# An exploration of the experience of midwifery care by women asylum seekers and refugees.

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## Acknowledgements:

Dedication

I would like to dedicate this work to my father who is now 85 years of age. His experience as an escaped prisoner of war in 1939 and 1940 lead him to spend months of his young life (19) as a refugee fleeing from the enemy. The care and sustenance he received from the Italian farmers kept him alive and able to go on and have a family.

Because of the ability of my father to survive extreme circumstances I believe almost anything is achievable. Just as my father persevered and survived I would like to encourage women asylum seekers and refugees who are in need of midwifery care not to lose hope. I want them to be aware that although they feel frightened and alone at times there are a group of people who would like to help, care and support them through a major life altering event. This group, just as the Italian farmers supported my father, will also support them, they are their midwives.

# Contents

## Abstract

**Background**: There were approximately 63,097 known asylum seekers in England in 2002 (Heath *et al.* 2003). Women asylum seekers may be more seriously affected by displacement than men, leading to increased isolation, poverty, hostility and racism (Burnett and Peel, 2001a). In England, Black African including asylum seekers and newly arrived refugees had a seven times greater chance of maternal mortality than White women (CEMACH, 2004 p244). Furthermore, women from ethnic groups other than white are twice as likely to die as women in the white group. In the CEMACH report a large number of women who died spoke little English. Access to local information about asylum seekers and refugees was difficult to obtain and suggested a disorganised service provision for this group of women.

**Aim**: It was the intention of this study to explore and synthesise the experience of midwifery care by women asylum seekers and refugees in one large maternity unit in England.

**Design**: Longitudinal exploratory case study research utilising a series of interviews.

**Sample**: Four women from: Afghanistan, Rwanda, Somalia and Zaire. Three women were asylum seekers and one was a refugee. One woman spoke fluent English.

**Setting**: Liverpool Women's Hospital and the women's homes.

**Years**: The study took place from December 2002 – July 2003.

**Methodology**: The research was developed from a constructionist paradigm which identifies that multiple realities can exist for individuals who experience

a similar phenomenon. Truth within this perspective is constructed by the individual. The researcher (LB) was the main instrument of data collection. Interpretation was generated via the researcher and was verified by the women at the final interview. The underpinning foundation for this study emerged as symbolic interaction theory (Mead, cited in Morris, 1967 p43; Blumer, 1969).

**Methods:** Following ethical approval consent was obtained with the help of professional interpreters. Exploration was facilitated by in-depth interviews at five time points throughout the antenatal and postnatal period. Photographs taken by the women themselves were used as a prompt for conversation.

**Analysis:** The researcher's interpretation of the data  identified emerging themes and categories. The process of analysis involved decontextualisation, display, data complication and re-conceptualisation (Miles and Huberman, 1994 p10). Three key themes were generated: the influence of social policy, understanding in practice and the perception of 'self'.

**Results:** Synthesis of the results suggested that social policy directly affected the lives of the women. At times, "taken for granted" communication created a barrier to understanding for the women. Stereotype was socially constructed and pervaded the care environment. The women perceived 'self' as a response to social interaction. The midwife-woman relationship relied heavily on gestures and symbols and the women's descriptions are related to symbolic interaction theory.  Midwives capable of understanding the subtle cues in communication may be able to negotiate negative stereotypical images generated by society. Women had little or no information around childbirth.

**Recommendations:** Midwifery care would benefit from a deeper understanding of how the women in this study perceived 'self'. An advisory post may provide the link between maternity care and broader public health issues. Midwives should engage with asylum seekers and refugees to develop partnerships in care. A collaborative partnership may assist in creating relevant information around childbirth for other asylum seekers and refugees. Innovative methods of dissemination of information related to childbirth should be facilitated by a collaborative approach with non-governmental and community organisations.

**Glossary**

**Asylum seeker:** Is a person who has submitted an application for protection under the Geneva Convention. They are waiting for the claim to be decided by the Home Office but they have not been accepted in the UK as a resident (United Nations, 1951).

**NASS: The** National Asylum Support Service is a government department in the UK which delivers welfare support for asylum seekers.

**Refugee status:** This person has been through the asylum seeker process and has been accepted by the Home Office as a refugee under the Geneva Convention (United Nations, 1951) and granted either:

**Indefinite Leave to Remain** (ILR) –Permanent residence in the UK.

**Family reunion:** - Granted to one spouse and any child related to a person who is granted refugee status. The children of that marriage should be under the age of 18. They are given Indefinite Leave to Remain (ILR) - permanent residence in the UK.

**Exceptional Leave to Enter or Remain** (ELE or ELR) ELR grants the right to stay in the UK for 4 years. The woman is expected to return if the home country situation improves.

**Refusal:** The person's application for refugee status is rejected but she has a right of appeal, within strict time limits.

# Chapter 1:        Background

## 1:1 Introduction

This thesis provides an in depth exploration of the experience of midwifery care by three asylum seekers and one refugee during 2002 and 2003 in Liverpool. The reason for trying to understand more about this topic of interest emerged from my clinical experiences as a midwife. Alongside my midwifery experience I have brought to this research my life experience, which has emerged from being a white, employed, educated woman who speaks English only. In addition to who I am I have grown with the knowledge that my father was a refugee for a short while during world war two. My experiences have increased my awareness of how important the support, care, empathy and ability to appreciate goodness in any individual may affect one person for the rest of their lives.

Because of my life experiences I believe I have a raised awareness of the importance of empathy towards women who have been displaced. I acknowledge that my feelings, values and beliefs have affected the way that I perceived the issues raised within this study. This perception has led to the design of this case study research. I have socially reconstructed and interpreted the experiences of these women with the aim of providing a deeper understanding. I can only hope this intent may have been achieved.

I believe that society has socially constructed a group of women to be either asylum seekers or refugees. Homogenising people in this way stems from an attitude which underpins much of our life today. Imposed categorisation has positioned these women outside of those who are not asylum seekers or refugees. However, all of these women are individuals with separate stories to tell and are not homogeneous. I do not believe that this categorisation is representative of all women who society defines as an asylum seeker and refugee. Seeing these women from a homogenous perspective will gloss over many differences. This perspective does not describe who and what these women are about. Therefore, I have decided to link the socially constructed categories of asylum seeker or refugees into the lives of the four individual women's lives in order to contextualise their stories in today's society and make sense of the findings. Even so, this is an uncomfortable position for me to accept and I still have difficulty in grouping the women in this way.

In conceptualising the women's stories I comment on society at times and culture on other occasions. Culture within this study is in relation to the use of symbols which contribute to every day life. This includes attitudes, manners, dress codes, language, rituals, norms of behaviour and systems of beliefs (Jary and Jary, 1995). Culture is socially created and this creation involves how people interact and react to each other on a daily basis. Culture, then, may alter meanings by the norms created within that culture. Culture is affected by history, economic and political influences and changes, and evolves constantly. I believe that people can not live outside of culture and that things we take for granted, such as age and gender, are affected by the

cultural construct given and how they are symbolically represented within society. The cultural construction, then, affects the type of symbols used and the way people choose to use them within interactions. I believe that the theory of symbolic interaction (Mead, cited in Meltzer *et al.* 1975 p45; Blumer, 1969) is a useful approach to understanding the construction of culture and that the impressions of self and others emerge from this position.

Society, within this study, is defined as a smaller aspect of western culture where governmental policy, information technology and mass media all play a part in affecting how a cohesive group of people lives together. The influences of society may directly affect the lives of individuals. Understanding the meaning that society has upon individual lives will help us to understand how society works microscopically. Therefore, to understand society, researchers should enter the social worlds of individuals, where reconstruction will contribute to the generation of understanding (Crotty, 2003).

In considering the depth and importance of the women and their lives I have attempted to reconstruct their meanings to provide a deeper understanding. Achieving depth of understanding has involved engaging in the process of research in a way that would ensure transparency. Understanding the data was at times messy and the reading of the women's words were revisited constantly. Spontaneous events sometimes occurred, such as an unplanned meeting with one woman who spoke fluent English. This event was captured with field notes and was incorporated into the data analysis. The research process involved respecting and protecting the vulnerability of these women,

gaining ethical approval and applying the principles of goodness (Guba, 1990) to guide credibility, validity and relevance about the study. The analysis has identified a possible way forward.

## 1: 2    Structure of the Thesis

This study used an in-depth longitudinal case study design (Stake, 1995) and is presented in a format relevant for submission for a Master of Philosophy. Chapter one describes the approach taken for this thesis.

Chapter two describes how literature was accessed and presents relevant evidence around the topic of asylum seekers and refugees, starting with an international perspective. The chapter identified the national policy for asylum seekers and refugees and how they are supported. The sections on national maternity systems present how women access care and are cared for in the UK in general. The chapter expands on existing evidence about women asylum seekers and refugees and will help to contextualise the study of how women in the UK may be living today. Literature accessed for the background is summarised and a justification for this particular study is given.

Chapter three describes the methodology and philosophical framework that underpinned the study that led to a deeper understanding of the theory of symbolic interaction which emerged from the data. The aims and objectives of this research are stated.

Chapter four presents the many ethical considerations for the study. Chapter five contains a description of the methodological considerations and relates to the method, sample, setting, study design, data collection and data analysis.

The results of the thesis are presented within chapter six where there is an introduction to the women and their stories. The description of the women leads onto the key themes generated from the data, namely; the influence of social policy (chapter seven), understanding in practice (chapter eight), and perception of 'self' (chapter nine). Within each of the themed chapters there is a discussion of the findings. The results section provides a final conclusion and summarises the previous three themes.

Chapter seven examines how social policy influences the lives of asylum seekers and refugees. Policy is related to dispersement, housing, integration, ill health and coping. Chapter eight discusses the theme of understanding in practice. Interpretation of the women's words suggested that taken for granted communication, access to information, and building relationships were categories of importance to them. In chapter nine the women's perception of 'self' is related to their personal shifting identities, their role in society, and the relationship between professional power. The conclusion to this chapter is followed by the final conclusion of the results section which draws all themes together.

A description of the limitations of the study is presented in chapter ten followed by a discussion about the thesis as a whole in chapter eleven. This

chapter aims to pull the thesis together in a cohesive manner. Chapter twelve synthesises and engages theoretical considerations of how undertaking this study has affected my perspective on this topic and describes my personal journey over the past three years. This chapter identifies my feelings of discomfort during the study and looks at theory generation.

Recommendations for practice are suggested in chapter thirteen followed by implications for future research which are discussed in chapter fourteen.

A reference list is provided and appendices include examples of data generation and data display. Copies of national and international presentations together with a conference proceeding are contained in this section.

# Chapter 2: Literature Review

## 2:1 Introduction to literature review

The aim of this chapter is to describe and summarise the method of searching literature accessed about asylum seekers and refugees. International, national and local information will be presented. Evidence surrounding asylum seekers and refugees in the United Kingdom (UK) will be included. A picture of the national and local maternity system will be drawn and related to the mortality and health of asylum seekers and refugees. Issues related to communication will be discussed. The effect that policy and the media may have for asylum seekers and refugees will be considered.

## 2:2 Search techniques

Literature was accessed by searching electronic databases inclusive of Cochrane, Academic Search Elite, Dialogue Data Star, Biomed, CINAHL, PsycInfo, PubMed, Medline and NELH. Search terms included phrases such as asylum, asylum seekers, women asylum seekers, refugees, refugees and women, childbirth, refugees and asylum seekers. In addition, perspectives and theory from established texts have been incorporated. Statistical information from international, national and local databases has been included to give an epidemiological assessment of migration and asylum seeking. Grey literature from newspapers and relevant web sites that focus on current events have been reviewed in order to contextualise a broader picture.

## 2:3    International perspectives

It was during the 1990's that receiving governments started to refer to people as asylum seekers (Stalker, 2001). However, categorising and grouping people into asylum seeker or refugee sends signals that the group are one homogeneous cluster. Those entering the country and wishing to claim asylum are not from one religious, social, economic or ethnic background. They are men, women and children who are from a range of ethnicities and faiths. Even within their country of origin there may be differing fundamental beliefs and values. The economic backgrounds of individuals also vary widely and many may be professional people who have the financial means and contacts to escape their countries (Refugee Action, 2005). For the purpose of consistency within the literature review the term asylum seeker and refugee will be related to existing evidence, whilst being mindful that those who are grouped as such may differ considerably.

Asylum seeking and becoming a refugee in today's society is complex and affected by many external influences such as governmental policy, society, culture, mass media representation and individual responses. A description of the international context may help to contextualise the social picture and place the phenomena in today's setting.

Historically, migration and displacement has occurred due to war and natural disaster. During the last century, population changes have become more common and were attributed to technological innovations during the industrial revolution (1750-1914). These changes provided people with better means of

transport which assisted them to travel longer distances. The ability to travel further may have contributed to seventeen million people in 1856 leaving Europe for North America (Stalker, 2001).

More recently, during and after the two world wars (1914-1945) the UK recruited soldiers from its colonies from the West Indies to meet the labour shortage in transport and the National Health Service (NHS) (Stalker, 2001). Nationalism during the world wars drove people to migrate towards their country of birth and those who appeared not to belong to a specific country of their own became unwanted and rejected in many places.

World trade and politics became increasingly influential in the lives of ordinary people. Economic growth in the 1960's caused a labour shortage in the Western-European countries that attracted 'guest-workers', which some governments actively advertised for. When economic recession hit 'guest-workers' could either return home or stay in the Western country they were occupying and send for their families.

In 2003 the UK embraced a European Union agreement (EU) (European Community, 2002) that permitted the movement of residents of the member states to move freely and live and work in another country. The actual number of people who migrated from the UK to the European Union in 2002 was 125,000. Less people from the EU (89,000) chose to migrate into the UK (National Statistics, 2005).

People leave their country of origin at short notice in times of war and persecution. They will leave their family and friends and everything that they hold as important to them. They may need to pay 'smugglers' to obtain false documents especially if they are escaping political persecution. In times of natural disaster documentation may have been destroyed or there may be no documentation at all. Smugglers demand large sums of money and for some, seeking safety in the UK has meant they paid with their lives (Watts, 2002; Murphy and Slater, 2003; Bowcott, 2004).

Population flows suggest that most asylum seekers and refugees migrate to their neighbouring countries which have scarce resources to provide for their needs. For example, The United Nations estimated that in 2002 Iran hosted 1.9 million refugees and Pakistan hosted 2 million (Home Office, 2002a). However, there are variations to the way that statistics are calculated in each country. This variation results in gaps in information about unaccounted for individuals and statistics often lead to some confusion around the topic of asylum.

Confusion arises because of the disruption caused by war and natural disaster and the subsequent governmental disorganisation which may follow. When such events occur there is fluidity of population movement which can not be assessed. Further statistical confusion occurs because migrants may choose to slip from one statistical category to another according to opportunity. For example, migrants in the 1960s crossed borders as migrant workers and

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not asylum seekers. However, migrants who have jobs to come to are now rarer and therefore may try and gain access into the UK by claiming asylum.

An added problem is governmental classification of who is an immigrant. For example Sweden excludes Asylum Seekers from its data on inflows and outflows whereas Germany includes them (Stalker, 2001). Changing category from migrant worker to asylum seeker may account for the increase in the number of asylum applications from less than 22,370 in 1993 applications to over 71,365 in 2001 (National Statistics, 2002). More recently, this figure has fallen (49,450) and the fall may be attributed to the UK embracing EU regulations in 2003.

Asylum seeking forms a small part of a large international migration picture. Unexpected influxes of people may predispose countries to tighten their migratory regulations. In the UK influxes occurred in the 1970's (30, 000 Ugandan Asians), the 1980's (The Vietnamese boat people) and more recently in Kosovo. The downward trend in migrating numbers has been attributed to tighter border controls due to restrictive asylum policies (Craig. *et al.* 2004). Another explanation for this trend in the UK is the permitted movement of residents of the member states of the EU (European Community, 2002).

Restrictions and policies of determent produce a negative climate for those seeking asylum to live in. Subsequently, societies react with increased negative media representation (Oxfam, cited in Donnellan, 2002 p10) and racist violence against religious and ethnic minorities in host countries (Craig

*et al.* 2004). Racism is a growing trend and democratic countries are witnessing an increase in chauvinistic parties, such as the Font Nationale (France), the People's Party (Denmark) and the National Front (UK) (Craig, *et al.* 2004). A political response which supports alienation may explain increased racist violence in society in general (Macpherson, 1999; Casciani, 2002; Doward, 2005).

Racist violence adds to asylum seekers and refugees political marginalization, possible exploitation and personal danger. A pattern has emerged which indicates that international migration may have two possible outcomes; a negative response, which leans towards xenophobia, or a positive response, which embraces innovation revitalisation and tolerance (Craig *et al.* 2004).


## 2:4    National Policies

Political conflicts all over the world have caused the population of refugees to grow from 5 million in 1970, 13 million 1996, and to 20 million in 2001 (Refugee Council, cited in Donnellan, 2002 p6). In 1992 there was a rapid growth in asylum claims in the UK from 32, 000 in 1992 to 111,000 in 2001 (Craig *et al.* 2004). Even though there may be a popular view that the UK accepts more than a fair share of asylum applications the number is small compared to total population figures.

In 2003 the total UK population was  59.6 million of which 0.08 per cent (49,450) had applied for asylum. Of this 0.08 per cent a small number of applications were granted asylum (4,265) or granted leave to stay due to Humanitarian Protection (HP) or Discretionary Leave to remain (DL) (7,535)

(National Statistics, 2004). The difference in applications being made and accepted would indicate that there are political distinctions made between genuine refugees seeking asylum and those who are bogus.

Governmental statistics need to be viewed with caution and may be inaccurate (Audit Commission 1999, Burnett and Peel 2001a). For example, of the UK's population 7.9 per cent are from an ethnic minority group which includes both UK and foreign born people (National Statistics, 2005). Being foreign born may be determined from the lead male of a family which skews the statistics related to women.

Statistics which show an increased trend for asylum applications may have been the catalyst for wide spread policy changes and hostile media coverage. When the British government began to control immigration from the Commonwealth in 1962 and 1971 by passing the Immigration Act there was a suggestion that the imposed controls addressed a governmental realistic approach to immigration (Holmes, 1991).

Governmental controls and the process for seeking asylum within the UK today has been described as restrictive (Silove, Steel and Watters, 2000). Some difficulties emerge around the process such as asylum seekers being interviewed as soon as they arrive without legal representation and being given a nineteen page Statement of Evidence Form (SEF) to complete in English.

## 2:5    Asylum support in the UK

The Asylum and Immigration Act (Home Office, 1996) separated asylum-seeker support from Social Security by withdrawing income support. Previous to this, asylum seekers were able to claim benefits to the same level as UK citizens. After 1996 asylum seekers could apply for support at the port of entry, 'port applicant' or following entry to the UK 'in-country applicant'. Due to a backlog of applications being processed those who arrived before 2000 remained entitled to claim welfare benefits, this was discriminatory and directly affected those who applied after 2000.

The system of funding placed pressure on local authorities in London and in the South West of England and in 1999 local authorities were given separate powers and funding to support asylum seekers. Whilst the Home Office created a new department (National Asylum Support Service) the government decided to support asylum seekers with a voucher system and accommodation was provided by dispersal throughout the country.

When asylum seekers arrive in England immigration officers will record their personal details at an airport or port or 'in country' at one of two Asylum Screening Units (ASUs), based in Liverpool and Croydon. The Immigration Service will take an asylum seeker's photograph and fingerprints. They issue the applicant with an Asylum Registration Card which is an identity card that must be carried at all times.

When a couple applies for asylum there is usually one application made in the man's name. Unaccompanied children will make their own application. An asylum seeker may be detained if an immigration officer believes that he/ she will abscond. If detained, asylum seekers are held in Oakington Reception Centre in Cambridgeshire for approximately ten days while their application is fast-tracked. More than 6,500 asylum seekers were processed at Oakington in 2004 (Refugee Action, 2005). If the application is refused at this point when the person has not received the status of asylum seeker they have no chance of appeal. Status to remain has been known to take between six months and five years before the courts decide on the outcome. Until then there is a possibility that the individual may be deported back to the country of origin. If after asylum status has been granted and their application for leave to stay has been refused they may appeal. If the application is refused a specialised immigration lawyer may be then made available to the individual (Burnett and Fassil, 2002).

However, if the appeal is refused they are asked to leave their accommodation and return to their country of origin. A rejected asylum seeker can apply for a special allowance known as 'hard case' support. They are entitled to this only on condition that they sign up to return voluntarily to their country of origin as soon as possible or if they can prove they are too ill to travel (Refugee Action, 2005). A person who does not attempt to return to their country is left destitute and often has to rely on friends, charities and faith groups for food and protection.

Those who have been refused entry into the UK are rejected asylum seekers and can be detained by the Home Office in a detention centre and forcibly removed from the UK. Between October and December 2004, 2,755 asylum seekers were forcibly removed from the UK (Home Office Statistics, 2004).

Under NASS when an asylum seeker applies for accommodation they may be placed in temporary, short term accommodation. This can be either an induction centre or 'emergency accommodation'. Emergency accommodation could be a hostel or house owned by private landlords or housing associations. These are maintained by councils or charities and paid for by the Home Office. Allocation of housing is on a no choice basis and they are not provided with council housing or entitled to housing benefit.

Alternatively, asylum seekers may apply for a 'subsistence only' package if they are able to stay with family or friends. The subsistence that is available to asylum seekers comes from NASS (National Asylum Support System) and they cannot claim mainstream income support. Currently, single asylum seekers aged over twenty five are entitled to £38.28, while single people under twenty five receive £30 weekly. An asylum seeker is presently entitled to £42 a week per child under sixteen. This is seventy per cent of what a UK citizen claiming income support would receive. A UK citizen over twenty five receives £55.65 and someone aged eighteen and twenty four receives £44.05 (Refugee Action, 2005). Pregnant women may receive a maternity grant of £300 and the application must be made between thirty six weeks and two

weeks after the birth. Asylum seekers are not permitted to work but are allowed to undertake voluntary work and attend subsidised courses at college, but not higher education. The children of asylum seekers are entitled to attend the local state school.

## 2:6    National maternity policy

The national maternity policy in the UK has frequently changed direction  in response to policy (Acheson, 1998; Department of Health, 1999a; 1999b; 1999c; 2003). After the Peel Report (1970) which pushed for one hundred per cent of women to be delivered in hospitals there has been a drive to promote choice and control for maternity care (Department of Health, 1993). Although the altered attitude in policy was much waited for there was still little emphasis on the individual woman. Furthermore, there was a lack of evidence about how ethnic minority women would achieve choice and control for their maternity care.

A suggested reason for the lack of evidence  about ethnic minority women has been attributed to language barriers, the need for third party interpretation, sensitising research questions, and being difficult to reach (Bloch, 1999; Im, *et al.* 2004).

In addition to the national maternity system having little information about the experiences of ethnic minority women, and even less about the need of asylum seekers and refugees, there is national variation in service delivery

(Foster, 2001; Hall, 2001; Lavender and Chapple, 2004). The way midwives work in relation to the role of the midwife in the UK has expanded in response to policy and incorporated a broader public health remit (Department of Health, 1999b; 1999c; 2003). However, there has been a lack of guidance about how the role should be incorporated into existing practices (Bennett, et al. 2001).

Support for the role of the midwife in public health led to policy which facilitated the development of Sure Start initiatives (Department of Health, 1999c). This perspective urged midwives to collaborate more with external organisations and the wider multidisciplinary team. The multidisciplinary team may consist of midwives working alongside consultant hospital based obstetricians, General Practioners (GP), Psychiatrists, Haematologists, Physiotherapists and Radiographers. This list is not exhaustive and is dynamic depending on the variety of situations women may be in. The wider team may involve non- governmental organisations such as Refugee Action and the National Childbirth Trust, for example.

Midwifery has historically been controlled by legislation to serve a growing obstetric agenda. Controlling midwifery in this way has encouraged a hierarchical and patriarchal culture to develop (Oakley, 1993). However, within policy, phrases which focus on women centeredness, empowerment and modernisation recognise that individuals matter (Department of Health, 1999b; 2003; 2004). Modernising the way maternity care is provided is high on the government agenda (Audit commission, 1997; Department of Health 1999a; 1999b; 2001a; 2004). This includes an intention to involve users. The

involvement of users has been stimulated by evidence which suggests that consumers are dissatisfied with information received during pregnancy (Singh and Newburn, 2000). However, this dissatisfaction is expressed by those who are fluent in English and form part of the majority population. Little attention and time has been given to the views of those who do not speak English and whose culture differs from the dominant one. To add to a lack of information, the provision of antenatal and postnatal care offered is often inflexible and includes conflicting advice (Audit commission, 1997). However, the survey that is the basis for this finding excluded those who are the most disadvantaged in society. Therefore, inflexible care and conflicting information may be exaggerated for those who are at a disadvantage.

## 2:7    Access to care

To access mainstream maternity care in the UK usually involves a process of referral from the GP. Therefore, the woman must first register with a GP. The GP then refers to the leading carer, who is usually an obstetrician. At a similar time the referral is sent to the midwifery service. Maternity care for ethnic minority women is difficult to access (Sandall et al. 2001a) and is an issue which continues for women asylum seekers (McLeish, 2002). However, when midwifery care is targeted to women from ethnic minorities in deprived areas their experience of pregnancy and birth can be improved dramatically (Sandall, Davies and Warwick, 2001b). Sandall's evaluation (2001b) demonstrated that even though the case load for the Albany Practice was weighted in favour of Black African or Caribbean women (45% compared to 42% Caucasian),

Albany women were more likely to seek their midwife when first pregnant and have a home birth.

Women may choose to be cared for independently of the mainstream system and this involves the woman approaching an independent obstetrician or midwife for maternity care. This pathway for referral makes negotiating the pattern of access difficult for those who are newly arrived into the UK. Especially if the woman is unaware that she must register with a GP initially.

Proposed recommendations will mean that all low risk women being referred directly to a midwife as lead carer (Department of Health, 2004). The impact of this proposal may prove difficult to measure due to the regional variations in services within the UK.

## 2:8    Pregnancy and asylum seekers and refugees

Social exclusion exists for many in society (Social Exclusion Unit, 1999; Huestis and Choo, 2002; Knight and Plugge, 2005). The extremes of poverty and exclusion may be felt by those who have the added experience of being displaced. There is evidence that suggests women are the most seriously affected by displacement (United Nations Development Programme, 1999). The psychological needs of pregnant asylum seekers or refugees are compounded by the influences of past experiences that may include exposure to massacre, detention, torture, rape and sexual assault, and destruction of homes and properties. The repercussions of displacement lead to isolation, poverty, hostility and racism (Burnett and Peel, 2001b). However, women's

experiences and fears both outside of and within their own cultures have been minimised (Oakley, 1993; Levenson and Coker, 1999).

It is estimated that twenty five per cent of all female refugees are pregnant at any one time world wide (Sachs, 1997). However, statistics are inaccurate and this can only be an estimate at best. There are known health inequalities which are exaggerated in poorer countries (World Health Organisation, 2000). The health status of women at greater risk due to emergency migration may be compromised further by undetected health related problems in the receiving country (Kahler and Sobota *et al.* 1996). However, it has been observed that women in refugee camps may have better obstetric and reproductive health outcomes than those of the host population (Odero and Otieno-Nyunya, 1996: Hynes and Shiek *et al.* 2002). Odero and Otieno's (1996) work was country specific (Kenya) and included a large retrospective sample of 7,630 women. Therefore, this is not applicable to the UK and may not be a true reflection due to inaccuracies of data collection associated with retrospective studies (Bowling, 1993).

Women who are from ethnic groups other than White are, on average, three times more likely to die than White women in the UK (Lewis and Drife, 2004), a trend which has increased from twice as likely chance of dying in a previous report (CEMD, 1999). Even though these data do not separate ethnic groups who are White this is an important statistic that has implications for women who are asylum seekers and refugees. Furthermore, Black African women including asylum seekers and newly arrived refugees have a mortality rate seven times higher than White women and have major problems in accessing

maternal health care (CEMACH, 2004 p244). Of the women who died in the UK during this time the report showed that asylum seekers and refugees were over represented and had a high rate of non-attendance for maternity care. Perinatal mortality is linked to social class. However, this is a weak measurement for poverty (Steel and Reading, 2002). Steel and Reading (2002) suggest that the infant mortality rate for social class V is double that for social class 1 and if the overall infant mortality rate was reduced to that seen in class 1 and 11 almost 1000 deaths would be averted. Again mortality rates are based on a homogenised class perspective previously commented on (p15). Analysis by mother's country of birth rates would suggest that there are differences for ethnicities (Steel and Reading, 2002; Richens, 2003). However, statistics may vary in relation to mother's country of birth, birth within marriage, and babies jointly registered to single mothers. Despite variations in the categorisation of data, trends would indicate that ethnic minority women incur a higher perinatal mortality rate with the largest cause of death related to low birth weight (Steel and Reading, 2002).

Evidence related to asylum seeking women and refugees suggests that in the UK there is inadequate nutrition for breastfeeding mothers, poor facilities for the preparation of formula milk, and women are frightened and intimidated (McLeish, 2002). In addition to this women may be frequently moved during pregnancy by accommodation providers in the UK (McLeish, 2002). McLeish's study has been an important influence for national guidelines (Burnett and Fassil, 2002). However, this evidence was based on interviews at one time point and did not follow the women through this experience prospectively, which may be a more in-depth perspective to adopt.

Experiences, feelings, emotions and perspectives may have altered overtime (Robson, 1998). In addition, women who were in the postnatal phase were over represented (twenty nine compared to four in the antenatal phase), which may have created a bias to the data. Furthermore, there was a skewed recruitment strategy due to the reliance on 'gatekeepers' to select and refer suitable women. This meant women may have been excluded who would have taken part. There was a selection bias to English speaking women as the 'gatekeepers' were more able to make convenient arrangements. In addition, the interviews were translated in some instances by friends or family, which is recognised as a potential negative influence within the translation process (Edwards, 1995; Sanders, 1999; Temple and Edwards, 2002: Flores, 2005). Despite reservations with this study findings have been incorporated into national guidelines.

## 2:9    Summary of literature review

There is a lack of specific evidence that would inform practitioners about the midwifery experiences of women asylum seekers and refugees in the UK. There is none that would help professionals to understand these experiences in the study hospital. We do not know much about individual reasons for migration, how women who are childbearing cope and the consequences of such an action for the woman, child, family and society. Political, religious, demographic or economic factors are the basic reasons which have driven people to move in the past, and continue to do so today. However, even when governments create barriers to entry into a country, people remain driven to overcome these to gain access to an alternative society. In order to explore

aspects of migration, seeking asylum and becoming a refugee it is important to focus on the level of individuals. This intent will help shed light on the picture of migration for childbearing women. This study aims to provide an insight into these problems.

# Chapter 3:        Methodology

## 3:1    Introduction to methodological approach

Qualitative inquiry may be the obvious choice for researcher's who desire to understand and explain the views of women (Robson, 1998; Bowling, 1997; Denzin and Lincoln, 2000). This current study uses this methodological approach. Previous research in relation to women asylum seekers and refugees failed to explore their maternity experiences from a longitudinal perspective (Burnett and Fassil, 2002; McLeish, 2002; Sawtell, 2002). Furthermore, all other qualitative studies related to involving women who are asylum seekers and refugees document that there are inherent communication problems. In order to provide a new perspective on this issue, this study used photographs. The women were able to prompt the conversation from their point of view by using their own pictures to direct the discussion. This present study aimed to explore the experience of midwifery care by women asylum seekers and refugees in a holistic way by using case study research in a longitudinal design based on a constructionist interpretative framework.

## 3:2    Philosophical stance

The paradigm chosen to frame this research is from a constructionist perspective which appreciates that multiple realities exist (Phillips, 1990). Because each individual has a personal reality, truth may be constructed and

reconstructed but remain real to them and independent to the researcher (Lincoln and Guba, 1985).

Kuhn (1962) suggests that the paradigm sets the parameters in which the world may be viewed. Following this perspective, this research utilised a collective case study approach (Stake, 1995). The perspective recognised the individuality of each woman and did not intend to compare or contrast life events. The women's stories were instrumental to developing an understanding of their experiences. I aimed not to determine what was right or wrong, or true or false; but to acknowledge that there would be representations given by the participants formed from their own social worlds which had meaning for them.

## 3:3    Ontology

Establishing what is known within this study emanated from the data. Therefore, the data generated the theory that would inform understanding. Adopting a constructionist stance permitted me to interpret the data from the perspective of the individual. Ultimately the individual findings were relevant to each individual woman. The truth for each woman was different and I acknowledge that this can not be extrapolated to others. I agree that:

> *From the perspective of those engaged in its creation, knowledge would appear more closely comparable with a badly made patchwork quilt, some of whose constituent scraps of material are only loosely tacked together, while others untidily overlap, and yet others seem inadvertently to have been omitted, leaving large and shapeless gaps in the fabric of the whole (Becher, 1989: 7).*

Because of this belief the truth may be reconstructed by my interpretation and I can hope only to produce a different patchwork quilt and one that possibly could be understood in a deeper sense and which the women believe is relevant to them.

.

I believe that I am not able to generalise the findings of this study to all women who experience midwifery care and who are an asylum seeker or a refugee. However, some of the women's stories may resonate with other women. Because this was a collective case study there were different perspectives that were represented. For example, one woman spoke fluent English whereas the other three did not. The insight gleaned by the uniqueness of the women helped to identify patterns which may be the same for others in a similar position.

Because of the intent of this study there was a need to identify a method which would capture meaning for the women. An objective reductionist approach to this study would have skimmed over the women's experiences and was therefore inappropriate. Reductionism assumes that truth may exist independently of feelings and emotion and that the findings will be statistically generalisable to others (Crotty, 2003). However, within the context of this research the women's feelings were of paramount importance and demanded an approach that would engage women, rather than create distance. I believe that research about humans and social life is complex and can not be carried out in a laboratory in a detached, isolated, clean environment (Bowling, 1997). The constructionist paradigm underpinning this study embraced the

messiness of life at the cost of statistical generalisability.

A phenomenological perspective (Van Manen, 1990) was initially considered. Cresswell (1998) describes an intent of phenomenological research to be to try and understand a particular concept. Furthermore, an element of this approach implied that there would be a desire for me to see life as these individuals see it within their lived experience (Bruyn, 1966). However, as a white, working class, educated women, who lives in permanent accommodation and is supported by a family, I doubted that this goal would be possible to achieve. Moreover, a phenomenological stance meant that previously held beliefs would be bracketed from the research (Denzin and Lincoln, 2000; Cresswell, 1998). The topic of asylum seeking and being a refugee in the UK is a contentious issue which is debated frequently. I have been constantly exposed to societal debates and therefore my views, feelings and emotions would never be bracketted, but always contaminated. In essence my views, emotions, feelings and anecdotal experiences have contributed to the research idea and need to be made explicit, which I have attempted to present within chapter one (Introduction).

The political interest surrounding current immigration issues in the UK inspired me to consider a critical theorist point of view (Kincheloe and McLaren cited in Denzin and Lincoln, 2000 p279). The focus upon power and oppression (Crotty, 2003) for women escaping war and disaster was evident within existing literature (Burnett and Peel, 2001a). Therefore, this stance appeared to be applicable to this study. However, a fundamental part of this theory

relies on the intent of the researcher to challenge expectations and opinions (Kincheloe and McLaren cited in Denzin and Lincoln, 2000 p279) and within the challenges there would be criticism of fundamental beliefs and attitudes. Adopting this approach to the study may have appeared racist to the participants. Another inappropriate aspect to this study of critical theory focuses on an emancipatory attitude. However, I was aware that ethnic minority women may view their position within their religion and society as crucial to who they are. Consequently, women in this study may not have wanted to be emancipated from their traditional beliefs. In order to explore if emancipation would be an appropriate aim for the women in this research it was imperative for me to explore their experiences before laying a critical theorist's lens over the data. Therefore, this approach was rejected.

Women are the foundation for a feminist approach within research (Oakley, 2000; Olesen cited in Denzin and Lincoln; 2000 p215) and initially I assumed this stance to be relevant for the study. Although within my study all of the participants and the researcher are women I decided that this perspective was inappropriate, even though there were elements of this approach that made sense. The approach made sense because of the women's level of inequality, a sense of being socially oppressed which was compounded in many instances by the fact that they were women in a binary opposition to men (Madriz cited in Denzin and Lincoln, 2000 p835). Despite these issues I believed it was important to realise that homogenizing women's relationships with men may lead to ethnocentric assumptions portraying only exploitation, subordination and conflict, whereas the women concerned might put more

stress on co-operation and the importance of family bonds (Chua, Bhavnani, and Foran, 2000). Moreover, embracing this stance would have led this study towards challenging, emancipating and socially transforming participants and social situations which the study did not intend to do.

Rejection of this philosophy generated personal discomfort because I fundamentally believe that social injustice and the plight of women in society should be challenged. However, there was a desire to explore unknown life experiences of individuals whose situations were far from my imagination. There was no apparent evidence that suggested that the women who took part wanted to be emancipated. The intent was not to transform but to reconstruct and interpret (Denzin, 1992) the experiences of the women involved in order for their experiences to be understood by others.

## 3:4    Issues around translation

My interpretation of the data generated the themes which informed my understanding. Interpretation within this study needs to be separated from translation. Interpretation in this instance is related to the methodology which informed analysis of the data. In three cases translation was via an interpreter who was fluent in the language of the participating woman. The knowledge which the translator generated was from the woman's words. Although, verification of the woman's meaning was checked at the final interview, checking was also via a translator. Multiple realities were fundamental to the

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understanding generated by interpretation and I can never escape this within the boundaries of this study.

Another part of the ontological perspective for this study involved me being the main instrument of data analysis. Therefore, in this study understanding cannot be devoid of my influence and I agree that it is futile to search for data that is uncontaminated (Hammersley and Atkinson, 1995). The findings are my interpretation of the women's constructions. Recommendations and implications for practice have been generated from the findings but the final interpretation lies with the reader.

Differing philosophical paradigms may have altered interpretation and understanding within this study. However, I believe that situating the philosophical stance in a constructionist paradigm and linking the findings to a symbolic interactionist interpretation is appropriate for this research and adds depth and richness to the findings.

## 3:5  Epistemology

Interpreted understanding generated within this study emanated from a relationship between the woman and researcher, or the woman, researcher and translator. Therefore, at times there was an added layer of interpretation to negotiate via a third party translation with three of the women. This was a pragmatic solution as I speak only English and needed to communicate with others who did not have English as their first language. I acknowledge that

like researchers, translators bring their own assumptions and concerns to the interview and the research process (Temple and Edwards, 2002). The relationship between the knower and the known is not a passive act and demands engagement in order to understand. I agree with Schwandt (1994) who proposes:

> *Knowledge and truth are created, not discovered by mind. They emphasise the pluralistic and plastic character of reality- pluralistic in the sense that reality is expressible in a variety of symbol and language systems; plastic in the sense that reality is stretched and shaped to fit purposeful acts of intentional human agents.*
> (Schwandt cited in Denzin and Lincoln, 1994 p125)

Within this study understanding was socially constructed (Steier, 1991) and directly affected by external events such as policy and media. They were plural because the research included me as the main data collector, but also the added layers of interpretation which the translators may have added during the research process.

Remaining objective throughout the research process was an impossible ideal within the remit for this research. Stepping outside of the research process to adopt an objective attitude was not intended. I acknowledge that people are influenced by the world around them and prejudices may be held deep within the psyche of a person. This may be a limitation. However, I agree with Gellner's perspective of prejudice:

> *The chief cause of our errors is to be found in the prejudices of our childhood. Our mind has been imbued from infancy with a thousand other prejudices of the same sort (Gellner; 1992; p8).*

One could say that the previously held beliefs of the researcher were a main concern in this study. Even though this is a major influence in this study, understanding what the women have experienced is important and may not have been captured without this exploration. Understanding in this study is based on an awareness of my previously held beliefs and the ability to disable them in order to understand others and ourselves (Schwandt cited in Denzin and Lincoln, 2000 p195). I acknowledge that the research process is value laden. Even framing the research question, choosing the design strategy for the research, and deciding where the research took place all contributed to influences that may be placed upon the ultimate analysis and interpretation. I agree with Lincoln (cited in Guba, 1990 p67) who suggests that separation of the researcher from the research process is not necessarily a good thing as this process informs the research. The methodology adopted for this study makes interaction between the women, the researcher and the setting important, together with the assimilation of external influences upon the women and the researcher. All aspects needed to be considered when understanding was generated.

The involvement of language within this study can not be minimised. As highlighted by Steier (1991) constructing is a social process rooted in language not located outside of ones head. Furthermore, interaction involves a dynamic internally constructed process (Charon, 1979). The participants in this study may never have been given the opportunity to voice their concerns, or reflect upon their situation except for this research. The development of this case study provided a vehicle for this type of knowledge to be generated.

Case study research permitted a sharing of the research process which enabled the researcher to listen to the words of the women over a prolonged period of time. The research was longitudinal which sanctioned meeting with the women to converse about their experiences prospectively. This process enabled each story to be contextualised by place, time and setting.

In this study the introduction of photographic prompts was an attempt to see the women's experiences from their visual perspective. However, there can never be a shared value within this study because the backgrounds of the researcher and participant are so different. Even so, we did connect, and this connection permitted a sharing relationship to develop which was further enhanced by the women choosing which pictures they wanted to discuss.

In summary, the paradigm of choice is situated in constructionism and the underpinning theory for this study evolved into a symbolic interactionist perspective. Collective case study research enabled data to be collected about four individual women over a prolonged period of time. This approach helped me to recognise the women's uniqueness and individuality. I acknowledge that I can not be distanced from the research, and that closeness is crucial in the re-constructed versions of new knowledge that was generated from the interpretation of meaning generated from collective cases.

# Chapter 4: Ethical considerations

Clinicians base their ethical principals on beneficence, non-malificence, autonomy and Justice (Hendrick, 2000). These principals emanate from Kantian perspectives (Kant, cited in Sterba, 1998 p171) of deontology and the need to recognise that there is a duty to protect individuals who participate in research. The rules which govern midwifery are grounded in Kantian principals (NMC, 2004) for example:

> *If you are participating in a clinical trial, you must still adhere to the Code, as well as the midwives rules and standards contained in this document. If you have any concerns about the trial, you have a **duty** of care to the woman and her baby and must voice those concerns to the appropriate person or authority, which may be the ethics committee.*
> (NMC, 2004: 21)

Participants in research should have confidence in the investigators which involves mutual respect between investigators and participants (British Psychological Society cited in Robson, 1998 p470). In the case of this study I was particularly mindful of how women asylum seekers may view organisational representatives as authoritarian figures. Therefore, I was careful to approach the participants in a respectful manner. Self awareness, demeanour and body language were an important consideration for me throughout the research process.

The potential for psychological consequences for the participants was considered. The vulnerability of women who are asylum seekers or refugees was considered during the research design. An exploration of experiences with women who are asylum seekers and refugees involved sensitive topics

and I appreciate Lee's (1993) recommendation to be acutely aware when undertaking research of this kind.

Consideration was given to trying to understand how the participants may feel about their participation. As a midwife I had previous experience of caring for women who were asylum seekers and refugees. In addition, I had cared for women who had experienced sensitive loss and bereavement. Experience in the practice area for twenty years enabled me to have empathetic qualities and an ability to console women in distressing situations. Furthermore, I was aware of and was supported by the multidisciplinary team. Therefore, if there was a sensitive and distressing event that may have needed extra support or referral I was in a position to facilitate this.

The perspective of the woman was considered in relation to being asked to take photographs of images which they felt they wanted to discuss with me during the study. The viewpoint was that the woman did not have to take any photographs if she chose not to. Furthermore, there was a consideration that because of potential political interest around the topic of asylum seekers and refugees that the women may feel frightened to take photographs because of potential personal repercussions. However, I explained that if photographs were selected by the women to be used this would be confidential within the remit of the research. Information was given to the women about the choice of sharing a photograph and that this would be without fear of failure or consequence.

The multi-cultural, multi-racial, multi-religious environment was familiar to me and, although not an expert in information related to a variety of different cultures, I understood the importance of a sensitive approach for the women. In order to ensure that the research would be sensitive to the needs of the ethnic minority women in this study, members of the link clinic were informed about the study, prior to me meeting the women. Their opinion was sought about the best possible approach for the women when inviting them to take part. The local link worker translators were asked if they were aware of any potential issues that could be anticipated before the participants were approached. The need for translators to protect confidentiality within this research was addressed and there was an assurance on my part to anonymise individual participants by providing a pseudonym. This process facilitated the development of relationships between local link workers and myself.

There was a need to ensure that the participant understood what was being asked of her if she agreed to take part and be able to feel free to ask me questions (Department of Health, 2001b; British Psychological Society cited in Robson, 1998 p473). The link workers were aware that at recruitment I would ask them to translate the information verbatim. Later during the recruitment I went over the information sheet with the woman and the translator. I was then able to ask questions to the participant to ensure that she understood what was being asked of her. For example, " Can you tell me how long you think the interview may take?"

The translator was then able to clarify the finer details of the study, before the women had chosen to consent. Ensuring understanding was of paramount importance. However, because of this attention to detail the recruitment process took from one to two and a half hours.

Asylum seekers and refugees may perceive people in uniform or those who represent organisations to be authoritative. Therefore, I was aware that researchers may be seen to be in positions of authority (British Psychological Society cited in Robson, 1998 p471). With this in mind I wore everyday clothes and did not wear a hospital uniform. This act may have symbolically removed a potential barrier to the researcher woman relationship. Therefore, I needed to ensure that participants did not feel pressurised to participate. Because of this I needed to stress to all women approached that they were able to decline to take part without fear of repercussion or retribution, and that their care would be unaffected. Facilitating women to decline from the research was evident in that more women declined than took part in the study. Furthermore, as the study was longitudinal in design the women were informed that they were able to withdraw at any point during the research. In fact one woman did leave the study due to moving and one woman disappeared before her six week interview after her asylum claim had failed.

Midwifery research must maintain the confidentiality of participants (Hendrick, 2000). The translators who contributed to the study were briefed on their need to ensure confidentiality. Confidentiality for the link translators is part of the remit of their role within the clinical area and the process did not appear to

present any problems. Furthermore, the participants were guaranteed that they would not be named but have a pseudonym incorporated into transcripts to ensure their external anonymity. I assured the participants that all information about them would be kept in a locked cabinet and their personal details would be separated from the interview transcripts.

As an employee of the hospital I had access to the clinical area where the research took place. However, as recruitment would take place in a colleague's department in the antenatal clinic area permission to access this area was approved prior to the study commencing. Furthermore, being employed in the clinical area I was familiar with the computerised systems and procedures in the trust. This familiarity eased the process of pre booking translators for the interviews.

Prior to recruitment all members of staff who worked in the area were made aware that the study would begin. I explained the research individually to each member of staff who potentially may have been involved in helping to identify the women. Clinic midwives were then able to identify women who may have slipped through the net of a large hospitalised computerised system. This contact seemed to make my presence in the practice area more acceptable and eased the process of identification.

Researchers need to protect participants from physical and mental harm and the potential added stress of taking part in research (British Psychological Society cited in Robson, 1998 p473; Department of Health, 2001b). The

potential for the women to display signs of stress existed in this study. Women asylum seekers and refugees may have experienced rape and torture before arriving in the UK (Burnett and Peel, 2001a; Burnett and Fassil, 2002). I could not be certain about the previous experiences of the participants and was aware that they  may have become traumatised by reliving their previous experiences when they took part in the in depth interviews. Prior to the research starting I ensured that contact of and access to other supportive systems was available, for example, The Social Inclusion Team and Rape Crisis. Furthermore, I relied on my skills as an experienced midwife who was familiar with caring for and supporting women in stressful situations and felt confident in my ability to support and care for the women who would participate in my study.

Following all ethical considerations the research was presented to the ethics committee and minor amendments needed to be made to the patient information sheet. Following the amendments ethical approval was gained from The Local Research Ethics Committee, The Faculty of Health Ethics Committee, University of Central Lancashire, and The Liverpool Women's Hospital Trust.

# Chapter 5: Methodological considerations

## 5:1  Case study research

As previously discussed (p 45), case study research was the most appropriate methodology for this study. Previously researchers have engaged women asylum seekers and refugees in single qualitative interviews (Burnett and Fassil, 2002; McLeish, 2002; Craig, et al. 2004) or survey (Udoeyo, 2003). Utilising a collective case study approach facilitated the ability to collect data in different ways, such as in depth interviews and photographs which were used as prompts for conversation. This use of photographs was a novel approach which allowed the participants to collect their own data to be included for discussion. The longitudinal design meant that I was able to meet with the participants five times which gave me a deeper insight about their midwifery experiences.

Case study methodology involves a process of identifying the case or problem, explaining the bounded system or context, describing or interpreting the issues and presenting the lessons learned (Cresswell, 1998). This case was identified as an exploration of the experience of midwifery care by three women who were asylum seekers and one woman who was a refugee. Although there are four women, the collective cases themselves create the case. This case study was bounded by time which spanned from between 11-20 weeks gestation to 6 weeks postnatal for each woman. Additionally the case was bounded by the contextual setting of the hospital and the women's homes. Furthermore, the study was bounded by language.

Learned lessons will be discussed in relation to the findings later in the thesis and described under the heading of 'recommendations' (p 178). Personal reflection situated later in the thesis will describe how the research process for this study has affected my personal beliefs (p 173).

Case study research has a focus on three particular elements; a contemporary phenomenon, a real life setting, and multiple sources of data (Robson, 1998). To unpick this assumption I would like to define what these three elements mean for this study.

The topic of asylum seekers and refugees in the UK is a contemporary issue which is socially constructed. In some instances the topic is contentious for many people in society and is reflected in the high priority this issue takes within the media (Leppard, 2004; Hennessy, 2005; Leppard, 2005). Understanding this contemporary phenomenon from the viewpoint of the individual in my study focuses on how their lives were socially constructed. In this way the focus was not the phenomenon of being an asylum seeker or refugee but understanding the experiences of the women and midwifery care because of the social phenomenon which created the contextual setting of their lives.

## 5:2 Method

The real life setting for the study emanated from everyday practice as a midwife. Data collection occurred prospectively in the real life setting of the

hospital or the women's homes. Data were collected in multiple ways from semi structured interviews, field notes and photographs taken by the women.

A collective case study approach was chosen because of the intent to generate patterns of experience that emerged from women within the local setting. Therefore the case was instrumental in developing understanding about the meanings of the women's experiences as opposed to an intrinsic singular case study methodology (Stake, 1995) which would have prohibited the intent of pattern generation.

## 5:3    Setting

Women in the study hospital are referred by the general practitioner (GP) to the obstetric lead carer. This is by a referral letter to the hospital. On receipt of the GP letter the women are allocated a consultant obstetrician. There may be a specific reason for the allocation such as maternal or GP request. The GP may however request that the women be seen by a certain consultant due to the consultant's specialist skills, for example in relation to diabetes.

The referral letter may indicate that the woman is an asylum seeker or does not speak English. In this case the administration staff will allocate the woman to attend the Link Clinic. If details from the GP are absent allocation may be based simply on the name of an individual. This is a clinic which runs one morning a week within the hospital setting. The clinic is staffed by midwives (usually about four) and five link workers. A consultant obstetrician, registrar

and a senior house officer staff an obstetric clinic in the same vicinity simultaneously. Therefore, if there is a need for medical referral this is managed in an opportunistic way. The clinic is designed to address the needs of ethnic minority women by providing language translation represented by the skills of the five link workers. The five key languages are Somali, Punjabi, Bengali, Chinese, and Arabic.

Women who attend, and do not speak one of the five main languages, may be provided with interpretation via the hospital service or a three way language telephone. After booking into the link clinic the women will be assessed for need to return. They may need to attend the hospital clinic for the whole of their antenatal care due to the reliance upon language support.

The women attend the hospital when they go into labour. They usually give birth on either a midwifery led unit within the hospital or the consultant led delivery suite. Each unit is within a short distance of each other and attached by a corridor on the first floor of the hospital.

After birth the women are cared for either in a single bedded low risk postnatal ward with en suite toilet and shower or a high dependency postnatal ward. The high dependency postnatal ward consists of four bedded bay rooms or a single side room.

The women are discharged from the hospital into the care of the community midwives. They may be discharged within six hours of birth, or, on some

occasions may stay in hospital for up to a month, depending on their health status. The community midwives are geographically based and their bases are linked to GP surgeries.

Demographic information related to how many women were asylum seekers or refugees in the study site at the beginning of this study was confusing and inaccurate. Consequently, it was difficult for midwives to liase about maternity care within the multidisciplinary team.

## 5:4 Sample

A principle that guided the selection of women in this study was the representation of women's experiences of midwifery care. A further principle involved whether the woman was an asylum seeker or a refugee. Therefore, purposive sampling (Robson, 1998) was used. Purposive sampling is defined as:

> a deliberately non -random method of sampling, which aims to sample a group of people, or settings with a particular characteristic (Bowling, 1999: 167)

Women asylum seekers or refugees were identified from routine hospital information in the antenatal clinic setting. I was able to identify the women as I had access to the link clinic area (described previously). Once I knew whether the woman was an asylum seeker or a refugee and aged over eighteen I approached her in the antenatal clinic at the study hospital.

Qualitative research does not aim to generalise and therefore the amount of women needed to fulfil the aims of instrumental collective case study research may be arbitrary (Glesne and Peshkin, 1992). Four cases may be deemed as an appropriate figure in order to fulfil the intent of developing a deeper understanding of the topic of interest (Stake, 1995; Cresswell, 1998). Ultimately this is a judgement call and is dependent upon the intent of the study. Fourteen women were approached and invited to take part and nine women declined to participate. Five women consented and one woman moved during the study period which left four participating women.

The intent of this study was to include migrating women regardless of their country of origin. The women's country of origin was respectively; Afghanistan, Zaire, Rwanda and Somalia. They spoke Punjab, Lingala, English and Somalian. Three different translators were needed to converse with the women who did not have English as their first language.

## 5:5   Study design

Diagram one portrays the longitudinal design of the study. The women were met during the antenatal and postnatal period of their pregnancy and childbirth. The initial meeting was at their booking appointment between 11-20 weeks of pregnancy in a specifically designated link clinic where translators were present. Whether the woman was an asylum seeker or refugee was identified prior to approaching for recruitment. At this meeting the women were given information about the study which was translated verbatim by the link translator, and invited to take part. I left the woman alone with the

translator to allow for open discussion. It was important for me to understand what the woman thought might be required in the study. This meant that on my return if the woman had decided to take part I asked some questions. The questions about how much the woman understood was via the translator. If the woman wished to participate consent was taken with the help of the translator. A disposable camera was given along with guidelines for using the camera which were given verbally.

**Diagram 1**

**Overview of study design**

| | Antenatal | | | Postnatal | |
|---|---|---|---|---|---|
| **Meetings** | 1st | 2nd | 3rd | 4th | 5th |
| **Gestation (W)** | 11-20 | 20 | 34 | 1 | 6 |
| **Recruitment** | √ | | | | |
| **Brief update** | | √ | | | |
| **Interviews** | | | √ | √ | √ |
| **Camera** | Given | | | Collected | |

This first meeting, where recruitment took place, took one to two hours approximately. The time depended on how the woman's appointment fitted in around the information giving, the understanding of the woman and the availability of the translator.

The second meeting was at the woman's next appointment at twenty weeks gestation in the ultrasound department before going in for the scan. Here the

woman was asked if there were any problems with the camera and whether she would like to talk with me. This meeting took approximately thirty minutes.

The third meeting was at thirty four weeks gestation in the woman's home. At this meeting there was an in-depth interview facilitated by a pre booked translator. In two cases the same translators were used throughout the study.

The fourth meeting was within one- two weeks of childbirth. Again this was an in depth interview which lasted between one to two hours with a pre booked translator. The camera was collected at this meeting in preparation for film development.

The fifth meeting was six weeks postnatal and was approximately one to two hours long. A copy of the film was given back to the women to keep. I invited the woman to select the photographs that she wanted to talk about. In addition at this meeting there was a discussion about the interpretation of the previous interviews by a draft summary of the interpretation read out to the woman by the translator. Any additional comments were documented and subsequently amended within the text for analysis. For example, one woman in the study spoke about a number which I took to mean an NHS number but this was actually a national insurance number.

The interviews lasted between one to two and a half hours and were taped or documented as the woman requested. Two women declined to have their

interviews taped but were happy for me to take notes during the interview; these were typed contemporaneously.

## 5:6    Photographs as a prompt for conversation

The representation of multiple realities is a fundamental part of the research methodology for this study. The novel approach of using photographs was designed to enhance the ability of the women to have freedom of expression. However, language barriers may have inhibited this freedom. Because photographs are made in an instant they represent the instant and provide a "quote" for experience (Ball and Smith, 1992: 16). The photographs within this study were used for prompts to conversation and all quotes in this study are from the women's words. Therefore, photographs taken by the women themselves and used as a prompt for conversation may have facilitated a deeper sense of understanding about their experiences from the women's perspective (Harper, cited in Denzin and Lincoln 2000 p717).

Disposable cameras were given freely, as part of the study. The women understood that the photographic image would be used to prompt conversation at the third interview. I informed them that the photographs were part of the study because I wanted to try and understand their points of view. I also asked the women to capture anything that they would like to talk to me about their maternity experiences. The women knew that they would have a copy to keep and that I would keep a copy. The intent of the additional aspect

of data collection was that issues of importance would be generated from the perspective of the woman (Denzin and Lincoln, 2000).

## 5:7 Analysis

Interpretive analysis of data facilitated a way to understand how the women contextualised the meanings that they placed on their experience as suggested by Little (1991 p85);

> To understand, explain, or predict patterns of human behaviour, we must first penetrate the social worlds of the individual- the meanings he attributes to the environment (social and natural), the values and goals he possesses, the choices he perceives, and the way he interprets other individual's social action.

In order for the analysis to be credible, interpretation should follow a systematic process. The process used within this study is suggested by Miles and Huberman (1994 p10). I collected data by field notes or taped recordings within the interview setting. I also documented field notes following the interview which created a contextual description of the setting. I then transcribed tapes and field notes as soon as possible after the interview. This was time consuming and involved one hour of tape recording for eight hours of transcription. This enabled a further immersion and familiarity with the data which may have been lost by another person transcribing the data.

Because of this immersion my initial impressions of emerging themes were documented as notes at the same time as the transcription. I revisited the additional notes when the data analysis began in earnest when the study was

completed. My initial interpretation was at times fed back into the next interview with the same woman. This process helped me to clarify and probe certain elements of the previous conversation. These questions were added to subsequent interviews with other women in an effort to explore potential patterns within the women's experiences. For example, the negative experience relating to a woman in the same ward was picked up on and the other women were asked if they had experienced negative responses from the women who they came into contact with in the hospital.

At the end of the study I read and re read the transcripts and this refreshed my familiarity with the data. This provided me with a general understanding of the women's words. The process of analysis took three key stages; decontextualisation, display and data complication (Miles and Huberman, 1994 p10).

Decontextualisation involved the women's words being placed into emergent themes. In effect the transcripts were pulled apart. The themes were the labels given to groups of meanings that were generated from the words. For example, issues around sign language or gender (Appendix 1). This process was intended to provide meaning in relation to individual words or a theme (Dey, 1993 p93-97). I used normal word processing, cut and paste techniques to separate the meaning out. However, the original transcript was kept in the same format and never changed. The original transcript was revisited through out the process of analysis and the quotes used within the thesis are taken directly from this document to ensure authenticity.

Numerous documents were generated for each theme. There were originally forty seven themes, which generated categories within each theme. For data management and to enhance clarity of understanding some themes were merged to leave fifteen themes. After further reconstruction I was left with three key themes.

The next key stage involved data display (Miles and Huberman, 1994). This was created in two ways. One was the creation of a word processed matrix which enhanced an understanding of pattern formation generated from the individual cases. Another display stimulated creative thinking and the ability to link theory to the data. This display involved creating fifteen separate segments drawn on the back of lining wallpaper each approximately twelve inches apart. An example of a photocopied section is included in the appendices (Appendix 2).

Each segment was headed with an emergent theme. From the theme I drew a flow diagram and related the theme to the issues in practice which were generated by the women's words. I linked emergent issues with relevant existing theory. This process acknowledged Lincoln's (cited in Guba, 1990 p78) belief that theory emerges from the data rather then precedes it.

The display was pinned to a wall and provided an overall graphical display of emergent theory which could then be viewed in one discussion. This process helped me to pinpoint the underpinning theoretical base that emerged from the data, namely of symbolic interactionism.

The key stage of data complication (Miles and Huberman, 1994 p10) was facilitated by the wallpaper display. This process involved building up the data to be recontextualised by theory and setting. The final outcome of this process was that data reduction was reconstructed to enable a gradual interpretive, theoretical and conceptual impression of the data to emerge. This process was time consuming and took the best part of a year to complete.

# Chapter 6:     Results

### 6:1          Introduction to the results section

This chapter aims to present the results of the study. An introduction to the women's cases contextualises who the individual women are. The presentation of the women in this way helps to identify how individual each case was.

There were three main themes which emerged from the data these were; the influence of social policy, understanding in practice and perception of 'self'. Within each theme categories were generated. Although the themes are presented in isolation they are interrelated. Because of this overlap individual quotes are used on more than one occasion as they began to represent different aspects of overlapping themes.

The influence of social policy theme generated categories related to dispersement, housing, integration, ill health, and coping.

The theme of understanding in practice generated categories of taken for granted communication, access to information, and building relationships.

The theme, perception of 'self', drew together issues related to the women's shifting personal identity, their role in society and how professional power influenced their identity.

Themes were synthesised within the theory of a symbolic interactionist interpretation of interpersonal non-verbal behaviour.

## 6:2    Description of the individual cases of the women

**6:2a   Case 1:** Meena was twenty six years old and accompanied by her husband and two children. Meena had been pregnant twice, and had given birth to two live children; a girl who at the time of this study was aged 5 and a son aged 3. She had given birth to both children at home in Afghanistan accompanied by her mother and sister. She was married and her husband had paid for his family to leave Afghanistan because of prejudice towards their Sikh religion.

Meena became pregnant 9 months after she had been admitted into the country and was an asylum seeker. She had managed to contact home and was aware that all of her family had been separated or killed. The location of the family members who remained alive was unknown. Meena spoke Punjabi and needed an interpreter to help us both to communicate with each other.

**6:2b   Case 2:** Layla was thirty six years old and was accompanied by her two children. She had been pregnant twice before and given birth to her children in a health centre in Kinshara in Zaire. Her husband had been present at the births and she had been assisted by a midwife based in the health centre. She did not disclose why she felt that she had to leave Zaire but said that there had been a war and this was terrible for her to live through and preferred not to talk about this. She had become pregnant this time 4 months after admission into this country. Her husband remained in the Congo and she was unaware of his location and if he was still alive. Layla was an asylum

seeker who spoke Lingala, and needed an interpreter to help us to communicate with each other.

**6:2c Case 3**: Grace was nineteen and unaccompanied. She had been pregnant once before when she was thirteen years old following a rape in her homeland, Rwanda. She had given birth to a girl at a friend's home in a village in Rwanda where she was accompanied by the friend, the friend's grandmother and a local woman, who had experience helping local women to give birth. Her daughter was now five years old and remained in Rwanda. Grace had become pregnant three months after admission into this country. Grace's family were separated and she did not know if her parents were alive or dead. The location of all but one member of her family was unknown and this was her brother who she knew to be living in London.

Grace had been taught English by the Red Cross organisation in Rwanda when she was approximately eleven years old. The sessions were free and Grace had felt that this would be a valuable language to learn. Her English was fluent and eloquent and we were able to communicate with each other freely.

The week before the first in-depth interview (34 weeks gestation) Grace had discovered from a telephone call to her friend that her little girl had also been raped, a shocking and distressing revelation which Grace commented on during our conversations.

**6:2d  Case 4**: Abeba was twenty three and accompanied by her husband and children. She had had three previous pregnancies, all of which were live births. Two children were born in Mogadishu in Somalia, at home, when she was accompanied by a local woman. One baby had been born the previous year in the study hospital. Abeba had been resident in England for two years and seven months and was a refugee with the status of 'Indefinite Leave to Remain' (ILR). She lived in a hostel close to her mother in law. She spoke Somali and needed an interpreter to help us to communicate with each other.

# Chapter 7:  Theme one

# The influence of social policy

## 7:1 Introduction to the influence of social policy

*'I mean my life became totally different'.*

From the perspective of the women their situation is one of social difference in relation to policy in England. This chapter aims to contextualise the women in the setting of the national and local society in England. The contribution of policy to the social difference of the women will be described. Issues such as dispersement, integration, housing, ill health,  and how women coped with their lives will be discussed.

## 7:2    Policies

*'I'm sick, I'm tired, I'm anaemic, I'm dizzy all of the time. I have to walk every day until they (NASS) come to the conclusion'.*                    .

Asylum approvals are limited and linked to a policy of determent (Home Office, 2002b; HM Government, 2005). Although this study does not intend to analyse governmental policy within the UK, a description of how this policy has affected the participants in this study is justified and will be included within this discussion. The repercussion of strict determent and refusal policies is to encourage those seeking asylum to escape these imposed restrictions (Craig, *et al.* 2004). This appears to have happened in Grace's case as she

disappeared from the study and her maternity care shortly after the following conversation, even though she was sick:

> *I'm sick, I'm tired, I'm anaemic, I'm dizzy all of the time. I have to walk every day until they come to the conclusion* (Whether Grace could remain in her house). *So it was really horrible for me.*
> (2 weeks postnatal: Interview 2, p14, L667)

Even though there is a recognition of how poor health may affect mortality and morbidity (Acheson, 1998; Department of Health; 2003) for asylum seekers and refugees there also appears to be a contradictory policy message. This policy signals a denial of how indecision, increased anxiety and dispersement can influence health outcome (Craig *et al.* 2004). Improving the health outcome for asylum seekers and refugees would mean that governmental organisations such as NASS and the NHS talk to each other to ensure the health of the individuals are considered.

A consideration of the individual in health led to the development of local initiatives, such as Sure Start (Department of Health, 1999c). An aim of Sure Start is to bridge inequalities in society to provide a more focussed service delivery. Addressing inequalities in health is directly related to public health issues. Midwives who were able to expand their role to care for asylum seekers and refugees from a public health aspect commented that they had job satisfaction although their roles became limited by systems and bureaucracies.:

> *We've managed to set up different sessions (clinics) but you have to provide food for the asylum seekers because they won't come otherwise. (Community midwife, Antenatal Clinic, March, 2003. Field notes).*

Even so, they were able to touch the lives of hard to reach groups in society.

However, the women in this study did not appear to access this service and

field notes from the study commented that although the researcher knew

about sessions to be held for pregnant asylum seekers Grace did not. She

commented on this at a subsequent interview:

> *R: what did you think about the extra aromatherapy session there was
> on the Saturday. What were your impressions?*
>
> *G. About the ?*
>
> *R. The session about the advertisement last time we met. I think it was
> supposed to be a drop in session.*
>
> *G. I didn't go to that one.*
> (34 weeks gestation, Interview 1: p1 L7).

Despite information being provided to Grace before the interview session she

declared that she did not go. Neither Grace nor any of the other women in this

study attended health promotion sessions that may appear as new innovative

ways to care for women asylum seekers. Sure Start initiatives are now in the

process of changing, being devolved and incorporated into new ways of

working (Edwards, 2005 personal communication). Reaching people who are

the worst off in society in relation to childbirth needs to be a reliable, easily

accessed and a familiar system to ensure all who need this service are aware

of the potential benefit to them (Richens and Currie, cited in Lavender et al.

2004 p129).

## 7:3   Dispersement


*'Oh God, Where are they taking me?'*


Accommodating asylum seekers in this country is determined by negative phrases such as 'burden' (Home Office, 1996). In 1996 the 'burden' was deemed disproportionate in London and the Southeast of the country. This led to the notion of burden sharing between regions of UK, which the Immigration and Asylum Act (Audit Commission, 1999) legislated for. Subsequent measures meant that asylum seekers would be expected to take what was available and that they would not be able to choose where they were accommodated.


All of the women had experience of being dispersed. Abeba commented on how the process happened to her:


> *Agency smugglers took money from me in Somalia to bring me to London. I arrived in London in a train station then they left. There were two people who said 'Where are you from, France, Spain?'. They checked my pockets. They got some one to speak with me. Then they finger printed me and took pictures. They gave me a letter to take to a solicitor full of forms. I said I want to go to Liverpool to see my mother in law. I went to Glasgow first in a hostel. Then they moved me to a house in Manchester. I had to get friends from there who paid for me to get here* (Liverpool). (2 weeks postnatal field notes: Interview 2, p8, L2).


All of the women appeared to be familiar with moving around the country and Layla commented that she was also in Glasgow at first:

> *I found out I was pregnant four months after coming to the country. This was a shock and I felt unwell and considered stopping this. I was living in Glasgow at the time and the doctor gave me a note to go to the hospital. I asked a friend about the directions to the hospital. She was from another country, Tanzania and speaks Swahili.* (34 weeks gestation field notes: Interview 1, p2, L28).

For Layla there were major ethical, social and personal decisions that she was contemplating in relation to abortion. However, there appeared little support for her in this situation. Moving and being unsettled made the women feel powerless with no control over their lives. This resonates with the accounts of other women (Lehmann, 2002; Craig, *et al.* 2004; Papadopoulos, Lees and Gebrehiwot, 2004). The women in this study appeared to accept being powerless with a quiet resignation, described by other asylum seekers and refugees (McLeish, 2002). Grace described her anxiety and loss of power associated with being dispersed:

> *They were saying they're taking me to Birmingham. I had no one in Birmingham. I don't know anyone at all in Birmingham. I was like Oh God, where are they taking me?* (2 weeks postnatal: Interview 2, p14, L 663).

The fear that consumed Grace about being re located to another part of the country resounded with her feelings of loneliness and isolation when she had been rejected by her brother who she knew was living in London:

> *My brother likes different things. I like different things. I've suffered a lot. Even he doesn't want to listen. He's living his own life. I'm living my own life, so it's different. I mean my life became totally different and I started thinking when I'm by myself when I'm alone. No one is there to listen to me no one is there to talk to me. Just talking was better I guess. Because no one was there I cried everyday. I wished I could do something wrong to myself. I mean I even used to hold knives and I used to tell myself I wish I could cut myself. I wish I could do this. I wish I could fly through the window and die.* (34 weeks gestation: Interview 1, p19, L918).

I became concerned about Grace's mental health during this interview and later in the interview I asked her permission to contact her consultant obstetrician. Grace was subsequently referred to a consultant psychiatrist who worked closely with her obstetrician. Loneliness and isolation are not associated solely with women who are asylum seekers or refugees (Heaman and Gupton, 1998; Perese and Wolf, 2005). However, there is a high rate of mental health issues related to asylum seekers and refugees (Drennan and Joseph, 2005). Furthermore, depression and increased suicidal tendencies are associated with how individuals adapt to life in the UK (Papadopoulos, *et al.* 2004) which is affected by post-displacement conditions (Porter and Haslam, 2005). Postdisplacement conditions should be considered in a humane light for those newly arrived into the country especially in relation to issues around childbirth.

## 7:4 Housing

***'it's too dangerous, here alone with the children.'***

Abeba was a refugee who had indefinite leave to remain and when I first met her she had been in this country for two years and seven months and was still living in temporary accommodation in a hostel. I later found that her main reason for becoming involved in this study was that she would have a forum to talk about her housing problems:

> *Are you going to help me with my housing....I've fallen three times down the stairs. I'm alone with three children, I have washing and drying...I was waiting for you to come (34 weeks gestation field notes: Interview 1, p1, L6).*

Her photographs stimulated conversation related to the conditions she lived in and as she began to describe why she chose to talk about one of her pictures, her opening sentence was, *'Look at the state I'm living in.'* The picture showed Abeba laying on the floor of her room. She lay on a dark patterned rug. The rug looked thin. Her eyes were closed and one arm rested on her abdomen whilst the other rested on her head. Her head was covered. Her back lay against a small pile of multicoloured children's toys, which were piled on top of each other against a beech coloured chest of draws. To the other side of the toys there were pipes attached to the wash basin and in front of the chest of drawers stood two of Abeba's children. A boy of two looked directly into the camera with a bemused look and was dressed in what looked like layers of clothes under his thick track suit top which was tucked into the bottoms. The little girl of about four years old stood behind the boy with her hands in her red coat pockets. The top of the chest of drawers was piled with a kettle, what looked like dried milk formula, tins and bottles of food and equipment which was covered in a yellow plastic bag. The whole impression of this image was one of cramped, cold and poor living conditions. She commented that she hated seeing herself portrayed like this and that this made her feel bad about herself.

Sharing a house with strangers meant that Grace could be housed, highlighting a lack of privacy when living in shared accommodation (Bentham, 2003). The lack of privacy commented on by Bentham (2003) was exemplified in this study when Grace's house mate (from Zimbabwe) came into the room during one of our interviews:

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R. *Hi ya...How are you?*

Woman smiles and sits down, obviously pregnant also.


W. *Are you having your baby in the hospital?* she said, directed towards

Grace.
Grace nods yes.

R. *Erm...* (feeling a bit uncomfortable) *we're taping this conversation is that ok with you if I carry on..* ? (Wanting her to leave due to issues of confidentiality and feeling as though the atmosphere had altered completely in the room).

W. *It's Ok.*

R. (Laughing nervously and attempting to distance from sensitive questions in relation to Grace I went on to ask). *How are you getting on together ....OK?*

W. *No she's strange!*

All laugh.

W. *I'm joking.*

R. *It must be strange being put in the same house together.*

G. *It's strange how it's not strange.*
(2 weeks postnatal: Interview 1, p5, L213).


Housing for all of the women was in deprived areas of the city that were associated with high rates of unemployment. There were usually signs that some houses were disused and the boards on the windows displayed graffiti. When I interviewed women the houses were usually cold and smelt of damp, even in the summer. The rooms were usually dark and had basic furniture. In one case there was seating in one room but not another. I knew this because on one occasion a community midwife called. I waited outside by politely removing myself from the room. However, this wasn't expected of me, presumably because the midwife knew me. Whilst I waited I was given a collapsible chair to sit on. The room contained only a mat and a fire. I noticed

this room again later in the study in the photographs that the woman chose to share with me and realised that the family were preparing food on this floor also. The effects of the living conditions upon families may be far reaching. There needs to be an exploration of how these living conditions may affect the emotions, behaviour and health of asylum seeking children as they grow.

## 7:5 Integration

**'Even if I wanted to I couldn't because I can't work'.**

For social reasons families tend to have more stable lives and are better integrated into the communities that they live (Stalker, 2001). The family is the natural and fundamental group unit of society and is entitled to protection by society and the State (General Assembly of the United Nations, 1948: Article 16). However, families are less traditional and more diverse today than previously (Morgan, 1975). For Grace 'family' meant being reunited with her five year old daughter in Rwanda. However, for Grace the reunification of her daughter in Rwanda was denied because she did not have refugee status. The consequence of this separation was traumatic and distressing:

> G. Yeah because this thing is really haunting me. Every night I see that girl (her five year old daughter back in Rwanda) cry and cry for help. And she's calling my name. She doesn't know my name, she doesn't know me. She just keeps on calling...on that night on Saturday night Sunday morning I had a weird nightmare. I couldn't sleep. She was showing me whoever raped her. What he did to her and she was rotten and disgusting down there. She was going to get help...she couldn't walk.
>
> R. This is your daughter you're talking about now.

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*G. Yeah. I woke up. I couldn't sleep. Whenever I closed my eyes*
*I could see her, flashes every time. I couldn't... I tried to stop it and*
*I said, ' no no stop It'. I couldn't she was crying...help me...help me.*
*I just cried the whole night. Only when it came to morning that's when*
*I tried to close my eyes.* (34 weeks gestation: Interview 1, p22, L1057)

This distressing dialogue depicted a nightmare, Grace had found out during the previous week that her five year old daughter back in Rwanda had been raped. This information was given to Grace via a telephone call to the old woman that cared for the young girl. The old woman was now sick and was worried about what would happen to the girl when she had, *'gone'*. The basic human right to reunification was denied Grace due to bureaucratic policy. It is difficult for asylum seekers and refugees to understand complicated access systems (Craig, *et al.* 2004). Failure to access fundamental rights creates feelings of powerlessness and hopelessness (McLeish, 2002). Policy makers need to be aware that their ideals may affect lives in a massive way.

Loss of power and hope are compounded for asylum seekers by the inability to work for the first six months of their stay in this country; even though this is another basic human right (General Assembly of the United Nations, 1948; Article 23). For Meena, her husband and her family the prevention from working ensured their economic status was lowered despite a desire to work:

*I can't work for six months because asylum seeker but I need to do*
*something here. (outside of 1st interview with Meena. Field notes*
*Noember 12th 2002, p1, point 5, L30).*

In addition, Grace expressed that she would like to train as a nurse and was attending a local centre to find information but was despondent because she would not be able to achieve her goal:

> *I just want to be useful. I would like to be a nurse but can't find out how...I've tried at the local centre. They can't tell me anything. Even if I wanted to I couldn't because I can't work.* (Field notes Grace: March 10th 2003, p1, L7).

Being prevented from working increases social exclusion and the ability to integrate into a new culture (Refugee Council, 2002). To be able to work whilst waiting for Grace's status to be confirmed may have meant she was able to contribute to her meagre income:

> *So by then they* (Refugee Action) *were first supporting me. They were giving me £20 per week, that's when I went into the hospital.* (2 weeks postnatal: Intervew 2, p3, L103).

Poverty in Great Britain is hidden, underestimated and makes women sick (Hunt, 2004). If asylum seekers do not claim their benefits at certain points in time they are deemed ineligible and may be left destitute (Home Office, 2002b: Section 55). The consequences of this are that women may be placed in the demeaning position of begging for nappies for their baby (McLeish, 2002) or homelessness (Sawtell, 2002). These concerns were very real for Grace:

> *I was tired, because I was thinking these people* (NASS) *want to take me back. When I have this baby, how am I to stand, I don't have any money, everything is on my mind. Every day I could think what will I ever do. I could just cry, I don't know where to start, I don't know where to look. By the time I was in the hospital I wasn't receiving any money, I was only receiving about £20 I was thinking how am I going to go home? And how am I going to buy nappies for my baby and how am I going to buy this and that?* (2 weeks postnatal: Interview 2, p13, L629).

Being poor, without money, without the support and contact of your family, unable to speak the same language in an unfamiliar setting may be classified as living in deprivation (Subnar and Bruce, cited in Malek *et al.* 1993 p93). This can lead to a decreased positive perception of self and further exacerbates problems. as explained:

> *I' ve been in a house before this hostel it was in Manchester. Burglars took everything. I've never settled down. If I had a house I would be able to have my mother in law stay. If I wanted to I could go out. I see the stairs here and my heart beats fast.* (6 weeks postnatal field notes: Interview 3, p2, L12).

## 7:6　Ill health

**'I felt unwell. I felt tired and sad.'**

The women in this study complained throughout of feeling unwell. Three of the women chose to take photographs which they decided to share with me. The majority of the photographs chosen by the women for discussion displayed unhappy images. For example, Layla said, *'I had a pain in my stomach that day and wanted you to know how bad I felt'* (6 weeks postnatal field notes: Interview 3, p1, photograph 4). Most feelings that were transmitted in the pictures captured a sense of sadness. Meena spoke of how tired she felt when her partner had taken her photograph. She said:

> *This was the day I went into hospital, I felt unwell. I felt tired and sad and I thought you would like to know this.* (6 weeks postnatal: Field notes interview 3, p1, picture 1).

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The intent of this study was not to measure the general health of the women. Therefore, it is difficult to say whether the symptoms the women felt were associated with the minor disorders of pregnancy or because of their state of health or their emotional state. In contrast to the photographs, their involvement and interaction during the interviews displayed an appearance of wellness and not illness. On some occasions there was laughter. However, the women were living in deprived conditions which is known to affect general health (Acheson, 1998; Department of Health, 2004) and this cannot be ignored.

Accessing maternity care for the women in this study had been guided by others in the community, such as the link workers or hostel employees, who had been able to negotiate the system. This at times appeared confusing to the women and Abeba described how she was meant to access the service if she had a problem:

> They (midwives) said, ' just get in touch if you have a problem'. I've never contacted them before and didn't know how to contact the hospital. Because of this I just turn up if I need them. (34 weeks gestation field notes: Interview 1, p5, L17).

Women from ethnic minorities are sometimes treated with irritation (Pollock, 2005) and are deemed to make a fuss about nothing (Bowler, 1993). Anecdotal personal experience has observed individual midwives may be irritated by ethnic minority women 'just turning up' especially when the clinical area is busy and short staffed. This study suggests that professionals may misunderstand health seeking behaviours of asylum seekers and refugees.

## 7:7    Coping

### *'I used to lock myself in and cry.'*

Trauma and re settlement into a new country impact on how people cope with life but are variables that are poorly understood (Omeri, Lennings, and Raymond, 2004). Grace described how she coped when she first arrived in Liverpool:

> *I used to lock my room every time and cry. Every day. No one knew me when I used to live there. They only saw me a few times. Like a visitor. But I used to lock myself in and cry. I have no one in this country. I have no one to take care of me.* (34 week gestation: Interview 1, p19, L914).

Even though Grace described that she felt desperately lonely and had difficulty coping she found comfort and support in her local church:

*R. Have you got a friend in mind?*

*G. Yeah. She's called B....and she said that she will be there. She's the lady I go to church with.*

*R. How did you meet her?*

*G. At church, that church down there.*
*R. Has she got children?*

*G. Yeah she's an old lady. But not really very old.*
(34 weeks gestation: Interview 1, p11, L511).

Religion played a part in the lives of all of the women. Photographs chosen for discussion portrayed times when the women were either preparing to go to or had finished attending their individual religious institution. There was a picture which Meena shared that showed her smiling, sitting inbetween her two

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children. She looked proud and elegant. One of her hands was visibly supporting the elbow of her son as she drew him near to her; he also smiled at the lens. Her little girl lent inwards to her mother and tilted her face onto one of her shoulders which was covered in a deep pink jumper. There was an obvious attention to detail in how the three were dressed. Meena had a small amount of make up on and her deep lips enhanced her smile. Meena described this as , *'a celebration before going to the Temple'* *(6 weeks postnatal, field notes: Interview 3, p1, picture 5).*

Meena's religion was Sikh and this had been the meeting place for friendship:

> *We know another family, they're from Afghanistan as well, we only came to know them here when we met in Temple.* (2 weeks postnatal).

A reliance upon religion has been described as stoical coping and can be linked to positive outcomes or negative mood states (Maltby and Day, 2003). For Grace a negative mood emerged:

> *The woman from the church keeps you in her home…she shouldn't be able to just keep you there. You have to do the shopping and cleaning and when that's done you can go.* (20 week field notes: Interview 1, p19, L940).

Grace's negative mood highlighted a lack of control about her life and how others may have been able to manipulate her. Grace may have felt the need to be consoled or protected in the church and instead of protection and consolation was led into a manipulative situation. The way asylum seekers and refugees cope with resettlement is individual and not homogenous and

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reflects their complex situation in society. Approaches to coping may reflect learnt cultural behaviour as Meena described how she coped with a previous labour when she lived in Afghanistan:

> *My labour started about midnight. The pains started at 12 o'clock but they were not very strong pains. They ....... (tape muffled and missing words) in families we shouldn't make too much fuss you know, too much noise. People in the family who are there they shouldn't know about this you know. (34 weeks gestation: Interview 1, p3, L107).*

Society needs to try and understand how asylum seekers and refugees cope and explorations should incorporate trying to understand how the underpinning values of particular cultures, such as religion affects this ability.

## 7:8    Conclusion of the influence of social policy

This chapter contextualised life in the UK from the perspective of the women. It has noted the policy contribution to issues of dispersement, integration, housing, ill health, and coping strategies.

Increased anxiety related to inflexible dispersement policy may negatively influence health outcome. The process involved in dispersement may increase the tendency for mental health problems in asylum seekers and refugees. Furthermore, there needs to be an exploration of how poor living conditions may affect the emotions and behaviour of asylum seeking children as they grow.

Reunification is a fundamental human right and bureaucracy prevents this. Policy makers need be more aware of the views of asylum seekers and

refugees which may lead to the development of humane legislation. Policy affects the way asylum seekers and refugees integrate. Integration may be stressful and this process may be influenced by societal representation. How individuals integrate affects their ability to cope.

This study suggests that professionals may misunderstand health seeking behaviours of asylum seekers and refugees. Practitioners should be made aware of how their non-verbal communication within the clinical setting may impinge on an individual's perception of self.

# Chapter 8: Theme 2

# Understanding in practice

## 8:1    Introduction to understanding in practice

This chapter will present how understanding was generated in practice. Taken for granted elements of communication have emerged from the data. Assumptions of what had been understood created a barrier to promoting health and wellbeing for the women. Imparting information and obtaining consent are of paramount importance and will be discussed in relation to the women's experiences. The implications of implied consent because of non-verbal assent will be discussed. Access to information will be related to the professional working environment. Increased risk of maternal and perinatal mortality will be linked to the inappropriate generation of information. Individualised approaches to maternity care were appreciated by the woman and there is a suggestion that developing community working for midwives will assist in relationship building.

## 8:2    Taken for granted communication

*'Nurses knew themselves......like it was understood they didn't have to ask me'.*

There is a human need for mutual communication (Habermas, 1984) and meaningful understanding (Habermas, 1989). Communication is filtered through pre-existing meanings (Clough, cited in Denzin and Lincoln, 2000

p107) and may be shaped by gender, politics and the influence of mass media. The ability of the study group to know and control their worlds appeared to be limited and guided by cultural and political influences. Understanding between women and midwives, within the context of this study, appeared to be complicated by language barriers and concepts which were difficult to express in alternative languages. The reliance upon symbols and gestures drew the focus of meaning to be situated within non-verbal and taken for granted communication. Understanding and meaning between the study participants and midwives emerged as a relationship to the theory of symbolic interactionism (Blumer, 1969; Charon, 1979). Within this theory individuals continuously adjust their behaviour to the action of other actors (Blumer, 1969).

In a hospital setting verbal communication is the primary source of information and health promotion. However, health promotion appeared to be non-existent and the women commented that there was a reliance on a symbolic representation when communication took place.

> *They (staff) used to (communicate) with sign language, 'I want a cup of tea', or something. They used to use (a) little sign language and I can understand yes and no. So, I was just getting by.* (Meena, 2 weeks postnatal: Interview 2, p4, L141).

> *We communicated by sign language but I was never sure I had understood properly.* (Layla, 2 weeks postnatal field notes: Interview 2, p5, L24).

> *I waved my hands (to communicate).* (Abeba, 2 weeks postnatal: Interview 2, p3, L28 ).

Relying on a system where understanding is taken for granted may contribute to misinterpretaion. For example, although good practice suggests that women are informed about the increased risk of cot death when co-sharing a bed (RCM, 2004), it is doubtful that Meena had this information. Safety precautions in relation to co-sharing a bed were described to Meena by gesture:

> *I took the baby from the pram (hospital cot) and tried to give him my milk and I just put him alongside me in the bed and I fell asleep. The baby slept as well, you know. Then somebody came, (a) nurse (or) somebody, it might have been (the) nurse in the night time. She came and she was just standing there and I got frightened I quickly opened my eyes. And she (MW) meant don't be frightened, it's not nice to have baby sleeping by your side. She showed me...just pick him up and put him in the pram you know.* (2 weeks postnatal: Interview 2, p658).

For Meena the prevention of cot death by correct positioning was explained at discharge from the hospital and was given via Meena's husband who understood little English:

> *Before they discharge me the midwife came to me, my husband was there. She tried to explain a few things how to lie down the baby in bed and how to register his birth and how to look after the baby, how to feed him, all (of) these things. But he didn't understand. My husband couldn't understand anything you know (just) little bit.* (Meena, 2 weeks postnatal: Interview 2, p13, L587).

The midwife in this instance had presumed that Meena's husband would be able to understand. "Taken for granted" understanding between the midwife and woman occurred even though one woman spoke fluent English:

> *Because she took my blood I wanted to know all of them (results). What are the consequences for instance (of) everything we took. I*

*wanted her to discuss what will happen in the future if I don't do that. But I don't know anything now. Knowing that yeah I'm negative (is) fine. Because you need to something about that. You know.*

*But I think she's done (written) a comment in here (the hospital notes) telling me (that the) test results came back (and) they are good. But now what we need (is) to discuss about your blood group is this..... OK I'd like to know that. And also, this blood thing is caused by this and that. There's things in there (the hospital notes) I don't even know what they mean. I don't even know what causes them.* (Grace, 34 weeks gestation: Interview 1, p15, L735).

An ideal speech situation (Habermas, 1984) may never be present in communication between different languages. A suggestion that understanding is not an isolated experience which is constructed but one that is negotiated appears to be reflected within the data (Gadamer, cited in Denzin and Lincoln, 2000 p194). For example, Meena commented that there were situations where verbal communication did not occur but the interaction, *"was understood (and) they didn't have to ask me" (Interview 2, p12, L515).* This comment reflected an episode when artificial milk was distributed routinely around the ward and depicted a situation were discussion was non-existent. Consequently, Meena had to consciously interpret the meaning of gestures and symbols that took place within this communication. Interpreting gestures and symbolic representation in practice led to her own hypothetical interpretation of the meaning that it was right to feed her baby with formula milk. The midwives who distributed artificial milk to Meena, who intended to breastfeed, did not explain the effect this act may have upon her breastfeeding experience. Information and purposeful meaning became hidden.

Pivotal to the perception of ethically based care is the ability to gain informed and valid consent for treatment. However, there appeared to be taken for granted compliance in relation to the ideology of trust when women commented about how consent had been obtained:

*The paediatrician came at 5pm the baby had to have a BCG. I was told, 'you will be given this'. But I didn't understand what the injection was and why the baby should have it.* (Layla, 2 weeks postnatal field notes: Interview 2, p3, L29).

Informed consent means giving clients as much information as they need (Jones, 2000) and can understand. This assumption rests on the reasonable person standard or Bolam test (Dimond, 2002). I doubt whether the reasonable person standard was considered when inappropriate translation was used within the practice area which was highlighted in the case of Abeba, who had an emergency caesarean:

*An Arabic interpreter was brought in. She was on duty at the time. But I speak Somali. The next minute all of the doctors and midwives, covered with masks were coming towards me. My eyes felt big and large and were coming out of my head. I felt scared and frightened.*

*Sometimes if you have an operation you think (that) you're dying. I thought I'd never see my husband or my mother in law again.* (2 weeks postnatal field notes: Interview 2, p2, L22).

In Abeba's culture a surgical procedure of any description would be linked with the cultural knowledge that women die during complicated childbirth. The circumstances around this incident were for Abeba terrifying; she thought that she would die. A fear of death in relation to childbearing was not an unusual consideration for these women. Layla had considered a termination of

pregnancy she was tempered by the thought, *'May be I would die during the operation'* (34 weeks gestation field notes: Interview 1, p3, L6).

When caring for non-English speaking women the multi professional team need to be aware that the cultures in which practitioners work in the UK are poles apart from the culture that these women originate from. An accepted procedure which is deemed relatively safe in this country may be viewed from a very different standpoint by a woman from a less privileged society. This scenario may not necessarily be addressed by simply providing the correct language and dialect of an interpreter. In some instances there are words which can not be translated directly into another language. Therefore, precise meaning may be lost in translation (McNaughton, 1988). The multidisciplinary team needs to understand how their action surrounding the care that they provide is understood by a woman who may have difficulty in interpreting that action as well as the words around it. There may, as Gadamer (cited in Mueller-Vollmer, 1986 p38) proposed, two different aspects to communication:

> *namely, the overcoming of the strangeness of the phenomenon to be understood, and its transformation into an object of familiarity in which the horizon of the historical phenomenon and that of the interpreter become united.*

Based on this theory, women who are asylum seekers or refugee's first need to understand that the risk attached to a caesarean section in this country is much less than that of their country of origin. This may help to reduce fear of death and a sense of overpowering anxiety. Understanding this concept may have been necessary before there was an ability to absorb any other

information in relation to their wellbeing. It is doubtful that statistical information in relation to risks of operative procedures was discussed with this group of women.

I suggest that actions and symbols used by practitioners in maternity care within episodes of communication with women who are asylum seekers and refugees may be of greater importance than has previously considered. "Taken for granted" distribution practices, such as Meena describes should be discouraged:

> *The nurses knew themselves, when they were giving milk to other baby's they (and) will leave bottles for me.* (Meena, 2 weeks postnatal: Interview 2, p12, L 514).

Problems surrounding episodes of communication may be exaggerated due to the singular, taken for granted gestures and symbols, such as non-verbal cues represented by nods or smiles, which come to represent that episode of communication.

## 8:3    Access to information

### ' I was never sure I understood properly.'

To a large extent midwives work within the culture of large organisations where the generation of information related to health promotion in childbirth may be influenced by dominant normative standards imposed within the clinical area (O'Caithian, *et al.* 2002). My data suggests that the process of

engaging in discourse which provided the women with clear and consistent information within this setting is lacking for women who are asylum seekers and refugees. Layla exemplified this feeling:

> *I felt that because there was no interpreter with me the midwife had to guess if she had understood. We communicated by sign language but I was never sure I had understood properly (Layla, 2 weeks postnatal field notes: Interview 2, p5, L22).*

Midwives have a duty to ensure that accurate, evidenced based advice is given to women (NMC, 2004). The woman has a basic human right to be enabled to understand the information provided (Department of Health, 2001b). Through midwifery experience and analysis of this data, it is clear that communication failure will occur unless both of these are achieved. This is inherently difficult when women are non-English speaking and midwives are constrained within an organisation which has a systematic approach to care. Previously (p 90), Meena's words suggested that the information provided by a midwife may have ticked a box on the midwife's list of duties for that day as even though her husband did not understand, the midwife continued with the information giving session. As a result of this action Meena's husband felt compromised enough to request help from a trusted member of the community as the translator pointed out:

> *Then he 'phoned me at home. On 1<sup>st</sup> January, New years day, He 'phoned me at home . He said,*

> *" Aunty, I can't understand would you come to help us".* (Meena's link worker, 2 weeks postnatal: Interview 2, p13, L583)

CEMACH (2004 p47) reported that barriers to communication exist within practice and contribute to maternal mortality in the UK. Only a small proportion of women who died had access to translation services. In the other cases in the report family members and the woman's own children were used as interpreters. There is a pre conception that the use of professionals to interpret is a financial burden to the NHS. However, using professional interpreters will reduce unnecessary investigations which will save money in the long term (Flores, 2005).

This situation was reflected in the data from my study and Abeba described her booking session was translated via her young son. She commented that this situation had made her husband and children feel 'uncomfortable' (34 gestation field notes: Interview 1, p5, L12). On another occasion sensitive information imparted by the midwife at discharge was translated to Abeba via a male friend of the family:

> *He was telling me (information) but he was shy. I didn't want him to translate things like that but the midwife had already started.* (Abeba, 2 weeks postnatal field notes: Interview 2, p6, L6).

This picture paints an episode of communication which prevents autonomy. Abeba had no choice but to embrace this method of dialogue as she describes:

> *One side I feel shy and embarrassed and another side of me I need the midwife explaining these things to me.* (2 weeks postnatal field notes: Interview 2, p5, L34).

Advice and information related to childbirth should be presented in a culturally appropriate way and be tailored to the needs of the woman (Lavender, Moffatt, and Rixon, 2000). For example, when Meena described how she would breast feed after birth at her 34 week antenatal interview she said her knowledge was based on her past experiences:

*We don't let the baby breast feed there and then. First we give the baby little honey, with the little finger we will put in baby's mouth. (This is) the first thing we do then the baby sucks. The first thing we do is look after the baby's cord. After 6 or 7 hours then they will put the baby to the mother's breast.*

*I would like to try and feed the baby myself* (this time). *But because I have other two children I will try and bottle feed him or her at the same time, because I have to do so many other things. So I will bottle feed as well and give my own milk.*

Udoeyo (2003) suggests that ethnic minority women in Liverpool have a poor knowledge around the subject of infant feeding which is reflected in their infant feeding practices. Furthermore, asylum seekers commented that the majority of the information that they had around infant feeding was from members of the community rather than professionals (Koser and Pinkerton, 2002; Udoeyo, 2003). Lack of access to the infant feeding team for women in this study created a further barrier to information:

*R: Has anybody spoken to you about feeding methods?*

*G: No, no one has (surprised).* (34 weeks gestation).

The repercussion of limited access to information about infant feeding may affect the long term health of women who are asylum seekers or refugees in

this country, who are unaware that there are added benefits of breast feeding. Ensuring the best evidence surrounding infant feeding practice is imparted may contribute to involving the women more in their care.

Additionally, health promotion information appeared to be lacking for issues around sexual health. This was apparent even for Abeba who had been in this country for two years and seven months at the start of the study:

> *I know something (about family planning) from my Arabic friends. I understand a little about tablets and implants. I don't know where to get information about this from.* (Abeba, 6 weeks postnatal field notes: Interview 3, P6, L).

For Layla this was something that she had never heard of, '*What is family planning? I don't have any need for this. What is a smear?*' *(6 weeks postnatal field notes: Interview 3, p4, L2).* The lack of understanding about the women's ability to control their own lives in this way is of major importance as all of the women had been '*shocked*' and '*frightened*' by being pregnant in a new country initially. Three of the four women had considered terminating the pregnancy:

> *I found out I was pregnant four months after coming to the country. This was a shock and I felt unwell and considered stopping this (*Layla 34 weeks gestation field notes: Interview 1, p2, L28).

Health promotion related to breast and cervical screening is lacking for black and ethnic women (Rowe and Garcia, 2005). This may be an exaggerated

problem for asylum seekers and refugees. In this study there was a pattern of inappropriate information giving by midwives that resulted in difficult to access information and a lack of understanding for the women. Health promotion may be best delivered by utilising the ability of link workers (Editor, 1996), bilingual workers (Aylott, 1997) or interpreters who would like to be educated in this field of work, as Layla's interpreter suggested:

Interpreter:    *I would like a health educator's role. There was a woman who had HIV and I found the explanations for this very stressful but I think if I had known a bit more I may have been able to help more. (Field notes Layla's second interview, p8, L7).*

Addressing health promotion issues is a requirement for midwives and may be assisted by a proactive approach which incorporates alternative methods of dissemination such as mass media technology. Media and particularly the internet are a source of information for asylum seekers (Kosher and Pinkerton, 2002). Grace explained how she had focussed on a television programme to help her understand what her delivery room may look like:

*I just always watch ER so I try to focus on things may be it's their room. Because when I watch the TV I see those people I always think that the room is like that. I don't know I don't know what it looks like. (Grace 34 weeks gestation: Interview 1, p 11, L529).*

However there is little research about how the media might assist in disseminating information to asylum seekers and refugees. Imparting information in this way may contribute to the long term health of the mother, the child and the family.

## 8:4    Building relationships

*'I feel good ...because I know there's someone who's listening.'*

Evidence suggests that ethnic minority women may book late (CEMACH, 2004 p47). This may be because the system of referral is unknown to them and is difficult to navigate without help (Burnett and Fassil, 2002; Robinson and Segrott, 2002). Grace explained how the hostel workers had instigated contact:

> *I was at ...( The hostel) where I was staying. I was sick inside my room. I was sick and they* (hostel workers) *told me have you seen a doctor yet and I said no. They took me to* (the doctors) *and they checked me. The doctor told me  you are going to have to start having an appointment with your midwife in the hospital.* (34 weeks gestation: Interview 1, p14, L673)

For Meena the system was negotiated by reliance upon her link interpreter who was also known to her in the community setting. For example, the link worker described the process that she was involved in following Meena's discharge from the hospital:

> *Then again they contacted the hospital through me. I went to my clinic on Friday and got an appointment for registering his* (Meena's son) *birth the next Monday. And then arranging the midwife  visit here in the house. I done all these things for them. I got all the numbers when they discharged her.* (2 weeks postnatal: Interview 2, p14, L612)

The women in this study were fortunate to have help to access health care. Booking late and raised mortality rates for asylum seekers and refugees are

linked (CEMACH, 2004 p47). Mortality rates are especially raised for newly arrived asylum seekers who may not have existing communities around them to help to navigate a complex system. Direct access to a midwife may help to reduce high mortality rates for these women and is discussed later in the thesis (p160).

Access to a midwife for the women in this study was via a GP referral letter. A midwife provides care for women during pregnancy, labour and in the postnatal period (NMC, 2004). The main aim for midwives is to keep the care of the woman centred on her needs (RCM, 2001). Central to this aim is the midwife- woman relationship which may emerge from positive aspects of non-verbal communication (Rogers, 1995). For example, Abeba felt 'welcomed' (2 weeks postnatal field notes: Interview 2, p1, L20) on to the postnatal ward because the staff 'smiled' (34 weeks gestation field notes: interview 1, p4, L20) at her. In contrast, for Grace, negative symbolic displays were responded to by a placated and silenced response, 'I just kept quiet and sat down on my bed.' (2 weeks postnatal: interview 2, p6, L276).

Women in this study appreciated the care that midwives provided. There were episodes of care that described life saving techniques and Grace explained what this meant to her:

> *My God, the midwife was really patient with me.......*
> *so after the baby came out they  put him on my tummy so I could hold*
> *him for a while, they took him away, for some reason I don't know.*
> (Grace experienced a massive postpartum haemorrhage) *I was going*
> *but I could see loads of people surrounding me, and I didn't know but I*
> *had lost a lot* (of blood) *and they were like,*
> *'we're losing you, we're  losing you'.*

*They kept on talking to me to see that I keep awake, because even* (then) *I couldn't breathe, I was just going.* (2 weeks postnatal: Interview 2, p8, L370).

Appropriate sensitive care (Tiedemann, 2000; Fraser and Cooper, 2004) appears to be have been achieved in many instances in this study. Overall, the women were pleased with their midwifery care as Meena reflected:

*Looking back we never ever expected this good treatment, this nice treatment and* (how) *the people will behave towards us you know. We never expected in our life that people would be so nice and kind to us. I can't think anything better than this.( 2 weeks postnatal: Interview 2, p15, L649).*

Meena's positive responses to midwifery care were based on non-verbal episodes of communication and related not to the content of the dialogue but to the demeanour of the midwife:

*The way they (MW's) were speaking to us you know. Their manners they were treating us... very nicely, not in a rough way. Even though we could not speak English we understand that the person speaking made us very comfortable.(Meena, 34 weeks gestation: Interview 2, p6, L253).*

However, there were a few negative encounters with midwives as Grace commented:

*She (midwife) treated me like I knew nothing you know.... So I think she was quite rude but maybe she just didn't know what she was doing or she didn't have the answers to my questions. She didn't look friendly. You got scared when you ask her questions you don't feel free to ask her. (Grace 34 weeks gestation: Interview 1, p11, L545)*

Additionally negative attitudes emanated more from the general public:

Researcher: *How did you feel about sharing a room with other women?*

Grace: *Ah, The first week it was horrible, because of some woman she was really, really cruel and rude.*

Researcher: *What did she do?*

Grace: *She was white, the way she looked…. so every time, like, I ask her something she kind of reacts rude, the other women are, they are really alright.* (2 weeks postnatal: Interview 2, p6, L268).

Stereotypical attitudes are evident in midwifery and society (Bowler, 1993; Harper-Bulman and McCourt, 2002; Ali and Burchett, 2004; Pollock, 2005). Mass media plays an important role in today's society and may affect the view of the host population (Thompson, 1995). An impression which contributes to the sterotype may emerge from commentators and politicians who claim that asylum seekers choose to come to the UK because the country is a 'soft touch' (Gill, 2003; Harris, 2005; Jones, 2005). However, Meena and her family were unaware that their journey would culminate in the UK:

*We did not know we were coming to England. We told our agent, we told him, 'Look we want to go somewhere safe. Where our religion is respected and our children can get to go to school'. We want to be safe, especially what happened after 2-3 years there (Afghanistan).* (34 weeks gestation: Interview 1, p4, L160).

The natural human desire for survival and to protect their offspring appeared to be the emergent theme which is underrepresented within mass media (Clayton, 2005). Stereotyping may have accounted for the way that some of the women had received care. Midwives who believe ethnic minority women are natural mothers who may not require much pain relief, and who prefer to

be instructed rather then be offered information and choice, may have led to

the assumption that Layla did not need extra pain relief in labour:

> *I expected to be OK but I had lots of pain because there was no pain*
> *relief given. I asked but it was not given any. The midwife gave me gas,*
> *but this wasn't useful or helpful.* (2 weeks postnatal field noted:
> Interview 2, p2, L6).

Additionally, cultural stereotyping may have contributed to the way midwives

and health care assistants responded to Meena who wanted to breast feed,

but who was actually provided with formula milk via a distribution service

within the ward setting (p91).

Stereotypical representation within images of the way health care is delivered

may be a reflection of the way women see themselves in society (Winkivist

and Akhtar, 1997). Furthermore, little attention to explanation, midwives who

do not listen to the women's wishes, lack of informed consent, and lack of

punctuality by practitioners may reflect norms within a culture which led to a

pragmatic acceptance of care. As Layla described:

> *I turned up for my appointment with my doctor but he wasn't there. I*
> *never complained, we're used to this in my country. We sometimes*
> *wait for days.* (6 weeks postnatal).

Stereotypical portrayal, a lack of attention and listening, and lack of time given

to asylum seekers and refugees by professionals, symbolically reinforce

negative perceptions. This may be why Layla's perception of herself in society

emerged as someone who is unimportant and in a subservient position in

relation to the doctor. The women in this study came from Somalia, Rwanda,

The Congo and Afghanistan where resources in maternity care are scarce. The women may have previously been treated with little respect (Weeks, *et al.* 2005) and with a judgmental attitude (Ndhlovu, 2003). It seems logical to assume that women who are asylum seekers and refugees may be acutely aware of the symbolic implication of non-verbal behaviour and be conditioned to respond through symbolic body language through looks, hand gestures, and tone of voice. Negative conditioning may be increased for those who rely solely on trying to communicate without words, as in Layla's case:

> *They* (midwives) *communicated by sign language and I was never sure I had understood properly.* (2 weeks postnatal field notes: Interview 2, p5, L22).

Building a relationship needs engagement from both parties involved. For Grace, appreciating uniqueness was symbolically displayed by the midwife's ability to listen. She spoke about how she felt there was a value in face to face contact:

> *There are so many ladies out there. They come to the hospital everyday....some ladies can't talk about what things... but at least they could have one to one... you know talk to them.*
>
> *You know when I talk about myself I feel good about it because I know there's someone who's listening and understanding which makes me feel better. But I understand if there's something not done about it, no one speaks about it. You let it out. You know it's gone.*
>
> *But every time I keep it in my heart it hurts so much...So if people could come up like this, like the way you come up and speak to us. I think mostly this could be happy. Though the problem is not solved at that particular time, but believe it can be solved in the future. Because once you talk about something you come out with different solution to your problem.*

> *But once you keep it in your heart you don't know what to do. You just get more confused. That's when you hear of people committing suicide.*
>
> *Sometimes people don't want to have babies because of what they went through in the past. Sometimes they just hate themselves, which is not good.* (34 weeks gestation: Interview 1, p18, L868).

The ability of midwives to engage in discussion with women about their maternity care, and importantly about their lives, assists in creating a partnership in care (Pope, Graham, and Patel, 2001). However, for non-English speaking women asylum seekers and refugees this may be a privilege which is denied. Despite the need for individualised episodes of interaction:

> *You don't know what that means. Just to talk to some one who will listen. That means you're not in your own world. Because when I used to be in ... (Hostel) I used to lock my room every time and cry.....I have no one in this country.*
>
> *I started thinking when I'm by myself when I'm alone. No one is there to listen to me no one is there to talk to me. Just talking was better I guess because no one was there......I wished I could do something wrong to myself. I mean I even used to hold knives and I used to tell myself I wish I could cut myself. I wish I could do this. I wish I could fly through the window and die.* (Grace, 34 weeks gestation: Interview 1, p19, L912).

Professionals may prioritise the physical needs of asylum seeking women above any emotional or psychological need (Drennan and Joseph, 2005). Additionally, professionals acknowledged that the emotional and psychological needs of women were minimised over the needs of children (Reynolds and Shams, 2005). However, emotional support was an important factor for Grace. The women in this study commented that they trusted the professional to do 'good' above all else. Meena described that she trusted in the ability to good all of the time:

*I was relying on the staff; midwives (and) doctors. They were looking after me, I was a hundred percent relying on them and I didn't feel like asking them (why) you know. But (I knew that) what ever they were doing they were doing good for me.* (2 weeks postnatal: Interview 2, p7, L280).

Trust emerged in this study from the "taken for granted" knowledge that midwifery care is based on the ethical principals of doing good (beneficence) and not creating harm (non-malificence) (Hendrick, 2000). From the perspective of women who are asylum seekers or refugees physical needs pale into insignificance in the light of other issues, as Grace explained:

*So when I came back (out of hospital) it wasn't easy for me. I knew I had only two weeks to stay. So I had to start moving around looking for those people (Asylum Team). I went, I saw them. They told me they were going to help me. So when the two weeks were over she kind of managed to give me some money. Because it was Thursday and I had to get out of the house, and she managed to convince them (NASS) because for them they were saying they're taking me to Birmingham. I had no one in Birmingham. I don't know anyone at all in Birmingham. I was like Oh God, Where are they taking me?*

*I had the stitches. They were horrible I took some tablets. I didn't know I was allergic to them. I think they were antibiotics I got a rash. It was itchy. I'm sick, I'm tired, I'm anaemic, I'm dizzy all of the time. I have to walk every day until they come to the conclusion. So it was really horrible for me. I was like where are you taking me? So I started crying all of a sudden, because I really didn't know what I was going through.* (2 weeks postnatal; Interview 1, p14, L658).

The value placed upon individual attention can not be ignored. I suggest that to care for this group of women in an individual manner the midwife needs to have a raised awareness of how non-verbal cues may affect interaction. Identifying non-verbal cues will assist the ability of the midwife to interact with women who are asylum seekers and refugees, which may lessen fear and anxiety in relation to maternity care. Fear and anxiety may be allayed simply if information is provided. For example, the midwives talked of an 'up stairs'

where Meena would go when she went into labour. Although this may have been familiar and acceptable to the midwife for Meena this created an anxiety:

> *When the time was coming very near, I was really really frightened*
> *because they used to say,*
> *' you have to go up stairs'*
> *You know the delivery rooms. And I was used to being down stairs all*
> *the time in link clinic and scan area.  I used to think,*
> *'Oh my god, what's up stairs?'*
> *I didn't know what's up stairs.* (2 weeks postnatal: Interview 2, p7,
> L285).

However, when asked if Meena had explained her fear to the midwife, Meena commented that she would only talk about such things to her husband, despite the midwife asking if she had any worries at the end of the appointment with her. This places an alternative level to the communication problem between midwives and asylum seekers and refugees. It is important for the midwife to realise that concepts of midwifery and childbirth need explaining as well as basic information. Explaining or showing where and what 'up stairs' was may have helped Meena in this instance. Midwives need to be mindful of the importance of sharing verbal information with women asylum seekers and refugees. Spending time to explain via appropriate translation may symbolically represent the issues being discussed are of value. Sharing information is a fundamental part of forming a partnership.

Overriding the emotional needs of asylum seekers and refugees may be a symptom of the way midwives work. The cultural setting in which the interaction takes place may influence the actions of those who instigate the interaction (Denzin, 1992). Working in an environment that values how quickly tasks can be completed coerces midwives to focus upon practices which

hinders the ability to recognise uniqueness (Bryar, 1995). Midwives in a UK national survey have indicated that this type of detached, efficient and fragmented way of working may be attributed to a medical philosophy of care sustained in the clinical area by senior midwives and obstetricians (Lavender and Chapple, 2004). Conflicting ideologies ultimately result in midwives working 'with institution' and not 'with woman' (Hunter, 2005: 254). Grace suggested how she would like midwives to work:

> *That's good if your midwife visits you at home, because if someone visits you at home it's easier to talk about it* (problem). *But if you're at the hospital she's* (midwife) *got to do this and that. Sometimes they tend not to have time for you. They just say so many people are waiting. And when you look at it you see so many people are waiting and all of them want to be seen like the way you want to be seen. So if the midwife will see you at home it's much better.* (34 weeks gestation: Interview 1, p16, L792).

Community based working is not new for midwives (DH 1999a; 1999b; 2004). This role incorporates the ideal that the midwife will have the ability to address inequalities in health with the aim of reducing levels of ill health. A partnership in care emerges from a midwifery model of care which desires to care for women in a unique and individual way and will be facilitated by placing this partnership in care in a community setting.

## 8:5    Conclusion of understanding in practice

Communication between different languages is problematic. Throughout the world there is more non-communication than communication between human beings, because of language (Pernier, cited in Gerver and Sinaikott, 1978, p202). My study highlighted that this may happen to both non-English and

fluent English speaking women who are asylum seekers and refugees. This knowledge contributes to the hypothesis that midwives need to pay more attention to the taken for granted aspects of communication and not simply blame incorrect interpretation.

"Taken for granted" areas of communication may originate and mutate within the type of cultural setting in which midwifery practice takes place. If the cultural setting is underpinned by a systems approach to care eliciting if communication episodes have been understood may be ignored in a desire to complete a 'tick list' approach to care. Embracing difference and caring for women in an holistic way has been advocated, a model of care that is aimed for nationally (Department of Health, 2004). The key may be to consider why this model, although commended and advocated, is hindered from becoming a reality. My data suggests that midwifery care in this study was fragmented. A logical hypothesis would be to assert that if the culture in which midwives work is altered to accommodate uniqueness, a holistic approach to care may be achieved. The ability to engage in individualised midwifery care should be seen as a strength that would accommodate value placed upon psychological aspects of care. This type of care would focus more on communication, preserving personal relationships, being sensitive to the needs of others, being responsible for those around them and fulfilling these responsibilities. Midwifery care within a hospital setting may mean that midwives tend to work 'with institution' and be distracted from working 'with woman' (Hunter, 2005). Direct access to a midwife for women who are asylum seekers and refugees

may be the key. Access in this way may help to identify women earlier, reduce non-attendance rates, and build relationships.

The role of the midwife in imparting information plays a vital role in promoting the health and wellbeing of the woman and her new born. Neglecting to involve women in the intricacies of this communication contributes to disempowering women who are asylum seekers or refugees. This attitude may contribute to the provision of sub standard care and contribute to a negative personal perception.

This knowledge should be incorporated into all aspects of practice and communication between women from different cultures. The women's physical needs at times paled into insignificance compared to their emotional needs. When imparting information midwives need to be aware of how interaction, which relies on gestures and symbols, plays a deeper part in their episodes of communication. Understanding non-verbal communication in a deeper sense will lead to improved interactions between midwives, asylum seekers and refugees. This aspect of communication may be best understood by drawing from the theory of symbolic interaction (Mead, cited in Meltzer *et al.* 1975; Blumer, 1969; Charon, 1979; Denzin, 1992). Interpretation of action underpinned how women appeared to perceive themselves. Midwives need to know that their non-verbal cues and responses have an impact on the women's self esteem and understanding within child birth. Disassociating from interaction may lead to placated silence for these women. Developing positive and constructive non-verbal communication may contribute to a more positive

partnership between midwives and women who are asylum seekers and refugees.

Building relationships with pregnant asylum seekers and refugees may mean that midwives work in different ways. The working environment for midwives who care for asylum seekers and refugees may need to be evaluated in a multfactorial way. This approach may help to identify how competing ideologies can be developed to enhance, rather than stifle, the role of the midwife.

# Theme 3

# Chapter 9:   Perception of 'self'

*'It means people care (and) people don't look at us like .....shit....'*

## 9:1   Introduction of perception of 'self'.

The fluctuating nature of the women's lives is related to their perception of 'self'. The women's perception of 'self' was contextualised by their female role in society, which in this study is based upon women's socially situated role in relation to male dominance, as opposed to a purely sexual difference (Haralambos, *et al.* 2005). Genderised roles in the women's country of origin will be discussed and related to the women's maternity experiences within the UK. The data links how the influence of professional power affected the way the women perceived themselves.

## 9:2   Shifting identity.

*'there is no life for a woman there...but here you have hope.'*

Women who are translocated from their country of origin to a Westernised culture may experience a personal shift in identity which has been described as a nomadic identity (Gedalof, 2000) due to women's forced displacement. Personal identity for the women in this study may be linked to both genderised roles in society and their ethnicity. Women's awareness of difference in race is

increased because they have relocated to a predominantly white culture in the UK. When there is a raised awareness of race rather than gender women are more likely to perceive negative reactions as personally significant (King, 2003). It has been derived that because asylum seekers assume that Western countries will have the freedom of thought and speech and offer better opportunities for education, social advances and life chances (Robinson and Segrott, 2002), the fact that they are a woman in the UK becomes less threatening to them than the colour of their skin. A feeling which Abeba could relate to when her consciousness was raised by the negative reaction of others around her:

> *They laugh at me as I walk past. They think I don't understand what they're doing. I pretend I know what they've said and look up to them.....but when they talk to the English they are like, 'Hello love' and their face changes.* (6 weeks postnatal field notes: Interview 3, p4, L14).

Feeling threatened because of race or gender will raise stress levels (King, 2003) and may be a contributing factor to the health of the women involved in this research.

Gender is socially created and culturally defined (Haralambos *et al.* 2005) and is different than the anatomical and physiological display of sex which define the male and female human. Gender socialisation is influenced by interrelated signs, roles and rituals (Tong, 1998). The display of these characteristics is controlled by social norms which are influenced by the lived in environment such as societal values, literature, mass media, and political sanctions.

The individual perception of self which the women in this study held when living in their country of origin may be translocated to the host country. For example, Grace identified with the way babies may be conceived due to previous experiences. The existence of those feelings left Grace with a feeling of hatred for 'self':

> *Sometimes people don't want to have babies because of what they went through in the past. Sometimes they just hate themselves, which is not good.* (Grace, 34 weeks gestation: Interview 1, p18, L882).

However, self may be viewed from different perspectives. One perspective is when the self is represented as an individual (Mead, cited in Morris, 1967, p135); another where self becomes a multiple entity (Goffman, 1961). The multiple entity allows the self 'to put on a good show' by adapting faces to fit the type of interaction. This is an important concept for women who are labelled as an asylum seeker or refugee because their ability to 'put on a good show' may be a direct result of how they interpret symbols within the process of communication. This was highlighted by Grace:

> *They don't have families. They don't have no one to turn to and sometimes they can't express themselves. They're scared . They're in a scary world. They don't know what to do. But if someone can come up and talk to you. You feel there's someone who cares for you in this world . Just to talk to you. You don't know what that means. It means people care (and) people don't look at us like .....shit....I used to think people look at us like that .* (34 weeks Gestation: Interview 1, p20, L962).

Grace interpreted the gazes of others as a representation of how she perceived others regarded her. Symbolic interactionism theory helps to explain the process of how actors react to their interpretations of the action of

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others (Blumer, 1969). Mead (cited in Morris, 1967 p66) likens the interpretation of gestures to that of mirrored behaviour. He suggests that individuals 'call out' the type of behaviour they desire in the other by their gestures and actions. In this way Grace interpreted how she felt because of the looks and actions that were displayed in the behaviour of others around her, which were negative and made her feel worthless. Drawing on the theory of symbolic interaction would suggest that asylum seekers or refugees regard and interpret themselves through the eyes of others in society, the media, and professionals in practice. The women's self perception may be accepted as one of subordination and oppression and of feeling less than others in the new society because of their personal histories. Meena described how her life had been in Afghanistan:

*All of the women stayed at home they never went out. They were not allowed to go to school or to have an education. That's why I'm not very.....* (stopped there and did not clarify) (34 weeks gestation: Interview 1, p1, L39).

Characteristics displayed by the women which were related to their previous experiences may have been interpreted by individuals within the host country as vulnerable, pathetic, needy, and dependant (Harris, 2003). However, women may achieve high social status amongst other women in their country of origin and gain respect via their supportive childbirth roles, ultimately reaching the status of elder.

*I feel you're like some elder, somebody from my own family you know. And I feel very close to.* (Meena, speaking to the link worker. 34 weeks gestation; Interview 1, p8, L325).

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Therefore, within a childbirth setting in the country of origin the women were dominant and male exclusion was the norm (Moghadam, 2002). The women described 'women only' situations occurred and men were excluded;

> *The other neighbour, she was a midwife. She was in town by then. Her home was in the village. So we had to wait for her to come back in the evening. The experiences are quite different compared to the ones here. .....but there was the woman and her grandmother, and nobody else.* (Grace, 34 weeks gestation; Interview 1, P7, L345).

Even though there was female dominance around childbirth the women's social position fluctuated within their own societies. Often men regarded women as subordinate, which was reflected in values that were displayed in the regimes that the women lived in (Afghanistan, Congo, Rwanda, and Somalia). The role of women within the private sphere of family life may be used to oppress (Oakley, 1974) or used as powerful lever in which to exercise social control (Moghadam, 2002). In Grace's case her sexuality was preyed upon in her country of origin and she explained how she had been raped:

> *The reason was... I just don't want to talk about it. Even during that time people were raped things like that. So I ended up becoming pregnant. That's why that lady took me in. I was suffering and I was alone.*
>
> *But just now and then I keep thinking about it* (said in almost a whisper). *It hurts. So she took me in she took care of me. By then when I went to Ghana I wanted to abort it; they told me I can't do it. Because they didn't have those machines to do it so they told me you can't do it because if you do it you'll die. It was so risky.* (34 weeks gestation: Interview 1, p3, L137).

Sexual violence is abhorrent in any culture and is used as an instrument to display unequal power and as a political lever in war (Gedalof, 2000). The symbolic representation of women' s sex becomes a material target for those

who strive to dominate and control society. It appears that rape in Rwanda has become acceptable and is viewed as neither laudatory nor especially loathsome. In this context sex crime is seen as a misdemeanour and not a major crime (Donovan, 2002). It is unsurprising then, that the trauma of rape was hidden and not spoken about as the society in which Grace had escaped from would have viewed this event as a natural consequence of war. This research provided Grace with a forum in which she was able to reveal her experience of being raped. During the disclosures Grace became distressed and required listening to and referral to a multidisciplinary health team. Male dominance was not isolated to one woman or one country. For Meena male dominance took on another pattern.

> *At home we used to speak Punjabi all the time but men who go out and about they can speak Farsi. But I wouldn't speak Farsi because I never went out...we were not allowed to go out. I've never been to school.* (34 weeks gestation: Interview 1, p1, L30).

Mechanisms of social control within Afghanistan have been described as household rules and constraints, compulsory veiling and restrictions on women's mobility and travel. The control of women within patriarchal societies has been related to the honour and shame complex controlling women's behaviour and sexuality (Moghadam, 2002). In Meena's, and Abeba's case women in their country of origin are looked upon as less than men, illiterate, and uneducated.

For some women, feminist insights which comment on the oppression generated by men in their lives may be offensive. Women may prefer the

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security and status of a family and prefer not to challenge the private- public sphere (Moghadam, 2002). I agree with Gedalof (2000) who suggests there is a need to positively redefine locatedness within the society in which women live, and for society as a whole to value the work that women do within the home, place and community. In the women's country of origin women valued other women in their community. When location became fragmented and changing as in the host country the women valued, respected and trusted professionals:

> *But if there are any complications that I can't have a natural birth then those who know more can you know.... advise me about it and guide me about it . Because we know what we want but we don't know what's inside us. But those who know more about us can understand things about us.* (Grace, 34 weeks gestation: Interview 1 p17, L828).

The dominating characteristics of the women to the onlooker may be viewed as those which portray stereotype of uneducated and illiterate woman with a powerless demeanour. For a newly arrived woman into the UK there may be great difficulty in finding her voice due to her previous oppression. When Menna was asked why she chose not to express her concerns to a midwife she felt unable to share them even though she had been asked by the midwife if she had any concerns.

> *M: No I never thought to tell anybody else*
>
> *R: Why was that?*
>
> *M: I understand what you mean. But I'm not used to talking to other people you know.* (2 weeks postnatal: Interview 2, p6 L246).

Women who are permitted to stay with the status of refugee may be able to develop a sense of their own importance in time. However, this learnt behaviour may confront the stereotypical representation by society of an ethnic minority women having no voice, being oppressed and being less than others. Therefore, confrontation may occur as in Abeba's case:

> The staff on reception don't see us as human beings. They treat us like animals. There are about three good one's ...the rest are really bad. (6 weeks postnatal field notes: Interview 3, p4, L5).

However, Meena talked positively about how aware she was of the differences since she arrived within the UK :

> But here you've got a hope, it's entirely different here. Woman can open their mouth; they can go anywhere. They can talk to husband even openly. It's very different. (34 weeks gestation: Interview 2, p16, L706).

The political sanctions experienced when living in Afghanistan became more visible as her new life developed. This insight was expressed as a positive influence on the lives of her children for the future. However, this does not suggest that women who escape war and sexual abuse negate the influences of their society completely.

A subordinate role which is embraced by women in society may result in women conforming to the normative expectations of that society and lead to their display of stereotypical characteristics such as a, 'producer of carpets and reproducer of children' (Moghadam, 2002: 28). On admission to Westernised society subsequent dominant relationships may be perpetuated.

The need for a male dominated society to isolate women further by speaking a completely different language is a symbolic display of how women may be valued within that society. Persistent symbolic reinforcement about low social position may create a self belief for the woman who may see herself as valueless (Oakley, 1972) and powerless. A contributing factor to role acceptance may be the level of consciousness of this state of mind (Haralambos *et al.* 2005).

## 9:3    Women's role in society

*' Who will be with me you know, because I haven't got any family here.'*

The relationship displayed between Meena and her husband appeared to be supportive and caring and this was observed and documented as field notes during the prolonged exposure within the interview data. Therefore, it was surprising that she talked of a sense of feeling alone and feared that this may have implications for childbirth:

> *M: I worry about one thing all the time. Who will be with me you know, because I haven't got any family here. So that's the main thing I am worrying about when the baby is born who will be there? So I want somebody with me at that time......*
>
> *R: Who do you feel would be the best person to be with you?*
>
> *M: I've got only husband here so nobody will be there (34 weeks gestation: Interview 1: p7, L291).*

As previously described, traditionally childbirth for the participating women was firmly situated as part of a woman's world. All of the women had relied upon other women for support in labour.

> *First of all my mother in law was with me. Then my sister in law, my husband's brother's wife. They called T....and then the experienced woman we call Dia, (lay maternity attendant). She was there as well. They looked after me.* (Meena, 34 weeks gestation: Interview 1, p3, L93).

Meena was concerned that in the UK she would be alone during labour as were the other women.

> *The most important thing on my mind is when I go into labour is who will be there for me. (Layla, 34 weeks gestation field notes: Interview 1, p4, L18).*

Midwives aim to provide continuous support for women during labour because of the desire to build supportive relationships with women and the tendency of this type of support to reduce rates of intervention (Hodnett, *et al.* 2003). If this type of support could be guaranteed there may be less anxiety about labour support for newly arrived women. However, Meena's way of planning for this was to express that she would like to be accompanied by a respected member of the community in which she likened the preferred relationship to be that similar to a female elder:

> Interpreter for Meena: *Her husband says they talk about at home, that they want me there with her all the time . Because I have been with her all the time (since) she was pregnant (from) day one you know. He's told me very kind, 'Oh Aunty , you should be there at that time you know'......*(34 weeks gestation: Interview 1, p7, L310).

The reliance upon the relationship between Meena and her link worker reassured Meena that the presence of another woman within the birthing process may be accommodated. As in all cases the need for the continued support of their particular religious beliefs were needed. The women expressed that they continued to visit their religious institutions where they appreciated support from others with the same beliefs. The religious community in which the women located themselves appeared to provide support and contact with others in society. As Layla described:

> *My good friend will help this time and lives close to me. I met her in Church.* (34 weeks gestation field notes: Interview 1, p3, L12).

Meena valued the contribution of her link worker who was also one of the first women whom she met in this country via her temple. Meena's link worker interpreted for her at times within the maternity setting.

A lack of social support led women to worry about child care issues when the time came for them to give birth. Childcare during childbirth appeared to be easily accommodated within the women's country of origin but presented dilemmas for the women in the host country, when there was a need to rely on members of the new community:

> *We know another family they're from Afghanistan as well (and) when I started feeling ready for the baby....we only came to know them here when we met in the Temple and the community centre. Then my husband went to their house, they live in L.........area. He went there to their house and brought the lady and gentleman here and they stayed here until he took...to the hospital. They stayed in the house 3 or 4 days to look after children, cook meals for me and my husband as well, because he has to go the hospital.* (Meena, 2 weeks postnatal: Interview 2, p8, L352).

Trusting one's offspring into the care of relative strangers may create concern for Western women in fragmented, dysfunctional and developed societies and alarm bells ring when considering child protection issues. However, this cautious attitude may appear strange for women who are familiar with a community spirit where members care for each other as a community, as Layla described the attitude of looking after other children:

*In Africa the family or friends take the children and the friends and family cook and cleans for about a month. A friend came in each time (in previous pregnancies) to help cook and clean.* (2 weeks postnatal field notes: Interview 1, p2, L27).

The system of child protection within the UK has been influenced by instances of abuse (UNICEF, 2005; Laming, 2003). Women who have newly arrived in this country may be left without an option for childcare. Accounting for who cares for the children of asylum seekers and refugees during intrapartum care may not have been considered previously within the midwifery care for this group of women. Incorporating accountability for child care provision should be a consideration for the public health role of the midwife.

Whilst home birth in appropriate accommodation may prevent the women from leaving their children it may not provide a long term solution. Furthermore, Richens (2003) suggests that all women who are from ethnic minorities should be treated as high risk due to the increased risk of maternal death (CEMACH, 2004 p244). This perspective may disadvantage women from ethnic minorities as Sandall, Davies and Warwick (2001b) identified that midwifery care that is targeted to women from ethnic minorities in deprived

areas can dramatically improve their experience of pregnancy and birth. Therefore, place of birth should be considered by assessing individual circumstance.

It should be highlighted that health may deteriorate soon after arrival into this country for women asylum seekers (Burnett and Fassil, 2002) and there should be a consideration that women from ethnic minorities die for many reasons. I suggest that the deterioration of health after admission to this country may reflect an already compromised health status, problematic access to care, level of poverty, and a lack of self value. A main concern has been that the women who died did not speak English. If language barriers were addressed appropriately, risk related to childbirth may be reduced. Providing women with a choice about place of birth and assessing risk individually for women may help to provide the type of support that the women have been familiar with.

Increased risk of maternal death has been related to women who did not attend for antenatal care (CEMACH, 2004 p47). Ethnic minority women prefer not to travel for their antenatal care (Lavender and Chapple, 2005) which may predispose to missed appointments, ultimately compromising fetal well being. It is possible that an increased community based maternity service with appropriate translation service may better provide for women asylum seeker and refugees physical and emotional requirements in relation to childbirth and may help to achieve a natural birth.

Society devalues women who are asylum seekers and refugees by not offering choice in relation to childbirth. Lack of choice may be a further representation of the value given to these women by society. For newly arrived women into the UK the support from a midwife at birth may form the basis of a wish list:

> *That would be really, really good if the midwife's there, that would be like a bonus. But still in my mind I think that some other lady should be there like back home.* (Meena, 34 weeks gestation, P7 L306).

## 9:4    Professional power and women's identity

*' We thought we are in good hands and we didn't question anything you know.'*

There appears to be a functionalistic attitude (Hunter, 2005) to the way in which women are cared for within this maternity setting and practices of distribution were described:

> *The nurses knew themselves, when they were giving milk to other baby's they will leave bottles for me. Like it was understood they don't have to ask me, they put the bottles for him and I will feed him.* (Meena, 2 weeks postnatal: Interview 2, p12, L514).

Routine practices have a tendency to become accepted and normalised behaviour (McCourt, 2005). The episode described by Meena happened even though Meena was breast feeding. A routine based attitude to care displays a lack of individualistic attention. An individual approach to caring for woman in a maternity setting should be focussed and based on the needs of a particular individual (RCM, 2001). In this study the women were cared for in a maternity system which relied upon departmental and professional inter-dependence.

This system ensured that a large amount of women could be cared for in an efficient way. Midwifery routines that become enmeshed within maternity care are based on a detached positivistic attitude to service provision underpinned by guidelines and protocols. Routine approaches to care are encouraged when sanctions are imposed on carers if tasks are not completed in good time. Sanctions which dominate midwifery care may underpin the patriarchal and taken for granted culture in midwifery practice (Hunter, 2005).

An acknowledged consequence of fragmenting the women's experience into discreet components encourages the midwife to lose sight of the woman as a whole person and lessens the ability to develop a partnership (Guilliland and Pairman, 2001). Fragmentation of care for Meena affected the feeding pattern of her baby. Meena dutifully supplemented the feed because she trusted that the provision of artificial milk was founded in the belief that this was best type of care for her and her baby.

> *We were relying on everything. We thought we are in good hands and we didn't question anything you know. I think it's good.* (2 weeks postnatal: Interview 2, p14, L638).

Drawing from the theory of symbolic interaction may lead to a deeper understanding of how non-verbalised messages contribute to discourse and meaning in practice. Although a criticism of this theory originates from an inability to take into account the influence of a larger organisation, the power of this theory is situated in an ability to describe how symbolic representation emerges within interaction. Negative symbols used within interaction may lead to undermining the women's perception of themselves. In Meena's particular

case formula milk may have been the negative symbol that undermined Meena's perception that she was able to breast feed her baby.

In this study effective interaction appears to be on taken for granted levels (Denzin, 1992) because women took for granted that the actions of professionals were right. In this environment communication occurred by gestures and symbols, as Meena explained:

> *I press the bell (and) the midwife comes in, they say pain (pointing to her abdomen. I say yes (nodding) and they give me pain killers. I call them and they say milk (pointing to a bottle) and the midwife brings me a bottle (2 weeks postnatal field notes: Interview 2, p3, L27).*

Abeba commented on similar patters of communication:

> *I used to see the midwife three times a week but now it's weekly. There was no interpreter, we communicated by hand signs (2 weeks postnatal field notes: Interview 2, p6, L20).*

The acceptance of the professional status of the midwife paved the way for implicit trust. The assumption of trust permitted non-verbal communication, which was reliant upon gestures and symbols, to be taken for granted and accepted as the norm. Midwives symbolic interactions in practice may be more powerful to this group of women than language. The absence of a professional interpreter in some instances encouraged ineffective interactions between woman and midwife:

> *Abeba: I had an interpreter before the baby, not after. At no time after the operation (caesarean section).*
>
> *Researcher: Why not after?*
>
> *Abeba: The midwives didn't ask me if I needed an interpreter and so I didn't ask them. (2 weeks postnatal field notes; Interview 2, p3, L15).*

Why an interpreter was not involved in the care of a Abeba who had experienced an emergency caesarean, and who was distressed enough to feel that she may have died, can only be speculated. Abeba took for granted the fact that the midwife did not see the need to ask her if she wanted interpretation. As a consequence Abeba assumed that she must not need this service and did not ask for an interpreter to be provided. Maybe this displays a lack of empathy on the part of the midwife for Abeba's needs? However, the postnatal care of Abeba spread over several days and she was cared for by many midwives. Therefore, a lack of empathy may have originated from the system and culture in which the midwives worked rather than ineffective interactions with one midwife. I propose that neglecting to engage in linguistic communication was not simply a lack of empathy, but was an approach to care that may have been embedded within the culture of the clinical environment. Speculation may suggest that this attitude may have been a measure to silence the woman thereby creating a less demanding client for midwives in an understaffed busy environment. This act of virtual silencing of women by midwives was created by a reluctance to address issues of verbal communication and supports the observation that women can oppress other women (Anthias, 2002).

My data suggests that women may have indicated to midwives that they had understood the original meaning of the information which has been imparted even when they did not. Furthermore, midwives appear to have been satisfied that further clarification and explanation of imparted information was

unnecessary for the woman. This assessment is apparent when there are comments such as, '*I was never sure that I had the right information*' (2 weeks postnatal field notes: Interview 2, p5, L31), for example.

The enactment of power and oppression displayed by professionals may be accepted and unquestioned especially for those women who are newly arrived. As Layla commented:

> *I turned up for my appointment with my doctor but he wasn't there. I never complained. We're used to this in my country. We sometimes wait for days.* (6 weeks postnatal field notes: Interview 3, p3, L9).

Symbolic displays of how others value asylum seekers and refugees may lead to an acceptance of subordination. Professionals who silence or ignore individuals may create an inability for the asylum seeker or refugee to voice dissatisfaction with their care. Non-questioning attitudes of the women in the study was expressed as complete trust in the professional:

> *I didn't know why they gave the injection (BCG). They checked if it was OK to give it. I agreed but didn't know why it was given. I think doctors know more than me. I trust them and didn't know anything to do with immunisation.* (Abeba, 6 weeks postnatal, field notes).

Because of the non-questioning tendency of these women the individual moral stance of maternity carers becomes of paramount importance with the knowledge that asylum seekers or refugees place implicit trust in the maternity health care team. There is a need to explore how morality may contribute to midwifery care and to question what the intentions of an individual care

provider's attitude to asylum seekers and refugees may be. The ability to have insight into one's personal moral stance towards asylum seekers and refugees could be explored within pre and post registration midwifery curriculum development in the future.

In midwifery oppression of women may be subtle and contribute to the constructed difference and portrayed 'otherness' which may exist within a clinical culture which provides care for the masses. Some feminists would argue that the first step is in, 'seeing the self in the other' (Anthias, 2002) and this is the first step to relating to the other. I suggest that this self reflective approach to care may indicate how midwives view their care and generate an understanding of whether their care is right or wrong. It is important for midwives to establish if their individual approach to care emerges from distorted forms of care or genuine care (Tong, 2001).

In UK society there is a tendency to see asylum seekers in a negative way (Oxfam, cited in Donnellan, 2002 p10). The characteristics which emerged within the data suggested that the women were strong. Strength that at times may have meant giving birth alone:

> *It's too expensive to get a trained midwife in Ethiopia so women sometimes give birth on their own (Abeba, 34 weeks gestation field notes: Interview 1, p2, L13).*

Having a determination to fight for their survival under extreme circumstances emerged:

*By then you just travelled in a group of people. So as we travelled there was this lady. She was crossing to go to Ghana. The border so I had to go with her. Yeah I had to go with that lady who crossed over (into Ghana) . She said her child and crossed over, with my other brother, the young one. We crossed over. But she had to foster me. But she couldn't foster my brother. It was only one of us. (Grace, 34 weeks gestation: interview 1, p2, L89).*

The women were protective of their families:

*I don't where my family is, my husband's mother died and my husband's brother died a few months before (we came here). We can't go there, so I'm not very sure who's alive and who's dead. I don't know where they are. We just had to come here. (Meena, 2 weeks postnatal: Interview 2, p16, L722).*

While in the UK these women described instances were they were resourceful

in adapting to levels of poverty:

*You buy Asda products because they're quite cheaper. You could buy tin beans and spaghetti, you buy rice, you buy oil, sugar, salt and milk.* (Grace, 2 weeks postnatal)

Able to survive prejudice and be tolerant of a society with differing values was

a characteristic which Abeba had previously described:

*They laugh at me as I walk past. They think I don't understand what they're doing. I pretend I know what they've said and look up to them (6 weeks postnatal field notes: Interview 3, p4, L14).*

I suggest that if the host society refuses to recognise strength in character

developed on the journey of escape to the point in contact of the new country,

these strengths may be minimised and silenced. Childbirth may provide a

vehicle to draw upon the women's strength of character (Kennedy and

Shannon, 2004). Midwives who lack awareness of how important non-verbal

interaction is may sustain the women's feelings of worthlessness, vulnerability and lack of empowerment in relation to their maternity care. This practice may detract from involving women in their own care, or building partnerships in care. In many instances individuals do not have other members of a formalised community for female support and midwives are in a pivotal position to provide positive support and encouragement during childbirth events.

## 9:5 Conclusion of perception of 'self'.

The women's self image was developed within their country of origin and became translocated into the host country. This symbolically represented image may have determined the women's perception of self value. Traditions within the country of origin determined levels of public and private interaction. Embedded self image may be interpreted by society and midwives to reflect a person who is vulnerable, oppressed, and needy and does not consider characteristics of strength, perseverance and determination which may have been the determining factors of survival for these women during the period of their escape.

Professionals may be unaware of how much trust is placed upon their individual ethos of care. Lack of insight may lead to non-engagement between midwife and women who are asylum seekers and refugees in the clinical setting. Midwives are in a pivotal position to encourage self esteem in asylum

seekers and refugees. However, non-engagement may lead to substandard care which may further compromise an already increased risk of mortality.

## 9:6    Final conclusion of results section

Chapters six-nine present the findings of the study. An initial presentation of the cases of the women identified the uniqueness of each woman, all with different stories to tell. The data generated vast amounts of data which have provided an in depth interpretation of the way the women constructed their experiences of midwifery care in a local setting.

Interpreting the women's words has raised issues related to how social policy directly affected the lives of the women. The dispersement process identified that this may be inhumane at times for these women. Inappropriate accommodation highlighted that poor housing may affect long term outcomes such as integration, ill health and the ability to cope with life in the UK.

Issues around communication drew attention to the lack or minimal amount of information provided to the women. The use of gestures and symbols within interaction has identified that subtle dynamics may be involved in the interaction between women asylum seekers and refugees and midwives. Issues in communication were placed in the cultural setting of the way that midwives work. Poor communication may affect aspects of safety in relation to childbirth and the data highlighted that the effect of this should not be minimised. The way communication and interaction was described by the

women indicated that this may be a reflection of the way that they perceive 'self'.

The theme of perception of 'self' identified how social construction may influence how women asylum seekers and refugees perceive themselves. Female identity emerged from the data because of gender related issues. Women commented about their relationship with midwives and the data suggested that there are issues related to women and the power base that may exist between and within this relationship.

The women's experiences of midwifery care brought to light issues related to women accessing midwives. Women described both positive and negative experiences of midwifery care. The role of the midwife was discussed and the importance of health promotion was identified. Stereotype was apparent for the women in this study and the influences which society, the media and institutional racism may have been were discussed. The women's expectations of childbirth were identified.

# Chapter 10: Limitations

The status of all research depends on judging the quality of methods used. This has been traditionally based on assessing validity and generalisability (Robson, 1998: 66). Traditional assessment originates from a realistic perspective that truth exists independently of the researcher (Crotty, 2003). However, the researcher is at the centre of qualitative research and therefore this mode of enquiry demands an alternative strategy to judge goodness.

Judging qualitative research is still debated by researchers (Mays and Pope, 2000). Lincoln and Guba (1985) propose that the assumption of goodness within qualitative research is credibility, transferability, dependability and confirmability. The limitations of this study will be described in relation to these criteria.

This study used case study research, which in itself set limitations. The bounded limitations described in chapter five, involved time in the field which ended at the six week postnatal interview. I do not know what happened to the women after this time. Furthermore, there was the potential that during the span of the research women may have been dispersed to other locations in the UK. This scenario happened during the study when one woman moved to Manchester and another woman disappeared before the six week postnatal interview. This meant that the analysis was based on four women only, as the fifth woman moved after the twenty week meeting and before the 34 week interview.

A major limitation of this study was the need for third party translation during interviews with three of the women. Issues in translation processes and the conceptualising of terms remains an issue in cross cultural research (Im, *et al.* 2004). I acknowledge that this may have added a layer of extra interpretation to the data analysis. To ensure the interpretation of the interviews were credible a summary was presented at the final interview. However, even this was translated and one could argue that this reduces the claim to credibility. The inclusion of non-English speaking women was a pragmatic decision and enabled the voices of women not usually included in an academic exploration to be heard.

An added contribution to the data collection for Meena was that during the in depth interview at thirty four weeks her husband stayed in the room. As this was a situation in which I did not want to offend I did not ask Meena's husband to leave. However, I sought advice from the link worker who translated for Meena during the interview and also knew her well outside of the research, in the community. The link worker understood my apprehension about asking Meena's husband to leave the interview environment. She suggested that she would ask the husband not to be present for the following interviews tactfully. I was assured that this had not affected the relationship between Meena and her husband, or her husband and the translator. I was given the impression that both Meena and her husband felt a contribution to research was important and they were glad that Meena's views were included in the research. During the subsequent interviews I was able to probe more

about sensitive issues without a fear that Meena's answers may have other repercussions for her.

The underpinning paradigm was based on a constructivist stance and involved a qualitative exploration of experiences. Constantly asking "Did I get the story right" continued throughout the study continuum. Being aware that case study relies on the trustworthiness of the human instrument (the researcher) and hence the characteristics and skills of the investigator are of crucial importance (Robson, 1998: 160) and this made the rigor of process vitally important.

The process involved collecting data from three main sources, interviews, field notes and photographs. Along side of this was the collection of hospital statistics. Organisation via an audit trail kept the data organised and easily accessible.

A criticism of case study research arises from the inability to generalise new knowledge to the larger population which is studied (Robson, 1998). The intent of this study was not to generalise the statistical probability of experiences but to generate an interpreted meaning. The women in this study disclosed similar experiences which resonated with others (McLeish, 2002; Craig, et al. 2004) adding further credibility to the findings (Denzin and Lincoln, 2000). Therefore, the logical generalisation from this speculation would be that the interpreted meaning that emerged from the study may be transferable to women in similar situations.

A negative consequence of this methodology is that the interpretation of the women's words rests upon one person's perspective of understanding. However, the words of the women are authentic and valuable and represent a unique version of experience (Greene, 1996). Understanding which emerged from the data has shed light on important previously uncharted local experiences which may contribute to the understanding of others.

The experiences within this study represent the words of the women who participated and the voices of those who declined are silent. Therefore, the research is not representative of all women who are asylum seekers or refugees in Liverpool. There are many more stories which may be different. However, including those who wanted to participate in this case study provided a vehicle to understand their views.

# Chapter 11: Discussion of the thesis

## 11:1 Introduction to the discussion of the thesis

This study was undertaken as a consequence of the need to explore the experience of midwifery care by women asylum seekers and refugees. The exploration was undertaken by utilising case study research. The findings focus on society and how stereotype is associated with asylum seekers and refugees. Communication and information giving were an issue for the women and this chapter will present what this may mean to midwives. The role of the midwife and how the woman – midwife relationship emerged within the study will be discussed. The midwife's role in public health will be related to the women's expectations.

## 11:2 Discussion of methodological approach

Issues in relation to communication and asylum seekers and refugees are common in other studies (Rowe et al. 2001; McLeish, 2002; Sawtell, 2002; Craig et al. 2004; McCourt, 2005). This study incorporated the use of photographs as a prompt for conversation which other studies did not. Data were captured via case study research (Stake, 1995) which accommodated a multiple approach to data collection. This provided a deeper insight to the experiences of midwifery care by women asylum seekers and refugees. The insight has been gleaned from multiple interviews, field notes and photographs used as a prompt for conversation. The longitudinal design for

this research enabled me to become immersed in data collection and to build a familiar relationship with the participating women, whereas previous studies focused on the findings from one interview at one time period.

There are limitations which are associated with case study research and there is a recognition that statistical generalisations can not be made on small samples (Robson, 1998). However, there was no intent to generalise significance from the data but simply to interpret meaning (Miles and Huberman, 1994).

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This case study involved four individual women who formed the basis of the case. This methodology recognises that individuals construct truth independently of the researcher and therefore acknowledges that multiple realities exist (Guba, 1990). Therefore, truth within this study was never complete and never perfect. There was no one truth to be found but the interpretation represented versions of meanings for the participants involved and for myself as a researcher.

I believe that an exploration of midwifery care by women asylum seekers and refugees using case study research was an appropriate approach in trying to understand what the experiences of midwifery care meant to individuals.

The use of photographs in this study was intended to be used as a prompt for conversation and not to be analysed separately (Harper, cited in Denzin and Lincoln, 2000 p717). Therefore, they were not a portrayal of a 'quote' for the

image however, they may have added to how truth was constructed for the participating women (Pink, 2001) because the women decided what to photograph, share and discuss.

The underpinning theory which emerged from the data has suggested that the theory of symbolic interaction (Mead, cited in Morris 1967 p189; Blumer, 1969) may have provided an explanation of the relationship between the woman and midwife and the way the woman sees herself. However, criticism about the theory suggests subjectivity, supposition and speculation, because critics claim that it is not systematic or scientific (Ritzer, 1992). I recognise this limitation within this qualitative study but believe that the data suggested a link between the microscopic interactions of the women and the midwives. Therefore, the theory of symbolic interactionism facilitates one explanation of how this interaction can be understood and optimised. Furthermore, symbolic interaction as an analytic tool is usually associated with observational studies which this study is not. However, the theory emerging from the data provides an hypothesis that may inform further exploration by observation of interactions between midwives and asylum seekers and refugees in the practice setting.

## 11:3    Discussion of societal influence

Asylum seekers and refugees experience of society in the UK involves living in poverty, having poor housing, and having difficulty in accessing health services (McLeish, 2002; Sawtell, 2002; Udoeyo, 2003; Craig, et al. 2004).

Although most asylum seekers and refugees may face similar societal and economic difficulties as other members of ethnic groups, for those without legal status to remain, these difficulties are exacerbated (Craig. *et al.* 2004).

There appear to be contradictions within a social policy that, on the one hand, acknowledge the importance of assessing individual health needs in order to address inequalities in health (DH, 1999a; 1999b; 2003; 2004), and on the other, which appears to be underpinned by a disregard for humane considerations (Home Office, 2002b, Section 55). Poor housing has been attributed to poor health and was evident in this study. Safety issues, lack of privacy and the threatening behaviour associated with accommodation for asylum seekers and refugees is familiar to others living in similar accommodation with similar legal status (Sawtell, 2002). There were episodes of violence and aggression displayed to Abeba and her family, as Abeba described: '*I don't go out....a few days ago the man in the hostel tried to kick me'.* (34 weeks gestation field notes: Interview 1, p6 L12). On one occasion an 'English man' on the same landing had become annoyed with Abeba's children and he had hit them. Children of asylum seekers and refugees are at a higher risk of abuse and have a greater need for protection (Riddell- Heaney, 2003). Poor housing and deprivation may affect the long term health of asylum seeking and refugee families and demands further exploration.

The way asylum seekers see themselves may be based on how society's values are symbolically portrayed. This may be done overtly by a no choice dispersement policy (Burnett and Fassil, 2002) or more subtly by racist remarks, negative responses and intolerance. Increased anxiety related to

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inflexible dispersement policy may negatively influence health outcome (Porter and Haslam, 2005). The process involved in dispersement may increase the tendency for mental health problems in asylum seekers and refugees. Even within this small case study of four women, one woman (Grace) and one of the partners (Abeba's) needed to be referred to a psychiatrist in relation to mental health issues.

The health of newly arrived asylum seekers is of importance as there is a suggestion that health deteriorates after arrival into this country (Burnett and Fassil, 2002). This factor is compounded by evidence which indicates that accessing health services for asylum seekers and refugees may be difficult (McLeish, 2002; Craig, et al. 2004; Papadopoulos, et al. 2004). For the women in this study their physical needs at times paled into insignificance in relation to their social and emotional needs, leaving issues such as housing, dispersement, clothing, money and food to become their main concern. Having little regard for their own physical health may account for high rates of non-attendance for appointments in maternity care by this group of women (CEMACH, 2004 p47).

Stress related social issues for women who are asylum seekers and refugees may affect their ability to cope. How asylum seekers cope and adapt to life in the UK may be a factor which influences outcomes in relation to maternal mortality. Western coping strategies may be inappropriate for different ethnic groups. For example, Afghan people are not comfortable with the process of counselling because of the need to disclose personal information and possible repercussions of shame (Omeri, et al. 2005). In an Afghan culture psychology

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is incompatible with religion and there is a belief that, *'God will help you, not yourself'* and that *'no matter what happens to you, you are not to talk or cry'* (Omeri, *et al.* 2005:p28).

In this study the women described positive and negative ways of coping. There are existing models of coping. Exploring how these models can be applied to daily life in the UK may enhance coping skills. Escott, *et al.* (2005) found that women benefited from an enhancement of their own pre-existing coping strategies. However, this was a small study that included English speaking women only. If this study was replicated for asylum seekers and refugees in childbirth their confidence and self esteem may be raised. Data analysis in this study described how positive interaction encouraged individuals to feel as though somebody 'listened' to them (p106) and 'comfortable' (p102). It is imperative that the self esteem of asylum seekers and refugees is built upon. In order to focus on pre-existing coping strategies midwives need to explore the cultural beliefs of individual women and apply this understanding to tailor confidence building and information around child birth.

Transformational coping (Omeri, *et al.* 2004) stems from an individual's ability to view adverse or strange events as a challenge. This is opposed to regressive coping in which individuals cope by withdrawing and avoidance. Individual women in this study displayed individual coping strategies. Furthermore, different strategies were used at different times by one woman. For example transformational coping was displayed by Grace who

commented that she wanted to be useful when she attempted to find information about becoming a nurse (p81). She saw this as a challenge. However, she became disillusioned by the fact that she would not be able to achieve this because of her legal status which prevented her from working. Within the same woman her display of regressive coping was evident when she described locking herself in her room and withdrawing from society (p84).

Other ways that the women coped with UK society emerged from finding strength and support from their individual religious institution. Religious coping based on a total commitment to one's beliefs is identified with well-being (Fava and Ruini, 2003). However, a reliance on religion in order to be part of a powerful group or to provide protection and consolation may be linked to negative mood states and poor coping. Meena had a good experience related to finding friendship within her Sikh temple. However, Grace felt the need to be consoled or protected in the church and instead of protection and consolation was led into a manipulative situation (p85). How asylum seekers and refugees place their faith in religious organisations and the effect this may have on their ability to cope and integrate in to society in the UK should be an area for further exploration.

The way asylum seekers and refugees cope with resettlement is individual and not homogenous and reflects their complex situation in society. Reaching the UK as an escape from tyrannical and traumatic parts of the world from which asylum seekers and refugees run is fraught with danger (Stalker, 2001; Bowcott, 2004) and culminates with a policy of determent (HM Government,

2005). To reach the UK individuals need to be resilient, creative, adaptable, brave, courageous and determined. Society in the UK makes asylum seekers and refugees into people that are 'done to' (Craig, *et al.* 2004: 88) by creating powerlessness, lack of choice and control and being at the mercy of someone, however kind and helpful that some else may be. Individual coping strategies should be enhanced and not taken away from women asylum seekers and refugees. These strategies should enhance midwifery care.

## 11:4 Stereotype

Difference exists between every individual. Social classification is an attempt to minimise individual difference in order to organise society. Social elements that individuals may ascribe to being the same as another may be as subjective as they 'eat rice' (Pfeffer, 1998 p1382). Categorising individuals sets people apart and uses a process of binary opposition to achieve this, for example, black / white, female / male. Consequently society distinguishes a picture of 'them' and 'us'. Within UK society asylum seekers and refugees are assigned to the category of 'them' and this picture is reinforced by negative mass media representation (Oxfam cited in Donnellan, 2002 p10). Each side of the binary opposition related to societal classification and representation may evoke 'the other' (Pfeffer, 1998 p1382) and contribute to unprovoked racial prejudice, racial hatred and ultimately racial killings (Macpherson, 1999; Doward, 2005).

Mass media plays an important role in today's society and may affect the view of the host population. Within the UK the media usually adopts a negative perspective of asylum seekers and refugees. Representation may be due to the bias created by individual news makers. The journalistic profile describes a 'criminal' (Harris, 2003; Leppard, 2004; Opinion, 2004; Hartley-Brewer, 2004; Levy and Williams, 2004; Allen, 2004; Hope, 2004; Leppard and Fielding, 2005) who is a 'foreign' person or 'different' than others (Cohen, 1994; Vallely, 2003; Harris, 2003; McKittrick, 2004). This description focuses on a deceptive member of society who poses a 'threat' to the host country (Levy and Williams, 2004; Haralambos, et al 2005 p852; Leppard and Winnett, 2005). This portrayal is extended to a person who is determined to reach the UK (Bowcott, 2004) as an attempt to 'invade' (Gill, 2003; Hall, 2005) and pillage the welfare state (Travis, 2003; Jones, 2005). This alleged threat exists due to increased 'numbers' who enter the UK (Butler, 2003; Gill, 2003; Editor, 2003; Hall, 2005; Haralambos et al. 2005 p852; Leppard and Winnett, 2005). My study described how asylum seekers and refugees may experience a feeling of being ostracised in society (p114) which may have been caused by negative media representation.

The media perceive the UK as a 'soft touch' (Peters, et al. 2003; Travis, 2003). The 'moral panic' which ensues because of this portrayal prompts tightening of immigration policies (Cohen, 1994). The 'moral panic' spills over into political agendas (Leppard, 2004; Hinsliff and Bright, 2005; Wintour and Ward, 2005; Leppard, 2005; Bessaoud, 2005; Charter, 2005; Hennessy, 2005; Jones and Rennie, 2005).

In addition to individual articles Oxfam (cited in Donnellan, 2002 p10) showed that during an eight week survey of news papers from six Scottish week day newspapers the majority of articles gave a negative valuation of asylum seekers. However, the political stance of all six papers in the survey is unknown together with the personal biases of the reviewer. A reason for this lack of representation may be due to the ethnic dominance of media organisations, where the 'whiteness' of the press becomes subtle and invisible (Croteau and Hoynes, 2000). Invisibility ultimately promotes a 'taken for granted' approach to the generation of information (Malik, 2002) which presents a stereotypical portrait.

There is a suggestion that readers do not appear to challenge the interpretation of immigration issues put forward in the press (van Dijk, 1991). Even so, Philo and Miller (cited in Haralambos, 2005 p849) suggest that members of an audience are able to distinguish between hyped and authentic accounts of conflict. Additionally, there is a suggestion that direct experience of individuals may affect media impact in a positive way (Hartmann and Husband, 1974). If having experience of being with asylum seekers and refugees makes interaction more positive this may explain why theories associated with a 'hypodermic' models of media (Marcuse, cited in Haralambos, 2005 p843 ) in which attitudes are 'injected' in the audience and ultimately stirs quick action, may be discounted. My study suggested that midwives who are able to engage with asylum seekers and refugees on a deeper emotional level, rather than providing care from a 'tick list' approach

(p101) are able to distinguish between negative media representation and interact in a more positive way.

I agree with Thompson (1995) who argued that mass media provides us with the ability to discuss and debate information and provides us with more information than we would have access to otherwise. This social theory of media depends on a distinction between three types of interaction; face to face interaction, as in everyday social interaction, mediated interaction, involving paper or electronic connections linking individuals directly, or mediated quasi interaction which is created by mass media. Thompson's view states that the mediated quasi interaction presented by the 'monological' representation of TV or journalism does not come to dominate life today but that this portrayal intermingles with the ability of people to discuss and debate current issues.

I disagree that the hypodermic model is the dominant influence within midwifery regarding asylum seekers and refugees, as this stance does not take into account how diverse the audience of midwives may be, and the variety of responses each individual has towards each piece of media represented. Furthermore, this would not explain how midwives use the media, whether this is studied closely or is paid lip service to, running in the background to their lives. Moreover, this theory ignores how scenarios presented within media may provide a catharsis for individuals, who may be facilitated to vent their feelings before stepping back into their daily life. Desensitisation may prevent anger and violence from being displayed within

the clinical area. Midwives who engaged with the women in this study appeared able to minimise the affect that negative images may have had and care for women in a humanistic way which pleased the participants. For example, midwives who provide clothing and food (p72) an activity which is outside the accepted job description for a midwife.

Women who are asylum seekers or refugees live with a stereotypical portrayal of 'foreign', 'different' and some one who poses a 'threat' to society. However, the stories told by the women in this study emerged as women who were mothers, who needed to survive with her family and wanted to be in a place that would be safe (p103), similar to the majority of the maternal population in the UK. A 'take over' bid for the moral and economic standards within the UK suggested by Gill (2003) and Hall (2005), did not appear to be the focus of attention for the women involved in this study. Negative media representation (Oxfam cited in Donnellan, 2002 p10; Levy and Williams, 2004; Haralambos, et al 2005 p852; Leppard and Winnett, 2005) may contribute to the negative non-verbal symbols described in interactive episodes presented within this study (p126). My data questioned why Grace, who spoke fluent English, and asked pertinent questions related to her HIV status, was not provided with adequate information (p90-91). One reason may be as a consequence to symbolic displays related to  social class, dress, looks and the women's legal status in this country (Charon, 1979) influencing interactions between woman and midwife. Assumptions are frequently made by health professionals about women from ethnic minority groups that may directly affect the outcome of care (Dormandy et al. 2005: Permalloo, 2006).

Professionals may display these assumptions in their non verbal communication. People in society today are perceived as who they are by how others react to them. This phenomenon is accounted for in the theory of symbolic interactionism (Mead, cited in Morris, 1967 p189). This theory suggests that there are subtle changes which occur during social interactions. Changes occur because each interaction is altered in response to how each person perceives the other (Charon, 1979). From observations and field notes cultural stereotyping was evident. For example, one member of the administration team commented that if the woman had a non English name (p56) she would be given an appointment at the link clinic (p56) even though the woman may have been able to speak English. This was validated by a personal experience when an English friend who had married a Turkish man was sent an appointment at this clinic and on attendance was asked which language she spoke. This approach may shape the health care experience of the women which Reimer-Kirkham (2000) suggests is an individual response that creates stereotyping and not a response which is situated in culture:

*It is not the culture that shapes the health care experiences of individuals. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralised, homogenised, ignored, dehumanised, and ordered around (Reimer-Kirkham, 2000 p 352)*

Institutional racism is apparent in organisations (Macpherson, 1999), including maternity care services (Harper-Bulman and McCourt, 2002; Ali and Burchett, 2004) and can not be condoned in a maternity setting. There is recognition that midwives prejudices may undermine the mother midwife relationship (Kirkham, 2000). However, it is important to realise that the

participating women in this study expressed positive experiences related to the care of midwives (p102) and did not comment on an overtly racist attitude. My findings suggest that there may be a more subtle stigma pervading the care of these women, where they were silenced (p128) by a lack of engagement.

## 11:5 "Taken for granted" communication

Communication between different languages is problematic. Throughout the world there is more non-communication than communication between human beings, because of language (Pernier cited in Gerver and Sinaikott, 1978 p33). In my study there appeared to be communication problems for both English speaking and non-English speaking women, which suggests that communication problems are not simply related to language.

In some cases in this study, women did not have access to interpreters (p95). Midwives may have assessed the need to order interpreters in the clinical area as Harper-Bulman and McCourt (2002) suggested happened in their study. If assessment by midwives was the reason for lack of interpretation in my study, their assessments in the majority of the examples were wrong, as the women indicated again and again that they had misunderstood what was being said. This is an important fact for midwives to be aware of. Misinformation may affect the long term health of women asylum seekers and their families.

Midwives must not assume the level of understanding based on their own assumption of the degree of fluency, as this can be overestimated (McCourt, 1999). Even if the woman provides her own interpreter, communication may be misinterpreted. For example, in Harper Bulman and McCourt's (2002) study there is an example of a woman who could roughly interpret from English to Somali but could not interpret the other way around. This was a similar pattern to that described by Abeba in relation to the broken translation of the midwife who spoke Arabic even though Abeba was Somalian (p92).

A feeling of subordination was apparent for the women. Layla explained that she accepted this because she was used to this in her country of origin.

> *I turned up for my appointment with my doctor but he wasn't there. I never complained, we're used to this in my country. We sometimes wait for days.* (6 weeks postnatal).

Acceptance of subordination is suggestive of power differentials between women and their maternity carers. Power differentials may result in compliance, similar to previous research (Stapleton *et al.* 2002). Relationships in midwifery should be based upon positive regard (Rogers, 1967; 1995). Communication is more than language, as such, symbolic displays such as smiles and gestures may build self esteem, self worth and a positive self image. Without positive self regard we may begin to feel small and worthless and fail to be all that we can be.

Because there is a human desire to gain positive self regard there is a tendency to adapt behaviour in order to receive positive regard from others.

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The symbolic interpretation of positive gestures may be that asylum seekers and refugees receive positive regard from midwives only if they are worthy. For example, Abeba may have gained positive regard by not requesting to have an interpreter (p128). This was deemed a positive regard because the midwife did not ask if this service was required. In the clinical area women who are asylum seekers and refugees may subconsciously be receiving rewards of self worth by gestures which silence and placate them. Practitioners should be made aware of how non-verbal symbols used within interactions between asylum seekers and refugees may impinge on an individual's perception of self. Midwives should endeavour to create consistent and positive symbolic messages within their practice.

Providing information which is understood by women in general may increase the ability for the woman to have more choice and empower her to feel in control of her birth experience (Rowe, et al. 2001). There is evidence that indicates information tools improve knowledge, reduce decisional conflict, and stimulate consumers to be more active in decision making without increasing their anxiety (O'Connor et al. 1999). Although there have been local approaches in this study site, which involved service users in the design of information leaflets about maternity care (Lavender et al. 2002; Briscoe and Street, 2003; York et al. 2005) asylum seekers or refugees were not part of this debate. Engaging in a partnership with asylum seekers and refugees, to explore how culturally sensitive information about maternity care can be provided, should be an important consideration for maternity service delivery.

My study suggests that providing evidence and promoting health is an ideal which may not be reached for asylum seekers and refugees.

Information in relation to childbirth appears to be controlled by midwives (O'Cathain *et al.* 2002). However, asylum seekers and refugees access most information within their community (Kosher and Pinkerton, 2002; Udoeyo, 2003). There is a suggestion that the provision of information and facilitated discussion may be affected by hierarchical power structures which support normative patterns of care (O'Cathain *et al.* 2002; Stapleton *et al.* 2002). For women who are asylum seekers and refugees portraying normative patterns of care in this study was via signs, gestures and routine practices related to symbolic interaction (p89). In addition, the type, amount of information and the method of informing women appeared to be driven by the necessity for the midwife to complete a task list to get job done (p90).

Stapleton *et al.* (2002) described limited discussion around information for childbirth and commented on variables such as time pressures. Additionally, hierarchical power structures influenced what information was discussed and how this was presented by the individual practitioner. I suggest that this may be an exaggerated phenomenon for women who are non-English speaking. Taken for granted areas of communication may originate and mutate within the type of cultural setting in which midwifery practice takes place; one in which the overwhelming theoretical base of functionalism (Parsons, 1979 cited in Haralambos, 2005 p939). Hunter (2005) has noted that the consequence of delivering information in a routinised setting is that the

midwife loses the focus to work 'with woman' and begins to 'work with institution', which this study agrees with.

A deeper understanding of how non-verbal body language affects asylum seekers and refugees in maternity care, can help to address the health promotional aspects of care that midwives are required to meet (NMC, 2004). Raised awareness via training related to body language may enhance the midwives ability to understand subtleties within interactions. Blumer (1969) suggested that humans are able to imaginatively rehearse alternative lines of action before we act. In this way, midwives may be able to appreciate patterns within non-verbal communication. Role taking (Goffman, 1971) is a key mechanism that midwives should be aware of. This activity is fundamental to a deeper understanding of how symbolic interaction may provide a sense of meaning for both parties. This relies upon an understanding of the implications of the other's perspective to see what the actions of ourselves mean to other actors.

Symbols used in practice can be related to the generation of information. Information related to childbirth may be disseminated via media. There is a suggestion that asylum seekers and refugees access the internet for information about the UK (Koser and Pinkerton, 2002). However, the women in this study did not have access to the internet and had limited resources. As in Abeba's case, '*I don't have a video but I have a tape recorder.*' ( 34 weeks gestation field notes: Interview 1, p4 L32). For others, access to information in

their own language was regularly available and Meena's husband commented that they had Indian television channels that they were able to view at home.

Because of limited resources community based media to disseminate health promotion may be an option. Media has proved to be an effective tool to increase folic acid uptake in pregnancy (de Walle *et al.*1999) and reduce the perception of death associated with childbirth (John Hopkins University Centre for Communications, 2000). However this method of health promotion amongst ethnic minorities is under researched and should be evaluated (de Walle, 1999).

Resourcing the development of vast areas of health promotional media related to childbirth in many different languages would be costly; locally this may reach figures of up to seventy different languages. An alternative approach may be to embrace the traditional methods of sharing information originating from the women's country of origin. This may involve developing strategies by using narrative where health promotional messages within a whole story may 'fall out' (Fishman, 1993). This method of health promotion may be best delivered by utilising the ability of link workers (Editor, 1996), bilingual workers (Aylott, 1997) or interpreters who would like to be educated in this field of work, as Layla's interpreter suggested earlier (p99).

The role of the midwife in imparting information plays a vital role in promoting the health and safety of the woman and her new born. Neglecting to involve women in the intricacies of this communication contributes to disempowering women who are asylum seekers or refugees, leaving them unsure if they ever

have the right information (p95). Women described a fear of operative procedures and described how they linked this perception with death (p93). To pre-empt unnecessary feelings of subservience and fear, information should be provided about the safety of practices related to clinical procedures in childbirth. Better information about the relative safety of operative procedures in the UK may have lessened anxiety levels.

## 11:6 Accessible care

Gaining access to midwives in this study was negotiated by others on behalf of asylum seekers and refugees (p100) and suggests that barriers to access exist. Additionally, if the information from the GP in relation to the woman's language was missing this sometimes created an issue, especially if the women did not speak one of the five main languages represented by the link workers, namely, Somali, Punjabi, Bengali, Chinese, and Arabic. If the woman's language meant an interpreter was difficult to obtain, such as Latvian, the woman's appointment may have been delayed. This was a difficult situation for the midwife who although attempting to be kind and friendly may have left the woman none the wiser as to her state of health.

Although attempts were made to clarify the language of the woman before arrival at the clinic by telephone in many instances the women were not contactable until they arrived. At times, some women who were asylum seekers may simply arrive at the clinic door when the link clinic was not running and evidence validates that women from ethnic minorities may book late (CEMACH, 2004 p47). Although good practice recommends that the

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maternity service should revolve around the needs of the woman (Department of Health, 2001a; 2004), in this study the maternity service appears to drive the maternity experience of antenatal referral. Midwives appear to expect asylum seekers and refugees to conform to a systematic process where all boxes can be 'ticked' (p95).

As the referral system in this study was dependent upon appropriate GP referral, a proforma for the referral of asylum seekers and refugees may help to lessen missed information. This may help to organise the link clinic more efficiently facilitating the correct interpreter to be present as the woman arrives at the clinic. Women who arrive unannounced at the hospital need to have an improved access to interpretation as their access to care is seriously compromised. Direct access to midwives has been recommended (Department of Health, 2004) and this system is in the process of implementation locally (Edwards, 2005 personal communication).

The women in this study valued the care given by midwives. There were comments about welcoming gestures and patience shown to them (p101). For some the experience was far above anything that they had expected. Symbolic displays of kindness generated in the demeanour of midwives were absorbed by the women, in the absence of an interpreter and despite not understanding English. The skills that the women felt valued by were related to emotional support.

Women commented on the help that they had received by midwives listening to them. However, there was little evidence that this skill was achieved for non-English speaking women. This was especially evident in instances of traumatic events that occurred, as in Abeba's case when she had commented that the emergency caesarean section was worse than anything, 'This has been the worst experience ever' (shaking her head from side to side)( 2 weeks postnatal field notes: Interview 2, p9, L13).

Another skill that women commented on was the need for the midwife to support labour in a non-interventional way. They spoke about how women supported them traditionally in their country of origin (p122). However, they perceived that it may be a bonus to have a midwife there for them when they went into labour in the UK. Women feared that they would be alone in labour which raised their level of anxiety when delivery was imminent.

## 11:7   Access to information

The health needs of women who are asylum seekers may be multiple which may incorporate physical and emotional needs emanating from their country of origin. Previous illness such as; parasite infection, haemoglobinopathy, HIV, tuberculosis, anaemia and calcium deficiency may affect the woman physically. To compound these factors women may be experiencing loss and bereavement, loss of identity, racism and discrimination (Burnett and Peel, 2001a). In some instances racism (Ali and Burchett, 2004; Pollock, 2005) and the threat of physical violence remain in the host country (Bentham, 2003).To

care for the needs of this client group the midwife needs to adopt a broad remit.

There is an acknowledged public health role for the midwife (Department of Health, 1999a; 1999b; 2004) with a growth towards specialist areas (Wood and Watts, 2005a; 2005b). The midwife's role in public health is represented in literature (Department of Health, 1999a; 1999b; 2004) but appears difficult to define (Henderson, 2002). Although there is a new perspective about this role this type of service delivery is a long standing component of midwifery which has evolved over time (Oakley, 1984; Fraser and Cooper, 2004). Anecdotally, midwives who are involved in the care of asylum seekers or refugees become gradually aware of the multifactorial issues and problems which the women incur and evidence validates this claim (Harper-Bulman and McCourt, 2002; McLeish, 2002; O'Dempsey, 2002; Bentham, 2003). For example, I gradually became aware that for Abeba being part of this research study provided a way to highlight her poor housing, an aspect which is recognised by the department of health in the contribution to poverty and ill health (Acheson, 1998; Department of Health, 2003).

Addressing public health issues was attempted by some midwives. This approach involved providing cooked food during drop in sessions, advice on diet, additional coping strategies and the distribution of clothing. The role was not specifically designated and made the ability to link into community based organisations such as the social inclusion team a disjointed process. The midwife was not able to follow one person through the whole system all of the

time. The development of an advisory post for the care of asylum seekers and refugees may have a greater impact for these women.

New practices such as aromatherapy sessions were developed to help relieve the stress that some of the women experienced (personal communication community midwife, 2003). Newly implemented innovations in midwifery practice may assume that there are improved health outcomes for asylum seekers and refugees.

Health screening for asylum seekers and refugees within this study raised issues in relation to how the women felt information was discussed and consent obtained. Cultural stereotyping may have led the midwives to assume that the women wanted to be instructed rather than given choice (Harper-Bulman and McCourt, 2002). Alternatively, the urgency of time and midwife shortages within the clinical setting may have encouraged the midwife to skip pieces of information that the midwife felt was unnecessary (O'Cathain, *et al.* 2002).

How health care is delivered may be a reflection of the way women see themselves in society (Winkivist and Akhtar, 1997). When little attention is paid to explanation and gaining informed consent for procedures women may reflect that this practice is the norm within that society. Winkivist and Akhtar (1997) suggested that women from villages in the developing world have a more pragmatic and flexible response to those who were from a city and that health seeking behaviour was different. Three of the four women in my study came from a village setting and may have adopted the norms within society in

their country of origin. Therefore, when arriving in the UK, even though women experienced doctors not, 'turning up' for appointments (p104) they felt that there was no need to complain as they were used to this (Layla and Abeba). Their overwhelming positive comments may have reflected their ability to be adaptable as they would have done in their village. By the professional not 'turning up' there was an implicit symbol displayed of lack of regard and value for the individual, who sat waiting. This symbolisation may display norms which implies subservience.

Maternity carers need to be aware that their actions in practice may be symbolically re constructed as a reflection of the way women who are asylum seekers and refugees see themselves. To pre-empt unnecessary feelings of subservience and fear, information should be provided about the safety of practices related to clinical procedures childbirth. This should be delivered in a sensitive fashion by comparing the norms within the society that the women came from to the new society that they are living in.

This study suggested that professionals may misunderstand health seeking behaviours of asylum seekers and refugees. Some health seeking behaviours may emerge because of the way access to health care has been described by the professional. For example, Abeba was urged to, 'get in touch' (34 weeks gestation field notes: Interview 1, p5, L17) if she needed anything. For Abeba the only way she knew how to get in touch was to turn up at clinic. Cultural difference contributed to misunderstanding as the concept of getting in touch for the midwife may have meant telephoning before arrival, whereas, for Abeba, this meant to go to the hospital as she knew of no other way to contact.

## 11:8   Building relationships

The way midwives support asylum seekers and refugees varies from those who are able to engage in the emotional, social and psychological care of the women (p105) to those who disassociate and placate their existence within the clinical environment (p128). In some instances midwives felt drawn towards supporting asylum seekers in a deeper sense, such as providing drop in centres where food could be shared and clothes distributed (p72). However, there was no specifically designated post that would accommodate the ability to address public health issues on a long term basis. This meant that midwives who wanted to work in an extended capacity in this way were limited in their ability to achieve their goal of women centred care but achieved this despite the system.

Building a relationship needs engagement from both parties involved. Working in an environment that values how quickly tasks can be completed coerces midwives to focus upon values which are incommensurate with the ideology of a midwifery model of care, which recognises normalcy and the uniqueness of pregnancy (Bryar, 1995). Midwives ability to engage with women may have been influenced by a society reliant on mass media. However, midwives who were able to form a caring relationship with the women may have been more able to negotiate negative media influences (Thompson, 1995).

Alternatively, the influence of the cultural environment and associated peer pressure could have affected the level of engagement between asylum

seekers and refugees. (Lavender and Chapple, 2004; Hunter, 2005). Midwives in a UK national survey have indicated that this medical philosophy of care is sustained by senior midwives and obstetricians (Lavender and Chapple, 2004) and this overriding attitude may support the theory that clinical practices incorporate paradigms which stem from who defines knowledge, how it is generated and how the individual midwife applies this in practice (Powell-Kennedy and Lowe, 2001).

Interpretation of the women's words suggest that at times women may have been attended to in a detached, observational, biological sense which involved screening, blood tests, measuring blood pressure, ultrasound scans etc (p91) and there was little or no attention paid to their psychological needs. In this study, a medical model of care predominated which represented ideologies related to positivism and reductionism. These characteristics are sometimes related to a detached, unfeeling and inhumane response to care (Paley, 2002). I agree with Paley (2002) when he suggests that a medical model has the ability to provide answers to particular pathological questions and that the ideology is not at fault. However, he goes on to say that, *'Values'* *and 'attitudes' cannot be ascribed to conceptual systems, only to individuals'* (p33).

Although this type of care delivery may be related to individual midwives, other studies suggest that there is a cultural influence (Kirkham, 2000; Lavender and Chapple, 2004; Hunter, 2005). Cultural influences mean that

dominant norms within that environment can transpose values into the care of women.

Paley (2002) suggests that blaming the medical model for deficiencies in a caring approach may lead to feelings of powerlessness and impotence and resentment for nurses. Some studies have found that midwives dream of practicing autonomously in an environment that facilitates equity of care for women (Lavender and Chapple, 2004) a factor which they believe will provide job satisfaction. However, midwives sometimes feel that their work is directed by peer pressure to getting things done quickly which prevents providing quality care such as facilitating 'skin to skin' (Anderson *et al.* 2003). The feeling of powerlessness associated with a culture which encourages a medical model may be one reason why midwives become dissatisfied.

From the findings of this study I propose that midwives may be unaware of how much trust is placed upon their individual ethos of care. Lack of insight may lead to non-engagement between midwife and women who are asylum seekers and refugees in the clinical setting. Non-engagement may lead to substandard care related to poor information giving, which may further compromise an already increased risk of mortality for these women.

A lack of engagement because of a concept of obligation generated from 'doing one's duty' emanates from 'caring about' rather than 'caring for' (Tronto cited in Sterba, 2002 p346). For example, the actions of a practitioner who cares 'about' a client may display to an observer a 'good', efficient midwife but

this act may be seen to 'feign' caring due to a lack of relationship and increased professional detachment. Indeed, Mullet (cited in Code *et al.*1989), questions if nurses see their chosen profession as a reflection of their deepest values or a 'mere role' that they will escape at the end of the day. This may explain the potential of how 'caring' may become disingenuous and that an incongruous relationship may develop between caring and power (Paley, 2002). Ultimately, engagement in the caring relationship with women who are an asylum seeker or refugee may rest on the individual moral stance of the midwife. This stance may be influenced by external emotional forces therefore it is of paramount importance that midwives are morally aware of their own beliefs.

The midwife woman relationship should be based upon positive self regard (Rogers, 1967). Midwives should be aware that the perception of how the women feel about themselves may be as a direct result of the negative symbolic displays adopted by midwives in practice. Disassociating from interaction, as in Abeba's case (p128), may lead the women to feel that this practice is the norm and something not to be questioned. The result may lead to placated and silenced behaviour of the women.

I suggest that some midwives are more able than others to symbolically interact, which can have a positive or a negative affect. The process of interaction would mean that the midwife recognises the interaction as new and not part of their usual social world and is able to then undergo change of perspective in order to engage with asylum seeker or refugee. This model of

symbolic interaction was identified by Blumer (cited in Charon, 1979 p127). The ability of a midwife to adjust her actions based on the observation of non-verbal communication (Blumer, 1969) displayed by the woman would improve the maternity experiences for these women. I suggest that there may be a link between those midwives who have the capacity to base their perception of asylum seekers and refugees within the dynamic altering pattern involved in symbolic interaction and those midwives who are able to negotiate negative images portrayed by the press (Thompson, 1995).

From reflection, personal experience and field notes, I became aware that at times midwives were able to choose who they cared for. In this way, the case notes of asylum seekers and refugees, or ethnic minority women may have been removed and placed behind the case notes of women with English names. This means that midwives who are not able to consciously understand non-verbal cues and adapt their behaviour accordingly (Blumer, 1969) may have developed attitudes which are difficult to change. This attitude may leave racially tolerant midwives to cope with the extra demands that may be needed in the care of women who are asylum seekers of refugees. Raised awareness of the process of symbolic interaction may alter fixed attitudes and should be an area for further research designed to reduce institutional racism. By understanding the theory of symbolic interaction there may be a way to identify levels of client- midwife engagement. This information may help the midwife to understand the emotions of the asylum seeker or refugee which may then be captured in active communication and language.

## 11:9  Summary to the discussion of the thesis

This chapter presented the main discussion for the thesis. The methodology used for this study has been justified as an appropriate approach. However, there were limitations to the data.

Social policy contributes to life altering issues for asylum seekers and refugees which the women in this study commented on. Issues such as dispersement, integration and housing became an important part of their lives and may have compromised their health and led to greater inequality.

The negative influence of mass media was related to the way health professionals' stereotype asylum seekers and refugees. There was a suggestion that access to maternity information and services is unequal, which leaves racially tolerant midwives to cope with the extra demands that are needed in the care of women who are asylum seekers of refugees.

Accessing long term health promotion was an issue with little information provided for the women. The long term health of women asylum seekers and refugees may be compromised by inadequate information and access to services. For women who did not have easy and direct access to link workers in the community, there appears to be great difficulty in negotiating future appointments and screening.

The health concerns of women asylum seekers and refugees are multiple and be affected by political and social influences around them. The way the women perceive 'self' is central to the way that they experience midwifery care. Raised awareness for midwives about how their symbolic display of engagement in interaction, warmth and kindness, is of importance. Within midwife- woman interactions positive regard should be aimed for. Midwives should endeavour to create consistent and positive symbolic messages within their practice. This knowledge contributes to the hypothesis that midwives need to pay more attention to the taken for granted aspects of communication and not simply blame incorrect interpretation.

Communication should be based on the needs of asylum seekers and refugees and not simply an assessment of need by the midwife. Poor communication may be happening to women in general and not just asylum seekers or refugees as language was not a barrier for Grace who spoke fluent English. Power differentials within the woman-midwife relationship may privilege women who speak English. Information given via inappropriate interpreters may compromise the women, minors, family and friends. There is a need to highlight to women that they are within their right to ask for an interpreter. Empowering pregnant and parturient asylum seekers and refugees to ask for the basic human right to be able to communicate appropriately may be difficult to achieve. Resources should be available to facilitate this human right.

The women expected to feel safe and trusted midwives implicitly. However, concepts of maternity care which midwives take for granted appeared strange to them. There is a responsibility for individual midwives to improve care for asylum seekers and refugees. Midwives should not have a complacent attitude, such as, 'the woman did not ask for an interpreter', when the good practice issue lies in the hands of individualised care. Effective care should aim to embrace the transforming potential which lies within each individual woman. Enlightening midwives about how the women's previous experiences may have helped to develop a resilient, determined and powerful woman may detract from the negative stereotypical pictures generated by society.

Enhancing the women's pre-existing coping strategies for women asylum seeking and refugees may need holistic approaches. Evolving midwifery in such a way will symbolically elevate the value placed on the women's religion, culture, gender and their place in society. This approach should be based on transformative theory which may enhance the ability of women asylum seekers and refugees to cope and adjust to UK society.

The culture in which midwives work affects how midwives interact with asylum seekers and refugees. There appears to be a dilemma for midwives who may aim to care based on a philosophy of holism, normalcy and uniqueness but who work in an environment which is dominated by pathology, intervention and time constraints.

# Chapter 12: Personal reflection

Initially I believed that equality meant everyone is the same. From undertaking this study I have realised in a deeper sense that individual difference should be acknowledged and celebrated. Although I still believe that access to midwifery services should be the same for everyone, achieving this aim needs to focus on how different the ability is of individuals to reach this care. Because of this I understand that equal may mean different things to different people.

## 12:1 Feelings of discomfort

During this study there were uncomfortable moments of self perception. I had always believed that I was culturally sensitive, aware and did not stereotype. However, I am as guilty as the next person when identifying those in society who are different. I believe that the insights generated by a deeper understanding of symbolic interaction theory (Blumer, 1969) may help to explain this. Blumer identified that within individual social worlds reference groups may be subtly part of our sub-consciousness. An example of this was my initial meeting with Grace, which relied upon my intuition and gut response in relation to how different she was. I had been told by the clinic midwife that there was an asylum seeker who was about to book in for maternity care. I read the hospital notes and considered that the woman was probably Black as she came from Rwanda. I went into the clinic and immediately picked out who this person could possibly be. Grace's clothes appeared to belong to another

person and I automatically placed her in an asylum seeker category. There were other women in the clinic that appeared to be of Indian origin and I tried to placate the rising awareness that I too am guilty of stereotyping with that knowledge. But I knew deep within me that the uncomfortable feelings existed and could not be ignored.

Recognising this instinct led me to acknowledge the influences of past experiences and how society may subtly affect behaviour that we may feel tempted to overlook or take for granted. Acknowledging these feelings, being aware of the taken for granted, and learning from these episodes may be the way forward.

There were other uncomfortable moments which emerged whenever I was asked to speak about my research. The discussion nearly always involved individual polemic reactions and at times extreme views were expressed. Statements about the topic of asylum seekers and refugees appeared fuelled with either anger or pity. I attempted to stay out of the arguments which individuals appeared to need to vent as I needed others to be clear that my intent was to explore the women's experiences and not to anticipate the findings. By taking this stance I felt that I may have touched on what it may mean to be an asylum seeker in this country because I felt unable to adopt a particular opinion, just as at times the women in this study had felt about not defending their very existence.

These uncomfortable feelings are embedded in a society were mass media overlays every event of importance. Tagged on top of the representation by

the media were the political views which gained impetus during a national election in 2005 (Appendix 3). Situated amongst this context were daily emerging local events. For example, during the election a woman came into the antenatal clinic with her partner. They both said that they were asylum seekers and explained to the midwife that the woman had HIV Aids. The midwife called the asylum team to explore what support the woman and her partner had. The asylum team explained that the couple were known to them and that they were not asylum seekers. The obvious difference to the couple would be that they were entitled to free health care if they were asylum seekers. Care was provided, however, and I celebrated the fact that there is a humane response in times of extreme need. However, the local knowledge that asylum seekers and refugees may abuse a system which has good intent makes me feel uncomfortable. Awareness that abuse of systems is not isolated to those who are asylum seekers and refugees but other members of society who are citizens (McSmith and Clemen, 2005) helps me to place this into a broader context.

Acknowledging the discomfort helped me to realise that the behaviour of individuals has the potential to cloud perceptions. This realisation enhances my need to make clear how genuine women in this situation may be affected by the stigma of others. I thought about how distressed Grace had become when she explained that her five year old daughter had been raped. I remembered how paralysed I had felt that there was little that anyone could do to help retrieve the young girl. Genuine instances of need and genuine experiences of women who are asylum seekers or refugees are under

represented and may help to clear misunderstandings about their situations in the UK.

## 12:2   Issues related to photographs

I was disappointed that three of the women felt negatively about using their photographs as part of the research. Abeba disclosed:

> *This is the first time I have seen myself like this. I don't like the way I look. It makes me feel sad that I have come to this. I like to see the children, but not myself. This may be good for the researcher but not for me* (6 weeks postnatal ; field notes p5).

Abeba described that the pictures taken as part of this study were the first time she had ever seen of herself portrayed in this way. Additionally, Grace explained:

> *As for the cameras, I don't think this is a good way for you to find information. I don't like to use this.* (2 weeks postnatal, field notes).

Only one of the four women gave permission to use the images further in presentation of the research. Even this one woman (Meena) stipulated that her pictures could be used, but should only be shown to an audience of women. In order to respect the women's wishes the images have never been shown. All of the images within formal presentations are identified as being that of a women who did not participate in this study.

On reflection, although I felt that the photographs added an extra dimension to the final interview, because of the women's comments I would not incorporate this method of data collection for work with asylum seekers or

refugees in the same way again. However, research which is co-created with the women in the future may indicate that the women themselves would use this approach.

## 12:3   Theory development

For me one of the greatest insights has been the understanding and development of theory within this study. Previously, although able to link and criticise relevant literature to academic work, linking theory had been a tentative and difficult process for me. During this study there were so many influencing theories that at times the framework seemed impossible to grasp. Insight emerged after displaying themes and emerging theory graphically, a process which has been described within chapter five (Appendix 1 and 2) in relation to data analysis. Displaying complex theoretical notions in this way helped to clarify concepts. In clarifying concepts my understanding grew and I was able to see a deeper sense of the women's words during the analysis; which I can only have hoped to have shared with the reader.

With hindsight and the knowledge which grew from understanding the implications of the theory of symbolic interaction, I would have designed this study differently. The knowledge that the microscopic interaction between the woman and midwife was powerfully ladened with gestures and symbols demands to be observed. I now realise how important the perception of these gestures and symbols are for the women's perception of 'self.' I wish now that I had designed the study to accommodate my ability to observe individual

interactions between woman and midwife. This exploration may have identified what symbols are used, why, and how they are utilised within the interactions between midwife and woman. In addition further exploration may have identified what the women feel is positive and negative symbolic interaction and how they feel this type of interaction may affect their long term health. However, hindsight is a luxury which is beneficial only on reflection.

# Chapter 13: Recommendations

Overall the women in this study valued the way that midwives cared for them. However, when following the women through the journey of their childbirth experiences it became evident that there were aspects of the care that they received from midwives that did not address their needs. At times the physical needs of the women paled into insignificance because of the amount of social stress that shadowed their childbirth experience in this country. However, because of the system in which midwives work barriers to helping these women became difficult.

## 13:1  Advisory post

I recommend that an advisory post between the midwifery service and local community service be linked. This post may help to address gaps in the existing service, such as liaising about poor accommodation, accessing clothing, food deprivation and legal representation. This post may facilitate an improved system for health carers and governmental organisations to be able to talk to each other prior to dispersement and may be the difference between a seamless services or fragmented midwifery care. The development of this service may contribute to a more streamlined data collection that all departments may be able access to reduce missing information about individuals. In Liverpool there is a local social inclusion unit which has the ability to link with NASS and legal representatives. The bridge formed by such a post such as this may help to follow the women through their childbirth

experience. These posts across the country may be able to increase the ability of midwives to track the dispersement of maternity care throughout the country, thereby reducing the possible effects dispersement may have on mortality statistics. Negotiation between government departments and NHS carers may increase the chance of the provision of appropriate accommodation. Furthermore, a joint post may build the capability of midwives to be able to communicate at governmental and legal levels. The ability to communicate at this level may truly help to address the needs of these women. This thesis identified that there was some confusion around the perception of the role of the midwife in public health. This post may go one step further in specifying how a public health role may directly affect these women by maintaining communication at governmental level. Working in collaboration may develop links between cultural organisations and religious institutions which may help to understand better the needs of women and their families and the impact that religion may have on the dimensions of childbirth. Experience of caring for asylum seekers and refugees in this way will help to build capability with the aim of sharing this information to other colleagues in the future. Therefore this post would provide a vital communicative link between the trust and society.

## 13:2 Collaborative partnerships

The women commented they would like midwives to talk with them in their homes and therefore care for these women may be best based in a community setting. Midwives may be unaware that their working environment may contribute to detached interaction. To build relationships with pregnant asylum seekers and refugees means that midwives need to work in different ways. Pivotal to this would be an assessment of individual need. It may be for some women that hospital care is desired by the individual woman or deemed necessary by the health professional. Whereas for some, community based care may be a choice and be more beneficial. Therefore, hospital referral and medical involvement would be advocated when abnormality is detected and not driven by the fact that they do not have English as their first language. Resource implications create a barrier to this type of care but should be justified by an approach to individualised care which places the woman at the centre.

Access to midwifery care appeared to be obstructed by a complicated system of referral. Midwives should be the first point of contact for asylum seekers and refugees who become pregnant. This point of contact should be in the community and the development of an advisory post would facilitate this recommendation.

Where pregnant and labouring asylum seeking and refugee women are cared for is important. Involving their views on how midwives work in the future will

help to establish this. The women spoke about how their anxiety was increased because the anticipated intervention in a hospital setting. The ability to give birth at home may be preferred because of their traditional beliefs. Assessing the risk attached when women choose to give birth at home or in a midwifery led unit should be established at an individual level. This assessment should not be based on the sweeping generalisation that all asylum seekers or refugees should be placed in a high risk category. Birth at home may depend on appropriate accommodation which the midwife has the ability to assess individually.

## 13:3 Peer support for those who care for asylum seekers and refugees

During this study there were distressing events recalled by some of the women. The effect of this type of information left me personally distressed which was difficult to vent because there is no existing facility to share this information in a constructive reflective forum. I recommend that there should be increased peer support for midwives and interpreters who care for asylum seekers and refugees. This support may help individuals cope with listening to horrific stories that the women they care for have had to endure. This will generate a deeper understanding for the peer group which will help to provide an improved support system for women asylum seekers or refugees.

## 13:4   Non-verbal communication in practice

Women in this study were provided with little or no information about their maternity care. Midwives should have raised awareness of how important verbal communication and information is to these women. Midwives need to be aware that women obtain more information from members of their community than professionals and this information may be inaccurate. Knowledge about childbirth should be explained to asylum seekers and refugees by describing concepts of care as well as factual information. Better information about the relative safety of operative procedures in the UK may have lessened the women's anxiety levels associated with childbirth.

To develop better information midwives should have raised awareness of how non-verbal body language affects communication and understanding for these women. Training should be given in aspects of body language and the use of non-verbal cues in practice. In association with improved ways to communicate in the clinical area midwives should work with community organisations to disseminate information about childbirth. The information should be written by midwives in collaboration with asylum seekers and refugees. Liasing with asylum seekers and refugees to produce this information will help to provide this sensitive tailored information, in a culturally acceptable format, which addresses anxieties apparent to the midwife.

### 13:5   Disseminating information

Community and nationally based web sites that asylum seekers and refugees may access should display this information. For example, sites used may be The Refugee Council, Refugee Action, Social Inclusion Team, and The Royal College of Midwives. Media should be used to help disseminate information about childbirth. However, due to the limited resources that the women described in this study facilities for internet access, TV and video for health may be best situated in health centres in the communities that the women live in. This system of communication should be free. Language specific TV stations should be approached to disseminate information about choices in childbirth, the process of childbirth and what this means for different groups in society.

As information obtained by asylum seekers and refugees is more often accessed verbally via other members of the specific community (Koser and Pinkerton, 2002; Udoeyo, 2003) policy changes needs to incorporate verbal dissemination directly to users via community organisations. This form of dissemination takes into account the limited resources that the women described in this study had access to.

### 13:6   Stereotyping

Society may contribute to the stereotype of asylum seekers and refugees. Women commented that they had experienced attitudes in the hospital setting

which developed negative feelings about themselves which ultimately silenced their ability to communicate. Therefore, I recommend that other women who attend for their maternity care in the hospital setting be educated about real life stories of asylum seekers and refugees. This may help to reduce racialism and hatred. Furthermore, the time that midwives need to spend with asylum seekers and refugees may be prolonged due to the difficulties involved in communication. Other women should have the need for this explained and justified in an empathetic way. This may help to alleviate feelings for others regarding preferential treatment.

Asylum seekers and refugees should be made aware that communication should be based on their needs and not simply an assessment of need by the midwife. There is a need to highlight to women that they are within their right to ask for an interpreter. Empowering pregnant and parturient asylum seekers and refugees to ask for the basic human right to be able to communicate appropriately, but who may feel subordinate to those around them, may be difficult to achieve.

In order to build self esteem and confidence for these women, midwifery care should be based on a transformative model of care which will focus on the women's existing coping strategies. Training for midwives should incorporate and ability to recognise the women's strength, courage and determination. This information should help to develop information around childbirth for these women and contribute to improved communication. Transformative care may help to develop the midwife woman relationship.

### 13:7   Midwifery education

Midwifery education should include transformative reflection and equip the student to become able to see the ability and strengths of women asylum seekers and refugees who they care for in practice. The midwifery curriculum needs to include aspects of self reflection in relation to the ability to see women asylum seekers and refugees through a transformational lens, personal professional and moral ethics, and communicative episodes in practice. The ability to be reflexive may increase the knowledge that individual midwives directly affect the individual experience of each women.

### 13:8   Humane policy development

Policy makers need be more aware of the personal experiences and views of asylum seekers and refugees. Listening to experiences and views may provide a more humane and considered response to policy which directly affects individual lives and families. Participation at a governmental level may contribute to improved relations, improved integration and improved social policy. To balance representation in society the experiences of asylum seekers and refugees should be portrayed by the media in a positive way.

# Chapter 14: Future research

## 14:1 Observation in practice

The theory of symbolic interaction proposes that the image of other humans forms as a response to how symbols are interpreted within the microscopic interactive process between individuals. Because of the lack of observational evidence around the interactions between asylum seekers and refugees and midwives a research design which incorporates participant observation should be considered for further research.

## 14:2 Advisory post

The effectiveness of a new advisory post should be explored to elicit if women benefit from such a role. The women in this study appeared to be satisfied but there is no comparison in relation to the indigenous population, data which may be generated by the new post holder.

Women described at times that they had difficulty in expressing themselves. How newly arrived women in this country may be facilitated to talk about their fears and anxieties previously inhibited in their country of origin, may be an area for future research associated with this new post. Furthermore, the post holder should explore where asylum seekers and refugees would like to give birth.

Country wide post holders could standardise data collection in anticipation of collecting epidemiological information that may indicate trends in mortality, morbidity, dispersal patterns and living conditions. Exploring how these characteristics affects the emotions and behaviour of asylum seeking children as they grow may be a long term strategy.

## 14:3 Collaborative partnerships

Establishing partnerships between midwives and asylum seekers and refugees to develop improved information should be explored. Finding innovative ways to disseminate this information may lead to improved health promotional practice. How non-governmental and community organisations link with transit countries to disseminate information about childbirth in the UK may help to establish what newly arrived women know and need to know.

## 14:4 Coping strategies

Escott, *et al.* (2005) found that women benefited from an enhancement of their own pre-existing coping strategies. Further research should explore if this method is culturally acceptable and would be appropriate for asylum seekers and refugees. Harnessing coping strategies to a model of transformative care by midwives may be a way forward.

## 14:5 Midwifery education

Reflection around issues for asylum seekers and refugees may provide a safe way to explore sensitive issues in practice. Evaluating if this method of teaching affects practice should be considered.

## 14:6 Final summary

The intent of this study was to explore the experience of midwifery care by women asylum seekers and refugees. This was a longitudinal study which provided evidence over the span of the pregnancy continuum. The method provided a new insight to midwifery care in a local setting. Previous studies have not followed women through the process of maternity care in the UK but have relied on snap shot interviews to inform practice. Because of the prolonged time spent in collecting data a richer perspective has added to the body of knowledge around the issue of asylum seekers and refugees and midwifery care.

This study involved four women and therefore information can not be generalised to the all women in the UK who are involved in midwifery care. However, the words of the women in this study at times resonated with the words of other women asylum seekers and refugees in previous studies. Therefore, the findings may be very relevant to women in similar situations.

The novel approach to collecting data by photographs helped to incorporate data which emerged from the woman's own perspective of her social world. Furthermore, women were able to verify my interpretation of the data adding to the relevance of the findings.

My experience during this study was to be amazed at the resilience and determination that the women showed in their ability to adapt and cope with life in a new country. At times there were distressing and terrifying events that they encountered, coped with and overcame. I have been privileged to be part of their worlds for a short time. The transformational powers to overcome the desperateness of their lives should be an attribute that we as midwives can all learn from . For this I am grateful.

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445.

# Midwifery related terminology

### Anaemia
A reduction in the number of red blood cells, or in the amount of haemoglobin present in them. Anaemia may result from haemorrhage, excessive breakdown of red blood cells or failure to manufacture them.

### Antenatal
The time from conception to birth.

### Antenatal care
Regular monitoring of the woman and the fetus from conception to birth.

### Breast feeding
The process by which a baby gains its nourishment from milk secreted from the breast, by sucking on the nipple.

### Cervical screening test
This screening test detects abnormal changes in the cells of the Cervix and this enables an affected woman to have early treatment.

### Caesarean section
An obstetric operation whereby the fetus is extracted from the uterus through an incision made in the abdominal and uterine walls following the 24th week of pregnancy.

### Gestation
Gestation is a measurement in weeks and is attributed to the stage in pregnancy. The calculation of gestational age considers the first day of the last menstrual and the conceptional age of the fetus. Gestational age is calculated between 0-42 weeks.

### HIV Aids
A complex syndrome caused by Human Immunodeficiency Virus (HIV), which belongs to the retrovirus group. The virus damages the immune system.

### Infant mortality rate
The number of registered deaths of infants under the age of 1 year for every 1000 live births registered in any given year.

### Intranatal
An event which occurs during the process of birth.

### Labour
The act of giving birth to a child.

### Maternal mortality
The death of a woman as a result of childbearing and the statistic is measured by the number of maternal deaths per 100,000 live births.

**Minor disorders of pregnancy**
Common disorders which happen during pregnancy and do not necessarily have a negative outcome upon birth.

**Natural birth**
May be associated with normal childbirth as one where a woman starts, continues and completes labour physiologically at term, without intervention.

**Nurse**
A person who is qualified in the art and science of nursing, and meets certain prescribed standards of education and clinical competence.

**Obstetrician**
A qualified doctor who practises the science and art of obstetrics.

**Postnatal**
After childbirth.

**Postpartum**
After labour.

**Postpartum haemorrhage**
Excessive bleeding from the genital tract at any time from the birth of the baby up to 6 weeks after delivery.

**Termination of pregnancy**
An abortion which is induced, legally or illegally


**Definitions are related to those described in :**

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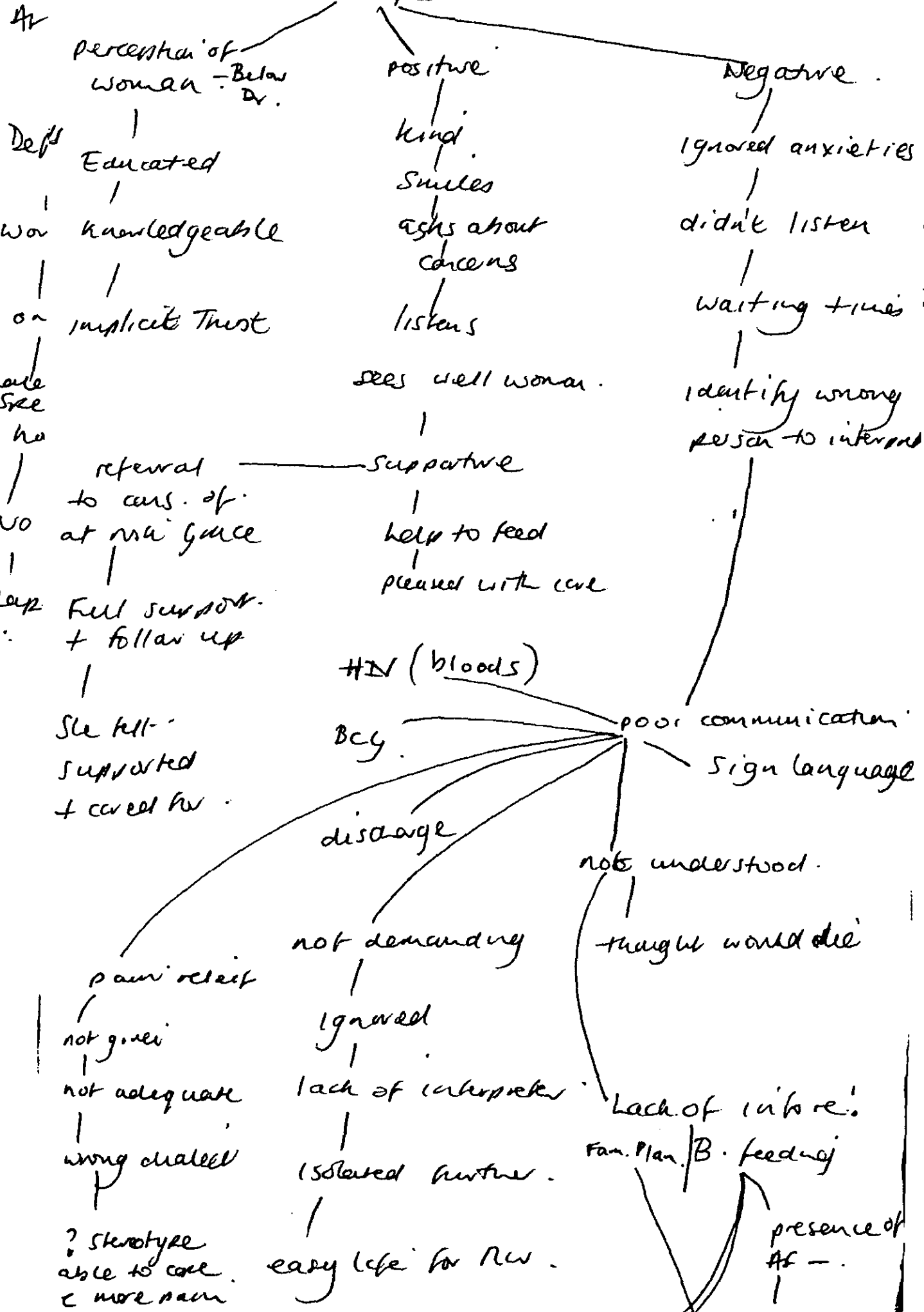
# Appendix 1

## Table of categories within the theme of social influences

| Appendix 1: Code: Social influence | P1/1 | P1/2 | P1/3 | P2/1 | P2/2 | P2/3 | P3/1 | P3/2 | P3/3 | P4/1 | P4/2 | P4/3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| economics/ resources | x | | | | | | | | | | | |
| religion | x | | | x | | x | x | | | | | |
| fear at homeland/ comparison of home | x | x | | | | | | | | | | |
| fear of intervention/ pain | | x | | x | | | | | | | | |
| | | | | | | | | | | | x | |
| agents | x | | | | | | x | | | | | |
| physical safety | x | | | | | | | | | | | |
| | | | | | | | | | | | | |
| isolation | x | | | x | | | x | | | x | | |
| support in labour | x | x | | | | | | | | | | |
| family | x | | | | | | x | | | | | |
| childcare/protection | | x | | | x | | x | | | | | |
| support by friends/co habitation | | x | | | x | | x | | | | | |
| mental health | | | | | | | | x | | | | |
| forced to mix with | | | | | | | | | | x | | |
| | | | | | | | | | | | | |
| affluence/poverty | x | | | | | | x | x | | | x | |
| trust professionals | x | x | x | | x | | x | x | | | x | |
| lack of trust | | | | | | | x | | | | x | |
| treatment/attitude | x | | | | | | | | | | | |
| confidentiality | | | | | x | | | | | | | |
| education | x | | | | | | | | | | | |
| gender | x | x | x | | | | | | | | | |
| nhs/ duty of care | x | | | x | | | x | | | | x | |
| decline blood | | | | | | | | x | | | | x |
| | | | | | | | | | | | | |
| reliance/dependance on interpreter | x | x | | | x | | | | | | x | |
| dependance on others | | | | | | | x | | | | | |
| availability of interpreters/lack of understanding | | x | | | x | | | | | | x | |
| not learn lang refugee | | | | | | | | | | | | x |
| family interpretation | | | | | | | | | | | x | |
| media/education/ health promotion | | x | x | | x | | x | | | x | | |
| information | | | x | x | | x | | | | x | x | |
| informed consent | | x | | | x | | x | | | | x | |
| sign language | | x | | | x | | | | | | x | |
| expressing attitude to hiv | | | | | | | | x | | | | |
| beureacracy | | | | | | | | | | x | | |
| | | | | | | | | | | | | |
| expectations | x | | | | | x | | | | | | |
| old remedies/care at home | x | | | | | | x | | | x | | x |
| BF practices/ AF | x | x | | | | | | | | x | x | |
| accomodation | | x | | | | | x | | | x | x | |
| access | | x | | | | | x | | | x | x | |
| hope | | x | | | | | x | | | | | |
| death | | x | | | | | x | | | | | |
| abortion | | | x | | | | x | | | | | |
| risk taking | | | | | | | x | | | | | |
| rape | | | | | | | x | | | | | |
| dispersement | | | | | | | | x | | | | |
| racism | | | | | | | | | | x | | |
| | | | | | | | | | | | | |

# Appendix 2

# Diagrammatic data display
# (Scanned image)

**Midwife**

Ar

**Perception of woman** – Below Dr.

Def'n
Educated
wo
knowledgeable
on
implicit Trust
rale
See
ho

referral
to cons. of
NO  at mw guice

leap  Full support
+ follow up

She felt
supported
+ cared for

**positive**
kind
smiles
asks about
concerns
listens

sees well woman

Supportive

help to feed

pleased with care

**Negative**
Ignored anxieties

didn't listen

waiting times

identify wrong
person to interpret

HIV (bloods)

BCG

discharge

poor communication

Sign language

not understood.

pain relief

not given

not adequate

wrong dialect

? stereotype
able to cope
c more pain

not demanding

Ignored

lack of interpreter

Isolated further.

easy life for mw.

thought would die

Lack of info re!

Fam. Plan | B. feeding

presence of
AF —

? stereotype
able to cope. easy life for mw.
c more pain

informed consent

previous knowledge
still using honey.

need to discuss

Benefits
available to women who Bfeed

Advice on Nutrition —
(Asda pasta + rice)

Co sleeping in bed

Cultural Beliefs

Bf Team not asked
miss woman.

No. of staff

Booking staff not call them
too busy.

HCA
MW leave
bottles.

(no nee
to say
anything.

AF —.

unaware of nee
no information
partial info
can't access

# Appendix 3

**Election manifesto displayed on bill boards in Liverpool during April 2005.**



It's not racist to impose limits on immigration.

ARE YOU THINKING WHAT WE'RE THINKING?    CONSERVATIVE

JCDecaux

# Appendix 4

Oral presentation for the

Africa Midwives Research Network

Conference, Maputo, Mozambique

Nov 24th-28th 2003

**NHS**

UNIVERSITY
— OF CENTRAL —
LANCASHIRE

*An exploration of women asylum seekers or refugees experience of midwifery care*

**Africa Midwives Research Network Conference, Maputo, Mozambique: Nov 24th-28th 2003**
*Lesley Briscoe, Dr. Tina Lavender, Dr. Bernie Carter, Dr. Eleanor Peters*

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# Background

• Increased trend in Migration world wide

• Applications for asylum in the UK Q4 2002      22,760
                                                             Q2 2003      10,585
• Iraqi, Zimbabwean, Somali, Afghan, and Chinese

• Tighter boarder controls

• Ousting repressive regimens Iraq and Afghanistan

• Speculation about illegal entry

• McClesh (2002)

• 2002 electronic data LWH / Inaccurate / Service Provision

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**Why Mothers Die 1997-1999**

(The Confidential Enquiries into Maternal Deaths in the United Kingdom)

• Higher mortality rates for socially excluded, lower socio-economic groups, very young and specific ethnic groups

• Socially disadvantaged 20 times more likely to die than women from social classes 1 and 2

• Women from ethnic groups other than white are twice as likely to die than women in the white group

• A large number of these women spoke little English

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# Aims

• To pilot methodology used

• To clarify and explore demographic characteristics

• To explore antenatal, intranatal and postnatal experiences of midwifery care

• To Identify how culturally sensitive midwifery care can be developed

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# Statement of Intent

*To explore women asylum seekers or refugees experience of midwifery care*

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# Methodology

Collective Case Study: 4 individual case studies
• Contemporary phenomenon
• Conceptual framework
• Real life context
• Multiple sources of evidence:
    • Qualitative exploration (Today)
    • Field notes and observation
    • Hospital statistics
    • Hospital notes
    • Literature
    • Media

Conceptual Framework *before* the study started

## Methods

• Longitudinal:

| Time point | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| 11-15w | 20w | 34w | 1w | 6w |

Disposable camera

## Sample

5 women————1 Moved          7 Declined

4 women

Demographics

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Age | 26 | 36 | 19 | 23 |
| Parity | 2 | 2 | 1 | 3 |
| History | LBx2 | LBx2 | LBx1 | LB |
| | At home | H/C | Friends | Home/ LWH |
| | Afghanistan | Zaire | Rwanda | Somalia |

## *Results*

## *Themes & Categories*

| Childbirth | Satisfaction, Expectation, Infant feeding, Family planning |
|---|---|
| Concerns | Abortion, Childbirth, Mental health |
| Language | Communication , Interpretation, Informed consent |
| Culture | At home, Here |

Case 2: Layla

Zaire-Congo:          Lingala:                    Interpreter



| Age | 36 |
|---|---|
| Parity | 2 |
| History | LBx2 : H/C Zaire |

Pregnancy confirmed: 4 months after admission

Status: Asylum Seeker/ Married: Partner in the Congo

At Home Husband ?

Location unknown

**Satisfaction**
"The staff and link workers are really wonderful."

**Expectations**
"I'm not worried about the labour just what will happen to me and how I will be looked after."

**Concerns**
"May be I would die during the operation". (TOP)

**Family planning**
"What is family planning? I don't have any need for this. What is a smear ?"

**Language**
"The worst thing was that all of the instructions were in English."

"I'm never sure I have the right information."

**Interpretation**
" I felt that because there was no interpreter with me the midwife had to guess if I had understood. We communicated by sign language but I was never sure I had understood properly."

**Informed consent**
"The paediatrician came at 5pm because the baby had to have a BCG, he said *'you will be given this'*, but I didn't understand what a BCG was and why the baby should have it."

**Culture at home**
"At home there is no food. If one person has food they all share because you have to give bread to the children."

**Culture here**
"My good friend will help this time and she lives close to me. I met her in Church."

**Case C: Grace**
Rwanda              English Speaking
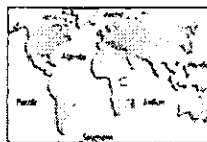
| | |
|---|---|
| Age | 19 |
| Parity | 1 |
| History | LBx1 /Friends Village |

Pregnancy confirmed: 3 months after admission
Status :      Asylum Seeker/ Single
At Home      Raped at 13,       baby Girl
Family separated, location unknown, one brother in London
Parents ? Dead or alive

**Satisfaction**
"Everyone was so supportive. They really supported me in every way. In my physical disability they were there and my mental disability they were also there."

"Yeah even the way she looked. She doesn't look friendly. You got scared when you ask her questions you don't feel free to ask her."

**Expectations**
"I just want to go through with having a natural birth I don't want to have any Caesarean or anything else. I just want to have a natural birth... I want them to stick on my planet. I want natural birth."

**Infant feeding**
"I was looking to feed him and they said you can't. The first time I had nothing. I was crying and he couldn't feed and I cried the whole night because the baby can't feed. And the nurse took him and gave him the formula milk which I didn't want them to give."

**Concerns**
"I cried everyday. I wished I could do something wrong to myself. I mean I even used to hold knives and I used to tell myself I wish I could cut myself . I wish I could do this. I wish I could fly through the window and die."

**Language: Communication**

"You don't know what that means. Just to talk to some one who will listen . That means you're not in you're own world . It means people care, people don't look at us like .....sh**....I used to think people look at us like that."

**Informed consent**

"She took my blood I wanted to know all of them. What are the consequences for instance everything we took. I wanted her to discuss what will happen in the future if I don't do that. But I don't know anything now. Knowing that yeah I'm negative fine. Because you need to know something about that.You know. She took lots of blood that day but we didn't discuss anything."

**Culture at home**

"I went into the garden and walked around. I had to walk and walk. In fact at the end I went into the toilet...you know those pit toilets. So they took me out of there."

**Culture here**

"I knew I had only 2 weeks to stay.....It was Thursday and I had to get out of the house, and she (Refugee Action) managed to convince them because they were saying they're taking me to Birmingham. I had no one in Birmingham. I don't know anyone at all in Birmingham. I was like Oh God, where are they taking me?"

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Conceptual Framework *after* study



Culture in UK

Previous experience

Pregnant Woman — Hospital — Link workers — Community midwifery

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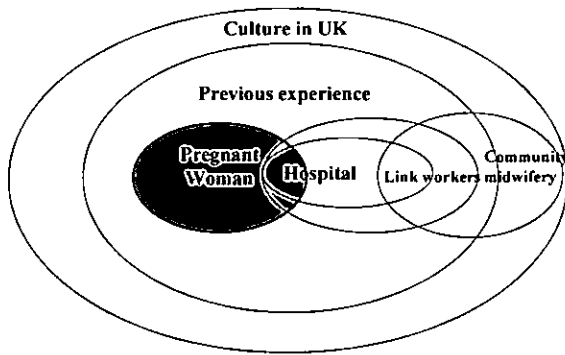


**Conclusions**

- May not be isolated to women who are Asylum Seekers & refugees
- Grateful for care / Lower Expectations
- Expected normal birth
- Concerned about intervention
- Lack of information: infant feeding / family planning
- Lack of interpreting service: emergency/ discharge situations

---

# Recommendations

- Provide culturally sensitive information in accessible formats

- Ask what the women expect about their childbirth at their booking

- Listen to their concerns and sign post for appropriate support

- Focus on professional interpretation for informed consent, ensure this service is available for all investigations

- Ask the woman to repeat back what she understands about the procedure / informed consent

- Ensure correct language/ interpreter used in emergency settings

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# Appendix 5

Oral Presentation for the

Demystifying Qualitative Research

Conference, Maritime Museum, Liverpool

10th October, 2004.

*Photographs as an interview tool with women asylum seekers and refugees*

**Demystifying Qualitative Research Conference. October 10th 2004, Maritime Museum, Liverpool.**

*Lesley Briscoe, Prof. Tina Lavender, Prof. Bernie Carter*

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# Aims

• Explore women asylum seekers or refugees experience of midwifery care utilising case study research.

• Explore if photographic images taken by the women used as a prompt to trigger conversation from the woman's point of view assisted in communication.

• Identify and examine women's key experiences

• Consider how culturally sensitive midwifery care could be developed.

---

# Why photographs?

• **Language Barrier**

• **Confusing ward based experiences**

• **Lack of information**

---

# Photographic research methods

**Making visual representation by studying society by producing images**

---
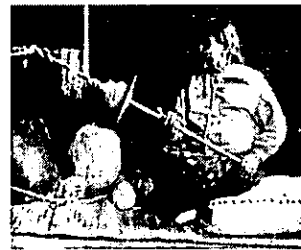
Examining pre existing visual representation studying mages for information about society

---

Collaborating with social actors in the production of visual representation

## Ethical considerations

**Standard ethics**

- Informed consent
- Confidentiality
- Harm/ benefit
- Exploitation
- Protection of participants

**Also consider:**

- Power relationships
- Cultural context of using photographs
- Political implications
- Moral and philosophical beliefs of the researcher

---

## Methodology

**Collective Case Study: 4 individual case studies**

**Methods of data collection**

- Qualitative exploration by in-depth interview; Prompted by photographs
- Field notes and observation
- Hospital statistics
- Hospital notes
- Literature
- Media

---

## What were the women asked to do?

- *Brief guidance :*

Photograph anything that was important to the women

Anything they wanted to share with the researcher

Regular updates about the camera use

---

## Methods

- Longitudinal:

| Meeting points | AN | AN | AN | PN | PN |
|---|---|---|---|---|---|
| Weeks | 11-15 | 20 | 34 | 1 | 6 |
| In depth Interview | | | X | X | X |
| Camera Given | X | | | | |
| Collected | | | | X | |

---

## Sample

5 women ———→ 1 Moved          7 Declined

4 women

**Demographics**

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Age | 26 | 36 | 19 | 23 |
| Parity | 2 | 2 | 1 | 3 |
| History | LBx2 | LBx2 | LBx1 | LBx3 |
| | At home | H/C | Friends | Home/ LWH |
| | Afghanistan | Zaire | Rwanda | Somalia |

---

## *Results of using photographs*

## Themes & Categories

### Photographs prompted discussion of:
- Personal wellbeing
- Surroundings
- Events
- Feelings towards the method



## Prompts about well being

This day I went to the hospital. I felt sad and tired. I was feeling unwell. I thought you (the researcher) would like to know this (Meena)

I had pains that day. I felt unwell. I didn't tell any of the midwives I thought this was normal. But I was worried about the pains (Layla)

This is the day I fainted. I remember this day more than others (Abeba)

## Surroundings

I see the stairs and my heart beats fast.This (photograph) shows how big they are, how difficult it is to get down them. I have fallen down the stairs 3 times since I've been pregnant.
Before I lived in this hostel I lived in a house in Manchester but burglars took everything from me. I feel I've never settled down. If I had a house I would be more settled.
(Abeba)

## Events

This (photograph) is a celebration. It is of my family before going to the temple.
(Meena)

I am having a good time . This was after baby born and our friends had come to stay. (Meena)

This was a special occasion. There was a party at the church, for the church's anniversary.
The children went too. Going (to church) helps me to feel better, seeing people. (Layla)

## Feelings towards the method

Look at the state I'm in. These are the first pictures in my life. I'm disappointed in myself. I don't like the way I look. The pictures are good for the researcher but not for me. (Abeba)

And another thing about cameras. I don't think cameras are a good idea...... you can't really give cameras to people who have gone into (their problems) for instance you've talked to me and you've come up with a solution . You've seen that something has worked out in real life. (Grace)

## Conclusions of using photographs

- As a prompt: superficial; more in depth disclosure

  with words during interviews

- Dislike of the method established

- Missing topics: Difficult concepts for

  the women to capture

## Implications

• Phase 2:
Ethnographic exploration of communication
between midwives, women who are asylum
seekers and interpreters.

• Observation
• In depth interviews

## Acknowledgements

The Women

Link workers and Interpreter

Sainsbury's, Crosby, Liverpool

Tesco, Woolton, Liverpool

# Appendix 6

# Oral presentation for the

# 27th Triennial Congress of the International

# Confederation of Midwives, Conference,

# Brisbane, 24th - 28th July 2005.

An exploration of women asylum
seekers or refugees experience
of midwifery care.

edge hill

UNIVERSITY
LANCASHIRE

27th Triennial Congress of the International
Confederation of Midwives, Conference,
Brisbane, 24th - 28th July 2005

Liverpool Women's Hospital NHS

Lesley Briscoe, Prof. Tina Lavender

---

**Definitions**
Asylum Seekers and Refugees are people who have left
their countries due to fear of persecution based on race,
religion, nationality or membership of a political group or
opinion.

**Asylum Seeker**
Waiting for their application to be processed.

**Refugee**
Indefinite leave to remain, Discretionary leave to remain,
Humanitarian protection.

---

# Background

- Increased trend in World Wide Migration.
- Applications for asylum in the UK fluctuate
- Liverpool one of the main dispersal areas
- Uncoordinated service provision
- McCleish (2002)
- 7 x greater chance of maternal death (CEMACH 2004)

---

# Aims of Research

- Explore how women asylum seekers or refugees experience midwifery care.
- Pilot methodology using cameras.
- Identify and analyse women's key experiences.
- Consider how culturally sensitive midwifery care can be developed.
- Clarify and explore demographic characteristics.

---

# Methodology

- Collective Case Study: 4 individual case studies.
- Longitudinal.
- Contemporary phenomenon.
- Real life context.

---

# Source of Evidence

- In depth interviews.
- Photographs taken by the women.
- Field notes.
- Hospital statistics.
- Hospital notes.
- Literature.
- Media.

## Method

☐ Ethical approval.
☐ Longitudinal:

|  | Antenatal | | | Post Natal | |
|---|---|---|---|---|---|
| Meetings | 1 | 2 | 3 | 4 | 5 |
| Gestation (w) | 11-15 | 20 | 34 | 1 | 6 |
| Interviews | | | X | X | X |
| | Camera given | | | Collected | |

---

## Sample

5 women ⟶ 1 moved            7 Declined
         ⟶ 4 women

Demographics

|  | Meena | Layla | Grace | Abeba |
|---|---|---|---|---|
| Age | 26 | 36 | 19 | 23 |
| Parity | 2 | 2 | 1 | 3 |
| | Afghanistan | Congo | Rwanda | Somalia |

---

## Meena - Afghanistan

Punjabi
Age: 26 years
Parity 2
At home
Husband
Healthy boy
PPH
Breast fed

---
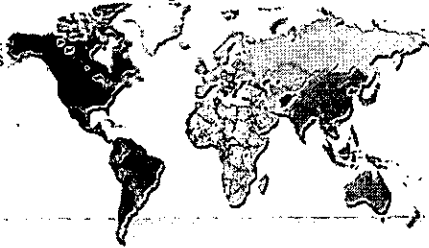
## Layla - Congo

Lingala
Age: 36 years
Parity 2
H/C Zaire
Husband at home
Healthy girl
Breast fed

---
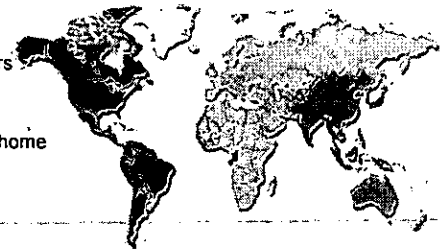
## Grace – Rwanda (English speaking)

Age: 19 years
Parity 1
Friend's village
Unaccompanied
Raped at 13 years
Healthy boy
Massive PPH
Depression
Psychiatric follow up

---
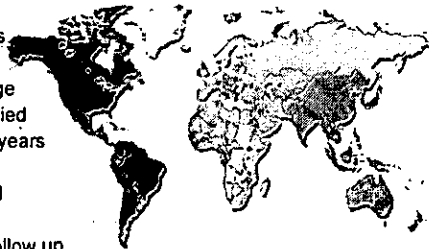
## Abeba – Somalia (Refugee)

Age: 23 years
Parity 3
Home/LWH
Husband
Healthy girl
Emergency C/S
Breast fed

## Process of Analysis

☐ Interviews read and re-read.
☐ Linking the discussion of photographs back to the data.
☐ Application of theory applied to the findings.
   ☐ Postmodernism.
   ☐ Symbolic interactionism.
   ☐ Social theory of media.



## 11 Themes

| | |
|---|---|
| ☐ Communication. | ☐ Role of the midwife. |
| ☐ Gender. | ☐ Role of the doctor. |
| ☐ Difference. | ☐ The role of society. |
| ☐ Maternal concerns. | ☐ The role the researcher. |
| ☐ Maternal expectations. | ☐ Media. |
| ☐ Morality and ethics. | |



## Media - Results

☐ Stereotype.
☐ Women's expectations.
☐ Health Promotion.
☐ Social morality.



## Stereotype



## What the Papers Say

Criminal

Registrar exposes migrants' new racket

SCANDAL OF BOGUS BIRTHS



## What the Papers Say

Demon!!

Britain's refugees, demonised down the centuries

# What the Papers Say

Sponger!!

**ASYLUM: THE JOKE'S ON US**

Those Sangatte refugees given work permits three months ago are refusing jobs, living in plush hotels and costing YOU £100,000 a day

---
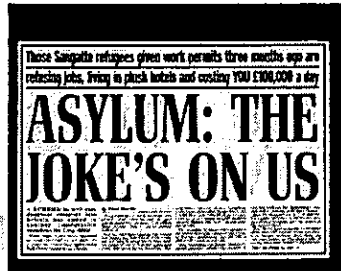
Did the subjective layer of media influence midwifery care?

---

# What the Women Say

*"Thank you from our heart. I'm very, very thankful to the hospital and you and everybody it was such nice experience. We never ever expected to be treated like this in our life. We are very pleased and very thankful."* (Meena)

*"The staff and link workers are really wonderful."* (Layla)

---

# Experiences Differed

*"She treated me like I know nothing you know.....So I think she was quite rude but may be she didn't know what she was doing or she didn't have the answers to my questions. She didn't look friendly. You got scared when you asked her questions you don't feel free to ask her."* (Grace)

---

# Facilitate Understanding

*"I felt that because there was no interpreter with me the midwife had to guess if I had understood."* (Layla)

*"I had an interpreter before the baby, not after. At no time after the operation (caesarean section)."* (Abeba)

---

# The Value of Face to Face Interaction

*"They come to the hospital everyday....some ladies can't talk about things....but at least they could have one to one....you know talk to them. But every time I keep it in my heart it hurts so much....So if people could come up like this, like the way you come up and speak to us. I think mostly this could be happy. But once you keep it in your heart you don't know what to do. You just get more confused. That's when you hear of people committing suicide."* (Grace)

## Stereotype

- Pleased with care.
- Face to face interaction affected positive interaction.
- Midwives appeared able to negotiate negative influence of the press.
- Avoidance of face to face interaction failed to meet women's needs.

---

## Expectations



---

## What the Papers Say

### Negative

- Strapped to a machine, deprived of control ...the miracle of birth for British women
- Survey shows that mothers' dreams of holistic experience end in hospital shock

Laura Barton
Thursday January 13, 2005
The Guardian

---

## What the Papers Say

### Sensationalises

- 'I was so completely traumatised by the fact that I hadn't given birth'
- Kate Winslet has admitted that having her first child by caesarean made her feel a failure. Lucy Atkins knows exactly what she means.

Tuesday March 23, 2004
The Guardian

---

## What the Papers Say

### Depressing

- Survey offers 'depressing insight' into maternity care

Sarah Boseley, health editor
Tuesday October 1, 2002
The Guardian

---

## Antenatal Care was Reassuring

"First when I found out I was pregnant I was a bit worried. I haven't got anybody here, my mother, my mother in law. Who would look after me? I felt really worried. But then I started going to hospital and they started looking after me, checking how the baby is doing. Blood tests and all these things, so I felt quite relieved." (Meena)

# Fear of Intervention

*"Ideally in labour ward I want natural birth. I want them to stick on my planet. I want natural birth. But if there are any complications that I can't have a natural birth then those who know more can, you know....advise me about it and guide me about it."* (Grace)

# Fear of Death

*"I thought may be I would die during the operation."* (Layla)

*"Sometimes if you have an operation (an emergency CS) you think you're dying. I thought I'd never see my husband and my mother in law again, and I never said goodbye."* (Abeba)

# Expectations

☐ Expectations appeared to be based on experiences from their own country of origin.
☐ Support from female relatives and the local women.
☐ Lack of antenatal care.
☐ Fear of death linked to interventions.

# Health Promotion

# Ideology

☐ Woman centred.
☐ Choice, control and continuity
☐ Partnerships in care.

# Informed Consent?

*"The paediatrician came at 5pm because the baby had to have an injection (BCG) he said",*
*'you will be given this',*
*but I didn't understand what a BCG was and why the baby should have it".* (Layla)

## Prevention of Cot Death

*"Before they discharged me the midwife came to me, my husband was there. She tried to explain a few things how to lie down the baby in bed and how to register his birth. And how to look after the baby, how to feed him all these things, but he didn't understand. He couldn't understand anything you know. Little bit."* (Meena)

## Long Term Health?

*"What is family planning? I don't have any need for this. What is a smear?."* (Layla)

## Eat Well!

*"By the time I was in the hospital (antenatal admission) I wasn't receiving any money, I was only receiving about £20 (48 Australian dollars) I was thinking how am I going to go home? And how am I going to buy nappies for my baby and how am I going to buy this and that? And how am I going to buy this and that for myself. They're (midwives telling you) like you have to eat well and I was how am I going to eat well?"* (Grace)

## Health Promotion

◘ Accepted norms within the organisation may be imposed upon women due to lack of informed consent.

◘ Health promotion may not be understood.

◘ The safety of the baby may be affected.

◘ Health advice may be inappropriate.

## Social morality

## Life in the Hostel

*"I hate the hostel residents; they bang on the door at all hours of the night. The receptionist doesn't understand and the police don't understand. A few days ago I was kicked by my neighbour (whilst pregnant); he got angry with the children playing on the landing. The English man slapped my children because they kept coming back to get a drink of water."* (Abeba)

# In Hospital

*"The first week it was horrible, because of some woman she was really, really cruel and rude....(in the end) I just kept quiet and (I'd) sit down on my bed."* (Grace)



# Intolerance

*"They shout at me but I'm not sure what they're shouting. They laugh at me as I walk past. They think I don't understand what they're doing. I pretend I know what they've said and look up to them....but what they talk to the English they are like, 'Hello love' and their face changes. If I had somewhere else to go I wouldn't stay here, I have no choice."* (Abeba)



# Symbolic Interpretation

*"It means people care, people don't look at us like sh**....I used to think people looked at us like that."* (Grace)



# Conclusion

◻ Mass approach to care of organisations may affect the way a midwife cares for the women who are asylum seekers or refugees.

◻ Development of partnerships in care may be reliant on the individual moral stance of the midwife as midwives who choose **not** to form a face to face interaction did not meet the women's needs



# Conclusion

◻ Women based their expectations on their previous experience which focussed on:
  ◻ Reassuring action of AN care.
  ◻ Fear of interaction.
  ◻ Operative procedures linked with death.
◻ Health Promotion involved limited discussion and imposed normative standards of the organisation which hindered informed consent.



# Recommendations

◻ More face to face communication.
◻ Normative standards override women's needs.
◻ Consequences of lack of informed consent.
◻ Observation: further research.

□ "When I used to be in G....(hostel) I used to lock my room every time and cry. Every day.

□ No one knew me when I used to live there....

...I used to lock myself in and cry." (Grace)

□



□ "You didn't know how many people there are.

□ My girl friend, she cries everyday because of her boyfriend....what he did to her and (he) tells her to abort.

□ She's going through that everyday alone." (Grace)

□

□ "They shout at me but I'm not sure what they're shouting.

□ They laugh at me as I walk past. They think I don't understand what they're doing.
□

□ I pretend I know what they've said....and I look up to them....but when they talk to the English they are like 'Hello love' and their face changes.

□ If I had somewhere else to go I wouldn't stay here, I have no choice." (Abeba)

**dirty war on migration**

The d... multi-culture, by Blair's social guru

migrant camp plan

...plan to house migrants in Africa

---

- "Yeah because this thing is really haunting me. *(her 5 year old daughter back home in Rwanda)* cry and cry for help.

- And she's calling my name. She doesn't know my name but, she doesn't know me. She just keeps on calling." (Grace)

---

- "An Arabic midwife, who was around at the time was brought translate....but I speak Somali. I was terrified.

- I was terrified. I was told to contact my family, but there was no time.

- Sometimes if you have an operation *(an emergency CS)* you think you're dying.

- I thought I'd never see my husband and my mother in law again, and I never said goodbye." (Abeba)

---

**The drawbacks of**

**Strength in numbers**

---

- "It might be difficult for me to look after 2 little children on my own because I haven't got my family here....

- ....So that's the main thing I'm worrying about when the baby is born....who will be there?" (Meena)

---

THE SUNDAY TIMES

All at sea on asylum

**ECHO**

**Restaurant chiefs fined**

EDITORIAL OPINION

Stop pretending asylum seekers are a prob...

□ "The Agency smugglers took me to the train station in London and left me there.

□ I went to a person in uniform who couldn't communicate much with me.

□ They finger printed me and took pictures.

□ They gave me a letter to take to a solicitor to fill in forms and get an (NASS) number." (Abeba)

□

---



**TRAFFICKING IN THE UK**
✦ The police and Unicef say that West African children are also trafficked to the UK – destined for domestic slavery here or en route to countries such as Italy to be prostitutes. The Sexual Offences Bill – currently going through Parliament – outlaws the trafficking of people for prostitution, but makes no mention of child trafficking for domestic labour. Visit www.enoughdesexploitation.org.uk and click on 'Latest news' for an outline letter you can send to Margaret Hodge, Minister of State for Children, asking for child trafficking to be made illegal.■

---



□ "We did not know we were coming to England. We told our agent, we told him....

□ ....Look we want to go somewhere safe. Where our religion is respected and our children can get to go to school.

□ We want to be safe, especially what happened after 2-3 years there (Afganistan)." (Meena)

---

□ "I turned up for my appointment with the doctor (GP in England) but he wasn't there.



□

□ I never complained, we're used to this in my country. We sometimes wait for days." (Layla)

□

---



□ "I cried everyday. I wished I could do something wrong to myself. I mean I even used to hold knives and I used to tell myself I wish I could cut myself.

□ I wish I could do this. I wish I could fly through the window and die." (Grace)

---

□ "You don't know what it means. Just to talk to some one who will listen. That means people care, people don't look at us like....sh**....I used to think people look at us like that." (Grace)

□

- "I don't know where my family is....I'm not very sure whose alive and whose dead."
- "I don't know where they are. We just had to come here." (Meena)

An exploration of women asylum seekers or refugees experience of midwifery care.

Lesley Briscoe
Prof. Tina Lavender

# Appendix 7

**Conference proceedings, International Confederation of Midwives, conference, Brisbane, 24th - 28th July 2005**

Maternity care is not solely medical and involves psychological approaches that include listening. However, women refugee or asylum seekers are less likely to speak English or to be literate (Burnett and Peel, 2001a). Novel approaches in research towards bridging linguistic gaps are limited. However a visual narrative approach (Harper, 2000) was incorporated into this study which used photographs taken by the women to be used as prompts for conversation. The intent was to add a dimension to qualitative exploration which had not been done before with this group of women.


## Aim

The intention of this study was to explore women asylum seekers or refugees experience of midwifery care. The feasibility of data collection by photographs taken by the women to be used as a prompt for conversation was explored. Furthermore, I aimed to develop a theoretical foundation which would inform midwifery practice in relation to the care of women asylum seekers or refugees.

## Method

Case study research was utilised which explored the individuality of women who did not have shared cultural values or experiences. The study was longitudinal and engaged the women at five time points. Women were met during the antenatal and postnatal period of their pregnancy and childbirth.

The initial meeting was at their booking appointment between 11-15 weeks of pregnancy in a specifically designated link clinic where interpreters were present. Prior to meeting the women I met with the link clinic translators to describe the study and request their services for recruitment. I checked the women's status as asylum seeker or refugee prior to approaching for recruitment. At this meeting the women were given information about the study which was translated verbatim by the link translator, and they were invited to take part. I gave the women time to ask questions and during this process I asked if they understood what was required from their time in relation to the study. This process was also facilitated by the interpreter. If the women wished to participate, consent was taken with the help of the interpreter and a disposable camera was given to her. This meeting took approximately 1-2 hours.

I met the women again at their next appointment at 20 weeks of pregnancy in the ultrasound department to ask if there were any problems with the camera and whether they would like to talk to me. This meeting took approximately 30 minutes.

The third meeting was at 34 weeks gestation in the woman's home. At this meeting there was an in-depth interview facilitated by a pre booked professional interpreter. The interviews lasted between 1-2 hours and were taped or documented as the woman requested. Two women declined tape recording their interviews and in this instance I took field notes, with their permission.

The fourth meeting was within one week of childbirth, again this was an in depth interview which lasted between 1-2 hours with a pre booked interpreter. The camera was collected at this meeting in preparation for film development.

The fifth meeting was 6 weeks postnatal and was approximately 1-2 hours long. I gave a copy of the film back to the women to keep and asked them to select the images that they wanted to talk about. In addition, at this meeting there was a discussion about my interpretation of the previous interviews and comments by the women were documented and subsequently amended within the text for analysis.

## Ethics
Ethical approval was gained from The Local Research Ethics Committee, The Faculty of Health Ethics Committee, University of Central Lancashire, and The Liverpool Women's Hospital Trust.

## The participants
I approached fourteen women and invited them to take part; nine women declined to participate and five women consented. The women who declined gave no reason. One woman moved during the study period which left four women who participated.

**Case 1:** Meena was twenty six years old and accompanied by her husband and two children. Meena had been pregnant twice before when she had given birth to two, live children; a girl who at the time of this study was aged 5 and her son was aged 3. She had given birth to both children at home in Afghanistan accompanied by her mother and sister. She was married and her husband had paid for his family to leave Afghanistan because of prejudice towards their Sikh religion.

Meena became pregnant 9 months after she had been admitted into the country and was an asylum seeker. She had managed to contact home and was aware that all of her family had been separated or killed. The location of the family members who remained alive was unknown. Meena spoke Punjabi and needed an interpreter to help us both to communicate with each other.

**Case 2:** Layla was thirty six years old and was accompanied by her two children. She had been pregnant twice before and given birth to two live children in a health centre in Kinshara in Zaire. Her husband had been present at the births and she had been assisted by a midwife based in the health centre. She did not disclose why she felt that she had to leave Zaire but said that there had been a war and this was terrible for her to live through and preferred not to talk about this. She had become pregnant this time 4 months after admission into this country. Her husband remained in the Congo and she was unaware of his location and if he was still alive. Layla was an asylum seeker who spoke Lingala, and needed an interpreter to help us to communicate with each other.

**Case 3:** Grace was nineteen and unaccompanied. She had been pregnant once before when she was thirteen years old following a rape in her homeland,

Rwanda. She had given birth to a girl at a friend's home in a village in Rwanda where she was accompanied by the friend, the friend's grandmother and a local woman, who had experience helping local women to give birth. Her daughter was now five years old and remained in Rwanda. Grace had become pregnant three months after admission into this country. Grace's family were separated and she did not know if her parents were alive or dead. The location of all but one member of her family was unknown and this was her brother who she knew to be living in London.

Grace had been taught English by the Red Cross organisation in Rwanda when she was approximately eleven years old. The sessions were free and Grace had felt that this would be a valuable language to learn. Her English was fluent and eloquent and we were able to communicate with each other freely.

The week before the first in-depth interview (34 weeks gestation) Grace had discovered from a telephone call to her friend that her little girl had also been raped, a shocking and distressing revelation which Grace commented on during our conversations.

**Case 4**: Abeba: was twenty three and accompanied by her husband and children. She had three previous pregnancies, all of which were live births. Two children were born in Mogadishu in Somalia, at home, when she was accompanied by a local woman. One baby had been born the previous year in the study hospital. Abeba had been resident in England for two years and seven months and was a refugee with the status of 'Indefinite Leave to Remain' (ILR). She lived in a hostel close to her mother in law. She spoke Somali and needed an interpreter to help us to communicate with each other.

## Photographs as a prompt for conversation
I anticipated that the women would need explanation about the use of the disposable cameras which they were given as part of the study. I gave guidance about how to use the cameras and described that they should capture anything that they would like to talk to me about once the photographs had been developed. The women appeared to be happy with this explanation. I ensured that the women understood that the photographic image would be used to prompt conversation. This method embraced the philosophy that multiple realities are constructed within the individual (Denzin and Lincoln, 2000) and issues of importance would be generated from the perspective of the woman. One copy of the photographs were kept by the women and I kept another. The women chose which photographs they wanted to discuss within the interview.


## Analysis

The data was read and re read many times. Common themes emerged which evolved into categories. An interpretive analysis was verified by the women at the final in depth interview. Gaps in the researchers' interpretation were altered in line with the comments from the women. This final interpretation was analysed.

## Implications of findings

The results of this study will raise awareness of how women asylum seekers or refugees experience midwifery care locally. New knowledge may lead to an improved understanding of how theoretical perspectives may influence the care of women who are asylum seekers or refugees, which may give insight into how culturally sensitive care may be improved. The comments generated by the women have given a voice to a group of women who may be marginalised from main stream research due to barriers in communication.


## Limitations

This study involved a small sample of four women, four to six is suggested as an appropriate amount within multiple case study research (Stake, 1995). Although small, the sample generated very rich, in-depth data. This gave insight into the midwifery experiences of women who are asylum seekers or refugees locally. However, it was not possible to include all nationalities due to the methodology chosen and the feasibility of including women who may have spoken 70 different languages (Local hospital statistics). Therefore, the knowledge gained is limited to the constructions of the women involved in the research and does not presume to generalise about the experiences of others who were not included.


## Acknowledgements

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