Meeting the health and social needs of pregnant asylum seekers: Midwifery students' perspectives.
Part 2: Dominant discourses and approaches to care

Pregnant women seeking asylum in the United Kingdom appear particularly vulnerable, having complex health and social care needs and could benefit from a woman centred approach to midwifery care. This article is the second of three parts and reports on the findings from one objective of a wider doctorate study. It focuses on exploring midwifery students' perceptions of how to approach the care of pregnant women seeking asylum. Although the design of the study is explored in article one, in this context, the data was subject to critical discourse analysis to meet this objective. Key words and phrases were highlighted which appeared to reveal power and ideology implicit in the language used when discussing midwifery care of the pregnant woman seeking asylum. Dominant discourses were identified which appeared to influence the way in which care was approached and the possible sources of these discourses critically analysed. The findings suggest an underpinning ideology around following policies and guidelines to meet the physical needs of the woman at the expense of her other holistic needs. Despite learning to adopt a woman centred approach in theory, once in practice some students appear to be socialised into (re)producing these dominant medical and managerial discourses with “midwifery discourse” being marginalised. In addition, some students appeared to have difficulty understanding how to adopt a woman centred approach and the importance of considering the woman's context and its impact on care. These findings have implications for midwifery educators and this article identifies that the recent Nursing and Midwifery Council requirement for students to undertake a caseloading activity could provide the opportunity for them to adopt a consistent woman centred approach in practice, rejecting dominant medical and managerial discourses. However, these discourses appear to influence midwives caring for women more widely and will be difficult to challenge.

Introduction

Pregnant women seeking asylum in the United Kingdom (UK) are perceived to be a particularly vulnerable group in society due to a number of contributing factors. These are explored in article one of this series of articles emanating from a PhD research project and a summary is offered below. They may be in poor physical health (Carolan, 2010; Burnett and Fassil, 2004). They may also have suffered traumatic experiences affecting their psychological health (Ukoko, 2007; Reed, 2003; Dumper, 2005, Refugee Council, 2009). They are more likely to have a complicated pregnancy with an increased risk of maternal mortality (Centre for Maternal and Child Enquiries, Centre for Maternal and Child Enquiries, 2011). In addition, they may be the subject of negative perceptions of asylum seeking by the general public (Lewis, 2005; Finney, 2004) and evidence suggests, by some midwives (Gaudion and Allotey, 2008; Lockey and Hart, 2004; McLeish, 2002).

Contemporary midwifery practice in the United Kingdom (UK) is underpinned by the concept of woman centred care. This is stipulated in the standards set by the regulatory body, the Nursing and Midwifery Council (NMC) (2009). It is also implicit within UK government policy documents, including more recently Maternity Matters (Department of Health, 2007) and re-enforced through Midwifery 2020, a UK

initiative which reviewed midwifery care (Midwifery 2020, 2010). The key message from these documents is that the woman should be central when approaching midwifery care and that her holistic needs, including her psychosocial and cultural needs should be assessed. It would appear essential that a woman centred approach to care is adopted by midwives caring for pregnant women seeking asylum whobmay be particularly vulnerable and have specific health and social care needs that require addressing.

To promote a woman centred approach to care, contemporary midwifery education programmes in the UK appear to have embraced woman centred teaching strategies. These encourage the application of knowledge drawn from different cognate areas to the pregnant woman's holistic needs. They have evolved from traditional teaching where facts were acquired in separate subject areas arguably resulting in knowledge being compartmentalised and difficult to apply to individual women (Davies, 2004b). Problem Based Learning (PBL) is one such teaching strategy which encourages students to construct and synthesise knowledge around a pregnant woman's perceived holistic needs, by providing appropriately designed triggers for learning (Haith-Cooper et al., 1999).

Despite these attempts by midwifery educators, evidence suggests that once qualified and practicing, some midwives have difficulty adopting a women centred approach to the care of pregnant women seeking asylum (Briscoe and Lavender, 2009; Nabb, 2006). Article one identified that some midwifery students appear to be influenced by dominant negative discourses around asylum seeking more generally (Haith-Cooper and Bradshaw, submitted). Another research objective was to focus on the clinical context; identifying dominant discourses specifically in the practice setting and how they may influence the way in which midwifery students approach the care of a pregnant woman seeking asylum. Midwifery educators have a responsibility for ensuring that all midwives are well prepared to care for asylum seeking women (Nursing and Midwifery Council, 2009). By investigating how students approach their care of these women, midwifery educators can be assisted in fulfilling this responsibility.

The Study

Detailed explanations of the methods selected, sampling and ethical considerations are included in article one of this series (Haith-Cooper and Bradshaw, submitted). In summary, eleven midwifery students from a group of thirty two pre-registration students in the second year of their programme volunteered to participate in the study which was conducted over a period of a full academic year. Two focus group interviews were conducted using a scenario of a pregnant woman seeking asylum who had just arrived in the UK as a trigger for the discussion. The participants followed the PBL process (Schmit, 1983) to explore the woman's possible health and social care needs. The group was familiar with the use of PBL as it was the main teaching method used in their programme. Consequently, in the research context, the facilitator role was minimal avoiding influencing the data being generated. The facilitator's main purpose concerned refocusing discussion when the conversation strayed from the task.

Following this, three participants were identified as having made contributions to the focus group discussion which warranted further exploration. They engaged in an

individual, semi-structured interview. Additionally, two participants, having encountered and cared for an asylum seeking woman in practice, submitted a written reflection of how they applied their learning from their research participation. The transcribed verbatim from the interviews and documentary data from the reflections were subject to Foucauldian critical discourse analysis (CDA). This interprets discourses as a flow of contingent knowledge over time, exercising power by institutionalising and regulating ways of thinking (Jager and Maier, 2009).

To address the above research objective, the language used was examined for institutionalised ways of thinking around approaches to the care of pregnant women seeking asylum. Key words were identified in the data which appeared to reflect power and ideology implicit within underpinning dominant discourses. Discourse strands or common topics representing a number of utterances were then identified and coded (Jager andMaier, 2009, p.46). A discourse is the abstract concept flowing from a “great milling mass” of discourse strands which CDA aims to “disentangle” (Jager and Maier, 2009,p. 36). Discourses which appeared to influence approaches to care were identified and critically analysed. This was to develop an understanding of possible social structures exercising power and regulating people's thinking and in this case that of midwifery students, therefore revealing the (re)production of these discourses (Jager and Maier, 2009).

Findings

Some participants contributed little to the focus group discussion therefore the findings predominantly represent the discussion from the more vocal participants. The quotes are identified with the participant number (P) and the data sets from which they originated fg (focus group) 1 or 2 or ii (individual interview).

Medical Discourse

The findings appeared to reveal an underpinning dominant medical discourse around childbirth which impacted on the midwife's role in practice. The medical model views the pregnant body as a machine, separate from the mind which is monitored for pathological changes through undertaking physical checks (Hunter, 2006). When discussing their approaches to the care of pregnant women seeking asylum, participants predominantly focused on meeting medical needs by undertaking physical care, at the expense of other holistic aspects of care. This appeared to be considered by the participants, as the “normal” role of the midwife, suggesting that all other non physical care was extra, or an unusual aspect of the role.

P8fg1 “And obviously, your normal role of the midwife, you do all your checks, making sure everything's fine. Mum's, baby's fine. Making sure, you know, that you're not letting asylum seeker take over your perspective.”

The word “obviously” suggests that the physical aspect of care being “normal” is a common understanding. “Not letting asylum seeker take over your perspective” suggests that the physical aspects of care do not change with the woman's individual context. This decontextualisation is explored further below. “Your checks” suggests that the physical tasks are led by the midwife's agenda rather than the woman's perception of her needs, thus presenting the woman as a passive recipient of care.

Managerial Discourse
The findings also appeared to suggest a discourse around managerialism entangled with medicalisation. In this context, managerialism presents as a reliance on local and national policies and guidelines constructed by managers and medics to manage physical care (Davies, 2004a). Here they appeared to influence decision making around the needs of the pregnant woman seeking asylum:

P10fg1. "are there any maternity guidelines in relation to asylum seekers"

Participants mainly referred to guidelines produced by the National Institute for Health and Clinical Excellence (NICE) in their discussions (National Institute for Health and Clinical Excellence, 2010). This appeared to lead to the pregnant woman seeking asylum being labelled as "high risk" and a "late booking" and then managed as a deviation from the normal pattern of antenatal care, as prescribed in the guidelines:

P8fg1. "Well, she'll be a late booking, so everything should be checked out."

P11fg1. "she won't have had any antenatal screening, so if she's coming from possibly a high-risk area…."

The idea of the woman being a "late booking" led to a discussion exploring the potential consequences for example, opportunities for early assessment of gestation, in keeping with NICE guidelines, were missed due to booking late.

P4fg1. "We need gestation on there as well…….. She might know"

"She might know" suggests a lack of trust in the woman's ability to know her body, re-enforcing the woman as a passive recipient of care and needing a medical scan to confirm her due date. Participants also explored how you would prioritise what is most important if you were presented with a "late booking" woman:

P8fg1 "The key thing you want to be doing is making sure you can send off her bloods, that you know, you're sending off stuff that you still can do and you're doing them as quick as possible."

Again, the medical aspects of care and the bloods, as identified in the NICE guidelines were considered the priority and speed appeared to be the essence.

"Midwifery" Discourse
This term has been used to encompass the discourse around a woman centred, holistic approach to care as explored earlier. In this context, the findings suggest that other holistic aspects of care including psychosocial and cultural aspects did not appear as important when discussing the needs of the pregnant woman seeking asylum. Indeed, when discussing emotional aspects, participants appeared to offer a medical perspective:

P10fg2 "I found some research about stress and linking it to fetal development. And how stress, the woman's cortisol levels are very high. Apparently some research

says that that can pass through the placenta and affect the baby's development once it's born."

In addition, when discussing language needs, participants focused on how physical care, in this example managing pain, could still be provided when there was no interpreter available to meet language needs:

P10fg1. "We were all just miming like crazy—She did understand, yeah…because some of the concepts are quite general, really. Like pain and things like that."

When discussing the social and emotional needs of the woman, the midwife's role was perceived to be minimal:

P12fg1 (social support) "it's not a midwife to sort it out, is it"

P12fg1(emotional support) "And I think the best way is to do minimal"

By minimising these aspects of care, participants appeared to neglect a woman centred, holistic approach. This suggests that in this context, midwifery discourse has become marginalised by the more dominant medical and managerial discourses influencing approaches to care.

The Context of Care

When approaching care from a woman centred perspective, it is argued that the role of the midwife involves looking beyond each clinical encounter to examine background factors which may influence the pregnant woman (Edwards and Byrom, 2007). The findings of this study suggest a discourse strand around the context of care. Participants appeared to have difficulty in reaching an agreement as to whether care of the pregnant woman seeking asylum can be provided in the absence of her asylum seeking context;

P8fg1 "..not letting asylum seeker take over your perspective."

or whether her context as an asylum seeker should be taken into account when approaching her care needs. Some participants requested that the group search out the literature relating to the asylum seeker's background in order to help them to identify her potential needs.

P3fg1. "There must be something out there that says they might have this need that need"

However, others argued that considering a woman's context, when providing care, leads to generalisations being made:

P8fg1 "But then you've putting them all in a box and we need to be staying open-minded…provide appropriate care according to the woman"

Meeting cultural needs was used as an example, to illustrate this difference of opinion:

P12fg1 "I suppose role of the midwife…understanding cultural differences"

P4fg1 "You can try and do that to a certain extent, but you can't know the cultures of everybody. She's arrived from Sudan, could be somebody from somewhere completely different. You learn as you go along, I think."

Another participant questioned this decontextualised approach to care:

P2ii. "Sometimes we can, we can kind of push away the work by going, I just deal with somebody as a person, you know….and that means I don't have to learn about cultures and I don't have to learn about general counselling skills and I don't have to learn about ways and skills for, for dealing with people from different cultures because you know, I just work on a one-to one basis…"

This was explored further in the individual interview involving this participant:

P2ii "all individuals exist within a context…I don't think it does any harm to try and educate yourself about, about cultures that you don't have any experience of if you're coming into contact with people from those cultures. It doesn't mean that you… make more assumptions about a person just because you understand a culture that they come from a bit better Yeah, I think it might even mean that you make less assumptions because yeah, because you understand the background a bit more."

Some participants agreed that one of the learning objectives formulated from the first focus group, should relate to learning about the Sudan which was presented as the asylum seeker's home country in the study's PBL scenario, in order to understand her context. This was then discussed in the second focus group:

P5fg2 "Well, looking at the map and Sudan to England, oh my God. Have you seen, you know, how far it is? The trauma it is, and it's like how on earth did they arrange the transport?"

Just "looking at a map" seemed to provide this participant with a little understanding of some of the experiences that asylum seekers may have had. Participants researched Sudan as a country, its history and why someone may be seeking asylum from there. They explored the poor economic situation within the country, the low life expectancy, the ongoing civil war and the starvation faced by the population due to economics and drought. The topics of human trafficking, slavery and forced prostitution were also discussed:

P2fg2 "Oh, that's disgusting. Those are refugees and asylum seekers"

One of the participants attached photographs of the Sudan to the intranet discussion area:

P5fg2 "God, it's like going back centuries and centuries, you know, compared to how we live, isn't it?…It must be quite shocking then coming over here. To see the traffic Buildings, tall buildings, cars"

Another participant used an article about a woman's experiences living in the Sudan to discuss reasons why asylum seekers may feel forced to flee:

P3fg2 "She talks about people being raped, houses being set on fire. She had to flee the…she calls them the devil riders who came on horseback with machine guns into the village, and they literally just shot everyone. They set the houses on fire and the women and children ran. And there were children being given babies and things and said, 'Take your brother, take your sister. Just run.' And the men stayed behind with daggers to try and defend the village. And then they came, they went and hid in the woods and then they came back and all the men were dead."

Participants also discussed the implications of traumatic experiences for pregnant women accessing maternity care in the UK. An example being:

P3fg2 "torture rooms as well being given medical names so women will be terrified to go into hospital because if they've been tortured, they may have been tortured in a room that's called the operating theatre".

They also discussed asylum seekers who are pregnant as a consequence of rape and how accessing maternity services in the UK may retrigger these memories:

P8fg2 "….they refuse the baby and they'll give it away or something. The baby's evil. Take away…this bad thing inside me. Take it away and you know. They believe that if…they'd been raped, they believe that any baby they conceive after they've been raped would be born evil, even if it's conceived out of love because their insides have been contaminated."

Following the second focus group, one participant identified a specific example of learning that had impacted on her practice. She became more aware of a woman's context and how she viewed a pregnant woman who was being been labelled as a "princess" by the midwives:

P8ii "It's been, 'Okay, what's going on? What's the story behind her because there's a story behind it?' So it's finding out that story. In that sense, it's made me more, well, less judgmental, I hope."

However, this participant was concerned that learning more about the context of asylum seeking had led to her making too many assumptions about what a woman may have been through:

P8ii"…but then I think has it made me overly prepared in the case of where I'm thinking, 'Oh, you know.' I'm thinking the opposite now, rather than treating…a woman. I'm treating her as a, oh, she's been potentially, you know, God knows what's happened to her. Am I, am I treating her too fragile, you know?"

This can be linked back to the contribution made by participant (P2ii) earlier in relation to learning about the woman's context and the need to find a compromise between generalising about a woman's context and neglecting to consider it at all:

P2ii "constant balancing act and taking into account someone's context and the fact that you can't make any assumptions"

Discussion

The findings suggest that despite learning to adopt a holistic, woman centred approach to midwifery care in the educational setting, once in clinical practice, some students appear to be influenced by underpinning medical and managerial discourses when approaching care decisions around the pregnant woman seeking asylum. They appear to place a significant emphasis on meeting physical needs at the expense of a holistic approach by implementing policies and guidelines to meet these needs. Consequently, rather than being central in her care decisions, the woman is reduced to the role of passive recipient. In addition, students appear to have difficulty in understanding how to consider the woman's context and how this my impact on her care needs.

These findings appear to support other studies which have focused on how qualified midwives working within the National Health Service (NHS) approach their care of pregnant women seeking asylum. They too appear to be influenced by the medical model at the expense of other holistic aspects of care (Briscoe and Lavender, 2009). This was also the case in a study undertaken in the Irish republic (Kennedy and Murphy-Lawless, 2003) and studies focusing on pregnant women more widely (Reynolds and Shams, 2005; Downe et al., 2009). Other studies reflect the idea of an underpinning managerial discourse influencing approaches to care of the pregnant woman seeking asylum, with a reliance on policies and guidelines (Nabb, 2006; Reynolds and White, 2010). This also extends to pregnant women more generally (Smith et al., 2009; Porter et al., 2007). In addition, there appears to be a lack of consensus in the literature around whether to approach care from an individual perspective (Schott and Henley, 1996b, Cowan and Norman, 2006) or if it is important to consider a person's context when making care decisions (Nairn et al., 2004; Squire and James, 2009).

As identified in article one of this series (Haith-Cooper and Bradshaw, submitted), discourses are a manifestation of power which is located within social structures. Dominant discourses are (re)produced in social contexts through interaction between groups of people (Jager and Maier, 2009). The findings from this study, in conjunction with other literature suggest that once working with health professionals within the social context of the NHS environment, some midwifery students become socialised into (re)producing the dominant managerial and medical discourses to which they are exposed with the marginalisation of midwifery discourse. The literature suggests that this practice is not limited to asylum seeking women. Instead all women could be subject to these dominant discourses when experiencing midwifery care.

There appear to be a number of contributing factors which legitimises the (re)production of these dominant discourses in the NHS environment. Fear of litigation appears to be a powerful driver of care provision and medically dominated policies and guidelines are designed to standardise care and reduce risk and consequently the incidence of litigation (Bates, 2004; Porter et al., 2007). In addition, the Department of Health (DH) initiatives control the way that midwives practice (Walsh and Newburn, 2002) and it has been argued that professional guidelines

produced by the NMC which regulate midwifery practice, are framed within a medicalised approach to care (Pollard, 2010). Most midwives in the UK work within the structure of the NHS and have to fulfil their contract of employment which includes following standardised policies which may be constructed by medical staff and managers away from where the caring takes place (Davies, 2004a). Walsh (2004) argues that it is difficult for midwives to have any power over the way in which they approach care when considering the rules originating from different sources which govern practice.

As a consequence of this control of practice, it is argued that some senior midwives are demotivated and continue to sustain this medical domination by the way that they approach care with unwritten sanctions and rules which can be difficult to challenge (Hunter, 2005; Lankshear et al., 2005). This impacts on midwives and in turn students who may feel pressured to conform and therefore feel unable to provide the care they feel to be most appropriate (Lavender and Chapple, 2004). Kirkham and Stapleton (2004, p. 124) discuss the concept of “doing good by stealth”, in that midwives are so concerned with the consequences of not conforming to policies and guidelines, that they may approach care in a covert way, in order to do their best for the women that they are caring for.

It is argued that the powerful medical model has become so engrained in midwifery care that it can be difficult to recognise (Gould, 2002). Some midwives define their role in relation to this, embracing the skills that accompany the use of medical technology (Davies, 2004a). There is a perception that the medical profession continues to exert power over midwives through having authority over their care decisions (Lankshear et al., 2005). However, in reality arguably obstetricians' decision making is also controlled by rigid policies and guidelines. Some midwives may (re)produce their perceived powerlessness through asking doctors for reassurance about decisions which should be within the midwives scope of practice (Lankshear et al., 2005). Consequently managerial discourses appear to have the most powerful influence over midwives practices as they adhere to the various policies and guidelines which focus on pregnant women's physical needs at the expense of other holistic needs (Stephens, 2004; Battersby and Deery, 2004). Although, some midwives support a philosophy of woman centred care, in reality in the clinical environment, it is difficult to employ this due to existing power relations (Porter et al., 2007; Lavender and Chapple, 2004). Consequently it has been argued that midwives are in an “entrenched position” within the NHS (Porter et al., 2007, p.532), wanting to change practice but powerful dominant discourses (re)producing their powerlessness to make changes.

The findings from this study, with their focus on following policies and guidelines to meet the physical needs of pregnant asylum seeking women, suggests that midwifery students accessing clinical placements are being socialised into this entrenched position in the NHS environment. This has been identified elsewhere with novice midwifery students initially considering emotional support as central to the midwives role, but once socialised in the clinical environment, adapting to conform to the medicalised culture of the NHS (Barkley, 2011). In addition these findings suggest that some students are witnessing the decontextualisation of the pregnant woman to a series of physical tasks and it can be argued that this has led

to confusion around their understanding of the concept of and approach to woman centred care.

Midwifery educators face the challenge of how to prepare students in the educational setting, to adopt a woman centred approach to care once working in practice settings. These findings support a previous study which suggests that women centred teaching strategies alone are not adequate in facilitating this in practice (Rowan et al., 2008). This suggests the persistence of the theory practice gap in midwifery education, a phenomenon coined in the 1990s which describes the gap between what it learnt in the higher education setting and the experiences of student in clinical practice (Corlett, 2000). It would appear that the professional socialisation of midwifery students, as they encounter clinical practice has contributed to sustaining this gap. To address these issues, it would appear that consideration needs to be given to both midwifery education and clinical practice. It is beyond the scope of this article to discuss the configuration of maternity services in any depth, therefore only suggestions for the enhancement of clinical practice are made based on current UK initiatives.

Midwifery led units or continuity of care schemes may facilitate midwives to adopt a woman centred, holistic approach to care, away from the medicalised environment (Magill-Cuerden, 2005; Lester, 2005). However, midwifery led units tend to be designed to care for perceived low risk women with high risk cases, which would most likely include asylum seekers, remaining in consultant led units (Magill-Cuerden, 2005). In addition, schemes such as team or caseload midwifery are not practiced widely, with “team midwifery” specifically being associated with high levels of burnout for midwives (Sandall, 1999). There are examples of local initiatives around the UK which could be integrated into the existing services such as in East Kent (Harris et al., 2006). Here, midwives with a lead responsibility for pregnant women seeking asylum provide antenatal and postnatal care to a caseload of asylum seekers, but also facilitate education for other midwives. It may be helpful to consider how such an initiative may be useful in different locations, where asylum seekers are dispersed.

It can be argued that midwifery educators need to address how students can be socialised in clinical practice to approach care in a woman centred way. Barkley (2011) suggests that students should be provided with increased community based placements away from the medical environment to promote a woman centred approach to care. It would appear that the traditional allocation of students to different clinical settings for a period of time to develop knowledge and skills relevant to that area appears incongruent with promoting a woman centred approach to care. Providing continuous care to a woman over her entire maternity journey, through caseloading, would appear to offer this opportunity (Lewis et al., 2008) and integrating caseloading into midwifery curricula has become a recent requirement of the NMC (Nursing and Midwifery Council, 2009). Early evidence suggests that caseloading encourages woman centred care (Rawnson, 2011). However, further research is needed over a period of time to adequately evaluate the effectiveness of caseloading in facilitating a woman centred approach to care for women, including asylum seekers.

Conclusions

This article has argued that some midwifery students appear to be influenced by dominant medical and managerial discourses at the expense of midwifery discourse when approaching the care of the pregnant woman seeking asylum. However, it is important to acknowledge the limitations of this study. It has focused on the perceptions of a small group of midwifery students, in one context, throughout the second year of a midwifery programme, based in one institution in Northern England. They may be influenced by different discourses to midwifery students and qualified staff elsewhere. In addition, these students had limited clinical experience and may still be grasping the clinical skills associated with midwifery practice rather than considering their identity as a midwife based on their ontological understanding of childbirth (Walsh, 2006). Although there is no attempt to generalise these findings, they do appear to support previous literature and offer an insight that may be useful in other contexts. In addition, this approach to care with its emphasis on physical needs appears applicable to all women accessing NHS maternity services and not just asylum seeking women.

This article has focussed on the way forward in addressing these issues and how caseloading may provide the opportunity for students to embrace a woman centred approach, away from dominant medical and managerial discourses by caring for a woman throughout her maternity journey.

As a consequence of undertaking this study, a new model for midwifery education, “the pregnant woman in the global context” has been developed and is explored in part three of this series (Haith-Cooper and Bradshaw, submitted). This model has been constructed partly to address the issues raised in this article and could be implemented alongside caseloading. It is designed to facilitate midwifery students to position the woman centrally in her care decisions and consider her holistic needs when approaching her care. In addition, it is designed to encourage the student to learn about the context of a pregnant woman seeking asylum and the impact that this will have on her health and social care needs. This could contribute to the idea of preparing students for the “reality of the future” (Midwifery 2020, 2010, p34)which arguably with increasing globalisation, will involve caring for a more diverse caseload including pregnant women seeking asylum.

References

Barkley, A., 2011. Ideals, expectations and reality: challenges for student midwives. British Journal of Midwifery 19, 259–264.

Bates, C., 2004. Midwifery practice: ways of working. In: Stewart, M. (Ed.), Pregnancy, Birth and Maternity Care. Books for Midwives, London.

Battersby, S., Deery, R., 2004. Midwifery and research. Comparable skills in listening and the use of language. In: Wickham, S. (Ed.), Midwifery Best Practice. Books for Midwives, Oxford.

Briscoe, L., Lavender, T., 2009. Exploring maternity care for asylum seekers and refugees. British Journal of Midwifery 17, 17–23.

Burnett, A., Fassil, Y., 2004.Meeting the health needs of refugees and asylum seekers in the UK: an information and resource pack for health workers. National Health Service, London.

Carolan, M., 2010. Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature. Midwifery 26, 407–414.
Centre for Maternal and Child Enquiries, 2011. Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. CMACE, London.
Corlett, J., 2000. The perceptions of nurse teachers, student nurses and preceptors of the theory practice gap in nurse education. Nurse Education Today 499–505.
Cowan, D., Norman, I., 2006. Cultural competence in nursing: new meanings. Journal of Transcultural Nursing 17, 82–88.
Davies, H., 2004a. Client-centred midwifery: no easy option. In: Wickham, S. (Ed.), Midwifery Best Practice. Books for Midwives, Oxford.
Davies, L., 2004b. Feminist approaches to midwifery education. In: Stewart, M. (Ed.), Pregnancy, Birth and Maternity Care. Books for Midwives, London.
Department of Health, 2007. Maternity matters: choice, access and continuity of care in a safe service. HMSO, London.
Downe, S., Finlayson, K., Walsh, D., Lavender, T., 2009. "Weighing up and balancing out": a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. British Journal of Obstetrics and Gynaecology 116, 518–529.
Dumper, H., 2005. Making Women Visible. Refugee Council, London.
Edwards, G., Byrom, S., 2007. Essential Midwifery Practice: Public Health.Wiley-Blackwell, London.
Finney, N., 2004. Asylum Seeker Dispersal: Public Attitudes and Press Portrayals around the UK. Summary of Research Project. University of Wales, Cardiff.
Gaudion, A., Allotey, P., 2008. Maternity Care for Asylum Seekers and Refugees in Hillingdon. A Needs Assessment. Centre for Public Health Research, Brunel University, Uxbridge.
Gould, D., 2002. Subliminal medicalisation. British Journal of Midwifery 10, 418.
Haith-Cooper, M., Macvane-Phipps, F., Ball, D., Pansini-Murrell, J., 1999. Problem based learning in a woman-centred midwifery curriculum. In: Conway, J., Williams, A. (Eds.), Themes and Variations in PBL, pp. 80–93 (Montreal).
Harris, M., Humphreys, K., Nabb, J., 2006. Developing services for women seeking refuge Midwives 9, 226–228.
Hunter, B., 2005. Emotional work and boundary maintenance in hospital based midwifery. Midwifery 21, 253–266.
Hunter, L., 2006. Women give birth and pizzas are delivered: language and western childbirth paradigms. Journal of Midwifery & Women's Health 51, 119–124.
Jager, S., Maier, F., 2009. Theoretical and methodological aspects of Foucauldian critical discourse analysis and dispositive analysis. In: Wodak, R., Meyer, M. (Eds.), Methods of Critical Discourse Analysis. SAGE, London.
Kennedy, P., Murphy-Lawless, J., 2003. The maternity care needs of refugee and asylum seeking women in Ireland. Feminist Review 73, 39–52.
Kirkham, M., Stapleton, H., 2004. The culture of the maternity services in Wales and England as barrier to informed choice. In: Kirkham, M. (Ed.), Informed Choice in Maternity Care. Basingstoke, Palgrave Macmillan.
Lankshear, G., Ettorre, E., Mason, D., 2005. Decision-making, uncertainty and risk: exploring the complexitiy of work processes in NHS delivery suites. Health, Risk & Society 7, 361–377.

Lavender, T., Chapple, J., 2004. An exploration of midwives' views of the current system of maternity care in England. Midwifery 20, 324–334.
Lester, A., 2005. The argument for caseload midwifery. MIDIRS Midwifery Digest 15, 27–30.
Lewis, M., 2005. Asylum Understanding Public Attitudes. The Institute for Public Policy Research, London.
Lewis, P., Fry, J., Rawnson, S., 2008. Student midwife caseloading—a new approach to midwifery education. British Journal of Midwifery 16, 499–502.
Lockey, R., Hart, A., 2004. Improving consultation with disadvantaged service users. British Journal of Midwifery 12, 784–789.
Magill-Cuerden, J., 2005. Making midwifery-led care inclusive care. British Journal of Midwifery 13, 214.
Mcleish, J., 2002. Mothers in Exile. The Maternity Alliance, London.
Midwifery 2020, 2010. Delivering Expectations. Department of Health, Cambridge.
Nabb, J., 2006. Pregnant asylum-seekers: perceptions of maternity service provision. Evidence Based Midwifery 4, 89–95.
Nairn, S., Hardy, C., Parumal, L., Williams, G., 2004. Multicultural or anti-racist teaching
in nurse education: a critical appraisal. Nurse Education Today 24.
National Institute for Health and Clinical Excellence, 2010. Antenatal care. Routine care for the healthy pregnant woman. National Institute for Health and Clinical Excellence, London.
Nursing and Midwifery Council, 2009. Standards for Pre-registration Midwifery Education. Nursing and Midwifery Council, London.
Pollard, K., 2010. How midwives' discursive practices contribute to the maintenance of the status quo in English maternity care [Online]. Midwifery. (Available: , http://www.sciencedirect.com.ezproxy.brad.ac.uk/science/article/pii/S0266613810001099 [Accessed 3 March 2011.).
Porter, S., Crozier, K., Sinclair, M., Kernohan, G., 2007. New midwifery? A qualitative analysis of midwives' decision making strategies. Journal of Advanced Nursing 60, 525–534.
Rawnson, S., 2011. A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England. Midwifery 786–792.
Reed, K., 2003. Gendering asylum: the importance of diversity and context. Feminist Review 73, 114–118.
Refugee Council, 2009. The Vulnerable Women's Project. Refugee and Asylum Seeking Women Affected by Rape or Sexual Violence. : Literature Review. Refugee Council, London.
Reynolds, B., White, J., 2010. Seeking asylum and motherhood: health and wellbeing needs. Community Practitioner 83, 20–23.
Reynolds, F., Shams, M., 2005. Views on cultural barriers to caring for South Asian women. British Journal of Midwifery 13, 236–242.
Rowan, C., Mccourt, C., Beake, S., 2008. Problem based learning in midwifery—the students' perspective. Nurse Education Today 28, 93–99.
Sandall, J., 1999. Team midwifery and burnout in midwives in the UK: practical lessons from a national study. MIDIRS Midwifery Digest 9, 147–152.
Schmit, H., 1983. Problem-based learning: rationale and description. Medical Education 17, 11–16.

Schott, J., Henley, A., 1996. Meeting individual culture and religious needs in a multiracial society. British Journal of Midwifery 4, 287–289.
Smith, A.H.K., Cantab, M., Dixon, A.L., Cantab, B., Page, L.A., 2009. Health-care professionals' views about safety in maternity services: a qualitative study. Midwifery 25, 21–31.
Squire, C., James, J., 2009. Refugee woman. In: Squire, C. (Ed.), The Social Context of Birth. Radcliffe, Oxford.
Stephens, L., 2004. Pregnancy. In: Stewart, M. (Ed.), Pregnancy, Birth and Maternity Care. Books for Midwives, London.
Ukoko, F., 2007. Childbearing women with no recourse to public funds: the health and social implications. MIDIRS Midwifery Digest 17, 585–587.
Walsh, D., 2004. Feminismand intrapartumcare: a quest for holistic birth. In: Stewart, M. (Ed.), Pregnancy, Birth and Maternity Care. Books for Midwives, London, pp. 57–70.
Walsh, D., 2006. The ontology of childbirth. British Journal of Midwifery 14, 662.
Walsh, D., Newburn, M., 2002. Towards a social model of childbirth: part one. British Journal of Midwifery 10, 476–481.