanding the Provider Contribution to Race/Ethnicity Disparities in Pain Treatment: Insights from Dual Process Models of Stereotyping. *Pain Medicine* 7(2), pp. 119-134.

Butler, A. S. and Behrman, R. E. 2007. *Preterm Birth:: Causes, Consequences, and Prevention*. National Academies Press.

Byers, B. D. and Jones, J. A. 2007. The Impact of the Terrorist Attacks of 9/11 on Anti-Islamic Hate Crime. *Journal of Ethnicity in Criminal Justice* 5(1), pp. 43-56.

Cantwell, R. et al. 2011. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. *Bjog* 118 Suppl 1, pp. 1-203.

Cardemil, E. V. et al. 2005. Developing a culturally appropriate depression prevention program: the family coping skills program. *Cultur Divers Ethnic Minor Psychol* 11(2), pp. 99-112.

Care Quality Commission. 2010. *Women's experiences of maternity care in England: Key findings from the 2010 NHS trust survey*. London: Care Quality Commission.

Chakraborti, N. and Garland, J. 2015. *Responding to Hate Crime: The case for connecting policy and research*. Policy Press.

Chamberlain, G. 2006. British maternal mortality in the 19th and early 20th centuries. *JRSM* 99(11), pp. 559-563.

Charles, C. et al. 1999. What do we mean by partnership in making decisions about treatment? *BMJ* 319(7212), pp. 780-782.

Choudhury, T. and Fenwick, H. 2011. *The impact of counter-terrorism measures on Muslim communities*. Manchester: DU.

Clarke, A. 1991. Is non-directive genetic counselling possible? *Lancet* 338(8773), pp. 998-1001.

Collins Jr, J. W. and David, R. J. 1990. The differential effect of traditional risk factors on infant birthweight among blacks and whites in Chicago. *American Journal of Public Health* 80(6), pp. 679-681.

Comfort, A. B. et al. 2013. Effect of Health Insurance on the Use and Provision of Maternal Health Services and Maternal and Neonatal Health Outcomes: A Systematic Review. *Journal of Health, Population, and Nutrition* 31(4 Suppl 2), pp. S81-S105.

Cresswell, J. A. et al. 2013. Predictors of the timing of initiation of antenatal care in an ethnically diverse urban cohort in the UK. *BMC Pregnancy Childbirth* 13, p. 103.

Creswell, J. W. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Crombie, I. et al. 2005. Closing the health inequalities gap: An international perspective. Copenhagen: World Health Organization.

Cronin, P. et al. 2008. Undertaking a literature review: a step-by-step approach. *British journal of nursing* 17(1), p. 38.

Cross-Sudworth, F. et al. 2011. Maternity services in multi-cultural Britain: using Q methodology to explore the views of first- and second-generation women of Pakistani origin. *Midwifery* 27(4), pp. 458-468.

Cross-Sudworth, F. et al. 2015. Perinatal deaths of migrant mothers: Adverse outcomes from unrecognised risks and substandard care factors. *British Journal of Midwifery* 23(10), pp. 734-740 737p.

Cross, R. M. 2005. Exploring attitudes: the case for Q methodology. *Health Education Research* 20(2), pp. 206-213.

Crotty, M. 1998. *The foundations of social research: Meaning and perspective in the research process*. Sage.

Crowne, D. P. and Marlowe, D. 1960. A new scale of social desirability independent of psychopathology. *Journal of consulting psychology* 24(4), p. 349.

Cruz, E. V. and Higginbottom, G. 2013. The use of focused ethnography in nursing research. *Nurse Res* 20(4), pp. 36-43.

de Zulueta, F. 1990. Bilingualism and family therapy. *Journal of Family Therapy* 12(3), pp. 255-265.

Degni, F. et al. 2012. Communication and Cultural Issues in Providing Reproductive Health Care to Immigrant Women: Health Care Providers' Experiences in Meeting Somali Women Living in Finland. *Journal of Immigrant and Minority Health* 14(2), pp. 330-343.

Department of Health. 2007. *Maternity Matters: Choice, access and continuity of care in a safe service*. London:

Department of Health. 2014. *DH Corporate Plan 2014-2015*.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320698/DH_corporate_plan.pdf:

Dhawan, S. 1995. Birth weights of infants of first generation Asian women in Britain compared with second generation Asian women. *BMJ* 311(6997), pp. 86-88.

Dingwall, R. 1977. "Atrocity Stories" and Professional Relationships. *Work and Occupations* 4(4), pp. 371-396.

Dodd, V. and Williams, M. 2014. *British Muslims fear backlash after David Haines murder* [Online]. www.theguardian.com: The Guardian. Available at: <https://www.theguardian.com/world/2014/sep/14/britain-muslims-backlash-fear-david-haines-murder> [Accessed: 04/02/2016].

Dominguez, T. P. 2008. Race, racism, and racial disparities in adverse birth outcomes. *Clin Obstet Gynecol* 51(2), pp. 360-370.

Downs, K. et al. 1997. Providing culturally competent primary care for immigrant and refugee women: A Cambodian case study. *Journal of Nurse-Midwifery* 42(6), pp. 499-508.

Draper, E. et al. 2015. *MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth*. Leicester: MBRRACE-UK.

Earnshaw, V. A. et al. 2012. Maternal Experiences with Everyday Discrimination and Infant Birth Weight: A Test of Mediators and Moderators Among Young, Urban Women of Color. *Annals of Behavioral Medicine* 45(1), pp. 13-23.

Edge, D. 2011. 'It's leaflet, leaflet, leaflet then, "see you later"': black Caribbean women's perceptions of perinatal mental health care. *Br J Gen Pract* 61(585), pp. 256-262.

Eggenberger, S. K. and Nelms, T. P. 2007. Family interviews as a method for family research. *J Adv Nurs* 58(3), pp. 282-292.

Ellis, N. 2000. Birth Experiences of South Asian Muslim Women. In: Kirkham, N. ed. *Informed Choice in Maternity Care*. London: Palgrave Macmillan, pp. 87-102.

Elsayed, A. and de Grip, A. 2013. *Terrorism and integration of Muslim immigrants*. Maastricht University.

Elwyn, G. et al. 2013. Option Grids: shared decision making made easier. *Patient education and counseling* 90(2), pp. 207-212.

Esscher, A. et al. 2014. Suboptimal care and maternal mortality among foreign-born women in Sweden: Maternal death audit with application of the 'migration three delays' model. *BMC Pregnancy and Childbirth* 14 (1)(141).

Essén, B. et al. 2011. An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth. *Journal of Psychosomatic Obstetrics & Gynecology* 32(1), pp. 10-18.

Essex, H. N. et al. 2013. Which women are at an increased risk of a caesarean section or an instrumental vaginal birth in the UK: an exploration within the Millennium Cohort Study. *BJOG: An International Journal of Obstetrics & Gynaecology* 120(6), pp. 732-743.

Falzon, M.-A. 2016. *Multi-sited ethnography: Theory, praxis and locality in contemporary research*. Routledge.

Farooq, S. and Fear, C. 2003. Working through interpreters. *Advances in Psychiatric Treatment* 9(2), pp. 104-109.

Fedorov, E. 2016. The Islamic State of Iraq and Al-Sham: the Group's Nation-Building Project Through the Instrumental Use of Violence [p. 32-49]. *McGill Journal of Political Studies* 7.

Fetterman, D. M. 1998. *Ethnography: Step By Step (Applied social research methods series; v. 17)*. Sage Publications.

Fiscella, K. 1996. Racial disparities in preterm births. The role of urogenital infections. *Public Health Rep* 111(2), pp. 104-113.

Ford, R. and Heath, A. 2013. *British Social Attitudes 2013: Attitudes to Immigration* <http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-31/immigration/introduction.aspx>: NatCen Social Research.

Francis, R. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationary Office.

French, J. I. et al. 2006. Readily treatable reproductive tract infections and preterm birth among black women. *American Journal of Obstetrics & Gynecology* 194(6), pp. 1717-1726.

Freud, S. 1925. Certain neurotic mechanisms in jealousy, paranoia and homosexuality. *The Psychoanalytic Review* (1913-1957) 12, p. 108.

Garces, A. et al. 2012. Home birth attendants in low income countries: who are they and what do they do? *BMC Pregnancy Childbirth* 12, p. 34.

Garrod, D. et al. 2011. Midwifery summary. *Br J Obstet Gynaecol* 118(Suppl 1), pp. e1-e11.

Gater, R. et al. 2010. Social intervention for British Pakistani women with depression: randomised controlled trial. *Br J Psychiatry* 197(3), pp. 227-233.

Gautier, P. A. et al. 2009. Terrorism and attitudes towards minorities: The effect of the Theo van Gogh murder on house prices in Amsterdam. *Journal of Urban Economics* 65(2), pp. 113-126.

Geertz, C. 1973. *The interpretation of cultures: Selected essays*. Basic books.

Gill, P. et al. 2007. Health care needs assessment: Black and Minority Ethnic Groups. In: Abingdon, R. ed. *Health Care Needs Assessment. The epidemiologically based needs assessment reviews*. Third ed. Abingdon, UK.: Radcliffe Medical Press Ltd., pp. 227-389.

Gillies, A. 2002. *Using research in primary care: a workbook for health professionals*. Abingdon: Radcliffe Publishing.

Giorgis, H. 2014. The Problem with the West's Ebola Response is Still Fear of a Black Patient. *The Guardian* 16.

Gissler, M. et al. 2009. Stillbirths and infant deaths among migrants in industrialized countries. *Acta Obstetrica et Gynecologica Scandinavica* 88(2), pp. 134-148.

Giuliano, A. R. et al. 2000. Participation of minorities in cancer research: the influence of structural, cultural, and linguistic factors. *Annals of epidemiology* 10(8), pp. S22-S34.

Giurgescu, C. et al. 2011. Racial Discrimination and the Black-White Gap in Adverse Birth Outcomes: A Review. *The Journal of Midwifery & Women's Health* 56(4), pp. 362-370.

Gladstone, A. 1959. The Conception of the Enemy. *The Journal of Conflict Resolution* 3(2), pp. 132-137.

Glaser, B. G. 1992. *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G. and Strauss, A. 1967. *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Glazzard, A. 2015. ISIS: The State of Terror. *The RUSI Journal* 160(4), pp. 85-87.

Goel, D. 2010. Perceptions of Immigrants in Australia after 9/11*. *Economic Record* 86(275), pp. 596-608.

Goffman, D. et al. 2007. Predictors of maternal mortality and near-miss maternal morbidity. *J Perinatol*. Vol. 27. United States, pp. 597-601.

Goffman, E. 1978. *The presentation of self in everyday life*. Harmondsworth.

Goodwin, L. et al. 2015. Immigration and Continuing Inequalities in Maternity Outcomes: Time to Reexplore the Client–Provider Relationship? *International Journal of Childbirth* 5(1), pp. 12-19.

Goodwin, M. and Chemerinsky, E. 2016. No Immunity: Race, Class, and Civil Liberties in Times of Health Crisis. *Harvard Law Review*, pp. 956-996.

Goulding, C. 1998. Grounded theory: the missing methodology on the interpretivist agendadnull. *Qualitative Market Research: An International Journal* 1(1), pp. 50-57.

GOV.UK. 2016. The national curriculum. In: Education, S.a. ed. <https://www.gov.uk/national-curriculum/other-compulsory-subjects>.

Gray, R. et al. 2009. Towards an understanding of variations in infant mortality rates between different ethnic groups in England and Wales. *National Primate Epidemiology Unit, University of Oxford, and Department of Public Health (November 2009)*, pp. 1-9.

Green, B. N. et al. 2006. Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of Chiropractic Medicine* 5(3), pp. 101-117.

Green, J. M. et al. 1990. Stereotypes of childbearing women: a look at some evidence. *Midwifery* 6(3), pp. 125-132.

- Greenslade, R. 2015. *Why it's wrong to demand that Muslims condemn Isis* [Online]. www.theguardian.com: The Guardian. Available at: <https://www.theguardian.com/media/greenslade/2015/nov/24/why-its-wrong-to-demand-that-muslims-condemn-isis> [Accessed: 05/03/2016].
- Guba, E. G. and Lincoln, Y. S. 1989. *Fourth generation evaluation*. Sage.
- Guba, E. G. and Lincoln, Y. S. 1994. Competing paradigms in qualitative research. *Handbook of qualitative research* 2(163-194), p. 105.
- Hajjar, L. 2004. Religion, state power, and domestic violence in Muslim societies: A framework for comparative analysis. *Law & Social Inquiry* 29(1), pp. 1-38.
- Hämäläinen, K. and Rautio, S. 2015. Participants' home as an interview context when studying sensitive family issues. *Journal of Comparative Social Work; Vol 8, No 1 (2013)*.
- Hammersley, M. and Atkinson, P. 1995. *Ethnography: Principles in Practice*. 2nd ed. London: Routledge.
- Hanes, E. and Machin, S. 2014. Hate Crime in the Wake of Terror Attacks: Evidence From 7/7 and 9/11. *Journal of Contemporary Criminal Justice*.
- Harper Bulman, K. and McCourt, C. 2002. Somali refugee women's experiences of maternity care in west London: A case study. *Critical Public Health* 12(4), pp. 365-380.
- Hart, J. T. 1971. The inverse care law. *Lancet* 1(7696), pp. 405-412.
- Harvey, M.-A. et al. 2015. Obstetrical Anal Sphincter Injuries (OASIS): Prevention, Recognition, and Repair. *Journal of Obstetrics and Gynaecology Canada* 37(12), pp. 1131-1148.
- Hayes, I. et al. 2011. Care of the migrant obstetric population. *International Journal of Obstetric Anesthesia* 20(4), pp. 321-329.
- Health Inequalities Unit. 2008. Tackling Health Inequalities: 2007 Status Report on the Programme for Action. In: Health, D.o. ed. <http://www.bristol.ac.uk/poverty/downloads/keyofficialdocuments/Tackling%20Health%20Inequalities.2007status.pdf>.

Healthcare Commission. 2008. Towards Better Births: A review of maternity services in England. *Commission for Healthcare Audit and Inspection*.

Heuschmann, P. U. et al. 2008. Ethnic Group Disparities in 10-Year Trends in Stroke Incidence and Vascular Risk Factors. *Stroke* 39(8), pp. 2204-2210.

Higginbottom, G. et al. 2013a. Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report* 18(9), pp. 1-6.

Higginbottom, G. M. A. et al. 2013b. Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery* 30(5), pp. 544-559.

Higgs, J. 2014. Health Practice Relationships. In: Higgs, J. et al. eds. *Health Practice Relationships*. Rotterdam: Sense Publishers, pp. 3-8.

Hoang, H. T. et al. 2009. Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia. *Rural Remote Health* 9(1), p. 1084.

Hoban, E. and Liamputtong, P. 2013. Cambodian migrant women's postpartum experiences in Victoria, Australia. *Midwifery* 29(7), pp. 772-778.

Hochschild, A. R. 1979. Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology* 85(3), pp. 551-575.

Hodnett, E. D. 2002. Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology* 186(5 SUPPL.), pp. S160-S172.

Hogan, J. and Haltinner, K. 2015. Floods, Invaders, and Parasites: Immigration Threat Narratives and Right-Wing Populism in the USA, UK and Australia. *Journal of Intercultural Studies* 36(5), pp. 520-543.

Holloway, I. and Wheeler, S. 1996. *Qualitative Research for Nurses*. Oxford: Blackwell Science.

Holloway, I. and Wheeler, S. 2010. *Qualitative Research in Nursing and Healthcare*. John Wiley & Sons.

Horvat, L. et al. 2011. Cultural competence education for health professionals. *The Cochrane Library*.

Houghton, C. et al. 2013. Rigour in qualitative case study research. *Nurse Researcher* 20(4), pp. 12-17.

Hummell, J. and Gates, A. 2014. Negotiating healthcare relationships through communication. In: Higgs, J. et al. eds. *Health Practice Relationships*. Rotterdam: Sense Publishers, pp. 57-64.

Hummer, R. A. et al. 1998. Sociodemographic differentials in adult mortality: A review of analytic approaches. *Population and development review*, pp. 553-578.

Hunt, L. M. et al. 1989a. Views of what's wrong: diagnosis and patients' concepts of illness. *Soc Sci Med* 28(9), pp. 945-956.

Hunt, L. M. et al. 1989b. Compliance and the patient's perspective: controlling symptoms in everyday life. *Cult Med Psychiatry* 13(3), pp. 315-334.

Hunter, B. 2005. Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery* 21(3), pp. 253-266.

Hunter, B. 2006. The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery* 22(4), pp. 308-322.

Hunter, B. 2010. Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *International Journal of Work Organisation and Emotion* 3(3), pp. 253-269.

Hutchinson, S. A. et al. 1994. Benefits of participating in research interviews. *Journal of Nursing Scholarship* 26(2), pp. 161-166.

Ibison, J. M. et al. 1996. Maternal mortality in England and Wales 1970–1985: an analysis by country of birth. *BJOG: An International Journal of Obstetrics & Gynaecology* 103(10), pp. 973-980.

Infant Mortality National Support Team. 2010. Tackling Health Inequalities in Infant and Maternal Health Outcomes Report. In: Health, D.o. ed.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215869/dh_122844.pdf.

Inhorn, M. C. 2006. Defining women's health: a dozen messages from more than 150 ethnographies. *Med Anthropol Q* 20(3), pp. 345-378.

Ipsos MORI. 2016. *Economist / Ipsos MORI March 2016 Issues Index*. [https://www.ipsos-mori.com/researchpublications/researcharchive/3715/Economist-Ipsos-MORI-March-2016-Issues-Index.aspx#gallery\[m\]/0/](https://www.ipsos-mori.com/researchpublications/researcharchive/3715/Economist-Ipsos-MORI-March-2016-Issues-Index.aspx#gallery[m]/0/):

Irwin, S. and Jordan, B. 1987. Knowledge, practice, and power: court-ordered cesarean sections. *Med Anthropol Q* 1(3), pp. 319-334.

Jayaweera, H. et al. 2005. A local study of childbearing Bangladeshi women in the UK. *Midwifery* 21(1), pp. 84-95.

Jayaweera, H. and Quigley, M. A. 2010. Health status, health behaviour and healthcare use among migrants in the UK: Evidence from mothers in the Millennium Cohort Study. *Social Science & Medicine* 71(5), pp. 1002-1010.

Jennings, W. and Wlezien, C. 2011. Distinguishing Between Most Important Problems and Issues? *Public Opinion Quarterly* 75(3), pp. 545-555.

Jomeen, J. and Redshaw, M. 2013. Ethnic minority women's experience of maternity services in England. *Ethn Health* 18(3), pp. 280-296.

Jonkers, M. et al. 2011. Severe maternal morbidity among immigrant women in the Netherlands: patients' perspectives. *Reproductive Health Matters* 19(37), pp. 144-153.

Jordan, B. 1987. The hut and the hospital: information, power, and symbolism in the artifacts of birth. *Birth* 14(1), pp. 36-40.

Jordan, B. 1997. Authoritative knowledge and its construction. In: Davis-Floyd, R. and Sargent, C. eds. *Childbirth and authoritative knowledge: Cross-cultural perspectives*. University of California Press, pp. 55-79.

Jorgensen, D. L. 1989. *Participant observation*. Wiley Online Library.

Kanthasamy, M. et al. 2013. Obstetric outcome of ethnic Turkish women in London: A retrospective case-control study. *Journal of Obstetrics and Gynaecology* 33(4), pp. 367-369.

Karlsen, S. and Nazroo, J. Y. 2004. Fear of racism and health. *Journal of Epidemiology and Community Health* 58(12), pp. 1017-1018.

Kayem, G. et al. 2011. Risk Factors for Progression from Severe Maternal Morbidity to Death: A National Cohort Study. *PLoS ONE* 6(12), p. e29077.

Kelaher, M. et al. 2008. Discrimination and health in an English study. *Social Science & Medicine* 66(7), pp. 1627-1636.

Kennedy, J. and Schweitzer, M. E. 2015. Holding People Responsible for Ethical Violations: The Surprising Benefits of Accusing Others. *Academy of Management* 11258(1).

Kington, R. S. and Nickens, H. W. 2001. Racial and ethnic differences in health: recent trends, current patterns, future directions. *America becoming: Racial trends and their consequences* 2, pp. 253-310.

Kirkham, M. et al. 2002. The inverse care law in antenatal midwifery care. *British Journal of Midwifery* 10(8), pp. 509-513.

Kirkup, B. 2015. The Report of the Morecambe Bay Investigation. London: The Stationary Office.

Kitzinger, J. 1994. The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health & Illness* 16(1), pp. 103-121.

Kline, F. et al. 1980. The misunderstood Spanish-speaking patient. *Am J Psychiatry* 137(12), pp. 1530-1533.

Knight, M. et al. 2014. *Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK*

and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12. Oxford:

Knight, M. et al. 2009. Inequalities in maternal health: national cohort study of ethnic variation in severe maternal morbidities. *BMJ* 338, p. b542.

Knight, M. et al. 2015. *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13*. Oxford: MBRRACE-UK.

Korkodilos, M. et al. 2013. Tackling inequalities in infant and maternal health outcomes. *Perspect Public Health* 133(1), pp. 23-24.

Kurinczuk, J. J. et al. 2009. Inequalities in infant mortality project briefing paper 1. Infant mortality: overview and context. *National Perinatal Epidemiology Unit, University of Oxford, Oxford*.

Lazear, K. J. et al. 2008. Depression among low-income women of color: qualitative findings from cross-cultural focus groups. *J Immigr Minor Health* 10(2), pp. 127-133.

Lecca, P. J. et al. 2014. *Cultural competency in health, social & human services: Directions for the 21st century*. Routledge.

LeCompte, M. D. and Goetz, J. P. 1982. Problems of reliability and validity in ethnographic research. *Review of educational research* 52(1), pp. 31-60.

Lephard, E. and Haith-Cooper, M. 2016. Pregnant and seeking asylum: Exploring women's experiences 'from booking to baby'. *British Journal of Midwifery* 24(2), pp. 130-137.

Levkoff, S. et al. 2000. The matching model of recruitment. *Journal of Mental Health and Aging* 6(1), pp. 29-38.

Levkoff, S. and Sanchez, H. 2003. Lessons learned about minority recruitment and retention from the Centers on Minority Aging and Health Promotion. *Gerontologist* 43(1), pp. 18-26.

Levy, V. 1999a. Maintaining equilibrium: a grounded theory study of the processes involved when women make informed choices during pregnancy. *Midwifery* 15(2), pp. 109-119.

Levy, V. 1999b. Protective steering: a grounded theory study of the processes by which midwives facilitate informed choices during pregnancy. *J Adv Nurs* 29(1), pp. 104-112.

Lewis, G. 2007. *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London:

Liamputtong, P. and Ezzy, D. 2005. *Qualitative research methods (2nd Edition)*. Melbourne, AU: Oxford University Press.

Licoln, Y. S. and Guba, E. G. 1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lincoln, Y. S. and Guba, E. G. 1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lincoln, Y. S. et al. 2011. Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research* 4, pp. 97-128.

Liu, F. and Maitlis, S. 2010. Nonparticipant observation. In: Mills, A.J. et al. eds. *Encyclopedia of case study research*. Thousand Oaks, CA: Sage Publications, pp. 610-612.

Long, A. F. and Godfrey, M. 2004. An evaluation tool to assess the quality of qualitative research studies. *International Journal of Social Research Methodology* 7(2), pp. 181-196.

Long, T. and Johnson, M. 2000. Rigour, reliability and validity in qualitative research. *Clinical effectiveness in nursing* 4(1), pp. 30-37.

Lundgren, I. and Berg, M. 2007. Central concepts in the midwife-woman relationship. *Scand J Caring Sci* 21(2), pp. 220-228.

Lynch, N. 2011. *Women's Experiences of Maternity Services in Birmingham East and North and Solihull. A Qualitative Study*. Involvement Innovation Ltd.

Lyons, S. M. et al. 2008. Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. *Ethn Health* 13(3), pp. 261-276.

Macintyre, S. 1978. Some notes on record taking and making in an antenatal clinic. *The Sociological Review* 26(3), pp. 595-611.

Manktelow, B. et al. 2015. *Perinatal Mortality Surveillance Report. UK Perinatal Deaths for births from January to December 2013*. Leicester:

Manktelow, B. et al. 2016. *MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2014*. Leicester:

Marcus, G. E. 1998. *Ethnography through thick and thin*. Princeton University Press.

Marmot, M. G. et al. 2010. Fair society, healthy lives: Strategic review of health inequalities in England post-2010.

Mays, N. and Pope, C. 1995. Rigour and qualitative research. *BMJ* 311(6997), pp. 109-112.

McCormick, L. K. et al. 1999. Recruiting adolescents into qualitative tobacco research studies: experiences and lessons learned. *J Sch Health* 69(3), pp. 95-99.

McCourt, C. and Pearce, A. 2000. Does continuity of carer matter to women from minority ethnic groups? *Midwifery* 16(2), pp. 145-154.

McCourt, C. and Stevens, T. 2009. Relationship and reciprocity in caseload midwifery. In: Hunter, B. and Deery, R. eds. *Emotions in midwifery and reproduction*. Basingstoke: Palgrave Macmillan, pp. 17-25.

McFadden, A. et al. 2012. Does cultural context make a difference to women's experiences of maternity care? A qualitative study comparing the perspectives of breast-feeding women of Bangladeshi origin and health practitioners. *Health Expectations* 16(4), pp. 124-135.

McFarlane, D. A. 2014. A Positive Theory of Stereotyping and Stereotypes: Is Stereotyping Useful? *Journal of Studies in Social Sciences* 8(1).

Mead, G. H. 1934. *Mind, Self and Society from the Standpoint of a Social Behaviourist*. Chicago: University of Chicago.

Meadows, T. A. et al. 2011. Ethnic Differences in Cardiovascular Risks and Mortality in Atherothrombotic Disease: Insights From the REduction of Atherothrombosis for Continued Health (REACH) Registry. *Mayo Clinic Proceedings* 86(10), pp. 960-967.

Misra, A. and Khurana, L. 2011. Obesity-related non-communicable diseases: South Asians vs White Caucasians. *Int J Obes* 35(2), pp. 167-187.

Moazam, F. 2000. Families, Patients, and Physicians in Medical Decisionmaking: A Pakistani Perspective. *Hastings Center Report* 30(6), pp. 28-37.

Morse, A. 2013. *Maternity Services in England*. London: National Audit Office.

Mumtaz, Z. and Salway, S. M. 2007. Gender, pregnancy and the uptake of antenatal care services in Pakistan. *Sociology of Health & Illness* 29(1), pp. 1-26.

Murray, C. D. and Wynne, J. 2001. Using an interpreter to research community, work and family. *Community, Work and Family* 4(2), pp. 157-170.

Mustillo, S. et al. 2004. Self-reported experiences of racial discrimination and Black-White differences in preterm and low-birthweight deliveries: the CARDIA Study. *Am J Public Health* 94(12), pp. 2125-2131.

Nair, M. et al. 2015. Factors associated with maternal death from direct pregnancy complications: a UK national case-control study. *BJOG: An International Journal of Obstetrics & Gynaecology* 122(5), pp. 653-662.

Nair, M. et al. 2014. Ethnic variations in severe maternal morbidity in the UK- a case control study. *PLoS One* 9(4), p. e95086.

Nakkeeran, N. and Zodpey, S. 2012. Qualitative research in applied situations: Strategies to ensure rigor and validity. *Indian Journal of Public Health* 56, pp. 4-11.

Naran, N. H. et al. 2008. The influence of metabolic syndrome components on plasma PAI-1 concentrations is modified by the PAI-1 4G/5G genotype and ethnicity. *Atherosclerosis* 196(1), pp. 155-163.

Nazroo, J. Y. 1997. The health of Britain's ethnic minorities: findings from a national survey.

NHS Choices. 2014. *Caesarean Section - Why it is necessary* [Online].
<http://www.nhs.uk/Conditions/Caesarean-section/Pages/Why-is-it-necessary.aspx>: Available at: [Accessed: 08/02/2016].

NHS England et al. 2015. Guidance for NHS commissioners on equality and health inequalities legal duties. <https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf>.

NHS Wales. 2015. Public Health Wales Strategic Plan. Creating a healthier, happier and fairer Wales for everyone.
[http://www2.nphs.wales.nhs.uk:8080/PHWPapersDocs.nsf/\(\\$all\)/52C18E8E3B3B60F080257E2700508245/\\$file/Public%20Health%20Wales%20IMTP%201516-1718%20v1%20010415.pdf](http://www2.nphs.wales.nhs.uk:8080/PHWPapersDocs.nsf/($all)/52C18E8E3B3B60F080257E2700508245/$file/Public%20Health%20Wales%20IMTP%201516-1718%20v1%20010415.pdf): Public Health Wales.

NHS Wales and Welsh Government. 2011. Together for Health. A Five Year Vision for the NHS in Wales. <http://gov.wales/docs/dhss/publications/111101togetheren.pdf>.

NICE. 2008. *Antenatal Care for Uncomplicated Pregnancies. NICE Guidelines (CG62)*.
<https://www.nice.org.uk/guidance/cg62>: National Institute for Health and Care Excellence.

NICE. 2010. *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*. NICE Guideline CG110.

<https://www.nice.org.uk/guidance/cg110>: National Institute for Health and Care Excellent.

NICE. 2014. Intrapartum care for healthy women and babies. NICE guidelines [CG190].

Noble, H. and Smith, J. 2015. Issues of validity and reliability in qualitative research. *Evidence Based Nursing* 18(2), pp. 34-35.

O'Mahony, J. M. and Donnelly, T. T. 2007. Health care providers' perspective of the gender influences on immigrant women's mental health care experiences. *Issues Ment Health Nurs* 28(10), pp. 1171-1188.

O'Neill, O. et al. 2008. *Safe Births: Everybody's Business*. London: King's Fund.

OECD. 2015. *How's Life? 2015: Measuring Well-being*. Paris:

Office for National Statistics. 2012a. *Statistical Bulletin. 2011 Census: Key Statistics for Local Authorities in England and Wales. The defining characteristics of the population: who we are, how we live and what we do*.

Office for National Statistics. 2012b. *Statistical bulletin: Births in England and Wales by Parents' Country of Birth, 2011*.

Office for National Statistics. 2013a. *Statistical bulletin: 2011 Census: Detailed Characteristics for England and Wales, March 2011*.
<http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011census/2013-05-16>:

Office for National Statistics. 2013b. *Statistical bulletin: Births in England and Wales: 2012*.

Office for National Statistics. 2013c. *Statistical Bulletin: Childhood, Infant and Perinatal Mortality in England and Wales: 2011. Deaths of babies in England and Wales and the factors that may influence their survival*.
<http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2013-02-27#mothers-country-of-birth>:

Office for National Statistics. 2015. *Statistical Bulletin: Births in England and Wales by Parents' Country of Birth, 2014*.

Office for National Statistics. 2016. *Statistical bulletin: Migration Statistics Quarterly Report: February 2016*.

<http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/migrationstatisticsquarterlyreport/february2016>:

Ólofsdóttir, Ó. Á. 2006. *An Icelandic midwifery saga-coming to light-" with woman" and collective ways of knowing*. University of West London.

Ostrower, F. 1998. Nonparticipant observation as an introduction to qualitative research. *Teaching Sociology* 26(1), pp. 57-61.

Pairman, S. 1998. Women-centred midwifery: partnerships or professional friendships. *New Zealand College of Midwives Journal* 19, pp. 5-10.

Pairman, S. and Mcara-Couper, J. 2006. Theoretical frameworks for midwifery practice. In: Pairman, S. et al. eds. *Midwifery preparation for practice*. Sydney, Edinburgh: Churchill Livingstone, Elsevier, pp. 237-257.

Paré, G. et al. 2015. Synthesizing information systems knowledge: A typology of literature reviews. *Information & Management* 52(2), pp. 183-199.

Parsons, T. 1951. *The Social System*. New York: Free Press.

Pearson, S. et al. 2010. Improving health outcomes in deprived communities: evidence from the New Deal for Communities Programme. *Department of Communities and Local Government*. Her Majesty's Stationery Office London.

Perry, A. et al. 2015. eSimulation: A novel approach to enhancing cultural competence within a health care organisation. *Nurse Education in Practice* 15(3), pp. 218-224.

Pettigrew, S. F. 2000. Ethnography and grounded theory: a happy marriage? *NA-Advances in Consumer Research* 27, pp. 256-260.

Phillimore, J. and Thornhill, J. 2010. *Delivering in the age of superdiversity: West Midlands review of maternity services for migrant women*. Birmingham: West Midlands Strategic Migration Partnership and Department of Health.

Pitcher, B. 2006. "Are You Thinking What We're Thinking?" Immigration, Multiculturalism and the Disavowal of Racism in the Run-up to the 2005 British General Election. *Social Semiotics* 16(4), pp. 535-551.

Public Health England. 2015. National Conversation on Health Inequalities.
<https://www.gov.uk/government/collections/national-conversation-on-health-inequalities>.

Puthussery, S. 2016. Perinatal outcomes among migrant mothers in the United Kingdom: Is it a matter of biology, behaviour, policy, social determinants or access to health care? *Best Practice & Research Clinical Obstetrics & Gynaecology* 32, pp. 39-49.

Puthussery, S. et al. 2008. 'They're more like ordinary stroppy British women': attitudes and expectations of maternity care professionals to UK-born ethnic minority women. *Journal of Health Services Research & Policy* 13(4), pp. 195-201.

Puthussery, S. et al. 2010. 'You need that loving tender care': maternity care experiences and expectations of ethnic minority women born in the United Kingdom. *J Health Serv Res Policy* 15(3), pp. 156-162.

Raine, R. et al. 2010. A qualitative study of women's experiences of communication in antenatal care: identifying areas for action. *Matern Child Health J* 14(4), pp. 590-599.

Raleigh, V. S. et al. 2010. Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. *Journal of the Royal Society of Medicine* 103(5), pp. 188-198.

Rautio, S. 2013. Parents' experiences of early support. *Scand J Caring Sci* 27(4), pp. 927-934.

Ravelli, A. C. et al. 2011. Ethnic differences in stillbirth and early neonatal mortality in The Netherlands. *Journal of Epidemiology and Community Health* 65(8), pp. 696-701.

Redshaw, M. and Heikkila, K. 2011. Ethnic differences in women's worries about labour and birth. *Ethn Health* 16(3), pp. 213-223.

Redshaw, M. et al. 2007. *Recorded Delivery: a National Survey of Women's Experience of Maternity Care*. Oxford: National Perinatal Epidemiology Unit (NPEU).

Reime, B. et al. 2012. Maternal near-miss among women with a migrant background in Germany. *Acta Obstet Gynecol Scand* 91(7), pp. 824-829.

Renton, D. 2005. 'A day to make history'? The 2004 elections and the British National Party. *Patterns of Prejudice* 39(1), pp. 25-45.

Richardson, J. E. 2008. "Our England": discourses of "race" and class in party election leaflets. *Social Semiotics* 18(3), pp. 321-335.

Richens, Y. 2003. *Exploring the Experiences of Women of Pakistani Origin of UK Maternity Services*. London: Department of Health.

Richens, Y. and Smith, D. 2011. Applied qualitative research in maternity care: a reflection of the barriers to data collection with 'at-risk' populations. *Diversity in Health and Care* 8, pp. 29–36.

Rienzo, C. and Vargas-Silva, C. 2016. *Migrants in the UK: An Overview*. *Migration Observatory Briefing*. <http://www.migrationobservatory.ox.ac.uk/briefings/migrants-uk-overview>: COMPAS, University of Oxford.

Roberts, C. et al. 2005. Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications. *Medical Education* 39(5), pp. 465-475.

Roper, J. and Shapira, J. 1999. *Ethnography in nursing research*. Thousand Oaks, California: Sage publications.

Ross-Davie, M. C. et al. 2013. Measuring the quality and quantity of professional intrapartum support: testing a computerised systematic observation tool in the clinical setting. *BMC Pregnancy and Childbirth* 13(1), pp. 1-12.

Rowe, R. E. et al. 2008. Social and ethnic differences in attendance for antenatal care in England. *Public Health* 122(12), pp. 1363-1372.

Royal College of Midwives. 2014a. *High Quality Midwifery Care*. <https://www.rcm.org.uk/sites/default/files/High%20Quality%20Midwifery%20Care%20Final.pdf>:

Royal College of Midwives. 2014b. *Postnatal Care Planning*. <https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf>:

Royal College of Midwives. 2015. *Kirkup Report on maternity system failings - 'could be happening elsewhere' says UK's top midwife* [Online]. www.rcm.org.uk: Available at:

<https://www.rcm.org.uk/news-views-and-analysis/news/kirkup-report-on-maternity-system-failings-%E2%80%98could-be-happening> [Accessed: 07/04/2016].

Rugkasa, J. and Canvin, K. 2011. Researching mental health in minority ethnic communities: reflections on recruitment. *Qual Health Res* 21(1), pp. 132-143.

Sandall, J. et al. 2016a. *Relationships: the pathway to safe, high-quality maternity care. Report from the Sheila Kitzinger symposium at Green Templeton College October 2015*. Oxford:

Sandall, J. et al. 2016b. Midwife-led continuity models versus other models of care for childbearing women. *The Cochrane Library*.

Sanders, J. et al. 2015. A wall of information? Exploring the public health component of maternity care in England. *Midwifery* 34, pp. 253-260.

Sargent, C. and Bascope, G. 1996. Ways of knowing about birth in three cultures. *Med Anthropol Q* 10(2), pp. 213-236.

Schlenker, B. R. 1980. *Impression management: The self-concept, social identity, and interpersonal relations*. Monterey, CA: Brooks/Cole Publishing Company.

Schutz, A. 1944. The Stranger: An Essay in Social Psychology. *American Journal of Sociology* 49(6), pp. 499-507.

Seal, R. P. et al. 2013. Using an Option Grid in shared decision making. *Practical neurology* 14(1), pp. 54-56.

Seeman, T. E. and Crimmins, E. 2001. Social environment effects on health and aging. *Annals of the New York Academy of Sciences* 954(1), pp. 88-117.

Shah, D. et al. 2011. The obstetric performance of Chinese immigrants residing in the UK. *J Obstet Gynaecol* 31(6), pp. 480-482.

Shaw, A. 2009. *Negotiating risk: British Pakistani experiences of genetics*. Berghahn Books.

Sheldon, H. et al. 2007. *Increasing response rates amongst BME and seldom heard groups - literature review*. England:

- Sheridan, E. et al. 2013. Risk factors for congenital anomaly in a multiethnic birth cohort: an analysis of the Born in Bradford study. *The Lancet* 382(9901), pp. 1350-1359.
- Sinclair, S. et al. 2000. Recruiting African Americans for health studies: Lessons from the Drew-Rand Center on Health and Aging. *Journal of Mental Health & Aging* 6(1), pp. 39-52.
- Singh, D. and Newburn, M. 2000. *Women's experiences of postnatal care*. National Childbirth Trust London.
- Slaughter-Acey, J. C. et al. 2016. Racism in the form of micro aggressions and the risk of preterm birth among black women. *Annals of Epidemiology* 26(1), pp. 7-13.e11.
- Small, R. et al. 2014. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC Pregnancy and Childbirth* 14(1), pp. 1-17.
- Smith, N. and Grundy, E. 2011. Time period trends in ethnic inequalities in limiting long term illness in England and Wales. *Ethnicity and Inequalities in Health and Social Care* 4(4), pp. 200-209.
- Solomon, H. 2016. *Islamic State and the Coming Global Confrontation*. Springer.
- Sorbye, I. K. et al. 2014. Preterm subtypes by immigrants' length of residence in Norway: A population-based study. *BMC Pregnancy and Childbirth* 14 (1) (239).
- Spradley, J. P. 1980. *Participant Observation*. Holt, Rinehart and Winston.
- Spradley, J. P. 2016. *Participant observation*. Waveland Press.
- Srivastava, P. and Hopwood, N. 2009. A Practical Iterative Framework for Qualitative Data Analysis. *International Journal of Qualitative Methods* 8(1), pp. 76-84.
- Stapleton, H. et al. 2002. Qualitative study of evidence based leaflets in maternity care. *BMJ* 324(7338), p. 639.
- Steed, B. L. 2016. *ISIS: An Introduction and Guide to the Islamic State*. ABC-CLIO.
- Stern, J. and Berger, J. M. 2015. *ISIS: The state of terror*. HarperCollins.

Stewart, B. et al. 2012. *NI Health and Social Care Inequalities Monitoring System. Sub-regional inequalities - HSC Trusts. First update bulletin 2012.* http://www.dhsspsni.gov.uk/ni_hscims_sub-regional_inequalities_-_hsc_trusts_2012.pdf:

Strauss, A. L. and Corbin, J. 1990a. *Basics of qualitative research*. Sage publications Newbury Park, CA.

Strauss, A. L. and Corbin, J. 1990b. *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage publications.

Tajfel, H. 1982. Social psychology of intergroup relations. *Annual review of psychology* 33(1), pp. 1-39.

Threadgold, T. et al. 2007. Constructing community in South-East Wales. <http://www.cardiff.ac.uk/jomec/resources/ConstructingCommunity.pdf>.

Tilley, S. and Watson, R. 2004. *Accountability in Nursing and Midwifery*. Second ed. Blackwell Sciences Ltd.

Tinkler, A. and Quinney, D. 1998. Team midwifery: the influence of the midwife-woman relationship on women's experiences and perceptions of maternity care. *Journal of Advanced Nursing* 28(1), pp. 30-35.

Tribe, R. and Morrissey, J. 2004. Good practice issues in working with interpreters in mental health. *Intervention* 2(2), pp. 129-142.

Tuckett, A. G. 2005. Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse* 19(1-2), pp. 75-87.

Twamley, K. et al. 2009. Recruiting UK-born ethnic minority women for qualitative health research – lessons learned from a study of maternity care. *Research, Policy and Planning* 27(1), pp. 25-38.

Tyler, S. 2012. *Commissioning Maternity Services: A Resource Pack to support Clinical Commissioning Groups*

<div data-canvas-width="387.36557999999997" style="left: 307.181px; top: 496.623px; font-size: 33.3px; font-family: sans-serif; transform: scaleX(1.0903);">. In: Board, N.C. ed. NHS South of England.

- van Ryn, M. 2002. Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care. *Medical Care* 40(1).
- van Ryn, M. and Fu, S. S. 2003. Paved With Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health? *American Journal of Public Health* 93(2), pp. 248-255.
- Varner, M. W. and Esplin, M. S. 2005. Current understanding of genetic factors in preterm birth. *BJOG: An International Journal of Obstetrics & Gynaecology* 112, pp. 28-31.
- Walsh, D. 1999. An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery* 15(3), pp. 165-176.
- Ward, B. W. et al. 2015. *Early release of selected estimates based on data from the 2014 National Health Interview Survey*.
- Watts, S. and Stenner, P. 2012. *Doing Q Methodological Research: Theory, Method & Interpretation*. Sage Publications Limited.
- Welsh Government. 2011. A Strategic Vision for Maternity Services in Wales.
<http://www.wales.nhs.uk/documents/A%20Strategic%20Vision%20for%20Maternity%20Services%20in%20Wales%20-%20September%202011.pdf>.
- Whittemore, R. et al. 2014. Methods for knowledge synthesis: An overview. *Heart & Lung: The Journal of Acute and Critical Care* 43(5), pp. 453-461.
- Wiggins, S. M. 2008. The partnership care delivery model: an examination of the core concept and the need for a new model of care. *J Nurs Manag* 16(5), pp. 629-638.
- Wikberg, A. et al. 2012. Intercultural caring from the perspectives of immigrant new mothers. *J Obstet Gynecol Neonatal Nurs* 41(5), pp. 638-649.
- Wilkins, R. 1993. *Sociological aspects of the mother/community midwife relationship*. University of Surrey.
- Wilkins, R. 2010. Poor relations: The paucity of the professional paradigm. In: Kirkham, M. ed. *The midwife-mother relationship*. 2 ed. Hampshire, London: Palgrave Macmillan.

Williams, A. et al. 2007. The prevalence of enduring postnatal perineal morbidity and its relationship to perineal trauma. *Midwifery* 23(4), pp. 392-403.

Wilson, S. 1977. The use of ethnographic techniques in educational research. *Review of educational research* 47(2), pp. 245-265.

Winkvist, A. and Akhtar, H. Z. 1997. Images of health and health care options among low income women in Punjab, Pakistan. *Soc Sci Med* 45(10), pp. 1483-1491.

Woods, C. G. et al. 2006. Quantification of homozygosity in consanguineous individuals with autosomal recessive disease. *Am J Hum Genet* 78(5), pp. 889-896.

World Health Organisation. 2015. *Ebola Virus Disease* [Online].
<http://www.who.int/mediacentre/factsheets/fs103/en/>: Available at: [Accessed: 03.02.2016].

Wright, O. 2015. Paris attacks: Women targeted as hate crimes against British Muslims soars following terrorist atrocity. *The Independent*.

Zaman, R. M. et al. 2006. Pakistan: culture, community, and filial obligations in a Muslim society. In: Georgas, J. et al. eds. *Families across cultures: A 30-Nation Psychological Study*. 1 ed. Cambridge: Cambridge University Press, pp. 427-434.

Zanconato, G. et al. 2011. Pregnancy outcome of migrant women delivering in a public institution in northern Italy. *Gynecologic and Obstetric Investigation* 72(3), pp. 157-162.

Zwart, J. J. et al. 2011. Ethnic disparity in severe acute maternal morbidity: a nationwide cohort study in the Netherlands. *The European Journal of Public Health* 21(2), pp. 229-234.

Appendices

Appendix One: Paper Published in the International Journal of Childbirth, March 2015

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Immigration and Continuing Inequalities in Maternity Outcomes: Time to Reexplore the Client–Provider Relationship?

Laura Goodwin, Billie Hunter, and Aled Jones

The United Kingdom has seen a substantial rise in immigration over the past 10 years. This new population has a high percentage of women of childbearing age (Office for National Statistics, 2012b), consequently placing an increased demand on U.K. maternity services. Previous research suggests lower satisfaction and worse maternity outcomes for migrant and minority ethnic women both in the United Kingdom and abroad. Most papers exploring ethnic health inequalities have centered on causal factors such as differences in socioeconomic status and host country language ability. Health care policies to tackle inequalities in the United Kingdom, based on these assumptions, have had limited success. Consequently, alternative causal factors need to be explored. This article discusses ethnic inequalities in maternity outcomes in the United Kingdom and proposes that research exploring the client–provider relationship in migrant women's maternity care could provide important new insights.

KEYWORDS: inequalities; midwifery; maternal mortality; obstetric outcomes; immigration; minority ethnic

INTRODUCTION

Recent reports suggest more than a fourfold increase in non-U.K.-born individuals residing in the United Kingdom in the last 50 years (Office for National Statistics [ONS], 2013), with a high percentage of these first generation immigrants being women of childbearing age (ONS, 2012b). Both U.K. and international research suggests an increased risk of both maternal and perinatal mortality for immigrant and minority ethnic women (Giscombe & Lobel, 2005; Zwart et al., 2011); between 2006 and 2008, the estimated mortality rate in the United Kingdom was 3 times higher for Black African and Caribbean women than their White counterparts (Cantwell et al., 2011), and estimated mortality rates were also comparatively higher for both Asian and Chinese than White women (Cantwell et al., 2011). Combining these ethnic inequalities with high levels of immigration has serious implications for the clinical safety of migrant women in U.K. maternity care. The recent CMACE report (Cantwell et al., 2011) criticizes the continuing

inequalities in maternity outcome between ethnic populations, and previous research has failed to provide effective solutions to narrow the gap. Policy recommendations have, until now, focused on issues such as socioeconomic status and language barriers as key factors in tackling health inequalities in this population. However, little attention has been paid to how midwife–client relationships may affect equity of treatment and patient safety for migrant and minority ethnic women. This is disappointing given that U.K. maternity care has been publicly emphasized as a partnership between client and midwife (Department of Health, 2007), and reviews of maternity services consistently highlight poor client–provider communication as a key factor in substandard care (Lewis, 2007; Redshaw, Rowe, Hockley, & Brocklehurst, 2007). The following section discusses research and policy in the area of ethnic inequalities in maternity outcome in the United Kingdom and concludes by recommending that the client–provider relationship is explored as a way to gain information on how to narrow the gap in maternity outcome between ethnic and migrant groups.



RISING IMMIGRATION

Although increasingly restrictive government immigration policies implemented over the past 2 years have arguably led to the reductions in year-on-year migration (ONS, 2014), migration in the United Kingdom remains high, with 212,000 more individuals entering than leaving the United Kingdom in the year ending December 2013 (ONS, 2014). Therefore, large non-U.K.-born populations continue to exist and grow within the United Kingdom. Indeed, a recent report from the Office for National Statistics suggests that the non-U.K.-born population quadrupled between 1951 and 2011 (ONS, 2013), with a rise from 5.2 million to 7.5 million non-U.K.-born U.K. residents between 2004 and 2011 (ONS, 2012a). Data from 2011 suggests that more than 13% of the current population of England and Wales were born outside of the United Kingdom (ONS, 2013).

The most recent *Migration Statistics Quarterly Report* (ONS, 2014) suggests that three-fourths of immigration to the United Kingdom are people migrating to work or study. Different changes in migration patterns are seen between European Union (EU) and non-EU citizens, driven by the different rights to immigrate to the United Kingdom and the impact of government policy. During the 2000s, steep increases in net migration have been largely because of immigration of citizens from the countries that joined the EU in 2004 (ONS, 2014).

In addition to rising in numbers, the U.K. immigrant population has also become more diverse (ONS, 2013). There have been particularly noticeable increases in national insurance number allocations to individuals from Romania, Poland, Italy, and Bulgaria; 23,000 Romanian and Bulgarian citizens immigrated in the year ending December 2013, more than double the 9,000 recorded the previous year (ONS, 2014). This increase in diversity of client culture and language has inarguable implications for U.K. maternity service provision.

IMPACT ON MATERNITY SERVICES

Increased immigration has had a visible impact on U.K. maternity services; with 25.5% of births in England and Wales in 2011 being to mothers born outside of the United Kingdom (ONS, 2012b). In fact, the increased total number of live births in England and Wales between 2010 and 2011 was only because of an increase

in births to non-U.K.-born mothers (ONS, 2012b). Furthermore, although the population of non-U.K.-born women of childbearing age rose from 2010 to 2011, the population of U.K.-born women of childbearing age fell (ONS, 2012b).

Estimated fertility rates further indicate high usage of U.K. maternity services by immigrant women. In 2011, the estimated fertility rate for U.K.-born women was 1.9 children, in comparison to an estimated 2.29 children per non-U.K.-born woman (ONS, 2012a). Even larger variance exists between minority ethnic groups; estimated fertility rates for Pakistan- and Bangladesh-born women have been shown to reach as high as 4.7 and 5.3 children per woman respectively (ONS, 2012b). Taken together, the large numbers of immigrant women of childbearing age and the high fertility rates seen in these women predict a growing use of U.K. maternity services by this population. Documented ethnic inequalities in maternal and perinatal mortality in the United Kingdom suggest potential differences in maternity care experience dependent on ethnicity; these are discussed in this article under the subheadings of "Women's Experiences of Maternity Care" and "Midwives' Experiences of Maternity Care."

Women's Experiences of Maternity Care

When reviewing literature on the maternity care experiences of minority ethnic and migrant women in the United Kingdom, several common themes emerge, including satisfaction with care, timely access to services, and client-provider communication issues, along with increased maternal mortality and morbidity rates.

Lower satisfaction with maternity care has been consistently reported for minority than for majority ethnic women in U.K.-based research (Redshaw et al., 2007; Singh & Newburn, 2000). In a survey by Raleigh, Hussey, Seccombe, and Hallt (2010), minority ethnic women were found to respond more negatively to questions about care during labor and birth than their White British counterparts. Similarly, McCourt and Pearce (2000) found that minority ethnic women were more likely to feel their care needs had not been met by maternity care staff.

Minority ethnic women have also been found to report less frequent contact with maternity services, including lower rates of postnatal check-up and midwife contact (Raleigh et al., 2010). A report by the Healthcare Commission (2008) found that women of Black and Asian origins were less likely to be booked within

12 weeks and have a scan at 20 weeks—procedures recommended by the National Institute for Health and Clinical Excellence (NICE) antenatal care guidelines (<http://guidance.nice.org.uk/CG62>).

Reduced access to U.K. maternity services by minority ethnic women is cited to be caused by a combination of English fluency level and constrained economic circumstances leading to lack of access to transport or childcare provision (Jayaweera, D'Souza, & Garcia, 2005). Findings from qualitative research suggests that host language ability is one of the most common barriers to accessing maternity services; in a study by Bulman and McCourt (2002), Somali refugee women reported missing their hospital appointment if they could not find an interpreter, and only a quarter of participants reported being provided with interpreters at any point during their maternity care. Similar findings have come from primary care research; in interviews conducted by Threadgold et al. (2007), many Somali women described feeling that they could not seek medical help and advice because of their lack of English. A lack of appropriate translation services, such as Language Line, was also reported (Bulman & McCourt, 2002), and general practitioners (GPs) often expected women to rely on their young children to interpret (Threadgold et al., 2007). When translators were not available, Somali women suggested that they were often turned away from GP surgeries or asked to wait until another English-speaking Somali person came in for an appointment (Threadgold et al., 2007).

Language ability, although unquestionably important, is only one of many factors behind low maternity care satisfaction. Second-generation South Asian women, for example, have described problems in communicating with midwives despite good levels of language fluency; reporting themselves as being muted, not actively listened to, and not given the opportunity to express themselves (Ellis, 2000).

The previously mentioned findings are extremely important in relation to maternity outcomes because the recent CMACE (Cantwell et al., 2011) maternal mortality report suggests that little or no engagement with maternity services is one of the most predictive risk factors for maternal deaths.

In line with warnings presented in the CMACE report (Cantwell, 2011), a wealth of research details poor maternity outcomes for minority ethnic women in the United Kingdom, including an increased risk of complications during pregnancy, unplanned cesarean section, and neonatal unit care (Raleigh et al., 2010). As previously mentioned, significantly higher maternal

mortality rates are found for minority ethnic than White British women (Cantwell et al., 2011); between 2006 and 2008, the estimated mortality rate was 8.5 deaths per 100,000 maternities for White women compared to 28.05 deaths per 100,000 maternities for their Black counterparts. Estimated mortality rates were also comparatively higher for both Asian and Chinese women at 12.24 and 15.11 deaths per 100,000 maternities, respectively (Cantwell et al., 2011). Recent reports of perinatal mortality show a worryingly similar pattern; mothers of Black ethnic origin were 2.1 times more likely to have a stillbirth and 2.4 times more likely to have a neonatal death than mothers of White ethnic origin (CMACE, 2011). Similarly, mothers of Asian ethnic origin were 1.6 times more likely to have a stillbirth and 1.6 times more likely to have a neonatal death than their White counterparts (CMACE, 2011).

Previous research on ethnic inequalities in health has explored potential causal factors such as genetic predisposition (Giger & Davidhizar, 1999), racism (Mustillo et al., 2004), language barriers (Jonkers, Richters, Zwart, Öry, & van Roosmalen, 2011), and socioeconomic status (Knight, Kurinczuk, Spark, & Brocklehurst, 2009), focusing on these latter two. Although a minority of studies lend weight to the argument that ethnic inequalities in health outcomes are mediated by ethnically determined genetic risk factors (e.g., Giger & Davidhizar, 1999; Naran, Chetty, & Crowther, 2008), such evidence is limited to an extremely small number of health conditions. The strong association between ethnic minority status and low socioeconomic status (ONS, 2013) is similarly rejected as a sufficient explanation of these inequalities, with ethnic inequalities in health persisting even after accounting for differences in socioeconomic status (Knight et al., 2009). Research conducted in the Netherlands, for example, found that women from the large Turkish and Moroccan populations showed no elevated risk of severe acute maternal morbidity when compared to western women, despite the well-documented lower socioeconomic status of these populations (Zwart et al., 2010). Sub-Saharan African women, however, showed an increased risk of 3.5, leading the authors to conclude that there are risk factors for negative maternity outcomes independent of social situation (Zwart et al., 2010).

As discussed earlier, language barriers are also insufficient in accounting for obstetric inequalities between native and migrant clients. This leaves the question; why *are* these inequalities occurring? Alternative explanations of ethnic inequalities in health are evidently needed to develop policies and interventions

to facilitate the narrowing of health inequalities in the United Kingdom. Before exploring alternative explanations, it is necessary to also examine the experiences of midwives providing care to migrant and minority ethnic clients.

Midwives' Experiences of Maternity Care

Care experiences are mediated by ethnicity and immigration status not only for the client but also for the health professional. Previous research suggests that midwives often feel that they are unable to have a "proper relationship" with minority ethnic women (Bowler, 1993, p. 161) and that clients from specific minority ethnic groups can be challenging to work with (Essén, Binder, & Johnsdotter, 2011). Ineffective communication has been cited as a major contributing factor to these strained relationships. As well as being stressful and confusing for non-English-speaking clients, communication problems prove frustrating and concerning for health care professionals (Bowler, 1993). Midwives, especially, are challenged in that they are unlikely to be able to obtain a full and comprehensive booking history, therefore limiting their ability to provide effective and timely care (Cantwell et al., 2011). The reliance on family members for interpretation has also been cited by midwives as a cause for concern, many highlighting the inappropriate nature of communicating health care issues through young children (Cantwell et al., 2011). Midwives have also voiced anxieties regarding the potential for spouses to be perpetrators of domestic abuse (Cantwell et al., 2011). If clients insist on using partners as their sole translators, it becomes extremely difficult for staff to voice concerns regarding such sensitive topics, potentially causing health professionals to feel they have not provided sufficient care for their client.

Differing cultural beliefs and practices can also cause difficulties in client-provider interactions. Essén et al. (2011), for example, found that Somali women viewed cesarean section (CS) as a practice likely to result in death or maternal morbidity. The fear and anxiety caused by such beliefs resulted in women developing ways to avoid this procedure; many lying to their midwives about symptoms, or waiting until the last minute to go into hospital when in labor (Essén et al., 2011). These women also reported changing antenatal clinic if CS was suggested, or denying assessment results (Essén et al., 2011). In the United Kingdom, cesarean section is generally seen as a life-saving procedure, a

stark contrast to the views of the women interviewed. Understandably, such divergence in views could make discussions regarding CS extremely stressful for both the client and midwife; clients are likely to become scared, midwives may feel unable to do their jobs properly, and conflict is likely to arise (Essén et al., 2011). The tensions resulting from such differing views is evidenced, in part, by the generalization from service providers that Somali women are a very difficult group to work with (Essén et al., 2011). In fact, health care providers interviewed in Essén et al.'s (2011) research frequently suggested that client's refusal of CS, because of cultural beliefs, was the direct cause of adverse maternity outcomes.

Irrespective of causation, health research implies a continuing inequality in maternity experience for minority ethnic and migrant women (and also for the midwives caring for them). So what can be done to address these issues?

STEPS TO REDUCE INEQUALITIES

The current Secretary of State for Health in England, Jeremy Hunt, has declared that "The Government's ambition is to make health inequalities a thing of the past" and that their effort in this must be "relentless, evidence-based and systematic" (Department of Health, 2014). New legislation in England, introduced through the Health and Social Care Act of 2012, has created duties for reducing health inequalities not only for the Secretary of State for Health but also for National Health Service England and clinical commissioning groups. These leading health bodies must also, under this new legislation, provide annual assessment of how these duties have been met. Similar legislation is present in other parts of the United Kingdom; the "Together for Health" vision in Wales (Welsh Government, 2011) aspires to reduce inequalities, suggesting that it is "morally unacceptable" that some individuals have health, which is significantly worse than average. The Scottish government has a similar outlook, with a Ministerial Task Force on Health Inequalities set up to review new evidence and highlight areas for attention (The Scottish Government, n.d.). In Northern Ireland, the "New Targeting Social Need" policy focuses on improving the social and economic characteristics of disadvantaged areas and in turn reducing health inequalities, whereas a Health and Social Care Inequalities Monitoring System has been set up to monitor differences in mortality,

morbidity, and access to health and social care services (Stewart, Lyness, & Bell, 2012).

Despite the implementation of health inequality policy and monitoring, recent maternal mortality reports (Cantwell et al., 2011) suggest that more needs to be done to provide equitable and effective services to vulnerable women. In addition to a lack of clear application, previous policies for tackling ethnic inequalities in health have focused almost solely on the issue of socioeconomic status, whereas other factors have been largely neglected. One of the factors largely neglected by health research in this area is the effect of the client-provider relationship.

IMPORTANCE OF CLIENT-PROVIDER RELATIONSHIP

In contrast to the National Health Service focus on birth environment and socioeconomic status of mothers, qualitative research conducted with minority ethnic women seems to indicate the importance of client-provider relationships in improving maternity experiences/outcomes. In interviews with minority ethnic women, Puthussery, Twamley, Macfarlane, Harding, and Baron (2010) found that satisfaction with maternity care was consistently linked to the midwife-client relationship; women valued warmth and support, which led to trust and confidence in the provider. Similar research, conducted in the Netherlands, found that immigrant women attributed substandard care to poor doctor-patient interaction (Jonkers et al., 2011). Findings from research conducted with minority ethnic women parallel those from studies with maternity service clients in general. A recent study in the United Kingdom, for example, found that women who had a close and trusting relationship with their midwife were more likely to seek help, irrespective of immigration status/ethnicity (Lynch, 2011). A report of all U.K. maternal deaths further supports this concept, proposing that a poor quality of client-provider relationship is a key factor for substandard maternity outcome (Lewis, 2007).

In the U.K. health care system, maternity care is construed as a partnership between the woman and service provider, placing a mutual responsibility on both parties to engage with care provision and influence outcomes (Cross-Sudworth, Williams, & Herron-Marx, 2011). A positive client-provider relationship, therefore, is not only essential for women's satisfaction with care but also extremely important in determining maternity outcome. This concept is reflected in recent

CMACE reports (Cantwell et al., 2011), which suggest that emotional support and effective communication in maternity care is important for several reasons including the prevention of maternal mortality.

Despite such evidence, relational issues between midwife and client have been relatively ignored (Hunter, 2010). Models of client-provider relationships, however, provide credible theories for the barriers to positive maternity outcomes for immigrant women. The concept of "reciprocity" identified in Hunter's (2006, 2010) research, for example, suggests that balanced exchanges (equal give and take) lead to more happiness in the midwife-client relationship (Hunter, 2006). Midwives are able to provide more enhanced emotional support and efficient communication to clients (Hunter, 2006), which allows for more authentic empathy and emotional connection. This, in turn, results in both clients and midwives feeling more valued and supported (Hunter, 2006; McCourt & Stevens, 2009). In addition to feelings of value and support, midwives have suggested that the development of meaningful client-provider relationships increases their ability to perform "genuine caring" (Berg, 2005), and allows them to become safer practitioners (Ólafsdóttir, 2006).

As discussed earlier, quality of the client-provider relationship is variable between U.K. majority and minority ethnic populations (Puthussery et al., 2008). Minority ethnic women in Lynch's (2011) research reported feeling as though they had been treated in a disrespectful way because of their ethnicity, and that this had resulted in them feeling uncomfortable asking midwives questions. The denial of a trusting and caring relationship could lead to a lack of vital information sharing, which could have serious implications for the health of clients and their babies (Lynch, 2011). This is supported by Pairman's (1998) research, which found that sensitive issues were more likely to be disclosed in a trusting midwife-client relationship. Such research suggests that vulnerable immigrant women may feel unable or unwilling to disclose important and potentially life-saving information to their midwives. Lynch (2011), along with other researchers in this field, suggests that more targeted investigation is needed into the relationship between care providers and vulnerable women to adapt maternity services to provide effective care for an increasingly diverse client group.

A refocus on client-provider relationships in maternity care for immigrant women, therefore, has the potential to provide credible explanations for inequalities in U.K. maternity outcomes. This research would have added value in its potential to influence and

inform current government policy on health inequalities. Such research is currently underway at Cardiff University; exploring the midwife–client relationship for immigrant Pakistani women receiving maternity care in South Wales.

CONCLUSION

Literature discussed throughout this article suggests continuing inequalities in maternity outcomes in the United Kingdom; mortality rates continue to be significantly higher for minority ethnic and immigrant women than their white British counterparts, and midwives report more difficulty in working with this client group. Previous government policies to reduce these inequalities have focused on improving socioeconomic status and increasing language support; however, such measures have had little impact. To more effectively tackle health inequalities for this population, this article suggests that a change of focus in health research is needed. Qualitative research in maternity care experiences highlights the client–provider relationship as an extremely important factor in service satisfaction; therefore, this article suggests that a refocus on client–provider relationship may provide new ways to tackle inequalities in outcomes for minority ethnic and immigrant women.

REFERENCES

- Berg, M. (2005). A midwifery model of care for childbearing women at high risk: Genuine caring in caring for the genuine. *Journal of Perinatal Education*, 14(1), 9–21.
- Bowler, I. (1993). “They’re not the same as us”: Midwives’ stereotypes of South Asian descent maternity patients. *Sociology of Health & Illness*, 15(2), 157–178.
- Bulman, K. H., & McCourt, C. (2002). Somali refugee women’s experiences of maternity care in west London: A case study. *Critical Public Health*, 12(4), 365–380.
- Cantwell, R., Clutton-Brock, T., Cooper, G., Dawson, A., Drife, J., Garrod, D., . . . Springett, A. (2011). Saving mothers’ lives: Reviewing maternal deaths to make motherhood safer: 2006–2008. The eight report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. *British Journal of Obstetrics and Gynaecology*, 118(Suppl. 1), 1–203.
- Centre for Maternal and Child Enquiries. (2011). *Perinatal mortality 2009: United Kingdom*. London, United Kingdom: Author.
- Cross-Sudworth, F., Williams, A., & Herron-Marx, S. (2011). Maternity services in multi-cultural Britain: Using Q methodology to explore the views of first- and second-generation women of Pakistani origin. *Midwifery*, 27(4), 458–468.
- Department of Health. (2007). *Maternity matters: Choice, access and continuity of care in a safe service*. London, United Kingdom: The Stationery Office.
- Department of Health. (2014). *Reducing health disparities*. Retrieved from <https://www.gov.uk/government/publications/reducing-health-inequalities>
- Ellis, N. (2000). Birth experiences of South Asian Muslim women. In N. Kirkham (Ed.), *Informed choice in maternity care* (pp. 87–102). London, United Kingdom: Palgrave Macmillan.
- Essén, B., Binder, P., & Johnsdotter, S. (2011). An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth. *Journal of Psychosomatic Obstetrics & Gynecology*, 32(1), 10–18.
- Giger, J., & Davidhizar, R. (1999). *Transcultural nursing: Assessment and intervention* (3rd ed.). St. Louis, MO: C. V. Mosby.
- Giscombé, C. L., & Lobel, M. (2005). Explaining disproportionately high rates of adverse birth outcomes among African Americans: the impact of stress, racism, and related factors in pregnancy. *Psychological Bulletin*, 131(5), 662–683.
- Health and Social Care Act. (2012). London: The Stationery Office.
- Healthcare Commission. (2008). *Towards better births: A review of maternity services in England*. London, United Kingdom: Author.
- Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery*, 22(4), 308–322.
- Hunter, B. (2010). Mapping the emotional terrain of midwifery: What can we see and what lies ahead? *International Journal of Work Organisation and Emotion*, 3(3), 253–269.
- Jayaweera, H., D’Souza, L., & Garcia, J. (2005). A local study of childbearing Bangladeshi women in the UK. *Midwifery*, 21(1), 84–95.
- Jonkers, M., Richters, A., Zwart, J., Öry, F., & van Roosmalen, J. (2011). Severe maternal morbidity among immigrant women in the Netherlands: Patients’ perspectives. *Reproductive Health Matters*, 19(37), 144–153.
- Knight, M., Kurinczuk, J., Spark, P., & Brocklehurst, P. (2009). Inequalities in maternal health: National cohort study of ethnic variation in severe maternal morbidities. *British Medical Journal*, 338, b542.

- Lewis, G. (Ed.). (2007). *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving mothers' lives — Reviewing maternal deaths to make motherhood safer, 2003–2005*. The seventh report of the Confidential Enquiries in Maternal Death in the United Kingdom. London, United Kingdom: CEMACH.
- Lynch, N. (2011). *Women's experiences of maternity services in Birmingham East and North and Solihull. A qualitative study*. Retrieved from <http://www.linkstogoodpractice.org.uk/resources/women%E2%80%99s-experiences-maternity-services-birmingham-east-and-north-and-solihull>
- McCourt, C., & Pearce, A. (2000). Does continuity of carer matter to women from minority ethnic groups? *Midwifery*, 16(2), 145–154.
- McCourt, C., & Stevens, T. (2009). Relationship and reciprocity in caseload midwifery. In B Hunter & R. Deery (Eds.), *Emotions in midwifery and reproduction* (pp. 17–23). Basingstoke, United Kingdom: Palgrave Macmillan.
- Mustillo, S., Krieger, N., Gunderson, E. P., Sidney, S., McCreath, H., & Kiefe, C. I. (2004). Self-reported experiences of racial discrimination and Black–White differences in preterm and low-birthweight deliveries: The CARDIA Study. *American Journal of Public Health*, 94(12), 2125–2131.
- Naran, N., Chetty, N., & Crowther, N. (2008). The influence of metabolic syndrome components on plasma PAI-1 concentrations is modified by the PAI-1 4G/5G genotype and ethnicity. *Atherosclerosis*, 196(1), 155–163.
- Office for National Statistics. (2012a). *Population by country of birth and nationality report, August 2012*. Retrieved from <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/august-2012/population-by-country-of-birth-and-nationality.html>
- Office for National Statistics. (2012b). *Statistical bulletin: Births in England and Wales by parents' country of birth, 2011*. Retrieved from <http://www.ons.gov.uk/ons/rel/vsob1/parents-country-of-birth-england-and-wales/2011/sb-parents-country-of-birth-2011.html>
- Office for National Statistics. (2013). *Immigration patterns of non-UK born populations in England and Wales in 2011*. Retrieved from http://www.ons.gov.uk/ons/dcp171776_346219.pdf
- Office for National Statistics. (2014). *Statistical bulletin: Migration statistics quarterly report, May 2014*. Retrieved from <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/may-2014/msqr-may-2014.html>
- Ólafsdóttir, O. A. (2006). *An Icelandic midwifery saga—Coming to light: "With woman" and connective ways of knowing* (Unpublished doctoral dissertation). Thames Valley University, London, United Kingdom.
- Pairman, S. (1998). *The midwifery partnership: An exploration of the midwife/woman relationship* (Master's thesis). Victoria University, Wellington, New Zealand.
- Puthussery, S., Twamley, K., Harding, S., Mirsky, J., Baron, M., & Macfarlane, A. (2008). "They're more like ordinary stropky British women": Attitudes and expectations of maternity care professionals to UK-born ethnic minority women. *Journal of Health Services Research & Policy*, 13(4), 195–201.
- Puthussery, S., Twamley, K., Macfarlane, A., Harding, S., & Baron, M. (2010). "You need that loving tender care": Maternity care experiences and expectations of ethnic minority women born in the United Kingdom. *Journal of Health Services Research & Policy*, 15(3), 156–162.
- Raleigh, V. S., Hussey, D., Seccombe, I., & Hallt, K. (2010). Ethnic and social inequalities in women's experience of maternity care in England: Results of a national survey. *Journal of the Royal Society of Medicine*, 103(5), 188–198.
- Redshaw, M. R. Rowe, C., Hockley, P., & Brocklehurst, P. (2007). *Recorded delivery: A national survey of women's experience of maternity care 2006*. Oxford, United Kingdom: National Perinatal Epidemiology Unit.
- The Scottish Government. (n.d.). *Equally well: The report of the Ministerial Task Force on health inequalities*. <http://www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well>
- Singh, D., & Newburn, M. (2000). *Access to maternity information and support: The experiences and needs of women before and after giving birth*. London, United Kingdom: National Childbirth Trust.
- Stewart, B., Lyness, C., & Bell, C. (2012). *NI Health & Social Care Inequalities Monitoring System. Sub-regional inequalities—HSC Trusts. First update bulletin 2012*. Retrieved from http://www.dhsspsni.gov.uk/ni_hscims_sub-regional_inequalities_-_hsc_trusts_2012.pdf
- Threadgold, T., Clifford, S., Harb, Z., Jewell, J., Powell, V., & Jiang, X. (2007). *Constructing community in South-East Wales*. Retrieved from <http://www.cardiff.ac.uk/jomec/resources/ConstructingCommunity.pdf>
- Welsh Government. (2011). *Together for health. A five year vision for the NHS in Wales*. Retrieved from <http://www.wales.nhs.uk/sitesplus/documents/829/togetherforhealth.pdf>

Zwart, J., Jonkers, M., Richters, A., Öry, F., Bloemenkamp, K., Duvekot, J., & van Roosmalen, J. (2011). Ethnic disparity in severe acute maternal morbidity: A nationwide cohort study in the Netherlands. *European Journal of Public Health*, 21, 229–234.

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Appendix Two: Search Strategy for Literature Review

Search strategy

- Initial search of electronic databases using keywords.
- Screen citations for relevance - analysis of the words contained in the title, abstract and index terms. Exclude any irrelevant, get full texts of all relevant.
- Go through full texts and select relevant studies based on study selection criteria.
- Use reference lists of all selected studies to identify additional studies.
- Personal contacts used to identify other potential studies (published and unpublished).
- Use Google Scholar (put relevant study titles into search engine and all look at all citing research).

Inclusion criteria

- Past 15 years (since 1998) Published and unpublished
- English Language (or translated to English)

Databases Searched:

- AMED
- EMBASE
- ICONDA
- MEDLINE
- PsycINFO
- PsycArticles
- Joanna Briggs EBP Database
- PsychLIT
- CENTRAL
- CINAHL
- MIDIRS

Search One:

Population terms	1	Pregnan\$
	2	Infan\$
	3	Nullipar\$
	4	Multipar\$
	5	Women
	6	Mother\$
	7	Woman
	8	Matern\$

	9	Perinatal
	10	Neonatal
	11	OR 1-10
Exposure terms	12	UK-born
	13	Migrant
	14	Immigrant
	15	Minority
	16	Ethnic
	17	BME
	18	Native
	19	Foreign
	20	Foreign-born
	21	OR 12-20
Outcome terms	22	Outcome
	23	Complication
	24	Stillbirth
	25	Obstetric
	26	Mortality
	27	Morbidity
	28	Safe
	29	Health
	30	OR 22-29
	31	AND 11, 21, 30

This first search returned 23094 results, which was too many to remove duplicates from, or to screen for relevant titles. Decided to reduce the amount of search terms used to make it more specific to the research area.

Search Two:

Population terms	1	Pregnancy
	2	Nulliparous
	3	Multiparous
	4	Women
	5	Mother
	6	Maternal
	7	Perinatal
	8	OR 1-7
Exposure terms	9	Migrant
	10	Immigrant
	11	Minority ethnic
	12	Ethnic
	13	BME
	14	Foreign-born

	15	OR 9-14
Outcome terms	16	Stillbirth
	17	Obstetric
	18	Mortality
	19	Morbidity
	20	OR 16-19
	21	AND 8, 16, 20

Results:

Numbers in brackets are the results returned during pre-submission update of this search; 2013-current.

Total results returned	2090 (746)
Total number of selected articles after removal of duplicates	1494 (543)
Total number of selected articles after screened for relevant titles	203 (60)

Tool used to facilitate the evaluation of existing literature

Adapted from Long and Godfrey (2004)'s tool for evaluating qualitative research

(1) PHENOMENON STUDIED AND CONTEXT

Phenomena under study	What is being studied? Is sufficient detail given of the nature of the phenomena under study?
Context I: Theoretical	What theoretical framework guides or informs the study? In what ways is the framework reflected in the way the study was done?
Framework	How do the authors locate the study within the existing knowledge base?
Context II: Setting	Within what geographical and care setting is the study carried out? What is the rationale for choosing this setting?

	Is the setting appropriate and/or sufficiently specific for examination of the research question?
	Is sufficient detail given about the setting?
	Over what time period is the study conducted?
Context III: Sample (events, persons, times and settings)	How is the sample (events, persons, times and settings) selected? (For example, theoretically informed, purposive, convenience, chosen to explore contrasts)
	Is the sample (informants, settings and events) appropriate to the aims of the study?
	Is the sample appropriate in terms of depth (intensity of data collection, individuals, settings and events) and width across time, settings and events? (For example, to capture key persons and events, and to explore the detail of inter-relationships)
	What are the key characteristics of the sample (events, persons, times and settings)?
Context IV: Outcomes	What outcome criteria are used in the study?
	Whose perspectives are addressed (professional, service, user, carer)?
	Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)?

(2) ETHICS

Ethics	Was Ethical Committee approval obtained?
	Was informed consent obtained from participants of the study?
	Have ethical issues been adequately addressed?

(3) DATA COLLECTION, ANALYSIS AND POTENTIAL RESEARCHER BIAS

Data collection	What data collection methods are used to obtain and record the data? (For example, provide insight into: data collected, appropriateness and availability for independent analysis)
	Is the information collected with sufficient detail and depth to provide insight into the meaning and perceptions of informants?
	Is the process of fieldwork adequately described? (For example, account of how the data were elicited; type and range of questions; interview guide; length and timing of observation work; note taking)
	What role does the researcher adopt within the setting?

Is there evidence of reflexivity, that is, providing insight into the relationship between the researcher, setting, data production and analysis? reader to quickly grasp the essential details of a study and its potential value.

This has considerable potential as a means of communicating key messages about the study in a reasonably succinct manner. It can provide one part of the information set, and knowledge base, for a policy maker. The reader retains the option of going inside the tool for a more detailed insight into a particular aspect of the study.

Data analysis

How are the data analysed?

How adequate is the description of the data analysis? (For example, to allow reproduction; steps taken to guard against selectivity)

Is adequate evidence provided to support the analysis? (For example, includes original/raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity—searching for negative evidence, use of multiple sources, data triangulation); reliability/consistency (over researchers, time and settings; checking back with informants over interpretation)

Are the findings interpreted within the context of other studies and theory?

Researcher's potential bias

Are the researcher's own position, assumptions and possible biases outlined? (Indicate how these could affect the study, in particular, the analysis and interpretation of the data)

(4) POLICY AND PRACTICE IMPLICATIONS

Implications

To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?)

To what population are the study's findings generalisable?

Is the conclusion justified given the conduct of the study? (For example, sampling procedure; measures of outcome used and results achieved)

What are the implications for policy? And for service practice?

Appendix Three: Search Terms for Reviewing Relevant Media

Search Strategy

Media searched:

- National and local newspapers
- News websites
- Social media (facebook and twitter)
- Government policy and legislation/reports
- Healthcare organisation websites and guidelines/recommendations/reports

Main terms:

- MIGRANTS, IMMIGRANTS, REFUGEES, ASYLUM SEEKERS or variations of those words.
- MIDWIFERY, MATERNITY, NURSING, HEALTHCARE or variations.

In combination with terms such as:

- INEQUALITIES, GAPS, DEPRIVATION or variations
- POLICY, CHANGES, NEW, LEGISLATION, INCREASES, DIFFERENCES

REC Reference number: 14/NW/0145



PARTICIPANT INFORMATION SHEET

Please read this information carefully before completing the consent form

Project title: The Midwife-Client Relationship

Researcher: Laura Goodwin

I would like to invite you to take part in a research study. Before you decide whether or not you would like to participate, it is important to read the following information carefully. This explains what will happen if you take part, and that you are free to withdraw at any time. You should only participate if you want to; choosing not to take part will not disadvantage you in any way.

Please feel free to talk to other people about the study. If there is anything you do not understand, or if you would like any further information, please contact the researcher, Laura Goodwin:

Address: School of Healthcare Sciences,
Cardiff University
Eastgate House
35-43 Newport Road
Cardiff
CF24 0AB

Email: GoodwinL3@cardiff.ac.uk

Telephone: 02920 917727 or 07890399303

What is the aim of the study?

The aim of this study is to explore relationships between midwives and migrant Pakistani women in the South Wales region, in order to improve communication and emotional support in maternity services. We would love to hear your expectations of maternity care, when you first enter the services, and later discuss your maternity care experience with you. Your responses will help us identify the ways in which services could be improved to better support women. All interview information will be made anonymous so that no-one will be able to identify who you are, or which views you have expressed. Once the results have been analysed, the findings will be communicated to a variety of audiences that support, and are interested in, race equality and/or maternity care. These findings will also be used to help guide further research in the area of enhanced communication and support in maternity care.

Why have I been invited?

You have been selected from the antenatal clinic booking record by the researcher as you are

- first/second generation migrant Pakistani female
- currently around 3 months/6 months pregnant or it has been 6-12 weeks since you had your baby
- currently receiving UK maternity care in the South Wales region

If you agree to take part, no-one apart from the researcher and interpreter will know that you have done so. All data that is collected will be made anonymous. This means that it will not be possible to identify you from what you have said.

What does it involve?

Taking part involves an interview with the researcher and an interpreter

- Questions will be flexible and open-ended
- There are no right/wrong answers to any questions
- Questions may be left unanswered if you do not feel able to answer them

Interviews will take place at a location of your choice, and will last no longer than one hour.

Taking part in this research might also include being observed when you are receiving midwifery care in antenatal/postnatal clinics and wards. This observation will be as unobtrusive as possible, and ideally you should not notice the researcher's presence. The researcher will not interrupt your clinical care at any point, and you or the midwife may request that observation stops at any time, without giving reason.

What are the possible benefits of taking part?

There will be no direct benefits to taking part in this research. However results from this study will be used to provide researchers and healthcare professionals with very important information about the views and needs of women in maternity care services in the UK.

What are the possible risks of taking part?

It is unlikely that there will be any risks from taking part. However some people may find it emotionally distressing to talk and think about such important stages of their life. If you feel unhappy about any part of the interview you can ask the researcher to move on to the next question immediately. You also have the option to stop altogether, without providing an explanation.

Can I withdraw at any time?

Yes. You do not have to take part in this study if you don't want to. If you decide to take part you are still free to withdraw at any time and without giving a reason.

It is also possible for you to withdraw specific comments made during the interview. However this will need to be done before you leave the interview (as all data will then be made anonymous).

What happens when the study ends?

A report of the findings of this study will be published as part of the researcher's academic study for a PhD. A summary of this report will be available to the public; please inform the researcher if you would like a copy when it becomes available. (Please note that this will not be available for the next 24 months or so). The researcher will also be presenting a summary of the findings of this research at a variety of conferences and meetings (no one will be able to identify you from this).

Confidentiality

All data will be collected and stored in accordance with the Data Protection Act (1998). This means that all of the data collected throughout the course of this research will be stored securely and in a way that means it can be linked directly to you. Only the principal researcher and the primary supervisor will have access to data. On completion of the study, data will be retained for a further fifteen years and then destroyed.

What if I have a complaint about the study?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will try to answer your questions (phone 07890399303). If you remain unhappy and wish to complain formally, you can do this by contacting the Research Governance Officer at Cardiff University, Helen Falconer, at Research, Innovation and Enterprise Services, Cardiff University, 7th Floor, 30-36 Newport Road, Cardiff, CF24 0DE. Email: falconerhe@cardiff.ac.uk. Telephone: 02920 879277.

Who has reviewed this study?

The study has been examined by Cardiff University School of Healthcare Sciences Research Review and Ethics Screening Committee (RRESC), NHS National Research Ethics Committee, and NHS Research and Development Support Units.

Professor Billie Hunter (RCM) and Dr Aled Jones, from Cardiff University, are supervising the research. This research is being advised by BAWSO, Race Equality First, and Consultant Midwives from the local health board.

Giving informed consent to take part

We would now like you to think about whether you would like to take part in this study. If you think you might like to take part, please fill out your contact details below and give it to your midwife. The researcher will contact you in around 2 days' time to see if you would still like to take part.

Thank you very much

REC Reference number: 14/NW/0145



کارڈف یونیورسٹی

فہم لےنے والوں کے لیے معلومات
نام پورا کرنے سے پہلے مندرجہ ذیل معلومات پڑھ لیں
مندان مڈوائف اور کھلائنٹ تحقیق اور اگلائون
ہیں آپ کو اس تحقیق میں فہم لےنے کی دعوت دیتی ہیں
اس میں فہم لےنے کے لیے مندرجہ ذیل معلومات کو پڑھ لیں
اس میں آپ کو یہ بتایا جائے گا کہ اگر آپ اس میں فہم لیں گی
تو کیا ہوگا اور آپ کسی وقت بھی اس میں فہم نہ لینے کا فیصلہ
کر سکتی ہیں۔

اگر آپ فہم نہ بھی لیں تو آپ پر کوئی فرق نہیں پڑے گا
اس تحقیق کے بارے میں اگر آپ کسی اور سے بات چیت کرنا
چاہیں تو کر سکتی ہیں۔

اگر آپ کو کسی بات کی سمجھ نہیں آتی یا آپ کو اور معلومات درکار
ہیں تو آپ اور اگلائون سے رابطہ قائم کر سکتی ہیں
پتہ اسکول آف پبلک ہیلتھ سروسز
کارڈف یونیورسٹی

الین گریفٹس

3-3-34 پین پورٹ روڈ

کارڈف سی ایف 24 اے بی

ای میل Goodwin.3@cardiff.ac.uk

فون نمبر 0789039903 / 02920917727

اس تحقیق کا مقصد کیا ہے؟

اس تحقیق کا مقصد یہ ہے کہ ماہر پاکستانی خواتین اور مڈوائف کے
درمیان تعلقات کے بارے میں اور زیادہ جانا جائے تاکہ بات چیت
کو اور بہتر بنایا جاسکے اور آپ کو مل کے دوران بہتر مہمائی سہارا دیا
جاسکے۔

ہمیں یہ جان کر خوشی ہوگی کہ حمل کے دوران آپ کی توقعات کیا ہیں
اور بعد میں حمل کے دوران کس طرح سے آپ کا خیال کس طریقہ سے رکھا گیا
آپ کے جوابات سے ہمیں یہ پتہ چل سکے گا کہ خواتین کو اور بہتر
سہولیات کیسے مہیا کی جائیں۔

انٹرویو کے دوران آپ کے دیے ہوئے خیالات کو مکمل طور پر منجھ
راز میں رکھا جائے گا اور کسی وقت بھی پتہ نہیں چل سکے گا کہ آپ

کون ہیں اور آپ نے کس طرح کے خیالات کا اظہار کیا ہے۔
 جب سارے نتائج کا جائزہ لیا جائے گا تب ان معلومات کی
 ان لوگوں تک پہنچایا جائے گا جو زیادہ نیچے اور نیچے برابری اور مساوات
 میں یقین رکھتے ہیں اور دل پسندی لیتے ہیں۔
 ان نتائج سے ہمیں آئندہ پورے والی کھٹات اور زیادہ اور کم کے یہ
 سیر سہولیات مہیا کرنے میں مدد ملے گی۔
 مجھے کیوں مدد کیا گیا ہے؟
 تحقیق کرنے والوں نے ایسی نینڈ کلنگ کے ریسر سے سے آپ کا
 نام بیا ہے کیونکہ

آپ ہیلی یا حد سیری پیڑھی سے ممبر پاکستانی قانون ہیں
 اس وقت آپ 6-3 کی حاملہ ہیں یا 6-12 بنتے ہیں آپ
 کے بچے کی پیدائش ہوئی ہے۔
 اس وقت میں آپ ویلن میں زیر اور کم کی سہولیات دینے
 والوں کی گولڈنی ہیں۔
 اگر آپ اس تحقیق میں حصہ لیتے ہیں تو رضا مند ہو جائیں تو تحقیق کرنے
 والی اور ترجمان کے علاوہ کسی اور کی اس بات کا علم نہیں ہوگا۔
 اس میں کیا شامل ہوگا؟
 حصہ لینے کے لیے ترجمان اور تحقیق کار آپ سے ملاقات کے دوران
 کچھ سوال کو ہیں گئے

سوال بھلا ارادہ انسان ہوئے
 کسی ہی سوال کا صحیح یا غلط جواب نہیں ہے
 اگر آپ کسی سوال کا جواب نہیں دے سکتے تو آپ اس کی ٹیپوڈ
 سکتی ہیں

یہ ملاقات آپ کی منتخب کی گئی ہے پر ہوگا اور اس میں گفتگو سے زیادہ
 وقت نہیں لگے گا۔
 اس تحقیق میں حصہ لینے سے ہو سکتا ہے کہ قبل از پیدائش اور بعد میں آپ
 کا وارڈس پارٹنر میں جہاں پر آپ کے خیال رکھا جائے ہے تحقیق کار
 وطن پر محدود ہو

اس کے دوران آپ کو تحقیق کار کے وطن پر صرف کا احساس نہیں ہوگا
 کسی ہی سرے پر تحقیق کار آپ کی دیکھ بھال میں مداخلت نہیں کرے گا
 آپ یا آپ کی والدہ کسی سرے پر دوبارہ جانے بغیر اس مرنے
 کو روکنے کی درخواست کر سکتی ہیں

اس میں وعدہ لینے سے کیا فائدہ ملے گا؟
اسی تحقیقی میں وعدہ لینے سے براہ راست آپ کو فی فائدہ نہیں ملے گا
تاہم اس تحقیق سے اور ان کے نتائج کو تحقیق کرنے والوں اور صحت
کا خیال رکھنے والوں (یعنی مددگار اور ڈاکٹر) کو پڑے سے لینے والی
خوشن کی ضروریات اور ان کے فیالات کے بارے میں بہت ضروری
معلومات حاصل ہوں گی۔

اس میں وعدہ لینے سے کیا فائدہ ہو سکتا ہے؟
اس میں وعدہ لینے سے کسی ہی فائدے کا امکان نہیں ہے تاہم کچھ لگن
کو اپنی زندگی کے اس ایم جی کے پر بات پیٹ سے ذہنی پریشانی ہو
سکتی ہے۔

اگر اس ملاقات کے دوران کسی سوال کا جواب دینے میں آپ کو مشغول
ہو رہی ہو تو آپ دوسرے سوال پر جانے کے بعد توجہ کر سکتی ہیں
کیا میں کسی وقت بھی انکار کر سکتی ہوں؟
ہاں۔ اگر آپ وعدہ نہیں لینا چاہتی تو نہ ہیں اور اگر آپ وعدہ
لینے کا فیصلہ کرتی ہیں اور بعد میں انکار کرنا چاہیں تو کوئی بھی وجہ
بتائے بغیر کر سکتی ہیں۔

ملاقات کے دوران کسی بھی کہی گئی بات کو آپ والیں کر سکتی ہیں
تاہم اس بات کا فیصلہ آپ کو ملاقات سے جانے سے پہلے کرنا پڑے
گا کیونکہ جو بھی آپ نے کیا ہے اس کو منہ راز سے رکھا جائے گا
اس تحقیق کے فائدے پر کیا ملے گا؟
اس رپورٹ کی معلومات کو تحقیق کرنے والی کمی PMA کے یہ نتائج
کیا جائے گا

اس کے علاوہ محام کے یہ بھی دستیاب ہوگا اگر آپ کو اس کی کاپی
چاہیں تو آپ تحقیق کرنے والی کو بتا دیں۔
میں یقینی ہے اس بات کا خیال رکھیں کہ یہ اگلے 24 گھنٹے تک دستیاب
نہیں ہے۔

اس تحقیق کے نتائج کو سب سے کم نفروں اور میڈنگ میں پیش کیا جائے
کوئی بھی آپ کی اس سے پہچان نہیں کرے گا۔
راز داری۔

ساری معلومات ڈیٹا پر ویشن ایکٹ ۱۹۹۶ کے تحت محفوظ کی جائے
گی اور رکھی جائے گی۔

اس کا مطلب یہ ہے کہ اس مطالعے کے دوران محفوظ کی گئی معلومات
بہت حفاظت سے رکھی جائیں گی اور ان کا براہ راست آپ ہی سے
راز نہ ہو سکتا ہے۔

یہ تحقیقی مکمل ہونے پر ساری معلومات مزید 15 سال تک محفوظ رکھی جائیں گی۔

اگرچہ اس تحقیق سے کوئی شکایت ہو۔
اگر آپ کو اس تحقیق کے کسی ہی پلو سے کوئی بھی شکایت ہو تو آپ
تحقیق نمبر کے 7895399353 پر فون کر سکتے ہیں وہ آپ کے
سوالات کے چھاب دینے کی پوری کوشش کرے گی۔
اگر پھر بھی آپ ناخوش ہیں اور باضابطہ طور پر شکایت کرنا چاہیں تو
آپ ریسرچ گورننس آفس کے ڈف پونی درستی پلین فالکونر
Helen Falconer کو ریسرچ انڈیشن اینڈ اینڈرائز سرورسز کا ڈف
پونی درستی فون نمبر 0303 303 736 پر پورٹ روڈ کا ڈف سی ایف 24
ادگس ایپی پر رابطہ کر سکتے ہیں۔
ایک ایسی میل ہے Falconer.h@cardiff.ac.uk فون نمبر 02920 87923
پر رابطہ کر سکتے ہیں۔

اس تحقیق کے جائزہ کس نے لیا ہے۔
اس تحقیق کا ڈف پونی درستی سکول آف ہیلتھ سائنس ریسرچ
ریپو اینڈ انویسٹمنٹ سٹرینگ کمیٹی (PRECSC) اپنی ایچ ایس نیٹیل
ریسرچ انویسٹمنٹ کمیٹی اور اپنی ایچ ایس ریسرچ اینڈ ڈیولپمنٹ سپورٹ
پلانٹ نے جائزہ دیا ہے۔
پروفیسر بیل ہنٹر (Billey Hunter) اور ڈاکٹر ایلڈ جونز (Alldred Jones) نے
کا ڈف پونی درستی اس اس تحقیق کی نگرانی کر رہے ہیں۔
اس تحقیق میں حصہ لینے کا شوق باوجود، انویسٹمنٹ فرسٹ اور
کا ڈف اور ویل ہیلتھ بورڈ کی مؤدافرنے دیا ہے۔

اس تحقیق میں حصہ لینے کے لیے باضابطہ رضامندی دینا۔

اب ہم یہ چاہیں گے کہ آپ اس بات کے منظم کریں کہ اس میں آپ
کو حصہ لینا ہے اور اگر آپ حصہ لینا چاہیں تو کوئینٹ فارم پر اپنے
دستخط کر دیں۔

آپ کا بہت بہت شکریہ
لورا گلڈون

Appendix Six: Links to Study Website and Audio Tracks of Participant Information for migrant Pakistani women

English - <http://youtu.be/PaCwgF0jqy8>

Urdu - <http://youtu.be/G-0C6UWkuLo>

Punjabi - <http://youtu.be/BLvffPzyFo8>

Pashto - <http://youtu.be/v95r6-b5IEY>

Study website: <http://midwiferelationshipstudy.weebly.com>

Topic 1: Pregnancy and care

- Congratulations on being pregnant. - Is this your first Wales-based pregnancy?
- Tell me how it has been for you so far.
Prompt - being pregnant in general: Shifting of role in the family?
- What have been your main sources of support and information regarding pregnancy and childbirth? Are you satisfied with this support?
- When you first accessed South Wales maternity care, what were your expectations of the care/support they would offer?
- How do these services compare to maternity services in Pakistan?
- How do you feel about the accessibility of maternity services in South Wales?
Prompt – given enough information? Felt comfortable negotiating system?
- Do you think this is the same for all health care services in South Wales?
- Do you feel that your experiences are typical of migrant women living in South Wales? The UK? Worldwide?
- Do you have any friends or family who have been in South Wales maternity care? How do you think their situation is similar/different to yours?

Topic 2: Midwife-client relationship

- Tell me about your relationships with your midwives, so far? How would you describe them?
Prompt - would you describe these as positive relationships - why/why not?
- Do you think relationships with a health professional impact on a person's health outcomes?
- How does this apply to your relationship with your midwife?

- How do you feel about the quality of relationships between health care professionals (in general) and migrant women in South Wales?
Prompt – better/worse than native women? Why?
- Have you experienced any language barriers during your care?
prompt – trust, information sharing, rapport
- How have your midwives responded when there have been language barriers?
Prompts – appropriately? Respectful?
- Do you feel that adequate language and support services are provided for migrant women in South Wales maternity care?
- Have you had any experiences of miscommunication? Has this affected your relationship with your midwife?
- Is there anything you can think of which might prevent a positive relationship between migrant women and their midwives?
Prompt - have you had experience of these barriers?
- Is there anything you can think of which might create a positive relationship between migrant women and their midwives?
Prompt - have you had experience of this?
- Have you experienced any differences between you and your midwives in terms of beliefs/practices surrounding pregnancy and birth? How have they handled this situation?
- What have been the most enjoyable parts of this pregnancy so far? How has this been impacted by your midwife?
- What have been the most difficult parts of the pregnancy so far? How has this been impacted by your midwife?

Appendix Eight: Observation Guide

Midwife

Interpersonal skills

- Welcoming
- Touch
- Eye contact
- Talk directly to woman
- Body language/facial expressions
- Listen
- Respectful
- Humour/social talk

Information communication

- Clear speech – explain processes
- Make sure the woman understands all information
- Leaflets given (if appropriate)
- Individualised care apparent
- Ask/answer questions

Cultural considerations

- Acceptance of attitudes, beliefs and behaviours
- Exploring expectations

Woman

Interpersonal skills

- Friendly
- Eye contact
- Talk directly to midwife
- Body language/facial expressions
- Listen
- Respectful
- Humour/social talk

Information communication

- Clear speech
- Ask/answer questions
- Voice concerns
- Complete booking forms before appointment

Partner/family member/friend

Interaction with woman

- Body language/facial expression
- Communication
- Humour
- Empowerment

Interaction with midwife

- Body language/facial expression
- Communication
- Humour
- Respect

Surroundings

- Quiet or loud
- Level of privacy
- Information posters/leaflets around
- Positioning of chairs in appointment room
- Atmosphere
- Interpersonal skills of other staff members

Myself

Participants' interactions with me

- Eye contact/body language
- Direction of talk (at me vs at others)

Presence in the room

- Participants' awareness/response to this
- Altering of behaviour

Appendix Nine: Topic Guide for Second Interview with Migrant Pakistani Women

Thank you so much for letting me come and speak to you again. How has everything been going since we last spoke? How was your scan?

- Have your expectations/understanding of the maternity care system in Wales changed since we last spoke?

Prompt: how/why

- How do you feel about the maternity care services which have been provided to you so far?

Prompts - safe?; Supported?; Positive relationship? Least positive bits – why?; Best bits – why?

- Can you think of anything which might have improved your pregnancy/birth experience so far?

Midwife-client relationship

- Do you think your midwife has had an impact on your pregnancy so far?
- Do you think your midwife's role in your pregnancy has changed during your maternity care?
- Tell me about your relationships with your midwives, so far. How would you describe them?
- Have you had any experiences with miscommunication? Has this affected your relationship with your midwife?
- Have you experienced any differences between you and your midwives in terms of beliefs/practices surrounding pregnancy and birth? How have they handled this situation?

Findings from research

- Midwives have commented about benefit letters etc – what is your view on this?

- Midwives said they think family often hold women back from learning English – would you agree?
- Some midwives have said they are too embarrassed to ask about cultural beliefs/practices – scared they might offend. What is your view on this?
- It is suggested that health services are not supposed to use family members to interpret – how would you feel if interpreter was compulsory?

Topic 1: Views of migrant women as clients

- Would you say there are different types of client to work with as a midwife?
Prompt - Different how?; More/less difficult to work with?; Different needs?
- Would you say that migrant (Pakistani) women have different maternity care needs to UK nationals?
Prompt: what is different?; How does this affect the care given?
- What would you say are the most enjoyable parts of providing care for women from other cultures?
- What do you think are the reasons for a migrant woman not to learn English when she has moved to the UK?
- What would you say are the most difficult parts of providing care for women from other cultures?
- Are there any cultural practices that you've come across that you think are particularly positive/negative?
Prompt : does this affect your relationship with them?
- What are your views on the provision of letters for benefits, etc?
- What would you say best prepares you for working with women from other cultures?
- How supported do you feel you are in working with women from other cultures? Cultural awareness training?
- How do you feel about the quality of the language services available?
- Do you feel that speaking through an interpreter affects your relationship with your client?
- Whose responsibility should this be?
- What level of understanding of how the UK health system works do you think migrant clients have?

Topic 2: Midwife-client relationship

- Do you feel that you usually have a positive relationship with your clients?
- How do you think the presence of a partner/parent affects your relationship with a client?
- Do you think the midwife-client relationship can have an impact on pregnancy outcomes/women's satisfaction with outcomes?
- Do you feel that you have this same kind of relationship with your migrant Pakistani clients?

Prompt: why/why not?

- Can you think of anything which might prevent you from having a good relationship with migrant Pakistani clients?
- Can you think of anything which might help build a good relationship with migrant Pakistani clients?

Appendix Eleven: Scientific Review Approval Letter from Cardiff University's
Research Review and Ethics Screening Committee

School of Health Care Sciences
Head of School and Dean Professor Sheila Hunt

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt



07 February 2014

Cardiff University
Ty Dewi Sant
Heath Park
Cardiff CF14 4XN

Tel Ffôn +44(0)29 20687552
E-mail E-bost harmerl@cf.ac.uk

Laura Goodwin
C/O School of Healthcare Sciences
Cardiff University

Prifysgol Caerdydd
Ty Dewi Sant
Mynydd Bychan
Caerdydd CF14 4XN

Dear Laura

The Midwife-Client Relationship; A Focus on Interactions with Migrant Pakistani Women Living in South Wales.

Thank you for submitting your proposal to the HCARE Research Review and Ethics Screening Committee for:

- scientific review;

The Committee has now had the opportunity to review your proposal, and is happy to approve your plans with no amendments.

Please remember that this Committee (RRESC) is not a research ethics committee (REC), and is therefore not able to give you a favourable ethics opinion. In the view of RRESC your proposal will now need to be submitted for approval to the HCARE REC.

The submission date for the next HCARE REC is 4.00pm on Wednesday 12 March and the research proposal form and accompanying documentation should be emailed to me at Healthcare-Research@cardiff.ac.uk. Details on the format of the research proposal can be found at <http://www.cardiff.ac.uk/sohcs/research/ethics/index.html> including the research proposal application form.

Good luck

Yours sincerely

Liz

Mrs Liz Harmer Griebel
Research, Commercial and Engagement Manager

Appendix Twelve: Letter Approving Sponsorship of the Research by Cardiff University

Research, Innovation and Enterprise Services
Director Geraint W Jones
Gwasanaethau Ymchwil, Arloesi a Menter
Cyfarwyddwr Geraint W Jones



20 February 2014

Professor Billie Hunter
School of Healthcare Sciences
Cardiff University
Room 416,
4th Floor,
Eastgate House,
35 - 43 Newport Road,
Cardiff, CF24 0AB

Cardiff University
7th Floor
30 - 36 Newport Road
Cardiff CF24 0DE
Wales UK
Tel Ffôn +44(0)29 2087 5834
Fax Ffacs +44(0)29 2087 4189
Prifysgol Caerdydd
Llawr 7
30 - 36 Heol Casnewydd
Caerdydd CF24 0DE
Cymru Y Deyrnas Unedig

Dear Professor Hunter,

Title: The Midwife-Client Relationship. A Focus on Migrant Pakistani Women Living in South Wales.

I understand that you are acting as Chief Investigator for the above PhD project to be conducted by Laura Goodwin.

I confirm that Cardiff University agrees in principle to act as Sponsor for the above project, as required by the Research Governance Framework for Health and Social Care.

Scientific Review

I can also confirm that Scientific Review has been obtained from School of Healthcare Sciences Research Review and Ethics.

Insurance

The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals

On completion of your IRAS form (for NHS REC and NHS R&D approvals), you will be required to obtain signature from the Sponsor ('Declaration by the Sponsor Representative').

Please then submit the project to the following [~~delete as appropriate~~] organisations/organisation for approval [~~delete as appropriate~~]:

- the appropriate Research Ethics Committee(s);
- National Institute for Social Care Health Research Permissions Coordinating Unit (NISCHR PCU- to arrange host organisation R&D approval);

Once Research, Innovation & Enterprise Services has received evidence of the above approvals, the University is considered to have accepted Sponsorship and your project may commence.

Roles and Responsibilities

As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the Research Governance Framework for Health and Social Care. In accordance with the University's Research Governance Framework, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfill her delegated roles including ensuring adequate supervision, support and training.



Registered Charity, 1136855 Elusen Gofrestredig

There are no research-specific tasks delegated to NHS Host Organisation staff: the NHS staff will solely act as research participants

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

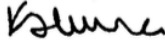
- ensure you are familiar with your responsibilities under the Research Governance Framework for Health and Social Care;
- undertake the study in accordance with Cardiff University's Research Governance Framework and the principles of Good Clinical Practice;
- ensure the Research complies with the Data Protection Act 1998;
- inform Research, Innovation & Enterprise Services of any amendments to the protocol or study design, including changes to start /end dates;
- co-operate with any audit inspection of the project files or any requests from Research, Innovation & Enterprise Services for further information.

You should quote the following unique reference number in any correspondence relating to sponsorship for the above project:

SPON 1302-14

This reference number should be quoted on all documentation associated with this project.

Yours sincerely



Dr K J Pittard Davies
Head of Research Governance and Contracts
Direct line: +44 (0) 29208 79274
Email: resgov@cardiff.ac.uk

Cc Laura Goodwin



Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East

HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7832
Facsimile: 0161 625 7299

07 March 2014

Miss Laura Goodwin
Postgraduate Research Student
Cardiff University
School of Health Care Sciences
7th Floor
Eastgate House
35-43 Newport Road
Cardiff
CF24 0AB

Dear Miss Goodwin

Study title:	The Midwife-Client Relationship; A Focus on Migrant Pakistani Women Living in South Wales
REC reference:	14/NW/0145
IRAS project ID:	120347

The Proportionate Review Sub-committee of the NRES Committee North West - Liverpool East reviewed the above application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Miss Helen Penistone, nrescommittee.northwest-liverpooleast@nhs.net.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

The Committee specified the following additional conditions:

- The Committee specified that there should be only one approach to potential participants and no follow up.
- Under the heading 'What are the possible benefits of taking part?' on page 2 of the Participant Information Sheet please add a sentence to clarify that there would be no direct benefits to participation.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with

before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter from Laura Goodwin		20 February 2014
REC application 120347/569348/1/742		25 February 2014
Protocol	1	19 February 2014
Participant Information Sheet: Clients	1	19 February 2014
Participant Information Sheet: Midwives	1	19 February 2014
Participant Consent Form	1	19 February 2014
Investigator CV: Laura Goodwin		
Investigator CV: Professor Billie Hunter		
Investigator CV: Dr Aled Jones		
Interview Schedules/Topic Guides: Group A	1	19 February 2014
Interview Schedules/Topic Guides: Group B at 36 weeks pregnancy	1	19 February 2014
Interview Schedules/Topic Guides: Group B at 6-12 weeks post-natal	1	19 February 2014
Interview Schedules/Topic Guides: Midwives	1	19 February 2014
Letter from Sponsor from Dr K J Pittard Davies		20 February 2014
Other: [REDACTED] approval email		13 February 2014
Referees or other scientific critique report: HCARE Research Review & Ethics Screening Committee approval		07 February 2014

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

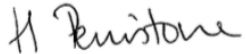
14/NW/0145

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



**On behalf of
Professor Neil Pender
Vice-Chair**

Email: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: List of names and professions of members who took part in the review
"After ethical review – guidance for researchers"

Copy to: Helen Falconer,
Cardiff University

Appendix Fourteen: Final Approval Letter from NHS Research Ethics Committee



NRES Committee North West - Liverpool East

HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7832
Facsimile: 0161 625 7299

14 March 2014

Miss Laura Goodwin
Postgraduate Research Student
Cardiff University
School of Health Care Sciences
7th Floor
Eastgate House
35-43 Newport Road
Cardiff
CF24 0AB

Dear Miss Goodwin

Study title: The Midwife-Client Relationship; A Focus on Migrant
Pakistani Women Living in South Wales
REC reference: 14/NW/0145
IRAS project ID: 120347

Thank you for your email of 10 March 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 07 March 2014

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter from Laura Goodwin		10 March 2014
Participant Information Sheet: Client	2	07 March 2014
Participant Information Sheet: Midwives	1	19 February 2014
Protocol	2	07 March 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

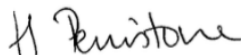
<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter from Laura Goodwin		20 February 2014
REC application 120347/569348/1/742		25 February 2014

Participant Consent Form	1	19 February 2014
Investigator CV: Laura Goodwin		
Investigator CV: Professor Billie Hunter		
Investigator CV: Dr Aled Jones		
Interview Schedules/Topic Guides: Group A	1	19 February 2014
Interview Schedules/Topic Guides: Group B at 36 weeks pregnancy	1	19 February 2014
Interview Schedules/Topic Guides: Group B at 6-12 weeks post-natal	1	19 February 2014
Interview Schedules/Topic Guides: Midwives	1	19 February 2014
Letter from Sponsor from Dr K J Pittard Davies		20 February 2014
Other: [REDACTED] approval email		13 February 2014
Referees or other scientific critique report: HCARE Research Review & Ethics Screening Committee approval		07 February 2014
Covering Letter from Laura Goodwin		10 March 2014
Protocol	2	07 March 2014
Participant Information Sheet: Client	2	07 March 2014
Participant Information Sheet: Midwives	1	19 February 2014

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/NW/0145	Please quote this number on all correspondence
-------------------	---

Yours sincerely



Miss Helen Penistone
REC Manager

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Copy to: Helen Falconer,
Cardiff University



Appendix Fifteen: Approval Letter from Local Health Board's Research and Development Office

04 August 2014

Ms Laura Goodwin
School of Healthcare Sciences
Cardiff University
7th floor
Eastgate House
Newport Road
Cardiff

Dear Ms Goodwin

Ref and Study Title : 14/CLC/5875 : The Midwife - Client Relationship: A Focus On Migrant Pakistani Women Living In South Wales

IRAS Project ID: 120347

The above project was forwarded to [REDACTED] R&D Office by the NISCHR Permissions Coordinating Unit. A Governance Review has now been completed on the project.

Documents approved for use in this study are:

Document	Version	Date
NHS R&D Form	3.5	Received 02/04/14
SSI Form	3.5	Received 02/04/14
Protocol	2.0	07/03/14
Participant Information Sheet: Clients	3.0	01/05/14
Participant Information Sheet: Midwives	2.0	01/05/14
Topic Guides: Group A first midwife appointment	1.0	19/02/14
Topic Guide: Group B 36 weeks pregnant	1.0	19/02/14
Topic Guide: Group B 6-12 weeks postnatal	1.0	19/02/14
Participant Consent Form	1.0	19/02/14

I am pleased to inform you that [REDACTED] has no objection to your proposal and that this study has been classed as pathway-to-portfolio. You have informed us that Cardiff University is willing to act as Sponsor under the Research Governance Framework for Health and Social Care.

Please accept this letter as confirmation of permission for the project to begin within [REDACTED]

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

- Inform the R&D Office if this project has not opened within 12 months of the date of this letter. Failure to do so may invalidate R&D approval.
- Inform [REDACTED] R&D Office if any external or additional funding is awarded for this project in the future
- Submit any substantial amendments relating to the study to NISCHR PCU in order that they can be reviewed and approved prior to implementation
- Ensure NISCHR PCU is notified of the study's closure
- Ensure that the study is conducted in accordance with all relevant policies, procedures and legislation
- Provide information on the project to [REDACTED] R&D Office as requested from time to time, to include participant recruitment figures

Yours sincerely,

[REDACTED]

CC R&D Lead [REDACTED]

Sponsor: Chris Shaw, Research Innovation Enterprise Services, Cardiff University

Professor Billie Hunter, College of Biomedical Life Sciences, Cardiff University

Dr Aled Jones, College of Biomedical Life Sciences, Cardiff University

Appendix Sixteen: Contact Detail Form for Expressing Interest in Participation

Researcher: Laura Goodwin

REC Reference number: 14/NW/0145



INTEREST IN PARTICIPATING

Name

Address

Telephone Number

Email Address

Language preferred

English

Pashto

Punjabi

Urdu

Best way to contact you

Address

Telephone

Email



CONSENT FORM

Project title: The Midwife-Client Relationship

Researcher: Laura Goodwin

REC Reference number: 14/NW/0145

Please read the study information sheet, then complete this form and return to the contact listed on your information sheet.

Please initial

- 1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- 2) I understand that my participation in this project will involve taking part in observations and digitally-recorded interviews. ☐
- 3) I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason. ☐
- 4) I understand that I am free to ask any questions at any time. I am free to withdraw or discuss my concerns with Laura Goodwin or Professor Billie Hunter. ☐
- 5) I understand that the information provided by me will be held totally anonymously, so that it is impossible to trace this information back to me individually. I understand that this information may be retained for a period of at least 15 years. ☐
- 6) I understand that the information I have submitted will be published as a report and that I can be sent a copy on request. ☐
- 7) I understand that at the end of the study I will be given an opportunity to express and discuss any concerns or questions I might have about the research. ☐

Name of Participant

Date

Signature

Name of Person

Date

Signature

taking consent.