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## Ethnicity and Reproduction

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## ETHNICITY & REPRODUCTION

*Sarah Earle and Sarah Church*

### Sociological definitions of ethnicity

It is useful to begin by defining what we mean by the term 'ethnicity', which Sookhoo (2003: 79) describes as 'a complex and multi-dimensional concept'. However, you will also no doubt be familiar with the concept of 'race' and, indeed, these are often used interchangeably. The term 'race' usually refers to genetic or physical variations between different groups - skin colour is a good example of this type of variation. However, sociologists prefer to use the term 'ethnicity'; many believe that the concept of 'race' carries the subtext of biological determinism, serving to reify racism and racist practices (Braun 2002).

The concept of 'ethnicity' recognises the socially constructed nature of 'difference' between social groups but there are some different definitions. Sookhoo (2003: 29), for example, states that:

Ethnicity is generally taken to mean 'shared origins' in terms of geographical regions, shared and distinct culture and traditions that are maintained over generations, and common language or religion, which all give a person a distinct sense of identity and group affiliation.

Sociologists usually agree that ethnicity refers to a common ancestry, a particular geographical territory, and to those who share a language, religion and social customs; these might include diet, name and nationality (Fenton 1999). Defining ethnicity is complex and there is no universally agreed classification. However, the most recently recommended classification for ethnic identification can be seen below (Figure 1).

### INSERT FIGURE 1

When thinking about ethnicity within practice, it is important to recognise that minority ethnic groups are not homogenous. There is a great deal of heterogeneity, including differences of socio-economic status, occupation, age, sexuality, and so on. Pfeffer (2002) has argued that the term 'ethnic' is usually only used when referring to those in *minority* ethnic groups, rather than to the 'White' majority. However, it is important to recognise that the term 'White' is unhelpful as it can conceal important differences between groups with diverse healthcare needs.

## ETHNICITY AND MATERNITY CARE

### Inequalities in health

In spite of the difficulty of defining ethnicity and measuring differences between ethnic groups, research studies consistently demonstrate wide-ranging inequalities in health. There is evidence of both increased perinatal morbidity and mortality amongst women from minority ethnic groups in comparison to other groups (Department of Health 1998; Maternal and Child Health Research Consortium 1998; RCOG 2001). It is unclear why such inequalities in health persist, but they are likely to be attributable to a number of interrelated factors such as lifestyle choices and health seeking behaviours, as well as the quality of service provision. It is also worth recognising that ethnicity, as a variable in reproductive data, usually hides the issue of poverty, which also contributes to inequality.

The *Independent Inquiry into Inequalities in Health* (Acheson 1998) has highlighted the significance of pregnancy, childbearing and infancy in the battle against social exclusion and The Royal College of Midwives (2000) has set out recommendations with a view to challenging racism within the maternity service. (see Figure 2)

### INSERT FIGURE 2

### Stereotypes and cultural misconceptions

Even when attempting to practise in a culturally sensitive manner, it is easy to stereotype individuals and to make false assumptions about their needs. Hunt and Richens (1999) suggest that health professionals sometimes hold strong stereotypical views about women from minority ethnic groups, which may affect both the way in which women's needs are perceived and the care they receive.

Bowler's (1993) now classic study, for example, describes the way in which midwives on labour ward perceive all 'Asian' women as 'non-compliant' and to be making a 'fuss about nothing' when complaining about pain. Richens (2002: 30) explores this further in relation to postnatal care:

As a midwife, I have sadly seen various situations where women did not receive the care they needed. Instead, they received care based on common stereotypes and quite often myths of Asian women . . . More recently I have heard of an anecdote surrounding 'plenty pain syndrome'. This is apparently a term used to describe Asian women when on the postnatal wards, who reply 'plenty pain' when asked on the drugs round if they require pain relief.

Often because the Asian woman's response was not specific and they referred to 'plenty pain' rather than an exact indication of where pain was felt, more often than not the drugs trolley would remain firmly closed . . .

Stereotyping can have a negative influence on the quality of care through a reduction of access to services. If, for instance, we take the issue of birth partners it is important to recognise that although the extended family is an important feature of some cultures, it should not be presumed that all women within minority groups are well supported. In their study of the childbirth experiences of Pakistani and white women, Bowes and Domokos (2003) report that the issue of support was important for most women; women were expected to be accompanied in labour. However, regardless of ethnicity, some women experienced labour all alone. One Pakistani woman reported that: 'From one o'clock to six o'clock, I was only on my own and I was crying. Nobody was there - nobody even looked at me' (Bowes and Domokos 2003: 98).

Women should not be stereotyped in such a way that the care offered to them is limited and their options restricted without negotiation or discussion. Bentham (2003:75) suggests:

...all midwives could think more about the care they offer, generate understanding and communicate more effectively with the women. This would help midwives challenge assumptions, challenge the culture of dominance and offer positive experiences, especially for those who may be missing their own mothers and female relatives who would normally be present at the birth.

Women should receive care which meets their needs, and respects and acknowledges them as individuals, irrespective of their ethnicity. Richens (2003: 16) states that 'women want good competent care.' However, despite the emphasis within *Changing Childbirth* (DOH 1993) on choice, continuity and control for *all* women, individuals from different ethnic groups report that their choices are limited when compared to white educated women (Neile 1997).

### **Ethnicity and cultural values**

The issue of prenatal screening is of considerable relevance to our understanding of ethnicity and culture. However, it should not be assumed that some women will refuse screening and genetic counselling due to their religious beliefs or that requests for screening will lead to selective abortion and 'femicide'. Whilst consanguinity for example, is common in Muslim families from south Asian and Arab regions, Gatrad and Sheikh (2000: 68) suggest that:

Using religious beliefs and cultural practices in a 'recipe book' manner can sometimes be used as a shield to avoid difficult and painful discussions. The assumption that since Islamic belief discourages abortion, Muslim parents should not be given the choice of abortion is unfair. Rather, this background information should be used as a backdrop against which to explore the wishes of the *individual couple* concerned. Whatever is eventually decided, parents have a right to be supported in their final decision, even if this goes against professional or religious opinion.

Despite that fact that there is an understanding that all pregnant women will request screening blood tests and undergo ultrasound screening in order to confirm fetal normality, in practice, the issue of pre-test counselling is one which has often been described as an inadequate service supported by insufficient resources (Green 1994).

Women need information and support in order to be aware of their options and to assist them in making decisions which are in keeping with their own personal beliefs and value systems. Midwives need to become aware of their own cultural beliefs and assumptions in order to become 'culturally competent' within a multicultural society.

#### **Language, culture and consent**

Power and privilege are mediated and perpetuated through language (Crawford 2001) and it is argued that language plays an important role 'in constructing social realities, delivering discourses, and representing particular ideologies' (Pugh and Jones 1999: 530). Sookhoo (2003: 87) argues:

Effective communication and an understanding of the expectations and practices of women from diverse sociocultural and religious backgrounds influence the degree of advocacy and empowerment that may be achieved . . . when caring for women the midwife shows a level of cultural competence that builds on her role in advocacy and empowerment.

English is the most commonly spoken language in Britain but minority language use is extensive and probably underestimated. An interpreter or 'cultural broker' (Schott and Henley 1996) can influence the provision of choice and control offered to women whose first language is not English. The use of relatives as interpreters is not considered good practice, a view which is driven by both cultural and gendered concerns. However, in reality, relatives are often used since the availability of adequately trained medical interpreters within the NHS is limited. Pugh and Jones (1999) go further and argue that

mistaken assumptions are often made about minority languages and that minority language issues are often oversimplified in practice. An example of this was noted by the Royal College of Nursing (cited in Holland & Hogg 2001) who identify some of the difficulties encountered when using translators:

- inaccurate translation of important concepts and ideas;
- bias and distortion;
- lack of confidentiality.

The role of the midwife in enabling appropriate, confidential and timely communication, is therefore paramount to good practice for women who cannot communicate successfully in English.

#### **Conclusion: Implications for midwives in practice**

Britain is a culturally diverse society and is becoming increasingly so. Recent figures suggest that the minority ethnic population includes 4.6 million people, or nearly 8 per cent of the population (ONS, 2002). Global change and recent changes to membership of the European Community have increased the numbers of refugees, asylum seekers and economic migrants and pose challenges to the appropriate delivery of maternity services within Britain. The following checklist can be used to reflect on how best you can support women from all 'ethnic' backgrounds:

1. Effective communication skills can be used to ascertain knowledge of cultural and religious beliefs and practices, which may influence the provision of maternity care and the role of the midwife.
2. It is important to remember that all women should be treated with dignity and respect regardless of whether their choices and beliefs coincide with your own.
3. An awareness of racism, the identification of discriminatory practices and a willingness to change is vital.
4. Midwives should strive to improve the care provided to all women particularly for those groups with higher rates of perinatal mortality and morbidity.
5. Recognition that individuals from some ethnic groups may also experience other forms of social exclusion such as poverty and unemployment.

### Useful further reading

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**Figure 1: Classification of Ethnic Groups in Britain**

**White**

British

Irish

Other White

**Mixed**

White and Black Caribbean

White and Black African

White and Asian

Other Mixed

**Asian or Asian British**

Indian

Pakistani

Bangladeshi

Other Asian

**Black or Black British**

Black Caribbean

Black African

Other Black

**Chinese or Other ethnic group**

Chinese

Other ethnic group

Source: ONS 2002.

**Figure 2: Tackling Racism - RCM Guidelines**

- Review policies, practices and procedures to ensure they are not making services inaccessible, unattractive or alienating.
- Develop policies and strategies to ensure equal access to services and, where found, action against racial harassment and discrimination.
- Secure staff commitment and effectiveness through education and training.

- Build an understanding of the local community and its needs through health profiling and community participation.
- Monitor how women from different ethnic groups access and use maternity services as a key to service improvement
- Develop clear service standards in consultation with service users minority ethnic communities.

Source: RCM 2000.