

Birth for some women in Pakistan

Defining and defiling

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Abstract

The thesis presents an empirical study that examines the birth experiences of women who have given birth in Pakistan. It seeks to understand birth experiences from the perspective of sixteen women - a sample of women recruited through acquaintances in the Punjab district of Pakistan and a sample of Pakistani women living in the north of England recruited through an over-50's club. It sets the interviewees accounts of the pregnancies and birth within their accounts of their life stories. This material is supplemented through observations collated during a number of visits to Pakistan over several years. Human inquiry (Reason 1996) has underpinned a multi-method approach. Two focus groups, participant observation and in-depth interviews were the methods of choice.

The aims of the study were, to contribute to a growing discourse on birth internationally and to explore the life and birth experiences of a small number of women who have experienced birth in Pakistan.

The methodology of choice was interpretive ethnography (Denzin 1997) with an anthropological bias. This was in keeping with the developing relationship between anthropology and midwifery. Reflection has been an important element of the research methodology and a reflective diary was kept throughout. Analysis was undertaken using adapted frameworks from Alasuutari's (1995), Polkinghorne's (1995) and Childress (1998) analytic models. The findings are arranged around one major theme, the dai (traditional birth attendant); her work, her life and her influence on birth for women in Pakistan. Sub-themes include, boy preference, the omnipresent medical model, birth systems, blood influences on life, shame and honour, and specifically from the women interviewed in the UK - coming to England and modernisation. Concepts that run through the whole are women's knowledge, the place of birth, western medical influence on birth practice and colonialism. Rich, thick, complex detail emerged from the women's stories and a dialectic framework was used to resolve multiple contradictions, such as, how women could be strong in the presence of adversity.

The thesis is written in the first person, which is a practice in keeping with my personal philosophy and commonly accepted in qualitative work (Swanson-Kauffman 1986, Webb 1989, Binnie 1988).

The format is firstly to set the scene; then review some of the life influences for women in Pakistan. A chapter follows on the rationale and methodology, including the methods used. Thereafter, a chapter has been devoted to how, as a white western woman I influenced the study, followed by an introduction to the women interviewed, including some life and birth stories. It was decided not to put these into an appendix due to the centrality of the women to the study.

To achieve the aim of the study, the final part of the thesis examines the findings using a dialectical framework and concludes with the use of Plato's allegory of the cave and the subsequent learning transformation that has taken place as a result of undertaking the research.

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For Roy, Carol and Kris

Glossary

Bhajee	older sister
Dai.	an untrained birth attendant
Doula	untrained but experienced birth attendant of the mother's choice
Izzat	honour
LHV	lady Health Visitor in Pakistan with 2 years training; one year in midwifery, one in Public Health
Mazzaar	religious man in Pakistan.
Mullah	religious man in Pakistan
Pir	religious man in Pakistan.
R...	a North of England town.
Sharia law	Islamic law or rules.
Sharm	shame
S...	a town in the Punjab Pakistan.
Twinning group	a group set up by R...Metropolitan Borough Council to link with twin town in Pakistan.
Zakaart (zakah)	one of the pillars of Islam, to contribute a proportion (2.5% of net savings) of wealth to the poor. " <i>A mutual social system devised by Allah</i> " Akpkr Pk (1993:330).
Zilla Council	County Council in Pakistan

1 CHAPTER: SETTING THE SCENE

1.1 Background and context

My work as community midwife in a North of England town in late 1980's was with a totally Pakistani caseload. This sparked an interest in the lives of Pakistani women. The opportunity arose to visit and work in Pakistan when I was asked to give advice on midwifery by the R... Metropolitan Town Council (RMBC), Twinning Group.

1.1.1 First visit to Pakistan

August 1989 was when the first field trip to Pakistan took place. This was organised and funded by R... Metropolitan Borough Council (RMBC) and S... County (Zilla), Pakistan. Five health care professionals undertook this first trip; they included a nurse, an eye surgeon, an environmental health officer and a hospital manager. During the visit, a social evening was arranged in a village and this was my first encounter with a dai. Also during a visit to the District General hospital, multiple disturbing issues became evident.

Patients were outside the hospital unable to gain entry because they were too ill. There were no doctors available. Nursing staff seemed afraid to take responsibility for the patients in case they would be blamed for their demise. Inside the hospital I was shocked by a ten year old with a gangrenous arm from touching a live wire and a fourteen year old girl who had spilt boiling milk on her vulva. Both these accidents occurred due to 'load shedding'. This is when electricity is rationed because there is insufficient in the national grid for continuous use, so it is turned off for many hours, then back on unexpectedly. The boy was connecting a wire to the neighbours' supply; the girl had been carrying milk when the electricity went off.

I tell these particular stories to give the reader some idea of the health facilities in Pakistan. There is no free health or social support system and as a consequence, many of the poor die before getting to a hospital, most because they cannot afford the transport or the cost of treatment.

There is a zakaat arrangement whereby Muslims apportion a percentage of their annual profit to the poor. A committee of trusted, educated and wealthy community leaders administer these funds.

1.1.2 Maternity hospital and midwifery practice

The first visit to the Maternity hospital was orchestrated; there was only one woman in the hospital, and she sat on top of a bed that had a mattress and sheets on. I lifted the baby's shirt to confirm my suspicions. The cord was off and the baby was about 10 days old. Both the mother and the baby had been brought in to the hospital especially for our visit. Later that same night, I called unexpected and with the permission of the doctor stayed all night. Every bed had at least one woman and maybe a baby or small child lay on it, with groups of women and children of all ages huddled around each bed. The women lay flat, attached to a drips and there were no mattresses, let alone linen on the beds. However, it was not the environment that shocked me but the way the women were treated by the staff and the midwifery practice.

The women were treated as if they were dirty. There was virtually no exchange of dialogue or support between the women and the staff. Frequent, repeated unsterile vaginal examinations were undertaken. I learnt that all the intra-venous (I.V's) lines had a drug in them to stimulate the uterus, "*this is modern western practice*". There was no oxygen or suction available in the hospital. Caesarean section births were carried out under Ether as an anaesthetic. The number of births per year at this hospital was over 3,000. Although I was prepared for the poor conditions and lack of resources the midwifery practice served to shock.

After returning home depressed, unable to think, let alone speak of the experience, it took six months before the overwhelming responsibility to help kicked in. Then, another midwife and I spent hours planning the return to help and teach if the staff wanted us.

1.1.3 Subsequent visits

Nine visits have been made over the eleven-year period. Each visit was for two to three weeks. The second and subsequent visits involved teaching the hospital staff and other community health professionals the basics of physiology, midwifery care and safe delivery, by working on the wards, caring for women, delivering babies, assisting at caesarean births and resuscitating babies. A number of other midwives and student midwives have also made the trip from the UK to work in this hospital.

An evaluation of the impact of British midwives on the midwifery practice in the Red Crescent Maternity Hospital, S... was undertaken during a specially funded research visit in October 1993. The findings are reported in Chesney (1994a) and my unpublished MSc. Dissertation at Surrey University (Chesney 1994b).

Thus, the opportunity to study birth in Pakistan arose from being a community midwife and undertaking nine working visits to a Maternity hospital in Pakistan. Over the years I had come to know many women who had given birth in Pakistan, their experiences were a source of fascination. The next logical step was to conduct an in-depth study of women's birth experiences in Pakistan. The entry criterion was simple: -for the participating women to have experienced birth in Pakistan.

The aim of the research at this stage was to explore some women's life and birth experiences in Pakistan.

The field trip to conduct the interviews in Pakistan was undertaken in 1997 and the details of this can be found in Chapter 6. Two groups of women were interviewed one in Pakistan, S... (n 6 + 1 Dr Q)¹, and one a North of England town, R... (n10). The sample was one of convenience using a snow ball technique (Lee 2000). Five of the ten women interviewed in R... self-selected following my attachment to an over-fifties luncheon club in the centre of the Pakistani community in R... (Taz, Fari, Shab, Farn, Naz). The

¹ Six women were interviewed about their life and birth experiences, Aia, Shu, Dai, Sha, Mrs A and Shad. Dr Q's opinion on dais' and my experiences are also recorded.

other five came though networking and community knowledge of the research (Ria, Bas, Ina, Ami, Dil).

Data have also been gathered through participant observation at the over fifties group in the UK and attachment to a women's hospital in S...Pakistan.

All seven women interviewed in Pakistan were approached through a mediator usually the interpreter (Kad). One participant (Aia) was the mother of a man we had become firm friends with. His second wife was also interviewed in the UK; another woman was interviewed on a bus journey from Lahore to S.... (Shu). Three women were interviewed at the maternity hospital, the doctor, the dai and a woman who was accompanying her sister-in-law (Sha). The last woman was interviewed at our accommodation in Pakistan, where her husband was the gardener (Shad).

More details about the women interviewed can be found in Chapter 6.

1.1.4 Summary and research question

This brief background and context narrated tell the story of how I became involved in the study of birth in Pakistan and how the idea of the research was born. The research question directly correlates with the aims of the study: What is life and birth like for women in Pakistan?

The aims of the research were to be achieved by exploring the life and birth experiences of some women in Pakistan.

Further aims were to:

1. contribute to a growing discourse on birth globally.
2. challenge existing knowledge on birth in Asia.
3. analyse with application to midwifery care.
4. challenge the reader's thinking to stimulate empathy.

Thus the substantive aim for this research is to provide insights into the life of some Pakistani women, ordinary women with ordinary lives. Swanson-Kauffman (1986) describe this as 'living inquiry', which is the parallel of living knowledge. Reason (1996) further expands this and calls it '*passionate, committed, involved and personal*'. It is not just knowledge for knowledge sake; it is knowledge for the sake of relating to people in a different way. I affirm my passion for, and commitment to, the women and the subject.

The context of the research is recounted through a chronological account of the visits and work undertaken at the Maternity hospital. The research includes an examination of self, autobiography (Chapter 3 and Appendix 1), (Chesney, 1999 and 2000). This examination was essential before I could move on to write up the women's words as an ethnographic research thesis. The stories told, reflections shared and observations made, will provide both the context and the content of the lives and birth experiences of women across three generations and four decades in Pakistan.

To demonstrate the unfolding of the text in the process of discovery, the next chapter explores the context for the research.

2 CHAPTER: CONTEXT OF LIFE FOR PAKISTANI WOMEN.

2.1 Life influences (1) Women's knowledge

The nature of this thesis involved a continuous review of applicable research rather than a discrete literature review. This is a principal that is upheld by Willis and Trondman (2000) in their text on theoretically informed methodology for ethnography. However, based upon my past experience of working with women in Pakistan, I felt that I needed to know more about certain major influences on the lives of women across cultures and specifically in Pakistan. I chose to undertake an initial review of two topics. The first was women's knowledge, this was selected as much to gain access to an awareness of my own knowledge and beliefs, as well as the women interviewed and served to increase my insight and knowledge into birth and its effect on the lives of the women interviewed. Subsequent to women's knowledge; the discourse on childbirth mortality and morbidity in Pakistan is explored in the second part of this chapter.

Since 1989, I have been avidly searching and reading literature on and about birth in Pakistan and other developing countries. This was undertaken out of interest and fascination with the culture of Pakistani women and in order to contribute to my way of knowing, so that I could communicate with the women I was caring for as a midwife. It is evident to me that the theoretical knowledge available had:

"Ascended from a body of knowledge dominated by power, state, social class or authority" Davis-Floyd and Sargent (1997:1)

Much of the pre modern text on birth in developing countries had been from the perspective of the educated. Also, Islamic social rules and norms appear to ring fence women to roles and positions in and for the home and family, restricting widespread media coverage as happens in the western world.

Behind the doors of their homes in Pakistan, women do have position and authority within a strictly family determined structure. Most pre-modern existing text reflects the privacy of childbirth. This parallels my childhood in the early 1950's, and two simple examples of this privacy are in the vocabulary and text, when the word pregnancy was whispered and pictures of breasts were considered shocking. Similar attitudes can be seen in Pakistan

today. This is suggestive of a time lag of twenty to forty years between Pakistan and Britain.

2.1.1 A recipe for research

Addressing any topic area (knowledge and morbidity) in separate parts of this chapter goes against the philosophy of holism and has a reductionist feel. Holism is inherent both within the research and my personal belief system. Separating the parts feels like a piecemeal division of a whole, extracting one or two ingredients, when they contribute to the already cooked cake. The metaphor could be taken further; the ingredients for the cake are the people, women and researchers, their systems, knowledge, their life and birth experiences. Who writes the recipe takes us back to the hegemony; how the researcher follows the recipe is vital to the 'taste' of the cake. The researcher has the power to select out 'juicy' pieces (themes) that may be the most 'mouth-watering,' leaving out the 'hard to digest' flavour, altering ingredients, introducing bias by omission. The 'taste' will depend also on the taste buds or existing knowledge and epistemology of the consumer (reader). Building on the culinary analogy, the researcher has the power to over/under-emphasise the taste by 'artificial flavouring' (poor analysis). This would clearly be contravening the ethics of research. Both the content and the method used in the production of this research 'cake' are the responsibility of the researcher. Some knowledge of the researcher's background and culture (Chapter 3) will enable the consumer of the cake (reader) to be make a judgement on the contents and trust that the 'freshness' (validity) has not been contaminated by additives or omissions (bias).

Sensitivities on who wrote the recipe, the method utilised to mix the ingredients, the baking and presentation of the research cake, have been laboured over especially due to the baker (researcher) being unfamiliar with the ingredients (from another culture). There is a body of opinion that believes previous British Colony populations have been 'used' by researchers, not to gain understanding, but as a kind of voyeurism to further impose imperialistic superiority.

2.1.2 Researched on

Researcher bias assumes superiority of knowledge and lack of internal cultural knowledge gained from brief field trips are issues that are particularly deplored by 'colonised' people who find their culture researched. The word 'research' for some of these people is considered the dirtiest word in the indigenous world's vocabulary (Tuhiwai Smith 1999:1)

"Western researchers and intellectuals assume to know all that it is possible to know of us, on the basis of their brief encounters with some of us. It appalls us that the West can desire, extract and claim ownership of our ways of knowing and reject the people who created and developed these ideas"

This statement has the power to make me see the limitations of the research, the quality and edibility of the cake. This is because the recipe and method have been designed and conducted by a cultural outsider. Yet an insider may not see the unfamiliar. The ingredients, women's words, have been baked in the oven of existing discourse and analysed from the epistemology of the researcher. To overcome the belief that as a westerner I will claim ownership and reject the women, I have tried to include transparency into the method and analysis. The whole cake has been tasted and judged by the critical readers and advisors. There are no delusions that the finished product will in any way resemble a cake from a Pakistani recipe. As a white western researcher, I have influenced the content by the amount of ingredients used (issues selected for analysis), however the original source of the ingredients were created by the women. The aim is that the cake will taste familiar and that other Pakistani women will be able to recognise and consider authentic the taste that will have original Pakistani spice.

Having declared one of the weaknesses in the method is the researcher's choice of issues for exploration, it would seem that a justification for the review of women's knowledge as grounding for the research is required. As stated, this is research undertaken by a woman about women, on a topic that is entirely woman-centred, from what I have always believed to be a moderate feminist perspective. However, women do not make up the world and taking a defensive or opposition stance is not enough to resolve or change. I am ever cognisant of the early feminist work which was over-dominated by the perspectives of the white middle class women (Oakley 2000). To have conducted this research from

such a position would have been perpetuating the colonialists' principles and would have been unforgivable. I knew there must be another way.

Oakley (2000) explains how she underwent a 'conversion', beginning by singing the praises of 'qualitative' research as a more 'truthful' way of knowing and ended up by advocating the use of qualitative and experimental methods as providing a sounder basis for claiming that we know anything. Quite simply Oakley (2000:13) said that

"The very charting of women's oppression needed quantification".

Although I am not sure that I have had a similar conversion experience, I began the research with the same zeal for qualitative ways of hearing the women's voices on their experiences. It would seem that one could not get away from the limitation in sample size within qualitative research that makes quantification nonsense. However, setting the women's words in the context of the statistics has been a conscious choice. The 'other way' that was eventually found, was to use a dialectic² approach as a route to wholeness moving away from dualism (see Chapter 9). In the route to holism, dialectics combines a philosophy with method. My personal philosophy connects with holism and a qualitative methodology that brings equality to researcher and researched using a dialectic debate which exposes multiple contradictions, and where possible, synthesises to a higher abstraction (Stepelvitch 1990:77). The first of the theoretical perspectives emerges as women's knowledge.

The aim of this part of the research will be to address and apply theory that will reject the division between the women and myself as researcher and evaluate where we all are in relation to knowledge and power. This could be described as the ecology of the research, the cement that binds us together, the environment, researcher, researched and context. I hope to conduct this in a sensitive, challenging, intellectual and stimulating way in order to integrate the whole into an ethnographic study of birth for some women in Pakistan. Belenky et al (1997), like myself, found the words of women they interviewed so moving,

² Collins (1994:435) defines dialectic as a dispute or debate intended to resolve difference.

their thoughts so important, that the world ought to hear them; but realised that serving as conduits to the words only, was doing them a disservice.

"...We exhibited an appropriate humbling respect for the wisdom of others, but also a cowardly reluctance to construct and communicate (and value) our own knowledge" Belenky et al (1997(xvi).

My experiences as a woman, mother, midwife, previous observer and frequent visitor to Pakistan, all bring a special dimension to the role of researcher. Alongside these experiences I have developed my way of knowing from application of theory: a 'knowing of myself in relation to others'. I feel this assisted me to approach the data from the women interviewed in R... with a changed frame of reference. Some of the contextual issues and revelations about myself, the positions held, the doubting dissident, through to an accepting of myself as a person, are all part of what I brought to the research and the research brought to me.

During each of the field trips to Pakistan we undertook participant observation at the maternity hospital, kept a reflective diary and made a report to the Twinning Group (sponsors for the trip) on return. Although some of these documents have not been used directly as data for the current research, it is inevitable that they form part of my knowledge, shaping the perspective for the research. I have also written a brief autobiography, which was a revelation to me. It made me consider my ways of knowing and how much I have changed and been influenced by my life experience and significant others. James (1987) maintains there is an inaccessibility of '*inner states or self knowledge*'. This knowledge may be inaccessible but influential. I have discovered, through reflection, that access to layers of the inner self is facilitated only in the safety and presence of those we trust not to judge by its content or disclosure. However, I have no doubt that there are deeper layers of self that have yet to be uncovered or revealed.

2.1.3 Pretender – personal development

Belenky et al (1997) became concerned during their research on 'women's ways of knowing' about why women speak so frequently of gaps in their learning and so often doubt their competence. This had real relevance to me. I empathised with the women in

the study who 'feared being wrong', or 'revealing their ignorance', or 'being laughed at' (Belenky et al 1997: 57). I never feel as if 'I know enough' and judged this to be the source of my reaction to control in the face of uncertainty. I sense that I am 'not a proper...' or 'someone will eventually reveal that I am an impostor'. This is in common with Belenky et al's (1997) received knowing, whereby knowledge and authority are construed as outside the self and invested in powerful knowing others, from whom one is expected to learn. There are many parallels and commonalties with this concept and Pakistani women, who are denied even basic education. However, personally I sense a developmental change, a move towards becoming a 'subjective knower', whereby I no longer feel that I have to accept what the experts say. Another person may be misguided or disagreeable. I have developed a tolerance for differences, since others must obviously believe in their opinion. There is the emergence also of an inner subjective knowing, based upon instinct, valuing intuition and life experience as well as text and theory. I am becoming more reliant upon intuitive processes that will, I hope, follow the pattern of Belenky's women towards self-protection, self-assertion and self-definition. I have become aware of an inner resource for knowing and valuing.

"In Western philosophy in the nineteenth and twentieth centuries, positivism gradually replaced the classical intuitivism.... In Eastern religions and mystic philosophy, inner contemplation and intuitive understanding are primary routes to basic knowledge" (Belenky et al 1997:55)

It is ironical that wealthy 'informed' Pakistani society has been influenced by the developed world (UK and USA) to value the technology and the medical model of the positivism, at a time when the Eastern philosophies are experiencing a resurgence of interest.

2.1.4 Authority and knowledge

"The power of authoritative knowledge is not that it is correct but that it counts" (Jordan, 1993 cited in Davis-Floyd and Sargent, 1997:58)³.

This oft quoted statement fits with the medical dominance in the NHS, my employers for twenty two years, whereby policies and protocols were and still are organisationally and medically driven, outwith the evidence or at times logic. Paradoxically I feel a certain unease with the term authoritative and considered that authority was not part of my thinking, vocabulary or action, I question whether this is because I have been drenched in authoritative knowledge and lost sensitivity, or whether this is the zeal of the converted? I judged this to be because it links with asserting authority in a superior commanding sense and I will move the earth for a request, yet resent a command. I have difficulty speaking or acting in an authoritative manner, believing that others also feel resentful of authority and questioning my right. It is only since working in higher education that I recognise just how much I had been socialised to accept the authoritative dominant values of the NHS. I had not considered that my knowledge, background or experience accorded me any 'authority' over that of others. I have worn the uniform of a nurse and a midwife and this is known to shout authority; I have used professional terminology to impress, which is acting in a superior way. I have quoted text to uphold my actions as the right ones. I have received the doctor's orders without question and passed them on to other women. The unease I feel on admitting this behaviour arises not from my blindness to authority, but my socialisation to accept and my lack of skills to command equality, as asserting authority feels like I am using the tools of the oppressor in a defensive way.

An example of gender difference may be seen in the common statement a man may make, *"I have a right to my opinion"*, whereas a woman would say, *"It is just my opinion"*, Tannen (1998). This is a stereotypical polarisation that is changing in the post-modern world.

³ Jordan's work was instrumental in defining the field of anthropology of birth. Her cross cultural comparisons have profoundly influenced this study

Jordan's statement on the power of authoritative knowledge, with its social influence, served as a reminder that what women have to say is less likely to be valued in the bureaucratic, male dominated, positivist health research world. Knowledge should be valued on equal terms with other forms of knowledge, not superior, exclusive or competitive, but as a contribution to a whole. The way to get to the whole is through a system of scientific inquiry.

In my employment with the NHS I saw a shift from a position of frustrated ignorance, not toward knowing, but to a realisation that authoritative knowledge counted not because of its 'rightness' or its superior way of measuring and rigour, but because of the environment, the social place. This perspective transformation initiated by Jordan's quotation had a liberating effect on me.

It is easy to identify the first stage in the perspective transformation because it took me through a polemic of censure of authoritative knowledge in the NHS. I have both revered and found wanting the much-acclaimed gold standard Randomised Controlled Trial (RCT's), as a way of knowing. Accepting my own knowledge and seeing its many imperfections helped me to reach a more rational position. This position is that knowledge is context embedded, person biased and power linked, so providing these factors are considered, all knowledge should be valued in the journey towards increased understanding. I recognised that I had moved through a process characterised by opposition and contradiction towards a different state of knowing – a dialectic approach to knowledge. Knowledge is made up of:

"The facts, feelings and the experiences, known by a person, also, an awareness, a consciousness, or, familiarity gained by experience or learning" (Collins, 1994:860).

No one has another's experience or feelings,

"We live through experiences rather than in them and we cannot live in anyone else's" (Oakley 2000: 8).

Consequently, there are as many truths as there are experiences. This is not only dependent upon the interpretation and constructions of the person who has the experience

but on the skills and ability of those communicating the knowledge. The safety of the environment to communicate is just as important as having the appropriate language and vocabulary to describe. What is considered truth will change according to context and time and there are no absolute truths. Guba and Lincoln (1994) would argue that there may however be common elements of truth shared between individuals and occasionally cultures. Similarly, Linderbaum and Lock (1993:157) found that:

'What is accepted as evidence or truth is crucial but variable in different cultures'.

Truth based upon the accepted evidence is not only context but also culturally framed. For example, Pakistani society may consider that the dai or the doctor knows more about her pregnancy and birth than the woman, when the truth may be that the woman knows more than both of them, however, she is unable to articulate it. The situation gives the dai and doctors the power over truth by virtue of the multiple experiences of the dai and the doctor's education to articulate. This principle can be applied across all cultures and is complicated further by gender dominance.

2.1.5 Gendered knowledge

Belenky et al (1997:13) contends that the concepts of knowledge and truth that are accepted and articulated today have been shaped in the main by a male dominated culture. This concept was further confirmed in 1996, when Golberger et al (1996:4) reported that;

"Gender is a major social, historical and political category that effects the life choices of all women, in all communities and cultures".

Debold et al , cited in Goldberger et al (1996:85) argues from hindsight that:

"In any attempt to understand women's epistemology there is a need to engage in how authorised knowledge has been gendered".

Goldberger et al (1996) found that Belenky's Women's Ways of Knowing had broken important conceptual ground on how knowledge is produced, comprehended and ultimately internalised, although often undocumented. Women go about these processes differently than men.

"The variations lie not in the biological differences between women and men, but in the divisions of labour and the value attached to those divisions in our society" Goldberger et al (1996:234).

The value attached to housework is considerably less than that attached to work outside the home that earns money. When the same value laden perspective is applied to the work of childbirth and child rearing in a western society, it has become the norm for the western woman to undertake both work to earn and work to care. However, it is still the norm in all levels of Pakistani society for earning to be the husband's responsibility and shame on the man whose wife works outside the home.

Not only did Women's' Ways of Knowing (Belenky et al 1997) locate gender relations, but they also identified the difference between women, for example, class, resources, experiences of family, violence or other forms of deprivation, acknowledging the effect on women's ways of knowing. This analysis proved relevant in the hospital in Pakistan. This perspective resisted the previous essentialist way of thinking about women as fundamentally 'all alike' a homogenous group, with common life opportunities and experiences (Harding 1996).

Some feminist text identified that traditional education does not adequately serve the needs of women (Belenky et al 1997:4). Harding (1996:443) clearly articulates that men and women have different socially developed ways of organising the production of knowledge. An example of this is that women researchers tend to seek niches of their own, rather than join the hottest competitors (Harding 1996:443). Also, women organise research around teams and co-operation rather than competition.

A further parallel with the Pakistani women in my developmental years was the feeling of being unheard and believing that I had nothing important to say or contribute. This will be covered in more depth later (see chapter 5).

When Goldberger et al (1996) listened to the voices of diverse women in the research into women's ways of knowing, five perspectives emerged. These have been easily applied theoretically to the women in Pakistan and myself.

1. Silence – Goldberger et al (1996) say that silence is a position of not knowing. It could easily be argued that this is not so, instead silence may be a position whereby the

person feels voiceless, powerless and mindless. This is a place familiar to me, and the woman interviewed, and is evident in the silence that hides the morbidity of childbirth later in this chapter.

2. Received knowing – is a position at which knowledge and authority are construed as outside the self and invested in powerful knowing others, from whom one is expected to learn. Davis–Floyd and Sargent (1997) found that we (women) have come through four centuries of external domination on knowledge. Such domination globally was typical of the colonialist regime and the subsequent disempowerment of the population, especially the women. However, as mentioned, the gender domination and medical hegemony has driven the already silenced woman’s knowledge on childbirth totally underground.

3. Subjective knowing – in which knowing is personal, private and based on intuition and/or feeling states, rather than on thought and articulated ideas that are defended with evidence. Such knowing has held a position of very low status in the knowledge hierarchy. However, subjective knowing has emerged strongly through this research, both from other women, strong intuitive personal private knowing was evident in each of the women’s stories. It is my responsibility now to formulate the concepts, apply theory where applicable and write up for an academic audience.

4. Procedural knowing – is the position at which techniques and procedures for acquiring, validating and evaluating knowledge claims are developed and honoured. Within this concept Belenky et al (1997) developed two modes of knowing that women adopt; separate and connected. The former is defined as an impartial stance, a trying to get to know, and this developed into the latter connected belief after entering into the place of the other person. Examples of separate and connected knowing in the text were when the women protected themselves by answering “tikhey” (no problems) to my questions, keeping their separateness, until they felt they could trust me as the researcher, then into the connected once they knew that I was a midwife. However, the key that took us both through the door of procedural knowing appeared to be my visits to Pakistan.

5. Constructed knowing is the position at which truth is understood to be contextual: knowledge is recognised as tentative, not absolute, and it is understood that the knower is

part of the known. In Belenky's (1997) sample, the constructed knowers valued multiple approaches to knowledge, subjective and objective, connected and separate, bringing out their personal commitment as the centre of the process. Constructed knowing is like an old shoe - it fits perfectly to the position I find myself in as I write this thesis. There is no one truth but each experience is a truth in the bed it sits, not extracted and placed in another. Knowledge can be silence and demonstrated through behaviour. It cannot always be communicated through the usual transferable medium (written word).

Concepts of knowing have been applied in some depth because of the relevance to the research, where each of us has developed our own ways of knowing. How this knowledge interacts with what Harding (1996) describes, as the 'local knowledge systems' became crucial to the research. Knowledge on the Islamic family system, segregated roles, the culture and the role of women especially, had grown from working with women in both Pakistan and the UK, however it was knowledge acquired from a very different cultural bed.

2.1.6 Knowledge – life –long process

Linderbaum and Lock (1993:150) identify the chasm between lay and professional knowledge through what they identify as 'contested knowledge'. Within this knowledge framework, they identified macro, intermediate and micro-level forces that interact in the construction of knowledge, macro being influenced by general social factors such as history and family influences; the intermediate being the health belief model: faith healer (Pir) or biomedicine. At the micro-level, contested knowledge would be deeply personal elements i.e. dreams, or spiritual and religious experience. All three levels interact with each other. People internalise, re-work and create new knowledge in a continuous life-long process. Linderbaum and Lock (1993: 159) also emphasised the role that emotions and feelings play on the generation of knowledge or what is taken as reality.

It is now widely recognised that there are many ways of constructing knowledge. Historical conditions create different resources and limitations for the production of knowledge, different knowledge is produced by different cultures and different cultures

know different things about nature and social relations, different theories of what constitutes knowledge and how to get it.

The question to ask is, how does authoritative knowledge relate to other knowledge? What distinguishes them from the indigenous knowledge? The dominant western scientific knowledge is undergoing a revision of its orthodoxy and its role and relationship of intuitive and tacit (implied or inferred) processes in knowledge generation are beginning to be taken account of, we are on the cusp of accepting many forms and levels of knowledge (Oakley 2000).

2.1.7 Colonialism⁴, knowledge and early anthropology

The earliest ethnographic⁵ studies involved colonies of the British Empire. It is ironical then that I return to conduct an ethnographic study to one of these former British colonies, Pakistan. Britain's management of the colonies was achieved through the collection of information from field workers. The role of the Deputy Commissioner (DC) in the colonies was to organise, collate and forward information to Britain, however, many of them collected information way beyond that required. Most of the field workers were men whose interests did not cover birth, however, their wives were better educated so the indigenous Pakistani women sought out their help and support around health. The wives of missionaries and British employees established many currently existing hospitals. One example is the Lady Dufferin Hospital in Karachi. The Viceroy of India's wife established women's hospitals in all the major cities in India and many still operate. Birth was women's work and largely unrecorded, men did not intervene and this may have contributed to the success of the mainly largely female managed hospitals.

⁴ Colonialism relates to the doctrine of British authority and originates from Britain conquering and ruling other countries that it named collectively as the British Empire (Protectorates). Pakistan was ruled in this way until 1946.

⁵ Ethnographic pertains to the elicitation of cultural knowledge (Spradley 1980) and the detailed investigation of patterns of social interaction (Gumperz 1981).

Gilligan (1979) points out women have been missing, even as research subjects at the formative stages of theory development. The early anthropologists who did write about birth, frequently recorded lists of seemingly irrational food taboos and folk belief. Freedman and Ferguson (1950: 431) identified that:

"There are practically no good, direct personal observations of childbirth among primitives (simple societies) by competent observers".

This statement is confirmed by Davis-Floyd and Sargent (1997) forty seven years later as being true, that is until the 1970's when women began to explore birth customs from the inside. Margaret Mead in the 1930's and Niles Newton (1967) conducted original work by women on childbirth and cultural patterning, further groundbreaking work was undertaken by Sheila Kitzinger (1989), and McClain (1981). Additionally Jordan (1989:925) reviewed the literature on the study of childbirth using a comparative framework. She said that:

"Efforts to reduce the contradictions between childbirth as a medical risk and childbirth as a social celebration have not yet succeeded."

Jordan (1989) acknowledges the rapid westernisation of the Third World, which is largely responsible for the re-defining of childbirth as the exclusive domain of professionals trained in mainstream scientific obstetrics. Harding (1996:341) said that: -

"The importation of Western industrial models into developing countries did not have the intended effect (of enabling societies to catch up). At best they were unsuccessful; at worst they offered advantages to the advantaged and further disadvantaged economically vulnerable people. At times destroying the environment on which daily subsistence developed, so called development was in fact a continuation of imperialism and colonialism 'by other means'"

The imported westernisation of obstetrics, with its obsession on hygiene, linked as it was to religion (Godliness) led, as Harding (1996) states, to the disadvantaged being further disadvantaged. Mortality rates were linked to women's behaviour. Women were blamed for not being clean; not nourishing their offspring and calling for help too late. Poverty and poor nutrition were used as a weapon to beat mothers with. Politics or the country's poor infrastructure (no clean water or drainage) was not seen as influencing factors.

Women were not represented in politics. They did not have any power and as a consequence were an easy target for blame.

Colonialism would appear to be a fine strand that is woven through the research. Whether this is because of the cross-cultural nature of the research can only be speculated, however, to ignore it would have been to introduce bias by omission.

Colonialism brought great changes to Pakistan, its railway systems, government and legislation, its hospitals and nurse training, none of it touched the rural communities where birth was and still is the domain of women by women for women. Such birth systems have retained the privacy and gender specialness. The longer this stays silent and hidden the more likely it will remain untouched by the western gender biased biomedicine. The question that haunts me is will writing about it not only celebrate its specialness but also make it vulnerable for criticism and take over? Knowledge about birth worldwide is scanty but growing.

Lindenbaum and Lock (1993:8) identify that the relatively stereotypical view of midwifery in anthropology is due to the narrow selection of studies undertaken and particularly the focus upon accounts that tend to celebrate indigenous midwives or birthing systems. The burgeoning of such studies followed the growth of feminist perspectives in social science, in which the proper task of feminist anthropology was considered to be the recovery of women's knowledge and sources of power and influence; Shelia Cosminski (1982) Carol Laderman (1983) MacCormack (1982) for example. There is no question as to the value of the reports but there are obvious disadvantages to generalising from such a narrow set of social context. It was found that in developing countries there was a swing towards romanticising traditional birth (Jordan 1993) which served to blind people to the dangers of birth for women in poor health.

2.1.8 Ecology of birth knowledge

It is Jordan's empirically based cross-cultural comparative study of birth that sheds some light on the realities of birth in different cultures with its socio-cultural context. Davis-Floyd and Sargent (1997:2) report Hahn and Muecke (1987:1314) as saying,

“Jordan’s work is not only a landmark cross-cultural study of childbearing, but also an insightful analysis of methodological issues in anthropology”, adding that “childbirth could be studied historically and behaviourally...and it should be recognised that childbirth has an ecology”.

Ecology, as I interpret Hahn and Muecke’s words, is the relationship between living organisation and the environment, this includes the knowledge and experiences of all involved and any such influences from the countries and cultures infrastructures.

The ecology of birth in Pakistan is at the very epicentre of this research. The environment of the birth - in a micro-sense in the birthing room, in a macro-sense it is the agency, position and relationships of the women in society. All those people and facets that articulate with the birth and life of women in Pakistan, including also the historical impact of the women’s stories, as they span four decades and three generations. All contribute to the ecology of birth and speak ultimately to the dynamic nature of women’s lives.

It could be said that part of the ecology was my own involvement in the women’s lives through the research.

2.1.9 My changing knowledge

It is easy to chart my passage through a sequence of epistemological perspectives, or what Perry (1981) describes as positions. Initially I was locked into basic dualism where I saw the world in polarities of right and wrong, two ends of a perspective, without a right or wrong, they were good and bad. Gradually I have moved to the recognition that there is a diversity of opinion and multiple perspectives, the dualist authority shaken. I feel with this move I have out-grown the dependency and trust I placed (and needed) in authority. This is liberating and offers considerable personal freedom. Having developed a relative confidence (albeit brittle and easily shattered), I have nurtured an analytical and evaluative approach to knowledge. In the last move, or what I felt was more of a leap, I recognise that knowledge is constructed, not awarded, approved of by an authority, but contextual, not absolute, mutable not fixed. Thus, my personal identity and position has evolved.

There are times when this personal freedom brings with it my need to 'control'. If I am free to go at my pace, there is the danger of turning the speed up to keep in step with change. Change is on an exponential curve and my thirst for knowledge appears insatiable. Acknowledging this brings a new awareness. I judge that I am now in a position to negotiate a slower positive spiral. When I reach the next position I aspire to accept my weaknesses, the relative lack of knowledge and academic ability, to enjoy and celebrate learning, to be freer, looser, but mostly to acknowledge and value what strengths I may have. I feel that I am able to do this now because I have come to value this type of knowledge in others.

2.1.10 Connected knowing

When reading Wagner (1997), I 'connected' to his story. As an American paediatrician, trained in the medical model, he subsequently got a job at the World Health Organisation (WHO) and was required to evaluate childbirth practices in Europe. This study opened his eyes to an alternative to the obstetric orthodoxy, which was, social midwifery, holistic care, and public health. Wagner systematically reviewed home birth as a safer alternative to hospital in an uncomplicated pregnancy. Subsequently he became a supporter of home birth. He is quoted as saying,

"Home birth is as different from hospital birth as night is from day...and ...trying to describe home birth is like trying to describe sexual intercourse" (Wagner 1997).

Wagner found that generally governments were willing to go along with the 'expert' opinions of obstetricians and technology, even in the face of scientific evidence to the contrary. Wagner recognised that he was being ostracised and marginalised because of his views. Obstetricians at the WHO roundly condemned him for expressing his informed opinion, using the fact that he had no right because he is a paediatrician and not an obstetrician, ignoring all the sound evidence he presented.

I connected with Wagner; his experience validated my own, which had been as a community midwife valuing home birth through an epoch of high technology and almost 100% hospital birth.

2.1.11 Power

Power is a concept that weaves through the sections artificially created to structure this review of women's knowledge. It permeates the lives of us as researchers and as women: Also, importantly, it is all pervasive in the life of the women interviewed. Issues of power relations shape systemic knowledge. One of the purposes of inquiry is to tweak the status quo, to tweak the 'power relations' (Reason 1996).

There is no doubt that I initiated the inquiry into birth in Pakistan. I was the one who set up the interviews and framed the questions. However, I was never happier than when the power imbalance was in some ways equalised; when the women said no to the interview request, or asked me questions about the research, my work or myself. I knew this contravened the recommendations of scientific inquiry, as it is said to blur the researcher, researched boundary and has the potential to introduce bias, i.e. the women will shape their story to my own. However, I judged by 'being human' and telling my life and birth story, the women's trust in me would grow.

Knowing how much information to share and when, became a skill that has developed through years of working with women as a midwife. Sharing some of my life and birth experiences eased my conscience about using the women's time, probing their intimate life secrets or stirring painful memories. When the women declined to be interviewed I celebrated their empowerment and congratulated myself on the informed choice given to them.

Reason (1996) said the purpose of research is not just a voice but to make it the peoples' voice; this feels important to do. I desperately wanted the research to be the conduit for the voice of the women. Quality human inquiry⁶ starts, not with the concern for theory or knowledge, but from the engagement with the reality of peoples' lives and how they live. The women's interest in my life neutralised my uncomfortable feeling of control. The journey for them and myself became as important as the findings.

Levy, (1998) used Lukes' (1974) conceptualisation of power. This provided a three dimensional framework to explain events and stories. The first dimension covers where individuals have power to make decisions over others, as clearly is the case with the doctor and the staff at the maternity hospital. The second dimension of power defined by Lukes' concerns the power to prevent certain issues being discussed and decisions made. This is evident in national and local politics and the media in Pakistan. The needs of women are not acknowledged and the problems of childbirth are largely ignored in the strongly male dominated society. The third and most insidious of Lukes' dimensions of power involves groups of people manipulated into accepting policies as beneficial that may in fact be harmful for them.

The widespread 'population control' programmes for the rural poor are seen as the government's answer to women's childbirth problems, and not society's economic difficulties. Yet, in a society that does not provide health care, and a culture that reveres large families, for 'support in old age' there is a need to have six children to get four alive. The population control programmes do not address the fundamental problem of poverty, unemployment and boy preference. Cleland (1971:1542) wrote;

"Dominance is most complete when it is not even recognised".

Taking the classic framework of power developed by French and Raven (1959), which links power with control, knowledge and regard by influential people (referent power), there is an obvious powerlessness about us as researchers and the women interviewed. It is an accepted principle that those who define what authoritative knowledge is, in any society, are the powerful.

"Dominant groups not only define themselves, but situations and other groups as well". (Roberts 1995: 296)

There is no doubt that the following quotation of Lukes' conceptualises power with a dominant gender bias. He also fails to address any potential for a counterbalance that

⁶ Human inquiry is participative, experimental, political and action orientated investigation (Reason 1996).

albeit limited, may be when women redress the situation of external societal power and oppression by wielding the matriarchal power in the home.

'Power is everywhere: not because it embraces everything, but because it comes from everywhere...power is not an institution, nor a structure, not a possession. It is the name we give to complex strategic situations in a particular society (Lukes 1974 1: 93)

Foucault did, however, recognise the ubiquity of power. Power, knowledge and truth are inextricably linked by Foucault (1980a:93), yet he denies that one makes the other.

"I know that as far as the general public is concerned I am the guy who said knowledge merged with power...If I had said, or meant, that knowledge was power, I would have said so"

Although Foucault's early work is concerned with domination and physical power, he moved increasingly towards a position that denies power as a repressive force, or coming from a dominating class. Upholding the omnipresence of power Foucault believed that power comes with resisters, which provided the opportunity to oppose the power holder. The following statement by Foucault (1980:2) has particular relevance to the discourse between the doctor and me at the hospital in Pakistan (see chapter 6).

"Truth isn't outside power, or lacking in power...Each society has its regime of truth, its general politics of truth; the mechanisms and instances which enable one to distinguish 'true' and 'false' statements. The means by which each is sanctioned; and the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true" (Foucault 1980a:131) upheld by Jordan (1993) and Belenky et al (1997)

Although the intuitive knowledge of birth in the rural communities is hidden from view and thus intervention of medical fraternity, there is a heavy blanket of medical control over birth in the hospital. Doctors are educated superiors and must be obeyed, in obstetrics the majority of the doctors are women. I have been horrified at the treatment meted out by women to other women, yet honoured to be in the presence of a relative (sister) giving another assistance following a caesarean section. The outpouring of love, consideration, kindness and gentleness put my own post-operative care as a nurse and midwife to shame. It seemed to me that what I was experiencing was what Lazerus and Phillipson (1990), Jordan (1993) Belenky (1997) found to be near complete devaluation

of the woman's subjective knowledge in the medicalised birth, yet the complete inverse of this by the relative. This made me re-think and re-examine my western cultural norms. Even with a woman centred holistic philosophy and the inculcation of tender loving care; my western practice could not match that of the caring (but uninformed) relative. The one to one undivided individualised subjective, connected knowing is the gold standard of care. My knowledge (theoretical) had not taught me how to care as the relative.

2.1.12 Summary, knowledge for living

This research uses human inquiry as its method, rejecting the division between the researcher and researched. It further aims to bring seamlessness to the discourse. Studying the many facets of knowledge has served to open out some of the influencing factors that make up the ecology of the research. Exploring what is truth and how knowledge is linked to the authority of the time, shines a particular light on this research over four decades. This raises questions about the influence of colonisation on me as the researcher and the women as participants. Moreover, the essential (to the research) knowledge on birth belongs to the women. Connected knowing with women who have the common experience of birth, has been behind the virtual wall of social silence and largely unwritten, this research is aimed to take a brick out of the wall and allow the voices of a few women to be heard.

The next part of this chapter relies on text knowledge of some of the effects of childbirth on women.

2.2 Life influences (2) Childbirth morbidity and mortality

One cannot study birth in any culture without addressing the health of its women. To build a picture of the life and world of women in Pakistan it is important to analyse their experiences from a social and a personal context. Because Pakistan as a country is as yet in its infancy, in world life terms (fifty-five years since independence), there has been little evidence of effective developments in assessing the health of its population. In 1991 the Government commissioned a Poverty Reduction Strategy, which included monitoring, and evaluation mechanisms, however:

“Resource constraints are just one of the maladies of Pakistan, weak, ill organised and inadequate public services delivery systems have in the past successfully neutralised plans and huge amounts of resources have been wasted” (Government of Pakistan 1991).

Research underpinning the health of women is scant, one exception is Professor Dr (Mrs.) Awan's research (1986) undertaken in a Lahore suburb in 1995. She is currently the President of the Maternal and Child Welfare Association Pakistan. The WHO funded her study, and the purpose was to determine the reproductive morbidity of women in an urban community in Lahore. The findings from this study have been used as a window into the suffering women experience as a result of childbirth and as a comparator to other statistics and my own experience.

The following part of this chapter addresses issues of female literacy, the rhetoric of health, mortality and morbidity, and the obstetric profile of women in Awan's study of menstrual and gynaecological problems.

2.2.1 Pakistan's statistics

Pakistan is growing faster than the efforts to address its many health related problems as found in the Pakistan Demographic and Health Survey of 1990-1 (Government of Pakistan 1991). An example to demonstrate Pakistan's inability to keep up with the needs of its population could be the number of hospitals. In 1950 there were 304 and in 1981 there were 600 (less than double), while the population more than doubled (33.7 million

to 84.2 million). In 1989, Scott identified that there was one hospital bed per 1,852 persons in Pakistan. An unrealistic but worthwhile comparator is one bed per 290 persons in the UK (Scott 1989). Any assessment of women's health status is particularly difficult since statistical estimations are either inadequate or contain serious discrepancies (Shaheed, Zia, and Warraich 1995). This lack of reliable information is combined with the women's cultural reluctance to express their need and results in a sea of suffering and an early death. Life expectancy for men is 57 and for women in Pakistan is the age of 57.7 years (Government of Pakistan 1991).

A more recent report outlining Pakistan's Government framework to reduce poverty is entitled the Interim Poverty Reduction Strategy (Government of Pakistan 2001). This was published by the Finance Division and maps projects against governance reforms, which include for the first time monitoring and evaluation mechanisms. However, one step to improve health outcome for women is:

"Provision of emergency obstetric care facilities through the establishment of 'women friendly' hospital in 20 districts under the women health project"
(Government of Pakistan 2001:46).

Murphy- Lawless (2003) criticises the importation of solution from the west in favour of valuing and making safe indigenous birth practice. The WHO (1992) have also tended to reflect health care that is heavily influenced by the dominant medical discourse that lies behind the high tech thinking of childbirth prevalent in the wealthy west rather than address the major problem of poverty.

Awan (1996) admits that there is a lack of reliable accurate data underpinning women's health in Pakistan. This was her main justification for undertaking the study that took place in 1992-3. At that time, the total population of the urban community in the study was 29,965. From this, a systematic sample of 629 women registered with the maternal and child clinic for the research. The area had very poor civic amenities; houses were old and multi-occupied with very poor ventilation. Water had to be transported from a central source. This source, like most other areas in Pakistan, is from a water table that is in close proximity to natural land drainage and as a consequence is likely to be contaminated and a distinct health hazard. As there is no organised waste disposal systems in the country it

is common for piles of waste material to be dumped in the street. Personal hygiene is very poor due to poor facilities and lack of education into its health benefits. Families cook food in the same room as they sleep, or in the courtyard where the animals are kept.

2.2.2 Research without choice

In Awan's study (1996), there is no mention about informed choice or how the women were recruited. As the study involved women succumbing to a gynaecological examination, it is surprising that some women did not opt out; there is no mention in the report of this. Omran and Standle's (1981)-multi centre, international, collaborative study included a clinical examination but participation was so low that the results could not be analysed. To Awan's credit, training for the interviewers appeared comprehensive and thorough. Two interviewers were trained dais who already knew the sample and had an existing 'comfortable rapport' with the women. An impressive total of fifteen days training was given to the interviewers who were also involved in the development of the questionnaire. It is interesting to note that during the interviewing the respondents were kept '*comfortable by entertaining them with cold drinks biscuits and packets of milk*'.

In her study, Awan (1996) describes the level of women's education as low. On further analysis of the findings, this is an understatement. 49.4% of the sample were illiterate and a further 31.8% were only educated for five or six years. Shaheed, Zia, and Warraich (1995) confirm the female literacy rate countrywide as 22.3% (average, rural and urban), admitting that this is one of the lowest in the world. The 1992 Economic Survey by the Government of Pakistan declares an upward trend in female literacy. The trend shows the improvement in literacy for urban women, - from 8.4% in 1951 to 13.9% in 1990. However, the increase is less for the rural women, from 7.3% to 11.3%. These figures must be taken in the context of 60% of the population living in rural areas. Awan's demographic data does not detail whether the children within the sample were in any education system. Nationally, female attendance at the primary level trails far behind that of boys. In 1993 an estimated 53.7% of girls compared to 84.8% of boys enrolled at primary schools. The drop out rate is also higher for girls, 14% drop out of secondary

school compared to 7% boys (Pakistan Demographic and Health Survey 1990-1). Women's education is neglected and the previous policy decision to segregate even primary schools served to effect the provision of female education. The government has recently reviewed this policy and via the Social Action Programme, calls for integration at primary level (World Bank, 1993)⁷.

Direct parallels can be drawn between Awan's (1996) study of the community and my own empirical observations in S... and its districts. There is however one major difference; the community Awan studied had a Maternal and Child Health/Family Planning (MCH/FP) service. Villages with upward of 20,000 populations around S... do not have this luxury. Thus the women's life risks in Awan's community should be considerably less than the majority in Pakistan. Choudhry (1997) studied eighty-nine rural health facilities in Pakistan and found that even where there were supposed to be comprehensive health facilities on paper, personnel were absent and the quality of service was poor. This fits the picture of a programme in S..., whereby a Health Visitor was employed to visit the surrounding villages, yet was unable to complete this undertaking because officials commanded her transportation. Consequently, the majority of the population seeks out treatment from sources other than through the rural health infrastructure.

The obstetric profile of the women within Arwan's study (1996) began with 86% of pregnancies terminating in live births. Spontaneous abortions accounted for 6.5% of the outcomes and 4.9% had induced abortions. Abortion can only be obtained privately. The mean duration of labour was 4.6 hours and only 8.9% had a prolonged labour (more than 18 hours). Two thirds of the women (66.8%) were delivered at home and 27.2% in hospital. Nearly half (47.9%) of the deliveries were conducted by a trained TBA, 28.9% by doctors and 10.2% by untrained dais or TBA's, with only 1% by female relatives. This is in direct contrast to my own experience and the UNICEF figures of 1989, whereby untrained personnel attended 83.6% of births.

⁷ The Islamic philosophy of education (Abedin 1996) is based upon social and spiritual values subscribing to the principal of an individual's obligation to seek knowledge and societies obligation to provide

2.2.3 Morbidity and Mortality

Pakistan's infant mortality rate is 103 per 1,000 live births (World Bank 1993). This is a reduction from the UNICEF figure in 1989 of 120 per 1,000 and shows a positive downward trend; however it continues to be one of the highest infant mortality rates in the world. The World Bank (1993) also report a maternal mortality rate of 600 per 100,000 in Pakistan.

Awan's sample (1996) of 629 women was found to have between them no less than 2,620 diseases, and 4.16 per woman. One hundred and ninety two women (38.9%) were found to have a vaginal infection, a staggering 81.8% complained of menstrual problems. Equal numbers of women complained of unusually heavy (39.3%) or unusually scanty (39%) menses, while 28% had scant and irregular menses. In my experience it was not uncommon for women to say they had only ever menstruated once or twice in their life, the rest of the time they were pregnant or breast-feeding.

Some of the women's concerns around menstruation may have origins in the Qur'an, Salahi's (1989) book offers answers to questions on the Qur'an and suggests that women have to differentiate between menstruation and a *normal blood discharge*, "haith" and "estihadhah". The purpose is purely religious, menstruating women do not pray, fast, or have sexual intercourse. However, with a *normal blood discharge* it is different. The wife of a prophet, Umm Salamah, is used as an example.

"...Let her calculate the nights and days which she used to menstruate every month, she should not pray, thereafter, she takes a bath, uses a piece of cotton or cloth (to absorb the bleeding) and prays." (Salahi, 1989).

The implication is that menstruation is not normal and MotherCare 2000:8 also documents that any blood discharge outside menstruation is normal. So much that women are exhorted to '*pay no attention to the normal (outside menstruation)*' (Salahi, 1989),

education. Education is not only the right of an individual (male or female) but also a moral duty.

except by *'taking precautions not to allow the blood to fall on her clothes or body'*. This thinking may be hazardous to the health of women who will confuse the normal with abnormal and fail to seek medical assistance for the abnormal.

2.2.4 The facts and the suffering

The most common gynaecological problem reported by women in Awan's study (1996) was lower reproductive tract infection (78.4%). 65.8% of these women were found to have cervical lesions, 60% were cervical erosions, the remaining were cervical polyps, tears or cervicitis. Urinary tract infections were present in 38.6% of women and 33.9% had vulval lesions. Postpartum complications were however the greatest source of morbidity. Prolapse was the prominent obstetric complication: 67.1% of the women were found to have a prolapse of the vagina and/or uterus, 90% of the women who were gravida 8 or more had a prolapse. In MacArthur, Lewis and Knox's study (1991), which was conducted in Birmingham UK into the health of 11701 women after childbirth, prolapse came under the less frequent symptoms thought to be caused by childbirth, with only 25 (0.2%) women having the problem.

Following prolapse, the next most common problem identified in Awan's study was dyspareunia. This was also one of the most frequently reported postpartum problems in the UK Bick and MacArthur (1994) survey. One interesting feature found in MacArthur's et al study was, that Asian women had significantly increased rates of backache compared with Caucasian women - 30.2% compared to 18.7%. However, backache did not feature in Awan's study (1996) in Pakistan.

2.2.5 Validation, silence and ethics

The suffering that underpins the morbidity statistics in Awan's study may seem inconceivable to us in the Western World. They do, however, validate my observations in Pakistan. Yet, they may only be the tip of the iceberg. Younis et al (1993) reports a high proportion of women internalise their health problems, building a 'culture of silence'.

They are silent because they feel ashamed to report symptoms. Some women may consider it to be punishment for past (in another life) deeds that have to be atoned for by suffering, much the same as the early Christians believed that health was given to serve and illness to correct (Herzlich and Pierret, 1985). If women believe the reproductive morbidity to be normal and part of their destiny, they are unlikely to report it or seek treatment. This explains why the gynaecological examination as opposed to taking the word of women was necessary for the study, even though the ethics of conducting the examination without consent must be questioned.

2.2.6 Summary

Scientifically acquired hard facts are what the policy makers in Pakistan and other developing countries work with. It is impossible to document coldly the findings from Awan's study, without feeling the suffering of the women who are experiencing the problems that the statistics speak of. Women's knowledge and intuitive ways of knowing related to their birth experiences are what the research is about; however; this knowledge cannot be blind to the statistics around women's health in Pakistan. Oakley (2000) agrees that using quantitative data to underpin the qualitative experiences of the women balances the rational and intuitive with the reliable and generalisable. Awan's study in the suburbs of Lahore offers a glimpse of the suffering that is the direct consequence of childbirth which women endure in relative silence.

The next chapter focuses upon the influence I had as a white western midwife and researcher on the research.

CHAPTER : MYSELF IN THE RESEARCH

3.1 Words feelings self and others

Having set the scene and provided some background of the life influences on women in Pakistan, the next part of the thesis examines the effect I had as a white western researcher on the research: namely, the world of and between the ethnographic researcher and the participant. I started to and through this research by being born into a small village the daughter of a lay Methodist minister (Appendix 1). My work as a community midwife with Pakistani women in R... formed the basis of a fascination with Pakistani culture. The journey then took me to Pakistan for the first time in 1989, where I had the opportunity to observe and work with women who were giving and receiving midwifery care. During the subsequent eight field trips to Pakistan, my knowledge of birth and women expanded exponentially. During these working visits, not only did I work in a Red Crescent Maternity Hospital, but I also socialised with the educated upper and middle class Pakistani women, and tried to put women's health on the politician's agenda. Back in R... I interviewed a generation of women whose birth experiences had taken place a decade before (1950-70) in Pakistan.

Based upon the premise that understanding emerges from research and the product of interaction between the researcher and the researched (Field and Morse, 1985), the following chapter focuses upon me in the context of research with women who have given birth in Pakistan. First, I will formulate a justification for the reflexive autobiographical approach and the style of writing. Following this, building on from my own brief story of my life (Appendix 1), the chapter will reveal how factors in my life have influenced current personal values, thinking and philosophy. Lastly, a selection of the emerging themes from my life story will be analysed in the context of their importance to the research.

Hammersley and Atkinson (1992) commented that there are very few authors that have reflected on the production of their own research text. I felt such reflection within this chapter to be an essential part of the 'honesty' that builds internal validity. It seemed important that the reader understand the reflective autobiographical approach that requires a type of 'novelist' style of writing was appropriate for the text. However, the

thesis was also written for another audience, for which the pure 'novelist' style is not acceptable. Although relatively little has been written directly relating to the organisation of ethnographic text, Lofland (1967) whilst agreeing that there is a lack of consensus over the appropriate form of writing, created a typology of styles, or as he called them, frames. The frame he described as 'generic, novel' emerges as appropriate to meet the needs of both the academic and professional audience of this thesis. Generic, novel is depicted by Lofland (1967:102) as '*organised by means of a generic conceptual framework was novel*'. I have amended and interpreted this to be an adapted novelist style that allows the participants to tell their story within a researcher designed conceptual framework.

Reflecting back upon and writing the story of my life has fulfilled many purposes, not least as a cathartic exercise to remind me of the chasm of differences and some powerful parallels between myself and the women in the study. Also, very importantly, to demonstrate how woman-focused I have become.

The sequence for this chapter is, firstly to explore the join between the participant women and myself. Then justify the autobiographical and reflexive elements of ethnographic research, followed by the recognition that there is much more to the research experience and the women's worlds than there are words to describe.

3.1.1 Reflexivity

James (1987) advocates a "*scrutiny of self as a touchstone for understanding the world of others*" further confirming that "*self knowledge is intimately linked with the possibility of understanding others*". Koch and Harrington (1998) call for the use of reflexivity to show rigour in qualitative research and Norton (1999) argues that reflexivity is both necessitated and demanded. However, a popular put down of reflexivity or autobiography is that it is 'mere navel gazing' this fits with Llobera's (1987) view of reflection as narcissism.

Consequently, although the method is ethnographic (words of the women), the ethnographic record is not analysed in a cultural vacuum; but through another's senses

and embodied knowledge. Belenky et al (1997) portrayed how she worked towards understanding of her fellow researcher's words.

" ...To understand her (other woman) intention behind the words, I would try to place myself in her place, before I can impose new words or meaning of my own or, imagine what might be so important to her to say, I must take care not to lose her meaning. Only then do I allow the words to flow from my fingers – the words are mine, yet hers as well, Belenky et al (1997 xv) called this process 'attending'.

'Attending' I realised after reading Belenky is the basic standard I worked to when analysing the women's words. This has come from a lifetime of socialisation in nursing and midwifery, conditioning not to be judgmental, to be objective yet empathic, to treat everyone as if she were your mother, sister or daughter. The commitment to 'attending' was made because of my way of knowing. Similarities and differences were evident when working with women in Pakistan. Such similarities lay in the background and socialisation of women in the home and not the workplace; the differences were in knowledge and experience, culture and language. The latter had the potential for major misunderstanding or misinterpretation; the former brought a bond of empathy embracing honour and respect. As implied, the bond of empathy was not evident to me in the workplace in Pakistan. Differences in social status swallowed up the woman-to-woman sisterhood. For there to be any positive interaction between the staff and women giving birth, the staff had to elevate the woman to the status of bhajee, elder sister. This same honorary family status was necessary for a western woman and Pakistani man to interact socially (Shab and Vez. chapter 6).

Current text does not specify how 'interpersonal experience' should be written up, but Scholte (1974) advocated a reflexive approach prior to analysis. It would also seem pertinent to take cognisance of what Hastrup (1987) identified as being a peculiar reality in the field: *'it is not the unmediated world of others, but the world between others and ourselves that is important'*. Thus by exploring and exposing the two, the *join* can be better understood.

"One must first determine ones own philosophical stance. ...for how can one decide what approach to adopt unless one knows which lens one is looking through..." Paley (2000:20)

My experience of both quantitative and qualitative methodology told me that there is no ideal research method. Paley (2000) confirms that the paradigm interpretation of the difference between quantitative and qualitative research is close to being incoherent. This led me to critically examine the factors influencing choice and implementation of method to conduct this research. Whilst there is no doubt that the subject under study will direct the method, it is the researcher who selects the subject in the first instance. Consequently the researcher's background, ontology, philosophy, epistemology, values and beliefs form the bedrock for both the choice and the form of the methodology. After studying oral history (Thompson, 1996), (Dunnaway and Baum, 1996), which is expanded upon in the Methods Chapter 5, I reached the realisation that ethnography was the most appropriate core method with which to study birth in Pakistan. It was felt to be important to address some of the influencing factors in the relationship between the researcher and the researched.

Okely and Callaway (1992) advocate there should be an autobiographical element within ethnography. The purpose of this chapter is to work through the self in order to contextualise and transcend my influence upon the data. This is what I have tried to do, without making the *I* an ego trip.

As I begin, the *I* is a voice of diffidence, especially in the face of science and the dominant research culture. It is in this sense that I knowingly, but defiantly, open my work to the critique of being non-representative. Wax (1971) advocates ignoring the self and the gender of the researcher. I disagree with this statement on the basis that the research involves gender, women's work and women's knowledge. There is no chance that a man could conduct this research, the women would not tell the story of their birth to a man, especially a stranger. No more could a man empathise with the birth experience, although this is not to say that men cannot have a positive influence upon the birth experience.

I have made a total commitment to honour and respect the women's words and to 'create a sense of openness', as identified by Kirkham (1997), this has formed the cornerstone of the research. Returning the transcript for each participant to comment upon has fulfilled part of this commitment; the rest lies with the interpretation analysis and writing up. My

personal philosophy hinges upon a humanistic paradigm as depicted by Davis-Floyd (2001). This is operationalised by ensuring the person I am interacting with *at that moment* is the most important person in the world to me. Whilst anyone can write these words and not fulfil the deed, my personal integrity would not allow this. However, I only have one medium to convince that of the written word. I hope through the consistency of approach to show my credibility. I have been through a stage where I felt that I had no right to write about another's life, feeling 'safe' only when I was writing about myself, as there was no danger of misinterpretation. This kept me away from the analysis of the women's words. However I have reached an agreement with myself and that is to apply the same ethical principal with the words of the women that I do for care and that is, to treat them as if they were my own.

3.1.2 Different worlds

The relationship between the women and me would be considered a dynamic intermingling of cultures, at times clashing other times merging. This intercultural experience is built upon a journey where each step is tentatively taken, always with the sense that one may have to retreat because a boundary or norm has been crossed. The women and I are without doubt at different points on a cultural spectrum, socialised in different worlds, but of the same age and gender with some common experience (as the women interviewed in R...). However, our life experiences, so common to ourselves, may be so shocking to each other.

Some of the women interviewed have lived in Britain for a number of years; they viewed the country through their own cultural lens; others will have never been out of their home town in Pakistan and the very presence of a white woman leaves them in awe. (Kad's comment). The women without exception have one common bond, their Islamic faith. As a Christian brought up in a small strongly Methodist community (see Appendix 1), some if not many of the basic values and beliefs may be well be shared with the women. As does the close strong family bond, whereby families stand together and defend each other, particularly at times of strife. Obey thy father and thy mother and respect your

elders, has been a basic tenet of my socialisation. In many ways, the Ten Commandments parallel the code of conduct within the Qur'an, even though the Old Testament in the Bible falls short of the five pillars of Islam, which provide a tangible framework for spiritual life. A good Muslim will be called upon to pray five times a day; fast during the month of Ramadan; make a pilgrimage to Mecca (Haj) at least once in their lifetime and make a declaration of faith and make a payment to Zakaat annually (2.5% of net savings). This has to be distributed to the poor and needy. However, as with any faith, there are the fundamentalists at one end of the spectrum with the non-practising believer at the other. Each of us sits with our own strength of belief at some point on that continuum.

3.1.3 More than words

As stated a reflexive approach has been used to shape the autobiographical 'connection' between the researcher and the researched. I have written simply as a human being and the story told includes the rational development of myself that comes from the immersion in another previously alien world. Jackson (1983) identified that when anthropologists become immersed in another culture, or in their own as a participant observer, they learn not only through the verbal and the transcript, but through the senses, through movement, through their bodies and whole being in a totality.

This total knowledge is used to rationalise the experience, notably from one's own cultural paradigm and attached to each individual's past experiences and socialisation. Field notes are then used as a trigger for bodily and subconscious memories. Okely and Callaway (1992:16) says '*we cannot write down the knowledge at the time of experiencing it*'. This would mitigate against the fieldworker keeping pen and notebook handy taking short 'time out' to jot down words that will later jog the memory. The more contemporaneous the experience can be recorded the more it is a full account; however, we cannot hope to write it all. Every time the record is read, recalled, re-written, re-read, a differing perspective emerges. Willis and Trondman (2000:) also note how the body can be treated as a memory. His words validate my own experiences and the feelings that

surface as I recount the words of the women, the observations made, the experiences lived. Flashbacks to the interviews, triggered by all manner of stimuli, jolt the senses to reveal yet another possible different perspective. Why this was not *seen* at the time is a mystery of the mind. Almost like the seedling had to grow darkly nurtured by other hidden memories from experiences or, as I suspect, attached to emotions that may not have been appropriate to reveal or deal with at the time. This could be classified as emotional grounded theory.

As stated there is infinitely more 'in the head' of both the researcher and the researched than words can possibly depict. Words may actually serve to reduce feelings not describe them. Kirkham (1997) highlights a lack of appropriate language to express the experiential, intuitive and creative dimensions of midwifery practice. An attempt to overcome this will be made through sharing my thoughts with other midwives and women and recording the 'feelings' as they erupt; raw, confusing, at times painful and insightful. Insight can be used to see further than the situation and often arise when a writer manages to 'outwit' her own 'police system'; memories or perspectives are kept hidden and become visible at a 'safe' time. I have taken the advice of Taylor and Bogdan (1995) and used the psychodynamic approach '*to develop a greater awareness of the unconscious influencing issues*'; a sixth sense developed to look beyond the word alone. In addition, the Polkinghorne (1995) analysis framework was used. This challenges the researcher to read the data from the different standpoints or perspectives, that is, oneself, participants and others involved.

3.1.4 Translate with integrity

One is challenged as a researcher to act as an objective scribe, devoid of influence or judgement to adhere to strict moral and ethical code, to do no harm. These words have the potential to become protective rhetoric, words that impress the reader. We only know if there is potential for harm by asking the respondent or her representative. Behar (1993:13) worried about the 'violence' to the life story by turning it into a disposable commodity of information. Howsoever the question is framed; it is the responsibility of

the researcher to protect the women's word. This was undertaken by seeking the advice of advisory members of the community (Shan and Bal chapter 6). Both are trained advocates whose sole purpose within the research was to protect the participants. The bare minimum ethical principle for me as the researcher is to analyse with integrity and honesty, accepting the comments of the respondents or their advocate as the final word.

It would be immoral to claim that I am devoid of judgement and to declare lack of prejudice and objectivity is too simple, easy and banal. I am still seeking the best practice. I begin with opening up my psyche for scrutiny, welcoming and accepting criticism with a commitment to change. Change is an ongoing process, which underpins the dynamic nature of the mediation between the women and me. Values will change over time, as beliefs will vary. Past life experiences and current knowledge and opinion will influence the women's interaction with me, as my past and current experience profoundly influences my practice. Indeed those who protect the self from scrutiny could well be labelled self satisfied and arrogant in presuming their presence and relations with others to be unproblematic. Bolton (1995) cited by Kirkham (1997:183) exhorts us to '*take the thinking out of reflection*' and to go with the feelings. Recording my feelings before, during and after the interviews, as well as after transcription and analysis, offers a dual purpose; as a brush to fill in the context and a reminder to spark the feelings and memories.

3.1.5 Ethnographic autobiography

A fundamental aspect of ethnography concerns the relationship between cultures or groups. The women's relationships with each other, their families and the society are indeed as fundamental to the research as is the relationship between the researcher and researched. Relationships do not take place in a cultural vacuum, but constitute a dynamic cross-cultural encounter. My own cultural norms and values on a simple superficial level can be gleaned from the synopsis of my life to date (Appendix 1). However, I can not hide from my unequivocal position as a white female, working class,

middle-aged woman with a strong work ethic and old-fashioned traditional moral values. For most of my life I have been grossly ignorant of my own and other cultures.

This is hardly the profile for an ethnographer studying a life experience in a different culture. As a consequence there is a lot of ground to be made up. One positive feature in my ignorance of other cultures is that I bring a relative lack of any pre-existing prejudice.

Fieldwork practice is always concerned with relationships (Campbell 1964). The ethnographer has to form long term links with others across the cultural divide, however problematic. The relationships with the women are indeed crucial to the research. Fundamental to this relationship is the communication medium, i.e. the interpreter. My experience with different interpreters has been documented in Kirkham (2000). In my low times I flagellate myself for even thinking that ethnography can be conducted across a language barrier. I justify and carry on by remembering the words of more than one woman interviewed, "*we would not have told anyone else our story*". This special relationship between researcher and participant, across cultural boundaries, is documented in Ruth Behar's (1993:16) life history; Esperanza's Story and raises the question of who exercises the right to write culture?

The autobiographical experience of fieldwork requires the deconstruction of the relationship with the women in the field. Okely and Callaway (1992) call for this deconstruction to be conducted with rigor. When this encounter is exorcised, the autobiographical account undoubtedly embodies, at an individual level, the discredited practice of the '*others*'. I anticipated the others in the research to be the dais or birth attendants. However, although the women were often happy to discredit their husbands and mother-in-laws, without exception they did not find fault with the birth attendants. Whether this is due to me being a birth attendant or because of the particular health belief model, it is hard to define. As a researcher/ethnographer my mission has been to use a self-conscious, critical and reflexive perspective, ever conscious of the possible power relations that exist. Power in all its shades and manifestations, along with knowledge, is a thread that weaves its way throughout the research.

3.1.6 Summary

In summary, reviewing the differing worlds of the researcher and participants, acknowledging the responsibility of the researcher to open out self for scrutiny, to translate with honour and search for words to describe situations that often contain more than words offer, shouts of the imperative that autobiography has to ethnography. To which the competence and integrity of the researcher is key. The researcher's trustworthiness will affect the relationship between the researcher and the participants. As a novice ethnographic researcher, I had no idea that research would bring with it such an awesome responsibility or such a painful breaking open of self. However, as I see and continually learn more about myself, it brings into focus the lives of other women.

The ethnographic situation (birth experience) is defined not only by the 'native situation' (life and the context of birth) in question, but also by the ethnographical tradition 'in the head' of the ethnographer (myself). The complex dynamics of the researcher-researched interface are, as stated, vital to achieve transparency of the method. To ensure these are better understood, the important influencing factors should be opened up for scrutiny. As the women are asked to put their birth experiences in the context of their life story during the interviews, as the researcher I opened up for scrutiny my life story, with specific relevance to my own childbirth experience and work as a midwife.

3.2 Emerging themes from autobiography

3.2.1 Love and respect for women

From my autobiography (Appendix 1) two themes were outstanding in their importance to the research; my feelings for women and the relative lack of cross-cultural interaction I experienced until the late 1980's.

Reflecting back, it is evident that there were two very influential role models to shape my deep respect and love for women. These were underpinned by segregated gender roles within my childhood home, which parallel those that are current in many Pakistani homes today. Unquestioning religious values and norms formed the bedrock for acceptable social behaviour; potential shaming or disappointing my parents formed effective

deterrents to pre-marriage sexual relations and controlled the peers I consorted with. All these I now recognise, as being part of the pre 1960's pre-enlightenment epoch whereby 'authority' was not questioned.

The choice of a caring women-centred profession served to reward me with incredible satisfaction; I placed myself as servant to society and my family. Such a childhood enabled me to empathise with the Pakistani culture that outside the home, in the world of work and academia, the woman is considered an *also ran*. Gender differences and boy preference came as major themes, both in my autobiography and through work with Pakistani women. My personal dogged determination and stubborn will to succeed is grounded in showing the men in our household that '*I can and we are equal*'. Through my teenage years in the 1960's, with the influence of modernism I saw other women demand rights, and feminism for me identified with equality. This background served to form my personal strategy to overcome the gender difference, which revealed itself as a drive to succeed in what seemed a world of men – academia. However, this proved to be an uphill struggle because I left school aged 14 years with only a basic education.

A wish to please and to prove myself, to take control of what I perceived to be a poor basic education, I was in triple jeopardy, being a woman, young mother with a bowel condition that is reputed to be linked to personality type (Crohns disease). I had been labelled highly-strung and sensitive following the death of my sister, who had been my surrogate mother. My brother and I were undiagnosed twins born as my mother was passing through the menopause. I was virtually ignored by three older brothers to the point of wondering if I existed. It is interesting to note that Adams (1994) observed separation rather than connection is the main organising concept on which life, birth and motherhood are constructed.

I cannot pinpoint the exact time the determination to show 'them' surfaced, and thus the beginnings of a working strategy to succeed that still drives me today, but I can remember the surprise in my brothers' eyes and voices when they were told I was to go into nursing. One of the interviews with women in R., a Pakistani midwife, Ina's story paralleled mine; however, her brothers had the cultural support to place real obstacles in her way. The real crunch to succeed and show 'them' came during my interview to

become a nurse. “*You are a risk to employ*” were words that set me on a path to prove otherwise. I could not; I would not ever have time off sick. This diffidence, arising from socialisation in a male dominated household and a non-academic background could be dramatically beneficial to the current research. This makes me remember my mother’s words of “*your day will come*”. There is undoubtedly a bond with the women I interview; a connection that understands the reluctance to question, yet the need to. Completing the autobiography has been the catalyst to the recognition of this.

3.2.2 Ignorance of culture

For a major part of my life, probably twenty plus years, I had no contact or experience of people from other cultures. When I listen to the racial prejudice through the media and the horrific stories from my hometown, I am shocked and disbelieving. I have to register the facts as the statistics reveal there are major problems. However, when one has never experienced first hand, the believing has a different quality. Recently my awareness has been raised by my daughter in another public sector (police). She works in a town similar to R... with a higher than average ethnic mix population. From her, as yet minimal experience, there is indeed prejudice both from within and without the service. Bharj (1995) has studied inequalities as a result of racial discrimination and the findings are horrifying. This makes me think that I am taking on an ostrich stance. Yet, I cannot stir emotions with racial prejudice that bubble immediately to the surface if I just think of women or child abuse.

3.2.3 Summary

Writing the story of my life and how it interfaces with the research has served to open up a theoretical window. This window clears the view to my influence on the data through the analysis. The reader will be in a position to uphold or question the discourse from the data themes and their application to theoretical principles.

Considering the audience for the thesis directs the discourse into a theoretical domain that has the potential to venerate or lose the women. Writing about one world for another has the potential for elaboration, gaps and sensationalism. As stated, the women themselves held my ignorance in their hands. The silence both within and without the research, coming as it does from all sides and multiple perspectives may be as powerful as the words shared. The use of the camera analogy for the analysis framework offers a real world object to imagine the process of lens and perspectives. The identification of the key issues (common elements) grew into main and sub-themes that could be focused upon in the findings chapter.

Once the strong elements had been identified, the many influences on the plot needed to be considered before the format to present could be determined.

After carefully underpinning theory to the methodology, it was then possible to take the reader into the research field trip whereby the data were collected from Pakistan. In the traditional research process, this stage would be the selection and background knowledge of the participants and research team.

4 CHAPTER METHODOLOGY

context or mental framework and are constructed or interpreted. Thus a persons' ontology describes how they view the world, some believe there is one reality that can be discovered (realism), others would argue that reality is socially constructed (relativism) (Guba 1990).

My philosophical position would in Guba and Lincoln's (1994) and Denzin and Lincoln's (1994) terms be described as that of a constructivist /relativist, as I believe that the knowledge on life and birth in Pakistan is subjective and relative to the context of the individual experience. Denzin and Lincoln (1994) define the constructivists ontology as;

"...relativist, in that the constructions are as alterable as the reality, the epistemology as subjective, whereby findings are literal and knowledge is created among the investigator and the respondents. The methodology of the constructivists is dialectic aimed as reconstruction of previously held constructions" (Denzin and Lincoln 1994:111/2)

Ultimately my ontological position has influenced both the theoretical attachment to underpin the empirical content (epistemology) and the methodology underpinning this study.

4.2 Methodology

Bentz and Shapiro (1998:34) view "*methodology as parasitic on epistemology and ontology*". Thus, how I view the world (ontology) who I am and what I consider to be valid knowledge (epistemology) has determined the methodology.

Methodology refers to the way in which knowledge can be gained, the approach adopted to answer the research question. Guba (1990:18) defines this as "*how the inquirer goes about finding out knowledge?*" The approach adopted to answer the research question, *what is life and birth like for the women in Pakistan* utilised a wholly qualitative design. Sandelowski (1986:31) refers to the truth-value of a qualitative investigation and how it generally resides in the discovery of human phenomena or experiences as they are lived and perceived by the subjects rather than in the verification of a prior conception of the experience. Significantly truth is subject orientated rather than researcher defined.

The plea by Harding (1996:431) was to 'let the methodology fit the question'.

"Qualitative research is a way of examining the world from the internal standpoint of an individual" (Cordingley, Webb and Hillier 1997:31)

Ethnography as opposed to phenomenology was selected as the methodology of choice because the question was to be answered from the women's perspective, not the researchers, although as the researcher I analysed and interpreted the women's words and stories. Birth as a phenomenon was in the context of the women's culture and other life experiences.

As the researcher my thinking, reading, interpretation of the associated discourse, handling of the research process, as well as being personal has followed certain methodological rules (Rew, Bechtel and Sapp 1993). The rules for a qualitative research design include rigour of data collection and analysis as well as ensuring researcher credibility. This was especially important because I was the instrument of data collection and analysis (Hammersley and Atkinson 1992).

Robson (2002:18) defines what is valuable to ensure rigour in 'real world research' and calls it a 'scientific attitude'. By this he means ensuring that the research is undertaken in a systematic, sceptical and ethical way. The researcher must give serious thought to the how and why of the method (systematic). Being sceptical means subjecting the researcher's ideas and findings to scrutiny both internal and external, and to uphold ethical codes of practice to ensure the interests and concerns of those taking part in the research were safeguarded.

I have endeavoured to demonstrate a 'scientific attitude' whilst questioning the hegemony of scientific knowledge. Both the methodology and method have been subjected to internal (myself) and outside (supervisors and advisors) scrutiny. The ethics protocol, chapter 4 was devised especially for the research.

Due to the different culture of researcher and participant, it was essential to be transparent about my beliefs systems. My perspective is that of a woman who discovered

education late in life, after marriage and a family, socialised from childhood to believe men earn and women work in the home. I have worked for over 30 years in a strongly patriarchal and hierarchical organisation, the NHS.

4.2.1 My type of ethnography, human inquiry

The purpose of the research was to describe the culture, lifestyle and birth experiences of two groups of women in a way that is as faithful as possible to the way they see it themselves. The goal when I began the research was to improve my own understanding of women's life and birth experiences in Pakistan, which would subsequently help to meet the needs of Pakistani women. As the research has progressed this goal has both expanded and been reshaped. It has expanded to include health professionals and policy makers in Pakistan and re-shaped to provide real life stories and content for students and health professionals in education.

Along with most practitioners, the rationale for undertaking a study of any kind relates to improving practice. Throughout the research, I examined my own learning. This had a cause and effect, one example being as I listened more, I got better at listening. As a midwife I had become a talker not a listener, a doer not an observer. The research gave me the delightful opportunity to observe life and woman-to-woman interaction; to hear stories that symbolised what life and birth meant to other women. Stories that had a message, demonstrated a point, had a moral, upheld a principle or parallel that could be applied to other situations. The powerful visual messages and stories not only fed into my practice as a midwife and latterly as a teacher, but also confirmed the importance of undertaking the study.

Observing women's lives, re-telling stories and identifying themes to stimulate learning fits into the current trend in teaching strategies, these strategies use critical incident scenarios and real world, real people clinical issues to spark learning. In the early 1970's, when the Nursing Times was one of the few professional journals around to complement professional education, I avidly read the 'case histories' and skipped the studies that included unfamiliar research jargon and statistics. I realise now this was because the

'cases' were about people and learning from people gave the learning meaning. This helped me to understand and subsequently improved the standard of care I gave. Herein lays a perfect rationale for conducting this research. Truth can only be a personal concept, dependant upon a particular context and time.

"Alternative research (such as this,) contributes to knowledge production by answering certain questions, this is in order to gain insight into the daily struggle of ordinary people." (Tandon 1989:15)

The interviews with the women opened with the question, '*please tell me about your life and family. Begin with where you were born*'. This initiated the search for the answer to the research question, what is life and birth like for women in Pakistan. The women, (both in Pakistan and R.), appeared keen to talk about others and often became vague, stilted and thoughtful when the inquiry focused upon the women themselves. However this reticence appeared to lessen when it came to the women telling about their birth experiences.

Reason (1996:15) argued that inquiry was about 'real questions',

'A real question you don't know the answer to arises from the 'self' and the need to fulfil your own inner self. It is more than curiosity but an expression of deep concern'.

I can trace back my avid interest in birth in Pakistan to the early 1980's when I was working as a community midwife, caring for women from Pakistan. I would ask questions about the women's lives and birth experiences in Pakistan. I was surprised to learn that the answers had multiple parallels with my own life and birth experiences. Reflecting upon the parallels helped me to understand my own and be more understanding of other women's lives. With this understanding came the energy and will to conduct this study of the life and birth experiences of women in Pakistan.

Although we learn from other peoples experiences Oakley (2000:15) says:

"We tend to make better sense to ourselves than to other people"

Oakley's quotation is a reminder that as the researcher I can never be as true to the women as I am to myself. Critiques may argue that my white, middle class (currently) background is a barrier to effective cross-cultural research. Yet my childhood in a large

working class North of England family, with strong religious beliefs, Victorian standards and gender division of labour, correlates strongly with the stories of life told by the Pakistani women.

When we act with knowledge and reflection, we seek knowledge that is useful to others. It is hoped that the knowledge from this research will have utility for others. Knowledge that is valid for a varied audience; midwives, health care professions, politicians and policy makers may also serve as the fulcrum for change. What life and birth is life for women in Pakistan may also be of historical significance to future generations of Pakistani women, both in Pakistan and the UK. The writing of a living inquiry may also be of interest to anthropologists and women from other races and cultures.

The linking concepts between the stories told by the women interviewed in Pakistan and those in R... will offer the opportunity for revision of the dominant western view of knowledge. Added to this will be the journey that I have made as a woman, midwife and researcher. Putting the two together will serve to complete the circle of engagement with the reality of peoples' lives.

Human inquiry is participative, experimental, politically and action orientated (Reason 1996). As such it is very different from the orthodox social science knowledge acquisition. This moves research from the narrow purpose of contributing to a field of knowledge, towards a living inquiry that is integrated into the lives of all those involved. Such inquiry is 'of use'; arising out of the needs and experiences of the people it serves, aiming to interrupt patterns of power that define the issues of the powerful. In addition to the immediate purposes, human inquiry aims to heal the fragmented experience that is part of the legacy of positivism and cause the participants to reflect upon the nature of knowledge making. When examining my type of ethnography it was easy to see the anthropological influence. Some of the text that linked to my epistemology were embedded in anthropology, for example, Okely and Callaway's *Anthropology and Autobiography* (1992), *Birthing in the Pacific* by Lukere and Jolly (2002), the *Translated Women* by Ruth Behar (1993) and *Women's Lifeworlds* by Edith Sizoo (1997). These texts offered a theoretical framework to accomplish the study of birth in Pakistan. It became clear that for me the quest was to understand and create living knowledge.

Willis and Trondman's (2000) *Theoretically Informed Methodology for Ethnography (TIME)* both illuminated and connected with my philosophy. Their view on theory and ethnography is that it is not interested in 'grand theory', although it does acknowledge that theory has its place. At the basic level, ethnography facilitates the recording and presentation of the 'nitty gritty' of everyday life to provide maximum illumination for the reader.

Willis and Trondman (2000) confirm that ethnographers go for the 'Ah Ha' effect where the effect hits home to the experience body and emotions of the reader. The credibility of the work then allows for openings of new understandings. The 'Ah Ha' effect serves to fuse old understanding with new. When the old and new are opposites or contradict, this can be described as a dialectic, a two way stretch (see Chapter 9): A continuous process of shifting back and forward between induction and deduction. The issue of how to present the (nitty gritty) data is of concern to all ethnographers. The method is to bring the registered experience into a relationship with the theory. Analytic points can be made without referring to a full account or to the whole intellectual history of the traditions from which the theory is drawn. Initially I found this shifting back and forth difficult, as I perceived that it was selling the woman short, not telling her whole story. However, a compromise was reached by telling each woman's abridged context and birth stories (chapter 6) as a stage in the analysis process.

I realised at times that I was standing too close to the women and could not disassociate the women from the data. It is well documented that this may not leave space for new concepts to be developed. Bourdieu (2000:8) made the statement;

"I cannot judge my work, while doing it, I must do as the artist, stand at a distance not too far".

Not only was it necessary to stand a pace back I was aware that with each reading of the data, I made judgements that had translation –related decisions attached to them. This was due to the cross-cultural nature of the research (see chapter 5) Illumination was through my own cultural lens and selective judgements on what was important and to what could this be attached theoretically were hard decisions to make.

The acronym TIME, (theoretically informed methodology for ethnography) has itself served to develop the interface between the data and the theory in a synergistic way. Theoretical perspectives can carve out dimensions, insights, concepts and tools, which can be taken and applied to a topic or theme. There is a need for dialogue between scientific knowledge (knowledge produced by specialist institutions) and other kinds of knowledge; knowledge of practical common sense and self reflectively, of common culture, such as will be found in this text. I had come through a rejection of scientific knowledge to the dialectic of seeing the value of the synergistic whole.

4.2.2 Text audience

Webster (1982:106-8) maintains that all text has multiple (minimum of four) audiences; the intended, the actual, the ideal and the fictional. The intended audiences after me will initially be the supervisors and examiners, followed by student midwives, midwives in practice and education or any person interested in birth in Pakistan. The actual audience may only be the supervisors and examiners of the PhD. It would provide me with greater satisfaction to be writing for the women participants themselves, the dai, birth attendants and/or the midwives in Pakistan; the very people who have helped me to write this thesis. However, the priorities of the women I really write for do not include studying my perception of birth for some women in Pakistan, albeit the writing is of their experiences. It is not written in their language, not just English as opposed to Punjabi, but it is in a professional language, using reference material, written again for professionals. The fourth of Webster's audiences was depicted as being dialogue with the others audiences he suggests other audiences may be fiction readers. It may be possible to use the data to inform the story of a woman's life in Pakistan as Diamant (1997) did with the biblical story of Martha the midwife in the Red Tent. For the ideal audience (midwives), it is hoped they will gain insights and understanding to apply to the care of women.

I sincerely hope that the text portrays the life and birth of women in Pakistan, as they would wish it to be, without offence, prejudice or bigotry. My short-term interest (in getting the PhD) must be measured against the longer-term effect of labelling women and

the potential for sensationalising, stereotyping and generalising from the findings. It must be stated clearly that the women in the research can in no way be considered representative of even one small group of women who have given birth in Pakistan, much as a group of fifteen women who had given birth in the UK would ever be considered representative. However, if we do not write, there would be no record, no opportunity to contribute to a body of knowledge and ignorance, bigotry and lack of understanding will continue. This is not to say that the written should replace the oral stories. These are essential and should continue. Perhaps the west can re-learn and take the time necessary to communicate in such a way.

4.2.3 Withholding, a legitimate strategy

Lee (2000) identifies that some researchers deliberately study non-controversial topics. He further states that gatekeepers may veto and subjects either hoodwink or decline to partake in the research. Whilst birth in Pakistan may not be controversial, it is certainly of a sensitive nature. Rather than hoodwinking or refusing to take part in the research, I would consider such strategies as legitimate to protect sensitive information being opened up in the public domain. The women in this study held my ignorance in their hands; however, they did this in ignorance of power. Most women willingly came forward to be interviewed unsolicited, albeit after getting to know me through others first, the others being the gatekeeper and previous women interviewed. The women withheld what they did not want to share. Two women declined to take part in the research; one was not at home after the appointment was made for the interview, the other said she had changed her mind. I celebrated their refusal, as this was a measure of the information around consent.

Fontana and Frey (1994) both state that silence is often justified in accounts of interviewing, but it is seldom considered in its own right as an area for reflection and inquiry. It was so important for the research with women who had given birth in Pakistan that the literature needed to be analysed further. Spradley (1970:80) states;

"The first principle of ethnographic interviewing is to establish rapport and free-flowing information"

Silence in this context would seem to represent a failure on the part of the interviewer. This is suggestive that silence can be seen to be overcome with better techniques or training. However, silence reflects neither interviewee nor interviewer inadequacy, it is not just an absence of voice, it may be a form of constructed knowing (Belenky et al 1997:146) or disconnection, or as a means of relating to authority. Interviewers are exhorted to be non-judgmental and withhold personal disclosure. I judge the rapport with the women interviewed to have been established on the basis of disclosing interest and giving information on my background. Other feminist researchers also condone this as a method to build rapport (Okely and Callaway 1992; Ribbens and Edwards 1998).

One successful professional woman referred to in Belenky's (1997:147) *Women's Ways of Knowing* said

"The older I get the more I realise that I am prepared to talk about things I care about, but only if I know the other person is listening".

There are multiple metaphors used to elevate silence to be above words. These would seem to highlight the importance of attentive, active listening. *'Reading between the lines'*, *'her silence spoke volumes'*, *'silence is golden'* and *'woman of few words'*. Indeed, silence is profoundly meaningful, especially when the text are built upon life story interviews which are necessarily partial accounts, shaped and constructed for the particular situation; the particular relationship(s) within the situation that of interviewer/ee, not forgetting the third person in Pakistan, the interpreter. Each one brings socio-cultural baggage and certain judgements and assumptions about the other. Making sense of what is left out of the interview is then no small undertaking.

Like any problem, it has to be acknowledged to be addressed. Poland (1998) maintains that one way of analysing silence is to begin by appreciating the multiple meaning silence has. There is the obvious one of withholding or resistance; another pertinent (to the research) meaning is the socio-cultural gap of difference. This may reflect what is taken for granted, much as when Kad (the interpreter) would not ask Aia how she felt after her first two babies died – *'because is it not obvious, she will be upset?'* Being a cultural

stranger could have a positive influence on silence. Aia's answer is not obvious, how would anyone know unless they asked and Aia did not appear to have the same reticence that Kad had in the reply. Contrary to this, a cultural stranger may interpret the silence from her own perspective only. That is unless she has considerable experience of the culture. My knowledge, experience and social interaction with Pakistani women for over a decade has brought me some understanding of the cultural norms and values and also the recognition that each woman is an individual.

De Vault (1990) found that making an understanding of silence is particularly salient, and although she does not propose a definitive list of types of silence, she recommends that reflection on all participants' perspectives is vital. Taking account of their role, the context and working on the premise that human beings are actively engaged in meaning making. The 'meaning' I wished to make as the researcher was grounded in the birth experiences of women in Pakistan. The meaning for the women and the interpreter was, without doubt, very different. The silences would come from all sides, from me when I was not following or had been told something so emotionally shocking that there were no words that I could frame the next question appropriately. My silence may also be judged as a cue to elaborate further. The women's silence could mean they do not understand the question, or maybe the memory evoked by the question was not for sharing, or the women did not judge it appropriate or interesting enough, or there was simply no answer. When considering the dynamics of the interview, Mishler (1991) reminds us that communication always entails the joint construction of meaning. Both may struggle to understand the other and the situation of the interaction may also be crucial.

4.2.4 Race as a methodological issue

Twine and Warren (2000:13) consider race to be a methodological issue. They used theoretical debate on the experiences of multiple researchers across a colour difference to reach the conclusion that; '*conducting research in a racialised field of power in the context of racial disparity and oppression has methodological consequences*'. The consequences can be both positive and negative. Positive in the sense that the participants

do not assume any researcher 'taken for granted' knowledge, and negative in the notion that '*whites are basically incapable of grasping black realities*' (Wilson 1995:324). Merton (1972) recommended that it is optimal to have both racial insiders and outsiders conducting research, because they reveal different – not better kinds of knowledge.

The cross-cultural nature of the research on life and birth in Pakistan and subsequent implications constitute an important strand that weaves through each chapter of this thesis. In Adler's (1995) demography of ethnography only 5% of submissions to the journal addressed race and ethnicity, none dealt with how racial ideologies and positions affected research method.

"After decades of self-reflexivity among ethnographers analysing the practices of writing and conducting field research, the lack of sustained attention to racialised dilemmas is particularly noteworthy, considering the degree to which other axes of power have been theorised" Twine and Warren (2000:5).

Further consideration also needs to be given to the perspective represented by Tuhiwai Smith (1999: 42).

"When research is mentioned in many indigenous contexts it stirs up silence, it conjures up bad memories, it raises a smile of knowing and distrust".

Tuhiwai's text focuses upon de-colonialising research methodologies further; information on colonial and postcolonial domination has been covered previously in chapter 2.

The depth of experience (of both the women interviewed and my own field experience) poses a major challenge to qualitative method. For decades, qualitative researchers have been pointedly concerned about the neglect of the inner realm. Arguing that theory and methodology do not adequately take account of the deep emotions or what has been referred to as 'brute being' (Gubrium and Holstein 1997:57). Again, an old type camera can be used as the metaphor to visualise the analysis framework (Polkinghorne 1995). The lens focussing at all times on the words of the women. The emotions and 'inner being' of myself as the field worker constitutes the first frame for the women's words.

These were opened up in the fieldwork log⁹ and reflective diary¹⁰, and framed the initial analysis the words of the women, which were then contextualised and juxtaposed simultaneously with the words (documented contemporaneously). The next filament (frame) which served to expose for scrutiny concerned my 'passionate engrossment'. Coffey (1999:136) advises on the need to address one's influence as a field worker on the words of the women and the emotional dilemmas. This has been a painful but enlightening journey and has documented in 'self as researcher' and 'the dilemmas of self' (Chesney 2000, 2001) and covered in some depth in Chapter 3. This process was an essential part of the analysis framework, which then more conventionally led to the creation of four key issues (Polkinghorne's (1995) common elements) and, because Dil was so different, a case-study approach was reserved for her story (Chapter 6). The key contextual issues (common elements) from the data collected, were cross-referenced and yielded strong elements, which I called sub-themes.

The events and happenings throughout the research cover both groups of women interviewed (S..., Pakistan and R., UK). Although the two groups could be described as vastly different, the criterion for the research was the same; that is birth in Pakistan; data have been cross-referenced for the findings. The next Chapter documents the field trip and data from the women interviewed. The whole is woven with narrative from my experiences as a midwife in the UK and Pakistan. The seed of the research grew from this ground. I saw birth in Pakistan through the eyes of a white western middle class midwife. I wished to temper it, to learn how the women felt about what I had seen. I wished to explore how such practice had developed. I wanted to know why people acted and reacted as they did. This could only be achieved by listening to the women's stories taken in the context of life, with all its personal, social and state influences. Explore the time in the life of the women, the time in my life as a researcher, the environment the interviews took place in, others present at the interview, the established relationship (or

⁹ The collective fieldwork log was a contemporaneous record of events kept by myself, Dot (research assistant) and Kad (interpreter) during the research field trip at the end of each day, this was typed into a lap top computer.

¹⁰ The reflective diary was a contemporaneous record kept throughout the research, completed following each visit to the over fifties group and after each in-depth interview in the UK.

not) with the gatekeeper, women, myself and the interpreter; so many influences on the plot. It is essential that the stories be read in the context of the influences.

Where appropriate, some of the unfolding stories are recorded in a case-study format. The women's stories have been divided into context and birth story in recognition of the specific context and in order to ensure that birth influences are documented and awarded due importance. The aim is that the reader will connect with the women and their story and be able to make a judgement upon the soundness of the themes drawn and the interpretation and analysis undertaken.

4.2.5 The five maps of reflection

An evolutionary developmental process has taken place in the seven years of study. Alvesson and Skoldberg (2000) identify five maps that serve as a framework to describe how reflection can be the frame that holds together the warp and the weft of the dialectic. The first of these maps involved looking at me as the researcher in the research process (Chesney 2000). This emerged to be almost a confessional and involved an exploration of how my life has been transformed by the research experience.

The second map of reflection involved introspection, whereby there was in-depth analysis and examining of myself in relation to the research field (Chesney 2001, Chapter 3). I found myself forever striving for self-awareness, opening out the effect I had on the women in the research. Thirdly, there was the tendency to use reflection as an inter-subjective exploration with a need to look at inner meaning and shared discourse. In the fourth reflexive map, Alvesson and Skoldberg (2000) used reflection to facilitate mutual collaboration. This collaboration was essential to harmonise opposing views, both in the data and within and between the data and existing text. For part of this there was a need to enlist the participants in reflection. Each of the women interviewed was asked to reflect upon their life and especially their birth experiences. The fifth aspect on the map of reflection epitomises the position I found myself locked into for some time and struggled to move out of. This involved the struggle to manage the power balance between the research and the participants. I became preoccupied with the dialogue and

equal representation to ensure equity and the opportunity to hear all the women's words. Although somewhat timidly, my position is changing and I am moving into shaping the words, through concepts, hoping to enhance the message and represent women's voices, both as individuals and as a group to give them more applicability and broader meaning.

The five maps of reflection served as a framework or model to structure the reflective journey into the data to uncover the parallels and differences with birth in the UK and Pakistan through the 1950's to the current time, and then re-discover the obvious. Although it is not always helpful to consider polar opposites¹¹ the multitude of factors influencing birth can be divided into dialectically opposing perspectives of positive and negative influences:

Table 1: Dialectic perspectives of influences on birth in Pakistan

Positive
Birth untouched by obstetric orthodoxy (in the home)
A belief in woman power
Support from women (social)
Negative
Poor health of the women, (pregnant too soon, too frequent, too many)
Abject poverty (chronic malnutrition resulting in chronic illness)
Obstetric practice with no infra-structure in the hospital

The birth experiences of the women who were participants in the research all took place before 1997 (when the interviews took place). The women interviewed in the first group in Pakistan; Aia, Shu, Sha, Mrs A, Shad, the dai told of life and birth experiences in the proceeding five years. Dr Q's story is included as it offers the educated professional

¹¹ The reality is often somewhere along the continuum of the polar opposites.

opinion on the dai and midwifery. Whereas, the second group of women interviewed in R..., Bas, Taz, Ina, (midwife) Farn, Dil, Ria, Fari, Ami (Riz's mother) Naz and Shab, were telling of their birth experience over a decade previously from 1950 to 1980. This is with the exception of Shab whose first child Rabia was born in Pakistan in 1992.

It is relevant to explain the differing time frame of the women's birth experiences, in order to explore the influence of obstetrics and the medical model on care. Only one woman from the Pakistan cohort (Shad) did not mention a hospital. Of all the women interviewed in R..., one still resided in Pakistan and two were on holiday in R... (Taz and Ina). The 'others' had lived in R... for a number of years. All the women interviewed in R... had given birth in the home.

4.3 Rationale for research and method

The rationale for undertaking the research was as stated, the presence of a virtual gap in existing discourse on birth in Pakistan. Belenky et al (1997) purposely included a number of disadvantaged 'forgotten' women, when they examined women's ways of knowing. Davis-Floyd and Sargent (1997:1) highlighted a paucity of good ethnographic studies on middle class ethnic minority women and their childbirth experiences.

"Such women have seldom been examined by academic researchers".

The study on women's experiences of birth in Pakistan would appear to go some way towards bridging this gap, as the woman participants span the social classes from a professor to a cleaner. None of the women in this study have ever been interviewed or taken part in this type research before.

The rationale for the method was to answer the research question what is life and birth like for women in Pakistan. Reason (1996) says that participative human inquiry moves away from the narrow social science purpose of research, towards a living inquiry that can be integrated into the lives of all those involved. Such inquiry, he says, faces the people. The research has made me address the importance of others in research, such as

the women who told their birth and life stories, the interpreters and gatekeepers. It has made me face myself as a person, woman, teacher, researcher and cultural outsider. It has made me face myself as the selector of themes, interpreter of meaning and applicator of theory. Also, very importantly, the women 'faced' their lives in telling their stories. This may have precipitated unmeasurable positive or negative feelings. In the writing there is a need to 'face' the responsibility of 'protecting' the women's words from misuse and misunderstanding. The weighty responsibility of re-telling the women's stories in a way that does not adulterate the original meaning is taken very much consideration was given to my personal ethical stance.

4.3.1 Ethics

Ethical approval to undertake this research was not sought in the formal sense. When the research began in 1997 ethics committees and research governance was relatively under-developed. Permission was given by both the twinning groups in Pakistan and UK to undertake the research field trip. Approval for the attendance at the over fifties women's group was gained verbally through the gatekeeper. Although the infrastructure for ethical approval was loose, great care was given to ensure each woman gave informed consent before the interviews took place (Appendix 2). For the women interviewed in R... (UK) the information was given when the women agreed to the interview and she was asked to take it home and read it carefully. I also asked that they show it to and discuss it with a trusted person, and restated the option to withdraw at any time. For the women in interviewed in P... permission was gained orally from relatives as well as the participants. This was not taken in writing; following a long discussion with Bal, Kad and Shan (interpreters) as they believed the women would be suspicious of the confidentiality once their name was written. The promise of total confidentiality by the use of pseudonyms was kept, although with such a small sample and specific experiences some of the women in the UK may recognise themselves. However, they read the transcripts of the interviews and returned them after approving the content. Explicit permission to publish their stories was not gained; however, the women appeared to translate the study as being a book in the making, asking for a copy when it was finished.

To demonstrate the importance placed upon the ethical stance of the research I developed the following ethical protocol. This was returned to multiple times during the research, especially when writing up and formulating the conclusion.

Table 2 Ethical protocol constructed for the research

Listen, listen, listen, and feel
Inspire, prompt, provoke revision of thought and practice, develop new understanding
Be realistic, resist the temptation to be over ambitious
Focus upon understanding the women
Challenge the reader's thinking to stimulate empathy, analyse with application to care
Shift, poke and prod the dark side, celebrate the light (by the use of dialectic)
Work towards some kind of purchase with policy makers
Consider and declare the researcher effect on the data

4.3.2 Inevitable bias

There has never been any intention to make direct comparisons with the western woman or western midwifery practice, between the women interviewed in R. and Pakistan, although it has been necessary at times to link the reader to the commonly known and understood concepts or parallels to exemplify. Despite the dividing years between the birth experiences of women in urban Pakistan in the 1990's and the birth experiences of women in rural Pakistan between the years 1950-1970, there were some obvious similarities, especially around the role and expectations of the dai.

How to communicate the findings of the research in order to stimulate thought became a challenging concept early in the research. There was also the aim to reach a standard that

would contribute to the expanding discourse on birth in other cultures. However, this was clouded by my lack of faith in my academic ability (Chesney 2001). The need to articulately shape the context and analysis of the women's words and apply appropriate theory served at one stage to obstruct active 'listening' to the data. The major problem however, arose from the responsibility towards the women and their words, not to distort bias or misrepresent the meaning underpinning the narrative.

Lang (1993) explored bias as a concept for writers of history. Although he was relating to various accounts and perspectives of authors in history, it was easy to draw parallels between the historian responsibility to 'get it near right' and the acceptance of their inevitable personal bias. The historian's dilemma helped me to move on and value my interpretations and theoretical application of the women's words, whilst acknowledging the inevitable effect I had as a researcher (Chesney 1998). Lang (1993:10) saw bias as a positive influence not a fault.

"Without bias, we know little or nothing about anyone's opinion of anything"

Not surprisingly, Lang identified that we generally take exception to bias when there is a disagreement with the perspective taken. Often, however, writers are not aware of their own bias; this unconscious bias tends to come through in omissions rather than prose. A particular parallel that connected Lang's work to that of the Pakistani research was his referral to Dee Brown's best selling work on the fate of the American Indian in *Bury my Heart at Wounded Knee*. Brown deliberately set out to present a biased case, biased in favour of the Indians, in order to offset the massive anti-Indian bias of other writers. Whilst I certainly did not set out to present a biased perspective of the dai, the one presented has not been made by scholars in the field previously (Jeffery, Jeffery and Lyon 1988). This made me question my own and the women's words and search even deeper for possible omissions. One can always blame the smallness of the voice (very small sample). An important stage in the research was one that reminded me that everyone has a right to voice experiences opinions and interpretation, as long as that is what it is declared as; an interpretation.

In the interpretation, Denzin and Lincoln (1994:9) advise to replicate the realistic tale and make it accessible to a broad audience.

"Honour the text, do not be afraid to put it in the complicated world and put together in such a way to show honesty and integrity".

I found this an excellent code to follow. Traditionally, science and research seen in the Western World have occupied privileged, preferred position, separate from other processes, judged as value free, apolitical, cumulative, progressive and disinterested in other fields, i.e. practice. Churchman and Mintoff (1993: 15) says that '*science should be the service of humanity*'. Similarly Guba and Lincoln (1994) considered '*people mattered*' and were concerned with the nature of knowledge. I connected with these principles and recognised my feeling of being a 'misfit' as a researcher, when the purpose of inquiry was simply to contribute to a knowledge pool or develop a theory only (Chesney 1998). Susman and Evered (1978) suggest that research (they were referring to action research) is a process that aims to contribute to the practical concerns of people in situations and develop the capacity of people (midwives).

4.3.3 Summary

This chapter began with a statement outlining my philosophical position for undertaking the research. Thereafter the link between my view of the world (ontology) what I see as knowledge, (epistemology) and the most fitting approach to answering the question (methodology) is interwoven with the rationale for undertaking the study. Included in this chapter is the ethical statement and personal protocol developed to overcome the lack of formal ethical approval. Lastly my concern around potential distortion of the data by researcher interpretation is expressed.

5 CHAPTER: METHOD

5.1 Introduction

“The status of all forms of research depends upon the quality of the methods used” (Mays and Pope 2000:50).

Making the reader aware of the processes involved in data collection, analysis and the reasoning behind the steps taken is important to enable judgements to be made about the quality of the research. This is known as decision trailing and according to Hammersley (1992) and Kirk and Miller (1986) is a useful way of demonstrating reliability and validity. This chapter presents, in a transparent way, how the data were collected.

A mixed method design was used beginning with one in-depth interview with the gatekeeper. This was followed by participant observation in the over fifties women’s group and two focus group interviews in R... (UK). Thereafter ten in-depth interviews were undertaken. In Pakistan participant observation was carried out in the maternity hospital, over a two-week period and in-depth interviews with women accessed through the hospital and from personal contact.

The rationale for the multi method approach was to gain information that would help place the women’s life and birth stories in context and to provide an initial sample source of participants. The main data collecting method became story telling through a life story interview (Atkinson 1998). The life story framework was selected after the focus group findings showed that some women had difficulty homing into their birth experiences, out of the life continuum. The recurring answer of ‘no problems’ may have also been due to reluctance by the women to share personal information in a group. Focusing upon the birth experience within the life story served to jolt the long-term memory and provide the important context for an ethnographical study.

Access to the participant¹² women in R... (UK) was through the gatekeeper to the over-fifties women's group (Ria), of which I became a member for a three-month period. The participants interviewed in Pakistan were accessed through personal contacts and a pragmatic convenience snowball-sampling frame. Further data was collected as field notes in a log (in Pakistan) and as a reflective diary (in the UK). In Pakistan Dot, Kad and I wrote up the field notes as a log at the end of each day. This became part of the research journal for the field trip. In this was recorded the findings, feelings and emotions from our individual experiences of the day at the maternity hospital, as well as ideas, fears, mistakes, confusion, breakthrough and problems that were encountered. Field notes were also made following each visit to the over 50's women's group in the UK. The notes made represented a condensed version of what was happening including any extraneous influences. On re-reading the journal served not only as a rich data pool, but also jolted the memory to see events (interview context) that had not been evident at the time.

In line with the aim and philosophy of the research, which was not simply a consciousness raising exercise, but an endeavour to take a step forward with knowing and apply this to understanding to the care of women. The methodology was focused entirely on the women's life and birth experience, in order to reach the women it was essential to address the means of communication.

5.1.1 Interpreter, a problem and necessity

One of the major issues that must be considered within the plan of any cross-cultural research is the assurance that both the researcher and researched are able to communicate. This issue has been a source of much concern during previous trips to Pakistan. Working across cultures presents huge potential for misunderstanding, if there is a language difference, the barriers to communication are insurmountable without the services of an

¹² The use of the term participant or women throughout the text is purposeful. The descriptor, informant does not recognise the involvement the women had in the method and has a colonial heritage linking to 'clandestine activities' which conflicts with the transparency of ethnographic methodology.

interpreter. Although Dot and I have been to spoken Urdu classes for four plus years, and have picked up much understanding from the frequent visits to Pakistan, we cannot claim fluency. Our spoken Punjabi breaks down barriers in its creation of mirth only, it does little to aid communication.

Collecting data in one language and presenting the findings in another (as we did for the interviews in Pakistan) involves what Birbili (2000) calls translation-related decisions, which have a direct impact on the validity of the research. The linguistic competence of the interpreter and her knowledge of the culture are of paramount importance to the research. Having considerable experience of working with interpreters in the health service and during each of the previous field trips (Chesney, 2000), I paid particular attention to the selection of interpreter to undertake the research field trip. Kad was recruited especially because of her language fluency and health background. However, this served to have both positive and negative influences upon her role. She was a paediatric nurse, unmarried and had never visited Pakistan before, although it was her family home. Kad was familiar with midwifery terms, and could speak Punjabi and Urdu fluently and had been socialised in a traditional Asian community with western education and nurse training. However, her age and single status served as a barrier during the initial interview. I had wrongly judged that her role of Sister on a paediatric ward, with a multicultural patient population would have prepared her to communicate across all the age range. However, it was evidently very different in Pakistan as portrayed later. There were also very positive interview experiences when Kad's skills were invaluable.

The translation process was carefully considered I also took advice and had multiple consultations with a team of supportive Pakistani colleagues and friends.

Shan is a midwife who acted as interpreter for me during a field trip in 1995 to undertake an evaluation of the changes that had happened since first working in the Red Crescent hospital in 1989. Shan also translated the tape-recorded data from the preliminary focus groups at the over-fifties group and has acted as advisor to the project. I frequently rang her for clarification of cultural issues.

Bal also acted as interpreter during the latest field trip to Pakistan in 2000. She has also read and commented upon all the data from the interviews. Bal came to England when she was aged sixteen and is now a mother of five - four daughters and a son - all born in R... and is now working as a nursery nurse teacher.

Kad acted as interpreter for the field trip in 1997 to collect the data from the women interviewed in Pakistan. All the interpreters have been invaluable to the research.

The 'Information for women' (Appendix 2) was not translated to Urdu, Sha, Bal and Kad advised that the women who were educated would be able to read English, and the women who had not received formal education would probably not be able to read Urdu. Instead we decided the interpreter would read out the information when asking for permission for the interview, asking the women to take it home to discuss with a relative. The consenting women chose a time and place at their convenience for the interview. Additionally they were advised that they could have with them whosoever they wanted. The interview scenarios in Pakistan were different with each woman.

5.1.2 Conceptual equivalence

Comparability of meaning in absolute terms is an unsolvable problem present in cross-cultural research. Birbili (2000:2) believes that;

"Almost any utterance in any language carries with it a set of assumptions, feelings and values that the speaker may or may not be aware of, but the field worker, as an outsider usually is not. Even an apparently familiar term or expression for which there is no lexical equivalence might carry emotional connotations in one language that will not necessarily occur in another"

Some linguists (Temple 1997) suggest that the effort should be directed towards obtaining conceptual equivalence and this is greatly facilitated if the researcher and interpreter have a proficient understanding of the language also as Birbili (2000) puts it an 'intimate knowledge of the culture'.

It was ironic that Kad had an intimate knowledge of the culture in Pakistan but from a different country, Dot and I were not of the culture but had visited and worked in

Pakistan multiple times previously. Whilst we were familiar with and could follow a conversation in Punjabi, our spoken Punjabi was incomprehensible. Yet Kad was fluent in both Punjabi and Urdu. One could argue that collectively we had a working, not intimate knowledge of the culture. However, we also knew that we would be missing some meaning and therefore could not claim conceptual equivalence.

In preparation for the research field trip Kad, Dot and I held multiple sessions where we rehearsed the interview scenario. Kad knew the intimacy of the questions and none of us foresaw the difficulties that subsequently arose in the real interviews (Aia chapter 6).

An interpreter was not employed specifically for the interviews in R...UK. Although a colleague midwife (Shan), who is of Pakistani origin and acted as an interpreter for me in Pakistan during the 1989 visit, transcribed the focus group interview tape recording (discussed later). Some of the women interviewed in the UK expressed diffidence about their spoken English. In an attempt to overcome this I offered to bring an interpreter to the interview. One or two asked Ria (gatekeeper) to interpret and she declined. Generally, the women did not want me to take another Pakistani woman (interpreter) into their homes. In resolution, most women chose to bring at least one English speaking female family member to the interviews. From my perspective this increased the depth and dimensions, however, there was potential to inhibit, as at Naz's interview there were three generations present, the youngest being unmarried and the issue of intergenerational silence referred to in Chapter 6 (Dil) and Chapter 8, sub-theme blood and behaviour.

There were multiple issues around the transcription of the interview data. These were linked to the manner in which the interview was recorded. Mostly in Pakistan I asked the question in English, Kad translated it into Punjabi and interpreted the woman's answer back to me in English; so I was able to transcribe the interview myself. Kad did undertake one interview alone¹³ in Punjabi and provided me with a written transcription in English (Sha). I found it easier to analyse the data gained from my own transcriptions as memory helped. However, the transcriptions of Shan from the focus group in the UK

¹³ This was with Sha (Chapter 6) there were many distractions (noise) and Kad found Sha's accent to be strong.

and Kad 's interview of Sha in Pakistan presented interesting analysis issues. I was able to stand outside the interaction to see for example, Kad's interview style and Shan's judgement when she deleted narrative not relevant to the interview¹⁴.

Knowledge of the culture, the ability to translate and an understanding of the research subject does not guarantee successful interpretation. It was realised early in the research that the personality and socialisation of the interpreter considerably influences the interaction (Birbili 2000). To maximise effective communication between researcher and researchee, the interpreter must be able to make a skilled and personal judgement on how the information is best managed.

For future research greater emphasis will be placed on ensuring that the interpreters personality and personal philosophy is in keeping with my own and that of the research and that she has an intimate knowledge of the culture (Birbili 2000).

The next section focuses upon the sample selection, the names of all the participants in the research have been changed to ensure confidentiality.

5.2 The participant sample

In the original proposal, the research question was to be addressed by involving participants in Pakistan only. As stated the sampling strategy was to be a pragmatic convenience sample using what has come to be known as 'informal snowballing'.

"The use of snowballing is widely recognised technique in qualitative research concerning access with stigmatised groups"
(Ribbens and Edwards, 1998: 63).

The decision to use this technique was made after initial contact with the potential participants in R... (UK) and, through necessity, in Pakistan. The 'advertising' for

¹⁴ Shan and I had discussed the issue that the women in the focus group may not realise that all their conversations were being recorded; to ensure their privacy was maintained we agreed that she would make a judgement on what should not be included. This occurred 17 times in 5 pages of transcript.

recruits was informal and the starting point was by word of mouth, local knowledge and previous contacts.

During the planning of the Pakistan field trip, the aims of the research were discussed with Ria¹⁵. She suggested that many women in R... (UK) had experienced birth in Pakistan and would be more than happy to talk about it. Ria invited me to interview her and 'come along' to an over fifties women's group she facilitated. As the criteria for entry into the sample was the experience of birth in Pakistan it was agreed with my Supervisor that the sample of women would extend to have two arms, one in R...UK and one in Pakistan. Hammersley and Atkinson (1992: 45) declare that the 'selection' strategy may change over the course of the research.

Changing the sampling strategy brought multiple added dimensions to the data. The women in R...were closer geographically and thus easier to access. This provided the opportunity to follow up interviews and return the transcripts for verification. I called back when it was more convenient (Chapter 6 Dil) and undertook a second interview at the request of the woman and her family (Chapter 6 Naz). The age difference in the two groups was evident. On average the age of the women interviewed in R... was 55 and in Pakistan this was considerably younger at 42. However, it has to be said that when asking the women's age in Pakistan most of the women gave an estimated year of birth. The age of the women linked to the recency of the birth experience. The women in R... (UK) were older and more likely to have experienced birth in Pakistan before they emigrated to the UK¹⁶. Whereas, the women interviewed in Pakistan, were more likely to have had a recent birth experience as the base for the research field trip was the maternity hospital in S...

¹⁵ Ria and I were both founder members of the Twinning Group administered by R... (UK) and S... (Pakistan) Metropolitan Borough Councils. I led the Midwifery team and Ria was involved in all the teams ensuring women's issues were included.

¹⁶ The one exception to this was Shab, she was interviewed in R...following the birth of her second baby, however, the interview focused on her birth experience in Pakistan some four years previous with her first child

The strengths and weaknesses of the sample selection were multiple. The major strength was the range of social groups represented, from a cleaner to a professor. A further strength of using two groups of women was the potential opening out of the data to linear time, by hearing birth experiences across generations. Putting the women's birth experiences together from the 1940's to the current day led to juxtapositions, parallels and seeing any development or change. The many weaknesses in the sample rise from the small numbers involved and the limited time available to establish a relationship with the women interviewed in Pakistan and for the women interviewed in Rochdale their memories may have clouded recall. However, Robinson (1995) found women have an intensity of recall for birth experiences, which was different from other memories.

5.2.1 Typical, extreme and diverse

Access to each of the women participants was peculiar to the place, time and availability of the women and researchers, there was diversity with each woman. Of the women interviewed in Pakistan, Aia (chapter 6) was the eldest and it was Pervez her son who said '*you should interview my mother she had nine of us in Pakistan*'.¹⁷ As researchers we placed emphasis on informed consent. Later we learnt later that Aia needed Pervez's permission, as her eldest son, to allow the interview to take place after agreeing herself.

Although Shu's story could be said to be typical obstetrically, (see 6.15) she had been pregnant nine times with five live children, she was atypical socially as a woman travelling alone in Pakistan. The dai who would not give her name may be considered extreme as she was prepared to talk about other women's birth experiences and not her own. It would have been fascinating to hear her birth stories, as it would have added a further dimension to the research. It would also have been interesting to be able to interview a mother or mother-in-law, who had been the decision-maker at a family birth.

¹⁷ Pervez brought his second wife to the UK to give birth to their son. She (Shab 6.2.24) was interviewed in R...about the birth of her daughter in Pakistan.

Sha (chapter 6) was both typical and atypical, she was at the maternity hospital in S...Pakistan caring for her sister's child and was inquisitive as to our presence. When she heard of the research she put herself forward. Sha had given birth twice, sadly both babies died in infancy. There was no bitterness or rancour around her inability to conceive again, simply an acceptance that her childlessness related to her poverty and Allah's will.

We came to interview Mrs A, like Aia, through a male family member, her doctor husband. Mrs A's husband was in charge of the sister hospital to the maternity, commonly known as the TB (Tuberculosis) hospital. Again the doctor 'offered his wife for interview' when he heard of the research. Contact with Shad was also through her husband, who was the gardener at the rest house, which was our accommodation during the research field trip. The arrangements for the interview are told in Chapter 6, whereby the original date and time had to be changed because of VIP's visiting the rest house. Shad could be described as typical of Pakistani women living in the suburbs, the opportunity to work for payment was made possible as there were wealthy people who wanted servants or cleaners.

Dr Q's story is included not because of her birth experiences; she refused to be interviewed. The story told (6.13) is from the fieldwork log that was completed by Dot Kad and myself at the end of a very trying day. This extreme example is one doctor's opinion of UK midwifery and the dai.

Access to three out of the seven women interviewed in Pakistan was through a male relative gatekeeper. This reflects the strongly patriarchal society. Three of the women were accessed through the hospital (the dai, Sha and Dr Q) during participant observation of birth practice. A four-hour bus journey provided the opportunity for Sha's interview.

The diversity of the sample of women interviewed in Pakistan is evident. There were some women at the hospital who took the information sheet home (after Kad had read it to them) home to seek the permission of the elders prior to interview, none of them returned. This is not surprising, as transport to the hospital would be costly, in time and money. There was no offer of payment for interviews, although in retrospect we could

have offered payment, at least for the transport, or offered to visit their homes, this would have necessitated a communication system and telephones are scarce in the rural areas.

The sampling strategy of women interviewed in R...UK was less opportunistic. Original contact with the gatekeeper (Ria) provided entry to the field (over fifties women's group) and the opportunity to undertake two focus groups, undertake participant observation and for the women to self refer for interview, five took this opportunity. A further five of the ten women interviewed in R...self referred for interview after hearing of the research from social contact with colleagues or myself. This constituted a snowball sample selection.

Dil was an extreme example of difference, as portrayed in detail (chapter 6). The sad coincidence when interviewing Farn was doubled when she told of her relative Naz being a dai in Pakistan. Yet Naz had chosen not to share this during the two interviews in the presence of her daughter, daughter-in-law and granddaughter. Fari the teacher friend of Ria, was initially not confident enough to tell her story without Ria being present, then was the only woman who chose to be interviewed in the community centre. Taz was visiting the UK and attended the over fifties group. When she said that she was returning to Pakistan the following day Ria said 'why not now?' The dynamics in Taz's home were strongly influenced by the past behaviour Taz's granddaughter.

Of the five women who had self referred through social contact in R...Ria as the gatekeeper, Ina the midwife and Shab the second wife of Vez could be described as having diverse constituencies. Ria's story of her work when she came to Britain in the 1950's provides a background of current social and political involvement with the Pakistani community. Ina had been a midwife in Pakistan for over 25years and had undertaken midwifery training similar to what was in existence in the UK at that time. Vez's mother was interviewed in Pakistan Aia and his second wife Shab who had recently given birth in the UK, was interviewed in R...about her the birth of her first daughter. Bas's daughter may have felt that she wanted to repay me for helping her to write a supporting statement to become a midwife, and she 'offered' her mother for interview. A record in my reflective diary following the interview with Bas was: 'that it was bland interview'. However, Bas's story typified the separation through work of the

men in the family, the loneliness of coming to the UK and the lack of support following childbirth.

The sample of women interviewed is in no way representative of Pakistani women either in the UK or Pakistan. The diversity of background does however allow for a glimpse into the lives of a broad spectrum of women, from wide social backgrounds.

5.3 Participant observation

The decision made about where and when to undertake participant observation as a method of data collection was influenced by politics, logistics, convenience, availability and acceptance. Politically, access to women in Pakistan is a sensitive area¹⁸. Visas for the research visit were issued through the Twinning group after the two executive committees approved the research proposal. Permission for the research was also gained verbally from the Deputy Commissioner of S.... Access to individuals was facilitated through known contacts in communities, (R...& S...) with whom trust had previously been established. This had the potential to short circuit suspicion around the use of the data that can arise especially in cross-cultural research (Tuhiwai Smith, 1999). The convenience and availability of both the participants and me was a major controlling factor.

All the women were asked if they were happy with my attendance at the group in R...UK and our presence in the hospital in Pakistan. The staff at the maternity hospital were familiar with our presence, as this was my seventh field trip in five years and Dot's fourth. However, informed consent was obtained each morning from the doctor and the 'staff nurse' in charge. The staff were informed of the aim of the research and given a copy of the Information for Women (Appendix 2). This made the field trip different to

¹⁸ A television company wanted to make a programme of my work in Pakistan and they were denied visa's for entry to the county.

others. Previously we had taught in the morning and worked in clinical areas in the afternoon and kept notes for the returning report to the Twinning group.

The staff were informed in writing¹⁹ of the wish to work with them and the purpose of the research visit prior to our visit. However, we also discussed the purpose of the research during social events (morning tea and lunchtime) and distributed the 'Information for Women', Appendix 2. Most of the staff (except the sweeper) were able to read English, but their spoken English was poor.

The interpreter Kad, Dot and myself worked a full shift every day (for two weeks) at the hospital. The specific remit was to observe the behaviour of staff and women in the hospital around birth and to ask key questions²⁰. Each night back at our accommodation we would tell each other the story of the day. From this, a collective fieldwork log was compiled, documenting the joint experiences onto the laptop as data. The data generated was analysed using the same process as the interviews (Chapter 5).

Data was also obtained from field notes made whilst 'hanging out' in both R... (UK) and S... (Pak). Malinowski, 1967, Carrithers 1992 Okeley and Callaway 1992). Examples can be found in the text of when the standards in a hospital in Pakistan were symbolised by the condition of the curtains (see later). The typical experience of a Pakistani woman solicitor who had recently given birth in the UK (Chapter 8.3 Nadia) and the grandmother who tested the breast milk with a fly (Chapter 9).

In ethnography decisions about where to observe and what to ask, as well as what to record, are crucial to the rigour of the research (Hammersley and Atkinson 1992). The observation strategy used in both R...and S...Pakistan was broad, with the remit to find out as much as possible about women's life and their birth experiences in Pakistan. As well as asking key questions²¹ and listening and watching intently, direct contact with

¹⁹ Staff nurse was informed by letter prior to the field trip.

²⁰ Key question at the hospital in Pakistan, What was your birth like? who brought you into the hospital?

²¹ Key questions, over fifties group R... (UK); Have you given birth in Pakistan? how long ago was this? would you be interested in talking to me about your life and birth experiences in Pakistan? Key questions in

women through the participant observation experience served as a vehicle to build the trust and confidence of potential participants and was the source of many anecdotal stories that brought further clarity to the data.

McNeil (1990) refers to the possibility that the participant observer will become over-involved with the people being studied and so lose the detachment that is considered by some to be essential to the observer role. It could be argued that a certain detachment was inherent in the cultural divide within the research, however, there was no denying the 'connection' that was felt with the staff and the women both in Pakistan and UK.

Field notes were compiled following each visit to the over fifties group, these were analysed using the same systematic process as the data from the interviews (see Chapter 5).

5.4 Focus group/ over fifties women's group

The original plan was to undertake focus group interviews with some women at the over-fifties group with a view to informing the interview guide. Two focus groups were undertaken; one tape-recorded. Due to multiple difficulties experienced, such as both times the women became so animated that they started talking to and over each other, this made transcription impossible. The ground rules had been laid down unilaterally and explained only once so it is hardly surprising that the women chose not to follow them. It is also very likely that I had not explained the importance of one woman speaking at a time. I also found it difficult to shut down the obviously charged multiple conversations that took place, for only one woman to speak.

Attending the group weekly from January to October 1997 (fourteen times) served to cement friendships and build trust and was the ideal opportunity for the women to check me out using their mentor, protector and leader, Ria, as the approver. At first I felt like a voyeur, using the women for my own ends. However, after sharing some of my expertise,

Pakistan, were would you like to tell me about your life and birth experiences? What was birth like for you?

for example, discussing breast examination, 'problems of the menopause' and resuscitation of the adult and child, we laughed and talked freely. This crossed many cultural boundaries. I shared the chores, peeling vegetables and serving the food. The women found it especially amusing that I could not cook.

For the first focus group six of the women 'elected' to bring their chairs around mine. This was hardly a willing consenting group, as it was their previous decision not to go to Paris that was the deciding factor. The Paris group was meeting with Ria to discuss the trip. I began by labouring the issue of consent, concerned over the arbitrary selection. The group appeared confused by my stressing their consent was needed. They had been told by Ria to 'get on with it'. Only later I realised that they may have wanted their lunch. Talking is done before the food then immediately after the food is served, everyone leaves. I was happy in the knowledge that the power within our relationship could and was equalised by women who chose not to contribute, or who give bland replies such as 'no problems' "Tikhey" with regard to their birthing experiences. Yet later, on a one to one basis they were happy to reveal many 'problems'. I came to accept and understand that the "no problems" was symbolic of:

"I do not want to be different, I want to be like other women", "My problems are not for open for discussion in the present company".

This served as effective and appropriate deflection and protection strategies. I became aware that the women may never have talked of childbirth with the group assembled and the group dynamics may militate against open and frank discussion. However, Ria had done the build up so I had to take it from there. I did not use the tape recorder on this visit and began by telling my own story. I shared my experiences as a mother and midwife, with some of the nicer experiences from Pakistan. I withheld the traumatic events and concentrated upon the people's kindness and hospitality, laced with normal but different births seen and conducted by us in Pakistan. Two of the women had given birth both in the UK and Pakistan, so they chose to reflect on the difference, this opened up the discussion a little. So much so that other women from the Paris Disney group who had finished, pulled up their chairs. I felt encouraged when this happened. However, the effect was to lose the concentration of the group. They began to discuss with each other their birth experiences in the UK in Punjabi. I could follow a single conversation if they

spoke slowly, however, multiple conversations across the group became very confusing and I knew I had lost it. So I backed off, regretting that I had not switched on the tape recorder but realising that it was too late. The lasting memory from this first focus group was how the spontaneous opportunity to share birth experiences had erupted into a virtual volcano of animated discussion and the statement from one of the women that an important role of the dai was "*to make you laugh*". This demonstrated to me that an untapped need had been identified. A specific request by multiple members of the group was that I return to continue.

For the second focus group (six women) I began by re-enforcing who I was, what I was doing and why. Stating simply, the aim of the study was to explore women's birth experiences in Pakistan. When I asked if they wanted to introduce themselves on the tape, I sensed a reluctance to be named, so I did not pursue this, recognising the need for anonymity. I thought I would be able to recognise voices. As each of the women knew each other it was unnecessary for them to introduce each other. It was important that the women were all of a similar age and all married, as younger, unmarried women may be forbidden to speak on such issues altogether (Harcourt 1997).

I explained slowly and simply the 'ground rules' and my role, not as a leader but to re-focus if necessary, encouraging them to speak to each other rather than me, avoid speaking all at once and to say what they feel.

At the beginning of the focus group interview, one woman said that the experiences of the women assembled would all be '*out of date*' as many of them were now grandmothers. This simple statement was so obvious, yet I had not thought about it before.

Reading the transcription of this focus group, interpreted and transcribed by Shan, was a revelation and formed a steep learning curve for me as an interviewer.

Until this time, I had not realised the effect and impact of my misuse of words, or the emphasis on the content. One example of this was when I kept mixing up the dai with the midwife, even though the woman was very clear.

W (oman) There was a gap of fifteen months between each of the children

- M (argaret) Were they born at home?
W. All at home
M. Who attended who was with you, the dai?
W dai, no, no, no, midwife (real emphasis)

Yet no more than two questions later I asked

- M. Did the dai push on your tummy?

And again the woman answered;

- W. Midwife, no pushed

Unbelievably further down I am recorded as saying;

- M. Did the dai give you any injections?

The woman by then had given up and answered, 'no'.

I squirmed with embarrassment when I read this transcript I had been repeatedly describing the dai as the midwife and had been totally oblivious to this until I read the transcript.

As in the first stage content analysis (Polkinghorne 1995) of the women interviewed in Pakistan, key concepts were identified from both the context and the birth stories of the women interviewed in R....

The decision to undertake the life story interview was made based upon experience in the focus group interviews. The intention initially was to base the key questions in the interview guide upon what the women felt were important issues around birth, from the focus group. However, they did more than that, the experience and findings served to alter the type of interview, from an open unstructured interview on the women's birth experience, to a life story interview on which the women's experiences of birth were probed in more depth.

The questions used in the focus group were specifically about birth experience and the women appeared to find it difficult to take them back to one specific event. Although birth is memorable and is remembered vividly, without the context and influences of their

life at the time, I judged the women did not know what to tell. Consequently, a life story format was used.²²

5.5 Life Story interviews²³

Atkinson (1998) said that the use of narratives for serious academic study began in psychology with Freud's (1958) psychoanalytical interpretation of case studies. Life story has been a primary methodology of anthropologists. As Spradley (1970) points out, the ethnographer heavily edits some life histories. Editing for this research took the form of selecting out from the narrative; the words were not changed, however, taking words out of context can change the meaning and a specific effort has been made to include the context where possible. Life history and life stories are similar, but the final product can serve a different purpose. The life story is more of an interdisciplinary approach to understanding, not just one life across time but how individual lives interact with the whole or in a specific experience such as birth.

In order to elicit the tellers' reality of the world, a non-standardised, unstructured but focused interview using a life story framework was the method of data collection.

"We become fully aware, fully conscious, of our own lives through the process of putting them together in story form. It is through story that we gain context and recognise meaning. Stories make the implicit explicit" (Atkinson 1998: 7)

Lofland and Lofland (1984) summarises the objective of the non-standardised format as being:

"to elicit rich, detailed materials that can be used in qualitative analysis. Its object to find out what kind of things are happening,

²² Atkinson (1998) makes the point that a life story method is distinguished by being in the first person, with the researcher removed as much as possible from the text. The story then becomes a primary document created through collaboration with the researcher and a secondary research tool for the researcher to use the information

²³ To provide some reality, it was decided to include in this chapter some reference to the women's stories

rather than to determine the frequency of the pre-determined kind of things that the researcher already believes is happening” (Lofland and Lofland 1984:76).

Using ethnography as the methodology was making an active choice that it was the women’s perspective on birth that was being sought, not the researchers. It would have been wrong for the researcher to use pre-determined closed questions in the interview. Key questions were used in an unstructured, but focused (on life events, specifically birth) interview guide. Interviewer effects have been covered in chapter 3 and race as a methodological issue in chapter 4, compounding this Gilbert (1993) reported white interviewers received more socially acceptable responses from black respondents than white. Similarly, black and Oriental interviewers obtained more socially accepted answers than white interviewers. This confusing phenomenon has been borne out by myself and explored in more depth in chapter 3.

Wrapped up as I was in the moral question around the ethics of researching women from a different culture to my own, I endeavoured to ensure the women's words would speak for themselves and that I would never assume the platform of 'expert' (Goldberger and Veroff 1995:16): The expert being someone who upholds that objective knowledge takes precedence over subjective. Locked into the position of questioning my right to analyse and interpret the women’s words prevented me from moving forward, until I found legitimacy in the stories. I hypothesised that the women’s stories may be reduced by analysis and the application of theory with the possibility of losing the individual woman. This perspective inhibited the move to embed the women's stories into a theoretical domain. I needed to let go of the belief that I would tarnish the data by interpreting it. However, I learnt that with subsequent application of theory the effect was reverence of women and their work. Following the exploration and application of theory, a sharper clearer vision of the individual woman is constructed. I particularly liked Ruth Behar’s (1993:16) metaphor of stringing beads when telling a life story.

“I undid the necklaces of words and re-strung them” (Behar (1993:16)

5.5.1 The lost art of story-telling

I have been profoundly influenced by Kirkham's work (1997) on Stories and Childbirth and acknowledge the tremendously powerful effect of language, which makes the inconceivable manageable from our experience. So many women of the world do not have the opportunity to formulate the written word, (if there are appropriate words) to communicate through popular media. They do however have the stories that can create epistemological space, which is the thinking and meaning sparked by stories, which when applied to practice increases understanding. Reflecting on events in the clinical area has become a very important part of learning the art of midwifery in contemporary UK education institutions.

Telling the story awakens the skill of oral transfer of knowledge, a skill that appears to have been lost, forgotten, lain dormant, denigrated or simply just not valued in the western modern society. The oral tradition of knowledge transfer becomes subsumed in the lonely written, printed multi-media message and loses the person so present in the verbal, in the unique richness of non-verbal communication. Re-learning the skill of telling a story is not easy; assessing the interest and level of the listener to ensure attention, to include just enough of the context not to lose focus and take the listener through a journey in the story is an art. The destination of learning from the story is a place remembered because it contains people, a message and meaning.

Story telling as a method requires re-learning the art of listening, not just to the words (or what we want to hear), but to what is absent in the written word - non-verbal, innuendo, inflection, tone, strength, such listening is reliant on real ability. As Heraclitus reminds us, "*it is wise to listen*".

Story telling was the major form of communication within cultures that lacked education. With education came the ability to communicate through reading and writing. Stories lost some of their popularity in favour of information.

It was clear that both groups of Pakistani women interviewed had not lost the art of storytelling; it would still appear to be the mainstay of knowledge transmission. Although each woman told multiple stories, there were more stories evident within the

data from the women interviewed in R... Not all were focused on the women's birth experiences; many provided a vivid richness portraying life as a context for birth. Behar (1993) referred to Walter Benjamin's contrast between story telling and information. Information is linked to industrialisation and capitalism with a need to be shot through with explanation, whereas story telling includes the extraordinary and the ordinary grounded in;

"Chaste compactness which inspired the listener in turn to become the teller of the story" (Behar 1993: 13).

Payne (1951:114) in the art of asking questions epitomised my feelings around interviewing women,

"People are exceedingly gracious when they give consent to be interviewed. We ask them to give their time, we may ask them to expose their ignorance, and we probe their thoughts on untold subjects...all this without even a penny for their thoughts. Free speech works both ways, we may have the right to ask, the respondent has the right to refuse and sometimes it seems as if we do everything we can to induce a refusal. We approach complete strangers, ask them a battery of impertinent (and personal) questions. The surprising thing is the small number of turndowns. Perhaps this signifies that if we wanted we could ask a question in any way we choose and get away with it. But if we keep in mind the ordinary rules of courtesy and good manners, we can avoid giving offence...."

At times it did seem as if I was intent upon sabotaging my research with my insistence on face to face consent (written consent was seen as intimidating and offensive, Chesney 1998). I know that I treated any sign of reluctance or reticence with a smile of admiration for my fellow woman, it made me feel good that women were empowered to refuse.

5.5.2 Stories from R... (UK)

Ria recounted the story of her first son's birth and how the dai and her mother took over when the doctors could no longer help. Fari's story, of following her husband to a new land, how having daughters put her at risk of being divorced or relegated to second wife and the games men play in the reproduction stakes. Bas told the story of being separated

from her husband for over 5 years, of living in a strange country and culture without support. Taz's past life following white leg and a fundamentalist daughter who condoned killing her own daughter; Ina, the midwife who told multiple stories about her training and work as a midwife in Pakistan for over thirty years. Farn's story included a photograph of me and her much loved daughter who died shortly after the photograph was taken, without my knowledge. Dil was different. She challenged stereotype. Her story needed telling in more detail (chapter 6). Naz told the beautiful but sad story of a lifetime of suffering following childbirth and, last but not least (of the R... women's stories); Shab, the widow and second wife who would give away her much loved baby to her husband's first wife.

5.5.3 Information from S... (Pakistan)

As stated, there were not as many stories within the interview data from the women interviewed in Pakistan. The stories were also not as striking or as separable as those told by the women interviewed in R... This supports Behar (1993:12) with the differential between stories and information. Multiple factors may have contributed to the difference, one being the transient temporary nature of the interview relationship. In Pakistan, we did not meet the women before the interview, whereas in R... we met prior to the interview at the women's over-fifties group, (with the exception of Taz). Although other family members were present during the interviews in R... (except Fari), there was no interpreter as in Pakistan. Also the venues for the interviews in R... were all but one (Fari) in the homes of the women, whereas in Pakistan there was only one woman interviewed in her own home (Aia), although Mrs A was in her husband's surgery which was attached to her home.

Key features from the data of the women interviewed in Pakistan were: Aia's health and family genetic problems; Shu's diabetes and the influence of the Pir on the health of her children. Sha, childless after both her babies died was now accompanying her sister to hospital. Allah's will and poverty prevented her becoming a mother. Mrs A' experiences of birth in a private hospital and her husband's belief that an instrumental delivery caused

their son's torticollis. Shad's bond with Kad the interpreter, her work ethic and missing child, the one her father-in-law had given to her sister-in-law. The stark key feature of the interview with Dr Q was that I should know my place; she was superior by virtue of her education, theoretical knowledge counts. Lastly, the dai who would talk about her work but not about her own births. Her knowledge gained from the experience of delivering seventeen babies a month mostly boys, told of intervention and patience.

Individual stories and related key events have been shared many times with midwives and students in the UK. This has served to spark understanding, so that the learning can be transferred into the care setting. I came to realise that these stories merged and metamorphosed into collective allegories or parables the more often I told them.

Undertaking and analysing the interviews personally has encouraged me to really listen to the whole of the communication. More and more is 'heard' with each reading and re-living of the interview, layer upon layer peeled away to reveal the multiple levels that can reveal a brighter, hopefully clearer picture of women's lives and birth experiences in Pakistan. One layer that took the analysis into further depths and clarity involved consideration of the women's stories as symbols.

5.5.4 Symbolism

The concept of 'birth beyond language', and the issue of an absence of vocabulary for many of the sensations that womanhood and childbirth evokes, heralds a huge and personal responsibility for delicate sensitive interpretation of women's words on birth. There is a possibility that some of the indescribable emotions, feelings and experiences can be transmitted and translated through a story, sentence or word that is symbolic of the experience and allows translation of symbols/ stories across cultures. However, there will always be the danger of cultural bias and misrepresentation (Birbili 2000, Twine and Warren 2000). This is less likely if the interpreter has knowledge of both cultures and their potential differences. The concept of semiosis will allow me to act as interpreter of the symbols the women used in their accounts of birth.

In a society where women are oppressed, the women may perceive censorship of their opinions so much that they become mute. This would result in a holding back or shrouding of what may be construed as questioning the hierarchy; where this is the woman's mother-in-law, husband, mullah, politician or anyone seen to be superior. The women may not feel they have a right to express an opinion, especially one of opposition. Whilst the women interviewed did not overtly question the hierarchy, religion or the gender domination (except Dil), their strong opinion shone through in the stories around relationships, the community, family and childbirth. However, the stories were shrouded in symbols.

The man who became the father of a fourth girl symbolised his acceptance by telling us that "*I will buy clothes for the baby*". His wife and his mother-in-law were so disappointed that "*they said let her die*".

Further statements that were symbolic include, "*I gave birth alone because I did not want my father to hear*" and is symbolic of socialisation in a society that deems men more important than women. Similarly, "*I was dressed as a boy and called a boy's nickname*" was confirmation of gender preference.

In a culture where it is of paramount importance not to offend, telling a story that has a negative message of any nature has the potential to insult. Thus, it may be necessary to wrap the message up in symbols. I was told a story that linked the deterioration of the hospital where the woman had given birth four times over a period of eleven years. The curtains were used as symbols of the deterioration. For the first baby there were new curtains in the hospital, for the second baby, the same (old) curtains were there, however they were clean. For the birth of the third baby, the curtains were dirty and for the fourth baby there were no curtains at all.

5.5.5 Story-teller

It has to be acknowledged that stories say as much about the teller as they do the subject. The story must connect in some way to the listener for it to be remembered to re-tell. Davis-Floyd and Sargent (1997) found that knowledge was situationally based. They

questioned the idea that knowledge is in peoples' heads, i.e. you either have it or you do not. They found that women 'knew' in one setting and did not in another. This was not a question of being semiotic, modest or intimidated by doctors or others, but of social interaction, in one group knowledge could be displayed and in another it could not. The social network of the dai, the women and her relatives are grounded in a community, this is where their knowledge shines. Outside the community/family, women do not share their knowledge.

Thus to give birth in her own home (over 80% of women in Pakistan, Kasi 2002) the woman is surrounded by other women who have a community 'standard' knowledge that values and includes intuitive women's knowledge. However, like Davis and Sargent (1997), I became aware of times when some kinds of knowledge count and others do not. An example could be drawn when Shu took her babies to the Pir, even though the first baby died, she took the second baby because she was told the reason the first baby dying was that she had not taken him to the Pir soon enough. For her own diabetes, Shu sought the assistance of the medically trained doctor.

5.5.6 Summary

The West lost a valuable source of knowledge transfer when it handed over the majority of its communication to the written word. The art of story telling brings the powerful non-verbal into the arena of communication. Non-verbal can be used where words are not yet created. Being present at the women's story telling brought to the data just as much as the words. The power of a story with a meaning, a learning point to be made, may equal a tome of theory and can amount to a vicarious experience. The statement, every picture tells a story, is suggestive that other senses are important in story telling. Observing, listening, touching and smelling are all-important to story telling and listening. The skill of the storyteller has involved a developed ear to listening to the story and the listener in the telling. Learning not to transgress cultural norms, shaping the words into symbols so they do not offend are all higher level skills that I have been privy to, in listening to the women's stories of their birth and life experiences. As all knowledge is situationally

based, knowledge transfer and its standing in the community will shape the practices of those attending birth at home in Pakistan.

5.6 Transcription to interpretation

A dilemma apparent within transcription that has received scant attention in the qualitative text (Edwards, 2001, Denzin, 1997) has served to trouble me since beginning the research. This is the potential for the transcription and application of theory to alter or contaminate the meaning behind the women's words. Compound this by what Lofland and Lofland (1984) describe as, the 'agony of omission', which is the choice of what to extract or leave out. One is left with the responsibility of the researcher to ensure the process is open to scrutiny and remains true to the philosophy of ethnography. The words of the women have remained central to the theory application, the selection of key concepts and main themes can be tracked back through the data, and my own personal bias and belief systems are explored in depth in the previous Chapter 3, *Myself in the Research*.

In the pursuit of openness, considerable effort has been taken to declare myself in the research, a virtual 'coming out' with the quest for transparency in favour of contextualisation of the method. It must be recognised that context is by nature infinitely delicate and infinitely expandable. Also, the use of paralinguistic and non-verbal information to inform and second-guess symbolic value across a culture is problematic (Du Bois et al 1983). I have to conclude that transcription is an inherently subjective process that can never be neutral. Gumperz (1981) cited in Hammersley and Atkinson (1992 :253) clarify the issues within the dilemma of transcription for me when they state:

" ... Transcription is inherently selective, this selectivity is based upon the knowledge, beliefs and interpretation of the researcher; researchers must strive to explicate their decision making".

I have tried not to disguise the system used, defined the procedures, been open to critique from all the readers along the way. Whilst recognising that I am undergoing a process of being created and re-created even as I write, read, think and speak, my position will

change. The women trusted me with their words; the reader needs to trust in my honesty and integrity. I need to open out the systems used in the process of collecting, analysing and recording of the women's stories so that the theory and discourse application does not serve to 'academicise' the women's words into sterility. So the research becomes a western perspective of birth for some women in Pakistan.

5.7 Analysis framework

There was a personal struggle to move into and beyond analysis of the women's words as far as the application of theoretical concepts. Difficulties were experienced in drawing boundaries around concepts as they overlapped, much as real life does. The result was a layering, overlaying and merging within a framework of the individual woman's story. Some of the concepts held personal painful parallels and connected to my own experiences of life and birth. The contrasts were, however, exquisitely culture bound. It is through this sieve of social context that the dialogue and discourse around birth in Pakistan is analysed. The whole is viewed through my cultural lens.

After being locked for some time into the autobiography part of ethnography, the move to analyse the data was a slow deliberate process, beginning with a search for an appropriate theoretical framework. This took me back into the data to consider different perspectives, which in turn contributed to the data analysis. Trinh (1989:) succinctly portrays the reality of analysis:

"What we 'look for' is unfortunately what we shall find...it is perhaps difficult for an analytically trained mind to admit that recording, gathering, deciphering, analysing, synthesising, dissecting and articulating are already imposing our structural activity. Rare are those who realise what they come up with is not a structure of their (women) narratives but a re-construction of the story" (Trinh 1989:141-142).

Whilst I do not consider myself a rarity I saw the truth behind Trinh's words. This led me to question every step in the process of analysis. Analysis of the data from the women interviewed in Pakistan was initially attempted using an amended Alasuutari's (1995)

framework. Alastuutari (1995) used the metaphor of purification of the observations and unriddling of the data. By this I interpreted that he meant taking the data and cleaning (distilling) until key concepts emerged, thereafter, the process of 'unriddling' involved interpretation of the concepts using current theory or published literature. On reflection, the action of 'cleaning' brought with it an uncomfortable feeling of misplaced power.

As a consequence, I searched the literature for an analysis framework that was more philosophically equitable between the women and me. Polkinghorne's analytic framework (1995:5) was attractive in its simplicity and applicability. This is based upon certain steps that are used in analysing narrative. Two analytic approaches specifically designed for ethnographic research are proposed, Polkinghorne (1995) and Childress (1998).

Polkinghorne's (1995:5) first approach is the analysis of narrative, involves collecting the data and analysing the content. This has certain parallels with Alasuutari's (1995) model of analysis, with the emphasis on the unriddling. The second approach Polkinghorne describes as narrative analysis, which involves asking questions of the text from the perspective of those involved and synthesising the context.

Polkinghorne's (1995) framework was adopted because it goes beyond simple analysis of the narrative into the deeper, broader 'narrative analysis'. This took the events and happenings (the women's words and my experiences) by means of a plot into stories. For example, the grandmother's account of the colostrum as poison (chapter 9) and my learning from the student midwife who acted as the woman's advocate (footnote 55) have become stories that will have meaning for any midwife providing care to women. Within the stories there were case (Dil chapter 6) and/or biographical episodes, for example the journey on the bus (chapter 6). The stories then move to common themes (Chapter 7& 8), then from the elements full circle back to stories as depicted through the transformation of learning (Chapter 10).

It was Behar's (1993:12) differentiation between information and stories that helped me to see that the data from the women in R...(UK) and Pakistan had differences. I hypothesised that the rationale for this was that in Pakistan it was not possible to establish

a trusting relationship with the women prior to the interview, thus, the stories told by the women were more information sharing and a simple content analysis of the data could be employed;- Polkinghorne's *analysis of the narrative* (1). The established relationships, (through the over 50's women group, and community knowledge), with the women interviewed in R., brought much more context. As a consequence *narrative analysis* (2) was a more appropriate analysis framework to utilise. Analysis of the data (1) was undertaken with both groups of women. and an attempt at narrative analysis was made with the transcripts from Pakistan.

Further to using Polkinghorne's seven steps. Childress's formulae was applied to all the data using multiple perspectives analysis (asking ontological and epistemological questions of the data) as recommended by Childress (1998).

Core and sub-themes emerged from the rich data that was nurtured from the application of Childress's questions and adaptation of Polkinghorne's seven steps (adapted from the seven principles for analysis of narrative):

1. Include description of context
2. Attend to the embodied knowledge
3. Mindful of influential others
4. Address the central character
5. Attend to the historical continuity
6. Generation of a story
7. Understandable and plausible

(Adapted from Polkinghorne 1995:5-23)

Applying the seven steps to the analysis framework gave a multidimensional approach to the findings.

Table 3 Analysis framework

<p>1. Polkinghorne (1995) analysis of the narrative (<i>parallels Behar 1993 'information'</i>)</p> <p>Analysis of narrative follows the traditional content analysis model. Concepts either from existing theory (deductive) or inductively from empirical material, theories concepts.</p>
<p>2. Polkinghorne narrative analysis (<i>Parallels Behar's 1993, 'context'</i>) Events /happenings</p> <p>Synthesised by means of a plot (at least 4 readings) into stories</p> <p>Stories to common elements</p> <p>Elements to stories (parables or allegories)</p> <p>Case-studies and biographical episodes</p>
<p>3. Childress (1998)</p> <p>Multiple perspective analysis – ask questions of the data</p>

Three examples selected are covered in more detail in the women's context and birth stories Chapter 8 are:

Ria's story of her son's birth, the transport story and Shu's life experience.

Ria's story applied to the 7 steps

(1) Ria's description of the birth context (6.2.11) clearly informs the listener of what was important to Ria (2 embodied knowledge). Throughout the story (6) Ria is mindful of influential others (3) her husband and the doctors', the central characters being her aunt and the dai (4). This took place some thirty years previous (5 attend to the historical continuity) and whilst the story was understandable and plausible (7) there were elements that more focused questioning may have clarified. These include the number and presence of multiple doctors at a home birth and the baby's head being 'out' for 'many hours'.

The transport story applied to the seven steps

The description of the bus journey and the context (1) is written in Shu story (6.1.4/5) and constitutes the direct experience of the researchers thus is embodied knowledge (2). We, the researchers were indeed mindful of the effect on the other people involved (3), namely the other passengers on the bus. The central character being Vez (4) who negotiated the removal of the other passengers and the historical continuity (5) in relation to the colonialist background of British rule Pakistan. The story that is generated (7) is almost too painful to be plausible, yet undoubtedly occurred.

Shu's story applied to the seven steps

Shu offered freely vivid description of her birth experiences (Chapter 6). Her embodied knowledge (2) explained and explored the death of her only two children. She was mindful that it was Allah who influenced whether she should be a mother or not (3) and Allah was also the central character (4). Historical continuity (5) was portrayed as she told of both her son's birth and eventual death Shu's current position in the family as 'helper to her sister-in-law'. The story told exemplifies the life of rural poor women (6) when taken alongside the neonatal mortality statistics (7).²⁴

The process of narrative analysis (as above) was the method used to analyse all the data. In order to become completely embedded in the events and happenings I read the reflective diary, fieldwork log and the interview transcripts over multiple times. Each time I saw, heard and experienced (cognitively) multiple different perspectives. As each new concept revealed itself I wondered why it had not been obvious before. However, the marker that underlined the themes came from taking the analysis one step further, as per Childress (1998) formulae. This step involved exploring the text (interview data fieldwork log and reflective diary) using certain questions.

1. What was my influence on what the women are telling me? This fed back into the 'me' in the research (Chesney 2000)

²⁴ Pakistan Government November 2001 Poverty in Pakistan, Interim Poverty Reduction Strategy, Policy Wing. Poverty Reduction Planning commission (Paper 1-PRSP)

2. Did the presence of others influence the interaction that took place between my self and the women being interviewed?

Both these questions focused upon relational ontology (selves in relation to others, Ruddick 1989:211)

Further questions asked of the data involved the epistemology of the women (what counted as knowledge to them) and the ontological framework (how the women made sense of their world). Where is the woman being interviewed coming from? What social experience underpins her story and why this part of her highly complex life can be opened up and shared?

The plot began to emerge through the epistemology and social relationships evident in the ease or unease of the dialogue, which at times was obviously rehearsed, (through previous telling). At other times there were surprises, to the women themselves and others present at the interview; stories of an intimate and sensitive nature about a topic that is not ventured into with ordinary conversation or to 'just anyone'. My passport to acceptance had in it a picture of me as a midwife and the immigration stamp of having visited and worked in Pakistan.

For each of the women interviewed there was a 'package' of data, which included floppy disks and hard copy of:

- Original interview transcripts
- Amended transcripts (women in Rochdale)
- Content analysis with lists of concepts (plotted onto a frequency table, for confirmation that the dai was the key person)
- Analysis following Polkinghorne (from which the sub-themes were formulated)

There were two further 'packages' of data, the reflective diary from each of the 14 field trips to the over 50's group and the field work log completed by Dot, Kad and myself during the research field trip to Pakistan in November 1997.

5.7.1 Further questions

Certain questions arose that I felt I had to address. First, could it be that as a relative stranger it was easier for the women to be outspoken and bold. Or was it that my stereotypical perception of Pakistani women was being challenged? Can any description from an outsider remain faithful to the framework of the subjects or is it inevitable that the stories are rendered in my terms? I could not go back to the women and ask them the answer to the first question; I needed to examine my hackneyed viewpoint. The more I analysed the second and third question, a clearer yet more complex picture emerged. It was an 'ah ha' moment for me when I read Behar (1993), who found that ethnographers, historians, journalists and fiction writers are all purveyors of a range of 'false documents'. Whilst the thesis would not be all false as in fiction, it could be accepted as valid to have the interpretation of an outsider.

"Telling of ethnographic tales relies on blurred or mixed genres, and makes it increasingly difficult to give a single label to the work. The text we write today partake of a criss crossed genealogy and fluctuating value...they are made in one place to be read in another"
Geertz (1983:36).

The realisation stirred by Geertz led me to question what makes ethnographic truths valid discourse. Just to ask the question is evidence of the influence that post-modernism has brought to me with its partiality of truth. When the women entrusted me with their stories they knew of the cultural border that the stories would have to cross in the writing. I did not hide behind a Pakistani researcher to have credibility as a researcher. Ethnographic data and their analysis need to be evaluated by women of the same generation and background. It would have given me great pleasure to be writing this thesis for the women themselves as the audience. The final recognition of ethnography as valid discourse comes if the content, words of the women and the interpretation and analysis 'hits home' for the reader.

A fitting theoretical underpinning to the words of the women arose from the understanding that ethnography is...

"A writing practice in which the other is inscribed and explained by the power of the ethnographer's language" (Grosberg 1989:23).

6 CHAPTER: THE RESEARCH FIELD

6.1 Introduction

The following chapter details, describes and analyses some of the data obtained from interviewing seven women in a town in the interior of the Punjab in Pakistan and ten women in the North of England town in the UK, about their birth and life. The words of the women are set into the context of the environment and interface with significant others, focusing specifically upon the women's birth experiences. As each woman is unique and in order not to reduce their life stories to 'snippets of information' as described by Childress (1998), key issues from the narrative have been explored from multiple perspectives. The inclusive perspective contains information on the context and the emotions of others involved. Namely the dai, female relatives, myself as researcher, Dot, a retired British midwife and Kad, a British paediatric nurse who acted as interpreter during the research field trip in November 1997. This visit was the fifth out of a total of nine field trips to Pakistan for me. Dot had been three times before and it was Kad's first ever visit to her parents' homeland.

In order to present a clear word picture for the reader of what birth is like for some women in Pakistan, it was decided to introduce each woman within the context of her life and the interview situation first; followed by the individual birth story. This constituted the first stage of content analysis. It became evident that the data from the women in R.... contained more contextual knowledge. I judged this to be due to additional context information from the participant observation undertaken with the women in the over 50's group. As the researcher, I 'knew' the women in R... better. This knowing may have been because they were more westernised and could shape their stories so that I could connect with them. It was apparent that the data from the women interviewed in Pakistan had an 'information only' feel, where as the data from R... generally could be developed further.

The women interviewed were asked to place their birth experiences in the context of their life story. This was because a life story is not the experience itself but a representation of it; the findings from any research that uses this method could be argued to be more representative of how the woman sees herself, her ego and identity. Superimpose on this observation from cultural outsiders, with our own socio-cultural baggage, and the life story is

no more than what the women wish to tell and the researchers have the skill to interpret and write.

The format will be to first present the women interviewed in Pakistan, followed by those interviewed in R.... Each woman's story is written first as context followed by birth. These were the initial findings from content analysis (Appendix 4), referred to as 'analysis of the narrative' (Polkingthorn 1995). The key issues that emerged from each of the women interviewed are woven into the 'narrative analysis', which will be presented in the main findings chapter. The whole will be laced through with my reflections and current relevant discourse.

6.2 THE WOMEN INTERVIEWED IN PAKISTAN

Table 4A: The women interviewed in Pakistan:

Aia, born in 1937, was interviewed in her own home and she was the mother of Vez ²⁵
Shu, was interviewed on the bus, she was born in the mid-1950's and was diabetic.
The dai was interviewed in the maternity hospital She did not want to give her name or age.
Sha was interviewed at the maternity hospital, she was born in the 1960's. She was at the hospital caring for her sister-in-laws young child.
Mrs. A. was interviewed in her husband's surgery. She was born in 1963, she worked as a Maths Professor.
Shad, was interviewed at the rest house and was born in the late 1960's. She was the gardener's wife.
Dr Q ²⁶ , was interviewed at the maternity hospital and was born in 1957, she was the Doctor at the Maternity Hospital.

²⁵ Pervez was a longstanding friend who lived in Pakistan. He would meet us at the airport and we stayed overnight in his home on the journey to S...

As stated, more than just biographical information was seen to be necessary to provide context to the women's stories. Key issues that arose from the interview were used as headings to elaborate on the context that underpinned the lives of the women, so that the reader would develop a paper relationship with the woman, seeing her individuality.

Following the contextual stories from the women interviewed in Pakistan, the women interviewed in R...will be introduced and the same analysis process undertaken.

6.2.1 Research field relationships

The relationship between Kad, Dot and myself during and immediately after the very first interview in Pakistan underwent considerable 'storming'. It became apparent that we (Dot and I) needed to convince Kad that we genuinely cared for Pakistani women. It was as if Kad could not comprehend why we chose to help and work with the women in Pakistan. Kad wanted to protect the women from our questions. Whilst we admired her for this, at first we took her actions to be defensive and almost paternalistic. She presented in Pakistan with a *'how can you possibly know or understand these women'* attitude. There was a particular incident outside the Imran Khan hospital in Lahore.

I stopped to talk to the mother of a child who was playing on the grass. As I squatted down to talk to the mother, a natural question that I could frame in Punjabi was *"how old is the child?"* Much the same as I would ask when talking mother-to-mother and not for the research. I sensed Kad's unease with this and did not continue except to give a big smile and say the child was beautiful.

As Kad pulled me away, she told me that I had no right to ask about the child. The reason was that I am white and the mother would feel obliged to answer. I realised then the source of Kad's mistrust. It appeared to be rooted in colonialist supremacy. Knowing this helped us to understand and work towards breaking down some of the barriers. It was essential to convince Kad that we would never 'use' women. We welcomed and wanted her to protect

²⁶ Dr Q refused to be interviewed about her birth experience, she is included because of her opinion on the dai

the women from feeling they had to answer, but also wanted her to know that woman-to-woman communication on personal matters may also come from a genuine interest and a wish to help.

At the beginning of the first woman's interview (Aia), I asked (through Kad the interpreter) a personal question. I was stunned when Kad turned to me and said:

"I cannot ask that question, this woman is my elder...it would not be respectful".

I was taken aback, Kad and I had had many meetings prior to the field trip; she knew the research was about women's lives and birth experiences. Why had I not thought about the potential age barriers before? I had no wish to offend anyone, least of all Aia, so I asked Kad if it was only herself that would be embarrassed or both of them. Kad explained that she would not like anyone to ask her mother such questions. Subsequently I realised that the barrier was not just age alone. Kad was unmarried and as such this excluded her from such talk. Harcourt (1997:101) describes how younger, unmarried women are forbidden to speak on personal issues.

This situation had the potential to compromise the whole research field trip; a resolution had to be found. Most of the women we would interview would be older than Kad. I asked her if she could consider that she was not asking the question, but me, using her voice. We both rationalised that she could do this, providing the woman being interviewed was happy. How we judged this was more difficult. After a long discussion and with no firm conclusion, it was decided that we would both use our intuition, in line with the woman's verbal and non-verbal response. Kad was given a clear mandate to protect the women from my western cultural norms and expectations.

As the interviews and field trip continued, Kad's acceptance of us became apparent. She became easier with discussion on personal matters and relaxed her shield of protection to the point of initiating questions herself. A similar situation arose in my community midwife days (Chesney 2000); when I learnt that it is possible to command respect, but true respect is given when it is earned.

The interview with Aia was not the first experience of listening to stories of family tragedy and heartache. During previous visits to Pakistan, stories that have shocked were sometimes told in a detached factual manner. Some have sat in a corner of my memory and when stirred, bring with them an all-consuming sadness. Two, in one field trip, involved a middle-aged doctor who ran a private obstetric hospital. The doctor had just had cause to sack her sweeper *chockador*, for taking money from the women before allowing them in to the clinic. The very same night of the sacking, the doctor's only child, a three-year-old daughter, was stabbed to death. She had stopped for a drink on the way to her grandma's. With regard to the blurred professional boundaries in Pakistan, Upvall, Sochael and Gosalves (2002) carried out research into the role of the Lady health Visitor (LHV) across all the four Provinces in Pakistan. Fifty-two lady health visitors (LHV's) were interviewed, and it was found that they often perceived that they were undertaking a medical role, as some physicians in the rural areas would refer all the female patients to the LHV. This information must be taken in the context of a distinct reluctance of doctors to work in the rural areas and there being only 816 Registered LHV's in Pakistan. Furthermore there is only one registered nurse for every three physicians (Ghauri 1998). We also observed a LHV whose role it was to visit outlying villages, prescribing and administering medication, working as a doctor. I reflected that it was not the role boundaries or the title that were important, but the presence of an informed person to advise and treat. Many of the large villages in the rural areas (up to 10,000 population) had no health facility at all.

6.2.2 Aia, context story

My own long association with Vez and his wives included being present on the birth of his son by a second wife, Shab. This forms the backdrop of this interview with Vez's mother Aia. As with each of our field trips to Pakistan, Vez met us at Islamabad airport. Knowing on this particular trip our mission was to interview women who had given birth in Pakistan, Vez offered his mother to be interviewed. I felt concerned that he had not consulted his mother before putting her forward to be interviewed. I pointed out that the permission was not his to give, and we would only proceed with full consent of his mother. Vez's reply was,

“as eldest son, his mother would not agree to be interviewed unless he said it was okay”.

So she would have needed his permission before agreeing to be interviewed. Such intra-family consent is a common Pakistani social norm, both in Pakistan and in R.... In 2002 the husband or a member of the in-law family are required to give consent prior to a caesarean section in Pakistan (personal communication, (P.c) Lee)²⁷. Consent for an educated young man to travel to England has to be gained from the matriarch back in the village in Pakistan. Consent to become a nurse or a midwife has to be gained from brothers (Ina Chapter 6). Permission was needed from a mother-in-law for a woman to act as my interpreter (Bal Chapter 6), the life of someone within an extended family is built upon collective decision making. Evidence of this is presented later, regarding the decision when to call the dai and crucially, when and if to take a woman with complications in labour to hospital.

Aia is a 60-year-old woman, whose face and body give the impression of a troubled life. She is small and round with a square shaped face, denoting her Indian Punjab origin, rather than the lean taller stature of her Pakistani, Punjabi sisters. The interview with Aia took place in the presence of Aia's daughter-in-law; however, she did not contribute at all. I viewed her role was one of 'protector' and 'advocate' for Aia. The presence of another when interacting with the world outside the family is standard practice. Attending a doctor or the hospital alone is unheard of. Later I will refer to 'being alone' as a reason not to go to go hospital when in labour and 'sitting in' during doctor's surgery, whereby none of the patients spoke to the doctor; that was the role of the person accompanying.

Aia's father's business was selling crockery. She attended school for seven years, learning Urdu and Arabic, not English. Her parents were *'very strict and old fashioned'*, they had eight children - four boys and four girls, one brother died of Typhoid. During puberty, Aia's sister-in-law informed her about 'periods'. Aia married when she was fifteen years old, delivering her first stillborn child when she was aged seventeen. Her second child was a girl,

²⁷ Lee is a pseudonym used for a midwife teacher who has worked for over 50 years in Midwifery in Pakistan. Lee undertook her midwifery training in the 1950's in the UK and Bachelors degree in the 1970's in America. Lee is the link person in a joint project between myself at the University of Salford and and the Lady Dufferin Maternity Hospital in Karachi through the British Council.

born at seven months but '*died after living only fifteen hours*'. For this birth Aia '*was alone*'. Not only was there an ambiguity about the number of births Aia had experienced, but also where they took place: "*I had all my babies in hospital*" yet, "*VeZ (the eldest live child) was born at home with the dai*". As stated, I did not feel it was appropriate to explore or probe further to establish exactly where VeZ was born. We had not established a close enough relationship and I did not want to be seen to 'doubt Aia's word'.

Aia seemed very happy to talk about herself and became especially animated when referring to her physical problems. However, one could detect the questions on childbirth were not important to her. It was evident that Aia appeared to be looking to us for help to ease her pain and suffering. It was also apparent that she gained some relief by being able to 'talk about it'. Petcheski and Judd (1998) said that the research process itself could become a way of validating women's experience. Benmayor (1991) Khana (1996) also identify that the process of research with women should be valued as much as the outcome. Despite Aia's appreciation of our listening skills, she still asked us to prescribe the latest modern, western medication.

The data obtained from Aia's interview is clearly 'information' and reflects poor questioning technique, based upon a limited relationship. Furthermore, it reflects the focus of birth from a midwife's and not Aia's perspective. Aia would have liked to talk about her health problems, not birth experiences. Thus, the interview with Aia tells the reader just as much about me as the novice researcher as it does about Aia's life and birth experiences in Pakistan.

6.2.3 Aia's birth story²⁸

Aia married her first cousin and the family has been blessed with special children. Aia's first two babies died. One was '*born in ball*', and the other she gave birth to alone. Thereafter, Aia became vague about the number of children she had given birth to, "*nine or ten*". A further baby died in infancy, the other in his late teens. During the interview, two other

²⁸ Kad acted as interpreter; I asked the questions and typed Aia's answers directly into the laptop computer

children were in the home, Vez's nieces. The older child (aged fifteen) looked very much like a younger Shano (Vez's daughter). With simple calculations, this family had six children who were, or had been, unable to communicate effectively, or live independently. The stress of this showed on the face of the matriarch. Aia's physical health was poor; she suffered from frequent bouts of debilitating jaundice and had chronic emphysema.

Aia attended for antenatal care "*when the doctor called her*", approximately monthly. This reflects the social status of her family. For her first birth she

"ignored the contractions for a while... then the baby was born in a ball, 15 minutes after the doctor came, he picked up the ball and the baby came out of it".

Her mother-in-law was dead and her sister-in-law was young, so she had no one to be with her. Although she went to the hospital for all the births (first telling), later Aia said that

"Vez was born at home and the dai came. No one pressed upon Aia's stomach in labour, but a plate with sand in it was placed upon her abdomen after the babies were born', she also had to lie with her feet crossed for four hours. Vez was born at home in Preshawar before the dai came ...children happen quickly; the dai cut the cord and took away the placenta. The position for delivery (in hospital) was ...feet in stirrups (our interpretation, following a demonstration of Aia holding her hands up)...."

"...in the hospital and birth at home, walked around until lay for birth"

Aia informed us that "...two more of her children had died, one aged fifteen...", query cause and "*one aged ten - twelve, an accident with a bus*".

Aia breast-fed all her children, after giving sugar water plus salt for three days,

"...to get rid of the bad milk"

A record made by us in the fieldwork log was that the information often did not add up. That is where the babies were born and how many. However, we did not pursue the discrepancies as this may have been construed as doubting, disbelieving, or worst of all, finding fault.

I struggled to search for the right words to say concerning the sad loss of her first two babies. For this reason I asked Kad if we could explore Aia's feelings at the time of the births. Kad turned to me and said quietly but emphatically

*“There was no point in asking such questions like – how did you feel?
As it would be obvious that she would be upset.”*

I was confused by Kad’s comments and at the time considered her comments immature and judgmental. Almost immediately I went on to consider that maybe she was right, perhaps I was imposing my cultural ‘way of helping’?

There was an ambiguity around the number of children Aia said she had given birth to. Also, the venue for Vez’s birth changed from home to hospital. Aia told us that she had given birth to nine or ten children; her vagueness may have a parallel with the story about the anaemic woman. This woman did not want to tell the GP how many children she had in case she was tempting fate and some harm may befall them. Such superstitious beliefs cross cultural barriers. I remember well being afraid to talk, even think about cot death, in case it was a premonition. Similarly, buying and bringing home the cot and pram before the birth is considered by some to be bad luck by some English parents.

Aia chose also to be vague about the venue for her births. She did say that all her babies had been born in hospital, yet her first was *“born in a ball before the doctor arrived”*. It is feasible that it may have taken fifteen minutes to get a doctor to the hospital. However, I cannot imagine that a member of staff would not have tried to rescue the baby from its watery grave, had she been in hospital. Also when Aia delivered her second baby (who lived fifteen hours) she was on her own, maybe again in hospital, but more likely at home. Aia’s story changed when she talked of Vez’s birth. He is her eldest son, and when he was born, *“the dai cut the cord”*. Aia’s reasons for lack of clarity can be speculated upon. She may have wanted to bridge the cultural gap and adjusted her story to fit what she considered were our terms of reference; she may have wanted to impress us as birth in hospital was more the western norm. The poor reputation of the dai, the upper castes would ‘pay for the best’; this was perceived to be the doctor.

Aia’s interview raised multiple important concepts within her birth and life story. Four especially fed into the context of life in Pakistan. The first involved the manner in which we, as white western midwives, were given the honour and status of a doctor. Having a relative that is a doctor accords the family the highest status in Pakistani society. Asking for medical

advice was according us the highest status position in Pakistan society and it may have been her way of complimenting us.

The wealthy educate both sons and daughters to become doctors. However, following marriage, few of the women will work outside the home as it carries the stigma that the husband cannot afford to keep his family.

Exploring the context of Aia's interview identified the ambiguity and vagueness around the number of children and their health, which hid the superstitions that exists in most societies.

The death of a child alters the evolutionary process and age theory. Western society expects age to bring death and the process to be, birth, marriage then death, whereas in Pakistan and other developing countries the process so often is, birth, death, marriage death.

Scheper-Hughes' (1993) anthropological writings on child death and mother love has provoked much debate in Brazil. The 'mortal neglect' of doomed infants and the practice of 'letting go' is characterised by the mother's apparent 'indifference'. By placing this 'neglect' in the rich cultural social and historical context, Scheper Hughes opens up a host of theoretical and methodological questions. Some of these relate to assessment of different cultural behaviours, one example may be when a mother considers it 'dangerous' to allow herself to love the baby when death will take it from her. Anger and recrimination may be seen as 'odd behaviour'. There may be a willingness to attribute the death of the baby to 'its aversion to life', making the death wholly natural, almost expected. The apparent 'acceptance' of death as a part of life for women in Pakistan was a major dilemma for me. However, Behar's (1993:77) quotation from the story of how Esperanza's first four babies died, also rung true of the women in Pakistan,

"babies who are living, had not yet died"

This links to an extract from the fieldwork log on 16.11.97:

"Kad said "someone is delivering; she has just come by tonga" (horse and carriage). As I walked into the labour room, I looked at the baby on the trolley. Immediately I was alarmed, for although the baby was not blue, pale or cold, she was lifeless. The staff ignored her... four of them surrounded the foot of the delivery bed. Aksar (Staff nurse in charge) was suturing the woman's cervix ...the vulval

area was swollen to ten times its normal size and I could not differentiate the tissues, there was just a mass of raw tissue. Aksa (staff nurse) kept chanting 'dai handled'. Kad dashed for my stethoscope...there was an odd heartbeat. I opened the baby's tiny mouth to begin resuscitation...her lips were moist and pink... but her tongue was black.... I went no further. I turned to inquire if the mother knew...staff nurse said without emotion, 'It's OK, it will be alright.' What did she mean?

Coming from a society where babies rarely die, and if they do it is a great human tragedy for all concerned, it must have been strange for the staff and the woman to see Kad and my reaction to the baby girl's death. Equally so it was hard for us to accept the blasé attitude of the staff. This experience was earth shattering for Kad and me, but neither the mother, relatives nor staff showed any emotion. Were they so used to death that in order to protect them it could be considered Allah's will? Would resuscitation have been attempted if this had been a baby boy? I castigated myself for not giving this baby just one breath of life or, at the very least, picking her up and giving her one cuddle. I did not reach out beyond the colour of her tongue, had I given up on her as well?

This baby girl seemed to epitomise the whole of the country's feelings towards its women. To turn its back on them, ignore and consider unimportant.²⁹ Small consolation was gained from knowing she will not suffer the vagaries of life as a woman in Pakistan. Following my self disgust I turned to anger, directed towards the staff, the relatives, the government, the society at large, the culture, men for having the supremacy. Anger turned to deep sadness, thereafter helplessness and shame. All that I could have done and I did nothing gave nothing. The woman herself, as a mother, would be feeling devastated. Her responsibility was to give her family a son and she had again failed; this does not mean that she did not love her baby girl, her indifference may have been to protect herself from the grief, or the baby from a life like her own.

²⁹ This is not a suggestion that women would feel this way towards their dead babies (Shad Chapter 6) was 'heart sore' many years following the death of her children.

Scheper-Hughes (1993) exposes the danger of inferring subjective world from visible behaviour and the ethical and political responsibilities of the anthropologist.

The interview with Aia was not the first experience of listening to stories of family tragedy and heartache. During previous visits to Pakistan, stories that have shocked were told in a detached factual manner, despite the women being ordinarily emotionally charged and sentimental. There was only one out of the seven women interviewed in Pakistan who had not experienced the death of a child (Mrs Ahad).

6.2.4 Shu context story

The next interview took place on the bus journey from Lahore to S...; the woman's name was Shu. The concepts that emerged from Shu's interview which bring light to the context of life for women in Pakistan were transport, gazumping and colonialism.

This important contextual issue began before we got on the bus for the four-hour journey from Lahore to S... We had stayed with Vez overnight because he had been unable to get us tickets on the one and only early morning train to S... Vez bundled us into a taxi and his car and we toured Lahore looking for transport to S..., which is a 100 miles south of Lahore. The expectation that Vez would be able to ring a taxi or bus company and they would pick us up at his home was not realistic. Subsequently I found out why. Gazumping is the way the transport business operates: Our booked transport would stop to pick up any other customers who were immediate business.

After two unsuccessful stops at garages we arrived at a very busy bus station. Vez and Roy (my husband) went off to negotiate a vehicle for the journey. We saw our luggage being offloaded so presumed the transaction had been successful. Trying to keep our eyes to the front, we were guided through the seething mass of people, diesel fumes, greasy pools of water and piles of rubbish, to a twenty-seater bus. Vez asked me to inspect the inside of the bus to see if it was acceptable. The curtains were pulled, it was dark and very dirty, and the smell hit me at the door. Strewn across the floor were piles of pistachio nutshells, peel from oranges and soiled paper bags with dark stains hiding suspicious contents.

There were six or seven dark figures sitting on the bus. We were told that it was air-conditioned and that it was about to leave for Lahore. I felt I could cope with the dirt, but the smell of sweating bodies and piles of rotting vegetation turned my stomach. I came off the bus and said "*No thank you,*" Vez's eyes narrowed and I felt guilty. Was I being a colonial snob? Vez had his daily business to see to, he had been so hospitable and courteous and we were holding him up. The dilemmas of previous visits washed over me as familiar feelings of frustration; helplessness and dissonance welled up. When I whispered to Vez that it was the smell, he dispatched a man who came scurrying back with a scented aerosol air spray. I was astounded when the man mounted the bus to spray both the human and vegetable contents of the bus. I was beside myself with shame and embarrassment. In the ensuing discussion with Vez, he informed us that we must consider this bus our only means of getting to S... that day. Cornered, I nodded to Vez and took a step towards getting on the bus. What followed left me reeling.

The man who had been watching and seen my head lower in a half nod of agreement strode onto the bus and ordered everyone off. It transpired that Vez had been negotiating with the bus driver for an empty bus. I asked Kad what was happening. She said the people getting off the bus were very angry, saying to Vez, "*we are your own people why are you doing this to us?*" I did not blame them at all and tried to inform Vez that they were on the bus first (had paid their fare) but his reply was, "*the deal had been struck*". For the cost of twenty-five pounds we had hired the bus; our money was evidently more attractive than the fares already paid by the passengers who had to get off the bus. With bowed heads, amid the dirt and pungent smells, we got on the by now empty bus to begin the journey to S....

Whilst waiting to set off, Vez asked us if we would agree for a woman to travel with us, as she was also going to S.... It was small recompense for the trouble we had given to her fellow countrymen and we readily agreed. This story is told to demonstrate some of the complicated issues that continue to operate in Pakistan, such as capitalism, colonialism and gazumping as a norm.

The woman's name was Shu. We had made polite conversation and she asked us why we were in Pakistan. Shu offered to talk about her life and birth experiences, without even being asked. It was unusual for a woman to be travelling alone, however, we did not feel it

appropriate to ask why this was the case. I typed the interview straight into the laptop. Shu told us her age (forty-two years), which in itself was enlightening as Shu's knowledge of her birth-date demonstrated her social class. Although it was a question we asked everyone, the majority of women gave us a frown and a guess, 'forty or fifty' was typical. Although there is legislation on statute for birth and death registration, the certificate for birth is not seen as important or necessary, that is until the former is needed for a passport, which for the vast majority of Pakistan people will never be a possibility.

Shu's father was the clerk to the Deputy Commissioner (DC). There is a DC appointed to every township by the Civil Service. They are rotated at least every three years to limit corruption. The DC is the most powerful man in any town and is the person to whom we relate in S.... The problem is the lack of continuity; we have dealt with over ten different DC's since 1989, some supportive some not.

It is against this backdrop that we, as white British midwives, have experienced two contrasting reactions to our presence in Pakistan. Both are inextricably linked to Britain's colonial history with Pakistan. An example of the first reaction came from a man who showed us his birth certificate with the date 1895 clearly stamped upon it. This made him 102 years old and he was still working as a Dhobie (washer) and night watchman. He believed that Pakistan had

"Gone downhill since the British left, there is no law and order or jobs now...the British built up Pakistan".

An example of the second contrasting viewpoint on the colonial past came from a group of elders we met after a meal at a hospital. They believed that Britain purposely did not build sewers or introduce a clean water system to 'control' the people. The latter group of gentlemen judged British society as decadent; using the divorce, crime, teenage pregnancy and illegitimacy rates as evidence to support what they judged to be an amoral society.

The incident around hiring the bus stirred in the people who had to be first of all sprayed and then removed exhibited justifiable anger and resentment towards both Vez and us. They could not believe that Vez would behave this way towards his own countryman. This was in the context of what was expected from us. Vez told us later that it was incidental that we were British, as other Pakistani people could have been the ones gazumping to get the bus

for their own requirements. There was another experience we had on a journey back to Islamabad airport, escorted by a council official. We had two punctures and as a consequence did not have a spare tyre. The driver spoke to a policeman who was directing traffic. He then stopped the next passing taxi that already had a fare, ordered him to take us to the airport first and then take the man to his destination. The taxi driver and the man followed the policeman's instructions without question and we were left grateful but embarrassed.

6.2.5 Shu's birth story

Shu informed us quite clearly that she had four boys and one girl living. One boy and one girl had died and she had two surgical abortions. We worked out that she had then been pregnant nine times, however Shu was adamant that she had been pregnant six times. This again fits the pattern of ambiguity and vagueness around the number of births a woman has undergone.

After confirming that none of Shu's pregnancies were multiple, again we did not feel it appropriate to pursue the matter any further as it may have appeared that we doubted or questioned her word. However, we reached the unsaid conclusion that Shu was not counting her abortions as pregnancies.

Shu told us she was educated from the age of six to fifteen years. She got married when aged fifteen years and delivered her first baby when she was aged nineteen. Her first born was delivered at home, "*as there was no-one to go to hospital with her ...so she called the midwife*". We noted in the fieldwork log that Shu felt that the hospital was of a higher status than the midwife was, and she (Shu) did not want us to get the impression that they could not afford the hospital. Shu said her husband was strict, saying

*"The dai complicates things, call the doctor, but the doctor did not come, midwife came"*³⁰.

³⁰ Often there was mixed undefined use of the terms dai and midwife, however, Shu and her husband saw a difference.

When the midwife did come she did not do anything although she,

“Did press on her tummy...but only a little as the baby came out quite soon”

Shu informed us that she *“walked around first and then she lay”*. When Shu got pregnant again she was diagnosed diabetic; the doctor told her that the child would be abnormal so the next two pregnancies were aborted. Shu said she went for an antenatal check-up *‘when the doctor called her’*. When asked what the doctor did at these visits, Shu replied *“just an internal”*.

All Shu’s births took place at home, however, with her fourth she was entirely alone *“my husband was ill in hospital.”* Her mother-in-law was dead; she even had to go for the midwife herself. All the midwife did was *“hold her stomach and made the pain go away”*. A private doctor came and gave her an injection that cost the equivalent of five pounds.

“After 15 minutes the baby came”.

Someone told Shu that her husband knew

“The midwives at the hospital were no good and they only complicated cases to get money”.

It is interesting to see how Shu’s husband was discrediting the midwife at the hospital. This story of complicating the birth to get money links also to many stories told to me by women in the hospital in Pakistan. The dai who would not give her name (Chapter 6.) also mentioned giving injections to get money. Finding a person to blame for why events go wrong is not a phenomenon peculiar to birth in Pakistan. The current system of monitoring ‘near misses’ through Clinical Governance for the latest clinical negligence insurance schemes is crucial in the UK insurance (Ashcroft, Elstein and Holm 2003). These feeds a culture where someone has to pay, evidence of learning from the situations is insufficient; money has to compensate, people held responsible. Human error, or the possibility that there is a force greater than the doctor, professional or even the woman can control, is not an option anywhere in the current UK system. However, in the rural areas of Pakistan, ‘in shala’ not only applies to time meaning ‘it will happen’ but that it is God’s Will. As Sha said in (6.26/7) with God’s will she got pregnant and it was his will equally that both of her babies died

When Shu was aged 22 years old she gave birth to a baby girl. The midwife delivered her and massaged Shu's abdomen in labour, however, the child was ill from birth and died when she was nine months old. Shu took the sick child to a religious man (Pir) but the baby died before the Pir could 'finish' what he had to do. The child that came after this one again got sick but Shu took the child *earlier* to the Pir and it lived. The Pir could not lose; the blame for not taking the baby sooner was squarely on Shu's shoulders. Blaming herself for not taking the child to the Pir earlier freed the Pir of any blame. This is a perfect example of the use of authoritative knowledge, whereby in defence of professional practice, women, family and, at times, the baby, are blamed when things go wrong. This is familiar practice in the medically dominated system of care delivery operating in the UK, whereby the woman not the state is blamed for poverty.

Norris (1998:13) links early religious tradition to the control of women by apportioning blame.

"...for three transgressions a woman would die in childbirth... the loss of a baby is not misfortune but the mother's fault"

Blame where one is not culpable and guilt for doing the best one knows are burdens that women and mothers carry silently. The sad part is that the women believe it themselves, so continue to blame each other, when support would be more helpful.

Shu was very superstitious. She told us:

"it was my eighth baby that got ill and died in her eighth month of life and was ill for eight days".

Previously Shu told us that the third baby girl died at nine months of age. She was convinced that someone had put an evil eye on her and her baby.

"When she was born she was fat and pale (denoting health) like an English person"

In a society where privilege and power are the monopoly of the fair skinned (Behar 1993:8) it is hardly surprising that Shu and later Farn (Chapter 6.) were pleased that their children had fair skin. At thirty years old Shu delivered another child, this child "*also had a curse*",

but again she took the child to the Pir. He gave his blessings and told Shu to put a bit of the Qur'an in cotton and tie it around the baby's neck³¹.

Shu's stories of her babies' deaths, especially the 'pale fat baby' would, with medical knowledge fit with Shu's diabetes. The option of taking her baby to the doctor instead of, or before the Pir would not even be considered; this would fit with scientific rationalism and a western health belief model, which could be described as the antithesis of Shu's belief. However, as Schott and Henley (1996) identify, superstition is also woven into the western culture, so much that it often goes unnoticed. What people believe can have a profound effect on their lives; tempting fate (Chapter 6) is a common cross-cultural belief. Making preparations for a baby before the birth or, in my own case talking about cot death, felt uncomfortable, in the irrational belief that I was preparing myself for it to happen.

The themes around difficulties with transport, colonialism, blame, guilt and superstition further colour the backdrop of the canvas on birth for some women in Pakistan.

6.2.6 The dai who would not give her name

An opportunity to undertake the third interview in Pakistan arose when a dai brought a woman into the hospital because her membranes had ruptured some twenty-four hours previously and she had not gone into labour. The context around this interview has two threads; one linked with our 'status' as white western midwives i.e. our *official* presence and all that this involved, the other pertained to the clinical issues around the management of labour. Firstly, we explained to the dai who we were and why we were at the maternity hospital. She was very interested and wanted to have her picture taken and be on the video. She formally agreed to the interview, yet when we began by asking her name, just for the records, explaining that it would be confidential, she would not tell us. She "*did not want the authorities to get it*". She also refused to talk about her own birth experiences - she had ten live children - but would gladly talk of her own practice as a dai. This may connect to the

³¹ Amulets or charms are used to ward off the 'evil eye'. In Pakistan people combine this approach with herbal cure. The evil eye is the name of a sickness transmitted by someone who is envious. Elsworthy (1995)

previously identified reluctance to talk of the children's health as it may be tempting fate (Chapter 6).

She proudly informed us that, as a dai she delivered between ten to twenty-five babies a month. The previous month she had delivered eighteen babies, fifteen boys and three girls. The ratio of boys delivered to girls is especially interesting; it is known that a family will 'pay' the dai more if she delivers a boy. The preference for boy babies becomes a priority if the woman does not have a son at all. The theme of boy preference is covered in more detail (Chapter 8).

The dai told us that she never before had brought a woman to the hospital, but this time the family had wanted to come, saying she will '*need stitches*'

Never bringing a woman to the hospital may have two meanings; either there has not been a need or, more likely, the dai has sent the woman but not actually gone to the hospital with her. The disagreement with the family over the management (stitches) may also be evidence of current media influence questioning traditional practice.

The interview was arranged around the question, what would you do if...? Beginning with how would she know if a 'case' was straightforward or if the woman needs an operation (symbolic of needing further referral to the doctor or hospital). The dai said an operation would be needed if: -

"The head and neck is across (transverse) "or if when I am feeling inside I cannot feel the head but the back or the bottom".

"If the baby was coming with feet first ...you would move the baby by pushing on the abdomen...If the pains were coming every five minutes, after three minutes and the baby is not moving any further.... Wait for an hour, two hours, see if the baby was moving forward, or not, see if the mouth of the 'verk' (uterus) is opening, if not then send them to hospital...don't wait at home at all..."

We explored the breech presentation more.

"Okay, if the feet are coming first, that is okay, if she is not a good dai she will send to hospital. If she is trained, she will do the delivery, ...she will get the foot out and then another and if it is not coming, she will start the drip and with the contraction the head will come...."

When we queried the drip in the home, the dai became distracted and said she did not understand. As we had no wish to corner, offend or sabotage the rest of the interview we elected not the probe and moved on. We reflected later that we had been given the 'book practice' Jordan (1993) found simple interviewing to be inadequate, she said:

"It is not that women lie, some have acquired the ability to judge what the interviewer wants intuitively, as competent social actors, they adjust what to tell"

We asked the dai if she listened to the fetal heart in labour. Her answer was in the affirmative. Further to this, we asked what should be done if the heart was slow and the dai told us she would do nothing. In retrospect, neither of us defined 'slow'. The dai described and demonstrated her actions if the baby was blue or pale or if it did not cry. *"You turn it upside down and pat on the back"* She then demonstrated how she would give mouth to mouth resuscitation. When asked what she would do if the mother had a 'fit', the dai shook her whole body, confirming her understanding of the question then said,

"This is polio; I would send her to hospital..."

When we asked what would be done if a woman were bleeding, we were told

"...I do deliveries patiently...you shouldn't give an injection to increase your bill, some (women) have a lot of bleeding because the dai give them too many injections... because of their bill... they are too forceful... that is why the bleeding happens."

"...there is an injection, inject it into the vein and ...lift the feet up...I do not know the name of the injection... it is the doctor that gives it".

The unnamed dai's knowledge of an injection to stop bleeding, even knowing it goes into the vein, was countered swiftly with the denial of it being part of her role to administer it. Yet, she openly said other dai give injections to increase the bill. To give an injection is seen as a higher level medical skill that is out of the domain of the lay person. Moreover, it appears the injection may be valued for its mode of delivery rather than its content. Upon reflection, student midwives in the UK also place the same importance on injections.

Drug legislation in Pakistan is in line with most other bills on statute; they exist but are not enacted. Ahmed (1991) confirmed this when he says; *"the laws of Pakistan criminal, civil or revenue just do not apply"*. Anyone can purchase Oxytocin providing they know its name;

local drug stores are on every street corner and throughout the bazaar. Dais buy Oxytocin, the pride of the delivery kit is the syringe and vial (personal communication). Jeffery Jeffery and Lyon (1988) calculated that fifteen per cent of women in the villages in India were given Oxytocin, not just for bleeding but to stimulate contractions, make the womb strong (dard barhana) and the baby come. It has been identified as the 'women's drug' in Bangladesh (McConville 1989 and Kitzinger 1989).

It is ironical that the climate in Pakistan affects the potency of Oxytocin; to maintain its efficacy it needs to be kept at four degrees centigrade. Even the hospital does not have a refrigerator, so when the drug is needed for haemorrhage it has lost ninety per cent of its potency. However, if repeated injections are given intra-muscularly at the potency temperature during the first stage of labour, the uterus will be hyper-stimulated and fetal hypoxia will result with an increased risk of a ruptured uterus, especially in the presence of any cephalo-pelvic-disproportion. Communicating my concerns to the doctor at the hospital with regards to the blanket policy of Syntocion for all women in labour, was not altogether successful.

The dai then went on to tell of the responsibility she had with regard to giving tetanus injections to each baby.

"Two hours after birth also polio drops ...I tell the child's mother and other women a lot that they should have their children injected and have polio drops...I give the children myself...one...two...three. On the eighteenth of this month it is our responsibility for the polio drops, I intend to get the centre ready for team...to see they are not giving too much to the child or too less..."

There followed a discussion on the placenta, the dai proceeded to tell of the function,

"That is where the child receives all its goodness"

She went on to demonstrate how she delivered the placenta, when asked what she did with it and stated emphatically that,

"She did not do deliveries on the floor. I do them on the bed and some good cloth..."

Obviously a misunderstanding, we reiterated the question, to which she replied.

"The placenta is put in the fridge at the hospital, but at home it is put in a container, close it and they put it where they (mother) want, some bury it underground, how can we carry them to hospital?"

On the question of pay the dai said,

"...there is no money given to staff for the delivery ...even if you give it to celebrate the birth, they do not take it"

Upvall, Sochael and Gonsalves (2002) in their study of LHV's across Pakistan found that 'extra fees' were collected. The researchers had personally witnessed this, even though it was not allowed according to government regulations.

The following story is taken from a record made in the fieldwork log (14/11/97) and symbolises the social value and effect on a family of having yet another girl baby.

"The woman the dai had brought in appeared wary of us; this became obvious when she was ready to give birth. I asked her permission for us to stay for the delivery and she shook her head. The dai tried to countermand this and pulled us into the room. The dai asked my opinion on whether the IV was necessary and asked me, through Kad, to 'check' what the staff were doing, to make sure they did everything right".

It is conceivable that the dai was prepared to talk about her practice freely in exchange for us 'keeping a watch over the staff' with regard to the care the woman the dai had brought to the hospital. This is suggestive of her not trusting the staff at the hospital.

On reflection, the dai answered to the western framed questions on management of labour were what she wanted me to hear. The 'right', in western terms, answers, were based upon a western paradigm. The dai midwifery knowledge was derived from the positivist perspective, which relates closely to an illness cure model as opposed to an existentialist and phenomenological informed humanistic paradigm, which one would expect of a traditional birth attendant. It was evident that the dai had undergone some western influenced training. As the research has evolved, the weight of western influence upon midwifery practice in Pakistan becomes ever clearer, even within dai practice. The textbook replies of the dai assured me that in western terms this dai was safe to practice, but she was not practising in town in a hospital in the UK, but in a village in the rural area of Pakistan.

The dai's interest in us and why we were in Pakistan, plus her determination to be on the video and to be photographed did not fit with the reluctance to be named and identified on tape. This, combined with her willingness to talk at length about her dai practice but not her own birthing experience, had us speculating. We understood fully why she did not want to be named, in case of retribution or being questioned by the authorities. Moreover this would have been an acceptable reason not to talk to us at all. However, we felt that she really wanted us to know that she knew her practice and was proud of it. We recorded that she may be reluctant to talk about her own children because of 'tempting fate', as discussed following Shu's interview, under the heading of Superstition. Perhaps she did not really understand the technology or permanence of the photograph or video, which even with limited availability and ownership in S..., was difficult to believe.

6.2.7 Sha context story

We met Sha at the hospital. She had come with her sister-in-law who was in labour. Her role was to care for her sister's other child. Gaining Sha's consent to conduct the interview was difficult. This was not because she was reluctant; she was very keen and made it clear there was status in being interviewed, but because Sha's dialect was so strong. Kad described her accent as 'rough'. It was necessary to ask Sha to repeat her replies. This was especially difficult because Sha was caring for a fretful child. At one time Kad said we would have to abandon the interview. This was explained to Sha, who promptly took the baby outside, handed him over to a stranger and returned. We were not entirely happy with this but did not want to disappoint Sha, so we swiftly moved through the interview, which was punctuated by Sha wanting to listen to her voice on the tape after each answer. Once it was audio taped, Kad found that on transcription it was easier to understand.

Sha was not sure of her age, "forty or fifty". She was married at aged fifteen. Our interest in age confused and amused her. We wanted an approximation. Kad and I could have guessed, wrongly, at fifty-five. After the interview Sha had given her age some thought and returned to us saying she was twenty and fifteen.

It was following this interview that it occurred to me how inconsiderate I had been to Kad. This was her very first experience of the Maternity Hospital and Pakistan. She had only known British hospitals and it must have been a culture shock to her. Although she 'fitted in' with the language and dress, the scenes and behaviour must have been totally alien to her. I had taken so much for granted, expecting her to follow dialects that were as thick as I imagined the Scottish or Welsh would be; difficult enough, without being engulfed in a totally alien environment that shocks the senses.

Due to the multiple difficulties around translation and the environment for the interview, Kad took Sha off outside on her own to continue the interview. By this time, Kad had helped me to interview three women previously, so had a fair idea of the focus for the questions. However, when I read the interview transcript, I realised how interrogative the style of interview was. I recognised it immediately because I had only just moved from there myself. Kad did not probe to open up Sha's answers on feelings. I realise that this is expecting the impossible. Kad was young, unmarried and was also in an alien environment, with incredible demands placed upon her.

Sha's determination for the interview to continue is suggestive of her being *important for the day*. In a society that values the role of motherhood; having experienced childbirth, not once but twice, without being awarded the place in society of mother is further excentuated by secondary infertility. Thereafter Sha is relegated to helping her sisters at the time of birth and caring for others' children, this must be heart rendering. Yet Sha believed "*it is up to God to give a mother a child*". With this belief then, Sha has to accept God has made a choice that both her children were to die and she was not to conceive again. The picture building is suggestive of Sha earning God's decisions for some transgression she is totally unaware of. This is reflective of what Norris (1998) identifies when she says '*lose a baby and die, it isn't your misfortune, it is your fault*'.

6.2.8 Sha's birth story

As stated, Sha had given birth to two babies and both had died. When we asked did she ever go to see a doctor her reply was,

"No never...with the first or the second...both were born after nine months...dai did not deliver baby, ...after that there had been a fault... scarring inside.... We are poor, so I cannot have any treatment...but it is up to God to give a mother a child"

Later Sha retracted the statement that the dai did not deliver saying,

"A dai delivered both children...at home, ...there were two other women with me my father's sister and my husband's sister". "No drip or injection", and "both babies cried at birth". .

The dai cut the cord with a knife, she had

'cleaned with clean soap', they did not (push)...with God's will the baby will come".

However, when we further explored, Sha did say that there were hands upon her abdomen "firmly" and, when we checked, "did the dai push?" Sha said

"Yes for both children... some dai put their hands on the abdomen and push (demonstrates)..."

The position for the birth was "I lay down to deliver..."

On being asked how did your babies' die?

"...Nothing really...got a cold...he was born in winter and he got pneumonia...the other a temperature and then God's will..."

Kad asked 'after the baby was born did you work or did you rest?

"No...what work would I have done?"

The 'matter of fact' way that Sha told of her babies' deaths does not link to apathy or passivity. Neither is it suggestive of her not caring, however, it is symbolic of her accepting the almighty power of Allah's to control her life, to give and to take away. Work is only considered so when there is payment, house or homework is a duty. Sha's duty now includes supporting her sisters with their children.

6.2.9 Mrs A context story

The next interview took place in the home and surgery of the Tuberculosis specialist physician and his wife, who gave her occupation as a Maths Professor. There are many mixed feelings around Dr A. We have met him many times both in R... and in S.... He is employed by the Red Crescent to run the TB hospital in S..., the twin to the Maternity hospital. Dr A felt that he could also run and manage the Maternity Hospital. The Deputy Commissioner informed us in November 1997 that the post of Hospital Administrator (Maternity Hospital) had been given to Dr A. We knew from past experience that this would not be well received at the Maternity Hospital. Dr Q objected strongly. She was not a Red Crescent employee (like Dr A), but a government appointment. The Red Crescent Association could no longer afford to place a doctor in this post.

Dr A provided the transport for us to get to the hospital every day. He also visited us every night at the rest house. All the time I sensed he wanted something from us, not just support for the Maternity Hospital. It did not take him long to ask. He wanted us to find him employment in the UK – anything, *“working in a nursing home, or as a kitchen hand”* so desperate was he to get out of Pakistan. . He had tried unsuccessfully to get his qualifications accepted by the UK. He had also tried to register on a management course in Manchester, but the fees were way out of his league. He told Kad that he wanted to leave his wife and children to marry English women (to secure a visa for the UK). He also tried to get us to support him for a higher position (General Secretary) of the Red Crescent Association, setting up meetings in Lahore and Islamabad for us to meet the President of the Red Crescent. We said we were happy to go, but with our own agenda for the Maternity hospital, i.e. a plea for Red Crescent funding for a doctor and not his promotion.

Kad made friends with Dr A's nurse at the TB hospital; her name was Faz. She was a midwife who had undertaken the twelve months course. Whenever Dr A was not in his clinic, which was often, Faz acted as the doctor, seeing patients, writing prescriptions for drugs, and administering medication. She even assisted as laboratory technician, staining the sputum to observe for the strain of TB. She lived in a house Dr A rented at the back of the clinic. Faz had one day off a month and went home to her parents, taking her meagre earnings. Two other girls lived in the house with her. Dr A was 'training' them, they were

not paid, yet they worked very hard. When we queried this he argued that he provided them with a roof over their head and food. One of these girls had a severe scoliosis. Both were very shy and giggly. Faz was extremely subservient in the presence of Dr A. She never looked at him directly, jumping to attention running into the room when he summoned, bowing and backing out of the room to follow the order. Just one example of his behaviour was when Kad and I were sat in the surgery with Dr A. He rang the bell attached to his desk, not for the next patient but for Faz. She came running in from the busy clinic where she was working. Dr A asked her to reach him something that if he had stood up and taken one step he could have reached himself. Kad called him lazy and told him he would not be able to work like that if he came to England.

We sat in Dr A's surgery waiting for his wife to come for the interview whilst he continued to see patients. We offered to leave, but he was very keen for us to stay as if our presence increased his status with the patients. We observed him order patients to sit with their back to him, so they would not breathe on him. He then listened to their chest through their clothes. Maybe he would take their pulse, but he spoke to the person accompanying the patient not the patient. One of the patients was a child of about five accompanied by a woman. The little boy's hair was sparse, his colour grey and his eyes, as well as being fearful, were sunken, dull and lifeless. Dr A listened to the boy's lungs and told us he had a tapeworm *in his chest*, gave his mother a prescription and the advice "*don't give him eggs for a week*". When we asked why, he said the protein feeds the worm. This child would undoubtedly be hospitalised if he lived in the UK.

Dr A's two children ran in and out of the clinic all the time, reminders of the health that children deserve. His daughter is nine years old and the son is aged five. His son had torticollis, a shortening of the neck on one side. Dr A told us this was as a result of him being delivered by forceps, yet his wife later told us that their son was born normally.

Although I had met Mrs A many times before and knew that she speaks fairly good English, she never initiated any conversation, always answering questions with monosyllables. She is thirty-two years of age, a Math's Professor at the Girls' Government College. Born in a village outside S..., her father was a landlord. To undertake her education Mrs A lived with relatives in the town. The village where her parents live does not have any health facility at

all. She had two brothers and one sister, there were five but one baby died at birth. Mrs A's mother came to S... town to deliver all her children. She did not talk to her mother about childbirth, ever.

"I read in my books when I got to eighth class (thirteen years). I talked to friends about periods and started mine aged fourteen"

Mrs. A's mother and uncle had arranged her marriage to Dr A and it was

"Because of my education I was older when married, aged twenty-four year"

Mrs. A was the only professional woman we interviewed about her birthing experiences. She was very proud to hold the post in the Girls College; however, she was unusual because she had young children being cared for by her mother-in-law whilst she worked. Once the children were older, some married women may return to previous 'respectable' occupations like teaching. This was evident in the social circle of the GP's wife we stayed with, however this was only with the support of the husband and mother-in-law (Bas Chapter 6)

When we visited Dr and Mrs A's house it was interesting to see that he assisted with making the tea, which was not the case in any other homes we visited. In fact, many of the women (Shab, Vez's wife, and a GP's friend's wife) considered the kitchen out of bounds to their husbands. Although Dr A was doing the western support in the home (in our presence) it was evident that they did not 'talk' about the birth or the cause of their son's condition.

6.2.10 Mrs A's birth story

Although she was pregnant within two years of marriage she said

"all my relatives were anxious that I start a family"

She received antenatal care from Dr S..... Dr S...used to be the resident doctor at the Red Crescent Maternity Hospital, and enjoyed an excellent reputation. For the past ten years she has been operating a private clinic in S.... However, tragedy struck when her only daughter (aged three) was murdered in 1989.

Mrs. A went to Dr S...’s at term and was admitted in labour “*I lay on a stretcher with a drip*”. When asked if she knew why she had the drip, her pragmatic (obvious to her) answer was “*to make the pains come*”. When asked if the pains were slow, Mrs. Ahmed replied

“I thought they were strong but the drip made them stronger”.

She did not receive any analgesia and remained on the trolley until delivery; she felt it was about three hours.

“It was painful when they pushed here (demonstrating hands on the top of the stomach) but when it got too much they stopped”

Twenty-four hours after the baby was born she came home. Her mother had been with her throughout.

“My mother-in-law looked after the baby. I returned to work after fifteen days”. When she saw my eyes widen and eyebrows lift, she spoke to Kad in Punjabi. Kad said:

“She does not want us to think she is lazy”

I knew immediately where this had come from. Dr A will have told her women return to work soon after childbirth in England. Both Kad and I said how some women were taking a full year off work to care for their children now and also, not all women worked.

For the birth of her son, Mrs. A said, “*everything was the same*” which was her cue to say our time was up. However, when we gently asked if the delivery was normal, Mrs. A was adamant that it was not a forceps delivery. We explained that her husband had said that the forceps were the cause of the little boy’s torticollis. This surprised Mrs. A as she said they had not talked about it,

“he was not there at the delivery, so how does he know...it was a normal delivery...just like my daughter”

The only thing she knew about the boy’s neck was when her sister noticed it and advised her to lay him on his other side and to put toys to attract him in his other hand

The management of birth at Dr S...’s clinic fits with the medically dominated, western practice of active management of labour; indiscriminate, induction, and augmentation. Intervention as it was in the 1970’s and 1980’s in Britain. This was without the support or

availability of analgesia (an induced or augmented labour is known to be more painful), or basic technology to control the drug dosage (calibrated drip control and regime for administration). Also, very importantly, the maternity hospital did not have the basics of resuscitative equipment, oxygen or suction and were using Ether as anaesthetic.

6.2.11 Shad's context story

Shad's husband was the gardener at the rest house we were staying in during the field trip in November 1997. He asked Kad what we were doing in Pakistan and Kad subsequently set up the interview with his wife. Kad's husband tried to set the date and time without consulting her, but we insisted that he sought her permission first. This may have been an exercise to appease our ethical conscience, he may have told her to come, but then at least we could then ask her consent.

The first appointment arranged to conduct the interview just did not happen. We were requested to stay in our room because the Chief of Police for the Punjab was holding a meeting at the rest house and he did not want the entourage distracted, or security put in jeopardy. Dot and I did not take offence at this request, but Kad was incensed and took it to be 'room arrest'. This was an interesting paradox; a young Pakistani woman, used to freedom and rights, and two British women accepting the patriarchal supremacy (Mernissi 1985). At the set time for the interview, the rest house and surrounding grounds were swarming with police, carrying hand and machine guns. Air conditioned Pajeros (large Range Rovers) queued on the drive, the atmosphere was electric. Interestingly we heard a knock on the door; it was the Chief of Police. He has visited R... many times and was like an old familiar friend. He asked after our health and, somewhat confusingly, offered his mobile phone for us to ring home. It would have been four am at home, so we graciously thanked him but declined.

A further date was not fixed for Shad to come for interview; her husband knocked on our door, very conveniently, a couple of days later to say his wife was here. Whether this was just opportune or whether he had been watching our movements for the right time and had his wife 'standing by', we will never know.

We set up the lounge, explaining the tape-recorder and who and why we were interested in talking with her, ready to begin the interview. Shad had her youngest child in her arms (seven months old) and as we switched the tape on, I saw the curtain dividing the rooms twitch. Thinking a cat had got in I went to look. It was Shad's husband who had positioned himself behind it to listen. Kad, thinking on her feet, asked Shad to hand the baby to its dad so we could continue. Keeping the baby amused served to prevent him from listening and eventually we saw him take the baby outside.

Shad was a pretty, slim woman with an open bright face; her eyes showed a depth of passion and spirit. Although she had not seen a tape recorder before and we demonstrated how it worked, she was not inhibited by it at all. The whole interview was a very positive, enlightening experience. Kad connected with Shad and vice-versa immediately, I analysed why. It was customary when being introduced to ask after family and establish if there was any connection. Consequently when introducing Kad, she was asked what was her father's occupation and how many siblings she had. Kad is one of fifteen children and I used to wonder why she was not proud of this, as her father was. Later I came to realise that there may be a certain stigma attached to being part of the largest family in a town where the norm is 2.2 children per family.

I had always thought of a large family as supportive, having brothers and sisters to support each other. However, as Kad eventually told us, the family has to live with the reputation of the worst and not the best. Although the girls in Kad's family had done very well (one an Oxford graduate) the boys were not achieving.

Shad was also one of fifteen children and, as stated, the mutual family size appeared to cement an immediate bond between Kad and Shad. There was a warm glowing presence that I basked in the reflection of and it undoubtedly benefited the content of the interview.

6.2.12 Shad's birth story

Shad did not know her age, ("*forty or fifty - my dad has the papers*"). She had delivered ten children and was holding down three cleaning 'jobs' and the one favour we could do her was to find her yet another.

Shad's mother had been a dai and delivered the first three of her children, the other were delivered by a dai called Hussein.

"My mother is dead now...also my aunt (dad's sister) and my mother-in-law is a dai."

In answer to the question about following the family's tradition Shad said,

"No...but if there is any work I will do it...I could work in a centre...but I could never take a 'case'...it's just when they are born (babies) I get scared"

Two of Shad's children were born at the Maternity hospital (one actually in the hospital and one with Dr T, (Whom I knew quite well.) Dr T... is the wife of the MOH; she had her own private practice in the hospital grounds. Those who could afford to pay were steered towards her practice out of the hospital and cared for by the hospital staff.

Shad did not have any antenatal care with any of her children

"My mother-in-law checked my abdomen at home"

With the first baby:-

"The water came with no pain then they put drip up... after an hour or so it just happened... when this girl was born there was so much water...so much that I couldn't bear it...they put the drip for strength"

The second baby was born: -

'Upside down...they said we are going to do operation, if it doesn't happen... I don't know what they put inside, I was unconscious and they did it...' (it was not clear whether she had an internal version then vaginal delivery or whether she had a caesarean).

"No money was paid at the maternity hospital ...only took our own medicines... Dr T... charged... but my mother-in-law paid"

Shad told us that her mum, sister-in-law and mum's sister were all with her at the hospital, but:

"They stayed outside for the births in hospital and Dr T....'s clinic. I did say come inside...but the doctor said no there were already women there and them (relatives) being there would not make the pain go away. They stayed at the door saw me through the glass ...if the pain was bad they wouldn't let anyone come in"

(It was common practice to send the relatives out of the delivery room)

Shad's mother-in-law delivered third and fourth babies but,

"We had an argument with my father-in-law, because of the rift we did not send for them, now we live separately"

Shad sounded sad about this, it must be especially hard to have lost one's mother and have no contact or support from the in-laws when there are ten children to care for.

For the three babies her mother-in-law delivered Shad said:

"She did not check inside or use force on the abdomen...but with all my babies I had an injection."

There followed a long and protracted discussion about the number of children Shad still had alive. Clearly Kad felt OK about seeking clarification; if the subject had not been about babies dying, it would have been amusing. Shad said she had given birth to eight boys and two girls telling us that *"four boys had died"*. That led Kad and myself to assume she had four boys and two girls still living. However, Shad said *"no I have three boys and two girls."* After asking if five had died, Shad told us she had given one son to her sister. We all smiled with understanding, but it raised our awareness of the potential for misunderstandings. It seemed that Shad's father gave the child to her sister,

"He just lifted it from my lap and put it in hers saying, it is up to her and God whether the child lives or not".

Shad said...

"she is my eldest sister...she used to cry a lot...at least I know that he (son) is educated, I cannot afford to send any of my children to school"

When we asked how old the boys were, when they died Shad said

"One was seven... one five, one... a day after he was born and another... was seven as well... One of the boys had a shortage of blood and the doctor said to give him some (blood)... I gave my own, taken in a bottle... but they could not get it to him in time" ...another was fitting at birth"

Shad found out she was three months pregnant shortly after this baby died, after she had given her blood.

"They said to give blood...my brother said I will give...but they would not take it from him. He was working...the five year old used to eat a lot of dirt... the seven year old got a temperature in his neck, we had to get treatment... the other got diarrhoea..."

Not surprisingly Shad told that she did not want any more children, she had been to the hospital twice for the operation, but since the children have died

"I have no faith to go inside, my heart feels weak, I cannot bear it..."

6.2.13 Dr Q (field work log extract 12.11.97)

Although Dr Q was not interviewed about her birth experiences, the following story outlining her perspective of the dai and my interaction with her is an example of the gap between the women and the medical position on the role of the dai.

During each of the field trips to Pakistan, I have worked at the Red Crescent Maternity Hospital in S.... Upon arrival at the hospital I would seek out the most senior person to ask permission to be in the hospital. On one particular day, the doctor's office was empty so we looked for staff nurse. A teaching session was set up with the permission of a woman in labour and the dai who had brought her in with ruptured membranes. During the session, first one member of staff was called out and then another. When I asked where everyone was going, I was told the doctor wanted them. Sensing that this was a sign of unrest, I excused

myself from the woman and the dai and went round to speak to the doctor.³² I knew as soon as I entered the door that the doctor was angry.

I began by apologising for taking her staff (*as she sees them*) for a teaching session and explained that I could not find her when we arrived at the hospital. She said that she was happy that I was teaching them, but I had to check with her that what I was teaching was appropriate. I was a little taken aback, then asked her politely why she did not come to the sessions (like the other doctors had done on previous visits). Immediately I saw she had taken this as an insult. Her reply was that '*she was educated; the staff were not*'. I made the statement that education was important but so was experience and there were many of the (her) staff with years of experience. Thinking I was complimenting her and her staff and trying to calm her down, I reminded her of times when I had worked with the staff and had been impressed with their success in delivering women safely and successfully. She seemed to interpret this as the staff could do it but she could not. I was slow to realise this and seemed to be digging myself in deeper with each word I uttered. This led to a specific part of the discussion around episiotomy and position for delivery.

Unfortunately this was the proverbial red rag, Dr Q said that the rationale I was giving for the upright position for normal birth and the conservative management of the perineum, was nothing short of 'dai practice' and showed just how ignorant I was. The current policy at the hospital was to put the woman in the lithotomy position for delivery and elective episiotomy for all primigravida. Coolly, I explained the education I had undertaken and the number of years I had as a practising midwife. I asked her was it possible that we (UK) may be ahead with research and evidence to support the practice I was advocating. She said that just was not possible, as she read the text her professors had recommended and if she practised like that, she would have failed her examinations.

By this stage she was almost at screaming pitch and although she could speak perfect English, lapsed into Punjabi to Kad (the interpreter), repeating over that she was the doctor,

32 Dr Quair was the only one of the three doctors who refused to be interviewed by me in 1993 when I conducted interviews with all the staff to evaluate our input as British midwives to the midwifery practice at the maternity hospital.

Professors who knew what they were doing had taught her. As I usually do when trying to dissipate someone's anger, I became 'ultra-cool', waiting for her to calm down, although at one point I informed her that I would not be shouted at or spoken to in that manner. This only made her angrier, she clearly was not used to anyone answering her back or questioning her.

I recognise that I should have walked away at this point; however, I was trying to rescue the discussion to turn it to a positive. She brought up the mortality and morbidity rates in the USA, saying that they do elective episiotomies for all primigravida and deliver in lithotomy in the hospitals there and their mortality rates are low. I tried to explain about birth in the Netherlands, but she would not listen. The implication was that if I was advocating such practice, then I was as ignorant as the dai. "*This is a hospital, we do it properly*" were the words the doctor kept repeating. She was adamant that Pakistan's mortality and morbidity rates were entirely due to the dai and their ignorant practice. She seemed to be especially venomous about dai practice in common with the thinking of the educated and leading text on the dai in India (Jeffery Jeffery and Lyon 1988). When I tried to bring in the education and role of women, plus their poor social health, underpinning the country's high maternal and peri-natal mortality rates, Dr Q did not feel this was justified and her solution was,

"There should be a law advocating that only a doctor should deliver a baby...like some states of America".

When I politely asked if there were enough doctors available, and had the mortality rates declined in those States in America that conducted such practice, she said emphatically "Yes."

I tried to be positive before leaving by saying that debate and discussion were healthy for developing practice. Her reply was,

"In Pakistan one did not question one's superior"

I had been put in my place.

A couple of days later I took in to show the doctor, Jordan's (1993:85) book *Birth in Four Cultures* and the 1994 Sept MIDIRS journal with Sutton's work on optimal fetal positioning, to add weight to my argument on the upright position for labour and delivery. Without

reading either properly, she skimmed through the journal, stopping at page 343 and pointing to the cartoon on cabbage leaves she looked down her nose at me and said,

"If this is what midwives in Britain read, cartoons in comics, then I am not surprised their practice is that of a dai".

The knowledge base that Dr Q was operating from was a modern western influenced, positivist, and illness cure model. This 'superior knowledge' devalued and denigrated 'other' humanistic experiential knowledge, regarding it as untested and from the uneducated.

6.2.14 Collective field work log

Dot, Kad and I kept a daily reflective fieldwork log. We would sit on the beds at the end of each day and relate our experiences. I would type the collective observations directly into the lap top computer. At the end of 13/11/97 we recorded an incident involving a woman in the labour ward; we were informed that she was:

"a primi one finger loose, waters gone".

I asked why she was lying flat on the metal labour ward bed (with no mattress) and was told that she had wet her Salwar and she did not have clean clothes or the money to buy cotton for a pad. They did not want her to mess the floor.

The same morning, on the doctors round, we listened to a woman (who had just lost her baby) be told by the doctor,

"You don't want any more babies, come back in fifteen days for a tubal ligation".

Both these incidents, plus the one referred to previously about ignoring the baby girl (fresh stillbirth), excentuated the chasm of cultural difference between us and our Pakistani sister midwives. Most of the staff did not show any empathy for the women in labour. I find it hard to criticise other midwives and have tried to explain away such insensitivity by understanding the impossible conditions the midwives work under. However, there is no valid justification to ill-treat another person. I do not wish to compound and continue the blame to the women who are lacking in care skills (in this case the doctors and staff at the hospital), but it cannot be ignored. Before it can be dealt with, it has to be acknowledged as

wrong. I have always worked on the principle of, would you want your daughter/sister/mother to be treated in this way? How can a society that values the family and the sisterhood within it, treat women so badly? Caring for those outside the family is not seen as a responsibility anyone can shoulder. Perhaps it is a burden big enough to care for the family, perhaps I do not understand.

Goldberger et al (1996: 351) proffers an unusual story about cross-cultural difference, which goes right back to the basics of language and behaviour.

“As a Japanese student in the USA, Nekko has become argumentative, defending her own opinions, proud of standing her ground. However she recognises this only when she is speaking English, when she reverts back to her own Japanese she falls back into the conformist mode “my facial expression is different, my voice and attitude changes” (Goldberger et al 1996: 351)

The parallel for Pakistani women is that the culture perpetuates itself; to treat other than her relatives kindly is to flout the cultural norm. Perhaps this also explains Kad's suspicion around *‘why we care for Pakistani women who are not friends or family’* and goes some way to explaining the importance of having the right name, knowing the right people, and name dropping in the culture.

Comments have been made many times in the hospital, focusing on our patience and kindness to all women (staff inclusive). One midwife working as a ward attendant because they could not pay her as a midwife said she would model on our care, as it was like all the women were our sisters. Whilst being delighted by this comment, I recognise that this junior midwife may not dare to be different in the presence of senior staff. But perhaps when she is assisting women to give birth in her village, she will include care and patience in her practice. There are parallels for midwifery practice in the UK when the national culture is one of blame (Kirkham 1999). The NHS culture supports medical dominance and the ward culture is the universal conformist (Leap and Hunter 1993).

6.2.15 Summary

I began telling the birth stories of the women interviewed in Pakistan, with a glimpse into my own experience some thirty-five years ago. This was to demonstrate how over time attitudes and birth practice have changed, how memory is sharpened by shaping the experience into a story, then telling and re-telling the story fixes it into the long term memory to recall at short notice. Five of the women tell their personal birth stories; one story focuses on the dais position and responsibilities at birth. The final narrative with a doctor at the Maternity hospital presents a particular perspective to the existing discourse on life and birth for some women in Pakistan between 1950 and 1997.

6.3 The women interviewed in R...UK

As previously stated, more than biographical information was available from the women interviewed in Rochdale to present the important context to the women's birth stories. Key issues that arose from the initial content analysis of the data are used as headings to elaborate on the context that underpins the lives of the women. Following this, a synopsis of the women's birth experiences is written as birth stories. This was undertaken to assist the reader in developing a paper relationship with each woman, seeing each woman's individuality as it shone through in the main themes which are explored in-depth in the findings chapter. The whole is integrated and applied to existing theory.

Willis and Trodman (2000:13) advocate "a half way house between the theory and the topic, connecting up relevant theoretical insights, concepts and tools (from wherever they come), which can all be put together and all can be applied to a specific topic".

The women's interviews in R... all took place after the initial interview with Ria, the gatekeeper to the over-fifties group. I attended fourteen lunch-time sessions, from which five women agreed to be interviewed. A further five women were interviewed following recommendation and personal contact. All but one interview took place in the woman's own home; Fari elected to be interviewed in the community centre.

Table 4B The women interviewed in R...

1. Through personal contact

Ria is a contact through the twinning group and gatekeeper for the over fifties women's group (aged 53).
Ami, was a contact through Riz, her daughter who was then a student midwife, (Ami was aged 59 in 1997)
Ina the midwife who worked for over 25 years in Pakistan she came to be interviewed through a relative of a friend (Ina was aged 63 in 1997)
Shab is the second wife of Vez, a friend who helped in Pakistan. (Shab's age in 1997 was 38years).
Bas was born in 1946 and was the mother of Siaq who wanted a career change from podiatrist to midwife (Bas was aged 59 in 1997).

2 Through the over fifties women's group.

Taz, is the grandmother of Sam (Taz was aged 63 in 1997).
Farn the mother of Fran who had a picture of Fran with me, taken 14 years previously (Farn was aged 59 in 1997).
Dil, is outstanding in her difference and aged 50 in 1997
Fari, is a teacher in the R....community and was aged 53 in 1997
Naz and three generations of women invited me to return and interview them again. (Naz was aged 69 in 1997)

6.3.1 The over fifties women's group

Hereafter follows the findings from the simple basic content analysis of the data collected from participant observation with the over-fifties Women's Group in R.... UK. The next stage in the analysis process used an adapted Childress (1998) and Polkinghorne's (1988, 1995) narrative analysis. This included re-listening and re-viewing the data multiple times, then asking questions of the text, worked only partially for the participant observation undertaken in R...as the text was of my own construction mainly (reflexive field notes). The core of the data emerged from in-depth focused, unstructured interviews with sixteen (+1 Dr Q) women; ten in R... and seven in S...Pakistan.

The key concepts that emerged from the observation and focus groups held at the over-fifties group emerged from a contemporaneously kept reflective field diary.

I became an honorary member of the over-fifties women's group when I attended a total of fourteen times between January and October 1997.

Table 5 Key issues/emerging themes from the observations and interaction at the over-fifties women's group (further key issues in Appendix 5)

1	Getting in the group (field).
2	Property, word and deed
3	Gatekeeper (difference of philosophies)
4	Social, cultural need.
5	Not for the researcher's ears.
6	Transcription to interpretation.
7	Embellished account.

6.3.2 Getting in the group (field)

I had been invited to attend the women's group by Ria. Ria is a member of the twinning group that supported the very first visit I made to S.... I had no previous knowledge about Ria's 'day job'; in retrospect I presumed wrongly that she was a housewife. She was employed by a charity, specifically to assist the elderly Pakistani people in R... with community life. During her interview Ria told me of the over-fifties group, saying the women would like to discuss their birth experiences. I knew nothing of the group and was overjoyed with this opening into the field. I asked if I could contribute to the group rather than 'take' for the purposes of my research. At that time my thinking around the 'giving' was the knowledge and expertise I had as a midwife. I realise now that the knowledge on offer was the scientific, highly valued in western society about the body and treatments, on such topics as menopause, resuscitation and breast examination. I had little sense then of the existence and value of 'women's ways of knowing' that Belenky et al (1997) and Davis- Floyd (1997) awakened in me. As a consequence, I went to the group devaluing, by ignoring, the intuitive woman-centred knowing and the therapeutic value of listening. What I was doing served to reinforce the scientific knowledge as superior to their own knowledge.

6.3.3 Property, word and deed

I specifically asked Ria to seek the women's permission for me to join the group, explaining that I would understand if they refused.³³

With my tape recorder and interview guide in hand, I attended the very first group. Ria had not asked the group's permission for me to attend and not even informed them that I

³³ I now remember the exact time that the research became the 'property' of the women and not mine, for the over fifties group it never happened with the group as a whole. The time was when the women (from the individual interviews) returned their read, corrected and validated transcripts to me, giving their acceptance to use the information within.

would be coming. Her rationale, “*I did not want them to be disappointed if you did not turn up*”. Ria herself was surprised when I arrived. This is but one more piece in the jigsaw of rhetoric and reality and separation of the word from the deed that had been a part of my previous field trips to Pakistan. Many other pieces hold stories of promises or arrangements made without the apparent obligation to follow through with the deed (Chesney 1994 and Jordan 1993). There are further examples of being offered hospitality without the expectation of it being accepted; Dil’s interview arrangement (Chapter 6) typified this.

6.3.4 Gatekeeper

There were twelve women at the over-fifties group on the 6.1.97. I listened silently to Ria’s introduction of the project and myself. I smiled a lot, but this was to turned-away eyes and shoulders. Scanning the room, I was hoping for a familiar face from my work as a community midwife in the area ten years past. I used up my limited Punjabi in the stilted introduction of the research and myself. The only faint movement or reaction came when I informed the group that I had visited their homeland several times. I understood their suspicion and reluctance. I explained to Ria that it would have been so much better if the women had been able to discuss whether they wanted me there before I arrived. Yet on reflection, this may have been hypothetical, I may not arrive and they might not have wanted me there. I judged the women’s reaction to be a reluctant, dubious acceptance, the latter purely because of Ria’s acceptance and knowing of me.

Ria had given permission for me to be there and also, very importantly, she had been interviewed herself. Without this introduction I am in no doubt that I would have been shown the door, metaphorically speaking, probably with turned, raised shoulders - exclusion through body language, but also by withholding their birth stories behind the statement ‘*no problem*’ or ‘*I do not understand*’.

The boundaries of Ria’s introduction and what initially felt like coercion of the women to be interviewed created some dissonance for me. I had no difficulty with them checking me out through Ria but I did have difficulty with Ria pushing them to be interviewed.

Ria had a distinct aura of 'rushed self importance'; the women were in awe of her. "*Ria is busy; we respect her for her good work*". Her request for women to put themselves forwards to be interviewed sounded like a command. I had to intervene at this point and explained that I had brought some information leaflets to be read before agreeing to be interviewed and that I would be coming back to the group. This did not deter Ria and she continued to push women forward. Their reluctance was framed in comments such as "*I will be interviewed if Ria will be present*". I judged this was to protect them from prying questions. However, I realised later it was for Ria to interpret for them. Ria's reply was "*you can speak English good enough ...you are just lazy...it will improve your English*". Her manner was stern and authoritarian.

After telling the women off for not speaking English, Ria proceeded to shout at them in Punjabi; this seemed incongruous, as she had told them they needed practice with English. However, the women appeared to be totally accepting of this. This made me reflect on a potential parallel. The first interpreter I ever worked with as a community midwife told me '*I must act with authority or I would not be given it*'. She could not conceive that authority in a power, influence or control sense was not acceptable to me. Neither did I (at that time) conceive that patterns of authority and decision making are culturally defined (Schott and Henley 1996) and relate to authority in family structure terms, whereby parents have authority over children, even as adults.

6.3.5 Extract from reflective Dairy (field notes) 17.2.97)

'There were eighteen women present. It felt good to be welcomed by some upturned smiling, friendly faces. I have now become a known and accepted member of the group. Ria proceeded to inform me that there were only three women attending the group; the other fifteen were 'helpers'. Although I did not ask for an explanation, it did appear strange and seemed top heavy with helpers. Later, I rationalised that the social stigma of 'needing' such a group reflected upon the family not providing social support for the women. Also it appeared the 'new' women have to earn their way into the group of helpers by virtue of knowing one of the helpers. The status of the helper appeared to elevate the woman to not needing the group for social reasons. The role of the helper was to provide, prepare and serve the food. The lead helper alongside Fari, Ria's friend,

was a GP's wife and this would fit with the hierarchy in society. The women's conversation would often include one or other saying 'my son or daughter, the doctor'.

The purpose of the group is to provide a safe place for women of the community to meet outside the home. The individual, family or the community may define safety. For the women it may well be 'safe' from mixed company of men, or for some of the men (elders of the community), it may be safe from becoming polluted by western norms; smoking, drinking, infidelity. However the cultural norms of this community are being changed from within. Ria organises trips for the over-fifties men and women. The latest has been to Buckingham Palace and Tatton Park. I was surprised when Ria informed me that she now takes both men and women on the trips. She did, however, confirm that the first few group trips were composed of all men, adding that she had to convince the men that it was important for their wives to come out and enjoy themselves. Since then '*things have moved on a pace*' and '*no longer do the men object to their wives taking trips in mixed company*'. Now, for every ten couples, there are twenty more just women.

The lead helpers in the group include a GP's wife, a teacher and an elder's wife. Ria often provided the raw ingredients for the meal and for a charge of eighty pence per person, a substantive meal was provided. I learnt that it is permitted to say one is fasting, but not dieting, if one did not want to eat. It is definitely not acceptable to say that the food is not to one's taste. Fari (teacher) informed me that some of the older women do not like pasta, only rice and chappatis; so when Ria brings pasta, these women 'fast'. Fasting has a direct religious penitent connection and the 'duty' is to acquire a high standard of sensitivity and purity (Salahi 1993). Offering a culturally accepted and revered reason for not taking the food is preferable to being honest and risks offending. This fits with the cultural norm of '*not wanting to hurt anyone's feelings by telling them the truth*', very much a feminine quality in western society. I was brought up with the adage "*if you cannot say anything good, do not say anything at all*".

6.3.6 Not for the researcher's ears

I planned to use an exploratory and phenomenological way in order to generate ideas for further exploration in the individual interviews. The first opportunity to use the audio tape recorder to record the views of the women at the group arose on the 17.2.97. I asked the women for their permission to use the tape-recorder. With it came the dilemma of interpretation and transcription. I had the assistance of an able translator, Shan. Shan had visited Pakistan with me when she was a student midwife in 1995. She agreed to transcribe the taped focus group interviews verbatim.

It became apparent during the very first focus group that the 'asides' some women used (in Urdu), may not have been meant for my (research) ears. Perhaps they spoke to each other without knowing and I would be unable to understand. I realised that I should have informed the women when I gained their consent for use of the tape-recorder that the tapes would be translated and transcribed by someone who could understand Punjabi fluently. This I did at the end of the focus group interview. The women shrugged their shoulders and looked at each other. Their raised eyebrows made me wonder whether they now doubted the permission for tape-recording. They could not remember what they had said.

Rather than return the transcript to them all for verification, I asked if one or two would review it. This led into a protracted discussion on who would take the responsibility for verifying and/or editing the contents. None of them seemed prepared to take on this task so, as an alternative, I asked them if it was acceptable to give the decision to edit to Shan. Thus, I asked Shan to make a judgement on whether the words were private or related to the research when she transcribed the tapes. I trusted Shan's honesty and integrity and knew she was clear about the confidentiality, would never gossip or do the women any harm. However, the women did not know this, so I explained that Shan was a midwife with a professional code of practice and could be trusted implicitly.

I suspect because it was long past the time to leave the women in the group agreed. The way Shan transcribed the comments she judged not appropriate for the research was to type 'Punjabi' in the script. This occurred thirteen times in five pages of script. This

frequency of the need to edit made me consider the ethical imperative of using focus groups as a means of data collection across a language barrier.

6.3.7 Embellished account

It was enlightening to reflect upon Ria's re-introduction and interpretation of the research to the women, as Shan transcribed it verbatim from Punjabi to English.

"...I am saying she (Margaret) is doing research on women's experience on women having babies here or there (Pakistan). She has come and gone to Pakistan a lot. The problem women are having in Pakistan; she is trying to help resolve. It is beneficial to us. She wants to know our experiences in Pakistan, so she can compare have the experiences worsen or are they better. If you wish to give an interview she can come to your homes, by giving address and making appointment or can interview you here. She will not mention names in any way, you will only be a number, meaning I spoke to a number of women and this is what they said, this is what happened and is happening now. How she can help the Pakistan government, how they can make improvements. They need to know if the situation has always been bad or good. Because it has not always been negative, because when I had mine there the situation was different and now there are a lot more facilities, but the situation are worse because making money is the only thought...all the caring has gone. Before a lot of care was given and love was gained from the patient, but now it is not thought of as a role but a business. There are a lot of doctors now, they frighten the patients by saying that it is going wrong with the baby and you require a caesarean section"

A woman interjected and said "caesarean first and then..." Ria continued,

"That's what I am saying, this is what she is going to compare, look at us we have had normal deliveries, for this reason it is in your benefit, if you wish to talk to her, you can talk here or in the privacy of your own homes. Nobody else will know, only she will, name will not be mentioned. How many volunteers are there?"

The contextual themes that emerge from Ria's account to the women, highlight some changes she made;

I thought Ria knew that that the research was about birth in Pakistan, not R....

- Ria used a coercive manner to persuade the women to be interviewed using a beneficence approach.
- I have never said that I was comparing anything (not even the R... interviews with those undertaken in Pakistan)
- Ria used embellishment and a power rationale, 'helping the government'

Ria used her own experience to influence the 'making money - do not care' and the 'caesarean' point.

It is to be expected that Ria would superimpose her own experience when explaining the rationale for the research. The transcript demonstrated clearly just how much can be changed in one translation alone. This has major implications for all health care professionals who use the assistance of interpreters to communicate with women and families. Exactly how much influence Ria's introduction and version of the research had on the women's stories can only be speculated upon. The context for the focus group interviews proved to be fraught with problems.

6.3.8 Ria context story

As already stated, I first met Ria as a member of the twinning group. This is a multi-professional, local authority run group that exists to support R... twin town in Pakistan, S.... It is through this group that I have made nine field trips to work in the Red Crescent Hospital in S.... Ria has been on the executive committee of this group and has supported the Midwifery Project since it began in 1989.

Ria came to England in 1950 from Uganda and immediately began working in the community. She began by working as an interpreter in schools and hospitals for the few Asian women who had immigrated to R... to be with their husbands, who had come to England seeking work.

"...When I came to the country I started to work...there were few families, there were more males than families came...whoever was they had a language barrier...they had no-one to speak the

language. They used to ask you to take them to the doctor, would you take to the Infirmary?

"...the kids coming to school they can't even tell us when they want to go to the toilet...they dirty and do it in the classroom' ...from there I used to go to the school..."

"...I used to go to infirmary quite often at my own expense, but it was lovely to help. The midwife used to come and take me in her car to the Asian woman's house. From then on the police got to know...they are the only ones who paid me, they used to come in a car pick me up take me there half an hour I would do the job...this is how I got involved..."

"...Sometime ...they see other people as a role model...I don't think it does do any harm to use people if they see others they say, 'it is good enough for me as well'. That is why I wanted you to come and interview me and then they will see how you will follow that. That is why I wanted the interview to be here (her home). You will see how many will follow that. They will let me give interview first right... if they had a fear of somebody else doing... then example I am using it now. I know you are recording and perhaps it will be bad for you...for cancer reference screening, you go forwards I drag the ladies there..."

Ria's husband was always there to support her.

"He always encouraged me, I will give him that...that is why I have always been able to...he has always been like a backbone of it...he supports me...he is not involved himself but he does not stop me either...he does not go out, his life is his work. I am very proud to say he has never drawn a penny from the State...none of us. I can say that he has always worked for his home, his family and his sleep for his life (he works nights in a factory)...he used to go out when he was young, doesn't go out much now...but he doesn't stop me..."

Being a Muslim, the Islamic religion and culture underpins Ria's belief system.

"Muslim believes that every child is born a Muslim, whether it is born into Christianity or what, Islam is the last religion on earth...child is born he comes to this earth as a Muslim then whichever parents religion he goes in there. Islamic way is to chant to the child 'you are a Muslim, you were born a Muslim.' they pray call for prayer that there is only one God Mohammed...his message goes to the child ear 'doing the head' is religious, circumcision and prayer...Islam will never change, even now.... Like the Bible has changed, the new and the Old Testament the Koran never changes. We say God moves in mysterious ways and you must never ask

questions...a lot of things are unexplainable...but because we have faith we just believe it. Koran gives us a lot of answers to the questions but there are still some questions...we just accept"

Ria had strong beliefs on most issues and examples of two are circumcision and caesarean sections

"The circumcision is part of that I have known all my life and I am fifty-three in June...so many nieces and nephews and cousins in family...anybody having experience of anybody dying of circumcision? There was a friend she was English and he was Muslim, she had read articles on circumcision. I said no I will not agree with that, ...the only suffering is when the child is older...that is why they do it in seven days when the child does not feel pain...as the child grows older then obviously the child will suffer more I am never witness any suffering."

"Now in Pakistan lots of women are being told they must have a caesarean. They charge from 22000-33,000 rupees (£500) the poor families have to beg borrow or steal... they put it into people head they need caesarean, in my close family there have been seven caesarean in the last year...they have normal pregnancy, why they put a scare they cannot deliver normally..."

Ria's strong character and leadership role for the Pakistani community in R... made her an ideal gatekeeper for the research. Her vital role in this respect was outlined previously (Chapter 6) Despite my personal unease with her authoritarian style, I will be eternally grateful because without her, this research would not have been possible.

6.3.9 Ria's birth story

As already stated, Ria was the gatekeeper for the women's group in R..., she was the first of the women in R... interviewed. The story of the birth of her eldest son in Pakistan plunges the listener/reader into so many facets of what is different and what is similar about birth throughout the world; firstly, the power relations in the birth room and the dominance of medical practice within a patriarchal society. During Ria's labour and the subsequent birth of her son, there was a reversal of the power dynamic when the doctors, outside the hospital technological environment, found themselves helpless. Such neutering of the medical power is rarely documented, but often recounted by midwives in

the labour suite coffee lounge. Ria's story depicts the visibility and value of ethno-centric knowledge and practice only after male medical knowledge and practices are no longer effective.

Ria's story portrays the importance of collective decision making and the skill of the dai and the relative, using non-invasive action and movement to facilitate the birth.

The vividness of Ria's story portrays the telling of it many times, which is in keeping with the oral history tradition. There were elements that I would have liked to clarify as a midwife. For example *'the 'head out for many hours'* could have been Ria's way of saying the baby's head was visible, or her interpretation of the findings on the vaginal examination with regard to the cervical dilatation. Ria made a circle with her hands of approximately four inches diameter. However, the opportunity to explore and expand upon these issues did not arise. This did heighten my awareness of the partial picture research allows.

"...He was born at home, he was booked for hospital, the room was 'booked' ...I was fast asleep. I had not been able to sleep for weeks, that day I was asleep"...

"I won't stop screaming... my mother said 'Oh give her something for the shock' ...they give me milk with butter in...and I was vomiting. That vomiting and screaming pushed the head it was about... (circle fingers four inches diameter) the head was out...."

Ria was due to have her baby in the hospital; this reflects her family's status and wealth. The phrase 'booking for hospital' was commonly used in the UK in the 1950/60's and originates from the time when hospital beds were scarce, before the Peel Report in 1970. Booking a bed was also used as an incentive to get mothers to attend for antenatal care early on first come, first served basis. However, it was unusual for a mother to be told that there was no bed available and she would have to have her baby at home (personal experience). Neither would she be turned away if she attended the hospital in labour. The subliminal message was that birth in hospital was preferable or superior to birth in the home, offering the opportunity to have a rest from household duties. However, women who had not followed the unwritten 'rule' and needed a bed that they had not been booked were treated 'differently' by the hospital staff. Eventually the term broadened to

include the fact that women had attended for antenatal care. The fact that women had to visit a midwife or doctor, who then acted as the agency for the 'booking', provided the state with a statistic depicting the uptake of antenatal care. This statistic was used to support the belief that antenatal care was essential to save babies and mothers' lives. So the term 'unbooked' now relates to women who have chosen not to avail themselves of any antenatal care. The power of the state and the professional agencies to make mothers conform 'for their own good', heralded the belief that the state and the profession knew better what was good for the woman than the woman herself did.

At the top of the medically dominated hierarchy, is always the hospital consultant specialist doctor. In Pakistan, general practitioners, who in the UK appear to be at the bottom end of the medical pecking order, are not called GP's; they have brass plaques on their walls calling themselves 'Consultant Community Physicians'. Most hospital 'specialists' have private practice outside the hospitals. This is not the same as the UK because there is no National Health Service. Hospital Care is not free at the point of delivery with open access to all. The doctors have a 'contract' with the hospital and the patient is billed. Services in the government hospitals are supposed to be cheaper than the 'private' sector. However, access to the doctor in the hospital is often fraught with financial hurdles or the necessity for introduction and contacts. This is much the same as practice in the UK pre-NHS, whereby the introductory letter could have come from an employer, vicar or magistrate. This was used as surety for payment.

Ria's relatives summoned the doctor when she was in labour. The number of doctors present again reflects the standing of the family in the community and the ability to pay. Although payment is often according to success with the outcome (dai are paid more for attending the birth of a baby boy) (Qureishi 1995).

"Then they called the doctor, four doctors that time...One doctor gave the injection to stop the vomiting, ...then the midwife came, ...she examined me and she said... 'what have you 'did' ...the head is out and there is no labour'. Because this injection was putting me to sleep, I was like a zombie...they lifted my hand and it would drop...that is how it was. They were making me walk...I did not know what they were doing..." Ria

Forty-seven hours passed

"It started Saturday night when Sh (Ria's husband) came about one-ish, from that time all Sunday and Sunday night... Monday when he was born, quarter past nine at night...they could not take me to the hospital because the head was out so much, they got the doctor from Lahore (fifty miles away) my husband did. On Monday afternoon they were about five or six doctors, midwives and nurses...God knows there were more staff in there...They kept saying they could only save one...either the baby or... they could not do the operation at all. They brought the ambulance from Lahore, but I was not in a fit state to take. They could not take me it would have been dangerous either way...They were doing 'everything'³⁴ checking blood pressure giving medication, but I wasn't starting in labour. If that injection lasted two days...that midwife...you know one of the village...not a midwife what they call a dai³⁵. (Ria)

Lets' do it our way

" It lasted two days...that midwife...you know, one of the village, not a midwife, what they call a dai. My aunt said 'let's do it our way' ...about four o'clock on Monday afternoon...she shouted at the doctor...she said 'you have done whatever you could for the last two days, now stay quiet and let us do it our way, whatever will happen will happen anyway. 'My aunt said 'right leave it to us' (her and the dai). So she made 'it' (demonstrates with hands, two pillars) with bricks... six of them... they put this bowl down on a clean sheet and literally (demonstrated squatting and pushing on abdomen and stretching of the vulva to push and pull my baby out"

Mgt: "She was widening the vagina with her hands"

Ria "Yes, my aunt was stretching my body, yes, I remember my mother holding me like that (both hands on her upper abdomen), holding and pressing down...she was pulling the baby ...and that is how it was brought out.... When he was born, nothing wrong with me, he (baby) cried after she cleaned his mouth and all that ...he cried. All he had was a lump on his head, which had been out for two days (I made an inner judgement here that 'out' was Ria's interpretation of the cervix being dilated four centimetres and not out of the vulva).

³⁴ 'Everything' pertained to what the doctors could 'do' in the home, check blood pressure, give medication.

³⁵ Again the interchangeable use of the terms dai and midwife.

In the position Ria was in, squatting on bricks, it would be difficult if not impossible to stretch the vagina or vulva to pull the baby out.

Ria emphasised the difference between the dai and the midwife when she told her birth story. Ria is a strong and confident woman. Midwives in developed countries do not undertake the practice of stretching the body. However, the position for the birth was fundamental to the progress of labour. McClain (1981), Newton (1975) Jordan (1993), Caldeyro Barcia (1979), Enkin, Keirse and Chalmers (1989)) uphold the vertical position (standing squatting kneeling or sitting) as physiologically more beneficial and preferred by labouring women to that of the supine or lithotomy position (Chapter 7).

A comparison of the different methods used by doctors was evident when Ria described what the doctors were doing when she was in labour at home. The doctors were out of their normal working environment, and did not have available the technological support or equipment that is available to them in hospital.

Mgt: What did the doctors try to do before the dai...?

"They did not do anything, giving medication, checking my blood pressure, doing this, trying this, they were just waiting"

The former activities of checking and giving medication are associated with the doctor's role, however 'just waiting' is not. On the contrary, it is midwives and dai who are known to practice the art of 'watchful waiting' on nature (in the presence of normality) of normality). However, the 'just waiting' in Ria's story appeared to be linked to 'doing nothing' and not knowing what else could be done, rather than an acceptance that normal labour and birth take time.

Ria further told how her mother held her from behind and her aunt widened her body, which links to the pushing and pulling; a practice I had seen in the hospital in 1989 and later. However, a dai in an urban clinic demonstrated to us how the position of squatting on bricks would mitigate against pushing on the fundus (stomach) and dilating the vagina. Yet Farn (Chapter 6) confirmed the practice of pushing on the stomach when she gave birth at home.

“She said you can go and lie down there...she tell my mum you put water in...hot water...she put my hand here (demonstrated under breasts) and tell me to push. She said, 'you do like this' ...my dai said push ...painful, you know...water broke...no injections my son born at half past two...all children no stitches...” (Chapter 6 Farn)

Ria’s memory of what her aunt and dai did to facilitate the birth of her baby, after the two days of the doctor’s trying, was particularly clear. Changing position and squatting would initiate the basic principal of physics, gravity, which would aid the descent of the fetus through the birth canal. Also, the movement from lying to an upright squatting position may serve to dislodge the fetus and facilitate rotation and descent through the birth canal and pelvic outlet. Whilst the dai may not be able to articulate this process, it is evident that both the dai and Ria’s aunt understood the importance of movement and position. They used this practice wisdom to facilitate the birth of Ria’s son.

When I have tried to introduce the practice of being ambulant and upright for the labour and birth into the Maternity hospital in Pakistan, the doctor has stated indignantly,

“This is a hospital they lie down for delivery”.

In practice, the women are put into a supine or lithotomy position, with legs either up in stirrups or toes straddling the lithotomy poles for the actual delivery. The implication was that squatting was dai practice and thus based upon ignorance. It seems apparent that the dai practice has more wisdom, confirmed by the research evidence, than the hospital ‘educated’ practice. However, it must be stated that many of the women who come to the hospital do so because birth at home has not been possible, although there are some women who have been influenced to believe that hospital birth is safer/better.

6.3.10 Bas context story

The interview transcript has been read and approved by both Siaq (Bas’s daughter) and Bas. It was Siaq who introduced me to Bas her mother. Siaq approached me about wanting to change career from a podiatrist to a midwife. My feelings prior to the interview with Bas contrasted with how I had felt about interviewing other women. I had felt that I was stealing the woman’s time for my benefit. However, Bas had invited me to

her house and had offered to be interviewed, albeit the offer felt like a 'thank you' for helping Siaz with the application form for midwifery. I was later to discover that Siaz had not informed her mother of the proposed change in career.

Bas was born in 1946. However, Siaz added that her mother was slightly younger than 59 years. It seemed that when Bas's husband registered her to come to England, he made up her date of birth. Bas's father was in the army "*the army was very good to him*", but this meant he was hardly ever at home. Bas had three brothers and two sisters. Although she began school aged six; she only attended for one year as she was "*frightened when a child was locked in a room by accident*" and as a consequence would not return. As education in Pakistan is not compulsory, especially for girls, Bas's parents accepted her not wanting to attend. Learning to read the Qur'an at the Mosque took Bas three years and eventually, aged ten, she returned to school only to leave at the age of sixteen. Bas came to England when she was twenty-four years old.

The death of Bas's father influenced her relatively late marriage at the age of twenty-eight years and also the troubled marriage of Bas's sister had an influence.

"Having one troubled marriage in the family (Bas's sister) affects the marriage-ability of other women in the family"

Siaz "It was very late (when her mother got married) this is because her father died when she was thirteen or fourteen and her mother was scared of what might happen. They were still worried ...what happened to my aunt..."

As with many of the women interviewed, probing the why's when the issues are so sensitive felt like intrusion, so no further details were sought about Siaz's aunt's troubled marriage.

It became evident as the interview progressed that the strong mother-daughter bond between Bas and Siaz was grounded in Bas's husband (Siaz's father) being absent for the first four years of marriage (and Siaz's life) and Bas's loneliness during her first years in Britain. This is explained in more depth in the sub-theme findings on coming to Britain (Chapter 8).

Despite the obvious close relationship Siaz had with her mother Bas, Siaz had not told her that she had applied to become a student midwife. I was totally unaware of this and as a consequence when I asked Bas how she felt about her daughter becoming a midwife, Siaz quietly whispered to me,

“I have informed her, but not told her I have applied...” without consulting her mother Siaz said, *“she says it is a good job as well...”*

As Siaz was acting as an interpreter so Bas could make herself understood, (she did not have the confidence to speak English), I knew that she could well understand it. She had lived in the county for twenty-four plus years. I began to justify the status of the midwife, however, slowly realised that Siaz had set the interview up for me to inform her mother.

Siaz “ she (Bas) says it is about girls getting educated, ...like people from the villages did not really want (to be a midwife), ...and they thought they are only going to get married and have children ... there are nurses and midwives now ...but then they did not want to educate them...”

The context surrounding Bas’s birth story included a comparison of the support she received from her family when she had her first baby in Pakistan, then the total lack of support she felt with the babies born in the UK.

6.3.11 Bas’s birth story

Bas gave birth to the first of her four children in Pakistan. She informed me that she did not have any antenatal care. The social and cultural divergence of perspective on childbirth is blatantly evident in the following narrative.

Mgt “If you did not have antenatal care how did you know when the baby was due?”

Bas “The pain started”

Bas’s exasperated reply spoke of *‘I thought you were a midwife and you did not know that!’*

I did not realise just how medicalised I had become.

Bas made comparisons between her births in Pakistan and R..., resting upon the lack of support in R.... Following the birth of Siah, Bas's eldest child in Pakistan, Bas was 'not allowed' by her mother-in-law to work for six to seven months. However, there were certain generalisations made by Bas, not confirmed in the interviews with other women interviewed, especially Mrs A and Shad.

"In Pakistan when labour starts (they) women come. You do not go into hospital to have baby ...those who do not stay at home...it costs (one thousand rupees) twenty pounds to them (women) it is a lot. To us it is nothing, there is not a fixed charge (for the dai...but they (mothers), pay what you want they give five to ten rupees and rice and things to use in her home...She comes for twenty-one days...and after...she would come twice a day...sometimes and massage...then they (mothers) would give her a suit (material to make a salwar kameez)... more money and goods...she would wash the babies nappies after the baby..."

"There was no rest here (R...) but if you are in a lot of pain they give you an injection and the birth is on the bed, whereas in Pakistan it is on the floor ...when I came here... no rest...wash towelling nappies...hard work...no washing machine...."Bas

The role of the dai was clearly a mother support role; what is less clear is who conducts the delivery, although earlier in the interview Bas related to the blind dai who came and delivered the baby by feel, being the same dai who delivered her mother.

Bas's account of social support and practical help provided by the dai (if the woman can afford to give either a few rupees or goods) demonstrates a network of support that is not currently available on the NHS, or affordable privately to the ordinary woman. Self-help groups, for example the National Childbirth Trust (NCT) post-natal support groups, have flourished in certain areas. However these offer help to a very small number of informed women. It is interesting to note the new NHS Strategy (Department of Health 1999) Making a Difference, recognises and supports the 'midwife assistant' whose role is in the support of the mother following childbirth. However, some three years later there is scant evidence of their development, especially in the community. This is despite evidence supporting the need since the 1980's (Oakley 1981).

This reminds me of when I was visiting women postnatally as a community midwife. A woman had just arrived in the UK and given birth. I called to conduct the postnatal visit, her husband met me at the door saying that he was pleased I had come to care for his wife as had to get back to work. His understanding of postnatal care was very different to what my role had developed into.

Bas told of how Siaz slept with her mother for the first three days of her life, then when the milk came in continued to breast feed for over two and half years.

6.3.12 Taz context story

Taz was born in 1934 and was visiting her relatives from Pakistan when Ria accosted her for the interview at the over-fifties women's group. The context around Taz's birth story held multiple facets; firstly, how Taz's grandson received me, then at the culmination of the interview Taz's daughter, Rob, verbally attacked her daughter, Sam, who had been acting as interpreter for the interview.

As I knocked on the door at the arranged time, a young man in a beard answered the door. He did not look at me, instead pointed to my shoes, which I immediately removed. As I stepped into the hall, he flinched back as if my being near him was abhorrent. I felt that he did not want to be contaminated by me. Sasson (1999) says that many fundamentalist Muslim men believe that all women are impure and that if they touch even the palm of a woman not legally bound to them, they will suffer red-hot embers applied to their own palms on judgement day. Later Sam told me:

"He (her brother) started studying Islam about six months ago and it has gone deeply into it...it has affected his life..."

Taz had an arranged marriage when she was fourteen years old and delivered her first baby when she was aged sixteen. When asked if there was a lower limit when a girl is allowed to marry, Taz said, *"there is now, but there was not when I got married"*. Taz had ten years of schooling prior to marriage. Thereafter she gave birth to nine children, two of them died, one a stillbirth and one at aged six months.

Following the interview with Taz, her daughter, asked me if I would like to see the new prayer room, it was a room attached to the kitchen without windows. Making small talk I began to explain the purpose of my visit to their home. Rob asked if I had children and the conversation came around to marriage. As I inquired if Sam's marriage had been arranged, I was hit with the force of her mother's reply. Sam's eyes rolled into her head, I had unwittingly touched a live family sensitivity cable. I immediately looked to Sam to offer my apologies.

Sam's mother (Taz's daughter) unleashed a tirade of abuse towards Sam; the gist of it was:

'...if someone had done what she had done here (in R..) in Pakistan, the police would have brought her back and the relatives would have killed her.'

As I looked to Sam to express my sincere regret at being the catalyst to this vitriolic outburst, I mumbled something about respecting differing cultures but also said that I could never condone anyone harming my daughters, no matter what they had done. I did not know how to put right the wrong I had done, Rob became very angry with me saying that we in the West did not understand the importance of family honour and that Sam had shamed the whole family. I tried to balance my respect for the culture and religion with my instinctive defensive and very protective feelings towards basic human rights. A familiar conflict of feelings and emotions drenches me during each trip to Pakistan. Rob said that Islam meant more to her than her own life, let alone her children. I have never actually met a mother who would condone her own daughter's murder before, although I had read of such atrocities in the popular media³⁶.

Sam said she had tried to atone for her wrongdoing but her mother was not listening, she was saying that children should respect their parents and should care for them, not

³⁶ One example is Sanderson and Self, (1999): This was about a widowed mother and her son who killed their seventeen-year-old daughter/sister when she became pregnant by her boyfriend. This was carried out on the basis that insulted honour is the ultimate disgrace in the Pakistani community. Shame must indeed be dreadful, so ghastly that it would push a mother to kill her own child

destroy them. My eyes met Sam's, (Taz was out of my line of view) and without words I tried to communicate my compassion for her situation, but felt hopeless.

I simply had to beg my leave, to escape, realising that all I was doing was turning my back on it as the world does with religious fanaticism. Sam put on her shoes and walked me to the gate; her eyes and body language were apologising for her mother. Rob stood resolutely at the front door. I took Sam's hand and squeezed it. She said simply "*this was not of your doing...*" She understood my feelings, she was protecting me from my own guilt at opening up the religious sore that was so obviously paining Rob.

6.3.13 Taz's birth story

As stated, Taz had an arranged marriage when she was fourteen years old and delivered her first baby when she was aged sixteen years. Thereafter, Taz gave birth to nine children; two of them died one a stillbirth and one at aged six months. Her children are now aged between twenty-six and forty-seven. The last three children were born in the hospital, the first five at home (again the numbers did not add up, however, I did not clarify and assumed the first stillbirth was not counted).

When Taz was asked if anyone had suggested having her second baby in a hospital due to the first being a stillbirth, Sam's response after asking Taz was:

"I doubt it for some reason" (shake head and laugh)

Mgt "...what made her go to the hospital for the last 5 babies then?"

Sam "...because she had already given birth quite a few times and, ... som'at to do with her legs, ...she got poisoning....and basically her leg was paralysed, and they packed her leg in sand...she spent two months in hospital and they put her leg in sand and she did not walk for a full year after the baby was born...she is saying she should not have got married at such an early age, because of the small gap between her children her health suffered"

The concept of spacing through contraception was not available knowledge. Also the knowledge available to prevent deep vein thrombosis thirty years ago was limited. I was horrified to hear that Taz was advised not to drink much, she was on bed rest and

immobile in a climate such as Pakistan's, dehydration would further precipitate the blood to clot.

Sam "...she could not drink much...but she eat everything..."

When I asked if Taz was given any injections, Sam replied

"...this doctor was brought to the hospital to give her injections..."

One would assume that the doctor worked at the hospital but this was (is) often not the case. Out of morning clinic hours, the doctor at the Maternity Hospital in S... would return to her home (often to practice privately). If there were problems at the hospital someone would be sent (on foot, or rickshaw) to bring the doctor. (This may take up to or over an hour). Thus it does not seem strange for a doctor to be brought to the hospital to give an injection. When I asked what the injection was for, Taz said, without hesitation,

"To speed up and make the baby come..." Sam added, "Because there were no pain killers...she suffered..."

6.3.14 Ina (midwife) context story

Dot, the retired midwife who was the research assistant during the field trip in 1997 and had accompanied us to Pakistan five times in total, arranged the interview with her Urdu teacher's mother-in-law who had given birth in Pakistan.

The interview was to take place in the Urdu teacher's house. When I arrived at the pre-arranged time to interview, I was informed that the women to be interviewed had gone to Birmingham. To honour the hospitality I stayed for a chat and customary drink. It was clear the family were expecting someone.

Eventually I was informed that an elderly relative who had been a midwife in Pakistan was being brought from another town, coming especially to be interviewed. During my hour-long wait a neighbour came into the house

Suddenly I heard this unforgettable distinctive booming voice that rattled with familiarity. It had been twelve years since I had heard it, yet with it came a flood of

memories and a multitude mixed of emotions. The woman came in to house and said '*I bet you do not remember me*'. How wrong could she be? The family and the experience were indelibly imprinted in my memory.

The woman was one of three sisters who were married to three brothers, who all shared a house. As a new community midwife in 1979 I was visiting the home to care for one of the sisters and her new baby postnatally. On the sixteenth postnatal day the baby's umbilical cord was still attached, hard, black and dry. As I was cleaning around the base of the cord, it snapped off. A blood vessel started to bleed. I was unable to stem the bleeding so drove the mother and baby to nearby casualty.

At that time we (community midwives) carried ligatures to tie off the cord if necessary. However, there was insufficient cord tissue left to be able to do this. I made the decision that it needed suturing. By the time we reached casualty the bleeding had stopped. I revisited the baby again that evening and daily until he was twenty-eight days old. He appeared fine. Nine months later I heard the baby had died of a chest infection.

I was mortified. Was there any link to the bleeding cord? I discussed this with the GP and remember rehearsing my resignation on my way to see him. Rationally, we discussed the life of a red blood cell; even if the baby had been anaemic following the incident he would have replaced the blood within three months. Or, he may have been borderline anaemic and a sickly child who did not have the resistance to fight the chest infection. I asked the health visitor, with my heart in my mouth, if he had been a sickly child. I could have hugged her when she said 'not to her knowledge'.

Twelve years later, in the house of Pav and Shaz, the aunt of the baby who had died told me,

"You were the only one who had shown special interest in the child, even taking him to see the hospital doctor".

I had never shared my concerns with the mother or her sister. I was terrified they might blame me for the baby's death. I did talk with the GP and the Health Visitor and felt they said the right supportive words, but underneath wondered if I should have done more.

This quotation of Atkinson and Silverman (1997) explains how revelation affirms inferiority, 'the no smoke without fire' belief.

"Viewing, hearing, or reading a confessional invites complicity with the penetration of the private self. The revelation affirms the inferiority of self." (Atkinson and Silverman 1997:313)

Seeing the aunt of the baby who died brought rushing back, with alarming clarity, feelings of guilt, shame and fear, yet incongruously, I was being thanked for taking the baby to the doctor.

A whole carload of adults and children eventually arrived at Pav's home. There was an immediate bond/connection with the older lady in the party. She looked at me directly, her eyes twinkled and she had a broad infectious smile. Her dupatta (scarf) was tightly wrapped around her head –no hair was visible and she had on layers and layers of thick clothes. There was a warm glow around her, she emanated confidence and superiority and had a 'presence', yet she was ordinary woman. I prickled with anticipation yet could not imagine how an interview could possibly take place in this room. By now there were eight adults; Pav, her husband Shaz and two sons, Ina, her daughter mother-in-law and husband with three young children aged between three and nine, all in a room twelve-foot square. The introductions took nearly fifteen minutes, then without being told the men went outside to sit in the car and the boys went upstairs. This left the women and children for the interview. Ina's daughter, who was aged forty-one years, sat between Ina and I on the settee, Pav wrapped in her blanket sat in the hearth. Ina's daughter's mother-in-law sat on the coffee table under the window. The children sat on the floor.

6.3.15 Ina, the midwife's birth story³⁷

Relating some of the context of Ina's life and belief systems provides a grounding to explore her practice as a midwife. The women interviewed in R... gave birth in Pakistan at the time that Ina was working as a midwife (1950-70). None of them spoke specifically

³⁷ This is written in the third person as Ina's daughter acted as an interpreter. Ina could follow my questions but was not always able to articulate an answer

of the midwife conducting the delivery. Some did mix and match with the descriptor of dai in one sentence and midwife in another. All the women related to the dai being the person who was called to be present at their birth in the home. Shu, Mrs A. and Shad tell of their birth experiences in hospitals, however the doctor was the dominant person in hospital and their birth experiences were much later in the early 1990's.

Ina began her training to become a midwife in 1956 as an unmarried eighteen-year-old with nine years schooling but no matriculation. In her twenty-five years as a midwife she worked for ten years in a large Civil hospital, and then fifteen years in a Red Crescent hospital, retiring aged sixty-five in 1997. Her training was at the Yalcot Medical College and lasted two and a half years. The midwifery course was for two years but Ina was late starting so had to do an extra six months.

"...A. Mrs Peters was the teacher at the medical college, she was the matron and she was Anglo Indian. Ina had to witness twenty five, deliver twenty five with five operations and see forceps...there was a need to write English for the injections and all names in English...there was no lectures on the body, they just showed a dummy and a film..." Ina

As an educated woman in the 1950's, midwifery was considered an unsuitable occupation for a woman; Ina describes how her father and brother tried to obstruct her.

"That is how she got late, her brothers and father did not want her to do, they tore up the form, they would not let her go. However, she was determined she had seen these beautiful nurses in Bombay when she was aged ten and from then on she wanted to be a midwife."

Ina's occupation as a midwife did not appear to impede the arrangement of her marriage.

Ina's daughter wanted her views on arranged marriage documented:

"Nobody gave me a choice, ...they do ask if it Okay, this is not a choice, you just have to say yes. Because if you say no they (parents) have to find someone else. I think it is alright if you are young. I got married when I was sixteen so it was all right, but if I was twenty-five I would want to choose my own. When you are young it is easier to rely on your parents. Today the youngsters are meeting each other, they tell their parents, but they go for person parents will approve of. We do not believe in marrying in the family, we have come across this but they have started to have abnormal babies. "

This last statement made me consider that the family held Christian beliefs; however later, Ina's daughter confirmed that they were Muslim,

"I am not like lipstick because of animal fat"

Ina married at the age of twenty-one or twenty-two and did not stop work thereafter, taking fifteen to twenty days off following the birth of each of her four children

Ina's work provided the family with a home.

"She lived with her family on top of the hospital she worked at. The hospital had four beds and did not do operations. She had one dai to help and the doctor in charge..." Ina

It is usual for the staff to live on the premises of the Red Crescent Maternity hospitals. Most of the staff at the research hospital in S... lived in residences inside the hospital wall. It is my considered opinion that this was the main factor in keeping the hospital open. The number of staff employed, the throughput and the hours of work would astound western midwives. Five trained members of staff run the hospital in S... supervised by one doctor. The throughput is at least eighty to one hundred out patients per day and three thousand births a year. The staff work shift duties and on-call, twenty-four hours a day for six days a week.

Ina's practice as a midwife involved her doing normal deliveries.

"Only normal deliveries, if any operation call Dr Mark at the Civil hospital" (Ina Chapter 6.)

It is not uncommon in the 1990's for a midwife to have completed her training without either observing or undertaking a delivery (P.c Kamal 2002)³⁸ and, as a consequence, they will not be allowed to supervise a labour or birth. However it is not always possible to ensure there are two members of staff on duty, especially at night, so as time passes after training, depending on the hospital, the trained midwife may by default build experience in undertaking births. However, if anyone else were on duty, Lady Health Visitor, Staff Nurse or Doctor, the midwife would not be allowed to deliver the baby.

When asked her opinion about undertaking an episiotomy, in light of the 'modern' practice of all first time mothers having one in the S... hospital (Dr Quaisr), Ina predicted that the reason they are done is:

"They do not wait the time they speed things up" (Chapter 6)

This confirms what the un-named dai says (Chapter 6).

Ina was happy to answer any question, however her answers tended to be single statements. She really came to life when telling particular stories of women. This demonstrates to me the popular way of learning through oral history and real life scenarios.

"...A woman arrived at the hospital with the baby's head out for 3 days; they had taken her on a bullock cart ride to shake the baby out. She came in full of mud and my mother (Ina) washed her, fed her, they (relatives) had not even given her food or water for three days...the baby delivered.

This story has parallels with Dil's story where "mud" was coming from a woman who had been left to die by the doctors. Dil washed the woman, gave her food and clean bedding and very importantly, 'massaged her belly' so the "mud" left her body. The administration of traditional non-invasive ethno medicine saved both women's lives. Both stories demonstrate the silent suffering of women that can be alleviated by women like Dil and Ina.

6.3.16 Farn context story

The extraordinary tragic coincidence that forms part of the context of the interview between Farn and I is acutely poignant.

The interview was set up though the over-fifties group. I vaguely remember someone in the group telling me that she was Farn's mum. I had no idea who Farn was, but did not

³⁸ Imtiaz Taj Kamal is known as the 'senior most midwife in Pakistan' (NCMH) and has spent 50 years promoting midwifery education.

admit this. I arrived for the interview at the arranged time. Farn opened the door but said it was prayer time, so I sat and watched as Farn knelt and prayed. On the settee by my side was a photograph album, opened at a page with a picture of me in my uniform with a group of other people. I could not remember the place or the people and only made a guess at the year by my build, uniform, hat and hairstyle.

When Farn had finished praying, she came over and pointed to a young woman in the picture saying that was her Fran. Not wishing to offend, I asked innocently after her. Farn told me that

“Fran had committed suicide, she tied a cord around her neck one-week after the picture was taken in 1984”

I said simply *“I am sorry I did not know”*. I tried to remember back thirteen years, but still nothing came.

Farn raised me from my desperate memory searching she said *“I will make tea then ask me what you will...”*

6.3.17 Farn's birth story

Two years after her marriage Farn conceived.

“I did not know I was pregnant (laugh) I think I don't know why my menses not coming (quiet) then I think I will see a bit of bleeding, then I tell my sister-in-law. I don't know...she said you can go to the doctor and I am coming with you...the lady doctor...I will take you. You know lady doctor (laugh) she look at me and said 'you are pregnant' I (laughing) don't know. You know when I am young I don't know these things...she say you are six weeks pregnant”

When I enquired if she was pleased Farn said.

“Yes, then I am coming back and tell my sister-in-law...she said you are not being sick, I said I want to eat more, I am hungry...my sister-in-law said, when I was having my baby then I am all the time sick...”

Both Farn and her mother were pregnant at the same time. Farn remembered the exact time of each birth.

"My son was born 15th March and his aunt was born 27th April. My son born half past two on the Saturday night. I not tell anybody...all night a little bit...bit...pain not sleep...then in the morning time I cup of tea. Then my auntie's come then (laugh) I not tell my auntie or anybody ...she going ten o'clock own house then after eleven o'clock the (pain) again started more and I tell my mum and she said you not tell me before...then my mum got the dai"

There are many concepts within Farn's hidden labour. It is uncommon for Pakistani woman to draw attention to or tell anyone that she is in labour; this is especially true if there are men in the house (Chesney 1994b). The shame of talking about pregnancy can lead women to give birth alone. Just being pregnant alone is evidence to the outside world that sexual activity had taken place. Loose clothing and staying at home are strategies to hide such shameful activity.

It is unusual for the woman to return to her birth mother's house especially for the first birth (Jeffery, Jeffery and Lyon 1988:98): however Farn did just that;

"Oh I was at my mother's house for a month before and after the birth"

Farn could remember so much detail, even of events some of thirty years previous. Simkin (1992), found women's memories of childbirth (first) after twenty plus years were 'strikingly accurate and vivid', fitting the adage 'etched in your memory or, 'I remember it as if it were yesterday'. O'Neil (1990:4) says that:

"Memory is part of a creative act that we work on the framework of our knowledge and experience of past events. The shape we arrive at is formulated (even dictated) by our present perspectives and preoccupations, letting us understand more about ourselves and our place in the world"

Farn's place in the social world became more visible when she began to talk about the dai, (who was her husband's relative) and unknown to me previously was also the relative of another woman who had been interviewed (Naz). Farn's precise memory around times appears to link to her special skill in remembering dates and times from years ago.

*"I remember everything y'know when I was two and a half, then my other sister she is ten months... she is fat and very nice and very white like English people..."*³⁹

Simpkin's (1992: 64) work around mothers' memories of their first birth experience compared to memories (of birth) following a six year gap in telling the story of birth. There were some 'flashbulb' memories for some of the women of vivid specific events and mostly the women had excellent recall of their labour, birth events, partners' and nurses' (USA) words and actions, pain and care and appearance of the new-born with only minor variation in detail. It was heartening to read this work as not only does it explain Farn's vivid memory, it also validates the findings within the methodology of this research.

"Womb open little bit'

Farn saw the doctor once in pregnancy,

"She said (sister-in-law) you are coming (to the doctor) and she gave me an appointment she (doctor) told me – you know that womb little bit open, you can go...every night you should sit like this (demonstrated kneeling on all fours with head down) for a few minutes "

When I asked if the doctor had 'felt inside'

"Yes...then she said you do like this for a few days and you..."

When I enquired, how long the kneeling should take and continue for, and had she had any bleeding?

"Only for a few days for few minutes (ten), no bleeding ...she examine me...then she said you do like this a few days... then you will come back"

As Farn had said, she only went once (to the doctor for antenatal); I asked why she did not return.

"Oh ...I was going to my mother's house..."

³⁹ I questioned whether this was colonial socialisation

This did not answer the question, however going to her mother's house symbolises safety and her mother caring for her, so Farn does not then need the services of a doctor. For all of Farn's births, the dai was called (who was her dad's auntie); she lived in the same street.

6.3.18 Ami (Riz) context story⁴⁰

Riz was a student midwife when she heard of the research; she said that her mother who had given birth to all her children in Pakistan would love to be interviewed. After ensuring her mother had given permission, I spent the most enjoyable afternoon at Ami's home. I was especially aware of my position, as not only a white western woman and midwife, but also Riz's teacher. It was clear that Ami was used to dealing with health care personnel on her own terms. She had a disabled daughter whom she cared for at home, supported by social services and community nurses.

Somewhat paradoxically, it became evident that it was more acceptable to place trust in a relative stranger than a relative or neighbour. Later I was to find out that the extended family network had broken down. The situation was a little unusual. Riz's parents were divorced and her father lived with Riz and her husband. On reflection, this would not have seemed unusual to me if it had been her mother living with her, why did I consider it so strange for it to be her father?

"She will only talk to anybody she can trust and know that it is not going any further. If you were an Asian woman she would know that it would get out."

Ami's marriage was fraught with problems (told by Riz),

"It is all so complicated...he has always been coming and going, but this time I had only been married about six months and he went. He went to Pakistan and got divorced there and sent mum the divorce papers. So then he came back last year and wanted to come and live with her and she said "no, no way". He has done this

⁴⁰ Riz was a very new pre-registration student midwife in 1997, she acted as an interpreter for her mother Ami. nurse

before and she has always had him back. He has been married before and come back (two other wives). She has always let him back, not a third time; as far as I am concerned there is nothing – he now lives with me...he has divorced his third wife. I don't know why, he is a sad man now really. He used to be popular at one time he had lots of money, he had his own business and he just went to bits cause he just. The money gave him the power that he never had at one time, he used it to his own disadvantage, and these women only married him for his money. When he had no money left, he used to come back to mum and she always accepted him."

This marriage story is only culture specific in the perspective of multiple wives. The frequent coming and going is a pattern across other societies.

Multiple issues arose from the interview with Ami; this was enhanced by Riz's presence.

6.3.19 Ami (Riz) birth story

NB: Riz who was a very new post-registered nurse and student midwife in 1997 acted as interpreter for her mother Ami.

Ami gave birth to four children in Pakistan, one boy and three girls.

" She had trouble conceiving...so was considered a difficult problem...she saw a doctor in the hospital and see a midwife in between who gave medicine. The doctor gave her tablets to eat and the midwife gave her a sachet to put inside...she cannot remember the name" (Riz)

Infertility is a curse in a society where the woman's role after marriage hangs upon her ability to conceive and give birth. Harcourt (1997) found the first action women would take when experiencing difficulty in conceiving would be to pray through the Mazzaars and then next go to the Pir. The Pir is a self-appointed holy man who focuses upon prayer or ritual for ill health. Only finally, and if they can afford it, do they seek out the services of a medically trained person. Oakley (1997) states that the search to cure infertility in childless couples is a thriving industry. This was borne out during my first visit to Pakistan whereby the doctor at the maternity Hospital interrogated me on the latest drug

regime to stimulate the ovary.⁴¹ This also puts into context the incongruous neon light sign in Lahore advertising 'test tube babies.' The irony is that developed countries are keen to support international programmes that assist in population control (Duden 1992). Such programmes concentrate exclusively on the control of female reproduction and put traditional economic goals before women's needs and choices.

The complex, multi-layered social and technical context surrounding fertility ranges from the woman in the village in Pakistan using 'sachets' of herbs in the vagina (as Ami did), to the complex world of technobirth and all manner of assistance to artificially conceive. When Ami did conceive she did not receive any antenatal care

*"The dai looked after her..., no antenatal care; everything was OK
... when she started in labour"*

The implication being that one should only have antenatal care or see a doctor if anything was wrong. The judge of when and what was wrong was the woman, her close women family members and the dai.

"Her mother-in-law keep a note of every time she menstruated and then she didn't and she counted nine months...she told her midwife when she started with the pains and the midwife used to come now and again to see what she was doing".

What the dai was doing during Ami's labour is referred to in the main theme on the dai this involved non-invasive presence and support. The position Ami adopted for labour and birth was of her own choice, despite encouragement from others (women and dai) to be ambulant and squat. This suggests that Ami had the confidence to say and do what she felt was right for her. For the care in labour, Ami told Riz: -

"Ah she is saying that for the first baby the dai encouraged her to sit and squat and she refused because it was not comfortable. Instead she lay on the floor...they (women and dai) kept saying get up and walk, but she refused. She says my sister was the longest ...with me her waters broke and she did not start with her pains so she carried on with her work and the pains came. They did not do

⁴¹ This reminds me of the story of the widow with five children whose mother-in-law could no longer afford to keep her; she had a proposal of marriage if she would give the man a child. However, she did not know if she had been sterilised or had a hysterectomy. She had heard the former could be reversed.

VE (vaginal examination) they just looking...they pulled her legs apart and kept looking...usually if not progressing the dai said 'I cannot take over they should be taken to hospital'. But she was fortunate and did not need to go. She said there is no form of monitoring at all, blood pressure, sugar, and she remembers in her village there were lots of deaths, babies, because nothing done, lot of women dies nobody checked urine, blood pressure, the dai was quite old when they died their daughters took over."

So many facets of pregnancy and birth care sit within this piece of narrative. 'They' in the text refers to the other women present. Shared decision making is covered later in (Chapter 7). The importance of position for birth is also covered in Chapter 7. Ami's link between the lack of antenatal surveillance and care correlating with high morbidity and mortality is insightful; however this is in the context of her daughter being a nurse and student midwife

Ami related her diet whilst she was pregnant, Riz, her daughter, acted as interpreter.

"Cheese and milk she eats, she is saying that she did not have any particular like, just ate whatever she wanted (they could afford it). She would eat meat because there was nothing else...she did not like it. She went off lentils and green but she drunk a lot of water and took sugar cane and she spit a lot and had discharge as well."

The diet Ami was having during her pregnancy appeared to be healthy; however, the sugar cane may be an influencing factor in her mature onset diabetes. The other bodily changes referred to; excessive saliva and increased vaginal discharge are considered normal bodily changes. It is interesting to note that she can remember them so many years after the event, or could it be the content of her daughter's midwifery programme influencing the data.

"She said that she was not given medication (in labour) but was given a lot of hot stuff, (not hot taste) but hot to touch...they gave her a lot of tea with sugar in, also aniseed flowers made into a paste to keep the strength,..." Riz

Riz added that,

"It is eye opening, you know we have never had this conversation before, I am learning, you know normally she does not talk like this, she is a very deep person, but when somebody comes she gets really excited".

6.3.20 Fari context story

Fari was Ria's best friend and chief volunteer at the over-fifties luncheon club. She also taught Maths and Urdu to women at the local community centre. Fari was the only woman who chose to be interviewed in the community centre. When she agreed to be interviewed she asked Ria to accompany her, to which Ria replied

"Do you think she is going to eat you? I know I have done it...you can speak English good...you are just lazy..."

Fari's honesty about not being able to remember made me question my own questions. At the end of the interview Fari told a very interesting story that opens out the relationships between husband and wife. Fari felt that sacrifice was a part of women's lives.

"Women have to sacrifice a lot...a lot more than men...I don't think men sacrifice anything. You know I was very fond of learning things...I used to wish I had a house made of books...so that I could read one, put one back and get another...I used to love reading, but with working and having children...."

Even though Fari had achieved such a lot in her life, becoming a mother, teacher and leader of a group, it would appear that she was unfulfilled and would have savoured education and knowledge through books, however, others' needs took precedence.

6.3.21 Fari's birth story

Fari admitted finding it hard to remember specific details about her birth experiences some twenty years previous. This made me reflect back on my own birth experiences in the 1960's and 70's, to see if I could remember specifics, or indeed answer my own questions. In the transcript I was asking the woman what someone else was doing, specifically the dai, when she was in the throes of labour and giving birth. I realised after Fari's interview that I may be asking the impossible. The very nature of labour and the accompanying pain requires concentration and focuses the woman entirely upon herself.

Thus, to consider what someone else was doing whilst concentrating on self may be totally unreasonable. However, other women were able to talk of who did what.

On reflection it was realised that the all-inclusive stories may have originated from 'women talk' after the birth experience. This is when the women who had been present and taken part in the decision making will narrate from their perspective. This time the woman's experience will have been integral and valued as she had now joined the exclusive 'woman given birth, so now has experience group'. Most of the women's stories had the ring of 'rehearsed and told before', with the occasional light in their eyes which hinted of the *'I haven't thought of that since the birth or seen it in the way I told it before'*.

Contrary to most of the women interviewed, I had little recollection of what the midwife was doing when I was in labour and giving birth. I had no opportunity to talk and recount the experience with the other women present. I had no wish to set eyes on the midwife ever again, if I could have recognised her as she wore a mask. I made two incidents into stories. I have told these many times, when other women have been talking about their birth experiences.

The first story was constructed around a question I asked the midwife when she was listening to my baby's heartbeat with a pinard. I asked *how is the baby?* Her reply was, *"that is for me to worry about and not you"*. I can remember feeling both 'told off' and relieved. Surely she would tell me if my baby were not all right.

The second story involved me asking the midwife if she had any children. This is a very common question for women to ask midwives (Bewley 2000). The midwife replied to me in a very haughty tone *"what, me go through this, not on your Nellie"*. The impression the midwife gave was that I was crazy to be putting myself through the birth experience. I also remember quite clearly wanting the midwife to examine me internally, so that there could be a confirmation of the *'pains working'* and my cervix dilating which would be evidence of progress. I was not confident enough in my own body knowledge to know or accept the messages it was giving to me. After all, the baby belonged to the midwife, who was had the monopoly of 'worrying'. Because Pethidine dulls labour memories, I have

very little other recollection of my two birth experiences, except that I was told that I was not pushing hard enough and if I did not push better my baby would be damaged.

The work of the dai is exemplified through a story told by Fari. Fari came over to the UK from Pakistan in 1965 when she was nineteen years old, just four months after the birth of her first child. When Fari told the story of how her labour started it had the ring of one told many times before.

“Well actually it was windy, very windy and my sewing machine was outside. I tried to lift it (sewing machine) and put it in the room. As I lifted it my waters broke. I thought maybe I was passing water or something, I was going there (toilet) and changing my salwar and knickers...quite a few times I did. Then my grandmother noticed and told my mum...she said, it is not...eh...she is going upstairs quite a few times...you should send for the dai. (Fari)

Fari’s story demonstrates how a change in her normal behaviour alerted her grandmother to the impending labour. Close proximity of the extended family network offers a knowledge of each other’s movements that is not possible unless daily contact or communication is a part of every day life. This is not effective in a society where there is separate family living. Behaviour knowledge comes from watching and observing, knowing and listening.

Oral knowledge may have an exclusive element, for example, communication around what to expect on the wedding night, or how and where the baby comes from, is not always available (Chapter 6. Naz). Sexual topics are not spoken of in the presence of single girls (Harcourt, 1997) and until a woman has given birth herself, she will not be allowed to accompany other women in labour (Dil, Fari). This is where friends or older sisters and sister-in-laws play a part. Fari presents as an extreme example of the lack of knowledge of the young woman about birth.

“...Well actually my auntie had marks on her, (pointing to the side of her abdomen), (laughing), I thought maybe the baby comes out from here...she had an operation or something. I did not ask, I just guessed, (laughing). I was pregnant for six months before my friend she told me the baby comes from there – pointing to the pubic area; I thought there is no room”. (Chapter 6 Fari)

The ignorance around what is to happen in labour and the birth for the first birth can be viewed from the perspective of the dai, the relative and from the mother-to-be. The mother-to-be may be afraid, although Fari said she was not. The trust she had in her mother and dai was absolute; she knew they would not hurt her or allow anything to happen to her, she felt safe. For the dai and the relatives, the responsibility is enormous, as any midwife who has assisted a close relative at birth can empathise with. However, there would be times when there was no other female relative on hand when labour started.

Fari could remember the massage the dai carried out,

"I think I was lay on my back I think the dai massaged me...I cannot remember the detail"

Giving birth alone was a feature in previous work (Chesney 1995, Jeffery Jeffery and Lyon 1988:106); women in Pakistan reported this, especially if labour started in the night. Rather than disturb the men in the household the women would labour and give birth alone. This was because it is embarrassing (shameful) to talk to men. As stated previously, sexual topics are hidden from the women pre-marriage and pre-birth, also it is totally prohibited to talk about sexual matters amongst mixed company, men and women. It may, however, be necessary to talk with one's husband about menstruation. "*Sometimes when appropriate*" was Fari's answer to the question do you ever talk with your husband about sexual matters?

However, even if there was no one else available and no means of communicating, a woman in labour would not tell her father or brother in-law (Chapter 6 Farn).

6.3.22 Shab context story

I was introduced to Shab who was Vez's second wife when she was thirty-two weeks pregnant. Vez had brought her to R... for me to deliver their baby. I knew just how devoted Vez was to his first wife. This raised some powerful emotions, as I became involved with both women. I recorded some of them in an article written with their permission (Chesney, 2001). I vacillated between thinking as a western wife, how could

Veze had intercourse with another woman whilst loving his wife, to being Shab the second wife who was required to hand over the baby to Vez's first wife knowing that was why the marriage and conception had taken place.

My cultural bias was evident in the quandary, Vez's first wife had sanctioned Vez's second marriage, and 'her arms ached for a baby to hold'. Both Hus and Vez's two children were affected by a recessive genetic disorder. Shab had been rescued by the marriage from a life of widowhood, giving her daughter a chance for education. She was happy as long as her husband was happy. It is unfortunate that the baby did not bond with Hus and although Shab gave up breast-feeding; she was the only one who could comfort him.

Further contextual issues from Shab's birth experience in R... surround an opportunistic visitor to the birth room, just as Vez and Shab's son was to be born. Although the visitor was a relative stranger (a neighbour), she was not asked to leave as this would be considered disrespectful. Yet because of her presence, Vez stopped massaging Shab's back, mopping her brow and being generally supportive.

6.3.23 Shab's birth story

The interview with Shab on her birth experience in Pakistan was undertaken ten days after the birth of her second baby in R.... As outlined previously, Vez had brought Shab as his second wife to R... in order to give birth to this very precious baby, who would then be given to his first wife.

As a consequence of the timing of the interview, it was hard to keep Shab focused upon the birth of her first baby, Rabia, now aged four in Pakistan. The tape recorder was not used because the pre-interview socialising led straight into the interview and the timing just never felt right. The events were recorded contemporaneously in my reflexive diary. I took short notes whilst Shab was talking.

There was another confounding context. The woman in whose house the interview took place (Vez's friend), was present at the interview and she had just heard that the third

attempt at embryo implantation (IVF) had been unsuccessful. Thus the discussion about Shab's birth experience in Pakistan and the presence of Shab and new baby seemed to excentuate the woman's situation and inability to conceive.

I was very well aware that Shab would be trying to please me with her answers. I was surprised at my question about comparison of birth experiences, as this was not the focus of the research. Shab's reply was: -

"The birth is much more difficult in Pakistan. ... my first baby was born at home, my mother and the midwife were in attendance.... The birth attendants in Pakistan are not as well thought of as the midwives in Britain. The midwife did not listen to the baby's heartbeat, but she did give me six injections to make the pains stronger. Both my mother and the midwife pushed on my stomach in labour...I did not have any stitches...I immediately held the baby but did not start breast-feeding for three days⁴². I breast fed my first baby for two years and at the beginning had very sore breasts for the first three days the baby was fed butter and water. Normal duties in the house were resumed after only three days. I was not allowed to wash for a full week and the house had to be kept warm, the windows closed to keep out all the draughts...nothing was eaten in labour but postnatally I ate semolina and butter..."

It became evident during the interview with Shab that Vez wanted to be present, he came into the room several times asking could he help. Each time he came in I sensed the embarrassment of Shab and their hostess. I tentatively asked if he wanted to talk about the recent birth of his son and was surprised at his enthusiastic response. However, Shab's permission had to be sought and as I expected, the lady who owned the house left the room. Despite ensuring that Vez was out of the room when I asked Shab, I am not sure if her permission for his presence was permission or submission. As stated, Shab's only wish was to please her husband.

Vez proceeded to tell Shab and me that in all his forty-five years he had never experienced anything as wonderful as the time of their son's birth. As he spoke, his eyes

⁴² Shab, on my recommendation, had breast fed her second baby from birth, but she said it was a good job her mother could not see her do it.

filled with tears. On reflection, telling us this was probably the only audience that he could share these feelings with. I have never before thought that Pakistani men may feel isolated and excluded from talk of birth.

6.3.24 Naz context story

Naz and the three generations of female relatives so enjoyed the first interview that they asked me to return a second time. Naz's husband was suspicious of my visits and challenged me to declare my business. The appointment for the first interview had been made at the over-fifties women's group. Naz was one of the two oldest women attending the group, she had a warmth and gentleness about her, with her snow-white hair and very pale skin and at age sixty-nine she was a strikingly beautiful woman. Although she did not speak often, when she did her voice had a soft lilting quality. The women in the group grew silent as Naz made comment. This was so obvious because there was always a hub of conversation whereby the volume rose according to the number of women present, reminding me of a youth club without the loud music.

It emerged from the interview that Naz's sister was a dai,

"The dai taught my sister to do injections" Naz

However, Farn, who was a relative of Naz, said it was Naz herself that was the dai. Unfortunately, both Naz's daughter and daughter-in-law had a very low opinion of the dai, so Naz was hardly likely to admit to her previous profession.

Childbirth morbidity had a shocking reality in Naz's life. After giving birth to nine children she was left with a chronic bladder dysfunction that the doctors had declared untreatable. Naz 'cried a lot' was understandable in light of such a debilitating disorder.

Naz's daughter and daughter-in law showed little compassion saying that

"She cries a lot and always seems angry and bitter...women have to accept and be happy with their lot...and things are OK now...she has" (Naz daughter of Naz)

Implying that money was now in abundance and this should make Naz happy. I asked Naz what she would like most in the whole world and her reply startled me.

"To come to Pakistan with you"

The context underpinning Naz's birth story covered how her mother-in-law treated her worse with each daughter born (Chapter 8). The three generations' interest in the placenta and blood (chapter 8) and the belief that the woman's ability to conceive and give birth was, '*women's special mechanism.*' (Chapter 6 Fari)

6.3.25 Naz's birth story

There were three generations present at both of Naz's interviews. At first I thought this was to protect Naz. However their interest in the interaction soon made it clear that they wanted to learn about their matriarch's life. They were one of the first interviews in R... so my technique was still very much the interrogative style, in fact my legitimacy for being in the home, out of uniform and not performing midwifery duties, made me feel like an illegal intruder. The initial greeting from Naz's husband may have compounded this. "*What is your business here?*" It certainly was not due to the reception from the three generations of women, who were friendly and genuinely seemed happy for me to be there, so much so that they asked me to return.

Naz said,

"There were no qualified midwives when I had my children, only dai"

To which Naz's daughter replied:

"We think dai are ignorant"

Later I learnt from Farn, who was a relative of Naz's, that Naz had been a dai in Pakistan. One can only imagine how Naz felt about her daughter's declaration of dai being ignorant. It could be said that Naz's daughter was ignorant, ignorant of her mother's experience as a dai. Naz had obviously never told her.

There was a fault in the tape recorder for the first interview with Naz so the notes are my own, taken at the time and transcribed into the reflexive diary.

During the stories of each birth, the daughters and daughters-in law appeared to forget that I was present; I became the proverbial fly on the wall.

“I did not know that...I have never heard this before ...Do you know where my mother was born (granddaughter to aunt)?”

I sensed they saw their mother (in law/grandmother) in a different light during and after Naz’s story telling; admiring and respecting her more for the knowing, truly alarmed at the past suffering, perplexed that it had never been discussed before. However, as stated previously, although Pakistani women spend a lot of time together, talking about sexual matters never crossed a generation. Sexual matters were for discussion with peers only and as usually peers have the same level of knowledge, information is limited.

Naz’s female relatives were aghast to learn that *“with each daughter, her mother-in-law treated her worse”*, as stated in Chapter 7, much the same as Ami, Riz’s mother experienced when she was required to dress her daughter as a boy (Chapter 6).

6.4 Case study, Dil the different

I first met Dil at the over-fifties group; she commanded attention from the minute I stepped through the door. Her English was perfect and she had quite a distinctive, booming voice. In a direct friendly and chatty way she asked me why I was there. It was such a nice change to be the one answering the questions rather than asking them.

Dil challenged every stereotype I had come across of a Pakistani woman; she was bold forthright, loud and carefree. The pace of her speech meant one had to concentrate carefully to stay with her and she left one gasping for breath. Dil offered herself for interview before being asked.

Unfortunately, Dil had to go to London on the day of the interview and she did not tell me. However, some weeks later I called on chance. There followed a most fascinating life and birth story, with wonderful parallels and differences. As such, Dil’s life and birth story was chosen to narrate in totality as a case study.

6.4.1 A strong woman named Dil

A total of twenty-five key issues arose from the content analysis of the interview undertaken with Dil in her home on 21.7.97. She was a researcher's ideal participant. Her effusive, bubbly, transparent and honest personality led to an open dialogue that drew me as the researcher into discrete corners of her life. However, she was not only interested in herself, her flamboyancy had a positive, almost electrical attraction, that acted as a magnet around the frank and searching questions that came spontaneously within the dialogue. I knew that Dil had not just learnt the English language, but inculcated the norms of the British society, its nuances and humour. Her northern accent, loud voice and direct approach sat outside all my experiences with Pakistani women.

Dil reminded me of a community midwife I once knew. The midwife connected with the women in her care in a very special way. She entertained them and cheered them up by singing and generally being chirpy and cheerful. Although not always positive, (which is reality), her philosophy was 'c'est la vie' and she was often heard to say '*Ee luv you mustn't let the buggers grind you down*'. The expletive could apply to society, social workers, politicians, the bosses, doctors, husbands, mother-in-laws, whoever was placing stress in the way of women. The women laughed with her, felt cheered by her, took with them a bubble of endorphin from the laughter she left in her wake. It is interesting to note that in the preliminary focus group held in the community centre in R..., a Pakistani woman commented that it was part of the dai role to make the women laugh. Although Dil laughed and cried in the interview, the laughter was predominant.

When asked for her age, Dil's answer had tacked onto it the same question for me. Then came the reply

"No I was born in 1947 (despite us both being aged fifty) I should respect you then (ha, ha, ha) I am very naughty - be careful"

The use of the terms 'respect' prefixed by 'should' epitomises some of the fundamental norms of the Muslim family and Pakistani society that Dil grew up in. Giving respect, certainly to one's elders, is a 'should', it is usual for honour and respect to be linked. To lose either (or be the cause of it being lost), has the potential to bring shame upon the whole family. These strong cultural norms are core themes in Dil's story. Examples of the

strength of these are seen in the family relationships, particularly between Dil's father and her elder sister. The theme runs strongly through Dil's formative years; in education, her early work life in teaching, then as a health worker and also very clearly around Dil's own marriage.

6.4.2 Dil the interview

Dil remembered word for word what the research was about, despite it being over a month in time between us meeting for the first time and the actual interview.

"...Thank God I remembered (laugh)...because I keep forgetting things...I forget things all the time...doctor says your brain is alright (laughing) I said I think you (doctor) need a psychiatrist"

I learnt quickly that Dil held strong opinions on almost everything and spent the first hour and half after meeting her, climbing up and up a frenetic register of interaction. I recorded in the research log that Dil had a contagious manic style that left me gasping for air to think. However, I did not feel silenced; on the contrary, whilst she did not appear to take breath, she listened intently with her eyes boring into and beyond the feeble (compared to hers) answers.

The 'high' of our first meeting contributed to me approaching the arranged (in Dil's home) interview date with excited anticipation. Dil had tempted me with some fascinating glimpses into her life and I was eager to learn more. I reflected that it was a huge 'relief' to be communicating freely, without any obvious language barrier. I had come to accept that to learn about birth in Pakistan, I would need to get this information through a surrogate, an interpreter or relative. Here with Dil there was a direct link. Further reflections on the dilemmas of the use of such interpreters can be accessed in previous work (Chesney 1998, 2000).

As I drove up the street to Dil's house, I had a strong feeling of *deja vu* (although I had not recognised the name initially). However, something did not fit and eventually I judged this to be because the street and indeed whole area had deteriorated considerably. I then remembered the street. Even a decade earlier it had been dilapidated and run down and was now even worse. Opposite Dil's house a car had been stripped and burnt out. Rubbish blew up and down; large cardboard boxes were strewn alongside an old frame

from a bike, dogs were fighting over piles of rotting rubbish. I mentally castigated the local council and environmental health, not that I contacted them; it was obvious that other visitors to the street had not bothered either.

Reluctantly I parked my car, double-checking that there was nothing left on the seats and it was locked with a functioning alarm. Even the door of Dil's home was familiar, although now the bottom half of the once white door had peeled away or been kicked off its frame. I could hear music in the front room so knocked firmly. A boy of about fifteen opened the door enough to put only his head round. The look on his face told me I was unexpected. Dil was in London. Like a deflated balloon, I asked him to tell her that I had called.

On my journey home I reflected on the concept of the word and the deed, covered in previous research (Chesney 1994b), whereby I postulated that in a society (Pakistan) that upholds Allah as the ultimate controller, if something (anything) happens, it is only with his blessing. The term 'in shala' (God willing) is attached to all intention or proposed arrangements. Thus if an invitation comes to go to London, then this is what Allah wishes. Dil's intention was to keep her word, to meet me for the interview (if God did not want her to do anything else). However, the deed (keeping the appointment) was not in her control as God had arranged the invitation to London. Understanding this principal is very important for all health workers in the UK, as in British culture we are socialised from a very early age to do what we say we will do.

The interview eventually took place two weeks later, when I called to see Dil opportunistically. The same young man came to the door, recognised me and shouted to his mother an old familiar cry; '*the midwife is here*'. Dil bustled to the door shouting, '*come in, come in*', and even recalling my name. I was shown down a corridor that needed the same attention as the front door, into the front room where Dil's son had been watching television; he immediately turned it off and offered me a drink. Again this confirmed the family's adaptation to British cultural norms, as in a traditional Pakistani family, the food and drink is offered just prior to leaving to sustain and refresh for the journey.

I did not really expect to undertake the interview on this visit, only to make another appointment. However, Dil, whilst chastising her son for the untidy room, sat down and said, *'what do you want to know?'* I reached into my bag for the tape-recorder, whilst simultaneously asking Dil if she had the research protocol around informed consent (given at the first meeting). She looked with suspicion at the tape recorder. I explained that the transcript would be returned to her for approval, however, there was a distinct reluctance. I knew there would be no value in recording the interview manually, Dil spoke so quickly, and I just would not be able to keep up. Explaining this, without putting Dil under any pressure, I said I honestly did not think there would be any point in conducting the interview. Preparing to withdraw (putting the tape-recorder away) Dil changed her mind. She wanted me to stay and interview her.

The interview transcript was returned to Dil's for her approval. She had marked it, as one would expect a teacher to mark an examination script. One or two typing errors and a mis-spelling of the town where Dil was born were ringed in red and corrected. Also she deleted a whole paragraph concerning a contretemps with a Colonel, the father of a boy she taught, and one line concerning Dil's feelings about her sister. Dil had obviously carefully read the content of the whole transcript, which made it especially surprising to learn that her pen had left one particular section untouched. This was the section I had previously assumed (wrongly) would be sensitive. Getting this wrong illuminated our cultural differences.

6.4.3 Dil's pre marriage and family relationships

Dil was born (1947) in Uganda to Pakistani parents. There were altogether eight children, four boys and four girls. However one boy and one girl had died. Dil was the youngest. When I asked did she know what her brother and sister died of, Dil replied.

"My father said, never talk about them in this house, nobody can mention their name, because something happen to my mother then, she go faint"

My own father had the same beliefs. I remember him saying *'let her rest'* when I was anxious to talk about my sister who died aged twenty-one, as if talking about her would

not let her rest. This was in the mid-1950's, my father's philosophy was that thinking or talking about the dead made people sad, so it was better not to talk or think about them but '*get on with your life*'. It would appear that this ideology crossed continents at that time.

At the age of eleven, Dil's whole family were turned out of Uganda, along with most other Asian stock, when Ide Amin took over the rule of the country, much blood was shed and even as an adolescent Dil cared for people.

"...When we came from Africa to Pakistan in 1960⁴³It was when Uganda..., it was horrible, things that were happening...people were being cut open, their chests, their ears cut off coming in Darasalab and... I treat and bandage... they taught us first aid, which is what we used to do. That and... the big things went to the nurses and doctors used to see big wounds...you should seen them screaming and crying...I used to go to the hospital instead of school...lots of people needed me..."

When the family returned to Pakistan they went to live in a town called Jelham. Dil's father took her to the grandfather's house, where they lived until Dil matriculated. Dil's father and mother were not educated. Her father was in the British army, travelling all over India. When he got his pension they went to Africa.

6.4.4 Dil through puberty

Dil described herself as, what was commonly called in my childhood days, a 'tom boy'. Such a girl would like (prefer) to play with the boys, enjoying the games that boys preferred. This appears to be somewhat of a paradox for a Pakistani girl, especially around the time of puberty. Naz's granddaughter pointed out that girls are expected to behave differently

"The boys will be running up and down and the girls just sort of 'sit here'" (Naz Chapter 6)

⁴³ ⁴³ This would have made her thirteen years old not eleven.

"When I was eight or so I used to climb up coconut trees.... Do you know about fifteen (years) I was playing football, we were going to have a match, we had divisions you know"

Dil describes her menarche as a totally unexpected event at the age of fifteen years. She was playing football with the lads when

"One of my friends came, she said you stupid... (whispering), I said what? She said your leg is red, I wasn't feeling pain at all, I said, how come? She said, come inside the room, she said I think you have 'started', I said what is that, she said you are javan (mature) now'

Ignorance around menstruation hinged upon the lack of communication on such issues that are covered later in the sub theme behaviour and blood (Chapter 8.)

Dil's education was at a missionary Catholic school run by nuns. As a consequence, the only source of information on puberty and sexuality came from equally un/ill-informed friends or sometimes older, wiser sisters. Dil's ignorance left her feeling ashamed of being totally unprepared.

"I had this problem, no-one was telling me. I washed my underpants and we dried with the fan. She (friend) put a pad, you know, like a bandage and put cotton in it, I sat on a chair doing this (holding her crotch) and I said, what will become of me, oh I am frightened, I am not feeling any pain. She said I don't know why you are not feeling pain when I started I did...I said I don't feel anything eeh (mimicking crying). She washed my salwar, when I came home I talked to my sister-in-law, I said this thing happened..., we used pads my sister brought from Islamabad...if we had no pad we made cotton with bandage...my sister-in-law gave me corset..."

The panic that Dil felt on finding blood emitting painlessly from her body may have many sources; some of them are covered in Chapter 8. Dil is no stranger to bleeding as a result of trauma; this would link to her surprise at this bleeding being pain free. Although she was totally ignorant of the onset of the event, which can be connected to intergenerational silence on these matters, there is evidence of strong cultural significance around blood. This meant the 'evidence' of bleeding had to be removed immediately. Washing Dil's underpants and salwar constituted a priority to herself and her friend. This

relates to the shame of 'other's knowing', even women who themselves may be menstruating. Sanitary pads are not a readily available or affordable commodity to most village women in Pakistan. The making of a 'pad' from bandage and cotton wool was a common practice. In the Maternity hospital in S... (2000) it is just cotton wool from a roll that is used to absorb the blood. Further analysis of the lack of provision for women's comfort and hygiene, for what to us in the west is a common monthly occurrence, it may be because menstruation is not a frequent event for women in Pakistan. After menarche the marriage is arranged, followed by recurrent pregnancies, then the only time bleeding from the genital tract occurs will be following childbirth.

Dil did not wish other young women to suffer the anguish and shame of nobody telling them. She took it upon herself, during her teaching 'job', to talk to the girls in their lunchtime so they would be prepared.

"In those days they did not mention at school, when the girls were about fourteen years old, I did at school, I used to take the dinner time ten minutes, what to do, I used to talk, in our own language...tell them to bring extra underpants. I had this problem and nobody was telling me, I felt ashamed that nobody was telling me"

6.4.5 Dil the teacher

Dil studied up to matriculation at the Presentation Convent School. At aged sixteen she finished as a pupil, then straight away returned to the school as a teacher. Dil was unclear about whether she wanted this as initially she stated that she did not want to, and then later begged her father for permission. There was great emphasis placed upon gaining her father's permission to work.

"I don't know what she said to my father, but he gave permission" (laughing).

Dil told two stories involving her experiences as a teacher in the school. The first involved her age, dress, being single and the connection to maintaining her father's and the family's reputation.

"I was like a child at the school I was the youngest teacher....Mother P. called me and said put some lipstick on (to look older) however, Dil replied "I can't put lipstick on, it is tradition, because I am unmarried and I have to look after my father's reputation. She (Mother P) said alright then don't wear Salwar and chemise, wear something else that would make you look like old lady (ha ha) because these sixteen and seventeen year olds sometimes you have a duty to look after them in the grounds. I said don't worry I can handle them"

This led on to the second, rather convoluted story that involved the son of an influential man whom Dil accused of bullying

"One day there was an Asian girl, they (boys) take the pin out of her hair and throw it into a tree.... One day I was standing talking with Mother Phermina, I walked away and she was so surprised that I walked away, but I was so angry, I called the boy here, I said don't raise your voice to me I am not S... (boy) I am Miss C... and what I will do you will regret later. He said, do you know who I am, I said you are a human being, not God, I said you have done, so go and pick it (hair slide) and take it and say you are sorry. He said I won't do...so I sent him to the office...I took Mother P... stick. He was Colonel's son...I said you are going to do it or I will not leave alone. If you do not teach a lesson then all the children will do... He got cane on hand in front of the whole school... I said he must apologise and he said 'you will regret this'. I knew his grandmother and told her, do not send your son to school otherwise I will be rude with him. His grandmother said, whatever you want to say to him do, the boy has done wrong, in our culture the teacher is the second parent, you should respect".

The story is enmeshed with the norms of a society, whereby elders are respected. One does not raise one's voice to a teacher; discipline is upheld by teaching lesson and wielding a stick. Yet these norms can be contravened depending upon the position on society. It is interesting to note that Dil approached the boy's grandmother to confirm her discipline as appropriate. However, this preceded a visit to the school by the Colonel:

"Mother Phermina said, he is in the office the Colonel has come...I said do not worry I will sort him out, I spoke in Punjabi and said if it happen to your mother or daughter what would you do? He said I have never laid a hand on the child, I have never said no to anything he has asked. I said I cannot do that, my father taught me manners and I want to teach manners to my students I do not want students going from the school without respect...he later said his

son must apologise ...Mother Phermina asked what did you say, I told her I have secrets, I know how to deal with parents..."

6.4.6 Dil as Family Health Worker

After Dil's father died (1972), there was no one to support the family; it became necessary for Dil to work. There were additional mouths to feed, marriages to arrange and dowries to find.

"It was advertised in the Pakistan newspaper the Daily Jang, because my father 'was died' and nobody was supporting us and I had three nieces. The other my father adopted, as she was my brother and sister-in-law's daughter. We arrange the marriage and we teach her Nahaise you know 'girls side'...my dad gave three sets of jewellery all from Africa; he said when she was six years old, her parents died. Her uncle brought her up, but they were poor, so my dad said, she is now my daughter, so I will treat her like daughter, so all the food my dad gave her There were five young children and my sister-in-law, my brother and mother to support"

It is common for only one wage to be supporting an extended family of up to ten in number. If the family can afford to pay for one of its members to come to the UK to work, then once in England they take on the financial support for all the family back in Pakistan. Dil transferred the caring skills she undertook as part of the family and undertook minimal training (six months) to become a Family Welfare Visitor earning two hundred rupees a month. The work took her away from home for most of the week. She would come home on a Thursday to spend the day of Friday, returning Friday night.

"After six months I gave injections (streptomycin and antibiotics) you could earn money in the villages, whatever money they gave me, I used to feel sorry for them, whatever they gave me I take it I never demanded anything of them. When I passed my Family Welfare Test, I went out to the villages to give them tablets according to their circumstances, contraceptive pill, condom, and cap. They would not use the caps because they were afraid...I used to put loop, the dai would hold my light, I had a speculum, I used to take temperatures first of all, if they were weak I did not do them (put loop in).

Dil, as stated, worked as a family welfare visitor and had a dai to assist her. One story Dil told about her work included the dai and the all-important massage.

"One day I went to the village very far away and there was a girl, doctor said she would not live a month, she was very thin, I said how long has she been like this, they said two years, I said you put anything into her? I said all right don't blame me, I am not saying it is a fact...I will try that is all to cure her. They said what will you do, I said I want some hot water, oil and I had some tablets, she had a temperature. First of all, I tried oil with my dai; we massaged all (body). I said my God... it was like mud that came out of her, honestly when you were massaging it was coming like mud, that is the reason she was so ill...I threw away all the old bed sheets. I said give me clean I put clean on the charpoy (I say that because I know you know what a charpoy is) so I washed it. I said I would come tomorrow..."

The doctors had given up on the sick girl and Dil and her dai used basic knowledge to save life. This role reversal is also paralleled in Ria's story, referred to previously. Dil and the dai used massage with hot oil, tablets (? antibiotics or analgesics) and cleanliness. The question Dil asked about '*putting anything into her*' may have related to either orally or vaginally. The rectum is not used for herbs and potions as it is considered unclean. Orally she may have been given purgatives in the belief that it will purge her of the fever. Vaginally an abortion stick may have been inserted into the cervix, or she may have had an intra-uterine contraceptive device introduced precipitating an intra-uterine infection. If this was so, massage of the abdomen must have been terribly painful for the woman, the tablets, if analgesics, they may have helped. The mud may have been pus and decaying tissue, the smell would have been significant although Dil does not mention this. The wish for the family not to blame Dil or the dai has parallels in Ria's birth story whereby the dai and the aunt did not want blaming if their efforts came to nothing.

Massage constitutes an important therapeutic tool for the dai. Dil's mother would '*talk as she massaged*'. Jordan (1993:26) also found with the Mayo birth attendants almost all of the '*business done was transacted during the massage*'.

Continuing to explore the work of the dai, it was revealed that Dil in her work as family support worker had a dai as an assistant.

"I had a light I used to tell my dai to hold the light...I had a speculum, I used to take their temperature first of all, if they were weak I did not use... (insert coil) (Chapter 6 Dil)

The role of the dai as assistant, to hold the light for the speculum, opens out her role contributing to women's health by sharing. This concept links to the education of the Lady Health Visitor whereby the trainee becomes the servant to the trained. The women and the dai discuss the proposed action and give support and guidance to the labouring woman. This is particularly evident in Ria's birth story.

Much as Dil had stated when she was caring for the woman who had mud coming from her, the dai attending Ria was not *'promising anything'* they would only *'do their best'*, *'what will happen will happen'*. These phrases are grounded in humility and humbleness, the opposite of the arrogance of the medical hegemony. There was no promise, no sense of *'we will definitely be able to do it' or 'only we can do it'* but an acceptance that nothing can be lost by us doing 'it' (applying midwifery knowledge). This is suggestive that medical hegemony had been successful in convincing even the dai and Dil that it was superior to the practice that comes from women's 'uneducated' knowledge. However, this knowledge was 'second best', first the doctor's knowledge was tried before the women's knowledge could apply. Such traditional women's knowledge grown from necessity, did not rely upon the props of technology or intention and was freely available, if not common knowledge. The doctors could not draw on this knowledge because it had been hidden from the public domain, not published or disseminated for fear of being ridiculed by the powerful educated.

The description of the work Dil undertook would sit in the role of the family planning nurse or midwife in the UK, with added clinical hands on. Dil and her dai massaged the woman with hot oil, threw away the old bed sheets, gave her some tablets (iron and Vitamin C), and took milk for her to drink. Dil said:

"I treated her like a child...it was like mud that came out of her... After a month she came back (got better), her mother-in-law was going to give her a divorce because she was ill. She wasn't doing the house job, not giving husband intercourse, so they said to me they would have to give divorce, her father was praying he was a very poor man" (Dil).

Poor sick women in Pakistan are about as low on the social scale as one can get. There is a well known saying in Pakistan that depicts how alone a sick woman can be:

"Even a woman's shadow deserts her when she is sick."

Dil's sister was a teacher when she got married and Dil's future work and marriage was influenced greatly by the outcome of her sister's marriage and by gratitude for her parents giving her an education. The relationship between Dil and her sister was confusing and upsetting for Dil.

"...my eldest she was like a mother to me but then she was cruel, very cruel...in our culture, elder sisters are always, ...even become hero, whatever happened to this sister, I do care about her, but she doesn't. In front of people she shows, but in her heart I know, she doesn't, because her action show you what is happen... "

Further impetus that persuaded Dil to get married was family pressure and gossip. The family did not support consanguineous marriage;

"...I heard my relatives were talking about us, thank God we are not like that...we knew what was right and wrong, because we had education, we were not idiots...because we were brought up in such a way that my father did not get us married to relatives"

Dil's rationale for not marrying relatives from the village appeared to be linked to the way village girls are expected to work. However, she regretted not marrying in the village;

"...with the work in our villages, and they take...and bring...big, big water in jugs from far away, and all sorts of things, and I, I was a spoilt child (laughing) I thought of good things, but I really regret that, really regret that..."

6.4.7 Dil's marriage

"I did not want to get married"

Dil told me twice that she did not want to get married. Her views were influenced greatly by both her sisters' experiences. Her youngest sister's divorce had a direct influence upon the wider family.

(Speaking quietly, her husband was in the next room)

"My sister got divorced, my eldest brother-in-law threw her (his wife) out... I said I do not want to get married... my dad said, so I

agreed with him, because he had given us education, only he could write his name..."

The shame of divorce is linked to the loss of family honour (izzat) in the family (Khan 1999).

The Islamic Sharia law has placed a number of obstacles in the way of divorce. Divorce without lawful necessity and without first exhausting all other means of resolving the conflict is unlawful and is prohibited in Islam.

"The prophet Allah nor his messenger called those people who divorce and marry others...the 'tasters' (Salahi, 1993:35).

The prospects for the divorced Islamic woman of being returned to the natal home to become a financial burden on the family must be daunting, however the stigma of being divorced has even further social implications. Other family members having been divorced complicated both Dil and Bas's marriages, Ami, Riz's mother was divorced. It is also interesting to listen to the Pakistani pronunciation of divorce, which accentuates the 'I' die vorced.

Carroll (1997) a lawyer has done considerable works on Islamic divorce. Being a woman herself she concentrated upon the effects on women, particularly women who are seeking divorce in the UK. Carroll found that:

'Muslim women were forced by ignorance and social pressure to subject themselves to an interpretation of Islamic law that is harsher than it is for women in Pakistan'.

Not only were women disadvantaged socially through divorce, but also financially. If they applied for a divorce the husband often would demand the return of the marriage jewellery or a substantial financial settlement. Muslim women are not entitled to a divorce without the husband's consent and no Muslim marriage can be dissolved without the husband pronouncing a talaq. The talaq begins the divorce proceedings and is the utterance of the phrase "*I divorce you*" once. The reason that this is spoken is due to the marriage being a verbal contract and thus its dissolution is normally verbal.

When a man intends to divorce his wife he has to make sure that she is not in her menstruation period and that the two of them had not had sexual intercourse during the

period of cleanliness after the bleeding. It is forbidden to effect a divorce if sexual intercourse has taken place. From the moment of the talaq there starts a waiting period that lasts three menstrual cycles. If the woman is pregnant, then the waiting period is until the birth. During this time the wife stays at home but is no longer obliged to do housework. If there is a change of mind within the waiting period then the couple need not have a fresh marriage or pay another dower. If they do not reunite then at the end of the waiting period, the woman returns to her parents' house. She is not entitled to maintenance but if she has custody of the children, he should support them.

Dil's marriage was secretly arranged and appeared to be most unhappy.

"My wedding was a secret because in my parents mind. Like it was magic what happened to me sister (she could not conceive and her husband was found to have a child in another village) My Nakah (part of marriage ceremony) was held in a car, my father did not want anyone to know"

When asked if she was happy about this arrangement Dil replied:

"Do not ask that question...ha, ha sorry (starts to cry)... he (husband) was here (UK) he went to Pakistan, he was engaged to someone and something went wrong"

Dil's unhappy marriage was exacerbated by being brought to the UK (five years later) where she could not use her skills to work. Naz and Bas also reported how coming to the UK was traumatic and how they cried and cried when they came to the UK (Chapter 8). Dil compared this life of isolation in the UK to what she had experienced in Pakistan prior to marriage. Dil's relationship with her brother-in-law was such that she blamed her sister for the divorce and wanted to go with her brother-in-law.

"My friends used to come and my nieces used to come I wasn't isolated... I got to go to cinemas with my cousin. In Lahore I was free (laugh) my cousin every time I used to go my brother-in-law used to take me out every night. He treated me like a younger sister...he is very good man...because my sister got divorced I do not see him now, when she got divorced she was only 19-20. In our culture unmarried girls do not know anything what is going on when I know it was my sister's fault (not conceiving) I felt so guilty, I wanted to see him, I wanted to go to him"

6.4.8 Dil's birth story

"The first (baby) was delivered in Pakistan the second in B... and the third in R..."

Both Dil and I realised whilst she was telling the story of her births that I had visited her postnatally following the birth of her youngest son in R... in 1982.

"The third you coming to look at"⁴⁴ ...the first after a month I start vomiting, I feel sick and wanted to pass a lot of water (quietly). I could not use (contraception) because my mother said my sister could not get pregnant. So 'I want you to have a child' ...I was alright because my mother looked after me and my eldest sister, she was so good, so loving, she said sit down, now don't go there...almost as if I forgot all the things"

The tender loving care given by relatives is a theme throughout this chapter. Dil's story told of her mother not only delivering Dil's first child, but also undertaking an episiotomy (cutting the perineum). The dai had done an internal examination and said it (baby) is not coming as the opening of the uterus was small.

"The dai came but she couldn't do anything. My mother did it, you know, just cut a bit, she was so nervous, the dai was so nervous, what to do, what to do, cause my mother delivered her grandchildren and nephews and nieces (but she never do it for other people) and my time came, although she was old, she said 'go' (to the dai) I will do it myself, my sister held my hand and gripped me ...I said don't worry, don't worry, I pray to God. My mother said push, push"

The role of Dil's mother and sister during the birth of Dil's first baby at home may seem unusual in contemporary Britain. Since the 1902 Midwives Act it is illegal for anyone other than a doctor or a midwife to deliver a baby. It is interesting to note that Pakistan has (even to this day) the same statute books as Britain (it was under British Rule until 1947). Thus the 1902 Act would hold that Dil's mother was breaking the law by

⁴⁴ I now know why the street and the door were so familiar, I had visited Dil as a community midwife with her third baby. What was surprising was that I remembered the street more than I remembered Dil.

delivering her daughter. However, like many of the laws on statute in Pakistan, like riding a bike at night without lights, it is not upheld, no one would prosecute.

Dil declared that she would have preferred one girl and that was the purpose behind the third pregnancy, however, the motive was purely selfish - to help with the housework.

"I prefer one girl, I would have liked a girl, this is the reason I try for the third time, I prayed for a girl...Of course you know now I can't work properly in the house, all the mess, I can't pick up them up all the time. If I clear this table go the other side, clean the other side, when I come back it is mess again. If it was a girl she would help me you know...I do not expect anything of the boys... I am trying to buy M. (eldest son) a house...then after one or two years he will get married...if they don't then they stay with me. Cause I survived lots of things, what don't want is my daughter-in-law to suffer same...you know I have struggled."

This perceptive statement made by Dil came at the end of the interview; she added that in her opinion,

" Men wanted power, they wanted to be boss all the time...men see their power to be over women, wanting power (over women). This was not just in the Pakistani culture "even in English", she concluded by saying "I know some of the families, ...what the men want, they want the women to do it"

Dil's life lay on a rich bed of social and cultural norms. Her father appeared to be the greatest influence on her young life, 'giving her education', much as Farn's father did for her. Dil returned this favour by protecting the family honour and working to support the family after his death. However, it was atypical for Dil as a Pakistani woman to work outside the home. Dil did not want to get married and subsequently in marriage was unhappy. She spoke of a yearning to return to Pakistan to work as a Family Welfare Visitor again. Dil's childbirth experiences supported by her own mother proved to be satisfying, however Dil's reply to my query about why she had not accessed health care training in the UK was *"I have had enough of exams and the way of teaching is very different here"*.

6.4.9 Summary

Dil let us into her life through the interview. She appeared not to hold back at all, her frankness and honesty had a fresh naivety that took us into the full, three hundred and sixty-degree social, personal and private family life. Her life and birth experiences may be typical of a Pakistani woman, but her reactions to those experiences were atypical, made possible through character, personality and education. Alternative options were available for Dil; she had the confidence and the knowledge to choose to return to Pakistan and to work, although she has not done so yet. Most women do not have this choice, most women fear social isolation.

I learned a great deal about life and birth for women in Pakistan from the interview with Dil. I learnt of my previous stereotypical viewpoint of Pakistani women. Although I had long admired Pakistani women's silent strength and womanly togetherness, Dil was far from silent and spoke from a position of commanding strength. She presented with vigour and character beyond any other woman I had met.

Through the interview I learned of the family influence on the lives of Pakistani women, the depth of gratitude, obedience and respect accorded to parents, putting others' wishes and needs above self. I saw how this was perpetuated through generations when Dil told how she was going without to buy her son (who would not work) a home. I learnt how basic care and massage can bring someone back from near death. I heard how a young teacher struggled with an undisciplined spoilt son of an influential man and, importantly, I learned that what is sensitive to divulge to one may not have the same importance to another. Finally, I learnt such a lot about word and deed and the phrase 'in shala' took on real meaning, that of another being in control. Because of all this learning from the one interaction with this remarkable woman I chose to include her story as a case study.

Birth in the home appeared to be an anathema to the doctors and the staff at the Maternity hospital in Pakistan. Home birth just did not feature in the curricula of midwives, lady health visitors or doctor. It was looked upon as for those who did not know any better, the ignorant, to be dealt with by the uneducated dai. Technology, drugs and intervention were modern so assumed to be better. It would appear that midwifery knowledge is not judged

by the doctor, midwife, lady health visitor or the wealthy educated woman to be effective. In Ria's story the doctors gave up after the medicine was ineffective or the technology of intervention could not be applied. The acceptance of uncertainty, which is out of human control, could only be dealt with by the dai and the woman who had not lost confidence in her body to birth. This very humanistic humble approach is dialectically opposite to the promise the doctors make philosophically by implying that biomedicine understands, has the answer and is the only option.

Lack of training or experience for normal home birth is the fundamental reason why doctors, lady health visitors and midwives consider home birth unacceptable in Pakistan. The props of drugs, technology and the scalpel are judged to be necessary to deal with the problems that are largely caused by the props in the first place. However, there are other stories that have not been published, but travel rapidly through the traditional oral route, through the midwifery grape-vine only, because doctors and midwives are on social levels of the hierarchy, they do not mix socially or professionally except to work side by side. The reason why these stories are not published can only be speculated, however, one of the reasons found by Tricia Murphy-Black (1995) is that midwives do not have the confidence to publish and when they do; other midwives judge their work to be inferior to that of doctors. Midwives as women continue with the learnt submissiveness and from an inferior stance.

The position held is in common with women of my social group in the UK; working class northern women, whereby the belief is that,

"It's only me and what I think, find or have to say is not important, I have not had a decent formal education, no-one will be interested in or value my opinion",

This position as stated by Farn, prevents women from sharing and/or disseminating their knowledge. If this is the position of women who have had some formal education, then the deafening silence of women's knowledge in countries like Pakistan, where sixty per cent of women do not receive any formal education, is entirely understandable.

6.5 Why the context and birth stories have been told

Reporting the context of the women's lives has helped place the birth stories into perspective. A synopsis of the birth stories offers the reader a holistic perspective of the individuality of the birth experience. The findings from the interviews have allowed me to take a small step on an ever-changing endless road to understanding some of the issues around birth, as it is for some women in Pakistan. This has been undertaken by using an interactive perspective, focusing upon the important life influences of the women, relationships with their birth attendants and significant others, thus providing the reader with some of the important context around birth for some women in Pakistan. Childress (1998) recommends a formula to provide vivid pictures that stimulate thinking to increase insight. This entails extracting the themes of the drama, which are the women's lives and birth experiences, and to include the scene (context) and emotions of those involved.

The data collection process used mirrored Childress's (1998) recommended formulae. We listened to what matters to the women, recording the contextual influences and researcher emotions in both the reflective diary (UK) and collective fieldwork log (Pakistan). Thereafter, a content analysis framework was created of the key issues that emerged. From these a monologue for each woman was produced for further analysis using Polkinghorne's (1995) framework of firstly analysis of the narrative then narrative analysis. This involved asking questions of the people involved in the interview (metaphorically). This process served to raise to the surface significant birth experiences told as birth stories then developed into key and sub themes.