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Experiences of Bangladeshi and Gujarati  
women in childbirth

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## ABSTRACT

This thesis is about the pregnancy and childbirth experiences of two different groups of Asian women in Britain. It sets out to address the issues surrounding pregnancy and childbirth from the women's point of view. This is an attempt to redress the balance in the previous research on Asian women which has often portrayed them as a homogeneous group with 'problems'. An overview of the literature focuses on how Asian communities and, in particular, Asian women are portrayed. In order to provide a context for the issues which emerge in this research, attention is paid, first, to how Asian communities and, in particular Asian women, are viewed by mainstream society and, second, to cultural attitudes towards the sexual politics of reproduction. The main theme of the research is the degree of control the women were able to exercise given the constraints of western medicalised childbirth practices in Britain, traditional childbirth practices and the role played by the women's relatives during pregnancy and childbirth.

The study draws on in-depth interviews (during and after pregnancy) with two samples of Asian women- the first Gujarati, the second Bangladeshi. In addition, two Gujarati case studies and two Bangladeshi case studies provide further insights into the lives of these two groups of women. The women's perceptions of their experiences of pregnancy and childbirth are emphasised by the use of the actual quotes which give some indication of the way these women conceptualised the issues which confronted them.

The final chapter of the thesis concludes with a discusses of the position of Asian women within the current childbirth debate and makes suggestions for improving the delivery of maternity services to the Gujarati and Bangladeshi women in particular and to Asian women in general.

## INTRODUCTION

I am a Gujarati woman born in East Africa. I came to Britain some twenty-five years ago to complete my education. Before I came to Britain I was raised within a closeknit Gujarati community in a large town in Uganda.

Whilst the number of years I had lived in Britain enabled me to understand most aspects of British culture and life style, I had very little experience of the National Health Service in general and the maternity services in particular until I had my two daughters. When I became pregnant I prepared myself by reading all the available literature on the subject and also attended antenatal classes run by the National Childbirth Trust. Despite the fact that I was well prepared, I found myself less and less able to control what was happening to me. At the time the thought crossed my mind that if I, who was fluent in the English language and totally conversant with the host culture could face so many difficulties, the position of inarticulate women with language problems must be worse.

My first daughter was born at term but she weighed less than five pounds as a result of which I was assigned an intensive care counsellor who, during one of her visits, informed me that she "generally told Indian mothers what to do and they did what they were told." Her comments were directed at my refusal to bottlefeed my daughter and my insistence on breastfeeding. This and other related incidents made me wonder how other Asian mothers coped with the views and occasionally, the prejudices, of the health care providers of the host community.

As a result of my personal experiences I became interested in finding out about the experiences of other women. From the accounts of indigenous as well as Asian women I learnt that some of them had had particularly unpleasant experiences. My own personal experiences and those of other British women seem to suggest that the medicalisation of pregnancy and childbirth in Britain had resulted in the transference of control from the women to the medical professionals. Pressure groups such as the Active Birth Movement and the Association for Improvement in Maternity Services and other organisations such as the National Childbirth Trust have made some inroads into enabling women to regain some control over pregnancy and childbirth. However, inspite of the growing awareness by the medical professionals about the dissatisfaction with the maternity services, their attitudes towards pregnant women has been

slow in changing as a result of which the kind of childbirth experience a woman has depends to a great extent on her ability to assert her needs.

Whilst the medicalisation of childbirth in Britain affects women from all social backgrounds, its impact on women from the ethnic minority communities has received very little attention to date. This lack of interest is particularly pertinent because the experiences of the indigenous white women cannot be extrapolated to explain the impact of medicalisation on women from the ethnic minority communities since they do not share a common language, culture or religion. In addition, women from the ethnic minority communities have come from cultures which attach different values and meanings to pregnancy and childbirth and in which the influential role played by older female relatives during childbirth is very significant.

This present project was undertaken in an attempt to address some of the major issues which confront a small section of the ethnic minority women whose roots originate in the Indian subcontinent. For many Asian women of childbearing age born outside Britain and especially women who have very recently settled in this country, becoming pregnant requires them to come to terms with childbirth practices which are significantly different from the traditional childbirth practices of their own communities. I am particularly interested to explore the perceptions of childbirth of two groups of Asian women namely the Gujarati and Bangladeshi women.

Whilst some Asian women of childbearing age may have become accustomed to the idea of the involvement of health professionals during childbirth, women who have migrated from countries where maternity services are less well developed and available to only those who can afford them, are more accustomed to receiving care during pregnancy and childbirth from untrained but experienced women (Blanchet 1984; Abdulla & Ziedenstein 1982). However, in Britain, most women have no alternative but to seek maternity care provided under the National Health Service and from services which were originally modelled to serve the needs of the indigenous white women.

Many Gujarati women I had spoken to indicated that they were unable to be in charge and accepted care passively. They also felt alienated and intimidated by the way services were provided. Their experiences motivated me to train as a National Childbirth Trust teacher so that the training would enable me to prepare Gujarati women to actively participate in the decisions concerning their pregnancy and childbirth.

After qualifying however, I found that my classes were attended by very few Gujarati women although I was offering classes in Gujarati. This in turn made me wonder how Asian women perceived their pregnancy and childbirth in Britain and how much control they were able to exercise over decisions which affected their experience of pregnancy and childbirth. Whilst Asian women have received a great deal of attention in medical research and literature which generally perceives Asian women as a problem, very little is known to date about how the present generation of childbearing women view their own pregnancy and childbirth in Britain.

The aim of this exploratory study is to highlight some of the issues surrounding pregnancy and childbirth by inviting Asian women to talk about their pregnancy and childbirth experiences as perceived by them. In the first chapter I have attempted to present a review of a range of published literature and previous research studies on South Asian communities to provide an insight into how the South Asian communities and in particular South Asian women are perceived in Britain. A more general review of the portrayal of South Asian women in the literature is developed further in chapter 2 by focussing specifically on the relationship between culture, gender and biological reproduction and social control of reproduction. The methodology chapter provides information on how the data for the study were gathered and the problems encountered during the course of the fieldwork.

The main part of the thesis is based on the actual accounts of experiences of two groups of Asian women. The main focus of the empirical chapters is on the issue of control in the management of their pregnancy, childbirth and post-partum period.

The final section of the thesis concludes with an overview of the position of Asian women in the context of British culture and current ideology surrounding childbirth practices in Britain and put forward suggestions for the health professionals and policy makers in the NHS as to how the maternity services could be improved for Asian women

## CHAPTER 1

## PERSPECTIVE ON SOUTH ASIAN WOMEN - THE LITERATURE

The main objective of this chapter is to provide a context for the present study on Asian women in relation to previous research which studied Asian communities in Britain. The survey of literature on various south Asian communities revealed that a large amount of literature has been amassed which provides information on their pattern of migration, education, social, cultural and linguistic backgrounds. This information is essential to an understanding of the Bangladeshi and Gujarati women who form the focus of the present study.

The main emphasis, however, will be on health issues, drawing attention to the particular bias which has marked much of the research to date and the inherent weaknesses running through a great deal of this work. Research on Asian health issues will be contrasted with developments in the area of pregnancy and childbirth within the majority population in an attempt to point to promising directions for future work and to set the scene for the present project.

The people originating from the Indian subcontinent are sometimes referred to as Asian, south Asian and, in a North American context, East Indian. These terms often cause confusion because they are sometimes used interchangeably and imprecisely. To add to the confusion, people from the Indian subcontinent are also labelled as 'black', 'ethnic minorities' and 'immigrants' even though about forty per cent of the black people have been born in Britain (Donovan 1984: 663; Parmar 1981: 20). Any reference to the term Asian in the context of this thesis refers specifically to south Asian women from the Indian subcontinent i.e. women whose roots are in India, Pakistan and Bangladesh.

The south Asian presence in Britain is not a recent phenomenon as small numbers of them have lived in Britain since the last century ( Tinker 1977; Desai, 1963). However, the vast majority of Asian immigrants from India, Pakistan, Bangladesh and East and Central Africa arrived in Britain immediately after the second World War and immigration from especially East and Central Africa and Bangladesh peaked in the seventies because of the change in the political situations in those countries (Adams 1987, Walvin 1984 )



There is a general tendency to view south Asian people as a homogeneous group but in point of fact they differ in many different ways. One of the major difference is that they do not speak the same language. For instance, in India more than 150 languages are spoken, including 12 major ones, and none by more than 30% of the population. In Pakistan, Urdu is the national language but four other major languages are also spoken. In Bangladesh varieties such as Sylheti and Bangla are spoken in addition to Bengali, the national language (Katzner 1977).

The people from the Indian subcontinent also differ in religious beliefs. Although there are a number of different religions practised in the region, the two main religions practised are Islam and Hinduism. These two main religions are further divided into religious groups. For instance, within Islam, the Muslims are divided into the Shia, Suni, Ismailis and Isnastaris sects. Hindus are not only divided by the three main religious sects; the the Vishnavas, the Saivas and the Saktas and by their numerous religious cults but are also distinguished by distinct caste groups. The four main caste groups being - the Brahmins, the Kshatriyas, the Vaishyas and the Shudras (Thapar 1966, Tinker 1977). In Britain, the Gujarati Hindus have retained many features of their religious beliefs and caste system. The Bangladeshis, on the other hand, do not belong to any particular caste group but are predominantly Suni Muslim.

Besides the religious and linguistic diversity found amongst the south Asian people, there are major differences in their pattern of migration and length of settlement in Britain as well as in their educational and occupational backgrounds. The prior settlement of Asians to East Africa was a significant factor in the patterns of immigration to Britain. In fact, 70% of Asians in East Africa were Gujaratis and they formed part of an economic stratification produced by British colonialism in which the British were the wealthiest and most powerful, owning most of the financial institutions and many of the production and distribution enterprises; the Asian were a powerless middle class, owning some larger enterprises, most of the retail distribution and providing middle level professional and artisan classes; the Africans at the bottom of the hierarchy were labourers and domestic servants (Tandon and Raphael 1978). The East African Gujaratis in Britain are consequently, by and large well-educated with middle class aspirations.

A great deal of research on south Asian communities has been concentrated on education ( Swann 1985; Willie 1984; Townsend 1971) and such research has often pointed towards

patterns of underperformance. There is also evidence, however, of high educational aspirations and parental support for education and the extent of under-performance is less marked, for instance, among Indian than Pakistani children and less marked in the case of Asian children in general than children of Afro-Caribbean descent. Discussion has often centred on the differences in community and family values, though more recently this approach which essentially 'pathologises' the ethnic minority child and places responsibility for under-achievement on the minority family rather than on the school, has been submitted to a great deal of scrutiny and discussion has tended to shift to the role of institutionalised racism in this process (Rampton 1981).

Similar criticisms have been made of the anthropological/sociological studies of Asian communities in Britain because of their narrow focus on culture, religion and the family structure. For instance, writers such as Parmar (1981) and Pearson (1983) through their critical analysis of the way Asian communities in Britain are perceived by the dominant white majority culture have highlighted the inherent weakness in ethnocentric studies. Pearson (1983) points out that much work in this tradition has been conceived within a framework of cultural pluralism and ethnic diversity. Differences in languages, religions and cultural norms are seen as preventing effective communication between majority and minority groups. However, in a society in which ethnic minorities do not have access to power, it is a small step to locate the cause of the problems in the minorities themselves rather than in the mismatch between the expectations of the various groups:

'Such an approach obscures and denies the crucial historical and contemporary power relations of race which have created an imbalance between certain 'culturally distinct' groups. There has been an essential lack of criticism, in that white 'experts' from a broadly descriptive and ethnocentric anthropological tradition have studied 'exotic' minority cultures, whilst their ability to provide sound, objective information has rarely been questioned.' (Pearson 1983:36)

This approach to research has persisted even in the face of a mounting volume of research which points unambiguously to the racial discrimination which ethnic minority communities face in the area of employment, housing and public services (Brown 1984; Smith, D. 1976).

## Research on the Health of the Asian Communities in Britain

Surprisingly, very little attention has been given to the question of health of south Asian people which addresses the issue of health specifically from their point of view. Donovan (1984), for instance, points to *Inequalities in Health* (Townsend and Davidson, 1982) which gives details of extensive inequalities in health and use of the health services according to class, place of residence, age and sex, but gives only two or three pages to the health of the 'black Britons'. This omission is particularly striking in the light of evidence that there is a higher concentration of ethnic minority families in the lower social classes than in the rest of the population.

The nature of research that has been undertaken to date has been confined mostly to two specific areas: there has been extensive medical research into the pathology of Asian pregnancy and secondly research on health set within an Asian cultural context. For instance, a survey of medical literature on health seems to suggest that health problems of Asian communities were mostly confined to rickets, mental health, tuberculosis, inherited diseases and low birth weight babies and the high incidence of perinatal mortality associated with Asian pregnancy. Since Asian women of childbearing age are more likely than any other group within the Asian population to come into contact with the health service, it would appear that they have been the subject of many medical research studies.

Initially, one special area of research interest was rickets where there has been extensive documentation of the number of cases and causes of rickets amongst pregnant Asian mothers and new born babies (Ford et al 1972; Preece 1973). Assumptions about the causes of the disease were mostly centred on the views of the medical professionals that the south Asian communities were in need of education vis a vis their diet and other habits which restricted their exposure to sunlight (Swan and Cooke 1971; Simth, A. 1968; Goel 1981).

In 1981, the Stop Rickets Campaign funded by the DHSS was launched to alert the British Asian communities to the danger of bone deformity resulting from a lack of vitamin D. Although the Stop Rickets Campaign helped to increase general awareness about rickets and the need for vitamin D supplements, the campaign was criticised for failing on several counts. The campaign had attracted criticism for inadequate consultation and involvement of the Asian communities in the decision making process prior to the launch and ignoring the call for the fortification of staple food stuffs such as chappatti (unleaven bread) flour

and butter which are more commonly consumed by Asian communities than other sources of foods rich in vitamin D (Ford 1979; Arneil and Crosbie 1963). The approach adopted by the Rickets Campaign only served to heighten the belief amongst the health professionals that Asian culture and especially Asian dietary habits were inferior and consequently blamed the victims for possessing such deficiencies.

Leading on from the initial medical research in rickets, Asian women became the subject of further obstetric orientated research. One area of research which has received particular attention is the high perinatal mortality rate amongst babies born to Asian mothers compared with British indigenous mothers (Gillies et al 1984; Adelstein et al 1980). Some of the reasons attributed to the cause of the high perinatal mortality rate are congenital abnormality and low birth weight of Asian babies. The birth weight of Asian babies is often measured against the standard growth charts and tables constructed for British indigenous babies. This is inappropriate since these charts do not take into account the genetic make of Asian parents or the stature of the mothers. However, it is often suggested that the low birth weight of Asian babies is linked to the 'inadequate' diet of Asian women whilst other causes such as social and economic deprivation are not given equal weight (Runnymede Trust and Radical Statistics Race Group 1980).

This preoccupation with the Asian diet has prompted a number of research studies (Wharton et al 1981; Haines, et al 1982; Bissenden, 1979) to investigate the link between low birth weight and Asian women's diet during pregnancy. Despite numerous studies on Asian diets there is no conclusive evidence to suggest a definite link between the inadequacy of the Asian diet and low birth weight, especially when pregnant women of social class I and II were studied (Abraham et al 1985; Alvear and Brooke 1978).

A comparative study of Asian and British-born maternity patients in Bradford (Lumb et al 1981) suggested that the pregnancy outcome of the Asian mothers was linked to other factors such as high parity, shorter intervals between pregnancies, greater maternal age and poor uptake of maternity services and the socio-economic status of the Asian mothers. However the recommendation proposed for reversing the present trends in low birth weights and perinatal mortality are seen in terms of Asian women changing their attitudes towards their reproductive behaviour and adopting attitudes and behaviour in line with the childbirth practices in Britain.

The examples of the medical literature cited here forms a

small part of much extensive literature amassed by the medical profession on Asian women. Some of the so called 'problems' of Asian women identified by various medical research on Asian women i.e. higher rate of perinatal mortality rate, low birth weight babies, poor diet, poor uptake of antenatal care resulted in setting up of yet another DHSS funded campaign - the Asian Mother and Baby Campaign (1984). This campaign has also attracted some criticism because it was set up largely in response to the concern expressed by medical experts over the failure of Asian women to conform to the British norm. One of the main aim of this campaign was to increase the uptake of antenatal care. Whilst it is important to recognise that a small number of women are at greater risk and therefore may require regular check up, for a majority of women check up has not proved greatly beneficial. In fact, a number of studies have shown that routine antenatal care does not lead to drastic reduction in infant mortality (Tew 1990, Enkin & Chalmers 1982). Hall & Chng (1982) study of Scottish women in Aberdeen concluded that:

"...expectations of what can be achieved have been unrealistic. The majority of antenatal admissions to hospital (other than for delivery) were for conditions which had arisen in spite of routine antenatal care, and were neither detected nor prevented by that care. Pre-eclampsia presented for the first time in labour or in the puerperium in 30% of cases. Intra-uterine growth retardation was detected by the clinicians in less than half of the cases." (Hall & Chng 1982 :66)

Rakusen & Davidson (1982) put forward a similar argument disputing direct correlation between improvement in infant mortality rate and increase in uptake of antenatal care but link poor maternity outcome with poverty, malnutrition and poor health:

"Improvement in antenatal services are therefore unlikely to have much impact on the problem while wider social issues remain untouched. Much perinatal mortality and morbidity lies outside the scope of antenatal service." (Rakusen & Davidson 1982 :21)

The decision to launch the Asian Mother and Baby Campaign was also criticised for assuming that problems of the Asian mothers were mainly linked to their cultural and language differences whilst ignoring the impact of their social and economic status.

A close examination of ethnocentric/anthropological studies on Asian pregnancy by the nursing profession seem to suggest that the solution for the health problems of the Asian mothers is located within their strange cultural

traditions. It would seem that often the main purpose of some of the studies was to make the health professionals aware of different cultural habits and behaviour of the Asian women in the hope that it would enable health workers to be sensitive to the needs of these women. However well meaning, the indigenous cultural 'norms' and values are often used as a standard to measure the deviant beliefs and value systems of Asian women. Beard (1982), for instance compares the use of contraception amongst four groups of ethnic minority communities against a small control group of unmatched English women. The examination of the family planning practices of the Asian women in the context of cultural and religious beliefs only serves to highlight the stereotypical images of Asian women with their arranged marriages and large number of children. Very often Bangladeshi women are used as an example of women with high parity whilst giving very little indication of the women's own perception of their fertility control. Instead, it is assumed that given time, the attitude of the next generation Asian women will be brought into line with those of the indigenous women with the help of the health professionals:

"It is clear that members of the ethnic groups studied are retaining many of their cultural ideals, which are often in conflict with limiting family size. This is in spite of all the free family planning services that are available. It will take several generations to alter ingrained modes of life but it is up to us health educators to provide knowledge about contraception in order to prevent further overcrowding, ill health and hardship in families already overburdened with problems. We also need to make the Bengalis aware that better antenatal care available in this country reduces the number of infant deaths, and so reduces the need to have such large numbers of children." (Beard 1982:421)

Phillips's (1985) and Charles's (1983) studies on Asian pregnancy also concentrates mostly on cultural and religious differences to suggest that Asian women have numerous problems because their religious and cultural beliefs are different and because they do not speak English. Charles (1983) in particular makes gross generalisations about Asian culture and religion based on her superficial observations of Asian women. Implicit in the generalisations about Asian women is the expectation that if only all Asian women could be encouraged to abandon their cultural habits in favour of 'western' dress and in particular 'western' diet their problems would disappear. For instance, Charles considers the Asian diet to be nutritionally unsound and sees the adoption of the English diet as a desirable outcome of women conforming to the western 'ideal':

"Many Asians are now inclined to eat English food but even if they eat chapattis they will eat meat as they now seem to realise that their diet is not very nutritious."

Since many such studies are carried in nursing journals and magazines for the purpose of sharing knowledge and experience with other health workers it only serves to perpetuate the stereotypes without informing the health workers about the real concerns of Asian women as perceived by the women in question. This can also have serious implications for providing unbiased care and medical advice when the views of the health providers have been coloured by negative images and misconception.

Whilst there is no shortage of literature focusing on the medical problems of Asian women from the perspective of the medical and nursing professions, there has been correspondingly only a small number of studies which specifically address the issues which concern Asian women from their own perspective. Sometimes this has had unfortunate effects. As Donovan (1984 :663) points out:

"There has been a bias in the work, characterised by a concentration on illnesses that interest doctors, central Government and the health service administrators; rickets, tuberculosis and sickle cell anaemia being examples. This concentration on 'interesting' or 'unusual' ailments has meant that the opinions of black people about their own health have been largely ignored, as have the obvious links between health and the large and growing literature on 'race relations' including levels of deprivation and racial discrimination experienced by black people in Britain."

Pearson (1983) also points to the problems inherent in this approach. When research questions are defined by the majority group, this is likely to create difficulties not only in identifying the whole range of health issues which affect ethnic minority communities, but also in terms of access to and uptake of the health services:

"Those who have 'integrated' (assimilated/become British) are clearly not a problem; it is those who steadfastly refuse to do so. Muslim women who are seen as 'cloistered' or 'imprisoned' in purdah cause 'problems' for services such as the National Health Service when they attend clinics and neither speak English nor submit to the requirements that they should be examined by a male doctor....The responsibility for communication and 'integration' lies (un)fairly and squarely at the door of the minority that speaks an 'alien' language." (Pearson 1983:38)

### Development in Research on Women's Health Issues

This bias in research is also in marked contrast to developments within the maternity services which have responded to the needs of indigenous British consumers. This has come about as a result of a great deal of research which has specifically addressed the issues surrounding childbirth from the women's point of view ( see Graham and McKee 1980, Oakley 1979; Kitzinger 1962). By focusing on childbirth from the women's perspective writers such as Ann Oakley and Sheila Kitzinger have highlighted how women feel about their childbirth experiences and how their experiences related to modern childbirth practice.

The recent trend towards hospital delivery for all women and the increased risk of medical intervention have become a major concern to many women because they effectively deprive them of the opportunity of exercising any control during pregnancy and childbirth.

Although it is generally accepted that some women are 'at risk' and may require constant medical supervision throughout their pregnancy and childbirth, it has been argued strongly that it is not necessary for all women to have 10 to 14 routine antenatal examinations during their pregnancy, give birth in hospital or to be subjected to unnecessary medical interventions (Kitzinger and Davis 1978; Oakley 1984).

Whilst the debate about who controls childbirth and who should control childbirth continues, research studies looking at the women's experience of childbirth have helped other women to challenge the attitudes of the medical profession towards a number of medical procedures. For instance, the studies looking at the experience of epidurals (Kitzinger 1987) and episiotomy (Kitzinger & Walter, 1981) have helped to highlight the implications of these procedures for women who did not require them or were not helped by them. Another area of modern childbirth practices which has been influenced by consumer dissatisfaction is the reduction in the number of unnecessary inductions (Oakley 1984 :207; Cartwright 1977).

Whilst there is no shortage of literature on childbirth which specifically addresses issues from the indigenous women's point of view, views of the Asian women as consumers have not been addressed in any shape up to the present. The only discussion in this area relates to the research carried out by Hilary Homans (1980) and Jenny Donovan (1986). The Homans study, based on the experiences of childbirth of indigenous white women and Asian women,



compares the impact of society i.e. the status afforded to childbearing women in the two different societies, the effect of cultural traditions and childbirth rituals on the two groups of women undergoing transition from women into mothers.

Jenny Donovan's research is an example of another study which specifically addresses the issues of health and illness from the perception of black women. Although Donovan's research, based on a small group of Afro-Caribbean and Asian women, did not have its main focus on childbirth experiences of women, it did however explore the issue of health and illness from the perception of the black women. Whilst, the impact of culture and religion were explored, greater emphasis was placed in the way the women themselves conceptualised their experiences of health and illness in the context of their own cultural and religious beliefs. In addition, the study also provided insight into how the women perceived their ability to exercise control over their health and illness within the National Health Services provision and within the context of their experience as 'immigrants' to Britain.

A review of literature therefore reveals a number of unmistakable trends. In various different fields, including education and anthropology, the tendency has been for the majority group to define the 'problem' and very often, to locate the cause of the problem very firmly in the minority communities themselves. In a similar vein, researchers have very often grouped together ethnic minorities as a homogeneous, monolithic whole, failing to perceive the tremendous social and cultural diversity which marks the many different groups. This tendency is certainly a recurrent feature of research on health: all too often medical researchers not only define the problems without consultation with the communities concerned but also explicitly or implicitly suggest that the causes of these problems are located within the communities themselves.

To avoid these same pitfalls, this present project approaches the question of women's health from the perspective of two different groups of Asian women. The women selected for the study were drawn from the Bangladeshi and Gujarati communities. The women from these two communities were chosen because of the differences in their socio-economic positions within British society and because of their cultural and social diversity. The main differences between Gujarati and Bangladeshi women were that Gujarati women were mostly from E. Africa and had lived in Britain over many years, were well educated, were Hindus and had middle class aspirations. Bangladeshi women, on the other hand, had recently from Bangladesh, were predominantly Muslim, were less well educated and were in a

disadvantaged position because of the lack of opportunity for education and employment and by being confined to inner city areas with multiple deprivations.

## CHAPTER 2

## SOCIAL AND CULTURAL HEGEMONY OVER REPRODUCTION

The previous chapter highlighted how people of south Asian origin from the subcontinent of India have been portrayed in the literature concerning race relations, immigration, education and, more specifically, in the medical literature. The material presented in the ensuing empirical chapters highlights how Asian women, and in particular Gujarati and Bangladeshi women, perceive their experiences of pregnancy and childbirth. The previous chapter also highlighted the recent development in research on women's health issues. The findings of these studies suggest that there is a direct relationship between women's concern about their health and the degree of control or lack of it that they have over their bodies. Since the issues of control and medicalisation are two important concepts which run through this thesis, it is necessary to understand what they mean.

Control according to the *Concise English Oxford Dictionary* (1964) is defined as "power of directing, dominate, command and regulate". However all these meanings have a common underlying sense which suggests a sense of 'power' or 'authority'. In the *Penguin Dictionary of Sociology* (1984) authority is defined as:

" If power is the exercise of constraint and compulsion against the will of an individual or group, authority is a sub-type of power in which people willingly obey commands because they see the exercise of power as legitimate."

Smith (1960) makes a distinction between power and authority. He defines power as "the ability to act effectively on persons or things, to take or secure favourable decisions which are not of right allocated to the individuals or their roles" and defines authority as "the right to make a particular decision and to command obedience."

Our impression about science is that scientific measurements are precise and any ideas based on science are therefore more superior in value and beyond dispute. Because modern medicine has its roots in science, it has been suggested that the use of science, and in particular the germ theory of disease helped the medical profession to establish their control over society:

" For example, the adoption of the germ theory of disease by medical practitioners led to a shift away from patient-centred medicine towards a system which reduced patient involvement and created greater patient dependence, which in

Freidson (1988) uses the definition of control to explain how power and authority have been used by the medical profession to become sole arbiters of health:

" If we consider the profession of medicine today, it is clear that its major characteristic is preeminence. Such preeminence is not merely that of prestige but also that of expert authority. This is to say, medicine's knowledge about illness and its treatment is considered to be authoritative and definitive." ( Freidson 1988:5)

Freidson argues that the authority vested in medicine is given added weight or power by legal and state sanctions which enables it to make policy decisions on health.

Zola (1978) also makes a similar observation about the control exercised by medicine by tracing the involvement of medicine in the management of society:

" Public health was always committed to changing social aspects of life - from sanitary to housing to working conditions- and often used the arm of the state ( ie through laws and legal power) to gain its ends( eg quarantines, vaccinations). (Zola 1978 :81)

Medicine is an elite profession which has maintained a high status and a position of power by exercising rigorous control to exclude anyone who does not qualify to gain entry into the profession. The membership of the medical profession is dominated by white males mostly from the upper and middle classes. In addition, any threat to the medical profession's supremacy is removed by imposing restrictions on other practitioners and lay health workers ( Donnison 1977).

The authority and power vested in the medical profession has become an effective instrument of social control and the profession exerts control over all members of society regardless of gender differences. The difference in class and status gives the medical professional control over a person seeking medical advice. Graham & Oakley (1981), Ehrenreich (1978) and others also make similar observations about the clinical encounter between a doctor and a patient and suggest that the difference in the power relationship has a potential for causing conflict because of the differences in the class, culture and gender of the doctor.

The power relationship created by the male domination of the medical profession is at its most influential when it comes to making pronouncements about women's lives, particularly in relation to women's reproductive lives( Oakley 1984, Doyal 1979). Doyal (1979) puts forward two reasons why women are likely than men to come under the jurisdiction of the

relation to women's reproductive lives (Oakley 1984, Doyal 1979). Doyal (1979) puts forward two reasons why women are likely than men to come under the jurisdiction of the medical control:

" First, women do, of course, have the capacity to become pregnant and give birth, and are usually responsible for subsequent child-care areas of human activity in which doctors are assumed to be 'expert'. Secondly, female 'deviance' usually consists of behaviour which is defined as 'sick' rather than criminal. They do, however, consult their doctor more often about problems defined as neurotic or psychosomatic, and women are one and half times as likely as men to enter a psychiatric hospital at some period in their lives." ( Doyal 1979 :218)

Oakley (1984) suggests that the power and the authority of the medical profession is further enhanced by the division of medicine into specialist disciplines:

" Division within medicine- obstetrics, gynaecology, paediatrics, neonatal paediatrics, fetal medicine, reproductive medicine - have segmented women's bodies into competing professional charters and domains of medical work; womanhood and motherhood have become a battlefield for not only patriarchal but professional supremacy; the medical profession has been able to harness paternal/patriarchal assumptions about women's personality and role to the service of its own ascent to professionalisation." (Oakley 1984:254)

Other than the control exercised by the medical profession, women are also subjected to social and cultural control which will be discussed later in this chapter.

The status afforded to medicine also gives it power to make pronouncements over the condition of life - ie only through the power of medicine can the quality of life be assessed. This medicalisation of life is another concept which has particular relevance to the understanding of women's reproductive lives. The *Penguin Dictionary of Sociology* (1984) describes medicalisation as:

" increasing attachment of medical labels to behaviour regarded as socially or morally undesirable. The implication is that modern medicine can cure all problems (including vandalism, alcoholism, homosexuality, dangerous driving and political deviance) once these are recognised as diseases."

Irving Zola (1978) describes medicalisation as an institution of social control equal to control traditionally exercised by religious and legal institutions:

" medicine is becoming a major institution of social

often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health. Moreover, this is not occurring through the political power physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by 'medicalising' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence." (Zola 1978 :80)

Ivan Illich (1976) refers to medicalisation as a form of sickness created by the medical profession to exercise control over society:

" Social iatrogenesis is at work when health care is turned into a standardised item, a staple; when all suffering is 'hospitalised' and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labelled a form of deviance." (Illich 1976 :49)

Oakley (1984) makes similar observations about the power that the medical profession has in converting a natural event into a medical emergency:

" For both birth and death normal signs have become neon lights flagging risks which demand and validate medical intervention. In the case of death, the heroic use of medical technologies interrupts a 'terminal' state. In the case of impending birth, electronically-evoked fetal heart signals enable a baby who could have entered the world through the untechnological vagina to do so, instead, courtesy of the surgeon-obstetrician's instruments and technical prowess." (Oakley 1984 :276)

The concepts of control and medicalisation are only aspects of a much larger social control of women. To appreciate the deeper significance of control and medicalisation of childbirth it is necessary to place them in a broader context of women's position and status within society. In this chapter, I wish to examine control and medicalisation by reference to a number of issues which are very relevant to the experiences of pregnancy and childbirth which are explored in detail in subsequent chapters. These issues include social and cultural construction of women's role in reproduction, the sexual politics of reproduction, the control over fertility, the control over childbirth through social and economic as well as religious, political and medical channels. In every case, I will be highlighting the special position of Asian women in British society. It is very important to remember, however, that these same issues also impinge on the lives of

I will be highlighting the special position of Asian women in British society. It is very important to remember, however, that these same issues also impinge on the lives of indigenous British women. Taking this common bond which unites all childbearing women, I want to focus upon the status women are accorded by their culture. The fact that this additional factor colours the experience of British Asian women, as members of a minority community living under two different cultural influences, will also be explored here.

The feminist movement in the sixties created an opportunity for a fresh look at the issues confronting women from a purely female perspective. This led to the establishment of studies which acknowledged that there was a special perspective on Women's issues (Oakley 1981, Ardener 1975). The starting point for many of these courses are the fundamental questions concerning the position and status of women and their impact on different aspects of women's lives. That is, to what extent has the status accorded to women as the other half of the human race influenced their role in the reproduction, economics and politics of a society? (Oakley 1981, Rosaldo & Lamphere 1974).

I would like to present a review of the literature which may throw some light on the status society attaches to women's childbearing role with specific reference to south Asian women. One of my main purposes will be to provide an additional frame of reference which will assist an understanding of the cultural ideology which, directly or indirectly, may be involved in shaping women's perception of their experiences as presented in this thesis. It is hoped that the exploration of the relationship between cultural attitudes and biological reproduction may reveal how much cultural ideology has been internalised by the women themselves and how far women collude with the system to perpetuate it.

#### Cultural Attitudes to Reproduction

Biological reproduction is the most basic function necessary for the survival of the human species. The way this biological function is interpreted and the meanings and values attached to it are determined by culture. Since human societies are set apart by their distinctive cultures there is a corresponding difference in cultural attitudes to reproduction (Mead & Newton 1967 :158). Whilst biological reproduction is necessary for the production of the next generation of workers and for the servicing of the labour force in a capitalist society, the role played by women in childbearing and childrearing is not given equal recognition with other forms of production (Smart et al 1978 ).

How a society defines reproduction is closely linked with the status that society attributes to women. Ortner (1974) in her discussion on universal subordination of women in all cultures suggests that cultural values and meanings are determined by men and therefore there is a tendency to link masculine activities to culture and feminine activities to nature:

" Returning now to the issue of women, their pan-cultural second-class status could be accounted for, quite simply, by postulating that women are being identified or symbolically associated with nature, as opposed to men, who are identified with culture. Since it is always culture's project to subsume and transcend nature, if women were considered part of nature, then culture would find it "natural" to subordinate, not to say oppress them."

Ortner argues that this universal subjugation of women based on the notion of 'is female to male as nature is to culture?' finds expression in the way culture and social institutions perceive and maintain ideas about the physical, social and psychological makeup of women which contribute to women being seen as closer to nature. This ideology concerning the status of women is conveyed by the images portrayed in religious texts, medicine, psychiatry, psychology and in the social and anthropological literature.

Similar attitudes and views supporting the inferior status of Asian women are also found in social structures based on caste and class hierarchy:

" Within the patriarchal joint family, women were considered as part of the males' property in the same way as a field belonged to the men of the family. The analogy of the field and the seed was used to describe the right of the men to the use of women and to the women's issue. Only sons inherited immovable property, the daughters taking with them a dowry in the form of goods to their marital family. These economic facts of patrilineal inheritance ensured that sons were valued and daughters were not, amongst propertied families in particular. Women could not sacrifice to the gods, because their presence was considered polluting, so a man had to have male children to perform the sacrifice which would allow his soul to rest after death."  
( Liddle & Joshi 1986)

Mukherjee's (1983 :180) descriptions of images of Hindu women in epic religious texts provide further examples of how ancient texts are interpreted. These ancient religious texts are influential in determining present day realities of the status a Hindu woman may expect to enjoy within a patriarchal



family. Mukherjee suggests that the appropriation of religious knowledge by the priestly Brahmin caste is also responsible for the subjugation of women:

"The appropriation of religious knowledge enables them to present and interpret religious scriptures in favour of the patriarchal family system. The patriarchal system favours the importance of a male child for inheritance of property and for fulfilling after death rituals. The implication of the interpretation of religious texts in favour of the male lineage was that marriage became obligatory for women"

Although under Islam men and women should enjoy equal status, Hussain (1984 :2) argues that the equality enjoyed by women in the life of the Prophet Muhammad was whittled away by the different interpretation put on the texts by the religious authorities:

" A number of studies and viewpoints emanating from Muslim societies and religious authorities posited an Islamic role for Muslim women in those societies. These were, however, representative of feudalistic and not Islamic thinking for they consistently sought to place women under the control of men. They were powerful and effective in their influence on the role of women because they reflected the feudalistic states in which all contemporary Muslim societies find themselves. As there are no Islamic societies to be found in the world today, various distorted interpretations of Islam have manifested themselves in Muslim societies."

Hussain and Radwan (1984 :46) elaborate the view concerning the ideal role behaviour of Muslim women, by citing the example of an interpretation expounded by Ayutollah Nuri (1964):

"...in Islam women are inferior to men because biological differences have determined this status for them. Ayutollah Nuri argued that since women and men have different biological functions to perform they are also psychologically equipped with different natures. Child bearing and and child care are the important functions of women. The female has a strong maternal instinct and consequently women are psychologically emotional creatures."

Muslim women's status in reality is in fact governed by Islamic laws and customs which confer on them an inferior status to men( Jeffery 1979, Mernissi 1985).

The position of Asian women is ambiguous: on the one hand they are afforded high status as mothers and as

producers of future generations of workers; on the other hand, society organised around a patriarchal system places women in a subordinate position in relation to men. As a result most women perceive either direct or indirect pressure to achieve the desired high status of mother. As it will become clear later in chapter 4, British Asian women's attitudes towards marriage and motherhood have not altered significantly since migrating to Britain.

The impact of these ideologies on contemporary Asian women is of particular interest because there seems to be very little evidence that there is a groundswell of women questioning their inferior status vis-a-vis cultural and spiritual ideologies. There seems to be no straightforward explanation as to why women tolerate this situation. A possible explanation may be the lack of educational, political and economic opportunities to counteract the influence of strong cultural and social conditioning (cf de Souza 1980 and Jeffery 1979). Jeffery's (1979 :99) analysis of Muslim women's status in a religious community in India suggests that socialisation of women is a key to achieving their compliance:

"But if people imbibe values which seem contrary to their interests, other questions need to be put. In particular, attention must be paid to the coercive dimension of socialisation even if that coercion is more subtle than economic power- and to the way in which power differentials can result in people being persuaded to hold views against their interests."

From my observation of Gujarati women in particular, as I will argue later in Chapter 5, it would appear that whilst some women were beginning to question the significance of religious rituals connected to pregnancy and childbirth, a majority of women were inclined to accept it as a matter of tradition.

However, the ambiguity over childbirth and the status of women is by no means limited to Hindu and Muslim women. McLaughlin (1974 ) draws a similar analogy from Christian theology in relation to the negative contribution made by a woman in procreation:

" Thomas grounds this view in Aristotelian physiology, in which the active principle of procreation is carried wholly by the male sperm containing the human embryo in potentia which needs only the mother's 'inner space' for the growth and nourishment" [ McLaughlin (1974) quoted in Rushton (1983)]

Arms (1975) and Rich (1977) offer parallel examples of Judeo-Christian theology which encouraged negative attitudes

towards women's reproductive roles in Britain and America:

"... early Christianity absorbed the Hebrew view that Eve's transgression caused women's travail in childbirth thus setting the foundation for the negative attitudes towards women's sexuality and childbearing which have continued in western civilisation for nearly two thousand years."

Rich (1977 :134) further links the role of the Christian authority in demeaning female biology and women's procreative role by citing Finney(1937):

"The misogyny of the church Fathers, which saw women- especially her reproductive organs- as evil incarnate, attached itself to the birth-process, so that males were forbidden to attend at births, and the midwife was exhorted to make her primary concern not the comfort and welfare of the mother, but the baptism of the infant-in utero, with a syringe of holy water if necessary."

According to Rich (1977 :128 ) what is of particular significance is that any change in attitudes towards women's reproductive role has come about only relatively recently.

Whilst earlier Christian beliefs about women's status and reproduction may be out of place and time in present context, Oakley (1980 :51) argues that the negative attitude towards the reproductive role of women, based purely on biological sex differences with the implied inherent weakness of the female psychology, is found to be present in both the medical-psychiatric and psychological literature.

Whilst medical-psychiatric and psychological research and writing is based on women in western industrialised societies, women from other cultures, for example Asian women, who have settled in the west would be subject to a similar interpretation of their reproductive role. This is exemplified by the vast quantity of 'problem'-orientated literature on Asian women amassed in Britain as documented in the previous chapter.

### Sexual Politics of Reproduction

This negative portrayal of women and reproduction has led to the examination of the rationale behind the maintenance and promotion of such views in contemporary societies. One area of research which has tried to tackle some of the issues confronting childbearing women is the sexual politics of reproduction (Homans 1985, O'Brien 1981, Roberts 1981). I will draw on contemporary research findings pertaining to childbearing women, both in Britain and the Indian subcontinent, to provide a framework for understanding the

issues which have shaped women's accounts of their experiences of pregnancy and childbirth outlined later in this thesis.

It would appear from the arguments presented so far that subjugation of women is rooted within social, cultural and religious ideologies. This raises a number of questions concerning the motivation for and the rationale behind the perpetuation of negative attitudes towards women in a wide range of cultures. It has been suggested by a number of writers ( Mernissi 1982, Kitzinger 1978 Okley 1975 ) that subjugation of women is achieved by exercising control over female sexuality and thereby removing the potential threat which it poses to men. According to Mernissi (1985 :41) the subordinate status of Muslim women resulted from the recognition of the power of and the need to suppress women's active sexuality:

"The absence of active sexuality moulds the woman into a masochistic passive being. It is therefore no surprise that in the actively sexual Muslim female aggressiveness is seen as turned outward. The nature of her aggression is precisely sexual. The Muslim woman is endowed with a fatal attraction which erodes the male's will to resist her and reduces him to a passive acquiescent role"

Aziz et al (1985) and Allen's (1982) make a similar connection between a Hindu woman's sexual passion and the responsibility vested in the male to keep it under control.

"It gives rise to the opinion that women are lustful and have insatiable, contaminating, sexuality, which has an effect of weakening men" Aziz et al (1985 :47)

This control over female sexuality is practised and perpetuated at an institutional and a personal level by the power men have over women. The most effective instruments of control exercised by men are rooted within the system of purdah/seclusion of women, the concept of Izzat, the concept of pollution and the control over fertility and reproduction. I wish to discuss here these issues in some depth by exploring their historical origin in order to provide a backdrop against which the current position of women can be assessed.

### Pollution

The concept of pollution associated with female sexuality is a widespread phenomenon within many cultures around the world (Thompson 1985, Rushton 1983, Jeffery 1979, Okley 1975). The potential for pollution inherent in childbearing women is linked with the monthly menstrual flow and with post-partum haemorrhage after childbirth. The negative attitude towards

menstruation is a historical phenomenon shared by all major religions from Christianity to Hinduism:

" Orthodox Judaism forbids sexual activity during menstruation. At the end of the period, a woman must go to the mikvah, a ritual bath, and be cleansed. Only after the mikvah can she have sexual relations again. The Catholic Church, too, used to urge abstinence during a period. The assumption was that a woman is unclean at this time and so should not be touched, which reinforces the feeling that there is something not quite 'nice' about menstruation" (Lever 1979 :59)

Whilst Hindu and Muslim women from the Indian subcontinent are subjected to similar explicit and implicit control which governs their behaviour during menstruation and after childbirth, their behaviour during these time is also affected by beliefs concerning pollution ( Jeffery et al 1989, Mukherjee 1983).

" Childbirth results in pollution, which adheres especially to the jacha (parturient mother). Childbirth pollution represent power but, unless it is controlled, it is an evil power and the jacha cannot capitalise on it to enhance her self-respect. It can damage the jacha herself and she wants her condition rapidly remedied. Further, both she and the baby are capable of harming and defiling other people" (Jeffery 1989 :124)

This control is not only perpetuated by social and cultural attitudes alone, but also involves restriction of participation of the women on the auspicious occasions and in religious activities(Aziz et el 1985, Mukherjee 1983).

Beliefs concerning the potential threat posed by menstrual blood to other people also reinforces negative attitudes towards women's sexuality and their procreative powers. Amongst Hindus and Muslims sexual intercourse during menstruation is considered harmful to men( Thompson 1985)

In connection with the potential threat posed by women during menstruation or after childbirth, Thompson's (1985) and Jeffery's (1979) study suggests that violation of pollution restriction was believed to cause more harm to women themselves than anyone else by possible attack by the malevolent spirits:

" Another form of danger women incur is the danger that will befall them if they break the menstrual taboos, designed to protect others from their impurity. Most women seem to believe that this will result in some kind of misfortune, ranging from leprosy and barrenness through to a particular unpleasant form of rebirth"

(Thompson 1985 : 705).

As we shall see in Chapter 5, Thompson's observation has a particular relevance to the way some British Asian women express concern about defying pollution restrictions.

Whilst contemporary British women from different cultural and social backgrounds may not feel under obligation to alter their behaviour to comply with religious ideologies, it is nonetheless important to bear in mind that not all women will be willing to disregard their beliefs even if these beliefs are in fact against their interests.

Again, beliefs concerning pollution are not limited to Asian and Muslim women. Laws's (1985) research exploring menstruation from the male perspective in Britain revealed the male cultural attitude towards menstruation and the power men exert in determining how women should behave during menstruation. Laws links negative attitudes towards menstruation with patriarchal ideology purporting to male superiority based on sexual differences. The identification of menstruation as a concern to women only also contributes to the maintenance of negative feelings towards menstruation. Law contends that the negative attitudes towards women and menstruation are generated and sustained in a variety of ways. For instance, the denigration of female sexuality and menstruation are perpetuated within male circles by the sharing of sick jokes linked with intercourse during menstruation. This has double edged implications for women. If, for example, women refused to cooperate, they are accused for using an illegitimate power over men. If, on the other hand, women should express a similar desire during menstruation, they are liable to cause disgust. Another area where menstruation is regarded less favourably is in the labelling and treatment of problems associated with menstruation by medical professionals:

" Medical men, especially gynaecologists, produce another important kind of ideology about women. They emphasise women's reproductive role as the only hope of health for women. Medicine institutionalises men's failure to empathise with female suffering and justifies it with the notion that inconvenient women's problems are 'psychosomatic'. Doctors frequently ascribe a woman's problem to her mother's influence suggesting that mothers inculcate 'unhealthy' attitudes into their daughters. They seek to persuade women to place their trust in male authority, not in female support"

Laws asserts that associating menstruation with something shameful, to be concealed so as to avoid causing offence to men's sensibilities, is yet another example of how women are prevented from making positive identification with their

sexuality.

Staton (1980), Rushton(1983) and others have reported that similar attitudes concerning pollution after childbirth still exist amongst Christian communities in some parts of Britain. Rushton(1983 :122) traces these pollution beliefs to the fourteenth and fifteenth century when churching of women carried moral and religious sanction and required all women to undergo purification rituals after childbirth.

This overt form of control over women is so deeply entrenched within most women's psyche that not only is it difficult for them to challenge it but they themselves exercise and police the control (cf Jeffery 1989 :31). Smart et al (1978) and de Souza (1980 ) suggest that control over women is sustained in the first instance by the process of socialisation of women within a family and secondly, through this socialisation, women are given the responsibility of maintaining the status quo:

" The family is the social context in which girls are socialised in their roles of dependency which they will carry out after they are married and have a family. Since the transmission of culture is the prerogative of women they tend to be instruments for the maintenance rather than transformation of values, norms and pattern of behaviour" (de Souza 1980 :23)

The implication of this is that the control is never traced back to source ie to cultural and social systems as defined by men. An example of how older women come to be associated with the instrument of control over younger women in the family is illustrated in the case of British Asian women in Chapter 9 in this thesis. It is interesting to note that involvement of other women in keeping alive the tradition of churching is also reported by Staton (1980) and Young and Willmott (1962).

It is therefore important that the customary practice of isolating pregnant women from other women who have just given birth ( chapter 9) and the confinement of women after childbirth ( chapter 8 ) be placed within the context of an ideology supporting the subjugation of women.

The work of Laws (1985), Roberts(1981) and others has been vital in raising the issues confronting indigenous British women and in exposing the root cause of women's oppression rather than blaming the victim for her oppression. It is in this light that the oppression of Asian women needs to be evaluated instead of the common practice of blaming the women for observing their cultural traditions( cf review of literature on Asian women in chapter 1)

Purdah/ Veiling, Izzat(Honour), Sharm(shame)

In addition to the negative influence on female sexuality of pollution beliefs, other issues which have particular relevance to female sexuality include the seclusion of women and the Asian concepts of Izzat(honour) and Sharm (shame).

The seclusion of women is achieved by keeping women in purdah or behind veils. Purdah is a symbolic means of separating women from physical and social encounters with men. Purdah or veiling involves the donning of outer garments to hide the shape of a woman's body, i.e. making her sexuality invisible. The form of dress adopted for this purpose depends on how strictly the purdah is observed. For example, some women wear the 'Burkha'- the all-enveloping cloak and veil, while others adopt a less strict form of purdah by covering everything except face and hands. There is some controversy about linking the origin of purdah to Islam as there is evidence that seclusion of women existed in pre-Islamic times (Hussain 1984). This suggests that seclusion of women was socially and culturally sanctioned. However, there is specific reference to covering of certain parts of the body in the Quran Sharif which may have played an influential role in determining the attitudes and behaviour of contemporary Muslim women towards purdah. Jeffery(1979) cites an example of a passage from the Quran Sharif which calls on all Muslims to cover certain parts of their bodies and, in particular, instructs women to behave in such a way as to not attract attention:

" There are parts of the body- the *satr*- which men and women must always hide. For men, this area is between the pit of the stomach and the knee. For women it is the whole body except the face and hands even in the company of other women. Only spouses may see one another '*satr*', but even between them complete nudity is abhorrent "

(Jeffery 1979 :20)

Thus, attitudes may be reinforced by the position of women in society as well as by the socialisation of women which conditions them not to challenge the status quo.

The custom of purdah is still a common phenomenon amongst Hindu and Muslim women in South Asia. However seclusion of women is not peculiar to South Asian women; it is also practised in other parts of the world from the Middle East to some regions of northwestern Europe(Mernissi 1985, Jeffery 1979). In some societies a woman is obliged to observe the purdah restriction not only with strange men in public but also with her husband's older male relatives(Thompson 1981). It must be emphasised that only financially well off families can afford to keep their women in strict purdah. As a result



pardah is equated with high social status, thus encouraging everyone to strive for it.

Amongst rural Hindu and Muslim women in the North East region of India, Jeffery (1989) reported that it was a common practice for pregnant women to conceal their pregnancy as long as possible because it exposed female sexuality which is regarded as too shameful to be publicly acknowledged. This negative attitude towards female sexuality resulted in the curtailment of social visits by pregnant women to their natal home so as to hide the fact that they were sexually active from their male relatives:

" A pregnant bahu (daughter-in-law) should display more sharm than usual, for pregnancy demonstrates her sexuality. A pregnant woman practices more than usually rigorous bodily concealment by pulling her shawl or the end of her dhoti down over her belly; to wear tight clothing during her pregnancy is shameless. Displaying pregnancy to the natal kin is a sharm-ki-bat (shameful thing) and a woman is unlikely to visit them after the fifth or sixth month of pregnancy." (Jeffery 1989)

In Britain, although not all Asian women practise pardah to the same extent, this is an influential concept in determining women's behaviour in relation to men. My observation of Gujarati Hindu women in the course of fieldwork suggested that pardah was not an issue for them whereas for Bangladeshi Muslim women pardah and the ideology surrounding it was important. As we shall see in chapter 5 (pages 91 & 119) that for many Bangladeshi women, who were anxious not to break the pardah restriction, gaining access to antenatal care was problematic especially if the consultation involved seeing a male doctor who shared their cultural origin.

Whilst the practice of pardah may not be obvious, the related concepts of 'Izzat' (family reputation or honour) and 'Sharm' (shame or embarrassment) are important issues for the majority of British Asian women in relation to social control. For instance, amongst British Hindu women obvious pardah or veiling is no longer practised but women appear to be concerned about preserving modesty in their manner of dressing and in their dealings with strange men in public. Aziz et al (1985), Thompson (1981) and others have argued that the responsibility of preserving the 'Izzat' or the 'Sharm' of the family falls on the women. Although the loss of 'Izzat' or 'Sharm' applies equally to men and women, the loss of 'Izzat' by women has grave implications because it is associated with a lack of control over female sexuality. A recent study by Aziz et al (1985 :52) on the role expectations of Bangladeshi youth suggested that there is a marked difference in the way society expects young men and women to behave:

" Gender role expectations become exaggerated in this stage. Most of the respondents felt that it is not shameful for a male to look at the body of a female with sensuous eyes; on the contrary, it is the female who bears the shame when a male looks at her so."

Dube's (1988 ) paper on the construction of gender in patrilineal Hindu society and the control over female sexuality makes similar observation:

" A girl who has come of age has to be protected not only from men but also from herself. The need to control female sexuality is often expressed through metaphors. Emphasising the necessity of not allowing young women and men to come close it is said that unless a physical distance is maintained between hay and fire, it is impossible to protect the hay from catching fire."

Such views and beliefs about female sexuality are deeply embedded in society and perpetuated by the socialisation process. As a result, the impact of forces controlling the attitudes and behaviour of British Asian women during pregnancy and childbirth need to be appraised within their cultural and social context. Purdah, Izzat and Sharm become issues for many British Asian women as they are expected to avail themselves of the maternity services managed by male dominated health care professionals, services which were initially set up to serve the needs of indigenous women. The fact that the present maternity services are insensitive to all childbearing women has brought the Health Service severe criticism from organisations interested in raising the concerns of women (National Childbirth Trust, Association for Improvement in Maternity Services) and also from numerous writers who have explored childbirth experiences from the indigenous women's perspective (Homans 1980, Oakley 1979, Graham & McKee 1979, Kitzinger 1962). Some of the issues raised by these writers and organisations could equally apply to women from minority communities who are doubly disadvantaged from having to adjust their behaviour to suit two different sets of cultural expectations.

It is only when we make the link between negative images of female sexuality and culturally and socially approved behaviour such as the seclusion of women and the display of modesty , that it becomes possible to understand the common concern which Asian women share with many indigenous British women about the need to be cared for by female medical practitioners and the disadvantages of maternity services dominated by male medical practitioners.

Whilst seclusion of women and other related concepts have a major impact on a small section of the British ethnic

minority communities, another aspect of control over female sexuality which affects all women is the control over fertility which I wish to discuss next.

### Control over Fertility

Another facet of female sexuality over which women have only limited control is their fertility. This is a universal phenomenon affecting women of all cultural and social backgrounds. The ample evidence amassed by feminist researchers and writers (Roberts 1981, Pollack 1985) and others on this subject indicates that men have appropriated a great deal of power over women's fertility.

Male control over female fertility is just one more aspect of the power men have over women. The retention of this control is greatly facilitated by the establishment of their authority over the major social and cultural institutions - religion, politics and medicine. At a personal level, men are also able to exercise control over individual women. Women are very poorly represented in all these institutions and in the well established hierarchical structures controlled by men. Roberts (1981) argues that the male dominated political, religious and medical institutions collude to undermine women in making independent decisions about their fertility. Since the major locus of control over female fertility is rooted within religious, political and medical institutions, I wish to discuss here how each of these institutions exerts control over British women belonging to different social, cultural and racial backgrounds.

Any decision about when and under what circumstances a woman can and cannot become pregnant has a major impact on her life. The lack of freedom to exercise control over fertility and the subsequent impact on woman's perception of her pregnancy and childbirth experiences is clearly demonstrated by Asian women in this thesis (see Chapter 4)

Social control over fertility determines that only pregnancy occurring within the context of marriage is approved. Although in Britain, unmarried mothers no longer suffer the same degree of ostracisation, nonetheless traditional views on marriage and motherhood still prevail. This, according to Oakley (1980 :72), is reflected in the bias in the numerous research studies on biological reproduction which are based exclusively on married women. The exclusion of unmarried mothers from such studies suggests that reproduction outside marriage is treated as abnormal behaviour.

Whilst there is a degree of tolerance towards indigenous unmarried mothers, the negative attitudes of Asian

communities in Britain towards unmarried mothers act as a repressive mechanism for controlling female fertility. For instance, amongst Hindu and Muslim communities in Britain, the position of unmarried mothers is unenviable because sexual relationships outside marriage are considered immoral acts. Since the shame attached to such liaisons affects all members of the family, extra care is taken to guard female fertility. Such attitudes towards control of female fertility exist not only in the Indian subcontinent (cf Jeffery et al 1989 :25 Azia et al, 1985 : 99, Caplan 1985 :41) but are also quite strictly adhered to by Asian women in Britain, as reported in this thesis.

Control over female fertility amongst Asian women is also perpetuated by the inheritance law and the need to preserve the patrilineal family system both of which encourage the desirability of a male child. Such beliefs put a woman under tremendous pressure to go through repeated pregnancies until she bears a male child even though such high fertility may in fact have a severe debilitating effect on her health (Ahmed & Watt 1986, Jeffery et al, 1989 :182, Kabeer 1985 :103). Whilst British Asian women's behaviour is not governed by the constraints of an agrarian economy, the preference for a male child can to a great extent undermine their ability to control their own fertility because they are pressured by their family. The importance of producing a male child is a major concern for many British Asian women as highlighted in the accounts given by the Hindu and Muslim women in Chapter 4 and Chapter 8 in this thesis.

#### Religious Influence on Fertility Control

In addition to the influence of social and economic necessities exerting their influence on female fertility, religious beliefs also play a part. For instance, amongst caste Hindus, vigilance over female fertility is not only tied up with the maintenance of caste purity by ensuring that a woman's procreative power is only realised through an appropriate man, i.e. her husband, but also with the need to produce a male child whose presence is required for the fulfilment of after-death rituals (Mukherjee 1983 :380)

Another area in which the influence of religious beliefs in the control of fertility is evident is in the decision concerning the use of contraceptives and the termination of pregnancy. The role of religious authorities has been influential in exerting psychological pressure on women who have tried to take responsibility for their fertility:

"Evidence from women fitted with intra-uterine devices indicates the human cost of wrestling with these beliefs. One woman fitted with an IUD returned to the

clinic after three months with no complaints but "no pregnancy for past year so now feels guilty"  
(Roberts 1981 :4)

Similar negative attitudes towards contraception and abortion are also supported by Islamic and Hindu ideologies ( Jeffery et al 1989, Aziz et al 1985) as reflected in the reasons given by some Bangladeshi Muslim women in this thesis ( see chapter 4)

### Political Control Over Fertility

In addition to social and religious ideologies dictating a woman's behaviour towards her fertility, a woman's ability to make independent decisions about whether or not to become pregnant or terminate her pregnancy is governed by political considerations which serve the interest of vociferous minority groups or the vested interests of the large drug companies( Roberts 1981, Rakusen 1981). For instance, in the inter-war period, there was a lot of resistance from mostly male politicians against any legislation which enabled women to have easy access to contraception and abortion. At the time any demand for contraception and abortion were dismissed on the grounds that such practices would lower the morality of the nation. In particular it was generally feared that unless female sexuality was controlled it would increase promiscuity and lead to the break down of the patriarchal family structure. Even today, many politicians who oppose the 1967 Abortion Act, have attempted to change the legislation to make it difficult for women to obtain legal abortion(Simms 1985 :90).

Not only does the attitude of the politicians towards female fertility determine the freedom women have to make independent decisions about their own fertility but it also determines the allocation of resources made available to the NHS and other organisations such as the Health Education Authority and the Family Planning Association with responsibility for educating the public on birth control.

Although the important function of the Department of Health and the Health Education Authority is to respond to the health education needs of the general public, the information disseminated by them is dominated by the medical professionals' view of how the members of the general public should be educated (Roberts 1981 :10). As it will become clear later in this chapter there is a general belief amongst health professionals that black and Asian women have too many children and they have taken upon themselves the responsibility for preventing these women from producing too many children.

In response to the health professionals' concern about the

high fertility amongst black and Asian women, the Health Education Authority and Family Planning Association produce health education literature to encourage Asian women to use contraception:

"The intersection of this stereotyping of black people as having too many children and attempts to regulate the production of children is well illustrated by the health education messages provided specifically for black women. More health education leaflets on contraception have been translated into Asian languages than on any other health issues." (Phoenix 1990 :227)

Although these organisations are anxious to increase the uptake of contraception amongst Asian communities, very little effort is made to ensure that all sections of the Asian communities have easy access to comprehensive information. Not only does the promotion of family planning information fail to take account of the needs of people who are not literate in their own language, but also the printed literature is often insensitive and not relevant if people are to make an informed choice. Even where attempts have been made to produce family planning literature in Asian languages, the information is often inappropriate and inadequate ( Rakusen 1981 :82).

#### Medical Control Over Fertility

The women who have no desire to become pregnant are dependent on the medical professionals for family planning advice. The attitudes of medical professionals such as general practitioners, health visitors and others involved in giving family planning advice have a major influence over women seeking advice on fertility control. The advice given by them is biased in the sense that they are affected by their personal prejudices and influenced by external pressures from drug companies and the availability of the contraceptives:

"It is evident that the range of contraceptive choices open to women is very much governed by commercial and/or population control interests, together with the prejudices and competence of their doctors." (Rakusen 1981 :96)

Helen Robert's (1981) paper on domination of the male on birth control issues shows that of all the interested parties with a vested interest in contraception, women, who are the mostly likely to use contraceptives, have less power than all the other interest groups. Thomas also (1985 :45) links the lack of control women have over fertility with the growing involvement of the medical profession. As a result women are at the mercy of male dominated general practice for advice and prescription:

" Most female methods are deemed to require medical intervention: the oral and injectable contraceptives require prescription; the intra-uterine contraceptive device (IUCD), the diaphragm and the cervical cap must be fitted; the various techniques used to establish the rhythm method require advice."

The experience of obtaining contraception from health professionals by women from ethnic minority communities in Britain may not be unlike that of many indigenous women belonging to the lower social classes. In fact, at one level the concern expressed by Barrett et al (1978) in their paper about the problems faced by middle aged white women in obtaining services from general practitioners runs parallel to the example of the problems faced by many Asian women. For instance, the quality of a consultation concerning fertility, abortion, an unplanned pregnancy or family planning decisions, with a male doctor would be determined by how women are perceived by white middle class male practitioners. At another level, not only would the range of difficulties experienced by women from working class backgrounds be shared by Asian women, but Asian women would be more likely to experience additional disadvantages on grounds of race, culture and language because of the different perception and treatment of them by the white middle class male dominated health service.

Under these circumstances the powerlessness women experience is heightened. The unfortunate consequence for many women is an unplanned pregnancy. At the same time as they are having to come to terms with an unwanted pregnancy, these women, particularly if they are Black or Asian, may also be victimised because their inability to control their fertility is seen as a sign of ignorance and weakness (Phoenix (1990)). These so called 'irresponsible, unreliable, or illiterate' women are more likely to have family planning decisions taken out of their hands by health professionals, as has been highlighted by Gordon (1983), Doyal (1979), and others who are alarmed by the male control over female fertility. Rakusen (1981) expressed similar concern about black and Asian women who are often offered injectable Depo-Provera without adequate information:

"There are considerable grounds for the widespread belief that black and Asian women are singled out in a racist way as prime target for DP. Of those women who 'are' asked for their consent, it is doubtful whether many of them are given even cursory details on which to base their decision" (Rakusen 1981 :81)

As we will see in Chapter 4 some of the tragic and avoidable consequences of contraceptive failure due to insufficient

information concerning the use of the contraceptive pills, the confusion about injectable contraceptive drugs, Rubella immunisation and the risk posed by unplanned pregnancy to women with serious health problem were also reported by Asian women in the course of the fieldwork in Camden.

### Fertility Control at a Personal Level

In addition to external factors affecting a woman's ability to determine her own fertility, at a personal level a woman's control over her fertility is often compromised by her husband or her sexual partner. Even in the present technological age, there is a particular lack of reliable contraceptives designed for men. In particular, none exists which requires regular ingestion into the blood stream. The greater choice in the number of contraceptives available to women puts them under greater pressure to prevent an unwanted pregnancy. Since very few men are willing to take an equal share of the responsibility for birth control, women bear the brunt of an unwanted pregnancy. Women in particular are at a disadvantage in the case of an unwanted pregnancy, as they and not the men are at the receiving end of the criticism. At the same time information on birth control is not freely available for women to make an informed choice in spite of the fact that a majority of contraceptive devices are specifically designed for use by women:

" First, women have been left with the responsibility for obtaining and using contraceptives. Second, men have easily absolved themselves from blame or responsibility should the contraceptive fail to prevent pregnancy. Third, the most reliable methods of contraception have been associated with the highest health risks and side effects for women. Finally, women have continued to be the ones who face the consequences when things go wrong - when a pregnancy occurs and/or when health and comfort deteriorate" Pollack (1985 :65)

The accounts of Asian women in Chapter 4 in this thesis provide an insight into the true extent of women's powerlessness in preventing a pregnancy. The women's experiences reveal the trauma they sometimes experience either because they were prevented from taking charge of their own fertility or because they were expected to take sole responsibility for preventing a pregnancy. However the experiences of British Asian women presented in this thesis are by no means unique as similar experiences are also recounted by indigenous British women (Graham 1977).

### Control over Reproduction

It is evident from the argument presented so far that the major cultural and social institutions dominated by men



collude together to oppress female sexuality and have a variety of mechanisms at their disposal to help them do so. One specific area of control over female sexuality which has generated and continues to generate a great deal of debate in Britain and other western industrialised countries is the male domination of women's reproductive lives. (Pratten 1990, Oakley 1980, Arms 1975, Rich 1977, Kitzinger 1962)

The many recent debates on childbirth have centred on the controversy surrounding the question of who should have control over childbirth- obstetricians, who are mostly male, or the childbearing women- and the concern about the medicalisation of childbirth. In the discussion of social control of reproduction I will focus on the social construction of pregnancy and childbirth, the medicalisation of childbirth involving antenatal care, antenatal education and the hospitalisation of childbirth

### Social Construction of Pregnancy and Childbirth

In order to understand the meanings societies attach to childbirth and the reasons for the recent controversy about childbirth, we need to examine childbirth in the context of social and medical ideologies and more specifically from the perspective of childbearing women.

The meanings and values attached to childbirth depend to a great extent on whether or not it is regarded as a 'natural' function and the extent to which different social groups agree or disagree with this. The meanings and values attached to childbirth are also determined by whether childbirth is regarded as a process of life or a function of medicine and whether childbearing women or the obstetricians should have the right to determine the management of childbirth.

From the arguments presented at the beginning of this chapter, (p 19) it is clear that social and cultural attitudes towards women and reproduction are based on negative stereotypes. However, there is some ambiguity in the social and cultural definition of reproduction. On the one hand biological reproduction is equated with nature and female pollution and therefore placed outside the masculine sphere of life. On the other hand, reproduction is brought under the jurisdiction of a male dominated medical profession by converting a natural event into a cultural event. Oakley (1980) argues that the cultural subjection of women is imposed to remove the threat from female sexuality and to control their procreative powers:

" Where the social order is ruled by men, women become the embodiment of an alternative government, which must be avoided at all costs. Two modes of avoidance are historically evident: separation and incorporation. According to the logic

of the first, the business of reproduction is given over exclusively to women. Its practice and control are divided off from the rest of the social life, so that no pollution of the one by the other is possible. But according to the logic of incorporation, women must give up their reproductive autonomy, their own right of control over reproduction, which is then 'mastered' by members of the dominant social group: the social, professional and gender elite of male dominated medicine." (Oakley 1980 :8)

The negative interpretations of women and their reproductive organs are also used by male dominated medicine to associate pregnancy and childbirth with ill health:

" All sorts of claims were made about the womb, and its associates, the ovaries, as the site and cause of female inferiority, from physiological pathology to mental disorder, from personality characteristics to occupational qualification ( or, rather, disqualification). It was not simply the process of reproduction that was perceived as disabling, but the possession of the apparatus, which evidenced its presence in a monthly flow of reminders about the incapacity of women to be anything other than slaves to their biology." (Oakley 1980 :12)

It would also appear that the reputation of the medical institution is dependent on making pregnancy and childbirth necessarily pathological events:

" One important norm within the culture of the medical profession is that judging a sick person well is more to be avoided than judging a well person sick. This 'medical decision rule' is applied to obstetrics as it is to other branches of medicine; every pregnancy and labour is treated as though it is, or could be, abnormal, and the weight of the obstetricians's medical education acts against his/her achievement of work satisfaction in the treatment of problematic reproduction." (Graham & Oakley 1981: 56)

Pascall (1991) argues that once the medical definition of pregnancy and childbirth was established, the male domination of childbirth practices was seen as a natural development:

" The historical and cultural peculiarity of male control over women's reproductive lives is obscured by medicine, the medium through which this control is mainly expressed. Perhaps medicine's greatest success is as ideology: it has overcome tradition and taboo to the point where male control of childbirth and related matters seems (almost) completely natural." (Pascall 1991 :166)

The medicalisation of childbirth and control over the management of childbirth have become controversial issues

because a majority of women neither agree with the medical definition of childbirth nor approve of the domination of obstetricians in the management of childbirth. According to Graham & Oakley (1981) the differences in perception are rooted in the qualitatively different ways doctors and mothers view the nature, context and management of reproduction.

A close inspection of differences in values and attitudes indicates that obstetricians regard childbearing as a medical subject which not only requires expert medical supervision but also requires only those with medical knowledge to have responsibility for providing maternity care. The treatment of childbearing as a medical subject and an illness is sustained because gynaecology and obstetrics are regarded as a single discipline which encourages the treatment of pregnancy as an illness and the treatment of pregnant mothers as patients:

" The overriding need was to propagate the belief that birth was essentially dangerous and only under obstetric control could the danger be reduced. If parents wanted live, healthy babies..... this could only be achieved by entrusting the management of pregnancy and delivery to obstetricians working in obstetric hospitals." (Tew 1990: 10)

This is in marked contrast to the way women view childbearing which they regard as a natural biological event similar to other biological processes. Women also regard childbirth as women's business and claim that it should rightfully remain within their domain because women are much more in tune with their bodies than male obstetricians (Goldthrope & Richman 1976, McKinlay 1973). This view is dismissed by the obstetricians who regard childbirth as their field of expertise which entitles them to have complete control over the whole process of childbearing. Graham & Oakley (1981:59) cite examples of interactions between obstetricians and mothers to show how obstetricians are only interested in symptoms which are medically defined and less interested in the women's subjective experience of pregnancy.

The other major difference in perceptions of childbearing lies in the way obstetricians regard pregnancy as a transitory episode which also determines how they measure a 'successful' outcome whereas for women childbearing is seen as having a lasting effect on their lives and their view of a 'successful' outcome is much more complex and encompasses adjustment to motherhood and establishment of a relationship over a longer period rather than just in the post-partum period ( Richards 1974, Kitzinger 1962).

From the argument presented here it is obvious why there has been so much concern expressed about isolating childbirth from its social context. By virtue of its segregation it

gives obstetricians power to define it in a medical context which enables them to exercise control over it. The ensuing discussion will focus on different aspects of medicalisation of childbirth.

The issues central to the medicalisation of pregnancy and childbirth are antenatal care, antenatal education, hospitalisation of childbirth, increasing medical intervention involving modern technology and pharmacological techniques, demoting the role of the midwife and the issue of safety in childbirth. Each of these issues will be briefly discussed here and I will return to these issues again in the empirical chapters.

### Antenatal Care

Once the social and medical construction of pregnancy and childbirth became established as pathological processes in the early part of this century, the clinical antenatal care and antenatal education became a further extension of social and medical control over women's reproductive lives (Oakley 1984 :252). Because of the high incidence of maternal mortality in childbirth, the surveillance of women's behaviour became an issue for the state and the medical profession. The behaviour of women's bodies was brought under control by the promotion of antenatal care and antenatal education. Oakley (1984) cites examples of reports published by the Departmental Committee on Maternal Mortality and Morbidity which encouraged the promotion of clinical antenatal care and antenatal education for mothers:

"Attention was drawn in both the 1930 and 1932 Reports to the need for all mothers to be cared for by registered midwives, for all to be examined antenatally and postnatally by doctors who would be responsible for abnormal deliveries and consultant referral where necessary. But if one single message emerged, it was that pregnant women were themselves deficient: they lacked the necessary intelligence, foresight, education or responsibility to see that the only proper pathway to successful motherhood was the one repeatedly surveyed by medical expertise." (Oakley 1984:72)

However, after the Second World War maternal mortality declined and the concern for maternal health shifted to that for the high incidence of infant mortality. As a result, the welfare of babies in utero intensified the organisation and provision of clinical antenatal care to the extent that monitoring the behaviour of women's bodies came under even closer medical scrutiny. One of the main criticisms levelled at the medical profession is that it robs women of autonomy over their own bodies and secondly the care it provides is less than satisfactory.

Despite the fact that clinical antenatal care has been in existence for the past seventy years and has also had the benefit of modern technology, there is considerable doubt about its effectiveness in improving maternity outcome. From the discussion in the previous chapter ( see page 9) it is evident that there is considerable doubt as to whether clinical antenatal care does any good, since almost 95% of women have a normal pregnancy and delivery (Tew 1990, Rakusen & Davidson 1982, Enkin & Chalmers 1982). One of the main criticisms of the present form of routine antenatal care is that it subjects all women to a range of screening tests, but is not effective in predicting and detecting problems which can be prevented.

A number of studies (Tew 1990, Enkin & Chalmers 1982, Farrant 1980) have not only raised doubts about the effectiveness of routine antenatal care but have also expressed concern that it may, in fact, do more harm than good:

" It is true that the screening tests are by and large non-invasive and free from direct hazard, but this in no way implies that there is no risk associated with their use. Their potential for harm derives primarily from their capacity for erroneously indicating the presence of pathology. The suspicion thus engendered may lead to heightened anxiety, or more seriously, to unwarranted intervention for the 'prevention' or 'treatment' of non-disease." (Enkin & Chalmers 1982 :270)

The danger of subjecting all women to routine screening tests, whose diagnostic accuracy are suspect, may cause unnecessary anxiety and stress while waiting for results:

"Women identified by routine antenatal screening as having an elevated serum level of alpha fetoprotein have been found to be considerably more anxious while awaiting diagnostic amniocentesis than women who had already recognised themselves to be at increased risk of bearing an abnormal child." (Fearn et al 1982 quoted in Enkin & Chalmers 1982)

As we shall see in chapter 10, what is often not fully recognised is the fact that many women who undergo these tests are needlessly put through a harrowing time when the accuracy of some of these tests has not been established beyond doubt. Farrant's (1980) study on the effects of alphafetoprotein revealed that the women who undergo the tests continue to experience a high level of anxiety even after the results of the tests are negative:

"This raised anxiety, which may not be relieved by a negative amniocentesis or even the subsequent birth of a normal child, may manifest itself in a number of ways,

including in some cases, increased tobacco and alcohol consumption." (Farrant 1980 quoted in Enkin & Chalmers 1982)

What is particularly significant is that a number of studies (Boyd & Sellers 1982, Garcia 1982, O'Brien & Smith 1981, Graham & McKee 1980, Cartwright 1979) which have looked at women's attitudes towards antenatal care have concluded that for a large number of women the experience of antenatal care is far from positive. The accounts of women in these studies suggested that the women were particularly concerned about the clinic appointment system which did not take into account either the needs of the pregnant women or of the children who accompanied them. The women's other complaints were that waiting time at the clinic was too long and when they were finally seen, the examination was hurried and their individual needs were not taken into account:

" Problems of access to antenatal clinics and unpleasant conditions in the clinic itself both contribute to the impression gained by mothers that they are not valued as individuals. To-day's 'efficient' antenatal clinic is 'task-oriented'. This means that the woman is looked after by a number of people in rapid succession, seeing each one for such a short time that she is unable to talk to anyone - midwife, doctor or another woman." (Garcia 1982 :86)

As we will see in chapter 5, the Gujarati and Bangladeshi women's account of their experiences of antenatal care was not very dissimilar to that reported by indigenous British women in the studies quoted here. Cartwright's study (1979) which represented the views of women from a working class background is particularly significant because it revealed that dissatisfaction is not confined to the more articulate and vocal middle-class-minority but equally affects all women regardless of their social and cultural backgrounds.

When antenatal care came into existence in the early part of this century, the main focus of antenatal care was restricted to educating the mothers about hygiene and baby care as the scope of medical antenatal care was limited by insufficient knowledge about the physiology of pregnancy. Although antenatal education does not carry the obvious overtones of medical control, nonetheless the ideology on which it is based stems from negative social construction of women. Oakley (1984) traces the oppressive nature of antenatal education to its historical origins in the early part of this century when the cause of high infant mortality was attributed to the ignorance of mothers. One of the main criticisms of antenatal education at the time, and it is still valid today, is that it fails to take into account the social and economic realities of women's lives:

"...thinking about public health moved from emphasizing

the environment to emphasizing the individual in the early years of this century, and the exigency of living in insanitary conditions came to be identified more narrowly as the responsibility of the individual: this provides part of the answer. The disadvantaged social conditions in which many mothers lived need not to be translated into reproductive mortality and illness if only mothers could be taught to make the best of things." (Oakley 1984 :258)

The other factors which played a crucial role in controlling women's behaviour during pregnancy were the different social class of the person who instructed mothers about 'mothercraft', the integration of antenatal education with medical antenatal care and the assumption that antenatal care did not exist in any shape or form until the medical profession invented it. Such an assumption clearly failed to recognise the existence of community based informal support and advice which women gave to each other. As we shall see in chapter 5 and 6, within the Gujarati and Bangladeshi communities in Britain, not only is there evidence of a traditional form of antenatal care, but also older experienced women take their role of supervising and supporting younger women very seriously. As it will become evident later, for many Gujarati and Bangladeshi women, the two contradictory approaches to antenatal care is a source of considerable conflict because they have to make a choice between the medical model of care and the informal traditional model of care and support provided by their older female relatives. As it will also become clear, for many women it was easier to dismiss the traditional model of antenatal care than to resist the pressure to accept the medical antenatal care package. Since the state also colludes with the medical profession, it is very difficult to reject antenatal care as the previous discussion about the state funded Asian Mother and Baby Campaign (see chapter 1 page 9) suggests.

With the advancement of scientific knowledge, not only have the clinical aspects of antenatal care become more technology oriented but also the focus on the education of mothers has changed with the almost 100% hospitalisation of childbirth and the introduction of technology in the management of childbirth. As a result antenatal preparation classes place a greater emphasis on preparing mothers for a high-tech birth:

"...there is plenty of evidence to suggest that curricula of hospital-provided antenatal education have a narrow objective of transmitting prevailing obstetrical policies to women rather than enlightening them in any more general way about the social or biological hygiene of motherhood." (Oakley 1984 :262)

As has been reported earlier ( see page 40) there has been a tendency to make a causal link between a poor uptake of

antenatal care and poor maternity outcomes. As a result the state and the medical profession have spared no effort in exhorting women to avail themselves of antenatal care. However, a number of studies (Tew 1990, Enkin & Chalmers 1982) not only dispute the existence of a causal link between antenatal care and maternity outcome but also highlight women's disenchantment with clinical antenatal care and antenatal education (Chamberlain et al 1978).

As we shall see in chapter 6, the Gujarati and particularly Bangladeshi women's uptake of antenatal classes was similar to that of indigenous women (Parsons & Perkins 1980). An important issue which emerged from these studies was that women from a lower socio-economic class were the least likely to attend antenatal classes. This is particularly significant for women in this study, many of whom were particularly disadvantaged because of their race, class and socio-economic status. Another important factor which also determines attendance at the classes is, as we shall see later, whether or not women consider it necessary to learn about a natural biological event which many other women have gone through without the need for classes.

#### Hospitalisation of Childbirth

By applying a medical definition to the process of childbirth, the obstetricians have not only appropriated control over childbirth but have also succeeded in divorcing childbirth from its social context. The other issue which is central to the medicalisation of childbirth is the hospitalisation of childbirth. With the almost 100% hospitalisation of childbirth, an impression has been created that childbirth is an illness and the only proper place for its treatment is not the home, nor other community settings but rather the hospital under the supervision of obstetricians.

The arguments often used in favour of the hospitalisation of childbirth is that a hospital, well equipped with modern technology, is a far safer place of delivery and that the hospitalisation of childbirth has contributed to the reduction in maternal and child mortality. However, neither of these claims have been supported by recent studies (Tew 1990, Fry & Ashford 1975). Marjorie Tew (1990) argues that whilst there has been a momentous improvement in the safety of childbirth in all industrialised countries, the claims made by the medical profession cannot be wholly justified. She contends that contrary to the claim made by obstetricians, impartial statistical analyses show consistently that birth is safer when there is less medical intervention:

"Far from being a record of conquering idealism and the realisation of an advance in human welfare through the



application of scientific knowledge to improve the natural process of birth by an altruistic profession with good reason to believe in the rightness of its methods, it turns out to be a record of the successful denial and concealment of extensive and unanimous evidence that obstetric intervention only rarely improves the natural process." (Tew 1990)

The medicalisation of childbirth has also legitimised the increase in the use of modern technology and pharmacological techniques which have become routine procedures:

"the importance of the medical context is established by the routinization of technological, pharmacological and clinical procedures during as many stages of the reproductive process as possible and in as many patients as possible" (Oakley 1980 :21)

Implicit in the medicalisation of childbirth is the assumption that all pregnancy and childbirth are potentially abnormal and hence medical intervention is fully justified in all cases. Whilst technological innovations have their roots in scientific discipline, there is mounting concern that many new techniques have been introduced without any clear evidence of their effectiveness in improving maternity outcome or conclusive evidence of the safety of some of these procedures over the long term. For example a range of new technological innovations such as induction, ultra-sound, fetal monitoring and biochemical placental function tests are routinely used without paying due consideration to the possibility of long term danger:

" Obstetricians deal with relatively few substantial problems- women may bleed in early or late pregnancy; they may be hypertensive or immunised; they may have abbreviated or prolonged pregnancies; or they may have growth-retarded or malformed infants. In response to these situations we use a variety of drugs ( the efficacy of none of these is well established). We assess maternal and fetal welfare by a variety of tests (all of which are still sub-judice). With the significant exception of Rh disease we have no specific form of therapy for prenatal disease." (Kerr 1980)

Although current childbirth practices involving modern technology and the supremacy of male obstetricians over childbirth have been with us since the beginning of this century, it is important to see this development within the context of the past history of childbirth and the important role of the female midwife. This assessment is particularly pertinent in the case of Asian women in this study as many women who have recently settled in Britain are more familiar with traditional female-centred childbirth practices.

### Disappearance of Female-centred-childbirth

Historically and cross-culturally, the management of childbirth was predominantly located in the hands of women. Whilst in the industrialised countries in the West, women have gradually lost control over the management of childbirth to men through medicalisation, in the non-industrialised countries this process of transformation has not taken place to the same degree. For instance, in many parts of the Indian subcontinent, particularly in the rural areas, childbirth is still managed by untrained but experienced women and men only play a marginal role. For example a recent study by Patricia Jeffery and her colleagues (1989) of Hindu and Muslim women in rural north India highlights the central role of female relatives and traditional birth attendants in the management of pregnancy and childbirth. Blanchet (1984) provides a further example of female centred management of childbirth in Bangladesh. In addition, even in Britain, older Asian women play an important role in the management of pregnancy and childbirth as Homans's (1980) comparative study of British and Asian women's experiences of pregnancy and childbirth shows. One of the reasons why women and traditional birth attendants in the non-industrialised countries have not lost control over childbirth is the low priority given to maternal health compared with, for example, population control and the lack of resources to develop and provide maternity services in all except urban areas (Jeffery et al 1989 :216).

I would also like to suggest that another reason why women in these countries up to the present have had little to worry about is because the intrusion of males in childbirth is tied up with the cultural and social ideology surrounding female sexuality. It is interesting to note that the desire to sustain the patrilineal system, the male control over female virginity, female fertility and the offspring's paternity does not include control over childbirth. Given that there is such a strong association of pollution beliefs, particularly in relation to the potential threat of pollution to men it is perhaps easy to understand their desire not to get involved with the management of childbirth. In order to avoid pollution from childbirth men normally keep away from a parturient mother and therefore the task of caring for a mother during childbirth and in the post-partum period is entirely left in the hands of women.

As it will become clear later in the empirical chapters which deal with the management of pregnancy, birth and post-partum care, the existence of a strong tradition of female centred reproductive care in the Indian subcontinent has a particular significance, for a number of reasons to British Asian women's perceptions of their experiences of pregnancy and childbirth. The demographic details in Chapter 3 in this thesis, will show that many Bangladeshi women having their

babies in Britain have recently migrated from Bangladesh and therefore have fresh memories of reproductive care controlled by female relatives and traditional birth attendants. The Gujarati women, many of whom were born in East Africa, are on the other hand, more familiar with the western model of childbirth. However a majority of the Gujarati women were living in an extended family with older female relatives who had first hand experience of childbirth managed by women. As it will emerge in Chapters 5, 7 and 8 some of the older women had a great deal of influence not only in the management of the pregnancy but also in the management of the post-partum care. I shall return to this topic again later in this chapter when I will discuss the impact of the current childbirth practices on Asian women.

Even in the West, traditionally and historically as late as the last century in Europe and America, childbirth was a female domain (Inch 1982, Oakley 1976, Arms 1975). Inch (1982), Versluisen (1981), Oakley (1976) and others who have traced the history of how childbirth practices in Britain have evolved suggest that until the end of the fifteenth century men were quite content to leave the management of childbirth in the hands of women. Inch (1982 :18) points to the influence the Christian churches had over acquisition of knowledge and in particular control over the proliferation of medical knowledge in order to remove any threat it might pose to spiritual theology. The other factor which prevented men taking interest in midwifery was the fear of pollution associated with childbirth. The purification rites after childbirth and exclusion of menstruating women for religious services referred to earlier in this chapter were arguments used by the church authority to discourage the involvement of male physicians in midwifery. Oakley, (1976 :32) on the same theme, adds a further dimension to pollution beliefs by suggesting that the strong disincentive for doctors to take up midwifery was linked to low prestige accorded to midwifery compared with other areas of medicine such as physics, surgery and pharmacy. Oakley goes on to suggest that men were willing to let women take charge of childbirth because they believed that women, as polluters, were better suited to dirty, demeaning work associated with childbirth and caring for a woman in childbirth was an extension of their role as housewives.

However the combination of the exclusion of women from medical training and the prosecution of women healers and midwives in the middle of the sixteenth century by the state and church authorities set in motion the gradual loss of their control over childbirth ( Oakley 1976 :26, Rich 1977 :135). Although after the Reformation, midwives were issued a licence to practice by the church authority they did not receive any formal training. Furthermore when professional training for midwives finally opened up for women, the

courses were organised and taught under the guidance of male physicians and who thereby gained ascendancy over midwives (Inch 1982, Oakley 1976).

During this time, not only were male doctors unwilling to be associated with childbirth, but by barring women from gaining entry into the medical schools, advancement in medical science ignored the field of midwifery. Since the training received by midwives at the time only equipped them to deal with normal deliveries, they had to call on male midwives belonging to the barber-surgeon guild to assist with the difficult deliveries. The surgical profession which developed as a separate branch of medicine also barred women from their organisation and, as a result, new techniques developed to manage difficult deliveries were used exclusively by male midwives. For instance, the invention of forceps in 1588, the introduction of chloroform for pain relief and the introduction of a flat table for delivery in preference to the birthing stool helped male physicians establish themselves into what was until then a female province (Calloway 1978). Since female midwives were not permitted to use forceps or administer chloroform, their skills were regarded as inferior in comparison with male physicians.

Although modern midwifery training prepares midwives to cope with difficult deliveries, and they are allowed to administer anaesthesia and minor surgical procedures such as episiotomy incisions, their status is still subordinate to that of male obstetricians (Robinson 1990 :72)

Whilst women are no longer excluded from entry into medical schools, female obstetricians have not been able to further the cause of women. This is partly because female obstetricians in the NHS are outnumbered by male obstetricians and secondly, because they still have to contend with institutionalised sexism operating within the NHS (Oakley 1976). Their desire to hand control over childbirth back to women and to intervene as little as possible in the management of childbirth could easily lead them into serious difficulties with the male dominated medical profession as is clearly demonstrated by the enquiry into professional conduct of consultant obstetrician Wendy Savage (Savage 1986).

Since the end of the First World War, the male take over of maternity provision has gone hand in hand with the hospitalisation of childbirth and secondly with the introduction of technology in the management of pregnancy and childbirth. The unfortunate consequence of the transfer of childbirth from the community into the hospital has meant that at present almost 100% of births take place in hospital. The medicalisation and the hospitalisation of childbirth has meant that from the early weeks of pregnancy right up to the six weeks after delivery, pregnant women come

under the control of the male dominated maternity services. The expectation that conception needs medical confirmation assumes that women are not in tune with their bodies. Furthermore, until the pregnancy is medically confirmed, a mother does not receive antenatal care and arrangements are not made for the place of delivery. The majority of women are not offered an alternative to hospital delivery and only those who are determined and knowledgeable about arranging home delivery have any choice in the place of birth. Once a pregnant mother presents herself to her general practitioner or the hospital obstetrician she is expected to conform her behaviour so that her body can perform to fit the medical definition of normal pregnancy. The control over pregnant women is maintained by expecting women to keep their antenatal appointments, subjecting women to a plethora of tests and examinations. Due to the increase in the use of technology such as the ultra sound, fetal monitoring, induction, Caesarian sections and other screening tests, a biological process has been turned into a pathological event requiring male intervention. As a result women have lost control over their own bodies (Oakley 1984).

In the previous chapter, I have already referred to the impact of hospitalisation and medicalisation of childbirth which has generated a great deal of concern for individual women affected by the high-tech births amongst the women's organisations representing the interest of childbearing women. The dissatisfaction with the current childbirth practices experienced by indigenous British women have been reported in numerous studies which have helped to bring the concerns of the women to the forefront. However, with the exception of studies carried out by Farrant (1985), Lewin (1985) and Homans (1980) none of the previous studies have included Asian women in their sample.

It would be reasonable to expect that many of the concerns expressed by indigenous women about current childbirth practices would be shared by Asian women. However, given that there is a wide difference in the social, cultural and religious background of Asian women, it would be misleading to make a sweeping generalisation about how Asian women would cope with the childbirth practices in Britain. Furthermore, as I have already argued in the previous chapter it is misleading to treat Asian women as a homogeneous group and therefore it would be equally misleading to assume that their responses would be identical. This should not come as a surprise as a number of studies (Oakley 1984, Macintyre 1981, Graham and McKee 1979) in Britain have indicated that differences in the social class and economic status of women have an important bearing on the uptake of maternity services. These studies reported that the poor uptake of antenatal care marked by non-attendance, late and irregular attendance was particularly high amongst women of working

class background. Oakley (1984 :269) provides a further example of the link between social class and the uptake of antenatal education. Whilst women from the higher social classes benefit from the alternative model of antenatal education offered by organisations such as the National Childbirth Trust, the model adopted by the NHS is geared more towards programming women to accept the hospital policies in the management of childbirth. It would seem that instead of empowering women by providing flexible services, male dominated maternity services tend to disempower women.

If the past experiences of indigenous women suggest a high level of dissatisfaction with maternity provision controlled by men, the concern of Asian women is easy to understand. I have already highlighted in the previous chapter the criticism leveled at the medical profession for their problem-centred construction of Asian women. Whilst medical literature and research have concentrated on the poor uptake of maternity services and poor maternity outcome, there has been little interest in evaluating the attitudes of Asian women towards the maternity provision. It is often assumed that maternity services based on science and medicine are superior to traditional methods of managing childbirth. As we will see later, Asian women in Britain have to cope with the conflicting models of childbirth - the traditional versus the medical. The behaviour of women is dictated by the degree of freedom they have in making a choice between the two different ways of managing childbirth.

In addition to differences in expectations created by the social, cultural, religious and educational background, Asian women have to contend with the effects of institutionalised racism. Because of the centralised provision of the maternity services controlled by a white middle class male dominated medical profession, Asian women throughout their childbearing years have considerable exposure to racist attitudes. The racism in the NHS not only fails to recognise the different needs of Asian women but there is a widespread expectation from the health care providers that Asian women should integrate into British culture and learn to accept what is on offer without complaint. It is interesting to see, as will be apparent later in the empirical chapters, what effect racism has had on Asian women. Asian women, particularly Gujarati women from East Africa, who were educated under the colonial system have internalised the racism and the consequence of it manifests itself in the conflict between the older women who support the traditional childbirth practices and the younger women who are confronted with the dominant cultural ideology which belittles any other cultural beliefs. As will emerge later in the empirical chapters, particularly in relation to antenatal care involving confirmation of pregnancy, dietary and general health advice and later in the hospitalisation for birth, the traditional beliefs are put down in favour of

the widely assumed superior medical model of managing childbirth.

To sum up, the social control of women is a universal phenomenon which does not recognise any cultural or racial boundary and pervades all aspects of women's lives. The social control of women stems from and is perpetuated by male dominated institutions which not only determine the social status of women but also determine how women should fulfil the role designated by their status. It is when fulfilling their reproductive role that the full force of the social and medical control of women becomes most evident. Given that the social and medical control impinges on women's perceptions of their reproductive career, the main focus of this exploratory study will be to address three underlying factors which may colour the perception of their childbirth experience:

- the impact of their own society's attitude to pregnancy and childbirth
- the impact of male dominated medicalised childbirth practices in Britain
- the impact of significant others during childbirth, in particular, the significance of the traditional role of female members of the family within the context of male dominated childbirth practices in Britain.

In addition to the focus on the perception of their childbirth experiences, the study will also attempt to explore the degree of control exercised by Asian women within the context of their cultural traditions and medicalised childbirth practices in Britain.

## CHAPTER 3

## RESEARCH DESIGN

For the reasons outlined in the chapter 1, the group of Asian women I will be focusing on will consist of Gujarati and Bangladeshi women. Before describing the methods used to study these women I would first like to discuss briefly some of the main features of Gujarati and Bangladeshi communities in Britain.

Gujarati Community

The Gujarati Indians originate from in the state of Gujarat which is in the north west region of India. The presence of Gujaratis in Britain is not a recent phenomenon as their presence in Britain dates back to the last century (Tinker, H. 1977; Desai, R. 1963)). After the end of the second world war the migration of Gujaratis to Britain increased significantly to swell the labour force. The migration of Gujaratis to Britain took place across two continents. Whilst many Gujaratis migrated directly to Britain, some first settled in east and central Africa and later migrated to Britain in the late sixties and early seventies (Brown 1984:18). Although the Gujaratis have migrated across two continents, many features of Gujarati culture and traditions have survived the migration. For instance, they have retained their language and religious beliefs. The language spoken is Gujarati and most are followers of the Hindu religion. The other features which have been retained are the organisation of the community into various caste groups and the structure and composition of the family. The extended family is a common feature with two or more generations of the family living under one roof. The level of literacy and educational attainment is fairly high with many men and women holding professional qualifications. Gujaratis occupy all strata of occupations ranging from factory work and the retail trade to the professions.

Bangladeshi Community

The migration of the Bangladeshi from the then East Bengal to Britain runs parallel to that of Gujaratis. The migration from East Bengal was predominantly from Sylhet- a north east region of Bangladesh. The early migrants to Britain were sailors who later settled in Britain (Adams 1987; Watson 1977). Unlike the Gujaratis, the migration of wives and other family members has been a very recent phenomenon prompted by changes in British emigration laws (Carey & Shukur 1985). Because the migration of whole



families has been a very recent event, Bangladeshi men retained much closer physical and emotional links with Bangladesh. Consequently, the cultural, religious and linguistic traditions have been preserved more strongly than in the case of the Gujaratis.

Bengali is the national language but people from Sylhet district speak Sylhetti which is a local dialect. All Bangladeshis are devout followers of Islam. Only a small section of the Bangladeshis have had educational opportunities and especially amongst the women the level of literacy is very low (LMP 1985). Although many Bangladeshi men are engaged in businesses and other professions, a majority are restricted to working in poorly paid jobs in the clothing industry and in restaurant work. The unemployment rate amongst the Bangladeshi people is higher than any other Asian group. (Carey & Shakur 1985; Department of Employment, 1985, 1987)

The profile of the two communities presented here is a very generalised one, it is meant to throw some light on the social, educational and religious background of the communities who were going to be the subject of the research.

#### Original Research Proposal

I was initially interested in looking at the experiences of Gujarati women during pregnancy and childbirth from their point of view. I was especially interested in seeing the extent to which Asian and in particular, Gujarati women were able to determine what happened to them during pregnancy and childbirth and the factors which affected their behaviour and attitudes towards pregnancy and childbirth.

In my original research submission I had intended to study in depth the experiences of Gujarati women living in Harrow. The Gujarati women of Harrow were selected for the proposed study for a number of reasons. Since it was important to me that the study should provide a channel through which the women could voice their feelings and opinions I did not want language problems to interfere with data collection. The other considerations for restricting the study to a local group of Asian women were the time and cost involved in data collection. Since I am Gujarati and my first language is Gujarati, the Gujarati women of Harrow seemed to be the most ideal group of women for my research.

Many Gujarati women of childbearing age live in an extended family, usually comprising of the husband's parents, married or unmarried brothers and unmarried sisters. During pregnancy and childbirth, a Gujarati woman who is living with her husband's family may be influenced by the attitudes of

the older women whose own experiences of childbirth took place outside Britain and within the confines of their own culture and community. In Britain, Asian women of childbearing age are exposed to two different cultural influences: those of their own culture and those of the host community.

In order to get a deeper understanding of the influences of two different cultural values and those of the women's family on their childbirth experiences, I had planned to target my fieldwork on the whole family: I had planned to interview forty Gujarati women who had given birth to their first baby in the previous three months and to look at their pregnancy and childbirth experiences. In addition, I had hoped to conduct separate interviews with twenty mothers-in-law from the same group of forty families. It was hoped that the material generated from these interviews would provide a means of comparing attitudes and behaviour of young mothers to be and the impact of older female relatives on their pregnancy and childbirth.

#### Comparison of Childbirth Experiences of Two Different

#### Groups of Asian Women

At the time of submitting my original proposal to Cranfield, I had not considered the possibility of comparing two different groups of Asian women. However, after I took on the post of Project coordinator for the Asian Parents Health Project at the Camden Adult Education Institute, I thought of the possibility of including Bangladeshi women in the study because it would provide an opportunity to compare the experiences of two groups of women from vastly different linguistic, religious, cultural and socio-economic background.

By broadening the study to include Bangladeshi women, there was a shift in the focus of the original research submission. It was no longer feasible to focus separately on the mothers-in-law as the essential focus of the study became the comparison of pregnancy and childbirth experiences of two different groups of Asian women. Although the same interview schedule was used for Gujarati and Bangladeshi studies, the process of collecting material from the two groups was affected by a number of factors. Some of the factors were related to my inability to speak Bengali and gaining access to the women in two different health authorities. To allow for the differences in the way the materials were gathered, I am going to discuss the methods of data collection in Harrow and Camden separately.

Access in Harrow

Since a majority of the women in Harrow are booked for delivery at Northwick Park Hospital, I had planned to draw my sample of Gujarati women using the hospital medical records as this would provide me with a large sample pool to make a random selection. I first approached the Harrow Maternity Services Liaison Committee to get their permission to be allowed access to the medical records. I was invited to meet the Consultant Obstetrician and the Director of Nursing services to discuss my research proposal. This meeting proved to be unfruitful as a number of objections were raised - their main objections were that their mothers were atypical of immigrant women and that they did not think it was fair to subject the women attending Northwick to more interviews as some of these women were already taking part in the research undertaken by the hospital. After the meeting I realised that my original plan involving these hospital patients would have to be abandoned because of the length of time it would take to satisfy the conditions set by the Consultant Obstetrician and the Director of Nursing Services. I also realised that if I did satisfy their conditions I would be changing the nature of my study. In order to save time I submitted my research proposal to the Harrow District Ethics Committee directly to seek their permission to carry out the research in the community drawing the sample from general practitioners in Harrow instead of hospital maternity patients who had delivered their babies in the last three months.

Prepilot in Harrow

After the Ethics Committee in Harrow gave me permission to carry out pilot survey, I had informal chats with small groups of Gujarati women who had given birth in the preceding three months. The purpose behind the initial informal chats was to find out the kind of issues which might be raised by the women which would indicate the line of research. A list of women who had given birth in the preceding three months were provided by the community nurse manager by going through the child age/sex register. Nine mothers were selected at random out of the sample of twenty and of these five agreed to take part in the survey.

From the survey of the Gujarati mothers who had given birth in the last three months, it emerged that these women were unable to recall their experiences of pregnancy and child-birth in detail due to lapse of time. However, the issues which were raised by these women centred round traditional foods after childbirth, the role of relatives in perpetuating the ceremonial rituals during pregnancy and after child-birth, type of delivery and adjusting to the demands of a new baby. In fact following the birth of their babies, it

seemed that the women's recollection of their pregnancy and actual delivery became patchy as they became preoccupied with their new born babies.

#### Access in Camden

From my experience of gaining access in Harrow, I submitted my research proposal directly to the Bloomsbury Health Authority Ethics Committee to obtain permission to carry out research on the Bangladeshi women attending University College Hospital. Once again the main reason for constructing a sample frame based on the hospital records was to obtain a representative sample of local Bangladeshi women in the borough of Camden.

The London borough of Camden is divided into two separate health districts; Bloomsbury Health Authority and the Hampstead Health Authority. A majority of Bangladeshi people live in the Bloomsbury Health District and a smaller community is located in the Hampstead Health District.

After I discovered that a majority of Bangladeshi women in Camden preferred to deliver at University College Hospital because the hospital provided interpreter service, it seemed more appropriate to draw a sample of the Bangladeshi women from the University College Hospital rather than from the Royal Free Hospital.

#### Prepilot in Camden

While I was waiting for the Bloomsbury Ethics Committee to approve my research proposal, it was not possible for me to organise an exploratory survey with the Bangladeshi women similar to the one I had carried out in Harrow. Since I could not approach mothers who had recently given birth from the hospital records or through the community clinics, I set up a group interview with a local Bangladeshi women's group in Camden. The group interview was conducted with the help of a Bangladeshi interpreter.

The group of women who participated in the interview were of mixed age and parity and also included women who were pregnant at the time. Because of the nature of the group a wide range of opinions were expressed about pregnancy and childbirth in Britain and in Bangladesh. Some of the issues raised in the group interview included communication problems with the hospital staff, treatment of their pregnancy as a medical problem, management of childbirth in hospital, difficulties of adjusting to a hospital environment and routine and problems of receiving antenatal and postnatal care from male medical practitioners.

### Revised Research Design

After the exploratory surveys in Harrow and Camden were completed it became necessary to modify my original research proposal for a number of reasons. After the decision was taken to broaden my research to include Bangladeshi women, the total number of interviews involving forty Gujarati and forty Bangladeshi families would have made the size of the sample unmanageable. Since I was constrained by time and financial resources the number of Gujarati and Bangladeshi families was reduced to fifteen in each group.

The exploratory survey in Harrow and Camden revealed that a study focusing on the women's experiences of pregnancy and childbirth in the postnatal period was not as fruitful as expected because the memory of events, particularly during pregnancy, diminished with time. In the light of this finding, I decided to follow the progress of Gujarati and Bangladeshi women expecting their first baby from their early pregnancy to the first three months after childbirth. Although this method would have provided a valuable opportunity to record the progress of the pregnant women at different stages of pregnancy, it also carried a possible risk of the women dropping out of the study. To minimise the number of incomplete interviews, the revised design was further modified to limit the enquiry to the last trimester of pregnancy and the first two months after childbirth. Although this method was a compromise, it was hoped that the events in the early months of the pregnancy may be recalled more clearly and in full whilst the women were in their third trimester of pregnancy.

It was hoped that one interview in the third trimester of pregnancy and one in the postnatal period would show whether there were any connections between the decisions made during pregnancy and at the time of birth and whether the women were able to stick to the original decisions they had made during their pregnancy.

### Methodological Consideration and Instrument Design

The research methods in social sciences have evolved from the 'positivism' model favoured by natural sciences which place greater emphasis on experimental and standardised interview procedures to test theories. Research methods based on the 'positivism' paradigm, have a major drawback when they are applied to social science research because they fail to recognise the true essence of everyday human activity and because the emphasis is placed on quantitative rather than qualitative analysis.

The other limitation of the 'positivism' model when applied to social science is that to prove a theory it is necessary

to replicate the results of the experiment or survey. In addition, methods based on the positivism paradigm demand that the research is conducted in the absence of any external factor, such as the influence of the researcher/observer:

" In survey research, for example, the behaviour of interviewers is specified down to the wording of questions and the order in which they are asked. In experiments the behaviour of the experimenter and the instructions he or she gives to subjects are closely specified." (Hammersley & Atkinson 1983 :5)

To counter the limitation of the positivism model, social scientists have developed an alternative model, the 'naturalism' model which takes into account real life situations (Blumer 1969, Schatzman & Strauss 1973). The 'naturalism' model unlike the 'positivism' model requires the researcher to have an empathy with the situations in their natural state. Blumer (1969) also stresses that methods which use scientific tests have a limited value in social science because scientific enquiry does not recognise that phenomena/events are firmly located within the social world.

One of the advantages which 'naturalism' has over the 'positivism' paradigm is that 'naturalism' embraces a wide range of philosophical and sociological ideas such as symbolic interactionism, phenomenology, hermeneutics, linguistic philosophy, and ethnomethodology. Although these traditions evolved independently, they put forward a shared notion that social values, behaviours and attitudes can only be understood from the perspective of the people under study. Ethnography is one of the most basic form of social research which draws on a wide range of sources of information (Hammersley & Atkinson 1983). In contrast to the 'positivism' model which sets out to test a theory, methods based on 'naturalism' generate a theory from the qualitative analysis of the empirical data. This idea of 'grounded theory' was put forward by Glaser & Strauss (1967).

Since the main aim of this study was to enable two different groups of Asian women to talk about their childbirth experiences from their own perspective, in another words using the idea of grounded theory, a number of different qualitative methods based on ethnography tradition are considered. The empirical data for this study were collected from in-depth semi-structured interviews, a small number of case studies and documentary analysis.

The semi-structured interview schedule was designed to fulfil two main criteria - firstly to serve as a tool for guiding the conversation allowing the respondents

freedom to raise issues which were important for them and, secondly the semi-structured schedule was designed to collect background information and provide an opportunity to explore specific issues of interest to the researcher ( Burgess 1982, Hammersley & Atkinson 1983).

### Case Studies

In social research, the case studies approach is often used to focus on selected social factors or phenomenon to provide a more detailed account of the situation:

"After a body of research evidence has been accumulated on a topic, selective case studies can focus on particular aspects, or issues, to refine knowledge. For example, case studies can be used to provide a more richly detailed and precise account of the processes at work within particular types of case highlighted by surveys, whether typical or anomalous; they can be used to substantiate or refine causal processes thought to underlie observed patterns and correlations" ( Hakim 1987 :62)

Given the complex nature and structure of the extended family, case studies were used in this study to isolate individuals in order to study their situation in detail with the hope that this will give a clearer understanding of the interaction between different family members and the way it affects a woman's perception of childbirth.

A small number of case studies of Gujarati women were carried out using the same in-depth semi-structured interview schedule constructed for the main study. The main purpose of Gujarati case studies was to compare childbirth experiences of women who were related to each other through marriage ie they shared common parents-in-laws and were expecting their babies within a short interval of each other. The other purpose of the Gujarati case studies was to explore the role played by female relatives during pregnancy and childbirth.

The case study approach was also used to study in depth Bangladeshi women who were difficult to access because of language barriers. The main purpose of Bangladeshi case studies was to enable me to conduct in-depth interviews in English with Bangladeshi women in order for me to get first hand impression of how Bangladeshi women perceived their childbirth experiences.

### Construction of Sampling Frame in Harrow

In order to obtain a representative sample of primipara Gujarati mothers in the third trimester of pregnancy, general practitioners in six different areas of Harrow were

approached. Although most of the general practitioners were willing to assist me, some were only willing to supply the names of the pregnant Gujarati women on their antenatal lists on the condition that I obtained the verbal agreement of all the pregnant women who were to be included in the sample pool. This meant visiting antenatal clinics in each area on two or three separate occasions to speak to the pregnant women about my research while they were waiting for their examination. The women were given a brief explanation about the selection procedure and told that those women selected for interviews would be sent a letter inviting them formally to take part in the research.

Although the visits to the antenatal clinics were time consuming, it provided an opportunity for the women to ask questions and get to know me personally before their interviews. Once I had satisfied the general practitioners and the pregnant Gujarati mothers, I was provided with lists of mothers from each of the six areas at six weekly intervals. By pooling women from six different areas I constructed a sampling frame from which the women's names were selected at random.

#### Piloting of the Interview Schedule in Harrow

The pilot of the interview schedule in Harrow was based on three Gujarati women expecting their first baby. The women for the pilot were selected at random using the systematic sampling technique.

The piloting of the interview schedule highlighted the problem of selecting primipara mothers using the systematic sampling technique. It was discovered that in any given month the number of primipara mothers in the third trimester of pregnancy varied enormously so that in some months the size of the primipara mothers pooled from different parts of Harrow would have been too small to construct a sampling frame.

The pilot of interview schedule amongst Gujarati women also revealed that timing of the follow up interviews was crucial as some Gujarati women maintained the traditional practice of paying a short visit to their parents' home six weeks after childbirth.

#### Construction of Sampling Frame in Camden

After I was given permission to conduct my research at the University College Hospital, I obtained a list of Bangladeshi women from the hospital antenatal register for a period of six months between July 1987 and December 1987.



Piloting of the Interview Schedule in Camden

The piloting of the interview schedule in Camden revealed a number of problems associated with conducting interviews through an interpreter. It became apparent that the length of time taken to complete each interview would be increased significantly and this may deter some women off from participating in the study.

The other difficulties encountered when the interviews were conducted through an interpreter were in retaining the meaning of some words and phrases in the process of translation and interpretation from English into Bengali.

Final Revision of the Research Design and of the Interview Schedule

After the interview schedule was piloted, the wording of some of the questions were altered and where more specific details were required more questions were added. The schedule was divided into two parts - Part I looked at antenatal experiences and Part II covered the postnatal experiences. A copy of the questionnaire in English is attached to the appendix.

To allow for the small numbers of primipara mothers in the third trimester pregnancy, multipara Gujarati and Bangladeshi women were included to increase the size of the sample. It was hoped that by including multipara mothers, the final size of the interview group would be thirty women: fifteen Gujarati and fifteen Bangladeshi women.

To overcome the problem of contacting some Gujarati mothers in the postnatal period, it was decided that all postnatal interviews were to be completed within six weeks of birth i.e. before the mothers went to pay the customary visit to their parents' house. The problem of conducting interviews with Bangladeshi women was resolved by recruiting five local bilingual Bangladeshi women to conduct interviews in Bengali using a Bengali interview schedule.

From my work with the Bangladeshi community in Camden I had observed that unmarried or young women interviewers without previous childbirth experiences would have been unacceptable to the pregnant women and therefore the women engaged to conduct interviews were all mothers. After their recruitment, the Bangladeshi interviewers were given training in interview techniques and part of the training was spent on translating the interview schedule into Bengali. The joint effort in translating the schedule turned out to be a very useful exercise as this helped to remove any ambiguous phrasing of the questions. A copy of

the Bengali translation is attached to the appendix .

Data Collection in Harrow

In Harrow, a list was made of pregnant mothers in their second trimester of pregnancy pooled from six different areas of Harrow at four weekly intervals between May 1987 and January 1988. Each mother in the batch was assigned a number and mothers were selected randomly for the interview using the systematic sampling technique. From each batch two or three women were selected depending on the size of the sample. The mothers were sent letters with a reply slip in Gujarati and English and a stamped addressed envelope was provided for the mothers to indicate on the reply slip the time and date when they would be available for interview. Care was taken to address the letters to both the women and their husbands because it had emerged during the pilot phase that some women were not prepared to give interviews without their husbands' permission. After an interval of one week those mothers who did not reply were followed up by a telephone call.

Response Rate in Gujarati Study

Number of women included in the sample frame	76
Number of women randomly selected for the study	25
Positive response to the letter	5
Number of women who did not respond to the letter	20
Number of women who agreed after the telephone call	12
Number of women who declined after the telephone call	8
Total number of women who agreed to participate in the study	17

In spite of the fact that I had spoken informally to almost all the women who were selected for the interview informally at the antenatal clinics the response to the letter was very poor; only about a fifth returned the reply slips agreeing to the interview. Although many more women agreed to give an interview after they were followed up by telephone, about two fifths declined for a variety of reasons. Of the women who declined, two women did not wish to participate in the study , one mother had given birth prematurely, a further had husbands who did not approve and the rest refused because they were very busy and could not spare the time. All the Gujarati women ( n=17 ) who agreed to take part in the study were interviewed although the total number of complete interviews I was hoping to get was fifteen. The reason for

including more Gujarati women in the antenatal interview was a precautionary measure against women dropping out of the study in the second phase of the interview.

#### Data Collection in Camden

A similar selection procedure was followed in Camden with the exception that a sampling frame was constructed from the list of mothers obtained from the hospital antenatal records. Initially each Bangladeshi interviewer was given six names and addresses of pregnant women expecting their babies between August and December to obtain complete antenatal and follow up postnatal interviews of three mothers. The interviewers sent out letters in Bengali and English. From my observation of Bangladeshi women, the letters were not expected to produce a large response because of the low level of literacy amongst the Bangladeshi women in Camden. The main function of the letter was to serve as a precursor to a personal visit by the interviewer to arrange the date and time of the first interview where a mother was willing to be interviewed.

#### Response Rate in Bangladeshi Study

Number of women included in the sample frame	56
Number of women selected for interview	30
Number of women who returned the reply slip	00
Number of women who agreed to take part after personal visit	14
Number of women who declined to be interviewed	6

In Bangladeshi study, getting the women's consent to take part in the interviews was complicated by the fact that many women were living in temporary accommodation without telephone facilities. As anticipated, none of the women responded to the letter. Since many women could not be contacted by telephone, the interviewers had to call two or three times to arrange a date and time for the interview. The women who declined to take part in the study gave similar reasons as those given by Gujarati women in Harrow. Because of these difficulties, the total number of Bangladeshi women who took part in the antenatal interviews (n=14) were less than I had hoped to interview.

#### Antenatal Interview in Harrow and Camden

All the antenatal interviews were conducted in the mother's home and each interview lasted between one and two hours. The length of the interview was determined by

communicativeness of the mothers, presence of small children and the presence of other members of the family. In some cases the length of time I spent with Gujarati mothers was in excess of two hours when I was asked to give information about the management of labour in the hospital. The Bangladeshi interviewers were often asked for help with official letters or telephone calls to sort out problems connected with housing or schools.

Almost all the conversations were tape recorded with the exception of a few interviews with Bangladeshi women who were not keen to have their conversation tape recorded. In these cases the interviewers noted down the main points on the Bengali interview schedule and immediately after the interviews made more detailed notes and translated the interviews from Bengali into English. The transcription of the whole antenatal interviews took between eight to ten hours especially as it also involved translation of the interviews into English.

At the end of each antenatal interview, the expected date of delivery was confirmed and arrangements were made to call again to complete the follow up interview in the first six weeks after delivery.

#### Postnatal Interviews in Harrow and Camden

The mothers were contacted by telephone a few days after the expected date of delivery had passed to arrange a second interview and if the baby was overdue, the mother was contacted again a few days later. In the case of women who could not be contacted by telephone, the mothers were visited at home to arrange a date and time for the interview.

All the follow up interviews in the postnatal period took place between three and six weeks after birth. Almost all the postnatal interviews took place at home with the exception of a few Gujarati mothers who were interviewed at their parents' house in Harrow. In most cases the postnatal interview lasted about an hour. Although the postnatal interview was shorter than the antenatal interview, the length of interview varied according to the number of interruptions during the interview for the mother either to attend to her baby or her other children and also interruptions caused by the arrival of visitors.

With the exception of those women who objected to have their postnatal interview tape recorded all the other interviews were taped and transcribed fully.

Interview Sample SizeAntenatal Interview

	No Complete Interview	No Incomplete Interview	Interview used in the Analysis
B	14	0	14
G	17	0	17

Postnatal Interview

B	14	2	12
G	17	2	15

By conducting follow up interviews in the postnatal period before six weeks of birth, the number of incomplete interviews were avoided. However, of the women who could not be interviewed postnatally, two Gujarati women had left Harrow to visit their parents in the Midlands earlier than expected and before the postnatal interviews could be arranged. Of the two Bangladeshi women who could not be contacted for the postnatal interview, one mother had moved out of the area during the final stages of her pregnancy and in the case of the second mother, her husband would not allow his wife to give a follow up interview after the baby was born.

Demographic Profile of the Women Studied

Of the women who took part in the main study their socio-economic status, education attainment, pattern of migration, length of settlement in Britain and family network appeared to be entirely consistent with the profile of the two communities presented at the beginning of this chapter.

Country of Birth of the Women

	UK	Bangladesh	India	Africa	Total No Women
B	1	13	-	-	14
G	0	0	4	13	17

With the exception of one Bangladeshi woman who was born in Britain, the rest were born in Sylhet in Bangladesh and more than half had been living in Britain under two years. About three quarters of the Gujarati women in Harrow had

been born in East Africa and had lived in Britain at least five or more years.

Length of Settlement in Britain

	Under 1 yr	1 < 2yrs	2 < 5yrs	5 < 10yrs	10 < 15yrs	Total No Women
B	2	6	3	-	3	14
G	-	-	2	5	10	17

Structure/Composition of the Family

	Extended	Nuclear	Total No Women
B	6	8	14
G	13	4	17

Because of recent changes in British immigration laws, it has been difficult for older dependant relatives to emigrate from Bangladesh. This was reflected in the greater proportions of Bangladeshi women who were living in a nuclear family. This is in marked contrast to their traditional joint family structure in Bangladesh. In contrast, Gujarati extended family units had migrated at the same time, consequently almost three quarters of Gujarati women were found to be living in a traditional family structure.

Socio-economic Status ( Based on Husband's Occupation)

	I/II	IIIA	IIIB	IV/V	Total No Women
B	3	3	3	5	14
G	15	1	1	0	17

The position of women's socioeconomic status were calculated according to the Registrar General's classification, however the data presented in the table should be treated with some caution because they were based on the husband's occupation and therefore do not give actual indication of the women's socioeconomic status (Delphy). In addition, since a majority of the Gujarati women were living in an extended households with more than one main wage earners, the actual position of

these women's socio-economic status was difficult to define. The main purpose for presenting the socioeconomic table is to highlight the concentration of women at the lower end of the socioeconomic scale and its implication for the welfare of women during childbearing years. Of the Bangladeshi women included in the main study about a third were in the socio-economic group IV and V. These groups had the highest number of families with heads of households often without jobs. A few men were employed as unskilled staff in the kitchens of hotels and restaurants. Of the rest, about a fifth in group III, worked in the clothing industry as skilled machinists and about equal numbers ran their own businesses in the retail trade or were owners of Indian restaurants.

In socio-economic terms Gujaratis in Harrow were in a more fortunate position. Almost all the families were in social class I/II with the head of the household working in one of the main professions like accountancy, pharmacy and banking. Of the remainder the head of the household were engaged in skilled and semi-skilled professions.

Educational Attainment of the Women

	College Degree	Advanced Level	Secondary 'O' Level	Primary	None	Total No Women
B	0	0	3	5	6	14
G	4	7	6	-	0	17

In terms of educational attainments, only a fifth of the Bangladeshi women had had an opportunity to study beyond primary education. About a third of the women who had spent a few years in the primary school were literate in Bengali and the rest of the women had never been to school but were able to read the Koran. Because of the low level of literacy amongst the Bangladeshi women, only women with education beyond secondary school had done paid work outside their homes.

In contrast, the level of literacy in English and Gujarati was fairly high particularly amongst the Gujarati women from East Africa who had been educated under the British education system. Consequently, almost all the women were either in full time employment during their pregnancy or had worked prior to their pregnancies in offices and other similar institutions.

Age of the Women during Current Pregnancy

	<20	20 - 25	26 - 30	31 - 35	36 - 40	Total No Women
B	3	5	2	2	2	14
G	0	2	11	4	0	17

The age range of Bangladeshi women was widely spread out. However, more women were represented in the age range early twenties and below with a few multiparous women who were in the age range thirty-five and over. The number of the women in early twenties who were expecting their first and second babies reflected their marriage in the late teens. On the other hand, the women aged thirty-five or more were expecting their sixth or seventh baby.

In contrast, a majority of the Gujarati women were expecting their first baby at the age of twenty-five or more subsequent babies in their late thirties.

The Bangladeshi women were of higher parity with a greater number of miscarriages and stillbirths compared with the Gujarati the women ( as indicated in the table below.)

Parity ( Previous Pregnancies including Miscarriage and Stillbirth)

	0	1	2	3	4	5	6	7	Total No Women
B	4	2*	4	-	-	2*	1*	1	14
G	7	6	3	1*	-	-	-	-	17

\* - Miscarriage or stillbirth

Weakness in Methodology

It must be emphasised that the method used to study the perception of pregnancy and childbirth of Asian women was an exploratory study and used qualitative rather than quantitative approach with the aim of looking at childbirth experiences from the women's point of view.

One of the main problems encountered in recording the experiences of two different groups of Asian women was my inability to conduct interviews with the Bangladeshi women in person. In spite of using trained bilingual interviewers to carry out interviews with Bangladeshi women, the interviewers faced a number of difficulties. The



interviewers found that many Bangladeshi women were too shy and were reluctant to talk freely about their experiences. Some of the women were acutely embarrassed to answer questions in the presence of their husbands or older female relatives. Another problem faced by the interviewers was conducting interviews with women living in temporary accommodation which provided very little privacy or space to conduct interviews without interruptions from children and other families.

In addition to the women's inherent shyness and the circumstances under which the interviews were conducted, the interviews with Bangladeshi women failed to generate answers to more specific details about their pregnancy and childbirth. This was partly due to the fact that many women had recently settled in Britain and as a result were not aware about the management of pregnancy and childbirth in Britain. To overcome the paucity of material generated from the interviews with Bangladeshi women additional methods were used to create a better understanding of the Bangladeshi women's experiences of pregnancy and childbirth. The following additional methods were used in the Bengali study to augment material gathered in the main interviews.

#### Documentary Analysis of the Hospital Records

After the interviews of the Bangladeshi women were completed I obtained permission to look at the medical records of these women at University College Hospital. It was not possible to look at the records of all the fourteen women who were interviewed because some of the records could not be traced and others were sent to other health districts when the women moved out of the area. From the remaining eleven medical records I was able to obtain specific details about the pregnancy, antenatal care, management of labour and delivery and postnatal care. However, it must be emphasised that the data collected from the hospital records should be treated with some caution because the hospital records were incomplete and the details on the records were often illegible.

#### Interview of Key Informants in Camden

In addition to documentary analysis, I also interviewed four key Bangladeshi informants whose work involved helping pregnant women. Two of these women were working as interpreters in Camden and another two were community social workers. The main purpose behind these interviews was to find out the major issues which concerned Bangladeshi women during pregnancy and childbirth. A separate unstructured interview schedule was designed for these interviews. A copy of this interview schedule is attached to the appendix.

My concern about the quantity and quality of material generated from the main Bangladeshi study and some of the issues identified by the key Bangladeshi women prompted me to carry out two case studies of Bangladeshi women who were able to speak English. I conducted the interviews myself as I had hoped that this would lead to detailed information which would provide a more comprehensive understanding of the issues facing Bangladeshi women. The case study interviews were conducted using the interview schedule designed for the main study. However it is important to point out that the childbirth experiences of the Bangladeshi women case study should not be compared with Bangladeshi women in the main study because the women in the case study were from different social and educational backgrounds.

In my original research proposal, I had intended to explore the traditional role played by female relatives during pregnancy and childbirth in greater depth by conducting separate interviews of older female relatives, particularly mothers-in-law. However, when the original research design was modified to include Bangladeshi women in the study, it became necessary to exclude female relatives to make the study much more manageable. As a result the important aspects of the involvement of the female relatives during pregnancy were lost. In order to add this dimension back into the study a small number of case studies were carried out. The purpose behind the case studies was to explore the impact of the family on the pregnant women. I was particularly interested in finding out the extent to which the management of pregnancy and childbirth were influenced by older female members of the family whose own childbirth experiences took place within a different cultural setting outside Britain.

## CHAPTER 4

## ASIAN WOMEN'S ATTITUDES TO CONCEPTION AND PREGNANCY

The fertility behaviour of Asian women has been the focus of many recent research studies (Zaklana 1984; Rashid 1983; Beard 1982) in an attempt to understand attitudes to family planning. The interest in fertility behaviour would appear to be motivated by a desire to increase the uptake of family planning services. It can be argued, however, that this emphasis fails to take into consideration the women's own perception of conception and motherhood.

In this chapter I wish to focus on two separate issues in an attempt to redress this imbalance - namely the feelings Gujarati and Bangladeshi women have about conception and their attitudes to pregnancy. These two issues have major implications for the way women behave in the management of their pregnancy and childbirth. There are of course, important differences between these two groups. Some of the Gujarati women, for instance, have been settled in this country for many years whilst many of the Bangladeshi women have arrived relatively recently. One would expect therefore, their attitudes to conception and pregnancy to be influenced by the strength of affiliation to the values and beliefs of their own culture and those values prevalent in British culture.

Attitudes to Conception

For most Gujarati and Bangladeshi women, rejection of either marriage or motherhood are unthinkable notions as their societies expect that they conform to the role destined by their fate. From the discussions in the Chapter 2 it is clear that the stigma attached to either an unmarried or a barren woman in both societies acts as a discouragement for women to question the status attached to marriage and motherhood (Ahmed, G. and Watt, 1986; Abdulla and Zeidenstein, 1982). The comments made by Bangladeshi and Gujarati mothers in response to the question of whether or not they had given any thought to becoming a mother suggested that both groups of women held similar views about what was expected of them from their societies. Without exception, there was a common consensus that children were a consequence of marriage and conception was only approved within the framework of a marriage. Whilst not all the women admitted that they had giving any serious thought about having children, they all expected to have got married first:

"No, I never thought about it. I always believed that marriage will come first and then whatever things happen will happen anyway. Pregnancy is common and something natural!" (Bangladeshi Mother Seventh Pregnancy)

This view was also shared by other Bangladeshi women who not only believed that conception was only possible after marriage but also seem to suggest that these matters were outside women's control:

"I was thirteen when I started my period and I was married when I was just fourteen. I didn't have time to think about it because I became a mother in the first year of my marriage."  
(Bangladeshi Mother Fifth Pregnancy)

This view concerning a society's expectation of women to achieve the status of marriage followed by motherhood were also echoed by many Gujarati women. A typical remark was:

".....deep down I always knew that I would have to get married one day and have children. I don't think there is any choice to do otherwise. No one expects you to remain unmarried. Once you are married it is expected that you will have children." (Gujarati Mother Second Pregnancy)

The women's perceptions of desirability of conception are shaped by the subtle pressure after marriage to have children. This often takes the form of blessings given to the married couple: "May god bless you with many sons". This sort of subtle pressure continues until a woman becomes pregnant. It seem that not only is a woman required to prove her fertility but she is also expected to bear at least one son (Ahmed, G. and Watt 1986). In Bangladeshi and Gujarati societies the birth of a male child enhances a woman's status within her husband's family because the family name and family inheritance is carried to the next generation through a male offspring who in turn would be expected to provide care and economic security to the parents in their old age ( Ahmad, M. 1979). It has been suggested by writers such as Naila Kabeer (1985) that in a traditional agrarian society, the women's contribution in other spheres of life is not given the same recognition as their potential for producing children to work on the land. Kabeer expressed doubts about whether high fertility benefits women personally, the traditional value placed on women's fertility and the relatively high infant mortality rate in the Indian subcontinent, act as strong motivation for women to produce children.

Amongst the Gujarati Hindus, there is additional pressure on women to give birth to a male child. It is believed that unless a son performs the rituals of death, the departed

person's soul does not reach heaven (Ahmed, G. and Watt 1986). Although such attitudes and expectations are becoming less acceptable, many women were nonetheless aware of what was expected of them:

"I went through a stage when I thought I would like to have children...it would be nice to have three or four kids. This was when I was 16/17 years old. Lots of people expect you to want only sons but I think sex of the baby doesn't matter. My mother-in-law's reference to my baby is only in terms of a boy and not a girl. Overall, in my experience, there is a general expectation that I am carrying a male child!" (Gujarati Mother First Pregnancy)

A similar position is taken by Bangladeshi women. It has been reported that Islamic law does not directly set out its opposition to birth control (El-Islam 1988). However, amongst the Bangladeshi Muslims, those with orthodox views believe that it is a sin to prevent a pregnancy because the children are considered to be gifts from God (Abdullah & Zeidenstein 1982 :195)

Since some of the women had lived in Britain for many years one would expect to find their attitudes to conception to be influenced by the attitudes prevalent in the indigenous population which has adopted more liberal attitudes towards premarital sex and unmarried mothers. This view, however, was not commonly shared by either Gujarati or Bangladeshi women. In fact the women's attitudes to conception appeared to be firmly moulded by their cultural traditions which sanctioned against both premarital sex and unmarried mothers. This view was shared by all women regardless of their length of settlement in Britain, educational attainment or socioeconomic status.

#### Planned or Unplanned Pregnancy ?

The term planned pregnancy suggests a deliberate action to initiate a pregnancy by giving up the use of contraceptive. At the opposite end, unplanned pregnancy implies that the pregnancy was an unfortunate accident due to the failure of contraceptive. However, using such broad categories as planned and unplanned pregnancy, excludes pregnancies which are planned in the sense that they are expected to 'just happen' without recourse to time or contraception. As we will see, there are also other pregnancies which do not so easily fit under the unplanned category and which occur not entirely as a result of contraceptive failure.

Although the Gujarati and Bangladeshi women also fell into the two broad categories of those who had planned their pregnancy and those who had not, the circumstances under which some of the women had found themselves pregnant were

a lot more complex and ambiguous than seemed at first apparent. When the types of contraceptive methods used and attitudes to family planning were examined, these provided clues to the individual circumstances and how much control in fact the women had been able to exercise over their fertility. Table 4A set out the circumstances under which pregnancy had occurred.

Table 4A: Contraception and Circumstances of the Pregnancy

Planned Pregnancy

	No Contraception	Condom	Pill	Total No Women
B	2	3	2	7
G	1	2	4	7

Unplanned Pregnancy

Contraceptive Failure

B	-	2	0	2
G	-	4	0	4

Only One Partner Keen on Pregnancy

B	-	-	-	0
G	-	2	2	4

Neither Partner Keen on Pregnancy Or Birth Control

B	-	-	-	0
G	2	-	-	2

Accepting Fate

B	5	0	0	5
G	-	-	-	0

About half the Gujarati and Bangladeshi women indicated that they had planned their pregnancy because they had stopped using birth control in order to conceive. Their typical remarks were:

"We planned this pregnancy because we wanted another baby. I came off the pill and we took other precaution for a couple of months. I became pregnant six months after I came off the pill." (Gujarati Mother Second Pregnancy)

A Bangladeshi woman who had also planned to become pregnant gave a similar explanation:

"We were trying for another baby because I had lost a

baby.. I had a miscarriage at three months because I had carried on taking the contraceptive pill after I had become pregnant. This time my husband used condom until it was safe for us try again."

(Bangladeshi Mother Fifth Pregnancy)

In addition to the women who had initiated their pregnancy by stopping the use of contraceptive, a number of women, who had never practised any birth control, also claimed that their pregnancy was planned because they were waiting for it to just happen:

"I did not use birth control before I became pregnant. This is my first pregnancy. I expected to become pregnant one day. We didn't try for it. God helped us."

(Bangladeshi Mother First Pregnancy)

When the circumstances of the remaining Gujarati and Bangladeshi women, who had not anticipated their pregnancies, were analysed the women fell into four sub-categories. These were: failure of contraception, a half-hearted attempt at birth control with only one partner keen on pregnancy, neither partner keen on pregnancy nor on birth control, and finally, women who accepted pregnancy as ordained by the will of God (see Table 4A)

Whilst the fertility control of the women who had intended to become pregnant was self-evident, the case of the women who had not consciously set out to become pregnant needs further explanation.

In the case of about a fifth of the women, pregnancy had occurred as a result of contraceptive failure. In all these cases the couples were relying on the condom to prevent a pregnancy. Since condom is a male contraceptive, some of these women felt that they were unable to prevent their pregnancy unless their husbands took their responsibility seriously as these comments suggest:

"As I suffer from very high blood pressure I can't take any birth control pills. My husband has to use the condom. The whole pregnancy was an accident. Don't know how it happened...maybe it is God's will."

(Bangladeshi Mother Third Pregnancy)

A Gujarati mother whose husband believed that the decision about birth control should be left to the man, also accidentally became pregnant when she was least prepared for it:

"My pregnancy was not planned. I did not want a baby just yet. I am not emotionally ready to take the responsibility of another baby. My husband uses a sheath so

I could not do anything myself to prevent this pregnancy. I suppose I am now resigned to it."  
 (Gujarati Mother Third Pregnancy)

Whilst these women felt unable to control their fertility, in the case of other Gujarati women, their pregnancy was not exactly an accident because some of them were using the contraceptive pill before they conceived. The comments made by these women implied that there was some disagreement between the couples about starting a family. In this case the partner who was most keen to have a baby effectively took a decision to initiate the pregnancy overruling any objections from the other partner. Interestingly, of the four Gujarati women, three women had reluctantly given into the wishes of their husbands, one such mother remarked:

"To tell you the truth, it was not planned. At least I was not ready to have a baby. I was a bit disappointed; I suppose I am a career women... I am very ambitious. For my husband it is the right time to have a baby because he is thirty-one and the right age to become a father. Initially he was worried about my reaction because he knew I was not too keen to have a baby." (Gujarati Mother First Baby)

Such remarks made by some of the first time mothers suggested that it would be wrong to assume that first time married mothers have less problems adjusting to their unwanted pregnancy than women who do not want any further additions to their family. Although the mixed feelings expressed by some Gujarati women who were expecting their first baby seemed contradictory in the face of strong cultural pressure for them to have a baby soon after marriage, it is important to recognise that not all Asian women necessarily welcome their first pregnancy.

In a majority of the unplanned pregnancies, husbands appeared to be more keen to start a family with one exception where a Gujarati mother who could not wait to have a baby had came off the pill without informing her husband:

" My pregnancy was half planned. I decided it was the right time for us to have a baby so I just came off the pill. We did not plan it together. He was not keen to have a baby because we had been married for just over a year. He was also concerned about bringing up children in this world and wondered whether it was safe to bring up children in this country. Besides he is extremely fond of his sister's children and feels that his sister's children are just like his own. But for me it is nothing like having your own otherwise you miss out a lot. When he first found out I was pregnant he was not overjoyed but later he got used to the idea." (Gujarati Mother First Pregnancy)



Amongst the women who had not planned their pregnancies, about a quarter of the couples did not practise any birth control. Amongst the Gujarati couples the greatest anomaly was found where neither partner wanted a further addition to their family and neither appeared to want to take the responsibility of birth control:

"We had not taken any precautions because I did not want to carry on taking the pill and I was not keen to have a coil fitted. My husband felt it was my responsibility and he was not prepared to use anything himself. When I became pregnant it took us a long time to come to terms with it. I even considered having an abortion but my doctor persuaded me against it." (Gujarati Mother Third Pregnancy)

Another Gujarati woman also cited a similar reason for her mixed reaction to her unplanned pregnancy. In her case too, her husband did not think it was his responsibility to prevent an unwanted pregnancy:

"After we were married I was on the pill but after my first baby was born I came off the pill because there was such a lot of talk about cancer. My husband did not want me to stop the pill but he was not prepared to use any contraceptive himself. When I became pregnant for the second time it did not matter because we wanted another baby but this time round it is different as neither of us wanted another baby." (Gujarati Mother Third Pregnancy)

Although these were extreme cases, it did show that couples who had accepted western norms about the small size of the family and seemed to be fully knowledgeable about family planning, experienced a great deal of tension. In both cases the tension existed because the attitude and behaviour adopted by the husbands indicated that they did not see family planning as a shared responsibility. It would seem that the ambiguity about fertility control was not related either to their lack of interest in family planning or to their religious beliefs but rather their inability to resolve who should take the responsibility for birth control. The unfortunate result of this conflict between the couples was an unwanted pregnancy which had more immediate impact on the lives of the women than on their husbands.

Bangladeshi couples who were not practising any birth control appear to be free of the tension experienced by the Gujarati couples. This was because some of the Bangladeshi couples did not believe in the principle of birth control and on the contrary believed that it was sinful to interfere with the wishes of God. In fact, the comments made by the women suggested that the locus of control was

not with the individual man or woman but was believed to be in the hands of 'Allah'. Consequently about a third of the Bangladeshi women (see Table 4A) accepted their pregnancy as destined in their fate, as this following remark illustrates:

"I was not very surprised to become pregnant. My husband and I believe that pregnancy is a gift from Allah so we do not mind having children. We must accept the consequences of pregnancy."

(Bangladeshi Mother Seventh Pregnancy)

This is quite a contrast to Gujarati couples who expressed mixed feelings about their pregnancy because the couples had not resolved their difference. No such ambiguity was expressed by Bangladeshi couples but instead the women derived comfort and strength from their belief in God. Whilst not all Bangladeshi women objected to the idea of birth control, some women expressed strong views against the practice of birth control and this was especially common amongst the older women who had recently settled in Britain.

It was apparent from the accounts given by Gujarati and Bangladeshi women that in many cases the overall control of their fertility was not entirely in their hands. Whilst many Bangladeshi women appeared more inclined to accept their pregnancy with grace, some Gujarati women experienced a great deal of tension in coming to terms with their pregnancy.

Since not all the women had been able to exercise control over their fertility, in the next section I will be focusing on the couples' reactions to the pregnancy.

### Feelings about Pregnancy

When the Gujarati and Bangladeshi women were asked to describe how they and their husbands felt when they first suspected their pregnancy, a wide range of feelings were expressed. The feelings expressed ranged from happiness to unhappiness and from mixed feelings to total acceptance of pregnancy as God's will. Table 4B sets out the reactions of the couples to the news of the pregnancy.

Table 4B: Couples Reactions to the Pregnancy

	Both Happy	W Happy H Unhappy	H Happy W Unhappy	Both Unhappy	Both Mixed	Both Accepting	Total No Women
B	8	0	1	0	1	4	14
G	7	1	5	2	2	0	17
-----							
	15	1	6	2	3	4	31

W - Wife

H - Husband

About half the Gujarati and Bangladeshi couples who had intended to have a baby expressed positive feelings when the pregnancy was suspected. The women who had consciously set out to become pregnant were obviously very pleased as these remarks suggests:

"We were very pleased when I finally became pregnant as we had been trying for a while. It was just the right time for us to have another baby, financially as well as having the right gap after my first child. We are not planning to have a third child unless the second baby is a girl. I would like to have a boy this time as most our Indians like boys, especially the dads who want a son."  
(Gujarati Mother Second Pregnancy)

A Bangladeshi mother also expressed similar sentiments but her pregnancy had a special significance for her:

"I am very pleased. My husband is also very happy I am pregnant. We wanted another baby because I lost my last baby. I was on the pill before I became pregnant with my fifth baby. Because I did not know that once I was pregnant I had to stop taking the pill. My baby died when I was eight months pregnant. This is going to be our last baby...we both want a boy. We hope we are lucky this time."  
(Bangladeshi Mother Sixth Pregnancy)

It was interesting to observe that considerably more husbands (about two thirds) were happy about the pregnancy than were their wives. This marked difference in the attitude towards pregnancy suggests that the pregnancy had more immediate impact on the lives of the women than it did on the lives of the men. This was certainly true for about a quarter of the women were not at all pleased to learn that they were pregnant, with more Gujarati women expressing negative feelings about their pregnancy than

Bangladeshi women. A few Bangladeshi women who had accidentally become pregnant, perceived their pregnancy as a threat to their health. One such mother remarked:

"I was not very happy at first because I am worried about my health. The doctor at the hospital had told me that I should not become pregnant for two or three years because I had a Caesarian operation. My husband was also anxious at first but now he is happy. He wants a nice boy."  
(Bangladeshi Mother Second Pregnancy)

On the other hand, some Gujarati women expressed a feeling of being trapped by the pregnancy which they had not planned:

"I was very upset when I found that I was pregnant whereas my husband was very pleased because he wanted another child. I would have liked to have had bigger gap between my pregnancies. I have been working hard to save money so that I can visit my family in India. I have not seen my family for nearly ten years but now there is no chance of seeing them until my second baby is bit older."  
(Gujarati Mother Second Pregnancy)

For others, coping with their unplanned pregnancy without the sympathy and support of their husbands was a very distressing experience; one such mother explained:

"I was not happy at all. In the beginning I became very depressed and withdrawn. Until I was over two months pregnant I did not tell anyone about my pregnancy so no one knew why I was so depressed. I did not want a third baby because I would have liked to have gone out to work and enjoyed some freedom from home. My husband did not mind having another baby, in fact he is very happy about my third pregnancy. He does not really understand why I am so upset"  
(Gujarati Mother Third Pregnancy)

A number of Gujarati couples reported that although they were pleased about their pregnancy they also had some misgivings towards their pregnancy. In a majority of these cases, the women tended to harbour more doubtful feelings than did their husbands:

"My husband was quite keen to start a family. I felt it was too soon after getting married but at the same time we were not getting any younger. We did not think I would become pregnant so soon. It was quite a shock for me..it had all happened so quickly for me. We are pleased but sometimes I really regret becoming pregnant because I would have liked to have waited a little longer."  
(Gujarati Mother First Baby)

The two Gujarati couples who were unhappy with their pregnancy were the same couples who had shown an ambiguous attitude towards birth control ( see Table 4A ). It is apparent that the ambiguous attitude they had shown towards birth control is reflected in their attitude towards pregnancy. Furthermore, whilst the lack of control over fertility caused unhappiness to both partners, each of whom experienced difficulties in coming to terms with the pregnancy, the consequences for the women were more serious as illustrated by the following comment:

"We hadn't planned to have a third baby. We already have a son and a daughter...it just happened! My husband was not at all pleased. He wanted me to get rid of it. It was quite a difficult time for me because, you know, in my own mind I did not want to do anything bad but there was no choice. When I spoke to my sister-in-law she advised me against termination and told me that it was my fault for not taking any precaution. My husband was most unhelpful... at night he would tell me to arrange a termination and in the morning he would change his mind about termination. I felt trapped from both sides, getting termination was difficult on the NHS and private termination was too expensive. In the end I could not go through with termination and just accepted that there was nothing I could do." (Gujarati Mother Third Pregnancy)

This particular case highlighted the difficulties faced by some women who may not be able to seek emotional and practical support from their immediate family. In dealing with such sensitive and emotive issue such as the termination of a pregnancy, family members may not be the most suitable people to provide unbiased advice. It is therefore very important to recognise that not all Asian women have support from their extended family when they are faced with difficult decisions of this kind and their effort to obtain professional advice should be taken seriously. Although the following example is an extreme case it does however illustrate the plight of a woman who had to resort to extreme measures to try and get herself out of a difficult predicament:

"When I found out I was really pregnant I was really worried. I spoke to my doctor and told her that we weren't happy about having this baby and would like to arrange a termination. The doctor told me to try some gin. I don't know if she said that jokingly to cheer me up because I was so depressed. Anyway I was so desperate I took a whole bottle of gin hoping I would lose the baby but nothing happened. I then took a lot of Indian herbal remedy hoping I would miscarry but nothing happened. In the end I just had to accept that there was nothing I could do..." (Gujarati Mother Third Pregnancy.)

In complete contrast, just under a quarter of the Bangladeshi women who were not practising any birth control accepted their pregnancy with equanimity as these comments illustrates:

" My husband and I believe that children are God's gift so we are pleased to have another baby. "  
( Bangladeshi Mother Seventh Pregnancy)

Another Bangladeshi mother also accepted her pregnancy as a matter of course:

"My husband is very happy to have more babies. I do not mind that I am pregnant again. We are pleased to have a baby now than later because as we get older it would be difficult to look after them."  
(Bangladeshi Mother Sixth Pregnancy)

#### Relatives' Attitudes to Pregnancy

The experiences of the Gujarati and Bangladeshi women suggested that there was general agreement amongst the women about the desirability of conception. A majority of the women indicated that they accepted their responsibility to fulfil the expectation of their society and more directly those of their family. However, some women experienced a great deal of conflict in the timing of conception and exercising of control over their fertility. In this section I am going to focus on the reactions of the husbands' relatives to see whether their views had any affect on the women's attitudes to conception and pregnancy. The analysis is restricted to the husbands' immediate family members because their views usually have a lot more impact on women than those of the women's own relatives. Table 4C sets out the reactions of the husbands' relatives to pregnancy.

Table 4C: Reactions of Relatives to Pregnancy

	Delighted	Mixed	Not Pleased	Accepting	Total No Family
B	7	-	-	7	14
G	11	2	2	2	17

Table 4C suggests that on the whole the reactions of husband's family to the pregnancy was quite favourable with the exception of a few Gujarati in-laws.

Since a majority of the Bangladeshi women's attitudes to conception and pregnancy were influenced by their religious and cultural beliefs, it is perhaps not very surprising to

find that their in-laws' views were very similarly influenced. Amongst the Bangladeshi women, none of their husbands' relatives expressed any doubts about the timing of the pregnancy or advisability of having further additions to the family:

"My parents-in-law were very pleased to know I am expecting another baby. My sister-in-law who lives with us also believes that it is a blessing from 'Allah'."  
(Bangladeshi Mother Fifth Pregnancy)

Another Bangladeshi mother made similar comments:

"My parents-in-law and everyone in my husband's family are naturally very pleased with our news. My mother-in-law would like us to have more children"  
(Bangladeshi Mother Third Pregnancy)

Similarly, the reactions of most of the Gujarati in-laws were very positive, particularly amongst the Gujarati women who were expecting their first baby. It is only in relation to the expectations of the in-laws that the reasons for some of the Gujarati women's negative attitudes to pregnancy become more obvious. For instance, those women who placed greater priority over their career development or improving their financial position experienced indirect pressure from their in-laws to have a baby. One such mother explained:

"I was most definitely not ready for a baby. Although there are other grandchildren in my husband's family, my husband is the eldest male so my parents-in-law were very anxious for us to have a baby. My mother-in-law often used to remind my husband that it was time to have a grandson in the family. When I became pregnant my in-laws were obviously very pleased whereas I would have liked to have waited until I was established in my career."  
(Gujarati Mother First Pregnancy)

On the other hand, the reactions of some relatives to the news of the pregnancy was less than enthusiastic because the relatives were concerned about the timing of the pregnancy and their concern for the welfare of the mother:

"My in-laws were not pleased to learn I was expecting another baby so soon. My mother-in-law felt that another pregnancy so soon after the first one was unwise. She felt that I wouldn't be able to cope with two very young children and my health would suffer."  
(Gujarati Mother Second Pregnancy)

However, not all the in-laws' negative reactions to the pregnancy resulted from their concern for their daughter-

in-laws' welfare. In the case of a Gujarati woman, who belonged to a different caste from that of her husband, the in-laws' displeasure at her pregnancy resulted from their strained relationship with her which affected their attitude towards her pregnancy:

"From my mother-in-law there was absolutely no reaction....she just ignored the fact that I was pregnant. She did not even ask when the baby was due. My mother-in-law has never accepted me as part of her family. We don't have mother-in-law/daughter-in-law relationship. My mother-in-law never even acknowledged my first pregnancy although we were living together at the time. My mother-in-law has not been able to accept the fact that she did not arrange her son's marriage."  
(Gujarati Mother Fourth Pregnancy)

#### SUMMARY

Some of the main issues to emerge from this chapter suggested that both Gujarati and Bangladeshi women's perception of conception was strongly influenced by their cultural beliefs. Although some of the women had lived in Britain for a number of years and had adopted western attitudes towards family planning, they all shared the common view that conception should only take place within the framework of a marriage. This view is clearly a confirmation of earlier contention that the preservation of a patriarchal family structure is a cornerstone of female subjugation as discussed in the introductory chapters.

However, the women's views on the timing of conception were divided according to their attitudes towards birth control and whether or not they were able to exercise any influence on the timing of their pregnancy. For a majority of Bangladeshi women timing of the conception seemed to be less of an issue as a number of women had recently settled in Britain and their views were still strongly influenced by the cultural and religious traditions of the country of their birth. On the other hand, for Gujarati women who had lived in Britain for many years and had gone a long way towards accepting British culture, fertility control was not an issue. Nonetheless for some Gujarati women fertility control became an issue because they were trapped between two opposing views. For some women the unresolved dilemma about birth control and which partner should have the responsibility for birth control resulted in a personal crisis and deeply affected the way they felt about their pregnancy.

Finally, the women's attitudes to birth control and the degree of control they were able to exercise over their fertility has implications for their subsequent attitude



and behaviour towards the management of their pregnancy and childbirth. The issue of control and its implications on the management of their pregnancy will be addressed in the next chapter.

## CHAPTER 5

## MANAGEMENT OF PREGNANCY

The last chapter explored the attitude of women towards their pregnancy and the degree of control they were able to exercise over their fertility. Some couples had accepted western ideals of planned parenthood and others were resisting the changes by holding on to their religious and cultural beliefs. Does this trend continue to have an effect on the decisions the women make in the management of their pregnancies? i.e. do women who have control over their fertility accept control over the management of their pregnancies and secondly, do women whose views on fertility are shaped by their religious and cultural beliefs, allow these beliefs to similarly control the management of their pregnancies?

Before a woman can make a successful transition to motherhood her status during the gestation period is ambiguous depending on whether her condition is regarded as normal or not. In non-industrialised and preliterate societies it is considered as a normal life event and it is not treated like an illness which requires expert medical supervision (Oakley 1977; Mead & Newton 1967). As the discussion in chapter 2 suggests that this is in direct contradiction to the way pregnant women in the western industrialised nations are treated (Haire 1978, Oakley 1976: 21; Arms 1975).

Even today in some cultures, for instance in rural Bangladesh, pregnancy and childbirth are still managed by experienced women whose expertise comes not from medical knowledge but from practice and skills passed on from one generation of women to next (Blanchet 1984).

It is often older experienced women who take upon themselves the responsibilities of advising and supporting a pregnant mother from the early signs of pregnancy and leading up to the first few weeks after childbirth. Any danger to the pregnant mother and her unborn child are safeguarded by observation of certain rituals and restrictions, e.g. this could take the form of dietary restriction, or restriction in the movement of pregnant women to the performance of ceremonies to appease ancestral spirits (Kitzinger 1978: 84; Paige K & Paige J 1973). Any discomforts in pregnancy are treated with either herbal or with traditional remedies based on the properties of certain foods.

In Britain, the traditional role of women as providers of

care and support for the pregnant women has been replaced by medical professionals. The trend towards the medicalisation of childbirth started after the first World War in an attempt to reduce the high incidence of infant and maternal mortality( Oakely 1976: 38).

At present the medicalisation of childbirth begins from the from the early weeks of pregnancy when any woman who suspects her pregnancy, is expected to notify her general practitioner who makes arrangements for antenatal care and hospital delivery. After the pregnancy is confirmed all pregnant women are expected to present themselves at their local clinic or maternity hospital for regular examinations to detect any abnormality or complication in the pregnancy. In addition, women are encouraged to attend antenatal preparation classes, and follow dietary and health advice given by the health professionals.

Women from India and Bangladesh who have settled in this country experience a totally different system of managing childbirth, especially if the childbearing women themselves or their older female relatives are familiar with non-medical female centred childbirth.

The data presented here makes it possible to examine how a group of Gujarati and Bangladeshi women approached their pregnancies in Britain when faced with culturally different approaches to the management of pregnancy.

Although Gujarati and Bangladeshi women share many common features in the traditional practices of managing pregnancy, there are also many differences. On a structural level, the differences can be accounted for by the socio-economic position each group occupies in Britain, the length of settlement in Britain, the differences resulting from the rural backgrounds of Bangladeshi women and urban backgrounds of Gujarati women and by the differences in educational attainment (see Chapter 3 page 67 ). Besides these structural differences individual differences include: how closely a woman identifies with her own childbirth practices, how much importance the woman attaches to the involvement of medical professionals in the management of the pregnancy; and the influence exerted by older female relatives, whose own experiences were based on non-medicalised practices.

Each of the above factors could have an important bearing on the decisions a woman makes during her pregnancy, starting with the confirmation of the pregnancy, regarding health and diet, antenatal care and the observation of traditional rituals surrounding pregnancy. The way Gujarati and Bangladeshi women managed their pregnancy will be examined here to see if these factors in any way affected

the decisions they made during their pregnancies.

### Confirmation of Pregnancy

If conception has occurred, it is signalled by an absence of the monthly period unless a woman has some other serious illness. A woman who is attuned to her bodily functions may suspect her pregnancy long before anyone else becomes aware. Some women have additional symptoms of pregnancy such as sickness, tiredness and dizzy spells which make the pregnancy more obvious.

In cultures where pregnancy and childbirth are considered to be natural processes, the symptoms experienced by a pregnant woman would be sufficient proof of her pregnancy. She would then wait for nature to take its course.

Gujarati and Bangladeshi women come from cultures where traditionally less emphasis is placed on the need to have a pregnancy confirmed by a health professional. However, individual women have different motives for suspecting their pregnancy i.e. women who are expecting to become pregnant are more eager to accept the symptoms as a sign of their pregnancies whereas women who had not intended to become pregnant may not be so eager to acknowledge the symptoms they are experiencing.

When the women in my sample were asked when they first became aware of their pregnancy, more than 1/2 had suspected their pregnancies when they missed their first period, 1/3 were still not sure and the remainder had nausea and tender breasts which made them suspicious even before they had missed their period. A few women reported that their mother-in-law suspected their pregnancies long before they had even thought about it.

In my sample, women who were attuned to their bodily functions had very little doubt about their pregnancy and did not need to have it confirmed. The first time mothers as well as mothers with previous pregnancy experience, who were anticipating pregnancy, commented:

"After I had missed my period, a few days later I started to feel dizzy and nauseous, I knew I was pregnant."  
( Bangladeshi Mother First Pregnancy)

"As soon as I missed my period, I suspected and felt I was pregnant. I had a funny feeling inside as I started to feel nauseous and my breasts became very tender and painful." ( Gujarati Mother Second Pregnancy)

However, not all women immediately wanted to believe that the symptoms they had experienced had anything to do with their pregnancy. This was particularly so with the women who did not want to become pregnant and hoped it was a false alarm, some typical comments were:

"When I missed my period, I just thought it was late. I did not want to believe that I could be pregnant but my sister-in-law suspected that I was pregnant."  
(Bangladeshi Mother Second Pregnancy)

"Just after missing my period, I thought I was pregnant but at the same time I didn't want to believe it. I thought my period was late because I had a bad cold and cough" (Gujarati Mother Third Pregnancy)

In Britain where pregnancy and childbirth have become medicalised, a woman has to seek medical confirmation of her pregnancy either through her own doctor or through a chemist. Since most women in Britain no longer have a choice in giving birth at home, women who are not keen to receive antenatal care still need to see their doctor to reserve a bed in hospital for delivery and obtain certificates which would enable them to claim maternity benefits.

It has been widely reported that many Asian mothers fall into the high risk category during the antenatal period because they do not take full advantage of maternity services (Barnes 1982). One of the main aims of the Asian Mother and Baby campaign (1984) was to urge Asian mothers to report their pregnancies as soon as possible to increase the uptake of antenatal care ( see chapter 1 page 9).

However persuading Asian mothers to conform to the requirements of health professionals depends on firstly, how eager the women are to seek medical opinion to confirm their pregnancy, and secondly on the implication of reporting the pregnancy to the medical authority i.e. what would be required of the expectant mothers by the health professionals once the pregnancy is confirmed.

To find out how eager the Gujarati and Bangladeshi women were to seek medical confirmation of their pregnancy, the women were asked how long they had waited to see their doctor. The Table 5A sets out the weeks when the pregnancy was reported to the doctors.

TABLE 5A CONFIRMATION OF PREGNANCY

	No. of Weeks of Pregnancy					Total No Women
	0 - 4	5 - 8	9 - 12	13 - 16	17+	
B	2	2	3	4	3	14
G	7	8	2	-	-	17
-----						
	9	10	5	4	3	31

The Table 5A shows that all but two Gujarati women had their pregnancy confirmed by the 8th week of pregnancy, but in comparison 1/2 the Bangladeshi women had their pregnancies confirmed after the 12th week of pregnancy and a few after the 17th week of pregnancy. The marked difference in length of time for confirmation of pregnancy amongst Gujarati and Bangladeshi women are examined here to offer some explanation towards this apparent difference.

Many Gujarati women have an advantage over Bangladeshi women because of their socio-economic and educational background. Their longer length of settlement in Britain has made it possible for them to become accustomed to the British lifestyle. Some of these factors have been responsible for Gujarati women adopting westernised attitudes to medicalised childbirth.

The Gujarati women seemed to be very keen to have their pregnancy confirmed as soon as possible. This was particularly apparent with the Gujarati sample in Harrow (cf Table 5A). The fact that the majority of the Gujarati women were registered with female doctors may have been an important factor in encouraging them to report their pregnancy early. On the other hand, some Gujarati women reported that they they felt equally at ease with male doctors and therefore did not feel any inhibition consulting their male general practitioners during their pregnancy. Many Gujarati women were less inclined to believe their pregnancy symptoms and placed greater faith in their doctors to confirm their pregnancy, as this comment from a mother suggests:

" After I missed my period I did the home pregnancy test. We did the test twice and each time we had positive result but we still doubted ourselves thinking we couldn't read the test correctly. I went to my doctor to have it confirmed and when he confirmed it then I was sure."  
(Gujarati Mother First Pregnancy)

On the other hand, some Gujarati women who had not planned

to become pregnant were just as anxious to consult their doctor to allay their fears of an unwanted pregnancy as one mother remarked:

"I saw my doctor straight away, as soon as I missed my period. I had gone to my doctor in a way to confirm that I wasn't really pregnant- in my mind I kept saying I wasn't pregnant...My husband had also suggested that if the doctor confirmed the pregnancy, I should get something from the doctor to get rid of the baby.

(Gujarati Mother Third Pregnancy)

In contrast, on cultural and individual levels most Bangladeshi women appear to share similar attitudes about the confirmation of their pregnancy by a health professional. A number of Bangladeshi women who had accepted their pregnancies as a wish of 'Allah' (see Chapter 4 page 78 ) belonged to the same group of women who kept the knowledge of their pregnancy to themselves much longer than any other group of women. A possible explanation for Bangladeshi women to delay reporting their pregnancy may be because they considered a pregnancy to be a natural occurrence which therefore did not require medical intervention (Table 5A). But this was not the full explanation, as many Bangladeshi women revealed in the interviews that they considered hospital births to be safer than home births in rural villages in Bangladesh. This perception of hospital birth as a safer place of delivery was also shared by Asian women in Homans (1980) study. It appears that these women had other reasons for delaying reporting their pregnancy earlier.

Some Bangladeshi women found it acutely embarrassing to seek consultation with a male doctor, especially if he was Bengali, because they were afraid to break the 'purdah' restrictions with anyone of the opposite sex from their own country. Even though the 'purdah' restriction is somewhat relaxed in Britain, many women in Camden still found it unacceptable to seek consultation with any male doctor. Some typical comments were:

"I became pregnant sometime in October but I did not want to see my doctor because he is Bengali. Although I have been registered with him for the past four years I have not consulted him once. I find it very embarrassing to talk to him about my pregnancy. My husband went to see him instead to get a letter for the hospital appointment. I did not see anyone about my pregnancy until I had an appointment at the hospital in January when I was three months pregnant."

( Bangladeshi Mother Fifth Pregnancy)

Another Bangladeshi woman who had delayed going to her own doctor explained:

"I did not see my doctor straight away but my mother-in-law bought some medicine from the chemist to do a pregnancy test. Then after about ten weeks I saw my doctor." (Bangladeshi Mother First Pregnancy)

For many Bangladeshi women there is a tension between wanting a medical service which they see as western and superior and the desire to avoid contact with the opposite sex so as not violate the 'purdah' restriction.

Even after women had put aside their inhibition of contact with the opposite sex, for some women the implication of reporting pregnancy early meant regular attendance at the antenatal clinic, coping with communication difficulties and having to rely on their husbands to accompany them to the clinic and also to help look after other children. For some of these reasons women left it as long as possible to confirm their pregnancy. This trend seems to be quite common amongst women who had previous experience of antenatal care in Britain. Some typical remarks were:

"I went to see my doctor after I was four months pregnant, although I was quite sure about my pregnancy. The delay to see the doctor was mainly waiting for my husband to be free so that he can be with me and my other children. I have no relatives in this country who can help to look after my children."  
(Bangladeshi Mother Third Pregnancy with history of high blood pressure.)

Another Bangladeshi woman who had previous experiences of childbirth in this country gave the following explanation for not reporting her pregnancy too soon:

"I waited three months before I sent my husband to get a letter for hospital appointment from my family doctor. I did not want to tell anyone that I was pregnant because I didn't want to go too early...if you go too early to your doctor then you have to keep too many appointments. Once I have been given an appointment I do not like to miss it because if you miss any appointments the doctors ask too many awkward questions."  
(Bangladeshi Mother Fifth Pregnancy)

### Summary

The main point to emerge from the early pregnancy



experiences of the Bangladeshi women suggested that for many women confirmation of pregnancy was both a cultural and an individual issue. The issue confronting Bangladeshi women is tied up with the fact that they are a recent immigrant group who have come to this society with a given set of cultural expectations about managing pregnancy. In Britain they are suddenly having to deal with another set of expectations. The discussion above throws some light on how they are dealing with the culturally alien concept of medical confirmation of pregnancy and the issue of consulting male doctors.

In contrast, for the Gujarati women confirmation of pregnancy was not a cultural issue because many women had adopted western views but the personal circumstances of individual women determined whether confirmation of pregnancy became an issue for them. Not only have Gujarati women lived in Britain for many more years than Bangladeshi women but their socio-economic and educational backgrounds are also more favourable than that of Bangladeshi women. Gujarati women are culturally closer to British culture because of their urban background compared to more rural backgrounds of the Bangladeshi women.

The issues raised by the Gujarati and Bangladeshi women in particular concerning the confirmation of pregnancy has implication for the diagnosis and management of health problems in pregnancy.

### Health in Pregnancy

The issue of pregnancy as a state of normality or ill health has been debated extensively with opposite views being put forward by the researchers in the field. For instance Hern (1971) suggests that pregnancy should be treated as ill health whereas Mckinlay (1972) argues that pregnancy should be treated as a normal biological event in the lives of most women and it is necessary for the survival of the species. However for many women such hypothetical issues do not match reality of their experiences.

The way pregnant women view their health in pregnancy is based on subjective experience. Their perception of health in pregnancy is defined by their cultural values. Most women do not generally equate pregnancy with ill health by itself although pregnancy is associated with a certain amount of discomfort caused by minor ailments. On an individual level, a woman's perception of her own health in pregnancy is influenced by her social and personal circumstances. For Asian women in Britain- how an individual woman from the Gujarati or the Bangladeshi

communities perceives her health will be determined by her personal circumstances as well as by the culture, i.e. British or her own culture, she identifies most with. For instance a woman who has been influenced by some of the British cultural values regarding birth control, may perceive her health in pregnancy in negative terms if she was unable to prevent her pregnancy.

On the other hand a woman whose cultural attitudes towards birth control is negative may accept pregnancy as well as her health in pregnancy as something which is not unusual. In addition, how a woman perceives her health in pregnancy also depends on how she perceived her health before she became pregnant.

The data presented in Table 5B was gathered in the third trimester of pregnancy to find out how Gujarati and Bangladeshi women perceived their health before and during their pregnancy.

Table 5B: Perception of Health Before and After Pregnancy

	<u>Before</u> <u>Pregnancy</u>		Total No Women	<u>During</u> <u>Pregnancy</u>		Total No Women
	B	G		B	G	
Very Good	1	2	3	-	1	1
Quite Healthy	12	14	26	12	8	20
Not Very well	1	-	1	-	3	3
Not Good	-	1	1	2	5	7
	-----	-----	-----	-----	-----	-----
	14	17	31	14	17	31

Taking the data presented in Table 5B, it appears that almost equal numbers of Gujarati and Bangladeshi women reported that they had enjoyed good health before their pregnancy. However additional material gathered during the interviews revealed that a number of Bangladeshi women who had described their health as quite good were taking tablets to control high blood pressure before their pregnancy and others were being treated for anaemia. This apparent discrepancy in their perception of health suggested that women from other cultures have a different concept of health and illness.

This trend was observed with other Bangladeshi mothers who did not qualify their remarks about their health before pregnancy whereas some Gujarati mothers who perceived their

health to be quite good qualified their remarks in line with a western concept of health, as these comments suggests:

"I didn't have any problems. I wasn't sickly. I thought I was bit overweight. I have had weight problems since the birth of my daughter."  
( Gujarati Mother Second Pregnancy)

Another Gujarati mother perceived her health before her pregnancy in similar terms:

"Quite good actually. Although I do suffer from lot of sore throats and cystitis after getting married. My mother-in-law suggested a herbal remedy to cure my cystitis but I prefer to take the antibiotics prescribed by my doctor because they work much faster."  
( Gujarati Mother First Pregnancy)

It would be misleading to conclude that Bangladeshi women had fewer health problems before pregnancy from the data presented here as some women were not very communicative or others found it embarrassing to talk to strangers about personal health problems. As one mother commented:

"I think it is shameful to discuss with other people about pregnancy." ( Bangladeshi Mother Third Pregnancy)

This was also mentioned by the Bangladeshi community workers who were interviewed separately after the main study was completed in an attempt to gather more material about the management of pregnancy in Bangladeshi communities. As one community social worker remarked:

"Lots of women try and hide their symptoms as far as possible and keep their bodies well covered with sari to hide the bulge. It is the way Bengali women are brought up to think that a pregnant women must cover her body completely....If a woman is in 'purdah' then the unborn child is also in 'purdah', so women do not go round flaunting their condition."

However a very small number of Gujarati and Bangladeshi women described their health in negative terms. The women's personal circumstances made them feel that their state of health was less than satisfactory as these following remarks illustrate:

"I was not very healthy. I feel very depressed because we are living in bed/breakfast hotel with only two rooms. I suffer from lot of headaches."  
(Bangladeshi Mother Seventh Pregnancy)

A Gujarati mother's perception of her own health was coloured by the fact that she was having problems with her husband as well as with her in-laws;

"I never used to go through days when things like flu would affect me. I am basically very healthy person... This time round, I didn't feel very fit before I conceived, I felt emotionally and physically drained out. I didn't feel 100% fit"

( Gujarati Mother Fourth Pregnancy)

Although the women's basic perception of their health before and during their pregnancy did not alter significantly, during pregnancy the numbers who had claimed to have enjoyed good health fell by a 1/3. The Gujarati women still claiming to have good health in pregnancy dropped by almost 1/2 whereas Bangladeshi women's perception of health before and during pregnancy did not change at all. Once again it would be misleading to suggest that Bangladeshi women had a more positive perception of their health during pregnancy than Gujarati women based on this data alone. This apparent difference in perception may be explained by Bangladeshi women's willingness to accept their pregnancy as unavoidable normal event in their lives. In addition Bangladeshi women's concept of health in pregnancy was influenced by their own culture: what would be considered to be health issues in Britain, were not perceived as such by the women. In contrast, many Gujarati women's perception of their health in pregnancy was influenced by medical model of health in pregnancy.

When Bangladeshi women were asked about their health in pregnancy, women who had either high blood pressure or anaemia did not think that they had poor health in pregnancy even though they were being closely monitored for these conditions (information obtained from hospital records). The following remark shows that for these women high blood pressure or severe anaemia were alien concepts and did not appear to constitute a threat to their health:

"I have no illness apart from morning sickness... My health is quite good."

( Bangladeshi Mother Third Pregnancy with a history of high blood pressure)

"Good health. I have no health problems in my pregnancy. This is my fourth pregnancy. I never experienced any problems"

(Bangladeshi Mother Fourth Pregnancy with severe anaemia)

Some Gujarati women, however were more conscious about the

effect their pregnancy had on their health whether the pregnancy was planned or not, as these remarks illustrate:

"I have not enjoyed good health in this pregnancy. From the beginning I have been unwell and tired. At the moment I have got a very bad cough and now I am on antibiotics. I have found this pregnancy lot more tough compared to my last pregnancy."

(Gujarati Mother Planned Second Pregnancy)

"Not really. I had mumps in early pregnancy. I couldn't eat. The mumps infection left me with a very bad ear infection. I felt very depressed and cried a lot. I felt very miserable. My husband was away from home a lot and I found it very hard to look after myself and my son who is only fourteen months."

(Gujarati Mother Unplanned Second Pregnancy)

Unlike the Bangladeshi women, the concern expressed by some Gujarati women about their health suggested that their perceptions of health were more closely aligned with the western concepts of health. The symptoms of conditions such as high blood pressure and anaemia in pregnancy were taken very seriously as this comment suggests:

"As soon as my pregnancy was confirmed I had some bleeding problems. I went to my doctor straight away. He was quite worried about it obviously. He saw me quite regularly for a week. He arranged for me to have a scan at the hospital....I was very anaemic just when I became pregnant. I was put on iron tablets which helped a lot. Now I have got high blood pressure and swollen ankles and swollen hands. I have been told to rest as much as possible....I usually have a nap in the afternoon and put my feet up as much as I can to keep my blood pressure down." (Gujarati Mother First Pregnancy)

#### Serious health problems in pregnancy

In some women the physiological changes associated with pregnancy may exacerbate health problems which existed before the pregnancy, putting both the mother and her baby at risk. Some of the more common serious health problems in pregnancy are high blood pressure, diabetes, anaemia, heart disease and malnutrition. A woman with any of these serious problems may find it inadvisable to contemplate a pregnancy or may need to stabilise her condition before embarking on a pregnancy to reduce the risk to herself and her baby. If a woman has already conceived then she is advised to seek regular medical supervision to monitor her progress throughout her pregnancy. The issue of poor access to the medical practitioners raised earlier in the chapter may have further implication for women who have serious health

problems before they become pregnant.

Some serious health problems experienced by Bangladeshi and Gujarati women are presented in Table 5C, most of the data came from the interviews with the exception of the data on anaemia in Bangladeshi women which was obtained from the hospital records\*. None of the women claimed more than one serious health problem.

Table 5C SERIOUS HEALTH PROBLEMS IN PREGNANCY

	Blood pressure	Anaemia	Depression	Total No Women
B	2	3*	2	14
G	2	2	3	17
	-----	-----	-----	-----
	4	5	5	31

In the course of their pregnancies, over 1/3 of women had experienced some serious health problems with either blood pressure, anaemia and depression. The serious health problems appeared to be more common with women who were not in control of their fertility (see Chapter 4 page 75). The Bangladeshi women seemed to be at greater risk because they faced added difficulties in gaining access to antenatal care. A Bangladeshi woman with a history of high blood pressure and previous eclamptic fits remarked:

"Although I was quite sure about my pregnancy, I didn't go to my doctor until I was four months pregnant because there is no one to look after my children. I usually have to wait until it is possible for my husband to take me to the doctor".

(Bangladeshi Mother Third Pregnancy)

This particular mother was at risk throughout her pregnancy and was admitted to hospital on a couple of occasions antenatally to stabilise her dangerously high blood pressure.

Gujarati mothers with blood pressure problems appeared to be aware of the risk of high blood pressure and did not hesitate to seek medical advice. Gujarati women also had family support at home to keep their blood pressure under control.

In some parts of the Indian subcontinent, a large baby is associated with a difficult labour therefore many pregnant women prefer to have a small baby. Nichter (1983: 238) reported that many women in the Indian subcontinent believe that delivery is easier with a smaller baby. This they believe can be achieved by increasing the intake of food to

keep the stomach full which in turn reduces the amount of growing space for the womb and the baby. Consequently any treatment, including regular prescriptions of iron tablets, which the women believe would increase the growth of the baby would be unacceptable to some women. A typical comment was:

"My aunt advised me not to take any iron tablets prescribed by my doctor because she has heard that women who take iron tablets in pregnancy have a difficult labour. The iron tablets makes the baby too big. A baby makes the labour long and difficult."  
(Bangladeshi Mother First Pregnancy)

However not all women had the same reason for not taking iron tablets. Some Gujarati and Bangladeshi women had difficulties remembering to take them regularly and others stopped taking them because they found the tablets did not agree with them:

"I had to stop taking the iron tablets because they made me constipated. I haven't told my doctor because I find it embarrassing to tell my doctor that I have got constipation." (Gujarati Mother Fourth Pregnancy)

"I have been prescribed extra iron tablets as I have suffered from anaemia since the birth of my first baby. I find I sometimes forget to take them because I am always so busy. I only remember my tablets when I get extremely tired and my back starts to hurt."  
(Gujarati Mother Third Pregnancy)

Evidence from controlled trials suggests that women who lack social and psychological support during pregnancy are more likely to feel unhappy, nervous and worried during pregnancy and more likely to have negative feelings about the forthcoming birth (Kitzinger et al 1989). Women whose personal circumstances were unfavourable or those who were going through an unwanted pregnancy reported that they worried a lot during their pregnancy. The Gujarati women who were unable to exercise any control over their fertility were most distressed because they perceived their pregnancy as a trap. One such mother gave the following explanation:

"I have to accept my pregnancy as there is not much that I can do. I do wonder how I will cope and manage two very young children when my second baby arrives. I am very worried.... I told my husband that I wanted to arrange an abortion. I was not keeping well when I had my first baby, who at time was only nine months old. I suffered from constant anxiety for first the six months. I was crying all the time. I tried to talk to my husband but he does not

listen. I wanted to go and stay with my mother but my husband kept putting it off and I became more and more depressed because I was not able to do what I liked."  
(Gujarati Mother Second Pregnancy)

The feelings of despair and anxiety were not confined to multipara women who did not wish to be pregnant. Similar views were expressed by women who were expecting their first baby. Contrary to expectation, women expecting their first baby were equally worried and unhappy during their pregnancy:

"The first month is not very important I think, but after that I would say the first four months I felt very unhappy. I used to say to myself 'my God' what's happening. I felt down in the dumps. I kept feeling that I shouldn't have become pregnant. I used to be very weepy and felt low. I saw my doctor couple of times because I was so unhappy but she told me that I wasn't the first woman to experience it. My in-laws were shocked at my behaviour because I used to act so funny. I wouldn't talk to anyone. They were worried and wondered what had happened to me." (Gujarati Mother First Pregnancy)

It would also seem from the above comment that if a women complains about psychological or emotional problems she may not receive as much attention as if she presented physical symptoms.

Although the level of unhappiness expressed by the women in the study varied enormously, their anxiety was not always directly connected with their pregnancy or childbirth. Brown & Harris's (1978) study also makes it abundantly clear that pregnancy and childbirth do not necessarily make a woman more vulnerable to depression. Their study of depression amongst working class women suggested that other social factors, for example lack of an intimate relationship, three or four children under fourteen at home, loss of mother before eleven, no employment outside home increased women's vulnerability to depression. This was particularly noticeable in the case of many Bangladeshi women. For instance many Bangladeshi women reported that adjusting to life in a strange country, separation from relatives and the added disadvantage of belonging to a lower socio-economic group coupled with poor housing had a far greater effect on their emotional wellbeing than the thought of being pregnant again. Bangladeshi women who were living in either bed and breakfast hotels or second stage accommodation were particularly vulnerable to depression as this remark suggests:

"I feel anxious all the time....I am worried because we live in a hotel...I am not able to relax because I am



not used to living in a hotel. It is difficult to look after children and stop them from making noise. We have only two rooms between us all. My children and I do not speak any English. For us it is very difficult to understand the rules of the hotel. The English lady who comes to clean the hotel is not very nice to my children and I feel she takes advantage of us because we can't speak English. My husband is unemployed and it is not easy for him to find a job. The situation is not good enough to have a baby while staying in a bed and breakfast hotel." (Bangladeshi Mother Seventh Pregnancy)

### Summary

The major issue to emerge from the above discussion suggests that women who had not been influenced by the western medical model of childbirth management believed that a pregnancy was a normal physiological occurrence. As a result it was not surprising that the women and Bangladeshi women in particular, did not perceive high blood pressure and severe anaemia as a potential threat to their pregnancy. The fact that some of these women were unaware of the seriousness of their state of health has implications for the management and treatment of serious conditions such as high blood pressure and severe anaemia. It also has implications for how the information is conveyed to the women whose first language is not English.

On the other hand, the accounts of women who were unhappy or worried during pregnancy suggest that the extent of their emotional problems linked to social deprivations may not have been fully appreciated by medical professionals. It is important to realise that women whose first language is not English may not be able to express their anxieties or make differentiation between physical and emotional symptoms.

### Minor Ailments In Pregnancy

In spite of the fact that 2/3 of the women in my sample (see Table 5B) claimed that they enjoyed good health in pregnancy which also included women who had some serious health problems, almost all women experienced a certain amount of discomfort as a result of physiological changes taking place in their bodies.

A certain amount of discomfort is experienced by most women but not all women are affected to the same degree and the extent of discomfort felt in one pregnancy is unique to that particular pregnancy. The minor discomforts of pregnancy are experienced by women of all cultures. However different cultures have evolved different methods of coping with them. Fortunately most discomforts in pregnancy are

transitory and do not cause any serious harm to the mother or the baby. However some women may need support and advice to cope with them.

Some common minor ailments associated with discomfort in pregnancy are nausea, sickness, tiredness, indigestion, backache, depression, sleeplessness, leg cramps and constipation. Some women experience the discomfort in early or late pregnancy and others are affected throughout their pregnancies.

This section looks at the range of common ailments Gujarati and Bangladeshi women experienced during their pregnancies. The Gujarati and the Bangladeshi cultures have evolved their own traditional methods, of dealing with minor ailments in pregnancy, involving properties of certain foods and herbs (Homans 1983). In Britain, women from these cultures have an additional method of dealing with minor ailments based on western allopathic treatment. How an individual woman deals with minor ailments will be determined by the severity of her complaints and by her attitude towards the form of treatments that are available to her.

Before we look at how Gujarati and Bangladeshi women coped with minor ailments, Table 5D shows the range of minor ailments experienced by some of the women.

Table 5D: Range of Minor Ailments Mentioned  
by the Women (Multiple Responses)

	Morning Sickness /Nausea	Tiredness	Heartburn /Indigestion	Total No Women
B	12	8	9	14
G	16	14	10	17
	28	22	19	31
	Swings in Mood	Aches/Pains	Constipation	
B	2	3	2	14
G	6	3	7	17
	8	6	9	31
	Burning feet/hands	Sleeplessness	Dizzy Spells	
B	4	3	3	14
G	-	-	4	17
	4	3	7	31

With the exception of two Bangladeshi women, the rest of the women in my sample complained of two or more minor ailments in their pregnancies. The Gujarati women had the largest number of ailments. The commonest ailment was either nausea or sickness which were experienced by almost all women. Some ailments such as tiredness, heartburn, dizzy spells and aches/pains affected almost equal numbers of Gujarati and Bangladeshi women. Whilst more Gujarati women experienced constipation, depression, and cramps, the Bangladeshi women's complaints were about sleeplessness and burning hands and feet.

The fact that so few Bangladeshi women mentioned constipation may be because some women do not like to talk about such subjects openly. It has also been suggested by the Bangladeshi hospital interpreters in Camden that sleeplessness amongst pregnant Bangladeshi women living in bed and breakfast hotels was quite common. The women's other common complaint of burning hands and feet was not confined to just pregnant women. When the women with this complaint were referred to the local hospital for further consultation they were told there was nothing seriously wrong with them. It is believed that women's complaints about lack of appetite, aches and pains and burning hands and feet are all related to depression and anxiety which affect many women living in temporary accommodation.

The way women react and cope with minor ailments in pregnancy depends on whether they consider the symptoms to be abnormal requiring special treatment or remedies and whether they have anyone to whom they can turn for support and advice. Traditionally Bangladeshi and Gujarati women receive advice and support from other women to cope with minor ailments in pregnancy. For some ailments traditional remedies are recommended and if no cure is available then the women are given support and reassurance. In Britain, pregnant women are also offered allopathic treatments for some ailments.

Taking an example of nausea or sickness as one of the ailments mentioned by the majority of women, we will look at the way these women coped with the discomfort caused by nausea and sickness, who they consulted and the kind of support that was available to them.

#### Management of morning sickness and nausea

Although nausea and sickness are quite common in pregnancy the way women cope with them depends on whether they had any previous experience of it and how severe they perceive their symptoms to be.

Women expecting their first baby have no previous

experience of what it is like to be affected by morning sickness. This was pointed out by a number of Gujarati mothers expecting their first baby:

"Awful! In the beginning it was terrible because of my sickness. I simply hated it...In the beginning I was too ill to appreciate the fact that I was pregnant and there was something good about being pregnant. I hadn't expected it to be like this, although I had heard that you do feel something, but not to the extent I was ill. It was simply awful, I stayed off work for nearly four months-it was that bad. It was just the sickness and any smell affected me. I could get to work but staying there all day feeling sick was awful."

( Gujarati Mother First Pregnancy)

"It has been very difficult being sick throughout the day. I found being sick a very unpleasant experience. I hadn't expected it - I found difficult to cope with it all day. I couldn't imagine what it would be like. You have to experience being sick to appreciate it....No-one can tell you what it will feel like, all they can tell you is basic-until you go through it yourself."

(Gujarati Mother First Pregnancy)

Unfortunately, the interviews with Bangladeshi women expecting their first baby did not generate information which could have thrown some light on how they had felt about being sick in pregnancy. It has been suggested by a Bangladeshi community social worker that some pregnant women do not like talking about sickness as many feel that it is not worth talking about because it is part of pregnancy and it is to be expected. In Bangladesh, a woman who is suffering from sickness would try and keep quiet about it especially from men in order to hide her pregnancy as long as possible. This was borne out by a remark made by a Bangladeshi mother expecting her first baby:

"Sometimes I feel sick...But I suppose its quite normal. I have to just put up with it. I am not worried about it." ( Bangladeshi Mother First Pregnancy)

Another Bangladeshi woman with previous experience of sickness in pregnancy commented in the same vein:

"I have been suffering from sickness which I think is common for a pregnant woman so I am just managing it."  
( Bangladeshi Mother Seventh Pregnancy)

Gujarati women with previous experience of sickness in pregnancy reported that they were more prepared in their

subsequent pregnancies and coped a lot better with sickness and nausea.

"During my first pregnancy I was feeling sick throughout my pregnancy. Fortunately we were living with my mother-in-law who helped a lot. I have had more nausea with this pregnancy but I have coped much better this time."  
(Gujarati Mother Second Pregnancy)

"Compared with my first pregnancy, I have coped with sickness without too much bother. I was no longer anxious because I had experienced it before. I knew what to expect-felt more confident." (Gujarati Mother Second Pregnancy)

The data in Table 5E shows the number of sources the women suffering from sickness or nausea had used to get support.

Table 5E: Advice About Morning Sickness/Nausea  
(Multiple Response)

	No Consultation	G.P.	Husband	Female Relative	Total No Women *
B	5	5	5	1	12
G	4	10	4	6	16

\* Total number excludes women who did not suffer from sickness or nausea.

From Table 5E it is apparent that the women who had suffered from sickness or nausea had used a number of different sources to obtain support. The Gujarati women took advantage of both the traditional source of support from their female relatives and the western medical system to cope with the discomfort caused by nausea and sickness. However on an individual level Gujarati women appear to be very keen to consult their doctors to get a medical opinion. This shift may be due to Gujarati women placing greater faith in the western medical system and having relatively easy access to medical services.

On the other hand, few Bangladeshi women had consulted their doctors because some women believed that sickness and nausea were normal symptoms of pregnancy and did not merit medical consultation. Others who would have liked to have consulted their doctors were prevented from doing so because they faced difficulties in gaining access to medical services. Many Bangladeshi women who have recently settled in Britain have left their traditional source of support behind in Bangladesh and hence very few women mentioned support provided by their female relatives. This lack of traditional support has made it necessary for the women to rely increasingly on their husbands for practical support and for getting help from any other

sources:

"I have no one to give me advice. I have to depend on my husband for everything. This pregnancy I have been feeling very sick all the time. When I could not cope with the sickness I told my husband about it. He managed to get some medicine from our doctor."

(Bangladeshi Mother Sixth Pregnancy)

Many Gujarati women were in the fortunate position of being able to make use of family support as well as the medical services. So they were able to get both to get emotional and physical support which was denied to many Bangladeshi women. For some Bangladeshi women lack of physical and emotional support caused additional distress as this remark by a young newly married woman shows:

"First few months of my pregnancy I can't eat anything. I was always feeling sick. Always felt nervous. Sometimes I became crazy to go to my mother's home in Bangladesh. My mother would know how to help me."

(Bangladeshi Mother First Pregnancy)

The women suffering from either nausea or sickness tried different remedies and others just put up with the discomfort. The data in Table 5F gives examples of the range of remedies the women had used for managing their nausea and sickness.

Table 5F: Types of Remedies Used  
(Multiple Responses)

	Nothing	Allopathic Medicine	Traditional Cures	Dry Toast/ Tea in bed	Total No Women*
B	6	1	4	1	12
G	3	4	7	2	16
	9	5	11	3	28

\* Total number excludes women who did not suffer from nausea/sickness.

Until very recently it was a common practice to prescribe anti-sickness tablets in pregnancy. Since it has come to light that some of these drugs can cause harm to the baby, their use in controlling sickness is generally avoided by both mothers and doctors. Almost all the Gujarati women had consulted their doctors about their sickness and nausea. A very small number of women were prescribed anti-sickness tablets. Of those women who were prescribed tablets many made selective use of them by either not taking them regularly or reducing the prescribed dosage. One such

mother commented:

"I had very bad sickness until I was over five months pregnant. I was admitted to hospital as my sickness lasted twenty-four hours a day. I was put on sickness tablets. I was suppose to take three tablets but I used to take only one. The doctors at the hospital were concerned that I was not able to keep any food down. When I was discharged from the hospital I used to stay in bed all day and avoided strong smells to control the sickness."

(Gujarati mother first pregnancy)

Another Gujarati woman who was distrustful of drugs indicated that she preferred to manage without drugs:

"I went through sickness stage when I used to be quite sick especially in the evening...For sickness you can't do anything- just go and be sick. I didn't want to take anything- I was told that there were things available that I could take. I just knew it was just one of those things- it would pass in time."

(Gujarati Mother First Pregnancy)

On the whole women who were aware of the harmful effect of anti-sickness drugs preferred to tolerate their discomfort than take medicine which could be harmful to their babies.

On the other hand, some Bangladeshi women who had recently arrived in Britain placed greater faith in allopathic treatment. One such mother who would have liked her doctor to prescribe some medicine for morning sickness could not understand why she could not persuade her doctor to prescribe her some medicine until she was over five months pregnant:

"First five to six months doctor wouldn't give me any medicine. He said it was not necessary to take medicine for the sickness. After my husband insisted I was given a phial of anti-sickness tablets which I completed."

(Bangladeshi Mother Seventh Pregnancy)

A number of women resorted to traditional remedies to cope with their sickness. The traditional remedies are based on the concept of 'hot' and 'cold' foods. The 'hot' and 'cold' foods are classified according to the effect they produced in the body (Storer 1977; Abdulla & Zeidenstein 1982:53). Since pregnancy is considered as a 'hot' state symptoms of pregnancy such as sickness or heartburn are treated with cooling foods like some fruits and milk products. Although most of these cures were based on foods and herbs, the type of remedies recommended by the older experienced women varied from family to family. (Table 5F)

A common belief amongst Bangladeshi women was the use of tart fruits such as unripe mango and tamarind to reduce the feeling of nausea and sickness. A number of Bangladeshi women reported that they had eaten sour fruits such as oranges and apples and sometimes sour pickles to get relief from nausea and sickness.

Gujarati women were advised to take a mixture of acidic food and spices to control their sickness.

"I was told by my mum to have drops of lemon in water to settle the stomach. My mother-in-law suggested that I should eat a grilled mixture of salt, lemon and cumin which I found very helpful. I was also prescribed some pills by my doctor but I tried not to take them."

(Gujarati Mother First Pregnancy)

However not all Gujarati women had faith in traditional cures. Some women followed the advice of their female relative so as not to offend them, as the following remark shows:

"I had sickness for nearly four months when I couldn't keep anything down. I was really suffering. My mother-in-law used to make me a drink from white chalk-like paste to stop the sickness. I had it a couple of times but I don't think it worked for me. I didn't believe it would work but I tried it so as not to upset my mother-in-law."

(Gujarati Mother Second Pregnancy)

#### Management of other minor ailments

The ease with which women seek advice and support for other ailments in pregnancy depends on the nature of the ailments and how free they feel about disclosing their complaints to their relatives and the medical professionals. All the women in my sample were asked if they had spoken to anyone concerning their ailments. The number of people the women who had consulted are recorded in the Table 5G (i) and 5G(ii).



Table 5G (i): Advice/Support For Other Minor Ailments  
(Multiple Responses)

	Heartburn		Constipation		Poor Sleep		Aches/Pains	
	B	G	B	G	B	G	B	G
Total No Women*	9	10	2	7	0	3	4	6
No one	2	-	-	-	1	-	-	-
Doctor	4	10	0	5	3	0	1	3
Husband	7	5	2	2	2	-	2	0
Relative	2	1	1	1	0	-	1	3
Others	0	1	0	1	0	-	0	0

\* Total number of women who suffered from the ailment.

Table 5G(ii) Advice/Support For Other Minor Ailments  
(Multiple Responses )

	Tiredness		Swings in Mood		Burning Hands/Feet	
	B	G	B	G	B	G
Total No Women*	8	14	4	6	4	0
No one	0	0	2	0	0	-
Doctor	2	0	0	2	3	-
Husband	5	10	2	5	1	-
Relative	4	8	1	0	0	-
Others	-	-	-	-	-	-

\* Total number of women who suffered from the ailment.

The trend set by Gujarati women in seeking support from their family members and doctors for sickness and nausea seems to continue for other ailments as well, whereas Bangladeshi women continued to rely mostly on their husbands. In Bangladesh older experienced women are available to give advice about common ailments in pregnancy and it is very rare for a pregnant woman to see a doctor.

In Britain in contrast, a number of Bangladeshi women reported that they always discussed everything with their husbands before consulting anyone else.

"When anything happens during my pregnancy I first discuss with my husband then go to my doctor."  
(Bangladeshi mother sixth pregnancy)

Another mother gave similar response:

"If there are any problems, I speak to my husband first who speaks to the doctor."

(Bangladeshi mother first pregnancy)

In Britain, in the absence of female relatives, Bangladeshi husbands are called upon to take on the responsibilities of supporting their wives. Although most husbands take their responsibilities seriously some find it difficult to come to terms with their new role which requires them to deal with female concerns. It has been suggested by Bangladeshi community workers that many Bangladeshi women keep quiet about their ailments because they do not like to trouble anyone. A typical remark made by a Bangladeshi social worker illustrates this point:

"Some fortunate Bengali women in this country can rely on their husbands for support but some unfortunate ones do not have any support even from their husbands and have to rely on community workers or social workers for help... There are two categories of husbands - there are those who are very caring towards their wives throughout their pregnancy and there are also husbands who want their wives to get on with their pregnancy without making a fuss, this causes a lot of extra stress in women... Some husbands' attitude is that their own mothers managed quite well during their numerous pregnancies in Bangladesh and this attitude leaves some women completely unsupported in this country." (Bangladeshi Community Social Worker)

Some ailments like tiredness, depression, sleeplessness and aches and pains required sympathetic treatment and physical support which some women were able to get from their family members. Besides sickness and nausea, almost 1/2 the women found discomfort caused by heartburn was just as distressing for which women used either allopathic or traditional cures. Some women tried a combination of both traditional cures and antacid prescribed by their doctors. The traditional cures for heartburn recommended bland drinks made from milk and reduction in consumption of spicy foods to reduce acidity in the stomach. Similarly, for constipation, women used a combination of high fibre diets and prescribed laxatives. Table 5H sets out the number of different remedies some women had used for heartburn and constipation.

Table 5H: Remedies Used for Heartburn and Constipation  
(Multiple Responses)

	Allopathic Treatment	Traditional Remedies	Total No Women*
<b>Heartburn</b> -----			
B	1	2	9
G	4	7	10
<b>Constipation</b> -----			
B	0	1	2
G	2	5	7

\* Total number excludes women who did not suffered from these ailments.

From Table 5H, it appears that many more Gujarati women made use of allopathic and traditional remedies than Bangladeshi women. Since many Gujarati women were concerned about taking drugs in pregnancy, medicine prescribed by their doctors for constipation or heartburn was used sparingly and whenever possible, they changed their diet to reduce the discomfort. One such mother commented:

"Half way through my pregnancy I started to suffer from bad constipation. My doctor prescribed some laxatives. I was not keen to take any medicine so I increased more whole foods in my diet."

(Gujarati Mother First Pregnancy)

Another Gujarati woman had also changed her diet to relieve discomfort from heartburn remarked:

"My mother-in-law advised me to drink cold milk and to cut down on sour fruits. I also cut down fatty foods from my diet. Although my heartburn did not completely disappear, it made a lot of difference."

(Gujarati Mother Second Pregnancy)

### Summary

Although the range of minor ailments in pregnancy experienced by the women were not peculiar to them [cf

Homans (1980), Oakley(1979)], the way women coped with minor ailments in pregnancy depended on their perceptions of discomforts in pregnancy, how much emotional and physical support they were able to obtain from their families and the health carers.

The Bangladeshi women who had philosophical attitudes towards minor ailments in pregnancy coped with their discomforts as best as they could. However women expecting their first baby in Britain seemed to be doubly disadvantaged because they were isolated and also experienced difficulties negotiating care from the medical services. Because many Bangladeshi families have been fragmented after migration to Britain, the traditional support and advice provided by older female relatives is not available to many women. In the absence of such traditional support some women have no choice but to rely heavily on their husbands. Whilst most Bangladeshi husbands take their responsibility seriously, it is difficult for many husbands to adjust to their new role which requires them not only to give practical support at home but also to negotiate with the health carers.

In contrast, a majority of the Gujarati women seemed more inclined to seek medical opinion for some minor ailments. In this respect they faced fewer difficulties negotiating care from the health carers because it was relatively easy to gain access to medical services. Unlike the Bangladeshi women, a majority of the Gujarati women are living with older female relatives who are able to give them support and advice about the management of their minor ailments. Consequently, many Gujarati women are not averse to using both traditional and allopathic remedies to alleviate their discomfort.

### Anxiety in Pregnancy

So far I have concentrated mostly on how Gujarati and Bangladeshi women managed the physical aspects of their pregnancy. Now I am going to focus on the emotional aspects of their pregnancy. In order to draw attention to the emotional aspects of pregnancy, I have made a distinction between them. However, it must be emphasised that they are interrelated and equally influence a woman's attitude towards the management of her pregnancy. Unfortunately 'modern' medicine tends to place greater emphasis on the physical symptoms presented by a woman rather than on her emotional state. Whilst swings in mood are attributed to hormonal changes, emotional problems which result from unfavourable personal circumstances are often overlooked (Graham & Oakley 1981, Brown & Harris 1978)). Often, what may seem a minor problem for some women, may cause a great deal of anxiety for others. Sometimes anxiety is expressed in a form which may not be recognised as such.

Asian women share many anxieties in common with other women in Britain. In addition, they may have specific anxieties about fulfilling cultural expectations of their reproductive role (see earlier discussion in Chapter 4 page 71). In this section I am going to look at the reasons given by Gujarati and Bangladeshi women as to the source of their emotional problems. I have already discussed the emotional distress caused by an unwanted pregnancy, particularly amongst Gujarati women (see Chapter 4 page 81). Although Bangladeshi women tended not to question the lack of control over their fertility and accepted pregnancy as ordained by their fate, they had other problems which caused them just as much distress.

The interviews of Bangladeshi and Gujarati women revealed that the women did not make a distinction between their physical and emotional problems. For some women the anxiety about a specific physical or emotional problem overshadowed the entire pregnancy and their anxiety appeared as a recurrent theme throughout the interview. Whilst some women had no difficulties expressing their anxieties and were aware of what caused them distress, other women did not feel at ease to discuss their anxieties. In Table 5I I have set out some of the main reasons given about what caused anxiety amongst some of the women in my sample.

Table 5I: Causes of Anxiety (Multiple Responses)

	Labour	Baby's Sex	Baby's Health	Housing /Money	Personal Health	Family	Total No Women
B	5	3	5	3	4	4	14
G	14	4	11	2	2	2	17
	19	7	16	5	6	6	31

It is apparent from Table 5I that none of the women had been spared from feeling anxious during their pregnancy. Most women had expressed one or more reasons for feeling anxious. Since the first interview took place in the last trimester of pregnancy, anxiety about the forthcoming labour was uppermost in the minds of the women. This was especially so amongst almost all the Gujarati women regardless of their parity. I only wish to draw attention to this fact at this stage as the question of anxiety concerning forthcoming labour will be discussed more fully in the next chapter.

It is also apparent that after labour, foetal abnormality or the health of the unborn baby was the second most anxiety causing factor. Although it is common for most pregnant women to experience some anxiety concerning the wellbeing of their unborn baby, the Bangladeshi women in my sample had added reasons for feeling anxious as a third of them had lost a baby in the past. One such mother commented:

"I am quite worried about my baby and I am thinking if it will happen again. Before this pregnancy my baby was stillborn. It happened when I was eight months pregnant. My doctor told me it was because I had continued taking the pills after I was pregnant. I was very sad because it was a boy. I am very worried if something should go wrong with this baby." (Bangladeshi Mother Sixth Pregnancy)

The anxiety of Gujarati women, regarding the health of their baby, could not be linked directly to any previous unfortunate experience. However, it appears that with the exception of two Gujarati women, their anxiety was in some way related to their ambivalent attitude towards their pregnancy. The women who were unhappy about their unwanted pregnancy felt that their own negative attitude was having a harmful effect on their unborn baby. One such woman remarked:

"I am very anxious for the baby. I feel my baby moves uneasily. I am anxious because I want my baby to be normal. I feel I am making the baby uncomfortable. I wanted to terminate this pregnancy but my doctor persuaded me against

termination. I feel the baby must be suffering psychologically because I have such negative attitude towards this pregnancy." (Gujarati Mother Fourth Pregnancy)

Another Gujarati women who had unsuccessfully attempted to abort her baby by taking traditional medicines and by consuming a large quantity of spirit, was very worried about having a deformed baby as her remark suggests;

"This time I have taken so many tablets as well as home made remedies in my early pregnancy. I am really worried they may have done some harm to the baby. The doctor can't tell me anything. I can't even talk to anyone. I will just have to wait and see."  
(Gujarati Mother Third Pregnancy)

Following the anxiety about foetal abnormality the third most anxiety causing factor mentioned by the Gujarati and Bangladeshi women concerned the sex of the baby. In most cases the women's anxiety about the sex of the baby was related to their communities' desire for them to produce a male child (see Chapter 4 page 79). Although it would be understandable for a woman who only has daughter(s) to feel under pressure to produce a male child, it became apparent during the follow up interviews in the postnatal period that the sex of the baby had caused just as much anxiety to women expecting their first child. It is very common for women who fail to produce a male child to blame themselves and consequently some women observe religious fasts and offer prayers to their family deity in an attempt to conceive a male child. A Gujarati mother who was desperate for a boy and had followed a special diet to increase the chances of conceiving a boy, remarked:

"We are not planning to have any more children if I have a boy this time. I had followed a special diet which is supposed to increase the chances of conceiving a male baby. As soon as I came off the pill I started this special diet which recommends you to eat acidic fruits and to cut down on all dairy produce. I was on this diet a few weeks after my pregnancy was confirmed. We might have a third baby if this baby is a girl. I would like to have a boy this time as most of our Indians like boys, especially the dads who want a son. Everyone hopes that I might have a boy." (Gujarati Mother Second Pregnancy)

This remark and similar remarks made by other Gujarati women in the study, suggests that the pressure to bear a son increases if the first child is a girl. The burden of failure and guilt is so great that some women are prepared to arrange private amniocentesis, followed by an abortion if they are carrying a female. This happens because of the unfair pressure experienced by some women as the following

comment illustrates:

"I feel that there is indirect pressure on me to have a son. My mother-in-law and her friends keep telling me that I must be carrying a boy, almost wishing it on me to have a boy. My husband's sister who is expecting her third baby recently had an amniocentesis and if the test showed that she was going to have a third daughter then she would have had an abortion. Fortunately for her, it is going to be a boy" (Gujarati Mother First Pregnancy)

Although amongst Bangladeshi Muslims, religious teaching does not encourage similar beliefs, male children are desired for economic reasons. Male children are seen as an insurance against old age and as an aid to economic survival. The birth of a male child is greeted with delight, the birth of a female child is considered a liability because after her marriage she will belong to her husband's family and would be of no use to her parents. In addition according to Islamic laws a man can have three wives and can divorce a wife who fails to bear him a son. The fear of husbands' remarriage induced many Bangladeshi women to undergo repeated pregnancies in order to produce a male child. A mother expecting her fifth baby who had three daughters and had one unsuccessful pregnancy was resigned to try again for a boy if her present pregnancy did not result in a birth of a son. Her anxiety was evident in the remark she made:

"I have three daughters so this time I hope it will be a boy. I am praying 'Allah' will help me this time... My family in Bangladesh are all praying for me to have a boy. My husband is very anxious that we should have a son. I am very much worried and think about the sex of the baby all the time." ( Bangladeshi Mother Fifth Pregnancy)

Many of the younger generation of Gujarati and Bangladeshi couples in Britain do not share such views. However cultural beliefs and traditions perpetuated by older members of their respective communities cause a lot of mental anguish for some women. As a result they subject themselves to repeated pregnancies in order to bear a male child. Women who do not succeed, carry the blame and guilt for failing. In some cases, their husbands are pressurised by relatives to get divorced and remarry. I shall return to this subject again in the discussion on the follow up interviews of women in the postnatal period and in the case studies which I conducted with Gujarati and Bangladeshi women( see Chapter 9 and 10).

Besides the fear of childbirth, foetal abnormality and the sex of the baby, increased family responsibility with the arrival of another baby, housing and financial difficulties



were cited as examples of other factors which caused a great deal of anxiety and depression amongst some Bangladeshi and Gujarati women. A Gujarati mother who was expecting another baby very soon after the birth of her first baby commented:

"I don't know how I will manage when the second baby comes. I feel so depressed. My husband does not share my concern. He believes that a young person like me should be able to cope with two young children. I feel emotionally and physically drained. Just the thought of having yet another baby to look after makes me depressed and anxious." (Gujarati Mother Second Pregnancy)

A few Bangladeshi women who were waiting to be rehoused, found that living in temporary accommodation caused them a great deal of anxiety.

"I feel very depressed sometimes...I am worried because my baby is due soon and we are still waiting for a flat. The children and I stay in the rooms all the time because I am afraid to go out anywhere on my own. My husband works in a restaurant and he often comes home late. I can't fall asleep until my husband comes in because I am worried about him." (Bangladeshi Mother Fifth Pregnancy)

### Summary

The Bangladeshi and Gujarati women's anxiety about child-birth and fear of producing a malformed baby was something they shared in common with other British women. The cause of these anxieties may be duly acknowledged and receive sympathetic treatment. However, the plight of women who are anxious about the sex of the baby or going through pregnancy under difficult personal circumstances may not be fully appreciated by health workers who are from different cultural and social backgrounds.

### Antenatal Care in Pregnancy

In the previous section I focused on women's perception and management of their health in pregnancy. In countries like India and Bangladesh where antenatal care is not organised at the national level, management of pregnancy is traditionally left in the hands of other women. Most pregnant women go through their pregnancy without consulting any medically qualified persons (Jeffery et al 1989, Gideon 1962; Blanchet 1984).

In Britain, antenatal care is provided for all mothers under the NHS. The antenatal care involves regular medical examination at the antenatal clinic run by general practitioners or at the hospital antenatal clinic.

For Asian women who have migrated from India, E. Africa and Bangladesh where antenatal care is only available to those who can afford it, antenatal care offered under the NHS may seem very attractive. However it has been reported that Asian mothers fail to make full use of these antenatal services (Clarke & Clayton 1983; Lumb et al 1981). Clarke and Clayton (1983) study suggested that poor uptake of antenatal care was not necessarily linked to a woman's attitudes towards antenatal care but depended on whether her general practitioner was on the obstetric list. As a result it has been suggested that some practitioners might not wish to enrol patients into formal antenatal care until the pregnancy is well established. Watson (1984) also reported similar trend in the late uptake of antenatal by the Bangladeshi women in East London and suggested the reason for the poor uptake of the antenatal services was more complex than it seemed at first.

For many Gujarati and Bangladeshi women having a baby in Britain makes it necessary for them to come in contact with health workers from the host community to receive antenatal care. How acceptable this service is to them would be determined by how comfortable they feel about receiving care, particularly from male medical professionals. In addition, women's attitude towards their pregnancy, language difficulties and location of antenatal clinics can be important considerations for women who are new to this country.

For some Gujarati and Bangladeshi women it is very important to feel comfortable with the person who gives them antenatal care in pregnancy. Asian women who also have communication difficulties, find it difficult to share their health problems with someone who does not share the same cultural beliefs. For some women the sex and race of the doctor can be very important factors in determining whether they come forward for antenatal care. The figures presented in Table 5J show where the women in the study were receiving antenatal care.

Table 5J : Antenatal Care

	Shared Antenatal Care				Hospital Clinic Only	Total No Women
	Asian G.P.		Caucasian G.P.			
	Male	Female	Male	Female		
B	4	2	1	-	7*	14
G	2	9	4	2	-	17

( \* all these women were registered with male G.P.s )

Looking at the figures in Table 5J, it appears that half of the Bangladeshi women were going to the hospital antenatal clinic and the rest were receiving antenatal care from their general practitioners. The Bangladeshi women who were attending the hospital antenatal clinic only were all registered with male Bangladeshi general practitioners. Some of these women had not reported their pregnancies to their family doctors until they were over three months pregnant. The late confirmation of pregnancy by Bangladeshi women was covered in the beginning of this chapter. It appears that women who did not wish to consult a male Bangladeshi doctor preferred to go straight to the hospital antenatal clinic where they requested to be examined by a female doctor whenever possible.

Although some of these women had no guarantee that they would be seen by a female doctor, they were not put off going to hospital. As one mother commented:

"I do not like to go to my own doctor because I feel embarrassed. I have to go to the hospital clinic because my baby is going to be born there... I am afraid to miss appointments because they(hospital staff) ask too many questions if I don't go. Sometimes I am lucky to see a lady doctor." (Bangladeshi Mother Fifth Pregnancy)

For these women communication difficulties encountered with hospital staff were preferable to breaking 'purdah' restriction with a male Bangladeshi doctor. The presence of a female Bengali interpreter at the hospital was another factor in some women's preference for attending the hospital antenatal clinic.

In contrast all the women in my Gujarati sample were receiving shared care between their family doctor and the hospital. Gujarati women in Harrow were in the fortunate position to be able to register with female doctors; two thirds of Gujarati women were registered with female doctors and half of these women were registered with Indian female doctors. Gujarati women who were attending the general practitioners' antenatal clinics were receiving joint care from the community midwives and their family doctors.

On the whole the attendance at the antenatal clinic by the women in my sample was good (see Table 5K). Just under a third of women from each group had failed to keep their appointments for a variety of reasons.

Table 5K: Attendance at the Antenatal Clinic

	Number of Missed Appointments					Total No Women
	0	1	2	3	4 or more	
<u>Primipara</u>						
B	3	1	1	-	-	5
G	5	1	-	-	-	6
<u>Multipara</u>						
B	5	1	1	-	-	7
G	5	-	-	2	2	9
-----						
	18	3	2	2	2	27

Amongst Gujarati women failure to keep appointments seemed to be tied up with feelings of ambiguity towards an unplanned pregnancy. For some women there were additional pressure for them to help out with the family business. As these remarks suggests:

"Quite a lot - tend to forget my appointments. I keep meaning to go the next day and the next day so I have missed a lot of appointments. I don't know- I suppose I am being lazy this time round because I didn't miss any appointments with my last two pregnancies."  
(Gujarati Mother Unplanned Third Pregnancy)

"I missed some appointments at the surgery because the Wednesday clinic appointments are inconvenient for me to attend. I can't manage to go because I have to help out at our family shop. I missed quite a lot in the beginning. Now I try and see my doctor during surgery time although my doctor would prefer for me to attend the Wednesday antenatal clinic." (Gujarati Mother Second Pregnancy)

The reasons given by Bangladeshi women for missing appointments were mainly not having anyone to mind their other children and having to rely on their husbands to escort them to the clinic. Some of these women lacked the confidence to go out on their own because they had been in Britain for less than a year. It was often not easy for some husbands to arrange time off work to accompany their wives to the clinic. Typical comments for missing appointments were:

" Yes, I missed some appointments. I don't have anyone to look after my children. My husband has to take time off work to look after my children. It is not always easy for him to take time off from work."  
(Bangladeshi Mother Third Pregnancy)

"Yes, I have missed appointments once or twice. Because it was at 3.30.p.m. We could not get to the clinic in time. When we arrived there was no doctor available so they arranged another date which I couldn't keep."  
(Bangladeshi mother seventh pregnancy)

Despite the fact that many Bangladeshi women experienced a number of difficulties attending antenatal clinic, their attitude towards antenatal care was very positive.

### Summary

For Gujarati women, who have been in this country for a number of years, receiving antenatal care did not pose any problem on cultural grounds although at an individual level women's personal circumstances determined the level of up take of antenatal care. This was particularly evident amongst women who were unable to exercise control over their fertility.

Bangladeshi women appear to be just as keen to receive antenatal care although their cultural attitude towards male doctors prevented them from making full use of antenatal care. On a personal level, communication difficulties, relatively recent settlement in Britain and their dependence on male relatives were important factors in determining level of utilisation of the antenatal care.

### Diet in Pregnancy

In the previous section, I focused on health in pregnancy including the use of certain foods which formed the basis of traditional remedies for alleviating some common ailments in pregnancy. An adequate diet is essential for maintaining good health but it assumes even greater significance when a person goes through a vulnerable phase - such as during illness or pregnancy (Homans 1983). Many cultures around the world have evolved dietary ideologies based on the concept of balancing 'hot' and 'cold' foods and on the restriction of certain food intake to restore the equilibrium of the body. In the Indian subcontinent the 'hot' and 'cold' theory stems from the ancient medical system of Ayurveda in India and the Unani system based on the Greek Humoral theory which was introduced when India came under Muslim rule (Storer 1977).

During pregnancy, the traditional dietary beliefs of Gujarati and Bangladeshi women have their origin in the Ayurveda and Unani systems. In addition there are dietary restrictions and taboos which have lost their original purposes and become incorporated into religious and individual family traditions. The practical knowledge about the inherent properties of certain foods classified

as 'hot' or 'cold' and other dietary restrictions in pregnancy are passed down the generations through women. In Ayurvedic tradition, pregnancy is considered to be a 'hot' state; therefore too 'hot' or too 'cold' items of food are not recommended.

Although Gujarati and Bangladeshi women share common beliefs about 'hot' and 'cold' foods their dietary habits are governed by different religious practices. The majority of Gujarati women belonged to the Hindu faith. Hindus believe in the sacredness of all life and therefore the killing of animals is prohibited. Most orthodox Hindu families are lacto-vegetarians i.e. they avoid eggs, fish, cheese and meat in their diet. A staple vegetarian diet consists of pulses, cereals and milk products and fresh vegetables. However not all Hindu women observe a strict lacto-vegetarian diet as many include cheese and eggs and occasionally poultry and mutton.

Bangladeshi women belonged to the Muslim faith which forbids the eating of the pig meat and its products. With the exception of pork Bangladeshi families eat the flesh of any other animal provided the animals are ritually slaughtered to make them 'halal'. The staple diet of Bangladeshi families consists of 'halal' meat, fish, rice and vegetables (Henley, A 1982).

In this section, I am going to focus on the dietary habits of Gujarati and Bangladeshi women during their pregnancy. Since dietary beliefs in pregnancy are strongly rooted in cultural and religious traditions, we need to address the implications of migration on these dietary beliefs. We also need to look at the role of other members of the family in safeguarding dietary habits in accordance with cultural and religious traditions. In addition, pregnant women have to take on board the dietary advice received from the health workers based on western nutritional concepts. Amongst the Gujarati and Bangladeshi communities in Britain, religious consideration outweighs external pressure to change their dietary beliefs. The need to maintain a strict dietary regime is strongest amongst the older generation who have been displaced from their country of origin. Traditional food allows them to retain their cultural identity and offers psychological comfort. Gujarati women are expected to retain strict vegetarian traditions in the home although Gujarati men are not under similar pressure to remain vegetarian. This often causes conflict for young Gujarati women whose ties with religious or cultural beliefs have become weakened because they have become westernised in their attitude towards a non-vegetarian diet. As these comments illustrate a number of Gujarati women expressed resentment because their in-laws had laid down strict rules about their following a non-

vegetarian diet:

"My father-in-law has very orthodox views on diet. My father-in-law believes that Indian women should not eat eggs, he therefore wouldn't approve of his daughters-in-law who ate eggs." (Gujarati Mother First Pregnancy)

"My in-laws have enforced vegetarian diet on me. I wasn't a vegetarian before I got married. My husband's family is strict vegetarian and the only thing that is allowed are eggs." (Gujarati Mother Fourth Pregnancy)

Many Gujarati women of the younger generation in Britain are not strictly vegetarian. Bangladeshi women in Britain do not face a similar conflict because eggs, fish or meat with the exception of pork are permitted in the diet. The normal dietary habits of the Gujarati and Bangladeshi women in my samples before and after they became pregnant are represented in Table 5L.

Table 5L: Dietary Habits Before and After Pregnancy

	Gujarati		Bangladeshi	
	<u>Before</u>	<u>After</u>	<u>Before</u>	<u>After</u>
Lacto-vegetarian (No eggs or cheese)	1	1	-	
Vegetarian + cheese	6	3	-	
Vegetarian + cheese + eggs	5	8	-	
Non-Vegetarian but no beef	5	5	-	
Non-vegetarian but no pork	-	-	14	14
Total No Women	17	17	14	14

The fact that the present generation of Gujarati women of childbearing age have slowly changed their diet after coming to Britain is reflected in their relaxed attitude towards western dietary habits which previously would have been unacceptable on religious and cultural grounds. Before pregnancy, with the exception of one Gujarati woman who was strictly lactovegetarian, just about a third of the women included cheese in their diet and less than a third included eggs and cheese and the rest were nonvegetarians.

After pregnancy, there was no significant change in the dietary habits of the Bangladeshi women, with the exception

of minor changes brought about as a result of altered taste. In contrast, there was a noticeable change in the dietary habits of some Gujarati women. Some Gujarati women reported that their diet had changed in a number of ways after becoming pregnant. Some of the changes in their diet were due to changes in taste, others were a direct result of dietary restrictions enforced by family members in keeping with the cultural tradition. In addition some women also modified their diet according to advice they received from health professionals.

When the women in the study were asked if they had changed their dietary habits in any way during pregnancy, a third of the women (8 Gujarati and 3 Bangladeshi) claimed that their appetite had changed (see Table 5M). These Gujarati women including some who claimed not to have increased their food intake were including more milk, eggs, cheese and fruit to comply with dietary advice they had received from the medical professionals. It is noticeable that whilst a few Bangladeshi women who had increased their intake of food, unlike the Gujarati women, none of the Bangladeshi women mentioned including additional foods recommended by health professionals.

Table 5M: Changes in Diet After Pregnancy  
(Multiple Responses)

	Increase Appetite	No Change in Appetite	More Dairy produce/Eggs/Fruits	Total No Women
B	3	11	-	14
G	8	9	10	17

It is interesting to note that quite a few Gujarati women were prepared to increase their intake of dairy produce, eggs and fruits although, according to traditional belief, intake of dairy produce and citrus fruits is inadvisable because they are believed to cause swelling in the joints:

"My mother-in-law told me to avoid sour foods like yoghurt and sharp fruits. She thinks it is inadvisable because it causes swollen joints in pregnancy. I am sure there is some truth in what they say."

(Gujarati Mother First Pregnancy)

Eggs are also considered 'hot' according to Ayurvedic tradition besides being an unacceptable source of food for orthodox Hindus as stated before. It appears that some Gujarati women were prepared to defy cultural tradition because they felt that by adopting the dietary advice given by medical professionals they were giving a healthier start



to their babies.

"I take more care about what I eat. Doctor told me to take more milk, fruits and vegetables in my diet. I try to drink more milk than I do when I am not pregnant...I would not take any notice of what my mother-in-law says. I listen to my doctor. It is my body and I should eat what I like."  
(Gujarati Mother Second Pregnancy)

Another Gujarati mother, who was very anxious to follow the diet recommended by her doctor, found that she could only do so at the expense of her in-laws displeasure:

"My doctor told me to increase my intake of milk and eggs because I haven't gained enough weight in my pregnancy. I try and have a pint of milk in my diet. Because my father-in-law has such orthodox views about eggs I can't eat eggs openly so I have one egg a day which I eat secretly in the kitchen. I feel I am eating for my baby and not for me. My mother-in-law and my sister-in-law are not very sympathetic because they did not have any problem gaining weight in their pregnancies."  
(Gujarati Mother First Pregnancy)

For non-vegetarian Bangladeshi women adopting the dietary advice given by medical professionals may not appear to be an issue and yet none of the Bangladeshi women interviewed mentioned milk, eggs or fruits in their diets. It has been suggested by the Bangladeshi interpreters in Camden that dietary advice which encourages intake of dairy produce is unacceptable to Bangladeshi pregnant mothers because they dislike the smell and taste of British milk which is not as creamy and rich like they are used to drinking in Bangladesh.

The fact that Bangladeshi women are non-vegetarian, does not mean that they do not have any dietary problems. Since the majority of Bangladeshi women have recently settled in Britain, many women crave for the foods which are indigenous to Bangladesh. Although such food items are available in Britain, they are costly and seasonal which takes them out of the reach of many Bangladeshi families on low income.

Many Bangladeshi women demonstrated a strong association with their cultural tradition in pregnancy by craving for the same kinds of foods which pregnant women in Bangladesh are known to crave in pregnancy. The different types of foods which some women craved in their pregnancies are set out in Table 5N.

Table 5N: Food Craving in Pregnancy  
(Multiple Response)

	Dried Fish Curry	Sour/Spicy Foods	Savoury Foods	Sweet Foods	Fruits	Total No Women
B	6	5	-	-	1	7
G	-	3	4	3	3	11

Of half the Bangladeshi women who had experienced craving for certain type of food during their pregnancy, a particular type of dried fish called 'shutki' was craved by almost all the women. Sour and spicy foods such as unripe mango and spicy pickles were also craved by almost all the women. The craving for foods which were native to Bangladesh suggests that their craving for these foods seemed to be an indication of their strong emotional association with their country of birth. Unfortunately the types of foods which many Bangladeshi women craved for are available easily and relatively cheaply in Bangladesh but not in Britain.

In contrast, the type of foods craved by the Gujarati women seem to suggest that their craving was a reflection of their attitudes to western foods. This was apparent from the fact that more than half the Gujarati women craved for pizza, potato chips and cakes.

Although many Bangladeshi women felt they were not always able to satisfy their craving they appear to observe fewer dietary restrictions compared to many Gujarati women. In Asian communities knowledge about dietary restrictions are passed down the generations by women and dietary restrictions are usually enforced by older female relatives such as mothers and mothers-in-law. The fact that in my Bangladeshi sample only a third of the women were living with older female relatives, could explain why so few Bangladeshi women mentioned dietary restrictions. In contrast, in my Gujarati sample over two thirds of the women were living with their mothers-in-law who made sure that their daughters-in-law were aware of the dietary restrictions. Examples of food which some women were not allowed to eat during their pregnancies are set out in Table 5P.

Table 5P Dietary Restrictions During Pregnancy  
(Multiple Responses)

	Sesame Seeds	Coconut	Ginger	Pineapple	Bananas	Garlic	Total No Women
B	-	-	-	3	-	-	14
G	7	6	3	-	4	1	17

Some of the dietary restrictions which many Gujarati women were required to observe were related to the food item considered either too 'hot' or too 'cold' according to Ayurvedic and Unani concepts. For examples, nuts, garlic and ginger were considered to be 'hot' and therefore just under half the Gujarati women were advised by their mothers-in-law to avoid eating nuts and about a quarter were advised to avoid eating ginger and garlic. Gujarati women who were advised to give up foods which were considered 'hot' for pregnancy remarked:

"In my early pregnancy I was admitted into hospital because I was feeling very sick. My mother-in-law would not allow me to eat anything on the menu which contained nuts. She told me that it was not good for the baby."  
(Gujarati Mother First Pregnancy)

However other restrictions relating to ritual were not always observed, for instance a few Gujarati women were advised to avoid sesame seeds in their diet to honour ancestral spirits or the family deity in the belief that their deity or ancestral spirits would in turn give protection during pregnancy. One mother remarked:

"My mother-in-law told me that I should not eat sesame seeds or coconut because it would give offence to our family 'devi' (deity). But I love eating 'pan' (stuffed beetlenut leaf) which contains both shredded beetlenut and coconut. She tells me off for being disrespectful to our 'devi' and believes that I will have problems in my pregnancy." (Gujarati Mother Fourth Pregnancy)

In some cases, dietary restrictions originated from someone in the family having an unfortunate experience and an item of food is avoided in the belief that that particular item of food was held responsible for that bad experience in pregnancy. In interviews where mothers-in-law were present, they explained why their daughters-in-law were asked to avoid certain food from their diet. As one mother-in-law explained:

"We do not eat any sesame seeds in any form during

pregnancy. If a woman eats sesame seeds in pregnancy, it (sesame seeds) encourages the growth of the afterbirth at the expense of the baby. The afterbirth leaves no room for the baby to grow." (Gujarati Mother-in-law)

A number of Gujarati women were not allowed to eat bananas because they considered bananas to be too 'cold' for pregnancy and others believed that the slippery nature of the bananas was responsible for inducing miscarriage or premature labour. A mother commented:

"I have been told by my mother and mother-in-law to avoid ladies fingers(okra) and bananas because they are both slippery and sticky. I have avoided ladies fingers but I have had craving for bananas- I get up in the middle of the night to have bananas."

(Gujarati Mother Second Pregnancy)

Sometimes dietary advice given by the female relatives and medical professionals can be a cause of conflict, as these remark shows:

"I love the smell of bananas- I can't stop eating bananas. Our people don't like me to eat bananas but when I asked my doctor she told me that it is okay to eat them. I don't think myself that bananas can harm you."

(Gujarati Mother Second Pregnancy)

"It is very confusing- at hospital they tell you to eat nuts and bananas. My mother-in-law tells me to avoid nuts and bananas. My mother-in-law used to advise so many other pregnant ladies and as she is my mother-in-law I have to listen to her. You just don't know how to react. I didn't know who to believe."

(Gujarati Mother First Pregnancy)

A number of Bangladeshi women were advised by their mothers-in-law to avoid pineapple during pregnancy because it is believed to cause miscarriage. The eating of raw pineapple is also associated with an abortion for unwanted pregnancy (Abdulla & Zeidenstein 1982). It was also believed that eating pineapples in pregnancy made the baby deformed as some of the remarks made by the women suggest:

"My mother-in-law said that pineapple is harmful for the baby. She said that a pineapple's skin is covered with 'eyes' and if I ate pineapple my baby's skin would be covered with spots." (Bangladeshi Mother Fifth Pregnancy)

The Gujarati women in my study were most affected by dietary restrictions in pregnancy. Although a majority of the Gujarati women were required to observe some restrictions, not all of these women were convinced that

any harm would come to them or their babies if they disregarded the advice of their mothers or mothers-in-law.

Many Gujarati women questioned the rationale behind such restrictions, particularly where the older female relatives were unable to provide adequate explanations for these restrictions. The attitude of Gujarati women towards dietary restrictions is recorded in Table 5Q.

Table 5Q: Attitude Towards Dietary Restrictions

	Positive	Mixed	Negative	Total No Women
G	2	6	8	16

About half the women in the Gujarati sample were not at all pleased about the restrictions that were imposed on them whereas about a third felt that, although they did not share similar beliefs with their female relatives, it was a small concession to make. Only two Gujarati women believed that they could not doubt the accumulated experiences of their mothers and mothers-in-law. The women who felt most displeased about the dietary restriction commented; for instance:

"My own mother did not observe any such restrictions because my grandmother forgot to tell her- this was nearly 25 years ago when such restrictions would have been more strictly observed. My mother was quite lucky. I do find it restrictive - especially living in a modern world and in another country and having to observe such restrictions is most inconvenient. It may be that sesame seeds did not agree with a woman and now it is just passed down the line- becoming incorporated into religious beliefs. I must say I don't believe in it." ( Gujarati Mother First Pregnancy)

Another Gujarati mother who did not share in the beliefs of her mother-in-law gave the following explanation for rejecting the advice:

"Well, if I was given a reason, I would be willing to do as I was told. But if she (mother-in-law) said that I can't then I may not, because I would like to know why. May be with certain foods I may have agreed to give them up if I was only eating it sometimes. Yet, they (mother-in-law) would still find it hard to accept that times have changed." ( Gujarati Mother First Pregnancy)

Many mothers-in-law felt that since they had observed the restrictions in good faith in their time, they wanted their daughters-in-law to follow the family tradition. In some cases the imposition of dietary restrictions resulted in a power struggle between older female relatives who tried to impose their influence over their daughters or daughters-

in-law.

However there were some women who expressed annoyance at having to observe restrictions they did not believe in and yet felt unable to defy the advice in case something went wrong in their pregnancy. A typical comment was;

" As she (mother-in-law) told me , I didn't want to upset her so I have stopped eating bananas even though I still crave for them. Even if you do go ahead and disregard their advice, and if then something were to happen or you have it at the back of your mind that worry- will something happen now that you have disobeyed? I think it is a stupid theory. My mother-in-law is not the only one, there are other women of the same age group who have told me that bananas are bad. I think it is stupid to say that the baby would slip out of the womb early."

( Gujarati Mother Second Pregnancy)

However a few Gujarati women felt that it was important to take advice from their female relatives because this advice was based on their past experiences, as these remarks illustrate:

"Both my mother and my mother-in-law had five children each, so they know quite a lot about pregnancy. I presume, I mean you have to take some advice from them- there must be some truth in it for them to tell you this. I don't feel badly about having to observe some restriction."

( Gujarati Mother First Pregnancy)

"It didn't bother me because I don't eat that much coconut or sesame seeds anyway. I just want to make sure that nothing goes wrong with my pregnancy. When I went out, I would avoid anything which was made with coconut or sesame seeds. I would just ask the people if they had added coconut or sesame seeds in the cooking."

( Gujarati Mother Second Pregnancy)

The Gujarati women who were living apart from their mothers-in-law (1/3 of sample) felt less obliged to take notice of the advice given by their female relatives. A typical comment was:

"My mother-in-law is not here to watch over me so I do as I please. I don't really believe that sesame seeds can do me any harm. I usually have some after a meal to finish off my meal but it is very little and it is not as if I am stuffing myself with it. My mother-in-law does know I do have it and if she notices then I tell her ,okay I won't have it any more but that is only not to upset her."

( Gujarati Mother First Pregnancy)

### Summary

Bangladeshi and Gujarati women come from cultures with well established concepts which link health with diet i.e. restoring the physiological state of the body by balancing the diet with 'hot' or 'cold' foods. Although Asian communities have accepted orthodox medical treatment in Britain, their strong beliefs in the traditional way of ensuring good health through a dietary regime become apparent during pregnancy. However many Asian women of childbearing age in Britain are confronted with the conflicting problem of receiving dietary advice based on two different concepts. This tension was particularly apparent with Gujarati women whose ties with cultural tradition have weakened since migration whereas as Bangladeshi women appear not to have this conflict because as recent immigrants, their identification with their culture and religion is still very strong.

It is important that health professionals who give dietary advice to Asian mothers should take into account their different dietary beliefs and appreciate the dilemma some women face when conflicting dietary advice is offered by the health professionals and by their female relatives.

### Ceremonial Rituals in Pregnancy

It is apparent from the previous section that observation of dietary restrictions have become part of the rituals which many Gujarati and Bangladeshi women were required to observe during pregnancy. In many cultures where the transition from pregnancy to childbirth is associated with danger, the fear of mishap is overcome by the introduction of certain rituals (Kitzinger 1978:84; Blanchet 1984: 73). Although the rituals in pregnancy and childbirth centre mostly around a pregnant mother, in some cultures the pregnant woman's partner or husband is also required to take part in rituals at the time of birth and in the postnatal period (Paige K. & Paige J. 1973). In addition to dietary restrictions, there are a number of other restrictions and religious rites which are performed by Bangladeshi and Gujarati women in the hope that the passage from pregnancy to childbirth will be achieved safely (McDonald 1987).

Because the transition from pregnancy to childbirth has been made relatively safe with medical advancement in maternity care, some of the rituals performed during pregnancy may seem unnecessary and out of place in modern Britain. The fact that the ceremonial rituals have survived after migration to Britain suggests that observation of

these rituals is crucial for retaining cultural values and identity. In Britain, Gujarati and Bangladeshi women are confronted with two different approaches to safeguarding the transition from pregnancy to childbirth i.e. ritualisation of childbirth versus medicalisation of childbirth. Their decision to observe some of the rituals would be determined by how meaningful they found these rituals in a British context where care during pregnancy is based on different principles i.e. on the medical model. In addition, we need to take into consideration the kind of pressure they are under to preserve their cultural traditions.

Although Gujarati and Bangladeshi women share many common ceremonial rituals in pregnancy, the analysis presented here concerns mostly Gujarati women because the interviews with Bangladeshi women failed to generate information on this particular issue.

In my study, a number of Gujarati women were not allowed to wash their hair for the first seven months of their pregnancy nor to come into contact with a parturient mother. Thus the customary visit to labour wards offered as a part of hospital antenatal classes might not be acceptable.

After the seventh month of pregnancy, a ceremony, 'Khorō', was performed which literally means "a mother's lap is filled" in anticipation of the baby's arrival.

At the time of 'Khorō' ceremony a woman is required to have a ritual bath and hair wash. During celebration of these rituals a woman seeks protection from her family deity for a safe delivery. This social occasion also gives the family relations opportunity to acknowledge the pregnancy. A woman is required to observe this ritual in her first pregnancy only and immediately after the ceremony, it is common practice amongst Asian women to return to their maternal homes for the remainder of their pregnancy and childbirth (Mayor 1984; Blanchet 1984 )

Not all women in my study were required to observe these rituals and restrictions and others chose to ignore them. Table 5R sets out the rituals and restrictions which Gujarati and Bangladeshi women were required to observe during pregnancy.



Table 5R: Ceremonial Rituals Observed During Pregnancy  
(Multiple Responses)

	No Hair Wash in Pregnancy	No Visit to Labour Wards	'Khorō'	Total No Women
B	-	-	1	14
G	5	4	9	17

The ritual at the seventh month of pregnancy was a common feature amongst Gujarati women. Almost all the Gujarati women expecting their first baby mentioned that they were required to participate in this ceremony and about a third had participated in this ceremony in their first pregnancy. Interestingly, only one Bangladeshi mother expecting her first baby mentioned that she had taken part in this ceremony. However, the fact that even one woman acknowledged this ritual suggests that this ceremony is also shared by Bangladeshi women. The women who had participated in the ritual remarked:

"I had a 'Khorō' ceremony at the seventh month of my pregnancy. My mother-in-law had invited a Brahmin (a Hindu priest) who tied a specially prepared coloured thread round my right wrist. To the piece of thread were attached a small cloth pouch containing soil from four corners of a cross-roads, a metal ring and a small coin. The priest chanted some holy words to ward off evil spirits and to give strength and protection for labour."  
( Gujarati Mother First Pregnancy)

Just under a third of the Gujarati women expecting their first baby were not allowed to wash their hair for the first seven months of pregnancy and with the exception of two women, the rest of the multigravidae Gujarati women claimed not to have washed their hair in their first pregnancy. Although the restriction for washing hair and the seventh month ceremonial ritual were only observed during first pregnancy, restriction on visiting the labour ward in pregnancy was not confined to the first pregnancy and about a third of the Gujarati women had avoided contact with other parturient women. The women who were advised to avoid contact with a parturient mother commented:

"I am not allowed to visit anyone who just had a baby-well at least for four weeks. According to my mother and my mother-in-law it brings bad luck in your pregnancy if you see a newly born baby's face or the face of the baby's mother." ( Gujarati Mother Second Pregnancy)

For some women this restriction was not lifted even if the two women were closely related:

"My brother's wife just had a baby but I am not allowed to visit her until my nephew is over two weeks old. My sister-in-law stopped me from visiting my brother's wife but I have spoken to her on the phone."

( Gujarati first pregnancy)

The ceremonial ritual at the seventh month of pregnancy was most favoured by Gujarati women because it was a social occasion in honour of their pregnancy. As this ceremony was performed within their own community they did not require the approval of the medical profession. One woman who was pleased to have had the seventh month ceremony remarked:

"At the end of the seventh month I had a small 'Khoru' ceremony. My in-laws invited immediate family members from both sides of the family. My husband's sister tied a piece of string which has special significance-it provides protection for the mother and the unborn child through childbirth. I felt very good about it."

( Gujarati Mother First Pregnancy)

In fact, women who were unable to participate in this ceremony felt most aggrieved as this remark suggests:

"My mother-in-law doesn't believe in such things. I was expecting to have a ceremony, I must admit. I would have liked to have had it. I was most disappointed."

( Gujarati Mother Second Pregnancy)

However not all Gujarati women were willing to observe the traditional customs and found other ceremonial rituals restrictive and unnecessary. The women's attitudes towards ceremonial rituals are recorded in Table 5T.

Table 5T: Attitude Towards Ceremonial Rituals

	Observed Reluctantly	Observed	Disregarded	Total No Women
<u>No Hair Wash</u>				
G	3	2	1	6
<u>No Labour Ward Visit</u>				
G	2	2	1	5
<u>'Khoru' Ceremony</u>				
B	1	-	-	1
G	11	1	1	13

From table 5T it appears that only one Gujarati woman refused to have anything to do with ceremonial rituals and the rest either did so happily or under duress.

It appears that Gujarati women found the ritual surrounding washing of hair most objectionable. As one mother remarked:

" I wasn't allowed to wash my hair for the first seven months of my pregnancy...It's very annoying and irritating. I mean, I find myself asking why would they ask you to do something like this and the only reason I think of is to make yourself sexually unattractive to your husband. As far as washing of my hair is concerned I have done nothing but complain to my husband. He told me that if I didn't believe in such customs then I should not do it. But living with your in-laws -they put a lot of emphasis on these things and make you feel as if you are a naughty girl...I was very annoyed when I was working-holding a managerial position, I did mind what my colleagues thought about my appearance ."  
( Gujarati Mother First Pregnancy)

Other Gujarati women who had expressed similar resentment about the hair washing restriction felt compelled by their female relatives to preserve family tradition. Gujarati women who were living apart from their in-laws were in a position to defy the wishes of their female relatives. One mother remarked:

"When my mother-in-law told me that it was a family custom that daughters-in-law should not wash their hair for the first seven months of pregnancy, I told her that I was going to work and I couldn't go to work without washing it. My sister-in-law who is also expecting a baby is not washing her hair because she lives with my mother-in-law. I did ask my mother-in-law the reason behind it but she didn't know. I felt, there was no point to it...It is unhygienic and yet my mother-in-law and other women are not prepared to accept that I have to look good for my job. I was made to feel like an outcast and a naughty person for disobeying." ( Gujarati Mother First Pregnancy)

It appears that the tradition of observing ceremonial rituals during pregnancy is deeply rooted, particularly amongst Gujarati women. Any ceremonial rituals which could be observed within the confines of their own communities created the least problems and in fact some rituals which proclaimed their pregnant status were most welcome. On the other hand, rituals which could not be observed discreetly i.e. hair washing restriction and restriction which stopped pregnant women going near a parturient mother, resulted in a tension between the women and their older female relatives. The younger women felt that without adequate

explanation, such restrictions were meaningless in modern Britain.

### SUMMARY

One of the main points to emerge from the accounts given by Bangladeshi and Gujarati women concerning the management of their pregnancy was that not only were there major differences in the way the Bangladeshi and Gujarati women managed their pregnancies but also there were major differences between individual women. This has implication for treating all Asian women as if they all belong to a single homogeneous group.

There were additional factors which influenced the behaviour of individual Gujarati and Bangladeshi women. Some of these factors were their attitudes to traditional management of pregnancy, their attitudes to medical management of pregnancy and finally by their socio-economic status within British society. For instance, the relationship between socio-economic status and utilization of the maternity services reported by Oakley (1984) and Macintyre (1981) could equally apply to Bangladeshi women many of whom experienced additional disadvantages due to language difficulties and racial differences.

Consequently some of the major issues concerning the management of pregnancy centred round the need for the medical confirmation of pregnancy, perceptions of health in pregnancy, antenatal care, diet in pregnancy and role of ceremonial rituals during pregnancy. For the Bangladeshi women, medical confirmation of pregnancy, concepts of health and illness in pregnancy and antenatal care were major issues because they had to resolve the conflicting expectations of their own cultural beliefs and those of the medical system. The way some Bangladeshi women coped with this conflict was to delay contact with the medical services as long as possible.

On the other hand, confirmation of pregnancy, antenatal care and concepts of health and illness in pregnancy were not major issues for the Gujarati women because the Gujarati women had adopted many western values concerning the management of pregnancy. However, because many Gujarati women were living within extended households, their views on the management of pregnancy were also influenced by their female relatives whose own experience of pregnancy were influenced by the traditional management of pregnancy. Consequently, advice on health and diet and the role of ceremonial rituals during pregnancy were areas where some conflicts became apparent.

## CHAPTER 6

## PREPARATION FOR CHILDBIRTH

In the previous chapter, I focused on the management of pregnancy in the Gujarati and Bangladeshi communities in Britain. From the accounts given, the women from both groups showed that the pattern of managing their pregnancy was deeply rooted in their cultural traditions and was in sharp contrast to the medically orientated model of managing a pregnancy in Britain. In many aspects of care in pregnancy, women were confronted with two different sets of cultural expectations which made it necessary for the women to make a choice. Whenever possible, women remained loyal to their own cultural traditions. However, because hospital delivery is more or less compulsory for most women and antenatal care comes as a package with hospital delivery, these women realise that they have to make a break with their cultural traditions and accept medical antenatal care ( see Chapter 5 page 118 ). As it became clear from the previous chapter, if most women accepted the need for antenatal care, does this mean that Asian women would similarly accept antenatal education i.e. find the idea acceptable?

As it is clear from the discussion in chapter 2 that from the beginning of this century, the medical management of childbirth was envisaged in much broader terms not only focusing on medical antenatal care but also stressing the need for the education of mothers in the art of motherhood (Oakley 1984). The idea behind antenatal education was based on the assumption that lack of education was one of the factors responsible for the poor outcome of pregnancy. Oakley (1984) in her historical analysis of medical care of pregnant women suggests that this concern was misguided in the absence of any real evidence and that the medical professionals had ulterior motives for advocating antenatal education for mothers i.e. gaining control over women. Tew (1990) also draws similar conclusion:

"The opportunity is taken, particularly in hospital classes, to familiarise the women with the intranatal interventions which they are likely to encounter, and to allay apprehension of the hospital settings, with its connotations of illness and emergency, the impersonality of its technological equipment and its sterile bustle. The women have to be persuaded that these off-putting features are necessary and a small price well worth paying for the promised advantage of greater safety in an event fraught with danger. Thus the hospital antenatal class presents an unrivalled opportunity for putting across obstetric

propaganda from authoritative sources to the target population, the women most immediately concerned, most likely to be influenced and most likely to ask for the evidence which would justify the propaganda." (Tew 1990 : 93)

Whilst an increasing number of women, including women from lower social classes, are taking advantage of antenatal classes, a number of randomised controlled studies have reported that with the exception of the reduction in the use of pain relieving drugs in labour, there is very little conclusive evidence to suggest that antenatal education is beneficial per se (Tew 1990, Simkin & Enkin 1989). It would appear that not only is there no conclusive evidence about the effectiveness of antenatal classes, but there is also concern about our present lack of knowledge concerning possible adverse or harmful effects of participating in the classes:

"The extent to which fear is created rather than alleviated by classes, and whether women succumb to peer or educator pressure to conform, or refuse needed medication or intervention is completely unknown. There has been little systematic evaluation of the extent to which negative feelings of anger, guilt or inadequacy are engendered when a women's or her partner's expectations, possibly raised by the antenatal classes, are not met." (Simkin & Enkin 1989:26)

In addition, a considerable doubt has been expressed about the value of the health promotion content of antenatal classes. It has been suggested by Lumley & Astbury (1989), Rakusen & Davidson (1982), Doyal (1979) and others that health promotion advice about diet, smoking, stress reduction and the importance of exercise is targeted at individual women to persuade them to change their behaviour in accordance with health promotion guidelines. However, one of the main criticisms levelled at health promotion programmes is that they not only fail to take into account the social and economic circumstances of individual women but also ignore the health promotion's potential for causing undue anxiety and guilt:

" Recognition of the social and environmental context in which individuals take up or continue certain behaviours has led some people to condemn health-education activities addressed to individuals as 'victim blaming'." (Lumley & Astbury 1989 :18)

Graham (1984) also draws attention to the recent development in health promotion, backed by the Government's health policies, which places an unfair share of the responsibility on women. She targets her criticism at

health promotion initiatives which fail to take into account the effect that class, gender, race and socio-economic status have on the women's ability to make 'correct' choices to prevent ill health:

"It assumes that women can act autonomously within the family, insulated from economic and social constraints. Yet research suggests that many women do not have the degree of control over their life-style in which such advice is meaningful and practical." (Graham 1984 :72)

At present, medical antenatal care and antenatal education are provided by two separate branches of the NHS maternity services. Antenatal education is offered through antenatal preparation classes in the community as well as in the hospital. In addition to the classes offered by the local health authority, women also have the choice of attending private fee paying classes offered by organisations such as the National Childbirth Trust and the Active Birth Movement.

In the last ten to fifteen years pregnant women have challenged the authority of medical professionals by questioning the decisions made on their behalf in the management of their pregnancy and childbirth. Many women believe that one way to regain some control over childbirth is to be fully informed about all the procedures by gathering information through antenatal classes and the mass media.

I am going to look at antenatal preparation in the context of the women's participation in antenatal classes and the kind of information they acquire to help them cope with labour and the postnatal period. Additionally I am going to look at the attitudes of women towards childbirth and the way such attitudes were influenced both by attendance at antenatal classes and by previous childbirth experiences. I have already touched upon the issues concerning acceptability and accessibility of medical antenatal care- do these issues similarly interfere with their participation in antenatal preparation? If formal antenatal preparation was culturally unacceptable or inaccessible what other sources of information were available to these women and how valuable did they find these sources of information?

#### Antenatal Preparation for Classes

The aim of antenatal preparation classes is to instruct pregnant women on the importance of health in pregnancy i.e. a healthy diet, exercise and relaxation and the harmful effects of drinking and smoking. The expectant mothers are also taught about the mechanics of labour, the

use of pain-killing drugs to cope with labour pains and medical interventions which may be performed to secure a safe delivery. Other topics covered during classes are the care of a new baby including methods of feeding, as well as the recovery of parturient mothers in the postnatal period.

Gujarati and Bangladeshi women were offered antenatal classes as a part of the antenatal care package. The invitation to the classes was either sent by letter or through a personal invitation from the parentcraft sister at the antenatal clinic. The women were either invited to attend the classes at the hospital or arrangements were made for them to attend local community clinics. Since attendance at these classes was voluntary, women were encouraged to register their interest in them. In Camden, separate daytime antenatal preparation classes for Bengali parents were run jointly by a parentcraft sister and a Bengali interpreter. In Harrow, some classes were run in the evening for the benefit of the pregnant women and their husbands who could not attend daytime classes.

The attendance at the parentcraft or antenatal classes is determined by a number of factors: for instance whether the women are aware of the classes and secondly whether they receive an invitation to attend them. Other factors which may influence the uptake of preparation classes are the women's previous experience of participation in such classes and what values other women of their peer group attach to formal preparation for childbirth.

#### Attendance at the classes

At the time of first interview which took place in the third trimester of pregnancy, all Gujarati and Bangladeshi women in my sample were asked if they had been invited to the classes and if they had accepted the invitation. Their responses are recorded in Table 6A(i) and 6A(ii)

Table 6A(i): Attendance at Classes by Primipara Mothers ( numbers)

	Not Invited to Classes	Attended All Classes	Attended some classes	Didn't Attend	Total No Women
B	2	1	1	1	5
G	0	7	-	-	7
	2	8	1	1	12

From Table 6A(i) it can be seen that with the exception of two Bangladeshi women, the rest of the women expecting their first baby (primipara) had been invited to attend the



classes. One of the Bangladeshi women who had not received an invitation to the class commented:

"I didn't go to any classes..I have no knowledge of where these classes are held."

( Bangladeshi mother first pregnancy)

It is however, interesting that of the three Bangladeshi women who had been invited, only one attended the full course and the other two did not complete the course. In contrast, all the Gujarati women expecting their first baby seemed to be particularly keen to take up the invitation to attend the classes. This was demonstrated by the fact that none of the primipara Gujarati women had missed any classes.

Table 6A(ii): Attendance at Classes by Multipara Mothers (Numbers)

	Not Invited to Classes	Attended All Classes	Attended Some Classes	Didn't Attend	Total No Women
B	5	0	2	2	9
G	1	1	-	8*	10
<hr/>					
	6	1	2	10	19

\* these women had attended classes during their previous pregnancy

Although my sample was not made up of equal numbers of primipara (first-time mothers) and multipara mothers (more than one pregnancy), it is noticeable that of the two thirds of multipara women, only three women had accepted the invitation to attend and of these only one Gujarati woman had attended a full course. As with primipara Bangladeshi women, about half the multipara Bangladeshi women had not received an invitation to attend and many of them claimed they had not heard of such classes. Their typical comment was:

"I did not know about their existence.No one told me about them." ( Bangladeshi mother sixth pregnancy)

Perkins (1980) also reported that 28% of 687 mothers in her study gave similar reasons for not attending classes.

It is also interesting that with the exception of one multipara Gujarati women who had attended classes for the first time during her second pregnancy, the rest of the multipara Gujarati women felt it was not necessary to repeat the classes in their subsequent pregnancies.

Although almost two fifths of Gujarati and Bangladeshi women (12) in my sample had attended some classes during

their present pregnancy, two thirds (19) had not done so for a variety of reasons. Of the two thirds, excluding just under half (8) who had not been invited, the remaining women gave a variety of reasons for not taking up the invitation to attend. Table 6B sets out the reasons for not attending.

Table 6B: REASONS FOR NOT ATTENDING CLASSES(Numbers)

	Couldn't go alone	No time	Not necessary	Total No No Women* childcare
<u>Primipara</u>				
B	1	0	0	1
G	-	-	-	-
<u>Multipara</u>				
B	2	0	2	2
G	0	3	6	8

\* total refers to women who were invited but did not go

It would seem that those Bangladeshi women who had earlier experienced difficulties gaining access to antenatal care also found it difficult to attend classes (see Chapter 5 page 104 ). Some felt unable to travel about on their own. As this remark illustrates:

"The Bangali lady who works at the hospital told me about classes for pregnant women...I have not been able to go because I have nobody to take me there."  
(Bangladeshi mother first pregnancy)

The remarks made by a number of multipara women suggested that lack of time, lack of childcare facilities and family responsibilities prevented many of them for participating in the classes. Their typical comments were:

"Yes, I have been invited to attend parentcraft classes..I haven't been able to go. I was very busy with my four children. I could not make time to go."  
( Bangladeshi Mother sixth pregnancy)

A Gujarati woman gave similar reasons for not attending:

"I have been invited to attend parentcraft classes but I haven't been able to go. The parentcraft teacher at the hospital told me off for not attending. I found the time did not suit me. I had no one to mind my kids in the daytime. If they had offered me classes in the evening I might have gone to some of them." (Gujarati mother fourth pregnancy)

Since the involvement of husbands during childbirth has become popular, it is expected that all husbands should attend classes with their wives. However not all cultures welcome the involvement of husbands or men in childbirth. When evening classes were arranged for the benefit of women and their husbands who were unable to attend daytime classes, it created problems for some women either because they were afraid to go out alone at night or because husbands were not willing to attend with them. One Gujarati mother commented:

"I have never been to any classes because my husband would have had to take me to the classes. They also expect husbands to attend but my husband was not too keen to go. My husband was too busy with our family business to find time in the evening to take me to the classes."  
(Gujarati Mother Second Pregnancy)

On the other hand, three quarters of the Gujarati women who had attended classes during their previous pregnancies felt that there was no benefit to be gained by repeating the classes. Their typical comments were:

"The parentcraft sister at the hospital clinic gave me the dates and time of the classes but I decided not to go. I had attended classes in my first pregnancy but they did not help me much." (Gujarati mother second pregnancy)

Apart from the difficulties associated with gaining access to preparation classes, a few multipara Bangladeshi women who had no previous experience of formal preparation for childbirth, questioned the value of antenatal preparation classes. A typical comment was:

"I haven't attended any classes...Four of my children were born in Bangladesh and the last one was born in U.K. and I did not attend any classes in Bangladesh or in this country. Besides I haven't got enough time to attend and moreover I think it is not necessary."  
(Bangladeshi mother sixth pregnancy)

On the other hand, the women who had taken advantage of the classes during their current pregnancy found it was a valuable experience. With the exception of two Bangladeshi mothers, the rest of the Gujarati and Bangladeshi women who had either attended full or part of a course were able to obtain information about labour and at the same time share ideas with other women in the class. Some typical comments were:

"I am glad I was able to attend all the classes- I found them very helpful. I have learnt so many things from

these classes which I didn't know before, like breathing exercises and about healthy diet and about coping with labour." (Gujarati Mother First Pregnancy)

"Yes, very helpful indeed. I found it helpful to share ideas and information with other women... I found the information about the process of labour and the pros and cons of coping with labour pains very interesting. I feel a lot more confident as a result of attending the parentcraft classes." (Gujarati Mother First Pregnancy)

It is possible that for some Asian women, the concept of actually learning about giving birth is culturally unacceptable. For them knowledge about the process of childbirth is acquired by assisting other women or through personal experience rather than through classes (Jeffery et al 1989). The explanation given by the Bangladeshi women who had discontinued the classes suggested that the current method of preparing women for childbirth made some women feel uncomfortable. One such mother commented:

"The lady in the class was talking about how a baby will be delivered in hospital. I felt very embarrassed because in Bangladesh we do not talk about such things. I had gone to the parentcraft classes because I thought I had to go.. I didn't know what it was all about but after I found out I did not want to go any more."  
(Bangladeshi Mother First Pregnancy)

### Summary

It appears that for the majority of the Bangladeshi women antenatal preparation was just as much an issue as was found to be the case with medical confirmation of pregnancy and antenatal care. Whilst they accepted antenatal care as a prerequisite for hospital delivery, acceptance of antenatal preparation for childbirth was difficult for a number of reasons. For some women antenatal preparation was unacceptable on ideological grounds, that is, for these women childbirth was a natural event and therefore formal preparation was not considered necessary; for others access and language barrier made it difficult to participate in the in the classes.

The opposite seemed to be the case with the majority of the Gujarati women for whom neither the acceptance of the concept of antenatal preparation or the concept of antenatal care seemed to be major issues. The Gujarati women's familiarity with the western medical system certainly seemed to influence their positive attitudes towards antenatal preparation as demonstrated in the uptake of classes by the women expecting their first baby.

However, whilst most Gujarati women accepted the concept of antenatal preparation for themselves, the involvement of husbands in the classes was less popular because of the belief that men should not be expected to play an active role during childbirth (see chapter 2 page 25) . In fact evening classes which were organised for the benefit of husbands discouraged some women from attending because their husbands were reluctant to accompany them to the classes.

If preparation for childbirth is to become more generally acceptable by women from other cultures, it is important that antenatal education should reflect the diversity of the women who attend the classes. If, for instance, the structure and content of the course only reflect the eurocentric view it may put off women from other cultures from making use of the preparation classes to gain support through sharing and learning from each other.

#### Information about Childbirth from Other Sources

The discussion in the previous section highlighted the poor uptake of antenatal preparation classes by some Gujarati women and a majority of Bangladeshi women. Since such classes are the main source of information about the management of childbirth in a British hospital, women who do not attend classes have to rely on other sources. In this section, I am going to look at which other sources were available for the women in my sample and how valuable they found them.

Traditionally in all cultures, pregnant women's knowledge about childbirth comes from the experiences of other women. Although this information is based on their subjective experiences, this is often the only source of information available to many first time mothers. Whilst most women learn about childbirth by sharing information, with other women, in many non-industrialised societies women learn about labour through practical experience by assisting other women in labour (Jeffery et al 1989; Inch 1982; Abdulla & Zeidensteins 1982).

In Britain, pregnant women have additional sources of information on childbirth provided by books and magazines and by the mass media i.e. television and radio programmes. A large amount of health promotion literature on pregnancy and childbirth is produced by the Health Education Authority which is funded by the central government. Some of the literature on pregnancy and childbirth produced by the Health Education Authority is translated into various minority ethnic languages, including Asian languages. However, as it was stated in chapter 2 page 34 there has been a great deal of concern

expressed about the literature produced for minority ethnic communities because not only is it often inappropriate and insensitive but there is also a tendency to concentrate on selective health issues which are based on the assumptions and misconceptions of the health professionals.

In addition, there is considerable doubt as to whether the promotion of health through health promotion literature and mass media campaigns is the most effective and efficient method of educating the public about prevention of ill health:

"There is a disturbing tendency in health education to regard mass media as a panacea to be applied as the treatment of choice despite the existence of convincing evidence that their effectiveness is limited." (Tones 1981)

Since there were a number of women in my sample who were expecting their first babies as well as mothers without previous experience of a hospital delivery, I wanted to find out what other sources of information they used to find out how childbirth is managed in a British hospital? All the women in my sample were asked if they had spoken to anyone about childbirth and secondly, if they had read or watched any television programmes on childbirth. The women's responses were categorised according to whether or not they had attended any classes in Table 6C.

Table 6C: Mothers' Other Sources of Information About Childbirth (No. of Sources)

Women Who Attended Classes						
	Assisted at Birth	Person/ Person	Media	Personal experience	None	Total No Women
B	1	3	2	2	-	3
G *	0	13	11	7	-	14
	1	17	13	9	-	18

\* includes women who had attended more than 50% of the course during their previous pregnancy.

Table 6C Mothers' Other Sources of Information About  
Childbirth (No. of Sources)  
Women Who Never Attended Classes

	Assisted at Birth	Person/ Person	Media	Personal experience	None	Total No Women
B	3	3	2	7	3	11
G	-	3	3	3	-	3
	3	6	5	10	3	13

From Table 6C it appears that about a third of the Bangladeshi women who had not attended any classes seemed to have missed out on information from other sources as well. It is worrying that out of the five primipara Bangladeshi women, three women who had not attended any classes seemed to have missed out on all other sources of information. This is particularly significant for first time mothers and mothers who are having their first baby in a British hospital as these women would be less than well prepared to cope with a medicalised childbirth. Some of these women also experienced difficulties in following television programmes and in reading printed literature in English, and some who had not received education beyond primary school had difficulties reading literature in Bengali also.

About a third of the Bangladeshi women, including those who had been to the classes, had obtained information through watching television programmes and/or books on pregnancy and childbirth.

For many Bangladeshi women who are new to this country, the prospect of having a baby in Britain was daunting as this following remark by a mother suggests:

"I have not talked to anyone. I find it embarrassing. Television programmes I don't understand. Most of the things are strange to me." ( Bangladeshi Mother First Pregnancy)

Since some of these mothers were interviewed in the presence of their relatives it was difficult to gauge how much they actually knew about childbirth which they did not want to acknowledge, in front of their relatives because it would cause embarrassment.

Although two thirds of the Bangladeshi women had never attended any classes nor obtained any information from the media, more than half had personal experience of childbirth and a few also had assisted other women in labour.

In Bangladesh their combined experience would have provided them with sufficient information to prepare for home births, assisted by lay but experienced female relatives or neighbours but such experience would not be sufficient to cope with technology orientated hospital births.

In contrast, the Gujarati and Bangladeshi women who had attended some preparation classes, had augmented their information on childbirth from other sources. It was also noticeable that Gujarati women faced fewer difficulties in obtaining information from other sources such as the media because most of them had a good command of English and were literate in their mother tongue.

Since almost all Gujarati and just under a third of Bangladeshi women had obtained information from lay persons and the media, I was interested to find out the range of information that was used by them. Table 6D sets out the range of information that was used by both groups of women.

Table 6D: Range of Information from Other Sources.

	None	LP	Books	TV	LP+Books	LP+TV	TV+ Books	LP+TV+ Books	Total No Women
B	6*	4	-	2	1	1	-	-	14
G	-	1	-	-	2	6	1	7	17
	6	5	-	2	3	7	1	7	31

LP= Lay persons      TV=Television

B\* never attended classes

Although my sample of Bangladeshi women was small, what is particularly worrying is that over a third of the women were totally isolated in terms of acquiring information about childbirth from other sources. It is also noticeable that relatively few Bangladeshi women had been able to take advantage of information provided in books and television programmes. They appear to be further disadvantaged by the fact that a very small number of them had traditional information provided by lay persons i.e. female friends and relatives. Gujarati women appear to be in a more fortunate position, being able to utilise information from a variety of sources- information from lay persons was available to almost all of them.



Information from lay persons

From the accounts given by the women it would appear that two thirds of the women had discussed childbirth with another person. Table 6E(i) sets out how useful the women had found this source of information.

Table 5E(i): Value of Information Obtained from Lay Persons(numbers)

	V. Helpful	Helpful	Not Helpful	No Response	Total No Women
B	1	4	1	-	6
G	2	8	6	-	16
-----					
	3	12	7	-	22

From Table 5E(i) it appears that with the exception of one Bangladeshi mother, the rest claimed that they had benefitted from talking to other women about childbirth. It is not surprising that Bangladeshi women in my sample found the information from other Bangaldsehi women who knew something about management of childbirth in Britain useful - this was often their only source of information.

A mother expecting her first baby in Britain found the information provided by her neighbour very helpful as her comment suggests:

"I have been talking to my neighbour who shares bed and breakfast accommodation with us. She had a baby born in this country- sometimes I talk with her about the system of labour in this country. I think it has been very helpful because it gives me new ideas by talking to others...I haven't read any books or magazines or spoken to health visitors or midwives because of language problems." (Bangladeshi Mother Seventh Pregnancy)

However it is difficult to evaluate the value of person- - to- person information from the positive responses of mothers because many of them did not have access to other information which would have enabled them to compare information from different sources. Secondly, a majority of the interviews took place in the presence of female relatives which may have prevented some women from under- valuing or criticising the information given by such relatives and friends.

Gujarati women on the other hand were divided in their opinion about the value of talking to other women about childbirth. Just under half the women in my Gujarati sample found the information provided by other women unsatisfactory. The level of benefit derived from talking

to lay persons depended on who was giving the information. For instance, some Gujarati women felt that the information provided by their older female relatives e.g mothers-in-law or mothers was based on old fashioned ideas and was unhelpful for young mothers who are required to equip themselves for a hospital delivery. Some of these women felt it was more beneficial to talk to other women in their peer group. One such mother remarked:

"I have spoken to my mother-in-law but in their time it was so different. They were not expected to make any noise or feel any pain as such. But I feel all women experience some pain in labour. I mean it is a painful experience to give birth. My mother also told me that you can't cry out with pain or make noise but just get on with it. My mother-in-law had all her children at home so her idea of childbirth is completely different... I found it was more helpful to talk to my sister who just had a baby. It was helpful to an extent that she is my sister and may be we are the same build therefore I wouldn't have too many problems, I hope." ( Gujarati Mother First Baby)

Other Gujarati women found the information based on the previous experience of other women confusing. They felt the information was insufficient to make decisions about pain relief. Some mothers found they became more anxious after talking to other women as one mother commented:

"I have talked to my cousin recently. I am really worried whether I will recognise the pain? What will happen? Whether it will go fine. My cousin told me to be brave because it can be tough in labour. I have spoken to my mother-in-law but she tells me not to worry. My friend told me that it is going to be really tough... I feel there is something they are all hiding from me. I have been told that labour is thousand times worse than period pain. It really scares me." (Gujarati Mother First pregnancy)

#### Information from television

About half the women in my sample had watched television programmes on childbirth. Table 6E(ii) sets out how valuable these programmes had been to the women.

Table 6E(ii): Value of Information Obtained from Television(Numbers)

	V. Helpful	Helpful	Not Helpful	No Response	Total No Women
B	-	-	1	2	3
G	1	4	9	-	14
	1	4	10	2	17

Although about half the women in my sample had watched programmes on childbirth, many Gujarati women felt that they had not gained anything from watching these programmes (see Table 6E(ii)). In fact, a few of them suggested that they became more apprehensive after watching another woman in labour.

"It is frightening... You can't let your imagination run wild. They talk about episiotomy and things like that and you think 'my God' I will have to go through with it. The film I saw of women in labour looked very painful. You don't know how painful it is going to be for you..."  
(Gujarati Mother First Pregnancy)

Although a few Bangladeshi women had watched programmes on childbirth, they did not express any opinion about them. However a comment made by a Bangladeshi mother tends to suggest that for some women watching a woman giving birth was not at all unusual or necessarily beneficial:

"I have watched it on television and I feel that it is something that happens to every woman. I don't know if it is helpful to learn from the television."  
(Bangladeshi Mother Sixth Pregnancy)

#### Information from Printed Literature

Table 6E(iii) Value of Information Obtained from Printed Literature (Numbers)

	V. Helpful	Helpful	Not Helpful	No Response	Total No Women
B	-	-	-	1	1
G	-	5	3	1	9
	-	5	3	2	10

It appears that the use of printed literature as a source of information was restricted to about a third of the women in my sample (see Table 6E(iii)). It is noticeable that only half the Gujarati women mentioned that they had referred to pregnancy books or the pregnancy booklet supplied by their local hospital. Although the level of literacy amongst Gujarati women in Harrow was quite high, the use of literature was not as widespread as one would have expected. However, it is not surprising to find that hardly any Bangladeshi women had referred to books because many were unable to read and write. It was also suggested by a Bangladeshi community worker that in Bangladesh reading material concerning pregnancy and childbirth was very scarce and other printed materials

were not easily available for a lay person. In Britain, reading materials in Asian languages are produced on a piecemeal basis and at present there is no coordinated policy at national level to fund production of comprehensive reading materials in Asian languages similar to the production of the 'Pregnancy Book' undertaken by the Health Education Authority. Although many Gujarati women were pleased to find the information on pregnancy and childbirth in leaflets and booklets, some of them would have liked to have more detailed information about the management of childbirth in a hospital. A typical comment was:

"I have read all the leaflets and the booklet which I was given at the hospital. I would like to know more about birth but the booklet does not cover it sufficiently in depth." (Gujarati Mother Second Pregnancy)

Some women found that the hospital booklet did not give enough detail about different methods of pain relief. This lack of information on pain-relieving drugs made some women very anxious about whether or not they should accept drugs in labour. A typical comment was:

"I read about pain relief in the hospital booklet which I was given at the clinic. I did not understand everything. I find that everyone tells you different things and when I read about it I got more confused and worried." (Gujarati Mother Third Pregnancy)

### Summary

Despite the fact that information on childbirth could be obtained from different sources, many Asian women and Bangladeshi women in particular faced difficulties in gaining access to information which was available to other British women. In the case of the majority of Bangladeshi women who have very recently settled in Britain, the findings in this chapter show how isolated some of these women are in terms of having only one or no source of information. This is in marked contrast to Gujarati women who have at least a variety of sources with which to compare information.

However amongst the literate Gujarati women, the use of printed literature and television programmes was not as wide spread as would be expected. This not only confirms the limitation of the mass media in health promotion reported earlier but the information produced by the mass media also does not reflect the cultural diversity of the British population.

Amongst the Gujarati women there appears to be a tension between accepting the information from their female relatives and relying on what they felt is insufficient information from other sources. It is essential that any future initiatives for the production of either television programmes or printed literature should be made in consultation with the target communities to ensure that they address the needs of such communities.

### Pain Relief in Labour

In many industrialised nations including Britain the medicalisation of childbirth has effectively removed the control of childbirth from women by making it necessary for all women to have hospital births. Furthermore, women are led to believe that childbirth is painful and that the pain can be controlled by administration of analgesic drugs. According to Inch (1982) the use of pain-relieving drugs in industrialised nations such as Britain and America is a poor substitute for the emotional support and confidence provided by female relatives and friends to a parturient woman giving birth without the use of drugs.

The fear of pain during childbirth was one of the commonest anxieties expressed by the women in the sample (see chapter 5 page 114 ). First time mothers expressed their doubts about their ability to handle the pain, being unaware of what it would be like whereas women who had a previous bad labour, expressed the fear that their forthcoming labour may turn out to be equally unpleasant and painful.

Since Gujarati and especially Bangladeshi women, come from cultures where the traditional supportive role of female relatives in childbirth has not been replaced by the use of analgesic drugs, the question arises as to whether Asian women in Britain find the use of analgesic drugs in labour acceptable. Furthermore if they do find them acceptable, what are the preferred drugs and what significant differences are there in the use of such drugs between the different groups of Asian women?

A pregnant woman theoretically can choose entonox (inhalation anaesthesia), pethidine injection or local anaesthetic such as epidural anaesthesia to obtain relief from the discomfort or pain experienced during labour. Her decision whether or not to use drugs in labour would be determined by how much information she is able to obtain about different drugs and on her previous experience of using drugs.

At the time of the first interview, all the pregnant women in my sample were asked if they had made any decisions about pain relief and were asked about their preferred choice. ( Comparison will be made with the decision made before and during childbirth in the next chapter). The decision about pain relief before childbirth is recorded in Table 6F.

Table 6F: Choice of Pain Relief Before Labour  
(Numbers)

	Nothing	No Idea	Not Decided	G/A	P	E	Total No Women
B	5	8	1	-	-	-	14
G	1	2	2	4	5	3*	17

G/A - Gas and Air

P - Pethidine

E - Epidural

\* Only the women expecting their first baby indicated their preference for an epidural.

From Table 6F, it appears that over half of the Bangladeshi women had no idea what kind of pain relief they would prefer in labour. This is perhaps not very surprising because most of the Bangladeshi women had no prior knowledge about the management of childbirth in a hospital. This was highlighted in the previous sections which looked at their attendance at antenatal classes and access to information from other sources. In contrast two thirds of Gujarati women, most of whom had attended antenatal classes, named a specific analgesic which they would prefer to use in labour. The data presented in Table 6F suggests that Gujarati women had an advantage over Bangladeshi women in being able to make informed decisions about pain relief. It also suggests that Gujarati women had a different perception of pain in childbirth i.e. they had become accustomed to the idea of pain and the need for pain-relieving drugs in labour.

It is also interesting to note that about a third of Bangladeshi women including a mother expecting her first baby had decided that they were not going to use any pain-relieving drugs in labour. I am particularly interested in why a third of the Bangladeshi women had decided not to use pain relief. Since access to information on pain relief was not easily available to Bangladeshi women, were their decisions based on their previous experiences of childbirth?. In Table 6G, I have set out the types of pain relief used by multipara Bangladeshi and Gujarati women.

Table 6G: Pain Relief Used by Multipara Women in Previous Labour(Numbers)

	Nothing	P`dine	Gas/ Air	Epidural	General Anaesthetic	Total No Women
B	8	-	-	-	1	9
G	0	3	1	5	1	10
	8	3	1	5	2	19

It appears that with the exception of one, multipara Bangladeshi women had not used any drugs in their previous labour and I was able to confirm from their medical records. However from this group of multipara women, five women did not know if they would use pain relief in their forthcoming labours. It is possible that some Bangladeshi women felt more confident in their ability to cope with their labour without drugs whilst the rest were unable to give a more definite response because of their unfamiliarity with the administration of drugs in hospitals.

Gujarati women on the other hand had all used some form of drugs in their previous labours. It is interesting to note that none of the multipara Gujarati women thought they could manage without pain-relieving drugs. Their need for pain-relieving drugs perhaps gives an indication of how they had coped with their previous labour. However none of these women wished to use epidural again, most of them would choose either gas/air or pethidine in preference to epidural(cf Table 6F) Their typical comments were:

" I would never ask for an epidural again! In my last labour I couldn't cope with the contractions. I had asked for an epidural injection. But unfortunately it worked on one side of my body only. I could feel the pain on one half of my body. I was in agony. They couldn't understand why it wasn't working on me. I think, psychologically, it made the pain on one side of my body seem ten times worse. I hope I can manage without any drugs this time but I am definitely not going to accept an epidural."  
(Gujarati Mother Second Pregnancy)

Another Gujarati mother who also had unpleasant experience with an epidural commented:

"I will not ask for another epidural again. In my last labour it worked well in labour but afterwards I couldn't

feel my legs. They had gone completely numb. It was terrible feeling. I couldn't move and for a few days I found difficult to walk. I think it is best not to use an epidural if you can avoid it."

(Gujarati Mother Third Pregnancy)

In the next chapter I will be focusing again on the use of pain relief and look at the types of pain relief actually used by both groups of women during their labours.

### Summary

It seems that the factors which influenced the decision about whether or not to consider the use of drugs for pain relief depended on the women's perception of pain in childbirth and on whether the woman had any prior knowledge of drugs on which to base their decisions.

This was borne out by the fact that none of the Bangladeshi women made any specific reference to any drugs because they did not appear to have sufficient information, whereas the majority of Gujarati women had decided which drug they would prefer to use in labour.

### Feelings About Forthcoming Labour

As the time of delivery approaches it is not unusual for pregnant women to experience a certain amount of anxiety, particularly if a woman is expecting her first baby and is unfamiliar with the management of labour in a hospital.

From the discussions in previous sections, it becomes apparent that not all of the women had opportunities to prepare for labour in a hospital. I am interested to find out whether women's attitudes towards their forthcoming labour were influenced by whether or not they had attended preparation classes and secondly the extent to which their attitudes were influenced by their previous labour experiences. At the end of first interview all pregnant women in my sample were asked how they felt about their forthcoming delivery. Their responses are recorded in Table 6H.



Table 6H: FEELINGS TOWARDS CHILDBIRTH  
(Numbers)

Women Who Attended Classes					Total No Women
	Confident	Prepared/ but Anxious	Anxious	No Response	
B	2	1	-	-	3
G*	5	3	5	1	14
	7	4	4	1	17
Women Who Had Not Attended Classes					
B	7	2	1	1	11
G	1	1	1	-	3
	8	3	2	-	14

\* includes Gujarati women who had attended classes in their previous pregnancy

From Table 6H, it is particularly significant that more than half of the Bangladeshi women, who appear to be not so well-informed about the management of childbirth in a hospital, expressed the least amount of doubt or anxiety about coping with childbirth. In contrast, almost half the Gujarati women appeared to be less confident in their ability to cope with childbirth despite the fact that they were better informed. It seems that attending classes or obtaining information from other sources did not necessarily inspire confidence in Gujarati women. In fact learning about the different medical procedures which they may have to undergo during labour may have increased anxiety in some women.

This anxiety was not peculiar to women who were expecting their first baby. Some multipara women, especially the Gujarati women, appear to be just as anxious about childbirth (Oakley 1979). In Table 6I, I have set out the level of anxiety expressed by multipara women in my sample to see whether personal experience of childbirth made any difference to the level of anxiety they experienced.

Table 6I: Anxiety Expressed By Multipara Women  
(Numbers)

	Anxious	No Anxiety	Ambivalent	Total No Women
B	-	7	2	9
G	4	4	2	10
-----				
	4	11	4	19

Although Gujarati women were better informed about the management of childbirth, only about a third of them appeared to have no anxiety about childbirth whereas the rest were still worried about their ability to cope with childbirth. On the other hand, almost all multipara Bangladeshi women, although less well informed about the management of childbirth than Gujarati women, seemed to be less worried about their forthcoming childbirth. From the Bangladeshi women's point of view it seemed as if ignorance was bliss because one could not worry about something one did not know. However, the explanation for the two different attitudes towards childbirth became apparent when I compared their previous experiences of childbirth. In Table 6J I have set out the previous childbirth experiences of Gujarati and Bangladeshi women.

Table 6J: Previous Childbirth Experiences  
(Numbers)

	Labour		Pain Relief		Delivery		Total No Women
	Spont.	Induced	Yes	No	Normal	Assisted	
B	7	2	2	7	7	2	9
G	5	5	9	-	3	7	10

Spont.- Spontaneously

From the account of the previous childbirth experiences it can be seen that the Bangladeshi women had uncomplicated labours and deliveries compared to the Gujarati women. With the exception of two Bangladeshi women who had Caesarian sections, the rest had spontaneous and comparatively short labour.

In contrast, Gujarati women who were more knowledgeable about the management of childbirth in hospital were drawn into the system i.e. arrived in hospital in early labour, felt out of control, required pain relief, felt further out of control and had an assisted delivery. From the accounts of previous experiences of childbirth given by Gujarati women, they had good reason for feeling anxious about their forthcoming childbirth. Gujarati women's account of previous experiences of childbirth also

suggests that merely possessing information about the management of childbirth in a hospital was not enough unless women were able to act on the information and take control of their childbirth.

#### SUMMARY

Although Gujarati women appear to be in a more fortunate position in terms of being prepared for childbirth in a western context, the preparation did not help to reduce their anxiety about childbirth. Gujarati women in their second and third pregnancy also expressed anxiety about childbirth because they were afraid of having another unpleasant experience. Whilst Gujarati women were a step ahead of Bangladeshi women in possessing information about the management of childbirth they were not able to use the information to their advantage.

Bangladeshi women on the whole appeared to be less anxious about childbirth and in fact women who had previous home births in Bangladesh felt more confident because they were under the impression that delivery in a hospital is a lot easier and safer. In addition women whose previous experiences of childbirth were straight forward did not express any anxiety. Bangladeshi women expecting their first babies also felt confident in their ability to cope with labour because many of them were not aware of the medical procedures or interventions which may have caused them anxiety.

## CHAPTER 7

## EXPERIENCES OF CHILDBIRTH

Although childbirth is a natural physiological process for the individual, it is a unique experience which is partly emotional and partly cultural. On the emotional level every woman has a different response to each birth so that one birth may seem painful and distressing whilst another may turn out to be a relatively easy and pleasant experience.

The physical and emotional aspects of childbirth are also culturally defined so that although women from different cultures go through the same physiological process, each culture attaches different values and meanings to pregnancy and childbirth (Kitzinger 1978 :105). As a result of this, women from non-western cultures who have recently settled in Britain, face great tension in trying to relate their childbirth experiences to their own cultural context when birth is actually taking place within the host's cultural context with different meanings and values attached thereto. This tension is further heightened by the fact that they may be faced with language problems during labour at the time when they are already under considerable stress because of labour pains.

Although the childbirth experiences of Asian women are not very different from the experiences of other British women, in order to understand the way Gujarati and Bangladeshi women conceptualised to their childbirth experiences, it is essential to understand the way childbirth is managed in the country of origin compared to the way it is managed in Britain.

The majority of Bangladeshi women in Camden came from the rural district of Sylhet in Bangladesh where home births were normal and women only went into local hospitals if complications developed during pregnancy. In my sample of Bangladeshi women about half the women had given birth at home and for some of these women it was their first experience of giving birth in a hospital. The following interview conducted with a Bangladeshi community social worker provides a typical example of a home birth.

"In Bangladesh some women go home to their parents in the last weeks of pregnancy to give birth and others give birth at their own home. When a woman starts her labour she remains active doing her tasks until she is in the last stages of labour. At this stage she will go into a partitioned room where she will be attended to by one or two female relatives who are used to helping in childbirth.

Her female relatives would give her support and encouragement throughout the labour until the baby is born. If labour is difficult the mother or mother-in-law would send for a village midwife or 'dai' who uses her manipulation skills to speed up a protracted labour. After the delivery, the mother and the baby are cared for by the relatives. The mother is not required to do anything except feed the baby because her relatives are there to look after her baby so that she gets all the rest she needs. If labour is difficult some women who believe in it will drink water especially blessed by a mullah to speed up the labour. Sometimes special properties of a rare dried flower are used by placing it in some water and after the flower has opened the mother is given the water to drink to hasten the labour. This practice of drinking blessed water is common with some women in Britain especially if surgery is indicated. However, some women find that if they are already admitted in hospital, they are not allowed to drink this holy water because it interferes with the hospital policy as no liquid is permitted before surgery. But this does not stop women from trying as on one occasion I helped a mother who was told that because of her previous difficult labour, elective Caesarean would be performed. This mother did not wish to have a section so she drank the blessed water and ate some dates and gave birth naturally." (Bangladeshi Community Social Worker)

Since the majority of the Gujarati women were from East Africa where home births had been phased out in favour of maternity homes or hospitals, they had no first hand experience of home births. Their knowledge of home births were based on the experiences of their mothers and mothers-in-law. Therefore a majority of the Gujarati women were not in a position to make a comparison between home births and hospital births and accepted hospital births without reservations.

Since the early seventies, there has been in Britain an increasing trend towards hospital confinement for all women regardless of whether or not they were in a high risk category (Tew 1978). Once the pregnancy is confirmed, a woman is booked in for antenatal care and a hospital delivery. A typical example of a childbirth shows how a birth is managed in a hospital setting.

Before the end of pregnancy a woman is given instructions to report the onset of her labour. When the labour starts a woman leaves the familiarity of her home to go into hospital where she is looked after by a team of obstetric staff who are at the same time looking after other women in labour. Unless a woman has a labour companion she may be left alone while the staff are attending other women. If on arrival at the hospital, her labour is making slow

progress, it may be accelerated with the rupture of the membranes or by use of a hormone preparation. If a woman finds her labour too painful she is offered pain-relieving drugs. In some cases, the acceleration of labour makes the labour too painful to cope with without additional pain-relieving drugs. The combination of acceleration of labour and certain analgesic drugs increases the chance of a woman requiring further medical assistance at the time of delivery in the form of either forceps, episiotomy or Caesarean sections. Inch (1982 :36) coined the phrase 'cascade of intervention' to explain how active management of labour could lead to a situation where further medical intervention becomes unavoidable.

In the past few years, pregnant women and organisations fighting for the rights of women to have more control during childbirth have questioned the increasing use of modern technology in the hospital (Riley 1977). Women who have very little information about the management of childbirth in a hospital have a limited range of information on which to base their decisions (see chapter 6 page 147). However, not all women are in a position to take control over their childbirth because not only does a woman need to be well-informed to make sensible decisions but she needs also to assert herself when confronted with expert medical advice.

In this chapter I am going to focus on the follow-up interviews to look at childbirth experiences of the women who were first interviewed antenatally in the third trimester of the pregnancy. The purpose behind the follow up interviews in the postnatal period was to find out how the two groups of women in my study coped with childbirth and whether there were any significant differences between the childbirth experiences of Bangladeshi and Gujarati women. I am also interested in exploring the differences between their expectations of labour and what actually transpired during their labour, and the differences between how they planned to manage pain and how it was actually managed during their labour. Finally, how much control the women were able to exercise over the management of their labour and delivery in a hospital regardless of whether or not they had any formal antenatal preparation.

#### ONSET OF LABOUR

As the time for the delivery draws near, most women feel impatient to get the birth over with. The impatience and anxiety felt by pregnant women is heightened by the fact that a great deal of importance is attached to the estimated or expected date of delivery. In addition, the modern medical management of labour not only places greater emphasis on the division of labour into distinct stages but

also places a time limit on how long each stage is allowed to proceed before actively intervening with either induction, acceleration of labour or a Caesarean section. In some countries such as Bangladesh where maternity services are not developed on the same scale as in the industrialised countries, pregnant women wait for nature to take its course and are not dictated to by expected dates of delivery or different stages of labour (Gordon et al 1965; Blanchet 1984). Although there may be pressing medical reasons for terminating a pregnancy artificially, the practice of induction two weeks past the expected date of delivery often causes concern to women who would prefer to start labour spontaneously. A majority of women if left alone start labour between the 38th and 42nd week of pregnancy as was the case with over two thirds of women in my sample. (see Table 7A)

Table 7A: Onset of Labour (Numbers)

	Spontaneous	Elective Caesarean	Induction	Total No Women
B	10	2	-	12*
G	11	-	4	15*
-----				
	21	2	4	27

\* Total numbers include only those women who participated in both the antenatal and follow-up interviews.

With the exception of two Bangladeshi women who had elective Caesarean, the rest of the Bangladeshi women started their labour spontaneously. On the other hand, with the exception of four Gujarati women, the rest of them started their labour spontaneously. These women started their labour spontaneously with either the rupture of membranes or with the regular contractions of the womb. The rest had their pregnancy artificially terminate: two Bangladeshi and one Gujarati women had their pregnancy terminated early because of their poor health and the remaining three Gujarati women were induced because they were overdue by ten days. Gujarati women who were induced because they were overdue were upset because they were not allowed time for their labour to start naturally. It appears that women who resisted induction were made to feel guilty for taking chances against the advise of their obstetrician as suggested by a Gujarati mother:

"At the end of my pregnancy I was feeling fine, had no problems. At my last appointment, in the week when the baby was due, the doctor talked about induction. I was scared- worried about the baby. The word induction means everything is artificial. I wanted a natural birth. A week later I was admitted for induction but I was so unhappy I

told the doctor that I wanted to go home and wait. I was allowed to wait for another week but unfortunately nothing happened so finally I had to be induced. After I had accepted epidural as I could not cope with the pain, the baby started to show signs of distress. One of the doctors who had discharged me a week before told me that he hoped that I understood why it was important to induce me earlier. They were making me more worried. After the baby was born, the doctor made me feel even worse by saying that it was just as well things worked out otherwise I would have ended up with a section. He finished by telling me that I should always listen to their advise, they (doctors) don't say things for fun." (Gujarati Mother First pregnancy)

Another mother with similar experience of induction felt that the treatment she had received was insensitive and had made her feel very anxious about going into hospital again, she remarked:

"I was overdue but I did not want to be induced because it didn't feel right. During whole of my labour I was used as a guinea pig for student doctors. They were all poking me which I found very painful. They didn't explain what was going on. I was in pain for twenty four hours before I was taken down to the delivery room. I was screaming and crying all the time. I didn't have anyone to comfort me. I also had the drip inserted in wrong place by a midwife and she even told me what she had done! I couldn't believe that it could be possible to be treated like that...I had a forceps delivery- the student doctor had to be shown how to apply them. I didn't feel very confident, I wanted the senior doctor to deliver me not the student doctor." (Gujarati Mother Second Pregnancy)

Although the number of women in my sample who had been induced was very small, the Gujarati women's concern about induction was similar to that expressed by native British women in the study carried out by Cartwright (1979).

It would seem that Bangladeshi women who had elective Caesarean were just as unhappy about the medical intervention. One of these mothers reported that she had resisted her admission into hospital until a few hours before her operation:

" The doctor at the hospital wanted to admit me a day before the operation. I was not very happy about the operation. I wanted to stay at home as long as possible in case my pains started. Unfortunately the pains did not start as I hoped they might do in the night. I went to the hospital in the morning and in the afternoon I had my operation." (Bangladeshi Mother Second Pregnancy)



ADMISSION TO HOSPITAL WITH SPONTANEOUS LABOUR

Pregnant women are advised to contact the hospital labour ward when they notice first signs of labour i.e. strong contractions coming at short intervals or if the the bag of waters surrounding the baby breaks. The decision about the time of admission is made by the labour ward staff. A hospital delivery makes it necessary for a woman in labour to leave her home environment and make a journey to the hospital. This causes added anxiety to pregnant women and their partners who are worried about getting to the hospital in time.

On the other hand, women who do not see their labour in terms of distinct stages may not feel it is necessary to rush into hospital until the baby is ready to be born. The account given by the Bangladeshi social worker at the beginning of this chapter also indicated that in Bangladesh it was a common practice for women in labour to continue with their normal activities until it is nearly time for the delivery.

However, how soon a woman is admitted at the hospital can be an important factor in determining the management of the childbirth and the pregnancy outcome. For instance, it is just as vital for a woman not to delay her admission if she has any abnormal symptoms as it is for her not to be admitted far too early in labour. In my sample of women who had gone into labour spontaneously, there was a marked difference in the time at which women arrived at the hospital (see Table 7B)

Table 7B: Time of Admission with Spontaneous Labour

	Early Stages of Labour	Advanced Labour	Total No Women
B	2	8	10
G	7	4	11
	-----	-----	-----
	9	12	21

From Table 7B it appears that almost two thirds of the Gujarati women including women with previous experience of labour had arrived at the hospital in early labour soon after contacting the labour ward whereas, with the exception of just two Bangladeshi women, both expecting their first baby, the majority of Bangladeshi women had arrived at the hospital in the advanced stages of labour. The interviews with Gujarati women revealed that a majority of the women had contacted the local hospital as soon as they noticed the first signs of labour and did not lose

time arriving at the hospital. Gujarati women also appeared to view hospital as a place of safety and were very eager to be admitted as soon as possible. This was understandable since none of them had considered home delivery or had any previous experience of home delivery. Since Gujarati women also had more access to information on the management of childbirth in a hospital, they accepted the need to report the onset of labour without delay. A Gujarati mother who was asked to wait a bit longer at home explained:

"My labour was both long and extremely painful... My labour started with a backache and I also had a 'show'. When I telephoned the hospital they told me to wait until the contractions were coming every ten minutes. In the meantime they advised me to take paracetamol for the backache. This went on for three days and each time I was told to wait until the contractions started or if my waters went. On the third day I insisted that I must have a check up with a monitor to see if I was in labour and only then they admitted me." (Gujarati Mother First Pregnancy)

Just as Gujarati mothers were keen to be admitted early in labour, Bangladeshi women delayed their admission to hospital. Their late arrival at the hospital could be due to the fact that many Bangladeshi women were more familiar with the management of birth in Bangladesh where women do not take to their bed at the first signs of labour but continue with their normal activities until the delivery is imminent. At the advanced stages of labour a woman would be assisted by her female relatives or a community midwife (see for instance the account given by the Bangladeshi social worker at the beginning of this chapter). In Britain, many women have to rely on their husbands for support, to make contact with the hospital and to arrange transportation to the hospital. Although Bangladeshi women on the whole accepted hospital delivery, they were also anxious to spend as little time as possible in an environment which was alien to them and where they would face communication difficulties with the hospital staff. Besides, many women without extended family support also had to take into consideration the welfare of their other children before setting off to the hospital as was the case with this mother:

"My labour pains started at lunch time a week before my baby was due. My husband called the ambulance at 11 o'clock at night when my pains were too much for me. I didn't want to go to hospital too soon because I have to think about my three daughters. It would be too much for my husband because the eldest is only six years. I do not know many people here who could look after my children. I am also afraid to go to hospital without my husband because I do not understand English."

(Bangladeshi Mother Fifth Pregnancy)

Bangladeshi women with previous experience of childbirth in Bangladesh also seemed to be using their own judgement as to when it was the right time to go into hospital. Comments made by Bangladeshi women suggest that they were more attuned to their body and did not see the need to rush into hospital with the first twinge:

"My pain started three days before the actual delivery. My husband called an ambulance at about 10pm on the 6th of October and I had my baby at 4am. My labour lasted four to five hours."

(Bangladeshi Mother Sixth Pregnancy)

Besides knowing when to arrive at the hospital, it has been reported that Bangladeshi women have additional reasons for leaving it as late as possible before setting off to the hospital. The practice of delaying admission to the maternity hospital was not an isolated incident found amongst the women in my study, as was confirmed by a Bengali interpreter based at the hospital. According to this interpreter late arrival at the labour ward was based on misinformation and fear of medical intervention.

"Some women wait at home until the labour is well advanced and sometimes women are admitted just in time for the delivery. Some of these women have heard stories from other women that if they arrive too early in labour then they would end up with a Caesarean section. In my experience, I found that quite a few didn't come into hospital until they were in full labour. In my opinion, the word operation to them seems to mean a big thing and having an operation is not easy.. Although sections are common in this country, in Bangladesh operations are not routinely performed and I think people are frightened of operations. Some people also believe, especially some husbands, that the doctor may carry out a sterilisation whilst a woman is having a Caesarean."

(Bangladeshi Interpreter University College Hospital)

In the case of Gujarati and Bangladeshi women whose labours had started spontaneously, the timing of arrival at hospital was an important factor in determining the management of labour. For instance, more than three quarters (8) of the Bangladeshi women who had delayed their arrival at the hospital delivered their babies, without medical intervention, within six hours of admission. In contrast, about half (4) the Gujarati women who had arrived at the hospital in the early stages of labour had their labours accelerated with hormone preparations to speed up the contraction of the womb. All these women found their labours unbearable and required

pain-relieving drugs. The following account of the labour experience of a Gujarati mother shows that arriving too early in labour could set up a chain reaction from which it was difficult to escape:

"My labour started with a 'show' and backache but I was told to wait until I had regular contractions. On the third day I insisted that they the (hospital) had to admit me. When I arrived at the hospital they told me that I was in early labour. I was in a lot of pain. I was given pethidine which didn't help much. They gave me epidural and in between I was using a gas mask. I then stopped dilating so they set up a hormone drip. The third top up of epidural only worked on one side and I started to feel sick. When it came to pushing, I couldn't push because I felt numb from waist down...The baby started to show signs of distress..In the end I had a forceps delivery with episiotomy as well as bad tear. I was very cross because this was not what I had expected my labour would be like. I feel they treated me badly-the midwife was suppose to encourage me to push the baby instead I was left to get on and that is why the baby was in distress." (Gujarati Mother First Pregnancy)

Other Gujarati women who had arrived at the hospital in early labour also had similar experiences because they were unable to control what was happening to them or to challenge the decisions made by the obstetric staff as the following remarks show:

"I started my labour naturally when my waters broke. My husband took me to the hospital straight away. I did not have any contractions or any pain. My labour was accelerated with a hormone drip. I was also given an injection of epidural in my back at the same time. The midwife told me that I wouldn't be able to cope without pain killers because I was induced. When at one stage the epidural wore off I could feel the contraction and I thought I was dying. I had a second top up of epidural. I had not asked for the epidural but I thought the midwife knew what was good for me. After I was in labour for over twelve hours they decided to do a Caesarean because the baby was upside down. They had not realised that the baby was coming down feet first although I had told them that I could feel the baby's head on the side of my ribs. They wouldn't believe me and said Mrs.P don't worry everything is just fine. We know what we are doing. In the end it was too late to do a Caesarean and I delivered him feet first. I had forceps delivery with quite a few stitches. Thank 'God' the baby is okay" (Gujarati Mother Second Pregnancy)

#### SUMMARY

From the accounts of the birth experiences of the Gujarati

women it would appear that not only were they open to the idea of hospital delivery but also sought the security provided by medical experts by arriving at the hospital as soon as possible. It would seem that their acceptance of a medical model of managing childbirth was further reinforced by their participation in the local health authority antenatal classes where alternative model of managing childbirth was not discussed.

In contrast many Bangladeshi women, including those expecting their first baby, who had recently arrived from Bangladesh were more familiar with home births than hospital births. Although many Bangladeshi women in my sample had claimed that they had a great respect for modern hospital, at the same time language difficulties and stress of being in an alien environment prevented them from rushing into hospital in the early stages labour.

Whilst some Gujarati women became caught up within the hospital system and became passive recipients of care, the Bangladeshi women intentionally or unintentionally avoided getting caught up in the system by delaying their arrival at the hospital. In the next section I am going to focus on the use of pain-relieving drugs amongst the Gujarati and Bangladeshi women to see if similar trends were apparent.

#### PAIN RELIEF IN LABOUR

Since there are a number of pain-relieving drugs available to women during childbirth, some women make their decision about a particular drug they would use before going into labour. This is usually based on the information they have acquired in the antenatal period. Other women who are not aware of pain-relieving drugs or have not made up their mind may have to make a quick decision after they have been admitted to the labour ward. Their decision is often based on the advice of the obstetric staff.

The decision whether or not to use drugs at all is based on the individual woman's perception of pain in childbirth and what she has found out about the merits or otherwise of the different drugs which are commonly available in the hospital. In Chapter 6, which focused on preparation for childbirth, I discussed whether the women in my sample had made any prior decision about pain relief and what drugs they would prefer to use in labour. In this section I am going to focus on the pain-relieving drugs which the women actually used during labour to see whether they were able to stick to their original choice and whether there was any significant difference in the use of drugs between those who had made a prior decision and those who had not.

In order to compare the decisions about pain-relieving

drugs before and after childbirth, I have reproduced Table 6F from Chapter 6 (excluding the women who did not participate in the follow up interviews in the postnatal period) and the actual drugs used during childbirth in Table 7C.

Table 6F: Choice of Pain-relieving Drugs Before Labour

	Nothing	Don't Know	Not Decided	Gas/Air	P <sup>h</sup> dine	Epi.	Total No Women
<u>Primipara</u>							
B	1	2	1	-	-	-	4
G	1	1	0	-	2	2	6
<u>Multipara</u>							
B	4	4	-	-	-	-	8
G	-	1	2	4	2	-	9
	6	8	3	4	4	2	27

P<sup>h</sup>dine - Pethidine

Epi. - Epidural

Table 7C: Pain-relieving Drugs Actually Used in Labour

	Nothing	G/A	P	E	G/A +P	G/A +E	G/A+P +E	Gen. Ana	Total No Women
<u>Primipara</u>									
B	3	-	-	-	-	-	-	1	4
G	-	1	1	1	-	1	1	1	6
<u>Multipara</u>									
B	6	-	0	-	-	-	-	2	8
G	1	3	1	-	4	1	-	-	9
	10	4	3	1	4	2	1	4	27

G/A - Gas and Air

P - Pethidine

E - Epidural

Gen. Ana - General Anaesthetic

When the data in Tables 6F and 7C are compared, Bangladeshi women who were either undecided or did not think pain-relieving drugs were necessary appeared to have used the least amount of drugs during their labour. From Table 7C, it is apparent that with the exception of three Bangladeshi women who had a general anaesthetic for Caesarean sections, the rest claimed that they had managed their labours without using any drugs. On the other hand, with one exception, all the Gujarati women had used at least one drug and just over a third of them used more than one drug. This marked difference in the use of drugs between

Bangladeshi and Gujarati women seems to suggest that Bangladeshi women were more able to handle the labour pains without drugs than Gujarati women. From earlier discussions concerning admission into hospital it would appear that the time of arrival and the progress of labour may also have determined whether or not pain-relieving drugs were necessary. For instance, a majority of the Bangladeshi women who had arrived at the hospital in the final stages of labour, having completed the earlier stages in the familiar surroundings of their homes, had left it too late for the administration of drugs.

However, although a majority of the Bangladeshi women had claimed that they had not used any pain-relieving drugs in their labours, documentary analysis of their hospital medical records revealed that a third of them actually had had pain-relieving drugs administered to them. This anomaly suggests that these women, none of whom had any previous experience of delivery in a hospital, had either accepted pain-relieving drugs without their knowledge or consent or had accepted drugs in the belief that these drugs were routinely administered to all women in labour, or, because of communication difficulties, the obstetric staff had failed to explain fully what the drugs were for. On the other hand, the routine injection of drugs like syntometrine before the birth of the baby were often mistaken for pain-relieving drugs by some women who claimed that they had accepted pain-relieving drugs. Their medical records however showed that these women had not been given any pain-relieving drugs. The following comments show that many Bangladeshi women were confused about the administration of drugs in labour :

"When I was admitted into the hospital, the baby was ready to be born. The doctor gave me injection as I was in too much pain trying to push the baby out. I do not know the name of the medicine I was given."  
(Bangladeshi Mother Sixth Pregnancy)

Another Bangladeshi mother, whose medical record showed that she had not been given any pain-relieving drugs, also believed that she had accepted pain-relieving drugs when she was given routine injection of syntometrine.

"I was taken to the hospital when it was time for the baby to be born. In the hospital I was given some liquid medicine through my arm as I was very weak and could not push the baby. I also had another injection to make it less painful to push." (Bangladeshi Mother Seventh Pregnancy)

Turning now to the Gujarati women, the more widespread use of drugs amongst them may be linked to their admission in hospital in the early stages of labour. Some women find the

hospital environment and the length of time spent in the labour ward increases their stress and this makes it necessary for them to accept drugs. However from the accounts of the Gujarati women it also seems that knowledge about the availability of drugs may have made it easier to ask for such pain-relieving drugs. In other words, knowledge of the existence of such drugs and the easy access to them may have increased their need for the drugs.

I am now going to turn my attention to whether or not the women who had made a decision about pain relief were able stick to their original decisions and whether there was any difference in the use of drugs between those who had decided and those who had not ( cf Table 6F) . In Table 7D(i) and 7D(ii) I have set out the women's decisions about pain relief and the pain relief actually used.

Table 7D(i): Use of Drugs-those Who Had Decided.

	Used Preferred Drugs	Used Preferred + Additional Drugs	Used Completely Different Drugs	Total No Women
B	-	-	-	0
G	2	6	2	10

Table 7D(ii): Use of Drugs-those Who Had Not Decided.

	No Drugs	Gas/ Air	P <sup>o</sup> dine	Epi.	General Anaes.	More than one drug	Total No Women
B	5	1	3	-	3	-	12
G	1	3	-	-	1	-	5

P<sup>o</sup>dine - Pethidine      Epi. - Epidural

From Table 7D(i) it is apparent that with the exception of two women, the rest used their preferred choice of pain-relieving drugs and about half had also used additional drugs besides the ones they had originally chosen. Although the use of drugs was related to their pain threshold and the nature of their labour i.e. whether the labour was allowed to progress smoothly or was artificially speeded up, it seems that once the decision to use drugs was made, the use of drugs during labour became inevitable. Gujarati women in particular appeared to be less sure of their ability to cope with pain without drugs and appeared



to be anxious about feeling out of control. Contrary to expectations, the women in my sample who had not made up their mind about pain relief, fared a lot better in terms of coping with their labour pains (see Table 7D(ii)).

### SUMMARY

It would seem that Bangladeshi women and especially the women with previous experience of labour had not built up their faith in the ability of drugs to provide relief whereas Gujarati women, regardless of their parity, seem to place their faith in the western drugs to obtain relief from pain during childbirth.

### MANAGEMENT OF DELIVERY

I have treated different aspects of childbirth separately, in order to compare and highlight the important factors which affected the women's experiences of giving birth in a hospital. I am conscious that this way of looking at the women's experience of childbirth gives a disjointed picture of events. In order to compensate for this I am now going to draw together the management of the labour and the delivery. I will be taking into consideration the related factors such as the onset of labour, management of labour in hospital, use of pain-relieving drugs and the role of a labour companion. Since there was a marked difference in the way the Gujarati and Bangladeshi women coped with labour, I was interested to find out whether similar differences were apparent in the management of their delivery? In addition I was also interested to find out whether or not attendance at antenatal classes had any influence on their childbirth experiences ?

In Table 7E(i) and 7E(ii) I have set out the childbirth experiences of the Gujarati and Bangladeshi women according to whether or not they had attended classes.

Table 7E(i): Childbirth Experiences of Women Who Attended Class

	<u>Onset of Labour</u>			<u>Pain Relief Accepted</u>	<u>Type of Delivery Labour</u>					Total No Women
	Sp.	Acc.	Ind.		N	F	E	Caes.	Camp.	
B	2	-	-	3	1	-	-	2	1	3
G	10	4	3	12	10	2	4	1	12	13
	12	4	3	15	11	2	4	3	13	16

Table 7E(ii): Childbirth Experiences of Women- No Classes

	<u>Onset of Labour</u>			Pain Relief accepted	<u>Type of Delivery</u>				Total No Women	
	Sp.	Acc.	Ind.		N	F	E	Caes.	Labour Comp.	
B	8	-	-	4	7	-	1	1	5	9
G	2	1	-	2	2	-	2	-	2	2
	10	1	-	6	9	-	3	1	7	11

Sp - Spontaneous  
 Acc - Accelerated  
 Ind - Induced  
 N - Normal  
 F - Forceps  
 E - Episiotomy  
 Caes - Caesarean  
 Comp - Companion

When the findings of Tables 7E(i) and 7E(ii) are compared it would appear that poor attendance at the antenatal classes, especially amongst the Bangladeshi women did not seem to have disadvantaged them to a great degree. It is apparent that with the exception of three Bangladeshi women, the rest managed to get through their labour without medical interventions and without the use of pain-relieving drugs. Of the three women who had assisted deliveries, two had an elective Caesarean section on medical grounds and only one had an emergency Caesarean section.

In contrast, although almost all the Gujarati women started labour spontaneously at home, about a third of them found that their labour was accelerated after admission into hospital and just under a third of them were admitted for induction. Gujarati women whose labours were induced or accelerated found that they could not cope with the intensity of contractions and required additional pain-relieving drugs. A mother who was overwhelmed by pain after her labour was accelerated remarked:

"When I arrived at the hospital I was getting mild contractions but once they set the drip up to speed up the labour the contractions became very strong and very painful. I tried the gas mask but I found it did not help so I had pethidine which made me very drowsy. I could still feel the pain. By the time I was asked to push I felt totally out of control. I wanted someone to take the baby out."

Some of these women found that the combination of acceleration with a hormone drip and pain-relieving drugs made them feel unable to manage the last stages of labour

on their own. About a quarter of the women had an episiotomy or a cut made in the perineum to enlarge the birth outlet and about half of them had an episiotomy to facilitate forceps delivery. This particular mother who was distressed and unable to push the baby out found that she did not feel strong enough to object to the medical student making unsuccessful attempts to apply the forceps. She continued;

"The medical students had four goes at applying forceps which really upset me because it was unnecessary. I was not in a fit state to object. I think the senior doctor should have taken over when the student doctor failed to do it correctly. The forceps caused a lot of bad bruising on me and my baby. The bruising made me bed ridden for three weeks. I was pleased to have had a natural birth but the unbearable pain I suffered after the delivery spoilt my experience." (Gujarati Mother Second Pregnancy)

#### SUMMARY

From the experiences of some of the Gujarati women it seems that being well-informed about the management of childbirth through antenatal classes was not enough since many of these women were only exposed to the way childbirth was managed in hospital. Many of the medical interventions such as acceleration and episiotomy were put across as routine hospital procedures. For this reason some Gujarati women were not able to assert themselves in the presence of medical experts. However this problem is not unique to Gujarati women as other British women also experience a similar loss of confidence when confronted firstly by a painful labour and secondly by medical experts advocating a particular course of action.

By adopting a western model of childbirth, Gujarati women were less able to exercise control once they were admitted into hospital, whereas the Bangladeshi women, despite the many disadvantages they experienced, managed to retain some control by delaying their arrival at the hospital.

#### LABOUR COMPANION

Traditionally in Asian societies, a woman in labour is supported by her female relatives or friends and men usually keep out of the way. In Britain, Asian men find themselves fulfilling the role of labour companion which is traditionally not theirs. Almost all the Gujarati women in my sample had their husbands as their labour companions and about half the Bangladeshi women had the support of their husbands although most of them waited outside in the waiting room. [see Table 7E (i) and (ii)].

Hospitalisation of childbirth and the modern belief that a husband is the only rightful person to support his wife during childbirth has devalued the traditional supporting role of female relatives. Almost all the Gujarati women in my study expected their husbands to be present at birth because they believed that that was the done thing. In a number of cases female relatives were expected to give temporary support but only whilst the husbands were on their way from their place of work. It was interesting to note that the female relatives who played an active role in providing support during pregnancy found that they temporarily lost their role to a male member of their family at the time of birth and were called upon to resume it again after the woman was discharged from the hospital. This often caused resentment among female relatives, especially some mothers-in-law who felt that their sons should not be exposed to childbirth. Some of these conflicting issues are covered again in chapter 8.

Turning now to the Bangladeshi women's labour companion, it appears that the role of labour companion is forced upon husbands and many fill this role out of necessity rather than by the express desire of the childbearing women or the men themselves. Since many of the Bangladeshi women were not able to speak English they needed their husbands to accompany them to hospital and act as their interpreter if the hospital interpreter was not available.

From separate interviews with a Bengali interpreter and a Bengali community social worker it was revealed that many Bangladeshi women felt very uncomfortable on being exposed in front of their husbands and preferred their husbands to wait outside the labour ward. However some Bangladeshi husbands considered their presence at the hospital necessary to ensure that their wives' 'purdah' was not violated by the presence of male doctors. They often insisted that there should be nobody present in the labour room except the midwife. Some Bangladeshi husbands also insisted that they should be consulted and their permission obtained before any medical procedures were carried out. The hospital interpreter gave the following example:

"If any pain killers are given or if any medical procedures are carried out in labour, the midwife or the doctor has to ask the permission of the husband first because a woman would not agree to anything without her husband's permission. For example, a woman in the antenatal ward started her labour with placenta praevia and she needed an emergency Caesarean. This happened in the middle of the night so while the police were sent to fetch the husband the doctor performed the Caesarean. This woman's

husband was very angry to learn that a section was performed without his permission."

(Bengali Interpreter University College Hospital)

It would appear that because of the hospitalisation of childbirth Asian men were forced into a new role which required them to make important decisions about procedures they knew very little about. The Bangladeshi men were not alone in facing this problem as the following account by a young Gujarati mother indicates:

"I started my labour with stomach cramps and after consulting my sister-in-law and my husband I went to the hospital. Although I was getting stomach cramps I was not having any contractions. That night I was given sleeping pills and told to rest before induction in the morning. My husband went home and in the middle of the night I started to leak and my cramps got worse. When the midwife examined me, she couldn't find baby's heartbeat and my waters were brown. She asked me to sign a consent form for a Caesarean. My husband had told me not to sign anything. I didn't know what to do. I didn't want to disobey my husband at the same time the midwife was pressing me to sign the forms. I was so frightened. My husband was against Caesarean because he had heard stories about Caesarean which made women weak and unable to do any work afterwards. My husband wanted me to be strong and healthy after birth. Because I knew his views I was put in a difficult situation. I was scared of my husband and at the same time I was worried about my baby. After the midwife warned me that I was putting my baby at risk I signed the form." (Gujarati Mother First Pregnancy)

#### FEELINGS AFTER CHILDBIRTH

Immediately after birth the emotions experienced by a woman can range from elation to a feeling of complete detachment from the reality of the event. No matter how many times a woman gives birth, each time her reaction is unique and unpredictable. The most common reactions expressed soon after the baby makes its appearance are that of relief that the hard work is finally over and that the baby is normal and healthy.

The way a woman reacts to the birth of her baby is very complex. Her reactions would be affected by a number of factors: for instance, whether the mother was emotionally prepared to have a baby, whether the pregnancy was planned or unplanned, whether there was any anxiety concerning the baby during the pregnancy. In addition, reactions after birth may also be related to the way the labour and delivery were managed and whether the woman's expectation of childbirth were realised. In this section, I am going to

focus on the reactions of the Gujarati and Bangladeshi women after the birth of their baby. Given that a wide range of attitudes were expressed about the impact of the pregnancy on their lives, I am particularly interested in the reactions of the women who had ambiguous feelings towards their pregnancy. I will also be focusing on the reactions of the women who were anxious about the baby either with regard to the sex of the baby or to any abnormality in the baby. In the postnatal interviews all the women were asked to describe their feelings after the birth. The women's reactions are set out in the Table 7F.

Table 7F: Reactions After Birth  
(Numbers)

	Positive Reaction	Mixed Reaction	Negative Reaction	Total No Women
<u>Planned Pregnancy</u>				
B	3	-	2	5
G	4	1	-	5
<u>Unplanned Pregnancy</u>				
B	2	-	-	2
G	2	5	3	10
<u>Accepting Fate</u>				
B	5	-	-	5
G	-	-	-	0
	-----	-----	-----	-----
	14	7	5	27

With the exception of three Gujarati women, the rest were very happy with the outcome of their pregnancy. The Gujarati women who had given birth to a baby boy appeared to be particularly pleased. This was because most of the Gujarati women were in their first or second pregnancy and did not already have sons. It would also seem that the women with daughters who gave birth to a son at the end of the current pregnancy had a much more positive attitude towards their labour in retrospect even though some of these women were initially very unhappy to find themselves pregnant. A Gujarati mother commented:

"Although at first I was not at all pleased to be pregnant I was overjoyed and excited to know it was a boy. My mother-in-law's attitude towards me has also changed because it is a boy. If I had a girl I wouldn't have been so excited, probably I would have cried with disappointment. I was very pleased with the whole experience. I think I had a much easier labour compared to

my last labour. I am still on a high having given birth to a boy." (Gujarati Mother Second Pregnancy)

One Bangladeshi mother on the other hand was very upset because she had given birth to her fourth daughter:

"We were hoping and praying that this pregnancy I would have a boy. My husband and I were disappointed because if we had a boy we would not have any more babies but now we will have to try again. When the midwife told me that it was a girl, I cried -no not another girl. I was very sad and upset at first but now I am okay."  
(Bangladeshi Mother Fifth pregnancy)

Although women who already had a daughter or daughters were under more pressure to produce a son, many first time mothers also secretly wished for a son so that they would be spared the pressure in their subsequent pregnancy/ies. However many first time mothers did not openly voice their anxiety about the sex of the baby until after the baby was born as this following comment suggests:

"We didn't know the sex of the baby until the nurse brought her back and announced it was a girl. I felt sorry for my husband because it was a girl. I didn't want to hold her or even look at her. I didn't feel any attachment towards her. I felt bit strange towards her -I didn't want to grab her like other mothers do. My husband pointed the similarity between myself and the baby but I was not able to respond. It took me a whole day to get used to the idea. I refused to hold her, maybe if it was a boy I would have grabbed him. I thought I was carrying a boy because everyone told me that it was going to be a boy."  
(Gujarati Mother First Pregnancy)

A Bangladeshi and a Gujarati mother who had a very painful labour experience felt that they were far too upset after the delivery to rejoice at the birth of their baby. The Bangladeshi mother explained:

"After the baby was born I felt that I won't get pregnant ever again. I found the labour very painful and then I had to have a lot of stitches afterwards. I was relieved to know that my daughter was healthy but I was not happy with my labour." (Bangladeshi Mother First Pregnancy)

The Gujarati mother who also had a similar experience of childbirth felt that the pain she experienced following repeated attempts to deliver her baby with the forceps had spoilt her normal birth experience. The mother felt very upset that a student doctor was allowed to have a number of attempts at using the forceps and the senior obstetrician did nothing to intervene.

Turning to the women who had either not planned their pregnancy or had an ambiguous attitude towards their pregnancy, it would seem that their ambiguity was also reflected in their attitude towards the birth of their baby. With the exception of two Gujarati women, two thirds of the Gujarati women continued to feel negative about their pregnancy and childbirth (see Table 7F). A Gujarati mother who was very unhappy about her unplanned pregnancy and had tried unsuccessfully to abort her baby felt completely drained of emotion and did not even wish to acknowledge the birth of her baby:

"I would never go through it again. Never, mostly because of the pain. The last two labours were not as painful. This time the labour was short but much more unbearable. I was feeling very anxious throughout my labour. I was very upset because I was convinced that I had harmed my baby by taking so many drugs in my early pregnancy... I don't even remember seeing the baby born. I did not feel anything when my husband told me that we had a son. He was very sleepy because I had taken pethidine an hour before he was born. He slept a lot and didn't cry for two days. I did not feel like handling the baby until the second day when I had a good look to see if his body was deformed. I felt relieved to see he had all his toes and fingers and he was not harmed by the medicine. I am glad now that everything worked out in the end and I am pleased he is here." (Gujarati Mother Third Pregnancy)

Another Gujarati women who was very unhappy about her third unplanned pregnancy continued to express negative feelings about her childbirth experience:

"The contractions started at midnight but by the time I got to the hospital they stopped. In the morning they broke my waters. I asked for pethidine because I didn't want to put up with any pain. I told the midwife she should either give me pethidine or do a Caesarean. I was not in the mood to go through labour-I felt indifferent to what was happening to me. I didn't enjoy my third labour. When he was born I was relieved that the pain was over. I felt numb-no feeling at all. Okay he is there, I will just have to get on with him. He didn't cry because I had taken pethidine very shortly before I pushed him out. I didn't know that pethidine would affect him... The nurse gave him an injection to counteract the effect of pethidine." (Gujarati Mother Fourth Pregnancy)

Another Gujarati mother who was also not happy about her pregnancy complained that she had sacrificed her career to please her husband and his family by having a baby when she was not ready to be a mother. She felt depressed because her



baby was born prematurely and could not hide her resentment towards her in-laws who thought of her only as someone who could give them a grandson:

"I went into labour prematurely. My son weighed only three pounds at birth so he was admitted to the special care unit for two weeks. I held him very briefly before he was taken away in an incubator. I felt very depressed and envied other women in the wards who had their babies with them. I discharged myself after three days because I found it too depressing to be in the hospital. Since I have brought my baby home my whole life revolves round the baby. I am not allowed to go out anywhere. It is just as well that I have produced a son; I think my life would have been made too difficult for me if it had been a daughter. My mother-in-law makes me feel that I should have no other interest other than the care of her grandson. "

( Gujarati Mother First Pregnancy)

A young mother who was not prepared for an emergency Caesarean section felt dazed and totally out of control because her husband and the hospital staff appeared to be making all the decisions. Her dilemma was evident from the time she was asked to sign a consent form for an emergency section whilst her husband had explicitly forbidden her to sign any forms. After the birth of her baby she continued to feel out of control:

"When I came round I was in shock. My husband told me that the doctors were looking after my daughter in the baby unit because she had breathing problems. I didn't know until the next day why my baby was in the baby unit. When I saw her photograph, lying in an incubator covered with wires I was really frightened and upset. I just cried and cried and wondered what I had done wrong. I thought that even if she lived she might be mentally handicapped. I had an operation on Thursday morning and I didn't see my daughter until Saturday morning. For the first two days I was in so much of a daze, I never asked why I couldn't see the baby. My husband told me that she was well looked after and I just accepted it. It is strange that I didn't ask, I really don't know why. I didn't understand why she was in an incubator or know what was wrong with her. I was disappointed with the way things worked out. I am upset because I didn't have a natural labour and because I could have lost my baby"

( Gujarati Mother First Pregnancy)

With the exception of two Bangladeshi women, the rest were relieved that their delivery had ended safely. Bangladeshi women who accepted their pregnancy as destined by their fate appeared to accept childbirth and the birth of their baby with equanimity. Bangladeshi women with high parity

particularly seemed to be undaunted by childbirth:

"I gave birth to my four children at home in Bangladesh with just my mother-in-law. I had no problem as my labours were very quick. I am an experienced mother so I can manage my delivery but I was pleased when it was over and the baby was all right physically"  
(Bangladeshi Mother Sixth Pregnancy)

Some of these mothers appeared to be more concerned about the health of their babies and about returning home as soon as possible to get away from the hospital where they felt ill at ease and to return to other children at home. A mother whose underweight baby was admitted to the special care unit felt very depressed because she could not take her baby home and because she was anxious about the other children she had left at home:

" My labour was not difficult. It lasted only three to four hours. My baby was born earlier than expected and only weighed about four pounds. I did not have my baby with me because he was in a baby ward. I was worried about my son because he was underweight. I was anxious to go home but I could not take the baby home until he was well."  
( Bangladeshi Mother Seventh Pregnancy)

#### SUMMARY

Some of the major issues to emerge from this chapter suggested that whilst each Gujarati and Bangladeshi mothers experience of childbirth was perceived by her as a unique event in her life, there were a number of major differences between the way Bangladeshi and Gujarati women coped with their labour and deliveries.

From the accounts of how the two groups of women coped with their labour it became apparent that the kind of experience they had was determined by the method of managing labour that they were accustomed to which in turn determined how eager they were to be admitted into hospital.

The experiences of Gujarati women suggested that they were eager to be admitted into hospital in early labour because they were only accustomed to a hospital as the safe place to give birth. In addition a majority of the Gujarati women were also eager to obey instructions concerning admission into hospital. Consequently a majority of the women arrived at the hospital in the early stages of labour.

On the other hand, a majority of Bangladeshi women were more familiar with birth at home and as a result they did not see any reason for rushing into hospital in the early stages of labour. In addition, for Bangladeshi women

admission into hospital created additional problems such as language difficulties and having to rely increasingly on their husbands for moral and physical support in labour. As a result it was not surprising that many women delayed their admission until they were in well-established labour.

The timing of admission into hospital seemed to play a crucial role in determining how their labour progressed and how it was managed. For instance, Gujarati women who arrived at the hospital in early labour found that although they had started their labour spontaneously, once they were admitted they were not able to avoid medical intervention. Partly as a result of medical intervention and partly due to their more favourable attitude towards pain-relieving drugs, many Gujarati women found that they could not cope with labour pains without using pain-relieving drugs. It was also interesting to note that not the Gujarati women were not only more willing to entertain the idea of pain-relieving drugs during their pregnancy but they also ended up using additional drugs besides the ones they had originally intended to use.

In contrast, the experiences of the majority of the Bangladeshi women suggested that because they delayed their admission into hospital until they were in well-established labour they were able to avoid medical intervention and also the need for pain-relieving drugs.

For the majority of the Gujarati women the participation of the husbands during labour was not a major issue although it was not always approved of by some of their older relatives. In contrast, for many Bangladeshi women who did not share similar views, involvement of their husbands during labour was culturally unacceptable for them and for their husbands. However, the experience of the Bangladeshi women highlights the difficulties encountered by the women who have to manage without the traditional female support during childbirth in addition to being confined in an alien hospital environment.

The range of feeling expressed by the women after childbirth in many ways reflected the attitudes they had adopted during their pregnancy. It would seem that the women, in particular Gujarati women who had either not planned to have a baby or had ambiguous attitudes towards their pregnancy continued to express similar attitudes towards their childbirth experiences. Whereas the Bangladeshi women who accepted their pregnancy as ordained by the will of God, seemed also to perceive their childbirth experiences in the same light.

The women who thought that their labour and delivery were badly managed and the women who had failed to produce a

male child were the most upset by their experiences.

The accounts of the women's experience gives some indication of the issues which confront women from different cultural and social backgrounds when they give birth under a hospital setting.

## CHAPTER 8

## POSTNATAL CARE

Postnatal Recovery- Hospital Confinement

From some of the discussions in chapter 5 it is apparent that there were major differences in the expectations of the women regarding the management of pregnancy. These differences in expectation often caused conflicts in the minds of the women who faced on the one hand pressure from their own communities to conform to cultural expectations and on the other hand external pressure from the host community to adopt western attitudes to childbirth.

Although some, in particular Gujarati women had adopted western attitudes to childbirth, they were not entirely able to ignore the influential role played by their older female relatives (see chapter 5). In the case of Bangladeshi women the 'purdah' restrictions and communication difficulties ensured that the women retained their cultural identity: they had fewer opportunities to become accustomed to western attitudes to childbirth. The only occasion when cultural traditions of the women played a lesser role was at the time of birth when the women had to accept the rigid hospital policy governing the management of childbirth.

In this chapter I am going to focus on the postnatal period immediately after delivery to look at the issues surrounding hospital and home confinements. I am especially interested to see whether there were any significant cultural differences in the approach to provision of care for mothers and new born babies. If the cultural expectations of the women were significantly different, were their expectations fulfilled? In this connection I am going to confine my discussions to the experiences of the women whilst they were confined to the hospital paying particular attention to their expectations of the nursing staff regarding infant and personal care.

In addition to nursing care I am going to focus on the observation of dietary and ceremonial rituals in the hospital and after discharge from the hospital. I am also interested in the role of older female relatives after childbirth, particularly as some of these women had played an influential role right upto the time of admission into the hospital.

Hospital confinement

After childbirth it is customary practice to confine the mother and her baby to the postnatal ward of the maternity hospital for a number of days. The length of confinement in the postnatal ward can vary from just a few hours after delivery with the 'Domino' service in health districts where such a service is available, to between two to five days for normal delivery where such a service is not available. In the case of Caesarean sections, women are confined to the hospital for about ten days. During pregnancy women can decide how long they wish to stay in the hospital after the delivery. Many women these days choose to go home after two days because they find the hospital routine too rigid and not conducive to rest. The recent NHS budget cuts has not resulted in the reduction of hospital births. Instead many hospitals have adopted a policy of early discharge as the number of maternity beds have been reduced.

About a quarter of the women, who had Caesarean sections (3 Bangladeshi and 1 Gujarati) including women (3 Bangladeshi women) whose babies were admitted into a special care baby unit, spent more than ten days in the postnatal ward ( see Chapter 7 page 174 ). Of the remainder most women spent on average between three to five days and a few were discharged within 24 hours of birth. In this section I am going to look at the women's experience of postnatal confinement with particular regard to nursing care and dietary requirements of mothers in the postnatal ward.

Since hospital confinement after childbirth was a new experience for many women and in particular Bangladeshi women many of whom were having their baby in a hospital for the first time, it is important to take into account their traditional practices of postnatal care. In other words some of these women would be judging their postnatal experience in the light of the care they were familiar with or had first hand experience of, whilst trying to come to terms with the western concept of postnatal care. The following account given by a Bangladeshi social worker gives a typical example of events following a home birth in Bangladesh and the six weeks or '40 days' convalescent period.

"As soon as the baby and the afterbirth have been delivered the 'dai' (village midwife) or one of the female relatives cuts the cord. The baby is given a bath straight away so that a male member of the family can perform a prayer ceremony called 'azan'. This is a very important ceremony for Muslim people because the first words a baby hears is that of 'Allah' to confirm that the baby is born

of Muslim parents. The mother meanwhile is carried to the bathroom and given a complete wash by her mother or her mother-in-law. If a mother is weak the bath is delayed for a couple of hours. In the first hours of baby's birth, the baby is given a little water sweetened with honey and the baby is breastfed after the mother has had her bath. For the duration of 40 days after delivery the mother and her baby are isolated because the mother is considered 'unclean' whilst she is producing discharge. The mother is confined to the bed for about ten days and within her house for 40 days. During this period she is not expected to do anything except feed her baby. For the first few weeks a new mother is given a special diet of fish and rice. Certain types of oily fish and meat, especially beef, are not given to the mother." (Bangladeshi Social Worker)

Although many Gujarati women of childbearing age are not familiar with home births, they share similar beliefs and customs after childbirth with Bangladeshi women with regard to dietary restrictions, ceremonial rituals and the 40 days confinement after childbirth. Although many Gujarati women in my sample had adopted western attitudes towards childbirth, they were nevertheless required to observe the ceremonial rituals and dietary customs after childbirth. This was particularly so with those women who were living with their in-laws. I have already discussed the role played by the older female relatives in safeguarding the traditional rituals in pregnancy which the older female relatives had to observe in their time (see chapter 5 page 127-129 ). The only time the older female relatives lose their influence over a young mother is during birth because it takes place outside their jurisdiction i.e. in the hospital. However, as soon as the birth is over, they re-establish their influence and ensure that dietary and ceremonial rituals are observed according to their family customs.

In Britain, the treatment of pregnancy, childbirth and puerperium places greater emphasis on the role of medicine and medical experts. This pathological treatment of pregnancy and childbirth encourages pregnant women to adopt a sick role right upto the time of birth. However after birth it appears that the women lose their sick role status because greater emphasis is placed on getting mothers on their feet again quickly. Although there are good reasons for encouraging women to make a speedy recovery and take responsibility for the care of their babies, the sudden change in attitude towards them often does not take into account the fact that individual women take different lengths of time to overcome the after effects of drugs used in labour or any surgical procedures they may have undergone. In contrast in traditional Asian societies the final act of birth does not signal the end of

the special status the pregnant women had enjoyed. Instead they continue to receive personal care from their female relatives in the first few weeks after birth.

Nursing care after birth

When the women in my sample were asked about their experience of nursing care they had received in the hospital, a majority of the women appeared to have had positive experiences whilst a few, mostly Gujarati women, were dissatisfied with the care they had received. The women's responses are set out in Table 8A.

Table 8A: Experience of Nursing Care

	Positive	Negative	No Response	Total No Women
B	8	1	3	12
G	8	6	1	15
-----				
	16	7	4	27

The positive response given by about two thirds of the Bangladeshi women indicated that they were pleased with the care they had received in the hospital. Their typical comment was:

"It was fine. The nurses and doctors were very cooperative."

In contrast the views of the Gujarati women were equally divided by one half who were satisfied with the care they had received and the other half who were upset by the treatment they had received. On the whole the comments made by the the Gujarati and Bangladeshi women, seem to suggest that the women did not wish to appear ungrateful to the nursing staff, although some mothers were not entirely satisfied with the care they had received as this comment by a Gujarati mother suggests:

" I had to write comments to describe how I felt about giving birth in my local hospital. I filled in the questionnaire stating my bad treatment but in the end I tore it up. I couldn't hand it in because I had given birth to my son in this hospital"

(Gujarati Mother Second Pregnancy)

Unfortunately, the Bangladeshi women's comments regarding their experience of hospital confinement were too brief to give a clear indication of how they really felt. It is possible that language difficulties may have inhibited many of them from questioning the care they received. Since communication is a two way process, the communication



difficulties experienced by the nursing staff may have prevented them from providing nursing care which was sensitive to the women's needs. It would appear that the language barrier and different cultural expectations were root causes of the misunderstanding and frustration experienced by many mothers. The issues which appeared to cause the greatest amount of conflict were the role of the nursing staff in the postnatal ward and the hospital policy regarding rehabilitation of mothers after the birth. The interviews with the hospital interpreter and the community social worker revealed that many Bangladeshi women expected the nursing staff to provide traditional support similar to that provided by their female relatives:

"In Bangladesh a newly delivered mother is surrounded by her female relatives who would look after the baby and at night time take the baby away from the mother so that the mother could get a good night's rest. In this country very few women get this sort of support, especially in a hospital. Some Bangladeshi women expect same sort of support from the nurses. They feel that the nurses are there to look after the baby whereas the nurses feel their role is to support mothers so that they in turn can look after their own babies. Perhaps this happens because the mothers do not understand the professional status of the nurses and their role in the hospital. Some women believe that the nurses are there to see to the needs of the baby i.e. change nappies, bath and comfort the baby whilst they are resting." (Bangladeshi Community Social Worker)

The other difficulties which were often encountered by the mothers was different cultural practices of postpartum care. For instance, women who expected to have complete bed rest in the first few days after delivery found the hospital practise of getting a mother back on her feet within a few hours of birth unacceptable. Although there are good reasons for encouraging women to become mobile, those women who were not aware of this practice found it very difficult to understand why the nurses insisted that they should visit the bathroom within six hours of delivery. The mothers reluctance to get out of bed was often misunderstood by the nursing staff:

"Many Bangladeshi women feel that the nurses are very unfeeling towards them because they are forced to get up when they are feeling very weak. The nurses think that the Bangladeshi women are lazy and dirty as they are slow to get up and use the bathroom. In Bangladesh a newly delivered mother is not expected to get up immediately; instead her female relatives will carry her to the bathroom and give her a complete wash."  
(Bangladeshi Interpreter)

Although a majority of the women were happy with the care they had received, a number of Gujarati women were clearly dissatisfied with their care. One of their commonest complaints was that they could not understand why they were paid less attention once the delivery was over. Their experience after the delivery seems to suggest that they were not only having to come to terms with the feeling of anticlimax at the end of delivery but they also felt that they became less important in the eyes of the nursing staff. A Gujarati mother who had a traumatic delivery explained:

"I was attended to by two doctors, a midwife and a paediatrician before my son was born but once the delivery was over I had to wait a long time before my cut was stitched up...After I was stitched up I was left unattended for four hours in the labour ward. No-one seemed to be bothered about me. I was finally taken to the postnatal ward. By this time I was really starving as I had not eaten for two days. I asked for some sandwiches but they never materialised. I was feeling very weak and faint from lack of food and I felt very neglected as if no-one cared for me." ( Gujarati Mother First Pregnancy)

Another Gujarati mother who had a similar experience felt that the cuts in the services were partly to blame for the poor nursing care she had received in the hospital:

"I found the care in the postnatal ward was inadequate because of a shortage of staff. I was left unattended for sometime after I was transferred from the labour ward. I was in a lot of pain from the bruising caused by a number of unsuccessful attempts the junior doctor had made to apply the forceps. I felt too weak to go to the bathroom but no-one came to help me. The first time I called for an assistant to go to the bathroom I was told off for ringing the bell. My stitches were extremely painful. The midwife promised to bring some ice to reduce the swelling and again I had to wait a long time for it. When a nurse finally brought the ice for me she didn't explain how I should use it. As I had never used ice before I just sat there wondering what to do because I was afraid of wetting the bed. I was told not to ring the bell for assistance because they were short of staff. In fact they used to remove the emergency bell at night. Because of my stitches I could not feed my baby sitting on a chair. I was told off for feeding him in the bed. I often had to feed my son standing up. I stayed in the hospital for five days thinking I will get more help than at home. The attitude of the staff was that second time mums have previous experience so they just expect you to get on with it but I

was in so much pain I needed more help." (Gujarati Mother Second Pregnancy)

Many women found it difficult to adjust to the well person's role which they were expected to adopt in the postnatal ward especially as they had been led to believe that pregnancy and childbirth were medical conditions. Women who had surgical intervention, like episiotomy or Caesarean section, felt that the nursing staff did not appreciate how much pain they were really experiencing. Some women felt that they were made to feel guilty for occupying a hospital bed when all they had done was give birth and were certainly not sick. Although a shortage of staff was a contributory factor, some women felt that the zeal with which some nurses set about getting mothers back on their feet did not give due consideration to their vulnerability in the postpartum period. A Gujarati mother who had undergone emergency Caesarean section was very upset with the unsympathetic attitude of the nursing staff:

"I did not enjoy my stay in the hospital. At the moment I feel I will never go back to that hospital again. I found it was difficult to manage with my stitches and yet I was expected to get on and do everything myself. Some of the nurses were very rude as well. Because I had a Caesarean section I was finding it difficult to walk back and forth to the special care unit to see my daughter. My stitches were so painful I found it difficult to wheel the breast-pump to my room and yet no-one helped me. In the morning, if I was resting, the nurses would make rude comments like 'Are you still sleeping' as if I was too lazy to get out of bed. I was originally booked in for just two days but as I had a Caesarean section I was not discharged for eleven days." (Gujarati Mother First Pregnancy)

### Summary

It would seem that women, whose perception of postnatal care was determined by their cultural values, were confronted with concepts of care which in many respects were unlike anything they had experienced before. This clash of cultural expectations becomes more obvious at the time of hospital confinement after childbirth as the women come to the hospital with one set of expectations of the care providers while the care providers attach a different set of values to postnatal care.

### Diet after Childbirth

Besides having to accept a western model of nursing care, for many Gujarati and Bangladeshi women hospital confinement after childbirth also meant having to accept the kind of food more suited to a western palate. Asian

women have differing dietary needs which are strongly influenced by their religious beliefs. Gujarati women, of the Hindu faith believe in the sacredness of all living creatures and are normally lacto-vegetarian. Even those who are not strictly vegetarian are most unlikely to eat beef. Bangladeshi women of the Islamic faith, on the other hand, are non-vegetarian but can only eat meat which has been rendered 'halal' and in any event are prohibited from eating pork. Food, the preparation of which includes animal fat or prepared food which comes into contact with a prohibited food item, would be unacceptable to orthodox Hindu or Muslim women ( see Chapter 5, page 123 for a more detailed discussion of the dietary habits of the women in my study).

Besides the influence of religious beliefs, there was an additional factor which determined the dietary needs of women in the postpartum period. This was their belief in the concept of 'hot' and 'cold' foods i.e. certain foods are considered 'cold' because they have a cooling effect on the body and other foods have special properties which raise the temperament. The classification of foods into hot and cold qualities is not according to the temperature of the food or the taste, but the effect produced within the body. 'Hot' foods tend to be high in animal protein, salt and certain spices e.g. meat, eggs, aubergine, ginger and dates. 'Cold' foods are sweet, bitter, sour or astringent e.g. milk products, cereals, fruits and leafy vegetables.

The degree of acceptability of food offered to either an invalid or to a woman during pregnancy and after childbirth depends on the 'hot' or 'cold' state of a person - the 'hot' and 'cold' state has nothing to do with the temperature of the body. According to this belief, a pregnancy constitutes a 'hot' state and period after childbirth constitutes a 'cold' state. The fine balance of bodily humours is maintained by dietary control i.e. during pregnancy 'cold' foods are recommended and after childbirth 'hot' foods are recommended (see Chapter 5 page 127 for a more detailed discussion on the dietary restrictions during pregnancy)

The traditional Asian diet after childbirth constituted on the principle of 'cold' state consisted of milk products, cereals, leafy vegetables and a special sweetmeat which the Gujarati women called 'katloo' and Bangladeshi women referred to as 'kalo jeera barta' ( Homans 1983). This sweetmeat is especially prepared in honour of the mother and is highly nutritious containing wholemeal wheat flour, nuts, a mixture of thirty-two different spices and sugar. Some of the spices in the sweetmeat are believed to have special properties to help strengthen the pelvic joints and speed up the involution of the womb while nuts

provide much needed protein for both mother and her baby. The high content of fibres in the diet also help to prevent constipation. In addition a drink made with an infusion of herbs such as dill seeds is given to the mother to cleanse her system and to increase milk supply. (Henley & Clayton 1982).

For many Asian women and their female relatives traditional diets in the postpartum period were important to aid recovery of a mother after childbirth and also for establishment of lactation. During pregnancy, while the women remained within their own communities, the traditional diets were easy to observe because their implementation did not involve anyone except the immediate family. However the implementation of special dietary regimes after childbirth not only required the approval but also the appreciation of the host community as to the value of such dietary beliefs in the postpartum period. Although the relevance of the traditional diet after childbirth may be lost to some of the present generation of Asian women of childbearing age, older women, who see themselves as the guardians of their cultural traditions, feel dutybound to ensure that their daughters and daughters-in-law follow the dietary advice. Apart from doing their duty, the advisory role of the older female relatives give them an opportunity of exercising their authority over younger women by virtue of their age and past experience.

Whilst, many hospitals in Britain have realised the importance of providing the kind of food which would be acceptable to patients with different dietary requirements, not all hospitals provide an adequate choice on the menu. All the Bangladeshi women, in my Camden sample gave birth at the University College Hospital. According to the accounts given by these women at this hospital there was no provision of 'halal' meat on the menu but vegetarian meals were labelled as 'halal' although the meals did not contain any meat. The Bangladeshi women were not discouraged from receiving food from home if they found hospital food unpalatable or unacceptable on religious grounds. However, women who had to rely on their husbands to bring food from home often had to wait a long time because many husbands could not take time off work in the middle of the day or because they had responsibilities of other children at home.

Gujarati women in my Harrow sample all gave birth at Northwick Park Hospital where the women had a choice of Indian style vegetarian meals at midday. The hospital operated a strict policy which discouraged maternity patients from receiving food from home because the needs of the vegetarian Gujarati women were catered for on the hospital menu.

Since the average length of time the Bangladeshi and Gujarati women spent in the hospital was three to five days, and in a few cases extending to two or three weeks, their dietary needs also affected the quality of care they received in the hospital. In addition, it is generally believed that good nutrition after childbirth is very important for a mother to regain her strength and to establish successful breastfeeding. (NCT 1985 :243). Given that diet after childbirth is very important, the women were asked to give details of the types of food they had eaten during their stay in the hospital and whether the hospital meals were satisfactory. In table 8B(i) I have set out the types of foods the women had during their hospital confinement.

Table 8B(i): Types of Foods Eaten In the Hospital  
(multiple responses)

	Indian Vege no eggs or cheese	Vege eggs+ cheese	Non- vege	Food from Home	Food from Home Only	Total No Women
B	8	-	-	5	4	12
G	15	5	3	8	-	15
	23	5	3	13	4	27

It is interesting to note that two thirds of the Bangladeshi women who accepted hospital meals ate Indian vegetarian food as non-vegetarian 'halal' food was not provided on the menu. Since Bangladeshi women were not prevented from receiving food from home about half the women who accepted some hospital meals also augmented their diet with food brought from home.

"I used to eat green salads and puddings like semolina or rice and my husband used to bring rice and fish curry from home." ( Bangladeshi Mother Fifth pregnancy)

About a third of Bangladeshi women did not eat any hospital food except for breakfast. Most of these women were orthodox Muslim and were concerned about eating even hospital vegetarian food because they believed that in a hospital kitchen, contamination with 'non-halal' food would be unavoidable.

"I am a devout Muslim and because my religion does not allow me to eat certain things I am not happy to eat hospital food. I am not sure how it is possible for a hospital to cook for so many patients and keep food separate for Muslim patients. I was not happy to eat

hospital food so my husband used to bring food from home everyday." ( Bangladeshi Mother First Pregnancy)

Almost all Gujarati women had some Indian vegetarian meals which were on the menu each day and about half the women who were not observing a strict vegetarian diet were able to choose 'English' vegetarian food containing eggs or cheese. A few were happy to eat non-vegetarian food. Although the local maternity hospital did not permit patients to receive food from home, it appears that about half the Gujarati women supplemented their diet with home cooked food which was smuggled in by their relatives. The home cooked food consisted of 'Katloo', seero (Indian semolina pudding) and a herbal drink made with aniseeds or dill seeds. Gujarati women who were living with their in-laws were more likely to receive traditional food from home because many mothers-in-law and mothers strongly believed that the traditional diet was essential after childbirth to speed recovery. Some female relatives were really put out because they were not able to care for their family member in the traditional way. One Gujarati mother explained:

"I didn't like the hospital food at all. I didn't enjoy the vegetarian or the non-vegetarian meals. I couldn't receive food from home. My mother-in-law was annoyed because she could not bring the traditional food which she felt I should be eating after childbirth. The other Indian ladies in my ward used to receive food from home and eat it secretly behind the drawn curtains. I wasn't prepared to do that. The only thing I was able to have was 'rab' (thick liquid food made from wholemeal flour, spices and jaggery).  
(Gujarati Mother First Pregnancy)

Although some relatives reluctantly accepted the ban on home cooked food, other women and their relatives were prepared to defy the hospital rules because they had a strong belief in the beneficial effects of traditional foods. One such mother explained how she got round the hospital rule:

"The food in the hospital has not improved at all since I had my first baby three years ago. They tend to give you a lot of potatoes which I believe are not good for you in the early days after delivery. The rice and curry were all mixed up and it didn't look very appetising. I used to receive food from home although it was strictly forbidden. My mother-in-law used to bring food at visiting time and while I was surrounded by my family, I used to eat the food then because the nurses did not come to check during visiting hour." (Gujarati Mother Second Pregnancy)

Whilst some women managed to avoid being detected eating

food brought from home, those women who were either found eating home cooked food or those whose relatives requested permission to bring food were reminded about the hospital policy. To discourage relatives from bringing food from home some mothers were told that home cooked food was banned because it brings infection into the hospital. Gujarati women who were told that their home cooked food caused infection were deeply offended as this comment suggests:

"I found the hospital food unappetising. My husband brought some food from home which my sister-in-law had cooked. When the nurse saw me eating the food he had brought she told him off. She told my husband that I would suffer from stomach pain because I was eating food brought from home. She made me feel that our food was bad. What made it worse for me was that I was confined in the hospital for nearly two weeks."

( Gujarati Mother First Pregnancy)

Another mother whose relative had tried to obtain permission to bring food was given a similar reason to stop her from bringing food:

"My sister-in-law wanted to bring some food for me because I was feeling very weak after the delivery. When she went to get permission from the ward sister she was told that patients were not allowed to eat any food brought from home because it could spread infection in the hospital." ( Gujarati Mother Third Pregnancy)

It would seem that, although the hospital management were very keen to provide Indian vegetarian food for Gujarati women, they were not prepared to entertain any flexibility in their catering policy which would recognise the deeply held belief in the nutritional and healing qualities of traditional foods amongst the Gujarati community in Harrow.

Since the two hospitals where the women in my sample were confined after delivery had made some provision for the dietary needs of Asian women, women who had eaten some hospital meals were invited to give their opinion. Their responses are recorded in Table 8B(ii).

Table 8B(ii):Opinion of Hospital Food  
(Numbers)

	Good	Tolerable	Not Satisfactory	Total No Women
B	3	2	3	8*
G	5	4	6	15
<hr/>				
	8	7	9	23

\* Bangladeshi women who avoided all meals except breakfast



were excluded.

From Table 8B(ii) it would seem that the opinion of the women was evenly divided between those who were happy with what they ate, those who were not pleased and those who found the meals were tolerable. About a third of the Gujarati women who were non-vegetarian said that they enjoyed the hospital food because they were able to choose vegetarian and non-vegetarian meals and therefore had more varied meals. A few Bangladeshi and Gujarati women also found the hospital food quite acceptable because they preferred to eat vegetarian food after childbirth. Their typical comments were:

"I must say I enjoyed the hospital food because I was always hungry. It was also nice to be able to eat food which I had not cooked myself and besides I was able to choose different food; sometimes I had English food and sometimes I had vegetarian food."  
( Gujarati Mother Second Pregnancy)

"At the hospital the nurse used to give vegetable curry and rice and sometimes I used to eat just salad and pudding if they were made without animal fat. I was happy to eat hospital food. It is good to eat vegetarian food because meat is too 'hot' after childbirth"  
( Bangladeshi Mother Sixth Pregnancy)

Some women made most of what was available on the menu and did not expect hospital food to taste like home cooked food:

"The hospital food was so so, I just managed to eat something. My mother-in-law was not prepared to bring food from home because she didn't want to be told off by the staff. I am a vegetarian and their vegetarian meals were not like what we have at home but they were not too bad."  
( Gujarati Mother First Pregnancy)

Women who found the hospital food unsatisfactory complained mostly about the size of portions which were often too small to sustain a mother who was trying to establish breastfeeding:

"I thought the hospital food was terrible! Again because of cut backs, the portions were very small, not enough for a breast-feeding mother. I did not feel satisfied with what I had. They also did not present the meals with any imagination, sometimes we were served the same bean curry for lunch and supper. I was not keen to eat too much beans because it causes indigestion. I used to rely on the food which my mother brought from home."  
( Gujarati Mother Second Pregnancy)

Other women found that although they were issued menus in advance and asked to select their meals, many felt this was just a paper exercise because the system did not work out in practice:

"Things have got much worse due to NHS cuts and this is why I think the food was so awful. The system of ordering meals in advance did not seem to work well for a mother admitted for short stay. As I am a vegetarian it made it difficult to get decent meals. I only had three meals and each time the staff had to search for a vegetarian meal and often I was kept waiting before they could find something for me. By the time the food was brought to me it was cold. It was very irritating but I had no choice as I was starving. My husband was very angry and wanted to complain but I felt it was not worth it."  
( Gujarati Mother Second Pregnancy)

Bangladeshi women, on the other hand, were mostly concerned about the lack of proper 'halal' meals on the hospital menu. Women who were concerned about eating food which was not prepared according to their religious belief had to rely on their relatives to bring food from home. As a result some of these women had to wait until late afternoon before they could eat a proper meal. The problem of food was a real cause of concern for women who were detained in the hospital for more than a week:

"The nurse gave me bread and milk but I do not like the milk in this country so I have tea. My husband used to bring food for me after he had collected my other children from school. He works at night so it is not easy for him to do everything. (Bangladeshi Mother Sixth Pregnancy)

#### Diet after discharge from hospital

It would seem that the belief in the value of traditional diet was quite strong amongst the Gujarati community in Harrow as almost all the Gujarati women were offered traditional foods after they were discharged from the hospital. A Gujarati mother who had a strong belief in the value of traditional foods explained:

" I have been having traditional food since the birth of my baby. My mother-in-law used to smuggle food into hospital. After I came home my mother-in-law cooked separate food for me for four more weeks. My mother also brought some 'katloo' for me. I feel it is important to eat our traditional foods because it helps with recovery. I am now eating the same food as the rest of the family but I still avoid heavy pulses such as beans which would give

colic to my baby." ( Gujarati Mother First Pregnancy)

However, not all Gujarati women felt it was necessary to eat the traditional foods after childbirth and sometimes even their husbands were sceptical about the value of traditional foods:

"My sister cooked the traditional food which I ate for a couple of days only because I don't like food cooked in ghee (butter). My mother was annoyed when she found out that I wasn't eating the right type of food. She told me that I was storing up trouble for myself in my later life because she thinks that I would suffer from aches and pains. Personally I don't believe in it."  
( Gujarati Mother Fourth Pregnancy)

"For a few days after I came home from hospital my mother-in-law cooked traditional food for me. My husband did not believe in this. He felt that English women do not eat this food and they don't suffer from a lack of it. My mother-in-law stopped cooking separate food because of my husband's objection but I still ate the 'katloo' and drank dill water." ( Gujarati Mother Second Pregnancy)

After the Bangladeshi women were discharged from the hospital they did not mention any special diet except many women were avoiding meat especially beef which they considered to be 'hot' and not recommended after childbirth:

"For a couple of weeks after I came home I did not eat any meat or any spicy food but instead I ate more fish and vegetables." ( Bangladeshi Mother Seventh Pregnancy)

Although a special diet was also believed to be necessary after childbirth, very few Bangladeshi women had their mothers or mothers-in-law living in this country to prepare special food for them.

### Summary

The Gujarati and Bangladeshi women came from cultures where dietary patterns were determined by religious beliefs as well as beliefs in the value of a specially formulated diet based on the concept of 'hot' and 'cold' foods. The beneficial effects of this special diet was particularly relevant during pregnancy and childbirth.

For many of the women hospitalisation after childbirth involved having to accept hospital food which clashed with their religious beliefs or their belief in the value of a diet based on the concept of 'hot' and 'cold' food.

Although, both hospitals attempted to cater for the dietary needs of Asian women, it would appear that the needs of many women were clearly not met. This appears partly due to a lack of consultation between the hospital and the local Asian communities and partly because one hospital operated a policy to discourage women from receiving food from home. It became apparent that a hospital policy restricting women from receiving food was not easy to implement because the hospital did not take into account the special significance the women attached to the traditional diet after childbirth. At the same time, whilst hospital policy which encouraged Asian women to bring food from home was to be commended, it nevertheless has to be recognised that the hospital had failed to meet its obligations to provide culturally appropriate meals for its large number of Muslim patients.

For Asian and, in particular Gujarati women, the traditional diet after childbirth seemed to play a dual purpose. The diet was used both as a part of the healing mechanism after childbirth and, for the relatives, the provision of such a diet was an essential part of a ritual which they were expected to fulfil to show a mark of their respect and affection for a member of their family who had just given birth.

#### Care of Baby- Choice of Feeding Method

For a period, breastfeeding waned in popularity but, since the health profession and mothers have come to recognise the benefits offered by breastmilk, breastfeeding is enjoying a renaissance. Although many more mothers in Britain start with breastmilk, the number of women who solely breastfeed their babies declines sharply four weeks after birth. (Stanway 1982). The increase in bottlefeeding also sets up an adverse trend for weaning; for instance a study of infant feeding across cultures showed that indigenous mothers had a tendency to wean babies early whilst Asian mothers delayed weaning (Marks 1979). A consequence of the late weaning practice is that it could interfere with the acceptance of traditional family food (Harfouche 1970)

Do British Asian women follow present trends towards infant feeding i.e. has there been a change in their attitudes towards infant feeding after coming to Britain? What other factors influence their choice of feeding methods?

Traditionally, most women on the Indian subcontinent breastfeed their babies. However the present generation of childbearing women have grown up in an age when

bottlefeeding is actively promoted as a credible alternative to breastmilk in the west and, particularly, in the under-developed countries. Before powdered baby milk became available pregnant women did not have to consider how they should feed their baby and in many under-developed countries where women cannot afford to buy formula milk this is still the case. In this section, I am going to focus on infant feeding practices amongst the Gujarati and Bangladeshi women in my sample. In Britain, pregnant women use a number of sources to obtain information about infant feeding before making their decision. These sources are antenatal classes, printed literature and female friends and relatives and also knowledge based on previous experience of feeding other children. I was especially interested in finding out whether there were any major differences in the choice of feeding methods between Bangladeshi and Gujarati women and secondly, whether the women stuck to their chosen method after birth? The women's intentions regarding method of feeding are recorded in Table 8C(i).

Table 8C(i): Intentions During Pregnancy

	Breastfeed Only	Breast+ Bottle	Bottle Only	Not Decided	Total No Women
B	5	7	0	0	12
G	12	0	2	1	15
-----					
	17	7	2	1	27

From Table 8C(i) it is apparent that almost half the women from my total sample had intended to only breastfeed, and about a third of the women intended to supplement breastmilk with powdered baby milk and of the rest two women had planned to bottlefeed and one was undecided. It is interesting to note that, with the exception of three Gujarati women, the rest had planned to solely breastfeed in contrast two thirds of the Bangladeshi women who although favouring breastmilk still intended to give their baby powdered baby milk. In fact only a very small number had decided in favour of breastmilk. This change in attitude towards breastfeeding is ironic given that the Bangladeshi women from a traditional society from rural districts of Sylhet where they would normally breastfeed, are preferring to bottlefeed when they come to Britain. However, the reasons for Bangladeshi women to prefer bottlefeed appear to be more complex. A Bangladeshi interpreter explained that some women come from Bangladesh already convinced about the advantage of artificial baby milk:

"The promotion of artificial baby milk has led many women in Bangladesh to think that supplementary bottle feeds are necessary. Although this practice is found amongst the well-off section of society it is nonetheless responsible for planting the idea in the minds of women that breastmilk alone is not sufficient for a growing baby. For Bangladeshi women who have already accepted the idea of supplementary feeds before they arrived in Britain, it is relatively easy to adopt bottlefeeding because artificial baby milk is readily available in this country."  
(Bangladeshi Community Interpreter in Camden)

When the women were asked to give reasons for their preference for breast and bottle feeding their typical comments were:

"I am going to breastfeed my baby but I am also going to give some baby milk because I want my baby to get used to taking milk from the bottle."  
(Bangladeshi Mother Sixth Pregnancy)

Apart from the anxiety concerning insufficient breast-milk, some women also experienced peer group pressure to introduce supplementary powdered milk:

"My aunt had all her children in this country and she told me that bottle feeding is easier than breastfeeding because you can easily tell how much milk a baby has taken. I am going to give breastmilk and powdered milk- that way, my baby has both."  
( Bangladeshi Mother First Pregnancy)

The change in attitude towards breastfeeding was also apparent amongst Bangladeshi women who had solely breastfed other children in Bangladesh. Six out of eight multipara women who had solely breastfed their other babies for three to four months had planned to use powdered baby milk this time:

"In my country, I did not give tinned milk to my other children. When I came to this country my sister-in-law and my neighbour told me that it is important to get the baby used to bottle early because when the breastmilk is not enough the baby will accept milk from the bottle without difficulty." ( Bangladeshi Mother Fifth Pregnancy)

On the other hand, the explanation for the expressed desire of a majority of Gujarati women to breastfeed their baby may lay in the current favourable trend within British culture towards breastfeeding. It seemed that Gujarati women who were able to gather information about infant feeding by attending classes or through the mass media were

favourably inclined towards breastfeeding:

"I would like to breastfeed if I can. After I heard the parentcraft teacher talk about the advantages of breastmilk I thought I would have a go. I found out as much as I can from reading magazines and books before I decided in favour of breastfeeding."

(Gujarati Mother First Pregnancy)

The positive image of breastfeeding was further reflected in the attitude of almost all multipara women who were planning to breastfeed their second or third baby. The decision of the remaining multipara Gujarati women who had planned to bottlefeed appeared to reflect their ambiguous attitude towards their pregnancy. One of these women, who had breastfed her other children, seemed to want to distance herself from any attachment to her unborn child:

"I breastfed my last two babies. This time I am going to bottle feed. I just can't see myself breastfeeding this time somehow. I don't know - the whole pregnancy has been wrong somehow. We hadn't planned it and I had even thought of terminating it. Now I am worried about the medicine I had taken in the early pregnancy. I feel just numb about everything." (Gujarati Mother Third Pregnancy)

Although Bangladeshi women were favourably inclined towards breastfeeding as demonstrated by their intention to combine breast and bottlefeeding, the fact that so few Bangladeshi women stated that they would solely breastfeed suggests that Bangladeshi women's attitude towards breastfeeding were not receiving positive endorsement from sources which promote breastfeeding in Britain. The Gujarati women's positive attitude towards breastfeeding could be attributed to the knowledge they had gained about breastfeeding from preparation classes and from the mass media whereas, for many Bangladeshi women, information which might have encouraged them to continue with their traditional practice of breastfeeding was inaccessible (see chapter 6 page 147)

In the follow up interviews, which took place between four and six weeks after birth, the women were asked how they were feeding their baby. The women's responses are set out in Table 8C(ii). Table 8C(i) is repeated to compare the women's original intention and the method of feeding adopted after the baby was born.

Table 8C(i): Intentions During Pregnancy

	Breastfeed Only	Breast+ Bottle	Bottle Only	Not Decided	Total No Women
B	5	7	0	0	12
G	12	0	2	1	15
	17	7	2	1	27

Table 8C(ii): Feeding Practices Between Four and Six Weeks After Birth

	Breastmilk Only	Breast+ Bottle	Bottle Only	Total No Women
B	1	8	3	12
G	8	5	2	15
	9	13	5	27

From Table 8C(ii) it is apparent that feeding practices after four weeks of birth seemed to present a different picture from what the women had planned. Four weeks after birth, the number of women who breastfed only had dropped from about half to a third. However, the number of women who had planned to combine breastfeeding with powdered baby milk increased from about a third to almost half and number of women who were only using powdered baby milk increased from two to five women [see Table 8C(i)]. The number of Gujarati women who were planning to breastfeed only decreased to about half as the number of women who were partially breastfeeding at four weeks went up by a third and the number of Gujarati women who had planned to bottlefeed remained the same. Interestingly one of these women who had planned to bottlefeed changed her mind after the birth of her son:

"When he was born I didn't feel anything, just relieved that it was all over. He was born under the effects of pethidine so he just slept and didn't even cry. I was a bit worried. I had decided to bottlefeed him but then I changed my mind and decided to breastfeed him."  
(Gujarati Mother Third Pregnancy)

When the feeding practices of Bangladeshi women were compared, there was a worrying trend towards an increase in bottlefeeding as the number of women who had planned to breastfeed dropped to just one. However, the number of women who were complementing their breastmilk with powdered baby milk remained the same. On closer examination of the



data it would seem that the increase in bottlefeeding followed a set pattern i.e. with the exception of two mothers, women who had planned to solely breast-feed, continued breastfeeding but only partially whereas out of the women who had planned to combine breast and bottlefeeding, two out of five gave up breastfeeding.

Since none of the women expressed any doubt about their ability to breastfeed before birth it would seem that the decline in breastfeeding was perhaps linked to other factors. Although there are women who cannot breastfeed for a number of reasons, other factors in the first few days after birth can effectively undermine any attempt to establish successful breastfeeding. Some of these factors are separation of mother and baby after birth, slow recovery of the mother after delivery especially if surgical interventions and drugs were used in labour. The following comment from a Gujarati mother suggests that a woman whose baby is admitted in the neonatal unit may need extra help with breastfeeding:

"I had planned to breastfeed my baby but because I had a Caesarean section and my baby was admitted to the baby unit I found it difficult to establish breastfeeding. I was told to express my milk with a breastpump which I had to wheel from another room. I found it difficult to wheel the pump because of my painful stitches but no one was prepared to help. The other problem was that I was given so much conflicting advice about feeding from different members of the staff I used to get quite confused."  
(Gujarati Mother First Pregnancy)

In addition, difficulties can arise with breastfeeding if adequate support is not available especially if the women come from cultures where breastfeeding support is traditionally provided by experienced older female relatives:

"I wanted to breastfeed in the beginning but unfortunately it did not work out. I found it difficult to feed the baby but I could not ask for help because I felt embarrassed to ask anyone. I then decided to bottlefeed"  
(Bangladeshi Mother First Pregnancy)

Although these factors could equally apply to indigenous British women, Asian women encounter special difficulties because of the language barrier, different dietary requirements, unfamiliarity with hospital routines and the customary practice of delaying breastfeeding initially to avoid feeding colostrum to the baby. Although not all Asian women believe that colostrum is harmful, the influence of some older female relatives may prove too strong to resist as this comment by a Bangladeshi interpreter suggests:

"Some mothers-in-law believe that a baby should not be fed on the colostrum. They believe colostrum is dirty because it is associated with labour. On one occasion a mother had expressed some colostrum for her baby who was in the baby unit. When her mother-in-law came to visit she was so outraged, she emptied the expressed colostrum down the sink."

(Bangladeshi Interpreter at University College Hospital)

The belief concerning colostrum is often misunderstood by nursing staff as a result of which women who appear to be uninterested in breastfeeding initially are often not given any encouragement when they are ready to start breastfeeding:

"Another problem faced by some Bangladeshi women is establishing breastfeeding. Just because a few women are reluctant to feed baby colostrum, it is assumed by the hospital staff as it is a common practice and even those women who have no such reservation are denied support. A small minority of women consider colostrum to be actually bad for the baby, some women believe that it is not good enough for the baby because it looks watery."

(Bangladeshi Community Social Worker)

This problem it would seem is compounded by language difficulties and a lack of understanding by the nursing staff about different cultural practices surrounding infant feeding.

### Summary

From the number of women who had planned to breastfeed including those who were going to supplement breastmilk with artificial baby milk, it was apparent that Bangladeshi and Gujarati women were keen to breastfeed their babies. It was also apparent that antenatal preparation for breastfeeding offered an additional inducement for women to take up breastfeeding especially amongst Gujarati mothers. Unfortunately, because the majority of Bangladeshi women had poor access to information through classes and the mass media they were not able to make use of current thinking on infant feeding which promotes breastfeeding. As a result their traditional practice of breastfeeding did not receive positive reinforcement. The fact that almost two thirds of the Bangladeshi women were planning to introduce supplementary bottle feeds from the beginning indicated that they were not aware that introducing bottled milk from the beginning would reduce the chances of building up their breastmilk supply.

Although, the number of women who were solely breastfeeding had dropped after four weeks of birth, only a small number of babies were fed entirely on artificial powdered milk. The increase in the number of women who were using powdered baby milk to supplement their breastmilk seemed to be related to a lack of support for breastfeeding and the women's lack of confidence in their ability to produce enough milk. Although a well-balanced diet is important for successful breastfeeding, the hospital meals were less than adequate for meeting the women's dietary needs. Other factors which may have been a contributory factor in the decline in the numbers of women who were breastfeeding immediately after birth may be due to women being confined in an unfamiliar environment and not being able to ask for help with breastfeeding.

The women's experience of infant feeding suggests that there are implications for health education antenatally and postnatally. Since infant feeding practice adopted in the early weeks of a baby's life could later undermine attempts to wean a child on to traditional diets, it is essential that women get all the support they need after childbirth. To ensure that the information on infant feeding reaches all women, the health education message should take into account the linguistic and cultural diversity of the Asian communities. In addition, since many women expressed anxiety about insufficient breastmilk, emphasis should be placed on the need for a balanced diet antenatally and postnatally and suggestions for ways to increase breastmilk supply should be made available through appropriate channels.

#### Postnatal Confinement at Home

##### Family support and ceremonial rituals

Traditionally an Asian mother who has just delivered a baby relies on her relations to provide care for herself and her baby. Since childbirth and the few weeks immediately afterwards are believed by many Asian people to be an 'unclean' state, the mother is restricted to the confines of her house for a period of forty days or six weeks. During this period a mother is also excused from household work and especially anything to do with food preparation while she is in this 'unclean' state. This traditional practice which isolates a mother to a separate area in the postnatal period is also shared by many other cultures round the world (Kitzinger 1978 :117; Blanchet 1984:99). Although it is restrictive, this practice ensures that the mother gets all the rest she needs since she is not allowed to enter the cooking area or participate in household chores. In Britain, hospitalisation of childbirth means that the isolation ritual only applies after the mother is

discharged from the hospital.

In addition to the ritual concerning isolation of mothers after childbirth, it is a customary practice amongst Asian mothers to return to their parental homes in the last weeks of pregnancy, where they stay for the birth and for at least six weeks immediately after the birth. Although this custom is commonly observed for the first pregnancy only, many multipara mothers go to their parents home for a rest after the baby is a few weeks old.

In Britain this custom is difficult to observe because a mother is expected to give birth in her local hospital where she is booked for antenatal care and delivery. However, a token practice is still observed by many Asian mothers albeit in a modified form: some women go back for a few days or weeks to their parental home after the six weeks 'unclean' period is over. Nevertheless for many women migration to Britain and hospitalisation of birth have meant that they have to rely on their husband's family for support after childbirth instead of their own parents or relations.

I have already discussed the involvement of the family members and in particular, the role of the female relatives in the management of the pregnancy (see chapter 5). The only time the traditional supportive role of the female relatives became less significant was at the time of the hospital admission for birth. In this section, I am especially interested in the support provided by the relatives after the birth. In addition I am going to focus on the significance attached to the ceremonial rituals in the postnatal period and the women's attitude towards them. In Table 8D, I have set out who provided postnatal support after the women were discharged from the hospital.

Table 8D: Postnatal Support After Hospital Discharge  
Total No  
Women

	Husband /Children	Husband's Relations	Mother's Relations	Total No Women
B	6	5	1	12
G	1	10	4	15
	-----	-----	-----	-----
	7	15	5	27

It would seem that migration to Britain had affected the traditional source of support. It is apparent from Table 8D that with the exception of five mothers (4 Gujarati and 1 Bangladeshi), the rest of the women were dependent on

their husband's family for immediate postnatal care:

"I have found it very difficult to cope because I had a Caesarean operation. I think without the help of my mother-in-law it would be impossible for me to manage. She helps me a lot with everything"  
( Bangladeshi Mother First pregnancy)

Although it was a traditional custom for women to return to their parental home for childbirth, the arrangement had to be approved by a woman's husband and his family. In the case of the women whose parents did not live locally, most women were not permitted to go out anywhere until the six weeks restriction was over.

"My mother has come to stay with us to look after me because my mother-in-law can't manage everything on her own because she is also looking after my sister-in-law's son. My mother and I will go to her house in a week's time when I will be free to go out. My mother came here because I am not allowed to go anywhere until six weeks after birth. Both my mother-in-law and mother believe that this custom must be strictly observed. I am not even allowed to go to the clinic to have my son innoculated against T.B. My mother-in-law will take him this afternoon to the clinic."  
(Gujarati Mother Second Pregnancy)

In a number of cases the husband's family made it difficult for the women to spend some time at their parents home:

"After I was discharged from the hospital I had to remain at home for six weeks and the only time my mother-in-law allowed me to go out was to visit my son in the special care unit as he was born prematurely. Although my mother-in-law had agreed that I should spend a few weeks with my mother, she (mother-in-law) only allowed me to stay for two weeks. My mother and I were really upset. My husband was also unhappy but he couldn't control anything. My mother-in-law likes to exercise her power and ownership over me." (Gujarati Mother First Pregnancy)

Only about a fifth of the women whose parents lived locally were able to go directly to their parents home after they were discharged from the hospital.

"I went to stay with my parents a few days before I had my baby and when I was discharged from the hospital I went back to my mother's house. It was very helpful to be with my mother. It gave me time to get to know my baby because I didn't have any housework to do. I also got lot of rest. My mother used to change the baby for me and she washed baby's clothes as well so I had very little to do except feed the baby." (Gujarati Mother First Baby)

The Bangladeshi women appeared to be the most disadvantaged in terms of traditional support as half the Bangladeshi women who took part in the follow up interviews did not have anyone except their husbands or older children:

"As my eldest daughter is seventeen years old she helps me a lot now. She looks after the baby - she feeds and changes the baby for me. My husband also helps me with my other children so I manage some how."  
( Bangladeshi Mother Sixth Pregnancy)

The women who appeared to have least amount of help at home were the women who were living in the nuclear family. These women had to disregard the beliefs about being 'unclean' because they had no choice and besides the absence of older female relatives meant that there was no-one who could have insisted that they observed the forty days restriction period.

"In this country it is very difficult to manage without help. In my country I used to go to my mother's house and she used to help me a lot. I have nobody to help me in this country. My husband doesn't help me because he thinks I should be able to manage."  
(Bangladeshi Mother Sixth Pregnancy)

"I only stayed in hospital for two days because I have no-one to look after my other two children. I have been doing everything myself since I returned from the hospital. Fortunately my invalid mother-in-law is not staying with me at the moment so I can just about cope but when she returns it will be difficult to manage as I will have to look after her as well." (Gujarati Mother Third Pregnancy)

Since two thirds of the Gujarati women in my sample were living with their in-laws and some of them also had parents who lived locally, they were in a more fortunate position to receive postnatal support than Bangladeshi women who were living in nuclear families. This fact, according to a Bangladeshi social worker, is often over looked by health professionals who assume that all Asian women live in a joint family and therefore do not require help from other sources:

"Some of the older family members are still living in Bangladesh so many families are nuclear. A vast majority of the women who have settled here have no immediate family support other than distant relatives. There is no closeknit family support which the health professionals believe we have. The health professionals are misguided in assuming

that in case of trouble we can rely on the extended family support and they don't have to do anything for us."  
(Bangladeshi Social Worker)

After a mother is discharged from the hospital, she needs time to recover from childbirth even though she may have had an uncomplicated birth. Some women not only have to meet the demands of their new baby but also have additional responsibilities of looking after other small children and running a home. In Table 8E I have set out the range of support that was available for the women in my sample.

Table 8E: Range of Support Provided By Relations  
(Multiple Responses)

	Nuclear Family -----				Total No Women
	Baby Care	Cooking	Household chores	Shopping	
B	1	2	3	6	6
G	-	-	-	1	1
Husbands Family -----					
B	3	5	3	5	5
G	4	8	6	10	10
Mother's Family -----					
B	1	1	1	1	1
G	3	4	4	4	4

From Table 8E it would seem that the women who were able to return to their parental home felt more able to accept help from their mothers or other members of the family:

"I felt more comfortable with my mum. It also gave her a chance to look after me and be with my baby. I could only stay with her for two weeks. It is so different being with your own mother. You don't have to do anything in the kitchen, she did everything. She made sure I had everything and even helped to look after the baby so that I could rest. I would have preferred to have spent a few more weeks at my mother's house."

(Gujarati Mother First Pregnancy)

The women who received help from their husband's family after they were discharged from the hospital felt obliged to help with housework and could not expect to get as much help as they would have got from their own mothers:

"I have been raised by my aunt who lives in Kenya so I can't go to her and my husband would not allow me to go

to my cousin's house. I have found it very difficult to cope. I am feeling very emotional and sometimes I feel very depressed. It is hard to look after a new baby - she takes up all my time. I am expected to do all the housework because my mother-in-law believes that it is good to be active and get back to normal as soon as possible. My mother-in-law cooked for me for a week and now she leaves it all to me." ( Gujarati Mother First Pregnancy)

Compared to the constraints which many women experienced as a result of the restrictions during pregnancy (see chapter 5 page 134) the restrictions after childbirth appeared to be less objectionable. However the restriction which required women to remain confined to the home for forty days was unacceptable to some women. A majority of Bangladeshi women who were also expected to remain within their homes for the same length of time did not find it a problem because many of them did not have their in-laws to impose the restriction. However those who were accustomed to the 'purdah' restriction were happy for their husbands to go shopping and deal with any other business. Some Gujarati women on the other hand felt that this restriction did not serve any useful purpose other than to give power to some members of their husband's family to exercise control over them. A Gujarati mother who was prevented from visiting her parents remarked:

"I can go to the clinic but I am not allowed to pay a social visit for six weeks. I am so unhappy because I can't go out. I can't complain about it to my parents because they would tell me that my husband's family is more important than them. I would like to go and stay with my parents but my husband's sister does not approve because my parents live in East London. Although she does not live with us she has a lot of power and lays down rules for us. I feel like ignoring everyone including my husband but my parents would not like me to upset anyone. I went out yesterday to do some shopping but told my sister-in-law that I had an appointment at the clinic. I do not like to deceive anyone but I don't see why I shouldn't go out "

(Gujarati Mother First Pregnancy)

## SUMMARY

One of the major issues to emerge from the accounts of the women's postpartum care suggests that both Gujarati and Bangladeshi women were dissatisfied with the care they had received during their brief stay in the hospital. Since with the exception of three women, a majority of the women had spent at least three days or more in the hospital, their dissatisfaction has implications for a greater understanding of the needs and expectations of the women



who come from different cultures.

The main cause of their dissatisfaction was partly due to the change in attitudes of the nursing staff towards the women after they were admitted into the postnatal ward and partly because many women's perceptions of postnatal care were based on the traditional approach. Many Bangladeshi and Gujarati women were at a loss to understand why they merited less attention from the medical staff as soon as delivery was over and yet during their pregnancy they were treated as if they were ill. It was particularly confusing for some women, especially Bangladeshi women who expected the same kind of care and attention they were accustomed to receiving from their female relatives.

Besides dissatisfaction with the nursing care, the lack of appropriate meals in the hospital was another issue which affected the women's perception of the care they had received in the hospital. It would seem that despite good intentions on the part of one hospital to cater for the dietary requirements of these women, rigid restrictions prohibiting women from receiving food from home was counterproductive. Many Gujarati women found that the hospital meals were inadequate and did not take into account the significance of traditional foods to the women or their relatives. Although Bangladeshi women did not have similar restrictions on receiving food from home, hospital meals failed to meet their dietary requirements in line with their religious beliefs. Failing to meet the dietary requirements of the women has serious implication for nursing mothers especially as some women may spend at least two or more days in the hospital.

It was worrying that the number of women who had intended to breastfeed their baby fell after birth. It was particularly significant in the case of the Bangladeshi women who had begun to doubt their ability to produce sufficient milk for their babies. The fact that Bangladeshi women had not abandoned breastfeeding altogether suggests that positive reinforcement and support in the first weeks of birth may give the women confidence in their ability to supply the needs of their babies without resorting to artificial baby milk. Gujarati women, on the other hand, were influenced by the current popularity enjoyed by breastfeeding. This was reflected in the number of women who had planned to breastfeed and the number of women who were only giving breastmilk after birth. However, the fact that some Gujarati women had also introduced powdered milk also indicates that support in the first few weeks after birth is crucial for women to continue breastfeeding.

Finally, emotional and practical support provided by the family is very important for the women to make a full

recovery after childbirth. In the case of Gujarati women, a majority of them were fortunate in having their female relatives to provide support after they were discharged from the hospital. However, it would be wrong to assume that Asian women do not require support from the health carers because they live in joint households: The experiences of Bangladeshi women indicated that many of them suffer from isolation and lack traditional support because their families have been fragmented after their migration to Britain.

## CHAPTER 9

## GUJARATI HOUSEHOLD COMPOSITION AND THE IMPACT OF FAMILY INFLUENCE - TWO CASE STUDIES

This chapter is based on the case studies of two Gujarati families and focuses on the pregnancy and childbirth experiences of two women from each family who were pregnant at the same time. From the accounts given by Gujarati women in the preceding chapters it emerged that the women's decisions concerning some aspects of the management of pregnancy and postnatal care were influenced by members of their family. These case studies therefore provide further opportunities to explore the interaction between two daughters-in-law from the same family who are pregnant at the same time and their husbands' family.

The opportunity to study the daughters-in-law from the same family was presented to me while I was drawing up a random sample of pregnant Gujarati women in my Harrow study. I discovered that on a couple of occasions I had drawn up names of women with the same surname but living at different addresses. When I realised that these women were related by marriage, I selected one woman from each family for the purpose of an in-depth case study to see whether belonging to the same family in any way influenced their experience of pregnancy and childbirth.

From the accounts of childbirth experiences of Gujarati women in the main study, it became apparent that the time when family influence was most noticeable was in the management of pregnancy and during the postnatal period. In the case studies I am going to focus specifically on these aspects to compare and contrast the behaviour and attitudes of the two daughters-in-law in the same family.

A Pregnancy in the Family

From my observation and discussions with the women in the main study, it became apparent that women who lived in an extended family found that their behaviour was closely scrutinised and regulated by rules and codes set by older members of the family. In some of the more orthodox families, women occupied a lower status than the men and even amongst the women there was a definite pecking order with the mother-in-law occupying the place at the top of the female hierarchy. The younger women in these families were obliged to maintain the family's honour by regulating their behaviour and observing family customs and traditions. It would appear that in Britain, the older members of the family who wanted to retain their traditional culture, perceived the indigenous values and

language as a threat to their own cultural identity. In addition, my observation of the Gujarati families suggested that some older women also perceive the acquisition of education and economic independence by younger female members of the family as a challenge to their authority and status. Thus the only possible course of action open to these older members of the family was to impose traditional beliefs and values on the younger members of the family in a way which allows them to retain some of their influence and status.

The purpose of the case studies is to look at pregnancies within the extended families as opposed to individual women in order to explore in depth some of the issues highlighted by the women in the main study and in particular explore the tension which existed between the daughters-in-law and their husband's families.

### Data Analysis

The material gathered from the two separate interviews of the two women in the case study and the two women in the main sample were analysed using cognitive mapping technique (Jones 1985 ) to show the interaction between the women and their family. From the analysis of the data it emerged that interaction between the pregnant women and their in-laws seemed to become more pronounced at certain phases of the pregnancy and immediately after birth. These phases were identified as the confirmation of pregnancy, management of pregnancy, antenatal preparation and the postnatal period.

### The Gujarati Family Case Studies

Before examining the women's experiences of childbirth against the background of family interactions, it is essential to understand the structure of the two families (referred to here as Family A and B) and the personal details of the daughters-in-law in the two families. Since the structure of the two families in the case studies was not identical, the experiences of the two sets of daughters-in-law will be examined separately.

In the Gujarati community the relationship between individual members of a family is described using precise terminology and this terminology is particularly helpful in understanding the precise relationships which are created as a result of marriage ( Trivedi 1920). Since the English language does not provide such precise definition of relationships, the women in the two families will be referred to by fictitious names to ensure confidentiality.

### Case Study of Family A:

Structure of Family A:

Meera and Kiren were married to two brothers in the same family. They had become pregnant within six months of each other. Meera, the older of the two, became pregnant first. Meera and Kiren lived in two separate self-contained flats which were separated by a flight of stairs. Meera and her husband owned the downstairs flat while Kiren and her husband owned the top flat. For all intents and purposes the two flats were run as two independent households. Meera and Kiren's parents-in-law who also lived with them, moving freely between the two flats. Although the brothers ran two independent households, their parents treated the two separate flats as a joint household and controlled the family affairs and the lives of Kiren and Meera. The husband's married sisters who lived locally were also influential in family affairs and particularly in decisions involving their brothers' wives.

Meera's parents and other members of her family lived locally. Kiren's parents were living in Kenya and her nearest relative in this country was her married brother who lived in East London.

Personal Background of Meera

Age	25
Country of Birth	Kenya
Length of Residence in Britain	13 years
Religion	Hindu
Caste	Lohana
Education	College-Business Studies
Became Pregnant	November 1986

Personal Background of Kiren

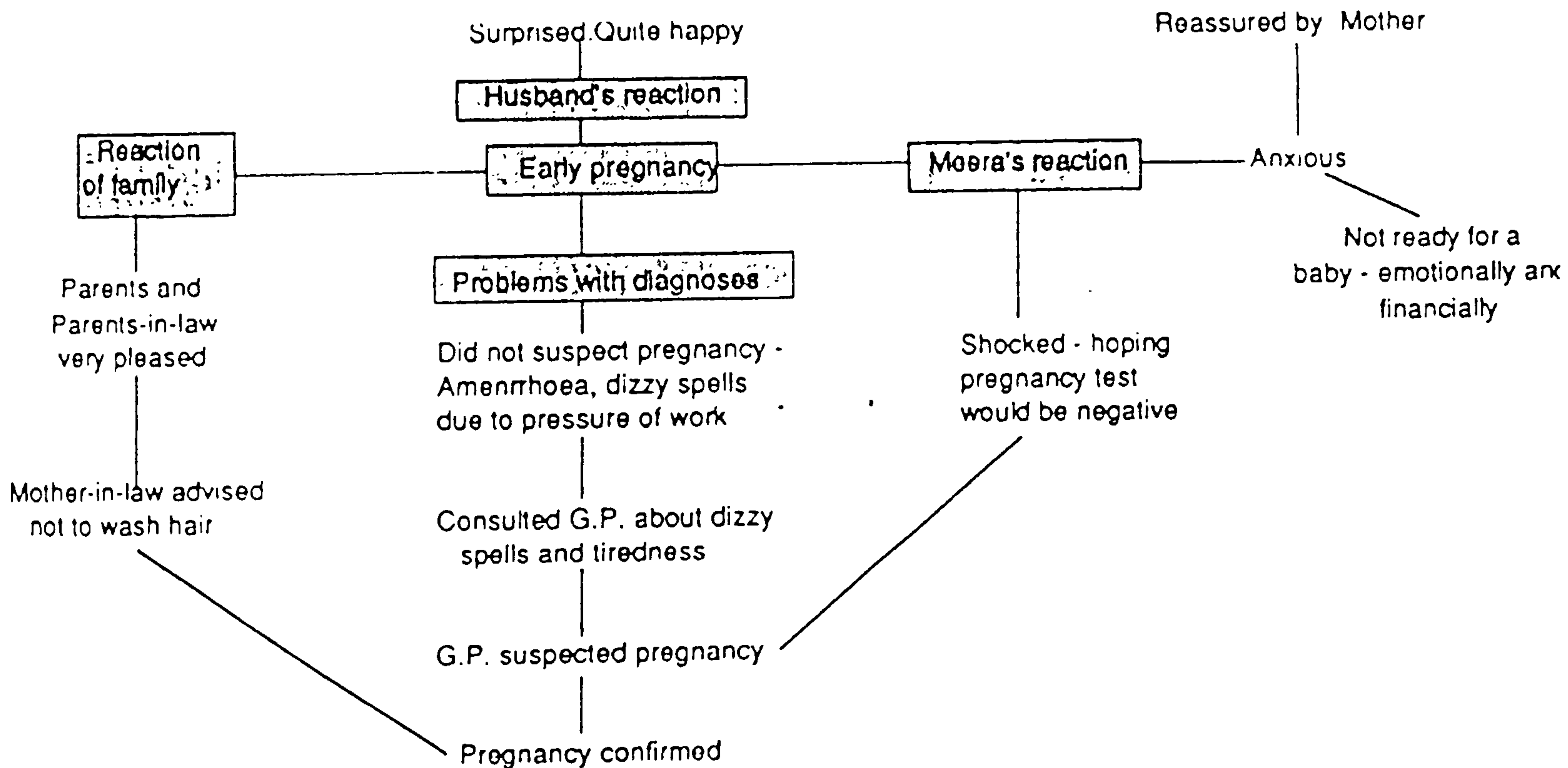
Age	24 years
Country of Birth	Kenya
Length of residence in Britain	3 years
Religion	Hindu
Caste	Lohana
Education	Secondary School
Became Pregnant	April 1987

As previously stated, the main areas over which the extended family had influence were early pregnancy, management of pregnancy, preparation for birth and the postnatal period. I am going to focus on the impact of the family on the pregnancy and childbirth experiences of

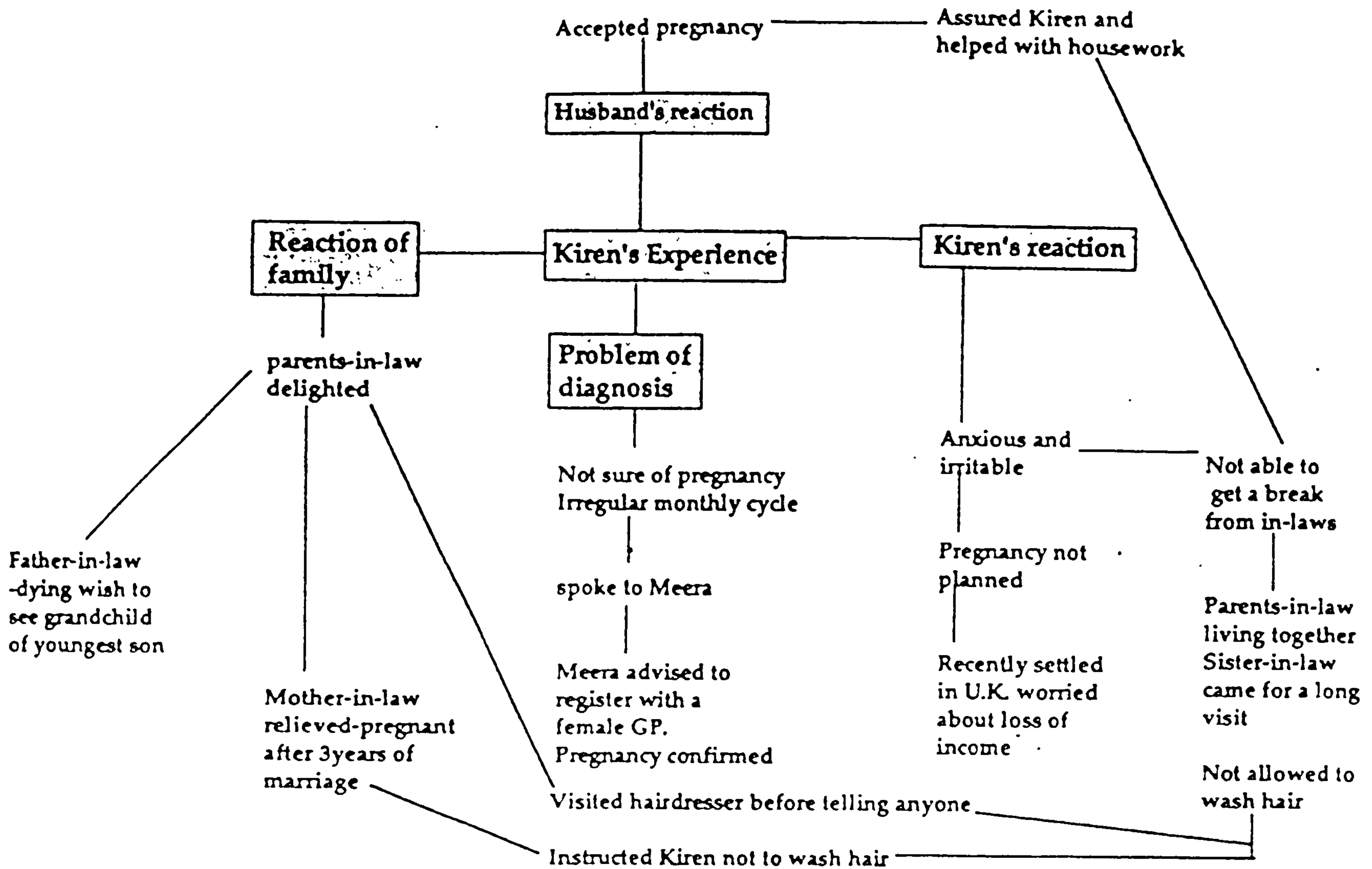
postnatal period. I am going to focus on the impact of the family on the pregnancy and childbirth experiences of Kiren and Meera under these themes using cognitive charts to illustrate the interactions between the women and their family.

Early Pregnancy

In early pregnancy, the major issue which concerned both Meera and Kiren were their own reactions to their unplanned pregnancies, reactions of their in-laws to their pregnancies and the difficulties they had encountered recognising the early symptoms of their pregnancies. The interactions Meera and Kiren had with their in-law family are set out in charts 9A(i) and 9A(ii).



9A(i) Meera's Early Pregnancy Experience



#### 9A(11) Kiren's Early Pregnancy Experience

From charts 9A(1) and 9A(11), it is apparent that neither Meera nor Kiren recognised the symptoms of pregnancy because they were both using birth control and had not intended to become pregnant just yet:

"In the beginning I did not suspect that I was pregnant because we took precautions against pregnancy. When I started to feel dizzy and tired and also missed my period I put it down to stress and pressure of work at home and in my job." (Meera)

In Kiren's case the pregnancy symptoms were confused with an irregular menstrual cycle following a laproscopy examination:

"We were using birth control and I also followed the safe period method to make sure I wouldn't fall pregnant. I had a laproscopy a few weeks before I missed my period but because the doctor at the hospital had told me that this examination might disturb my cycle I did not immediately suspect my pregnancy. The leproscopy examination was a part of a general examination I had undergone at the hospital to

second period I spoke to Meera who advised me to register with her female G.P."

For Kiren and Meera their pregnancies became very much a family affair as soon as they announced their pregnancies to them. The news of their pregnancies was greeted with approval by their in-laws suggesting that Kiren and Meera were at last conforming their behaviour to suit the family's expectations of them and their pregnancy gave the family additional reasons to mould their behaviour to fulfil the family's expectations of them. Whilst Kiren and Meera were fulfilling the expectations of the family, they appeared to be not as delighted at the prospect of their pregnancies as their family were. This was especially so as they had not intended to become pregnant just then:

"I was shocked to learn that I was pregnant because we had not planned to have a baby just yet as we had been married for only two years. I prayed for the pregnancy test to be negative. I was very upset at first because I was not emotionally prepared. As far as my in-laws are concerned a woman is not supposed to worry about a career ...they have very orthodox views and they believe that a woman's place is to be in the home and have children. For me my job is very important and not just for financial reasons." (Meera)

Kiren also found it difficult to come to terms with her pregnancy at first:

"At first I was very upset and worried to learn that I was pregnant. We had not planned to have a baby for another few years because we wanted to be financially secure. We have very recently bought our flat so pregnancy was the last thing on our minds. My parents-in-law also live with us and as my father-in-law is quite sick it is an additional responsibility."

Kiren and her husband had planned to wait a few years before starting their family, but Kiren felt that there was indirect pressure put upon them to have a baby by her mother-in-law:

"We had planned to have a baby after we were married five years. My mother-in-law told my husband that we were married over three years and yet there was no sign of a baby. My parents-in-law felt that we had waited too long to start a family and my mother-in-law was beginning to suspect that there was something wrong as we had been married for three years. When my mother-in-law learnt about my pregnancy she gave a sigh of relief!"

Whilst the close proximity of the two households enabled the parents-in-law to keep a close watch on Meera's and



Kiren's behaviour during their pregnancies, it also enabled Meera and Kiren to share the irritations they felt and provide support to each other. For Kiren this support was vital to survive in an extended family as unlike Meera, she did not have any close relatives who lived locally to provide emotional support during her pregnancy:

"Unfortunately, my mother is too far to give me support. My mum lives in Kenya and I don't have any support or a place I can go to to get a break from my in-laws. I have a brother in E.London but my parents-in-law do not like me to visit my brother because they believe that E.London is a rough place. The only person I can talk to freely is Meera because we both have to put up with our parents-in-law. It has also been helpful to talk to Meera about my pregnancy because she just had a baby."

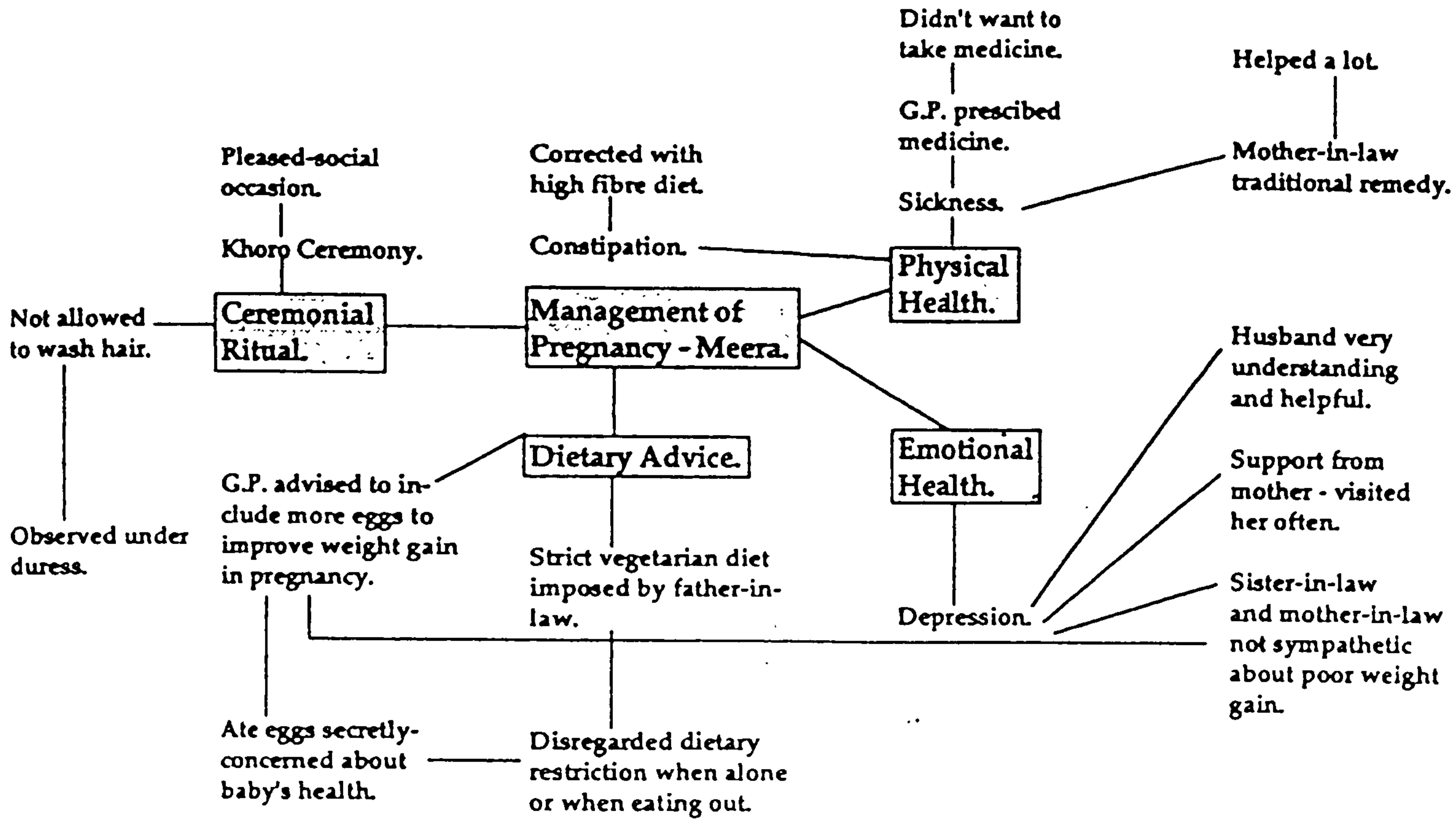
Whilst Meera was able to visit her parents to get a break from her in-laws, Kiren had no such respite as she explained:

"My mother-in-law is not pleased because I complained to her that I am getting very tired. Since my sister-in-law has come for a holiday it has resulted in more housework for me. My mother-in-law thinks that I am making too much fuss because she had eight children and she never made any fuss. My mother-in-law forgets that she did not go out to work and besides in Africa she had servants to do all the housework. My mother-in-law believes that an office job is not demanding and she also does not understand why I have to work outside the home. I felt very depressed and tired in the beginning of my pregnancy"

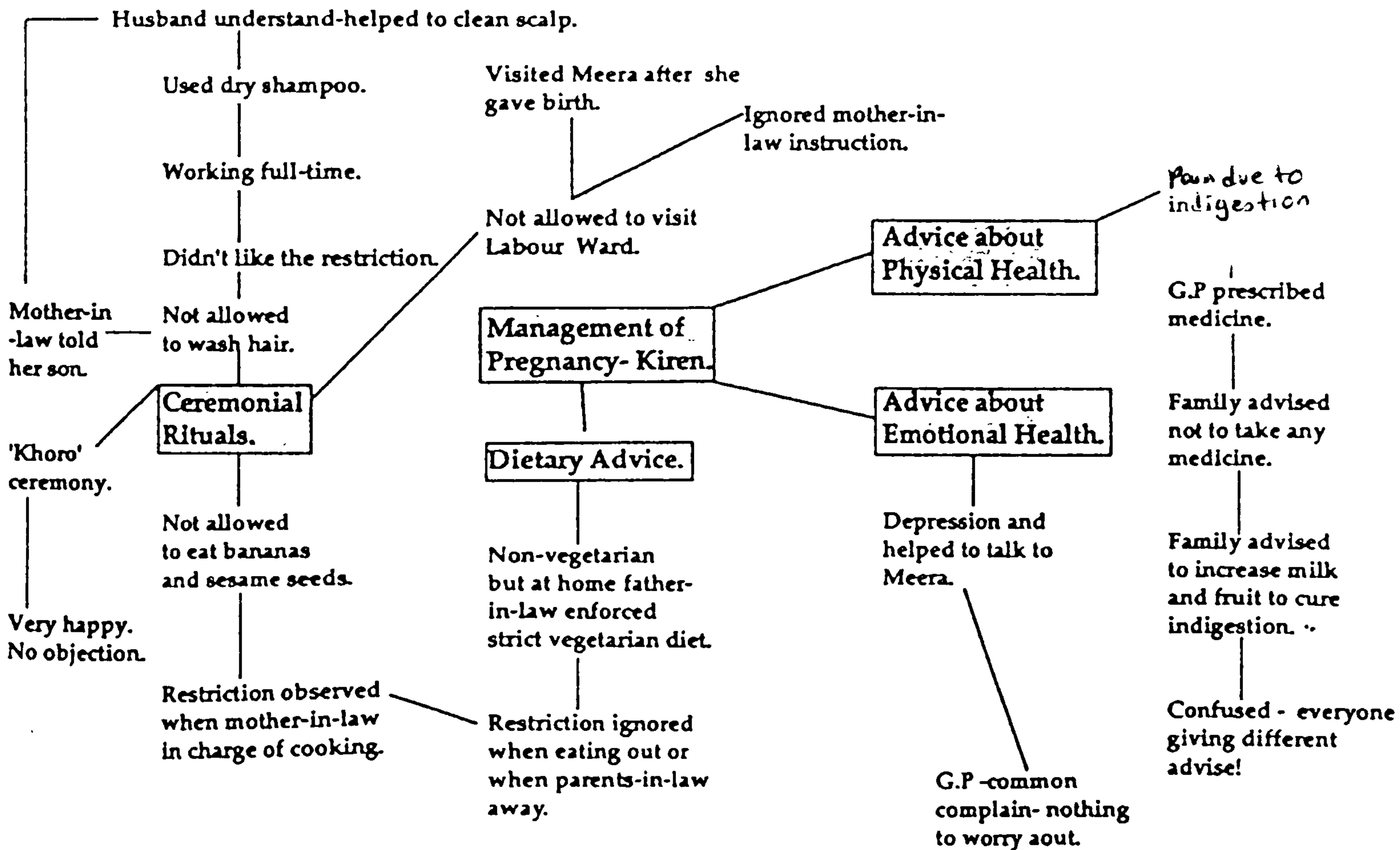
From the comments made by Meera and Kiren it was evident that they were both struggling to free themselves of the constraints imposed by their parents-in-law. It also appeared that their unplanned pregnancies added to the irritation they felt towards their family-in-law.

### Management of Pregnancy

Looking at the influences of the family concerning the management of pregnancy, certain observations can be made. The areas over which the parents-in-law appeared to have had the greatest amount of influence centred round diet, advice concerning health in pregnancy and ceremonial rituals as shown in charts 9B(i) and 9B(ii)



9B(i) Meera's Management of Pregnancy



9B(ii) Kiren's Management of pregnancy

neither Meera nor Kiren openly challenged the authority of their parents-in-law, they tried to exert their independence whenever they could. The fact that they were prepared to flaunt the instructions of the family suggested that Meera and Kiren did not share the traditional beliefs of their in-laws. This was particularly evident in their attitudes towards the orthodox vegetarian diet imposed on them by their parents-in-law. The conflict between the parents-in-law and the daughters-in-law was further compounded by the dietary advice given to the women by the medical professions. For instance, Meera was advised to eat more eggs to increase her protein intake as she was not gaining sufficient weight during her pregnancy and this advice was contrary to her parents-in-law's religious beliefs:

"I am vegetarian but I do eat eggs and cheese in my diet. I was not gaining any weight as I should have during my pregnancy. My doctor advised me to increase eggs and milk in my daily diet. My father-in-law has such orthodox religious views that he could not accept that Indian women and especially his daughters-in-law should eat eggs. I was worried about my baby so I have been eating eggs secretly. My mother-in-law and my husband's sisters did not have a problem gaining weight so they were not very sympathetic towards my problem"

Kiren, on the other hand was not vegetarian but she could only eat non-vegetarian foods outside her home:

"At home I am a vegetarian because my in-laws are very orthodox and would not like their daughters-in-law to eat eggs or meat. When I go out with my husband I eat meat but only chicken, no red meat. Once my in-laws confronted me and said that someone had seen me eating meat but I just denied it. There is nothing they can do when I am out."

The experience of Meera suggests that at the time of pregnancy many Asian women are caught between two opposing ways of managing pregnancy which only adds to their stress during pregnancy. Besides coping with conflicting dietary advice, Meera and Kiren had to observe other dietary restrictions imposed by their mother-in-law which the pregnant women appeared to interpret as the mother-in-law's way of exercising control over them:

"As soon as I became pregnant my mother-in-law informed me that from that day I should not eat bananas and any food containing sesame seeds. I do find it restrictive - especially living in this country. My own mother did not have to observe any restrictions. I must say I don't believe in it. When my mother-in-law or my husband's sisters are around I do as I am told because I do not wish

to offend them but when no one is home I eat sesame seeds if I want." (Meera)

Kiren, also found dietary observations imposed by her mother-in-law restrictive:

"As soon as I told my mother-in-law that I was pregnant she told me that there are certain things I can not do while I am pregnant and one of them was a ban on eating bananas and sesame seeds. I have to agree and follow her instructions otherwise she would complain about me to my husband. I agree to most things and then I do as I please when she is not around. I like using sesame seeds in cooking and when my mother-in-law is not around I use sesame seeds. When my mother-in-law is around she does all the main cooking because she knows best what her sons like and we, her daughters-in-law, are not good enough cooks as to satisfy her sons!"

In addition to non-medical dietary restrictions, some ceremonial rituals were considered necessary to avoid mishaps during pregnancy. The older women in the family retained their faith in the ceremonial rituals as a means of safeguarding the pregnancy and therefore wished to perpetuate the family traditions. However, their views were not shared by the younger generation of women like Meera and Kiren:

"I have not washed my hair for the past seven months. My mother-in-law told me that pregnant women in our family are not allowed to wash their hair. I found it quite difficult to accept it at first because I had not heard of it before. I would have found it a lot easier to accept if she had given an explanation for it. Since my in-laws live with us it is not easy to ignore the rules they lay down for us. It was a real nuisance while I was working because I was worried about attracting bad comments from my colleagues at work." (Meera)

Although Meera was unaware about the hair washing restriction, her experience was of some benefit to Kiren who had become pregnant after Meera. When the pregnancy was first suspected, Kiren consulted Meera first. The reason for keeping the news of the pregnancy from the mother-in-law was to delay the imposition of a hair washing restriction as long as possible:

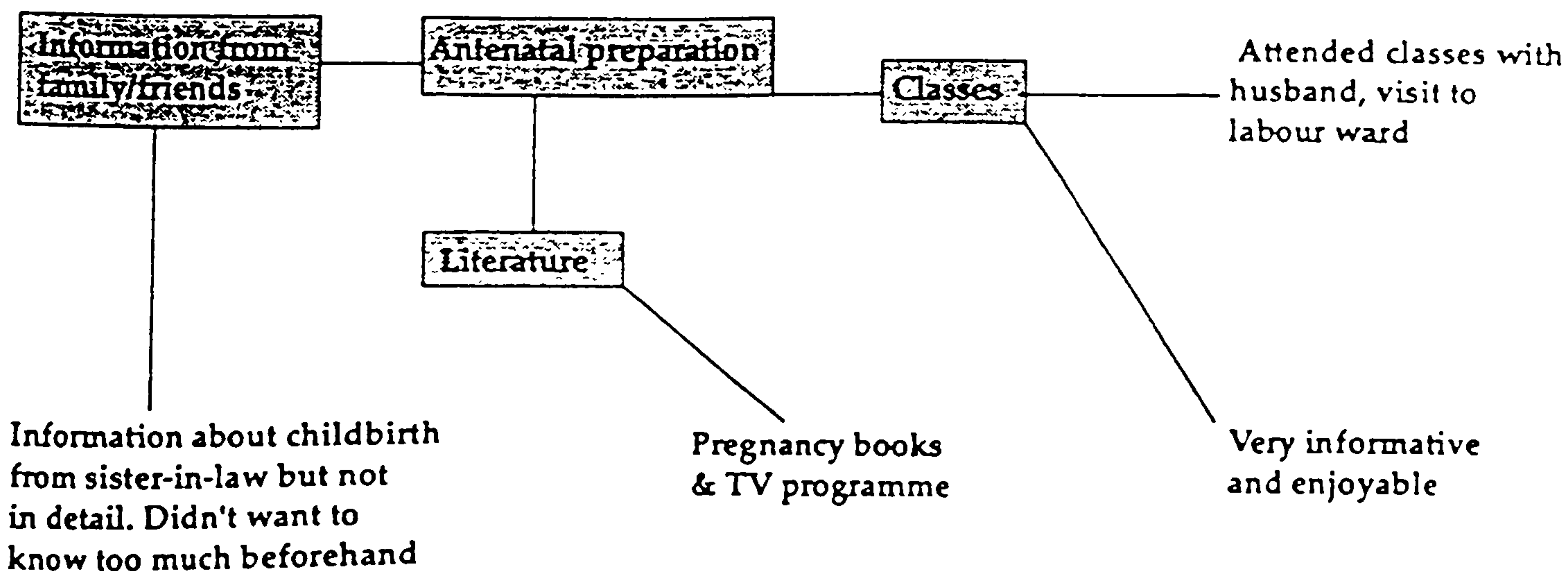
"I first heard about the hair washing restriction when Meera became pregnant. As I knew that this restriction would also apply to me as soon as my pregnancy was confirmed, I went to the hair dresser first to have a hair cut so that it would be easier to manage. When my mother-in-law realised I was pregnant, she told me that

hair cut so that it would be easier to manage. When my mother-in-law realised I was pregnant, she told me that from that day I was not to wash my hair and she told me in the presence of my husband to make sure that I did not ignore her instructions. I think it is unhygienic. I was really upset because I was working and I didn't want to go to work looking a mess. In the end I did accept it because it would have caused too much upset in the family. I used to use dry shampoo and damp towel to clean my scalp. My mother-in-law used to disapprove of that as well because I was breaking the tradition. My mother-in-law told me that she didn't have any problem looking after her hair through her pregnancies but then she didn't go out to work whereas I do and personal appearance does count."

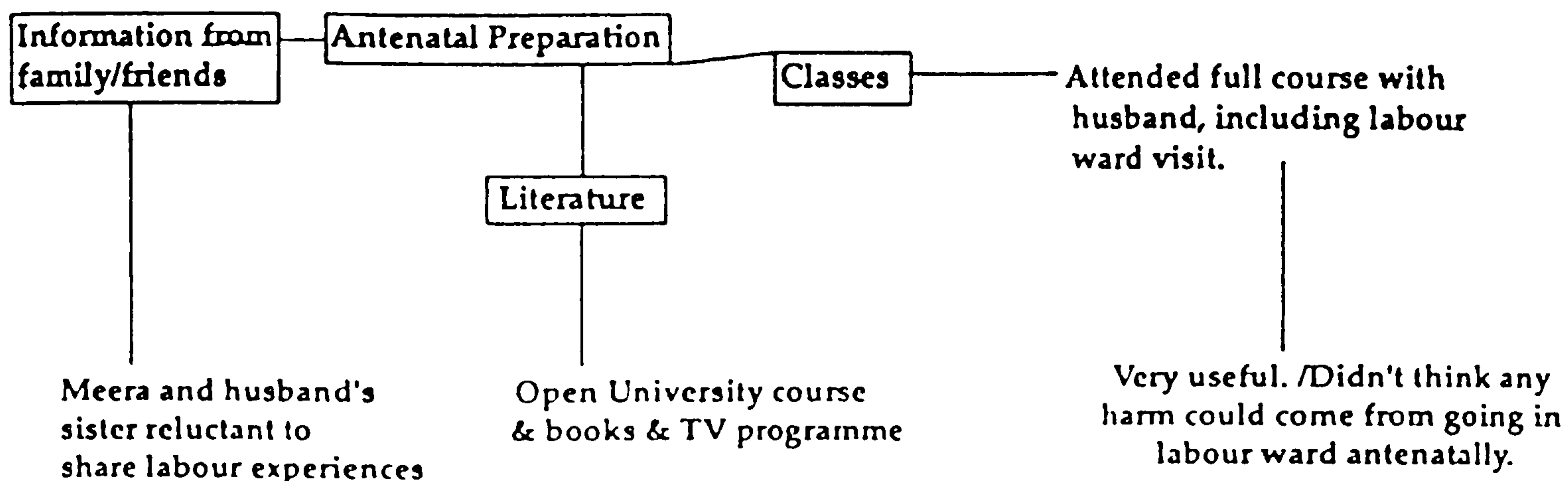
The accounts of Meera and Kiren suggest that although they objected to the restrictions imposed by their family, their cultural links with their community prevented them from behaving in a way which would have made them appear disrespectful in the eyes of the community.

#### Antenatal Preparation

For most older Asian women formal antenatal preparation involving attendance at classes was an alien concept. Although older women in their time may not have had any formal training to prepare for birth, the enactment of ceremonial rituals prepared the pregnant women for childbirth. One such ceremony commonly referred to as 'khoru' took place after the seventh month of the pregnancy (see chapter 5 page 131 ). In addition to preparation involving rituals, physical preparation for birth included the taking of herbal preparations to speed the birth process. For Meera and Kiren antenatal preparation included both the traditional form involving their participation in the ceremonial rituals and in the classes offered by the maternity services as shown in charts 9C(1) and 9C(11).



9C(1) Meera's Antenatal Preparation



#### 9C(11) Kiren's Antenatal Preparation

Although Meera and Kiren's parents-in-law appeared to exercise a great deal of influence over many aspects of their pregnancy, they were not prevented from attending the classes offered by the hospital. It is possible that either the parents-in-laws authority did not extend outside their home or they were unaware that their sons and daughters-in-law were going to the hospital for the purpose of attending classes.

Although Meera and Kiren were not prevented from attending classes, both of them knew that a visit to the labour ward which was a part of the antenatal classes would be disapproved of. Many Asian families believe that women who have just given birth are agents of pollution and other pregnant women should keep away from them to avoid any mishaps:

"My mother-in-law does not know that I had made a tour of the labour ward with the other pregnant women in my class. My mother-in-law found out about the labour ward visit from her daughter. My mother-in-law told me that she wouldn't like me to go. I didn't want to upset her so I didn't tell her that I had already done so." (Meera)

Kiren on the other hand, was left with no doubt that a visit to the labour ward would get her into difficulties with her mother-in-law because she was prevented from visiting Meera when she had her baby:

"I knew that my mother-in-law would not like me to go anywhere near the labour ward because when Meera had her

my mother-in-law for an explanation she told me that Meera was in an 'unclean' state. My husband and I were desperate to see Meera's new baby so we paid a secret visit to Meera at her mum's house. After I had visited Meera I didn't see any reason why I should not visit the labour ward with the other pregnant women in my class. During the visit I even held a new baby and so far nothing has happened to me. It is not that I don't believe in our culture or that I want to disobey my in-laws. It is just that I don't believe that any harm could come to me or my baby ... I will just have to wait and see when the baby comes!"

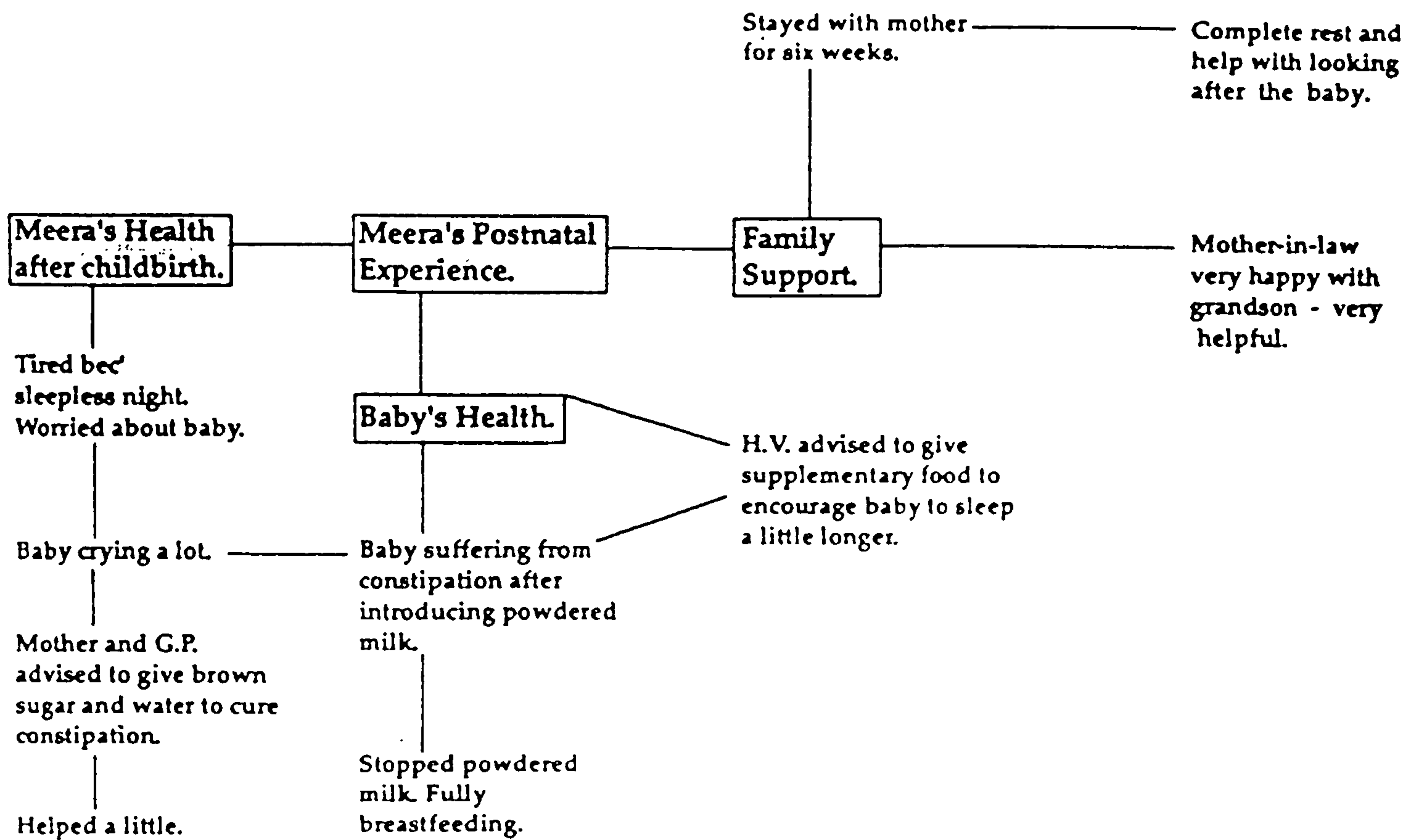
It is apparent that the extent to which Meera and Kiren were prepared to make adjustments to meet the requirement of two different cultural expectations, was determined by a number of factors. On the one hand, neither Meera nor Kiren was prepared to openly defy their in-laws and on other hand they were both attracted by the advantages which they believed would accrue to them from their participation in the classes. The solution they adopted to resolve the cultural dilemma was to keep their in-laws ignorant of their action. They were helped in this by the fact that their in-laws influence was curtailed by their unfamiliarity with the maternity services.

Since the hospitalisation of childbirth has resulted in the exclusion of the family during childbirth, I am going to move on to the involvement of the family in the postnatal period.

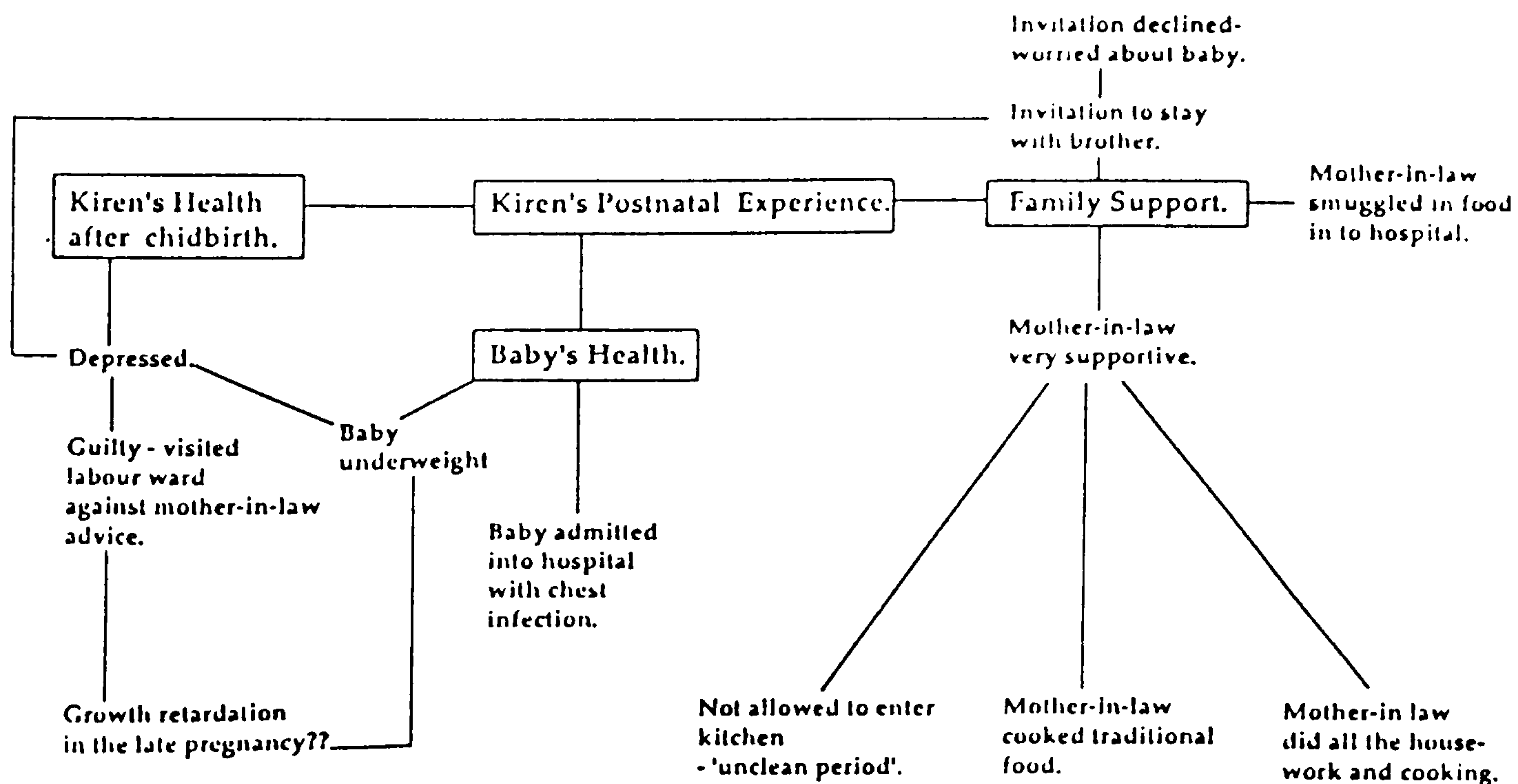
#### Postnatal Care in the Family

In this section, I am interested in exploring the interactions between the daughters-in-law and their family after they were discharged from the hospital. I am especially interested to see whether the cultural conflicts which existed between the daughters-in-law and their family persisted in the postnatal period.

Since it was a traditional practice amongst many Gujarati women to return to their parental home after childbirth, their postnatal experience was determined by who provided the support to them after childbirth. (see charts 9D(i) and 9D(ii)).



9D(1) Meera's Postnatal Experience



9D(11) Kiren's Postnatal Experience



In the case of Meera and Kiren there appeared to be very little difference in the quality of practical help they received from their family although Meera returned to her mother's house and Kiren was not able to do so. When Kiren returned from the hospital she found the practical support provided by her mother-in-law was most helpful:

"My mother-in-law has been very helpful. She did all the housework and cooking when I came home. She has been very good to me and while I was in the hospital she used to smuggle food into the ward because I didn't like the hospital food. She did not allow me to enter the kitchen until my baby was five weeks old. She did not want me to do anything except attend to the baby's needs."

Meera had also enjoyed the same care and attention at her mother's house:

"When I was discharged from the hospital, my parents came to fetch me from the hospital. I have been staying here for past five weeks. I will be going home next week. While I am staying with my parents I have had lots of rest, help and guidance from my mum and my aunt who has come especially to look after me. I have found it more easier and more comfortable to be with my mother. I do not have to watch what I do or say, and I feel at ease to ask and receive help and guidance from my mum and my aunt. They do practically everything for the baby and I only have to feed him."

Kiren, on the other hand, was not only grateful to her mother-in-law but also expressed remorse for defying her mother-in-law by visiting the labour ward during her pregnancy against her mother-in-law's wishes ( see page 226):

"I felt very depressed after my daughter was born. She had to be admitted to the special care unit because she was underweight. Even now I feel very down because my daughter did not grow much in my womb. I feel it is perhaps because I had disobeyed my mother-in-law and visited Meera after she gave birth and had also visited the labour ward while I was pregnant. I do feel guilty. I feel I am responsible for my baby's low birth weight. I can't put these thoughts out of my mind and at the same time I can't tell anyone not even my husband why I am so upset about my daughter. Perhaps I should have listened to my mother-in-law's advice."

Although Kiren was clearly upset about the low birth weight of her baby, a passing remark at the end of the interview seemed to suggest that her depression was also linked to her disappointment at producing a daughter:

"I think everyone was hoping our first baby would be a son. After Meera had a son I thought I might have a son as well because on my husband's side there are lots of boys. I don't know if I would like another baby because I don't think I can cope.."

### SUMMARY

The accounts given by Meera and Kiren seem to suggest that once their pregnancy was over and they were back in the folds of their community and no longer having to adapt their behaviour and attitudes to suit the demands of a 'hospital birth package', the conflicts between the women and their in-laws rapidly melted away. Further more, as a result of the care and support provided by the in-laws, the women even expressed some remorse at disobeying or belittling the beliefs of their in-laws.

### Case Study of Family B

#### Structure of Family B:

Kamla and Geeta were married to two brothers in the same family. Kamla was married to the younger brother and they lived apart from the rest of the family in their own flat locally. Kamla's parents and other members of her family lived locally.

Geeta, was married to the older brother. Geeta and her husband belonged to different castes. Geeta and her husband lived in a joint household with her widowed mother-in-law and her husband's older unmarried sister. Geeta's parents lived in India and her nearest relatives in Britain were her uncle and aunt who were both general practitioners.

Kamla and Geeta became pregnant within six weeks of each other.

#### Personal Background of Kamla

Age	27
Country of Birth	Kenya
Length of Residence in Britain	17 years
Religion	Hindu
Caste	Merchants
Husband's Caste	Merchants
Education	Secondary School
Became Pregnant	February 1987

#### Personal Background of Geeta

Age	29
Country of Birth	India
Length of Residence in Britain	6 years
Religion	Hindu
Caste	Lohana
Husband's Caste	Merchants
Education	Secondary School
Became Pregnant	April 1987

The case study of family B focuses on the influence of the family on the two daughters-in-law during different phases of pregnancy similar to those for family A. Since the structure and composition of family B was slightly different from that of family A, I wish first to throw some light on the family relationships that existed between the daughters-in-law and the family.

Although the expectations of the family members in family A and B were culturally similar, in family B the underlying additional factors made the interactions during pregnancy and childbirth more intense. This was especially significant in the case of Geeta and her in-laws because it was Geeta's second marriage and was not arranged in accordance with Indian tradition. In addition, Geeta and her husband belonged to different Gujarati castes. Although intercaste marriages have become more acceptable recently, Geeta appeared to experience added difficulties gaining acceptance in her husband's family because her previous marriage had been unsuccessful. Whilst Geeta was striving to establish her status in her husband's family, the recent death of her father-in-law made her mother-in-law and older unmarried sister-in-law more defensive. This was because their status had become precarious as a result of their bereavement and also because they had become dependant on Geeta's husband. It would seem that Geeta's pregnancy had provided additional reasons for the unresolved struggle between the three women to become intensified.

This power struggle was apparent even before the interview commenced as Geeta agreed to give the interview with a proviso that the interview be conducted in English only so that her mother-in-law would not be able to understand everything that was said by her. Although the mother-in-law could not participate fully in the interview she was present throughout and later I invited her to give her views on the management of pregnancy and childbirth and on the values of traditional rituals during childbirth.

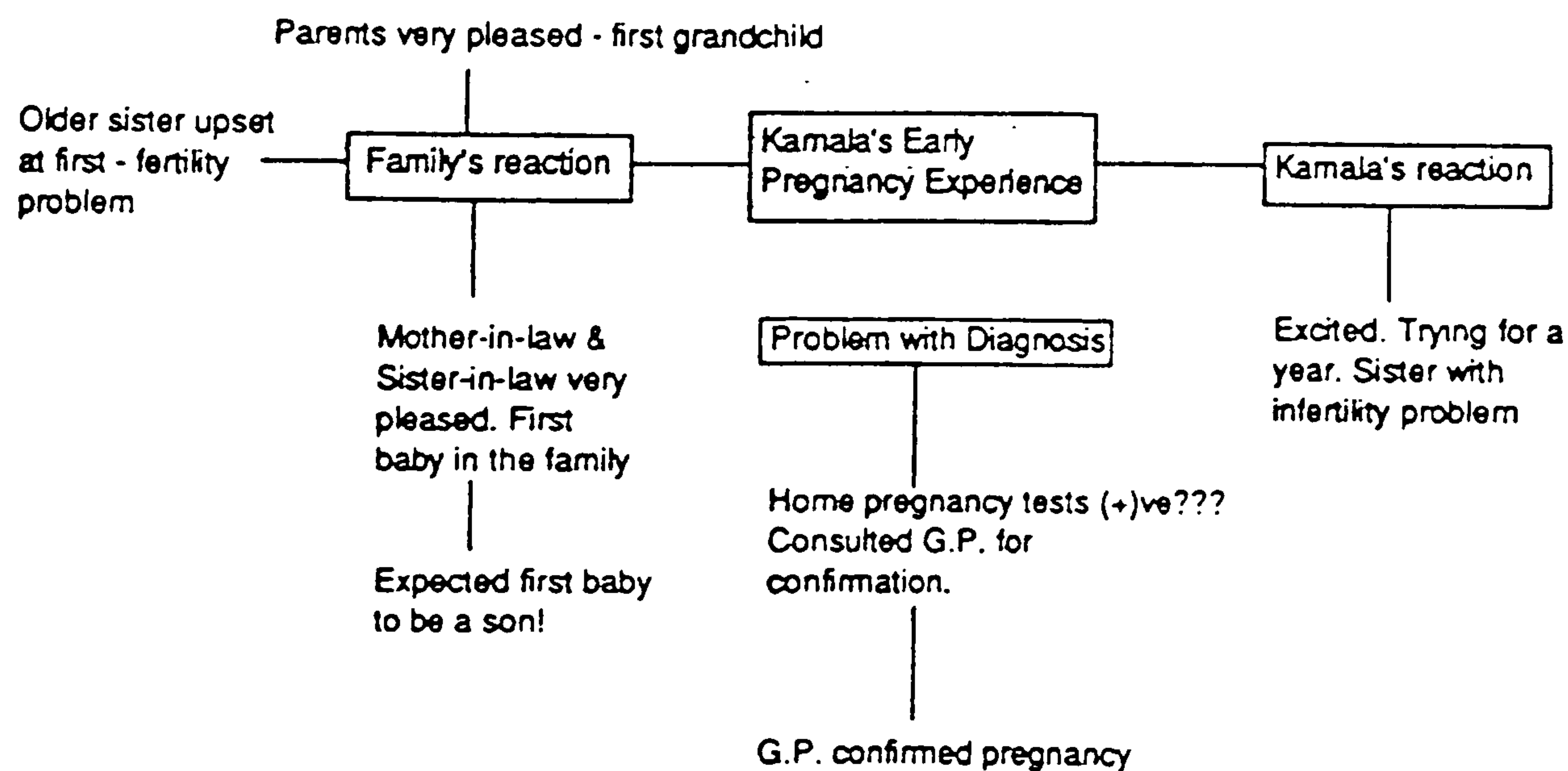
Whilst Geeta was constantly affected by the presence of her

Whilst Geeta was constantly affected by the presence of her in-laws, Kamla who lived apart from her in-laws was not. Kamla and her husband belonged to the same caste and their marriage was arranged by their families. The fact that Kamla's parents lived locally also seemed to work in her favour as she was able to deal with her in-laws with confidence.

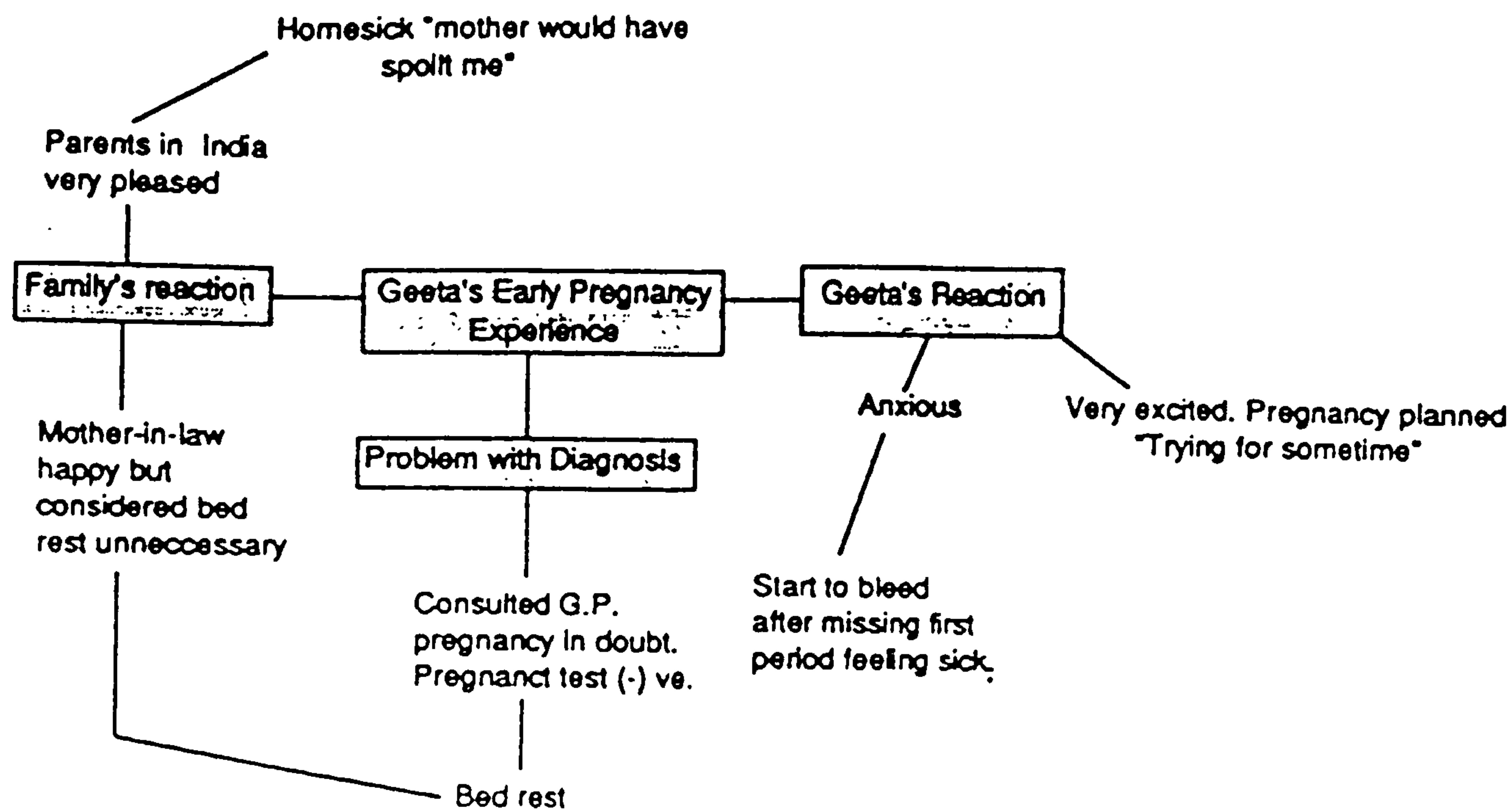
Against the background of Geeta's and Kamla's personal circumstances I am going to focus on the interactions which took place between the daughters-in-law and their families during different stages of pregnancy and after childbirth.

### Early Pregnancy

The immediate reactions of Geeta and Kamla and those of their families are set out in cognitive charts 9E(i) and 9E(ii) respectively.



9E(1) Kamla's Early Pregnancy Experience



#### 9E(11) Geeta's Early Pregnancy Experience

Unlike the women in the previous case study, Geeta and Kamla were very happy to be pregnant as both of them had been trying to conceive for some time. Kamla had been married for four years before starting her family and had resisted pressure from her in-laws to start a family earlier:

"We had been trying for a baby for about a year and when it happened I couldn't believe it. I was getting a bit anxious because we had been trying for a long time and because my older sister has been trying unsuccessfully for the past eight years. I thought I might have similar problems."

Geeta, on the other hand, had been married just over a year when she decided to start a family:

"I was so excited when I missed my first period. We have been trying for a few months but I didn't expect to get pregnant so soon." (Geeta)

Kamla became pregnant about six weeks before Geeta and the reactions of the two sides of the family were very positive and she found that her mother-in-law's attitude towards her became more caring:

"My mother-in-law is really pleased because my father-in-law passed away recently and my becoming pregnant has made the family come together. My mother-in-law and I weren't that close but since I have become pregnant she has

my unborn baby in terms of a boy and not a girl. I think everyone expects me to have a boy first. My husband's sisters are also pleased to become aunts for the first time.. On the whole everyone including my older sister who has infertility problems are happy for me."

Whilst Kamla's confirmation of pregnancy aroused a lot of interest in her parental and in-laws families, the accounts given by Geeta seem to suggest that the daily friction which existed in their joint household affected their behaviour and attitudes concerning the confirmation of Geeta's pregnancy:

"A week after I had missed my period, I started to bleed a little. I was having some problems with my mother-in-law and I am sure that the tension and anger I felt inside me was the cause of the bleeding problem. They (older women) used to work quite a lot in their pregnancies and my mother-in-law expected me to help with the household chores and felt I was making too much fuss about my pregnancy"

Although Geeta suspected that she might be pregnant, the symptoms of her pregnancy were not immediately recognised because the results of the pregnancy tests carried out by her doctor were negative. As Geeta's relationship with her mother-in-law was strained she was not prepared to give credit to her mother-in-law for recognising the symptoms of her pregnancy whereas she appeared to place more faith in her aunt who was a general practitioner and her own doctor:

"My mother-in-law was the first person to remark that I might be pregnant because she had noticed that I was experiencing dizzy spells and was also feeling sick in the morning. I couldn't believe that my mother-in-law was right when my own aunt who had checked me out expressed some doubt about my pregnancy and the pregnancy tests done by my doctor were also negative. My aunt suggested that I should take plenty of rest and my doctor prescribed some medicine for the sickness and the bleeding"

Geeta's mother-in-law, on the other hand, not only believed that Geeta was pregnant but also interpreted the symptoms of early bleeding as a common occurrence in pregnancy:

"My mother-in-law did not like the idea of me staying in a bed all day because she felt that slight bleeding is common in early pregnancy. My mother-in-law also spoke to other women of her generation who agreed with her. My mother-in-law had no doubt that I was pregnant and felt that bed rest was unnecessary. As I had also lost my job soon after becoming pregnant my mother-in-law expected me

to help her with the housework."

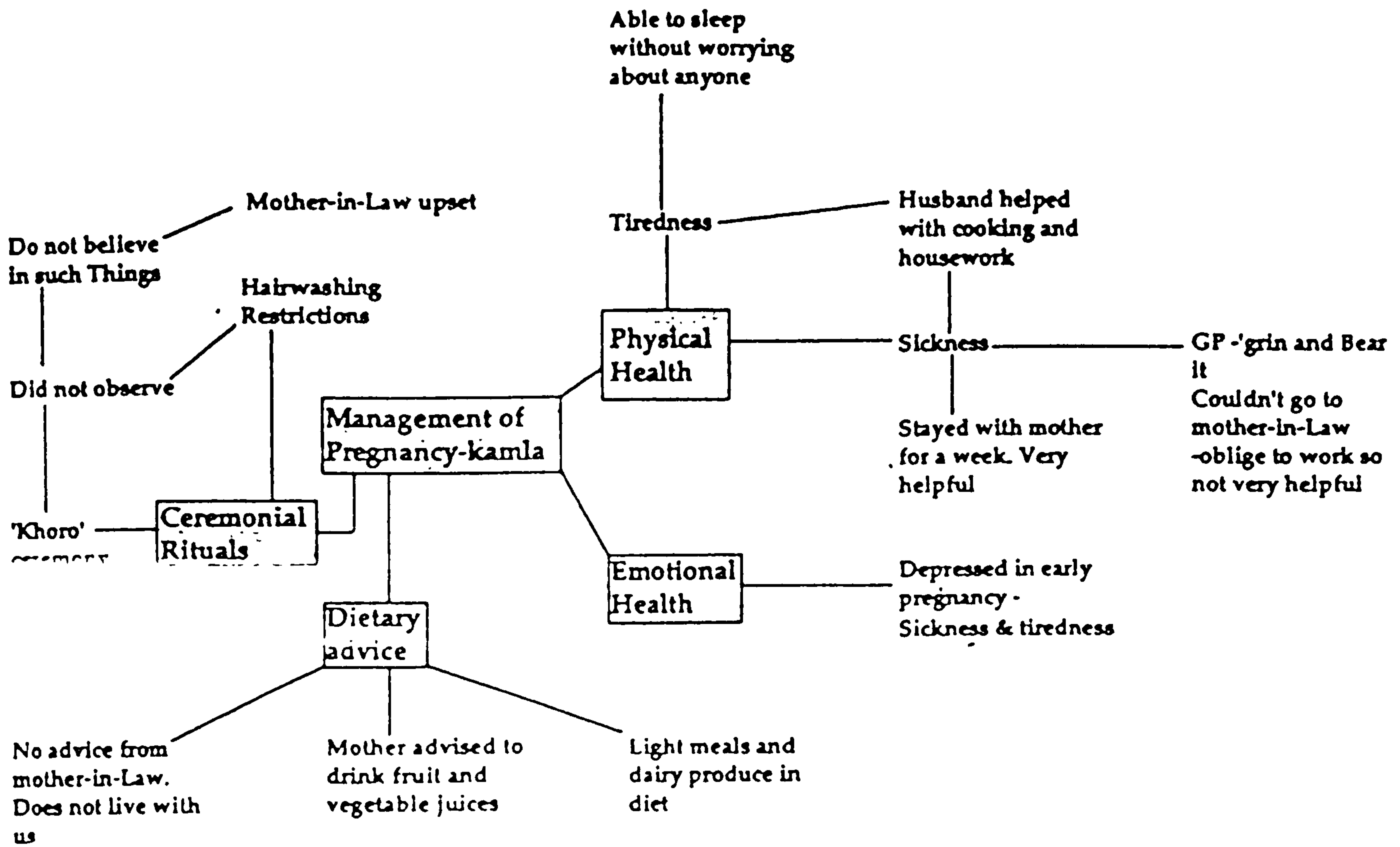
The disagreement between Geeta and her in-laws appeared to overshadow the prospect of a baby in the family as, unlike Kamla, Geeta failed to acknowledge the happiness a new baby would bring to the family. When Geeta was asked to comment on the reactions of relations to the news of the pregnancy, she spoke mostly about her parents in India:

"I spoke to my parents immediately after my pregnancy was confirmed. They are delighted because they were hoping that I would become pregnant soon. I wish they were here with me. At times I really feel homesick. If my parents were around they would have spoilt me - they would have lavished me with care and attention."

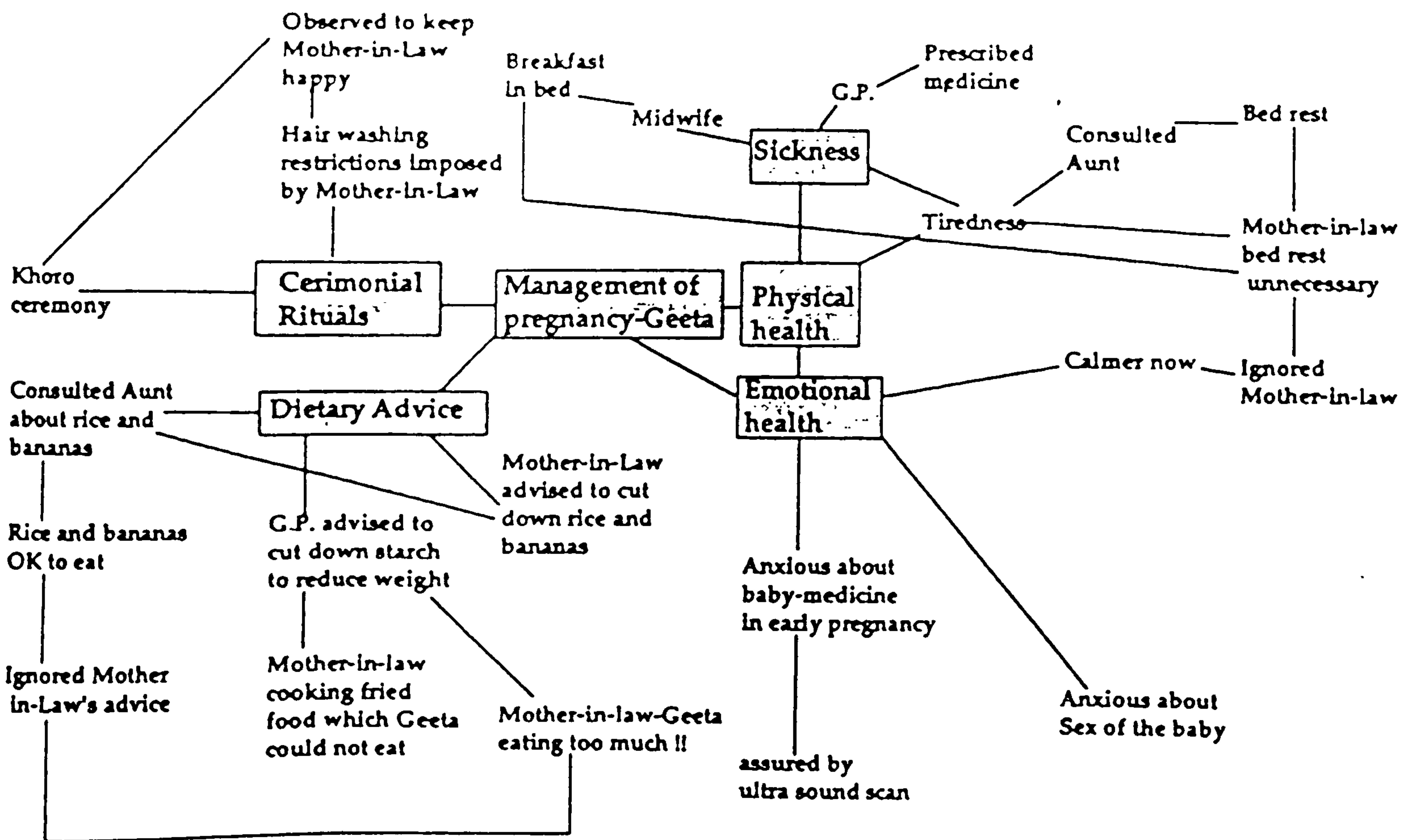
It would seem that in early pregnancy, the impact of the family's influence on Geeta was much greater than on Kamla because Kamla was not subjected to the pressure of living in an extended family. In many respects the experience of Geeta mirrored those of the women in the previous case study. In the next section I am going to see whether the relatives of the pregnant women influenced the management of their pregnancies.

#### Management of Pregnancy

As was the case in the earlier case study, the aspects of pregnancy over which the relatives expressed opinions were physical and emotional health, dietary routines and ceremonial rituals. The involvement of the relatives in the management of their pregnancies is illustrated in Charts 9F(i) and 9F(ii).



9F(1) Kamla's Management of Pregnancy



9F(11) Geeta's Management of Pregnancy



Charts 9F(i) and 9F(ii) it would seem that the way they coped with interference from their relatives concerning their health problems, dietary advice and ceremonial rituals during their pregnancies appeared to be determined by their willingness to take on board the opinions and advice offered by their relatives. For instance, the way they coped with morning sickness and tiredness seemed to suggest that Kamla felt more at ease accepting help from her husband and her own mother than from her mother-in-law although the mother-in-law had offered help:

"Being sick was the worst thing about being pregnant and it started much earlier than I expected. Fortunately, I was not living with my in-laws otherwise I would have felt obliged to help in the kitchen. My husband did most of the cooking while I was unwell. I also spent a week with my mother and even now she invites us for meals to help me. In the beginning I felt constantly tired so I used to go to sleep as soon as I returned home from work. I don't think I would have been so free to do as I please at my in-laws although they would tell you to rest you would still feel obliged to help."

On the other hand, Geeta's expectation of her mother-in-law and sister-in-law appeared to be ambiguous. On the one hand she appeared to reject the advice and help offered by her mother-in-law but on the other hand she complained that her mother-in-law was not very sympathetic or supportive towards her. It would seem that Geeta not only implied that she preferred to listen to her aunt's advice but also used the medical advice to justify her demand for support from her mother-in-law:

"I suffered from sickness and extreme tiredness for nearly four months. I spoke to my aunt about my sickness and tiredness and she advised me to rest a lot. My aunt is a doctor so I value her advice but my mother-in-law expected me to help her with the household chores as I was not working. I spoke to my doctor, and the midwife at the clinic, about morning sickness and they too advised me to take plenty of rest and the midwife suggested that my husband should bring tea for me in bed before I got up. My mother-in-law would not allow my husband to prepare breakfast for me because she did not consider it proper for a man to make breakfast for his wife. I used to get angry and often lost my temper because my mother-in-law was so uncaring towards me. My mother-in-law has old fashioned views- she told me that pregnant women in her times did not take to bed with minor complaints in pregnancy."

Besides the emotional upset caused by the conflict between Geeta and her mother-in-law, Geeta had additional reasons for feeling anxious during her pregnancy:

"I am worried about the baby, hope it will be healthy. I am so tense I hope it will not affect my baby. I can't stop thinking about the medicine I took for the sickness and bleeding before my pregnancy was confirmed. Although the scan did not show anything abnormal I will not relax until I see the baby. I am also worried about the sex of the baby because everyone expects that I will have a boy. I would also like a boy because a boy's life is a lot more easier than a girl's!"

Turning now to the dietary habits of Geeta and Kamla, Geeta's eating habit appeared to be affected by living in a joint family and became yet another point of disagreement between her and her mother-in-law. Any dietary advice given by Geeta's mother-in-law was contradicted and rejected on the bases of advice given by Geeta's aunt. The following dialogue which took place between Geeta and her mother-in-law illustrates the difference in opinion about the management of diet in pregnancy:

Geeta: "I have increased my appetite a lot - I am always hungry. I like eating hot spicy foods and especially things made out of rice. My mother-in-law feels I am eating too much rice. She told me to stop eating rice and bananas."

M-in-law: "Rice is not good because it does not contain much goodness and it also makes you fat."

Geeta: "I don't believe in any of these restrictions. I love banana and rice. I didn't eat them for a while and then I asked my aunt who told me that no harm will come to me if I eat anything I enjoyed eating so I eat everything and ignore my mother-in-law."

M-in-law: "Even the doctor advises you to cut down starchy foods like rice."

Geeta: "For lunch I usually cook simple foods like rice and chappatis and avoid fried foods which my mother-in-law prepares for lunch which she knows I can't eat."

The comments made by Geeta implied that she not only did not share the traditional beliefs about dietary restrictions during pregnancy but also seemed to devalue her mother-in-law's beliefs. The comments made by the mother-in-law suggested that the mother-in-law was trying to exert her authority over her daughter-in-law by imposing dietary restrictions and when she failed, she retaliated by preparing foods which her daughter-in-law would not be able to eat.

Kamla who was living apart from her mother-in-law did not get caught up in similar disagreement about diet with her mother-in-law:

"I have changed my diet to suit myself. My mother-in-law has not given me any advice about diet but she tells Geeta what she should eat and what foods she should avoid. My mother-in-law does not live with me so she does not know what I eat. If I am given a reason for avoiding something I would be happy to comply. My mother advised me to cut down sour foods because she believes that sour foods cause swelling in the joints so now I avoid sour foods."

Given that many aspects of Geeta's pregnancy became foci for confrontations, it was remarkable that when it came to observing ceremonial rituals, Geeta did not put up any resistance. It was more remarkable that Geeta did not take advantage of the precedent set up by Kamla who had refused to observe any ceremonial rituals:

"My mother-in-law had told me before I became pregnant that I would not be allowed to wash my hair for the first seven months of pregnancy. My mother-in-law had also told Kamla who became pregnant before me but Kamla refused to listen to my mother-in-law's instructions. I agreed to not wash my hair for the first seven months only because I am not working. I didn't want to upset my mother-in-law and also in case something did go wrong with the baby- she (m-in-law) would always remind me that I had been disrespectful to our family deity."

When the mother-in-law was asked to give her views she remarked:

"I have done my duty by telling both my daughters-in-law about observing this restrictions which all women in our family have done for generations. If now they go against my wishes then it is upto them"

It would appear that the psychological pressure applied by her mother-in-law and Geeta's anxiety about the effect of drugs which she had taken in early pregnancy may have influenced her decision to obey her mother-in-law. Kamla on the other hand maintained her independent stance in all matters concerning the management of her pregnancy including the observation of ceremonial rituals:

"Once my mother-in-law learnt that I was pregnant she told me that I should not wash my hair until after I had the 'khoru' ceremony at the seventh month. I told her that I had to wash my hair because I was working. Actually, my husband didn't like the idea at all and told his mother

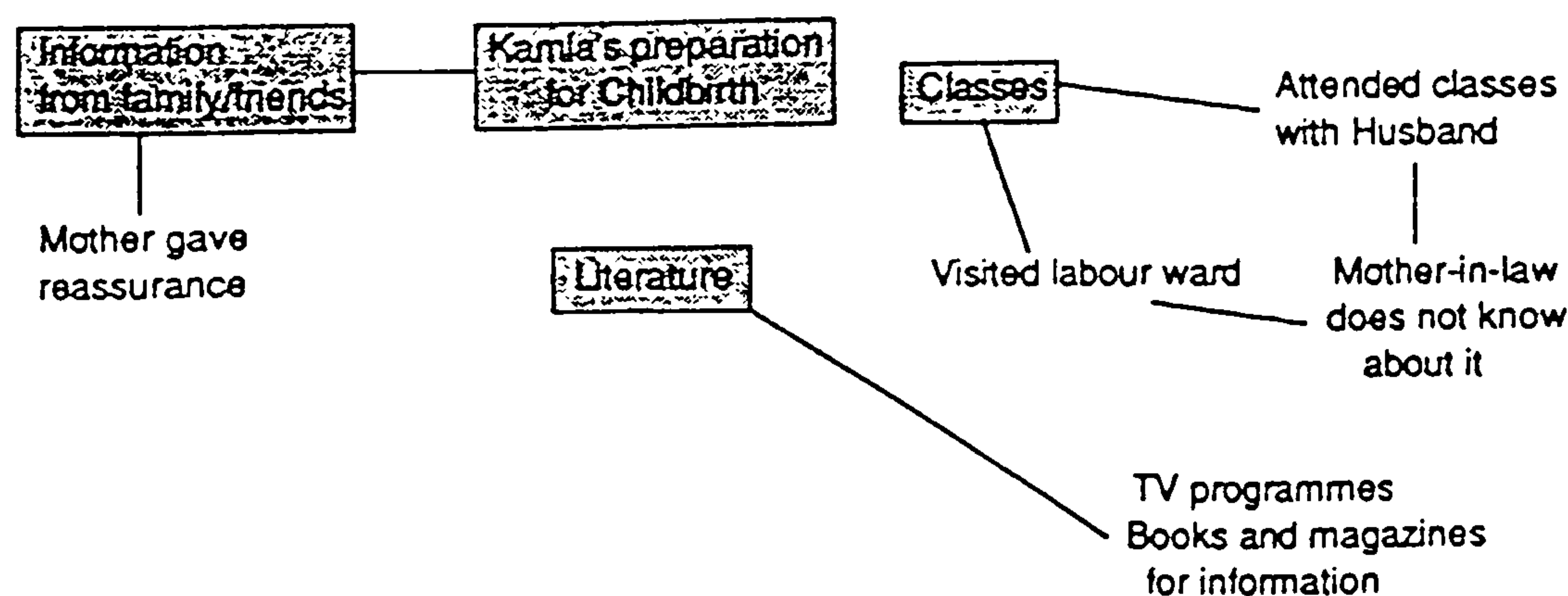
I had to wash my hair because I was working. Actually, my husband didn't like the idea at all and told his mother that he didn't want me to go without washing my hair for seven months. Yet my mother-in-law and other people who strongly believe in such things are not prepared to accept that I have to look good for my job. My mother-in-law told me it was up to me as she was not going to force me. I was made to feel like an outcast and a naughty person to disobey."

Once Kamla had declined to observe the ritual at the beginning of her pregnancy she excused herself from taking part in any further ceremonies and also had her husband's backing to withstand her mother-in-law's exhortation:

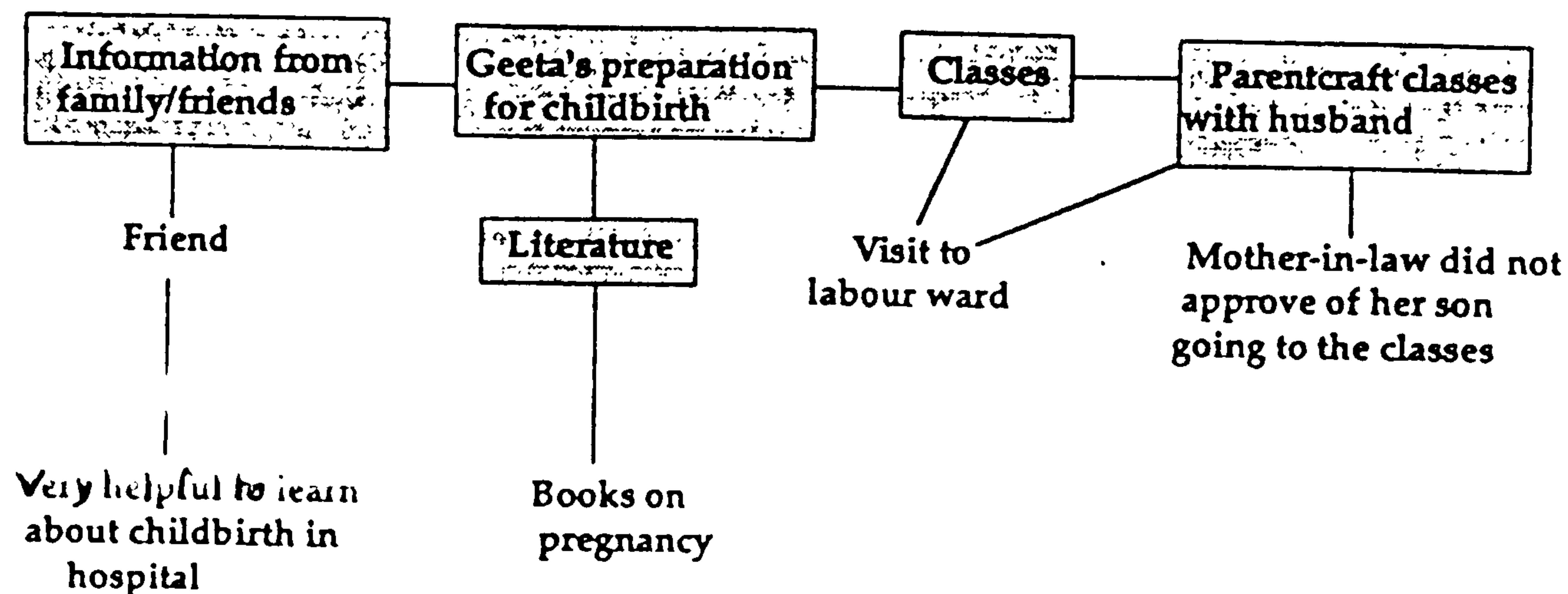
"Since 'khoru' ceremony involves washing hair for the first time, my husband and I felt that it was pointless for me to undergo this ceremony because I had been washing my hair regularly. My mother-in-law still insisted that I should have a 'khoru'. She was really upset and felt that I had let her down. I felt that since Geeta was observing everything, my mother-in-law would not be deprived of her pleasure."

#### Preparation for Childbirth

Like the women in family A, Geeta and Kamla also took advantage of the antenatal classes and other sources of information such as television programmes and printed literature to prepare themselves for childbirth- see Charts 9G(i) and 9G(ii).



9G(i) Kamla's Antenatal Preparation



#### 9G(11) Geeta's Antenatal Preparation

Although the members of Geeta and Kamla's family did not object to their participation in the antenatal classes, Geeta's mother-in-law did not approve of her son attending classes or assisting his wife in labour:

"My mother-in-law doesn't like the idea of her son being present at the time of delivery. She thinks it is shameful to have the presence of any man during childbirth. I don't agree with her so I have told my husband to be with me. My mother-in-law did not like it when my husband came to the classes with me but there is nothing she can do about it."

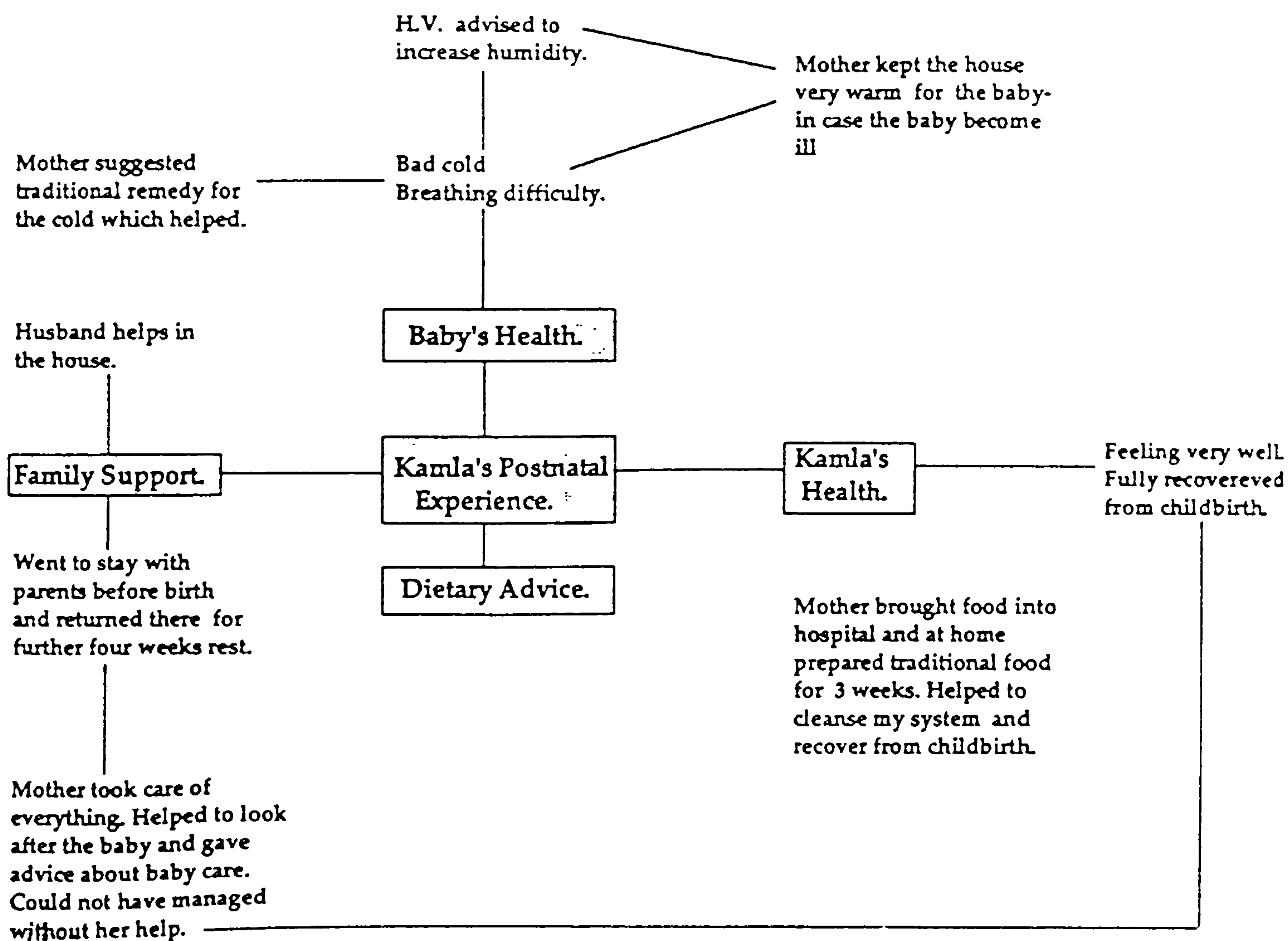
Geeta and Kamla had also ignored the advice of their mother-in-law and visited the labour ward during their pregnancies. However when Kamla was recovering in the hospital after the birth of her baby, they were not able to go against the wishes of their mother-in-law:

"When I was in the postnatal ward everyone from both sides of the family visited me except Geeta because she was pregnant. Neither of us thought any harm could come from visiting a mother after delivery. Geeta was not prepared to upset my mother-in-law and she did not want to tempt fate so she used to wait in the car while her husband visited me."

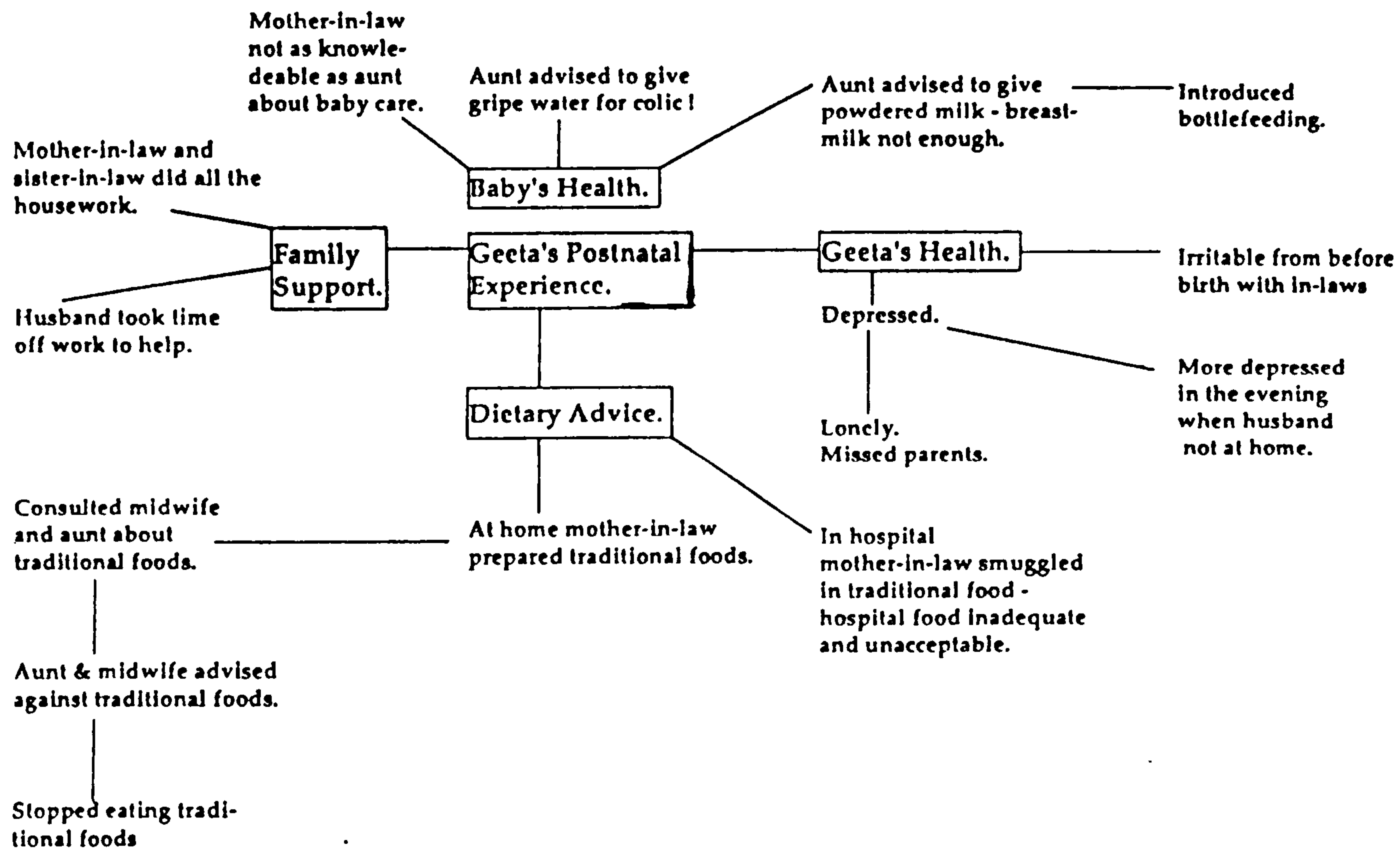
Since none of the relatives in family B were involved during childbirth, I will move on to discuss their involvement after Geeta and Kamla were discharged from hospital.

Postnatal Care in the Family

In many respects the postnatal support and the influence of the family in the postnatal period resembled the experiences of the women in family A. Kamla went to her mother's house a few days before the birth of her baby and returned to her mother's house straight from the hospital. Kamla's experience of postnatal care at her mother's house was similar to that of Meera's in family A. See charts 9H(i) and 9H(ii)



9H(i) Kamla's Postnatal Experience



### 9H(11) Geeta's Postnatal Experience

Geeta had no choice but to return home to her mother-in-law and the tensions which had existed between her and her in-laws during her pregnancy seemed to surface again. Geeta appeared to be more restrained in her comments during the postnatal interview which took place in the presence of her husband's older sister although she did not hide her feelings. She expressed her resentment towards her in-laws by dismissing the dietary advice of her mother-in-law when she returned from the hospital:

"I ate the traditional foods which my mother-in-law prepared for me for a few days but when I asked the midwife whether I should carry on eating this special diet, she told me to eat normal diet because the baby would not get used to ordinary diet! I also asked my aunt and she advised me to eat normal foods. My mother-in-law felt that I should carry on eating the special diet for a few more days. My mother-in-law believes that this special diet helps with backache and recovery especially as she had done it after each of her pregnancies. After I consulted the midwife and my aunt I told my mother-in-law to stop preparing special foods for me."

sister-in-law, it seemed that she wished to convey the importance she attached to the advice given by anyone other than her in-laws. From other comments made by Geeta it would appear that she did not have any real objections to the traditional diet. Like the other vegetarian Gujarati women in my main study, Geeta had received traditional foods from home prepared by her mother-in-law. Accordingly she was using the issue of traditional foods after returning home as a weapon against her mother-in-law:

"When I was in hospital my mother-in-law used to bring traditional foods for me because the hospital meals were inadequate and were nothing like the traditional foods recommended for women after childbirth. I used to share the food my mother-in-law brought with other Indian women in my ward."

Geeta appeared not to lose any opportunity to undermine her mother-in-law's authority by giving more weight to her aunt's advice. Consequently her aunt had more influence over her pregnancy and her behaviour after her baby was born. Geeta seemed to value any advice given by her aunt without any doubt as this comment suggests:

"I have been fully breastfeeding upto now but yesterday I went to visit my aunt who advised me to give him powdered milk as well because she told me that breastmilk is not enough for a baby. My aunt also advised me to give gripe water to the baby to wind him properly. I went to my aunt to ask her advice about how I should care for my baby. She has been very helpful because she is a doctor whereas my mother-in-law wouldn't know anything about colic."

#### SUMMARY

Although the impact of family in the case study B resembled in many ways that of the family in case study A, there were some striking differences in the behaviour and attitudes of the women towards the involvement of their family during pregnancy and after childbirth. It would seem from both family case studies that those women who were living with their in-laws were caught between two cultures. In the case of the women in case study A, their protest against traditional values and beliefs - observation of rituals, dietary and other restrictions - appeared to be the main cause of disagreement during their pregnancies and this disappeared after childbirth. However in the case of family B the relationship that existed between Geeta and her mother-in-law who were living under the same roof did not improve. The struggle between the women was not only due to a clash of cultures but also seemed to be due to a power struggle between them.



In comparison, Kamla had already established her independent status because she was living apart and consequently, whilst she was obliged to listen to identical instructions from her mother-in-law, she was able to ignore everything as the mother-in-law was not physically present to ensure that her instructions were carried out.

## CHAPTER 10

CHILDBIRTH EXPERIENCES OF BANGLADESHI WOMEN WHO WERE  
 BROUGHT UP IN BRITAIN - TWO CASE STUDIES

Like the preceding chapter, this chapter is based on two case studies of Bangladeshi women who were interviewed on separate occasions by me. The data gathered from these interviews was analysed in the same format as the Gujarati case studies to show the influence of the family, religion and culture on the subjective experiences of the two women.

The decision to conduct separate in-depth interviews with Bangladeshi women was made for a number of reasons. Although the interviews of Bangladeshi women for the main study were conducted by trained Bangladeshi interviewers, the material generated from these interviews was not as full as the interviews conducted with the Gujarati women. The kind of data that would have been generated from interviews with Bangladeshi women who had recently arrived in Britain would have been particularly valuable, but being faced with the reality of linguistic and cultural barriers I decided to interview Bangladeshi women who spoke English. Even if these 'well-established' women had adapted to the British environment, they would nonetheless be able to locate their experience within a traditional framework and thus, indirectly at least, throw a light on it. By conducting interviews myself I had hoped to find further explanations for some of the issues which were raised in the main Bangladeshi sample. Through my contacts in the Bangladeshi community in Camden, I approached two Bangladeshi women who had been raised in this country and were both pregnant at the time.

From the main study of Bangladeshi women, it emerged that for many women who had recently settled in Britain, becoming pregnant involved coming to terms with a totally alien maternity care culture which placed different emphasis on the management of pregnancy and childbirth. Since the women in my case study had lived in Britain from their early childhood and had received British education, I was interested to establish whether these women's attitudes, behaviour and expectations of pregnancy and childbirth had changed with the passage of time and by being brought up in the host culture. If so, to what extent did they retain their traditional values and beliefs concerning conception, pregnancy and childbirth? In order to understand the subjective experiences of the Bangladeshi women in these case studies, it is necessary to place their experiences in the context of their social and

personal backgrounds. Once again I have given fictitious names to conceal the women's true identity.

Personal Background of Hena

Age	23
Country of Birth	Bangladesh
Length of Residence in Britain	19 years
Religion	Islam
Education	Law Degree
Occupation	Housewife
Husband's Occupation	Accountant

Hena had come to Britain with her parents from Bangladesh at the age of four years. After she completed secondary school, her parents returned to Bangladesh to arrange her marriage. She was married at the age of sixteen.

After her marriage Hena and her husband settled in Britain. Hena had her first child after she was married for a year. After her first child was born she returned to full-time education to study for a law degree. Her second child was born two years later and she was expecting a third baby just before she graduated from law school.

Hena's parents and a married sister lived locally. Her parents provided a lot of support for Hena during her pregnancies and for her to complete her education. Hena's parents-in-law lived in Bangladesh.

Personal Background of Amina

Age	23
Country of Birth	Bangladesh
Length of Residence in Britain	19 years
Religion	Islam
Education	Degree in Home Economics
Occupation	Housewife
Husband's Occupation	Waiter

Amina came to Britain with her mother at the age of four to join her father. Amina's father died while she was at school. After she finished secondary school, Amina's mother took her back to Bangladesh to arrange her marriage. Amina was married at the age of sixteen. Her first marriage failed after a few months and a year later she got married again.

After her second marriage Amina and her husband came to settle in Britain. She had her first baby after she was married over a year. Her second baby was born the following year. When Amina's second child was one year old she became pregnant with her third child. After Amina got married

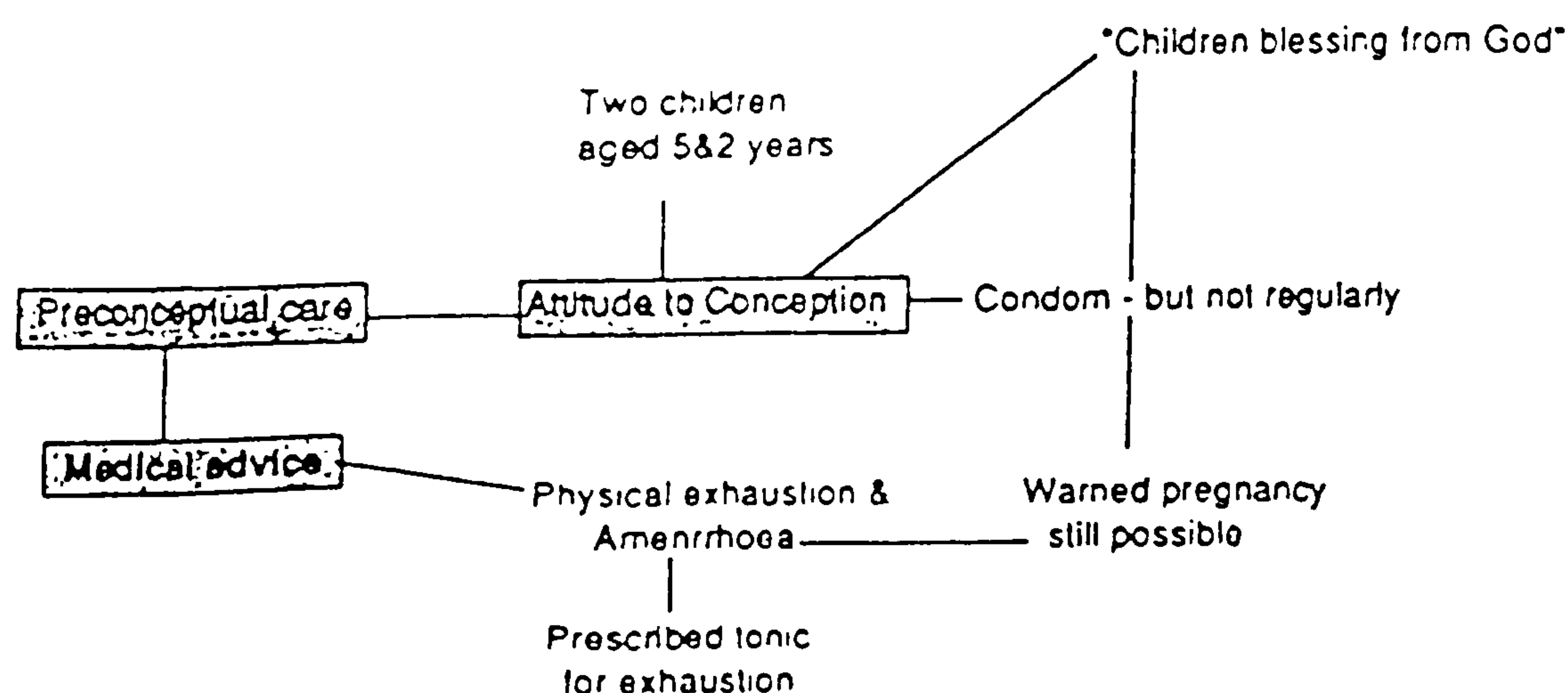
she completed a degree course at a polytechnic. Amina had given up her full time job with the local council and at the time of her interview was unemployed.

Amina's widowed mother lived with her and helped her with her children. Amina's married sister and her husband's brothers and sisters were living locally.

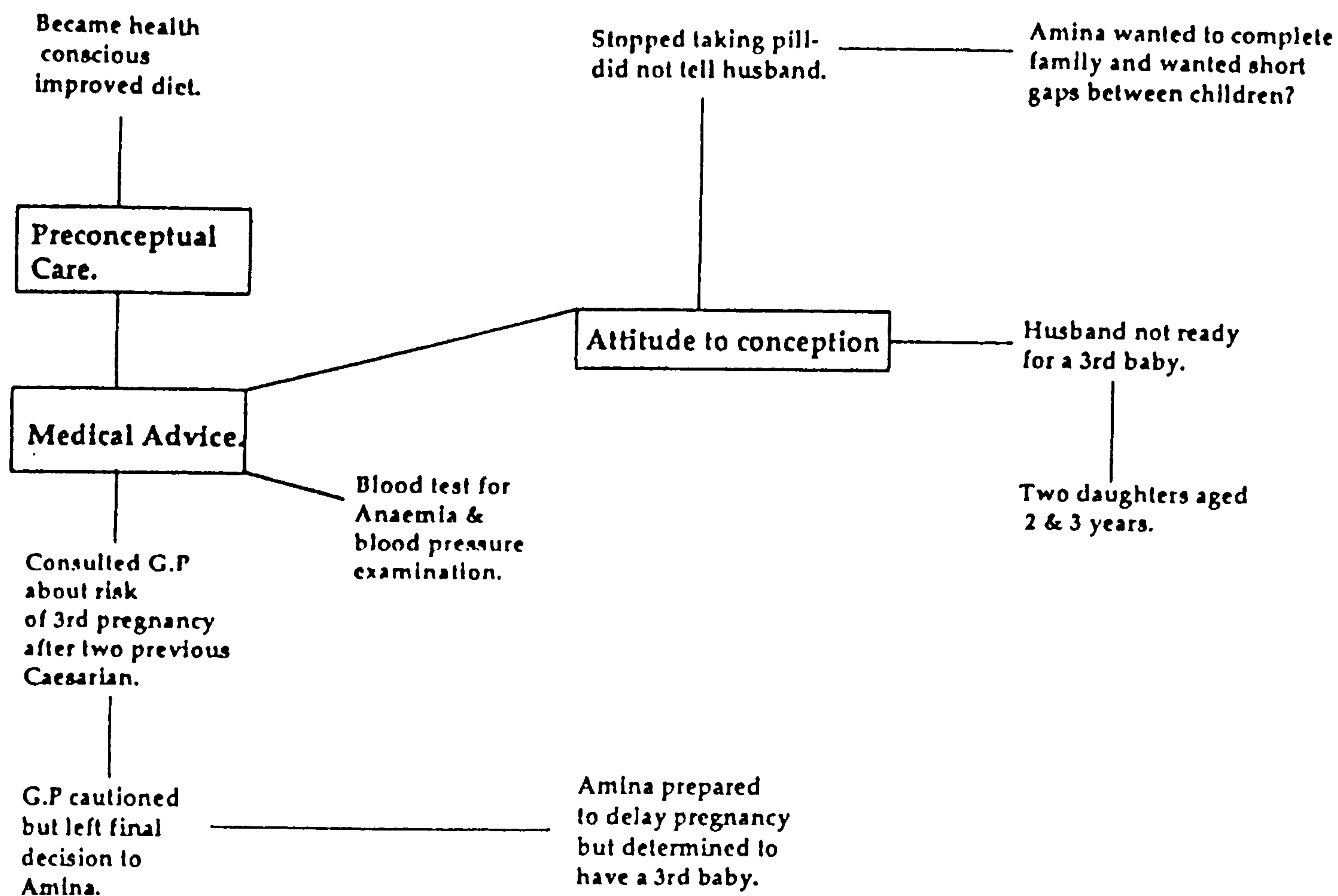
From the personal details of Hena and Amina it is apparent that the main differences between them and the majority of Bangladeshi women in my main sample (see chapter 3 page 65-67) were that they had lived in Britain from their early childhood and had received a British education. Given that Hena and Amina had these advantages over other Bangladeshi women in the main sample, I am going to focus on specific aspects of their pregnancy and childbirth experiences to see whether their educational attainment and their familiarity with the indigenous culture were reflected in their attitudes and behaviour during pregnancy and childbirth. The specific areas which I wish to draw attention to are their attitudes towards conception, reactions to pregnancy, management of pregnancy, preparation for childbirth, management of birth and postnatal recovery.

#### Attitudes to Conception

Since Hena and Amina had two children each from their previous pregnancies, I was interested in their attitudes to conception. Their responses are represented in charts 10A(i) and 10A(ii).



10A(i) Hena's Attitude to Conception



#### 10A(ii) Amina's Attitude to Conception

It is apparent that although both Hena and Amina had practised birth control, only Amina had taken birth control seriously to prevent a pregnancy. Interestingly, Hena's attitude towards birth control reflected the views held by a majority of the Bangladeshi women in the main sample (see Chapter 4 page 74 )

"We were not taking any precautions to prevent a pregnancy since the birth of my second baby. We don't go in for family planning because we think of children as blessings from God. We use condom from time, to time but not regularly, to prevent a pregnancy."

Hena's comment seemed to suggest that cultural and religious views on birth control superceded any health considerations:

"After the birth of my second baby I had consulted my doctor because my menstrual cycle had become irregular. My doctor had told me that I could still become pregnant although I was not menstruating regularly. He felt that my irregular cycle was connected with the hormonal imbalance and poor state of my health. My husband and I were aware

of the risk of pregnancy but we didn't think that I would become pregnant so soon."

It would seem that for Hena the concern for her own health became an important consideration in retrospect; especially as a result of her poor health before and during her present pregnancy. In addition, although she accepted the value of spacing her pregnancies for the sake of her health, she was not prepared to rule out having more children in future to comply with her religious beliefs:

"Although I was not mentally or physically ready to have another baby I was not unduly concerned that another pregnancy would further compromise my health. Now I feel that if every-thing goes well with this pregnancy, I would have a gap of at least four or five years before having another child. I have realised how weak I have become." Amina, on the other hand had stopped using the contraceptive pill to have her third baby:

"I was not at all surprised when I became pregnant because I had come off the pill the previous month. I decided to have another baby because I had given up my full time job. I wanted to complete my family while we were still young as this is going to be our last baby."

Amina's decision to have another baby within a short interval of her second Caesarean birth with its attendant risk and her concern for own health seemed contradictory and difficult to understand. The reason why Amina desired another child so desperately was not obvious at first. It only became apparent later that it was her cultural conditioning which urged Amina to have another baby in the hope that her third baby would be a son. For Amina, it would seem that cultural pressure to produce a son far outweighed any medical advice which cautioned her against a further pregnancy:

"I had consulted my G.P. before I came off the pill to find out if my uterus would be strong enough for a third pregnancy. After my second Caesarean section, the consultant at the hospital had warned me that my uterus was too weak to withstand any more pregnancies. My G.P. also reminded me that a third pregnancy would be hazardous but left the final decision to me. If my doctor had advised me not to have another baby I would have just delayed it but I would have had another baby because I wanted a third baby. I wasn't as concerned as I am now that my uterus might rupture. Once I had made up my mind, I had a blood test to make sure I was not anaemic. I took multivitamins and improved my diet to have a healthy pregnancy."

Amina's determination to have another baby was so strong

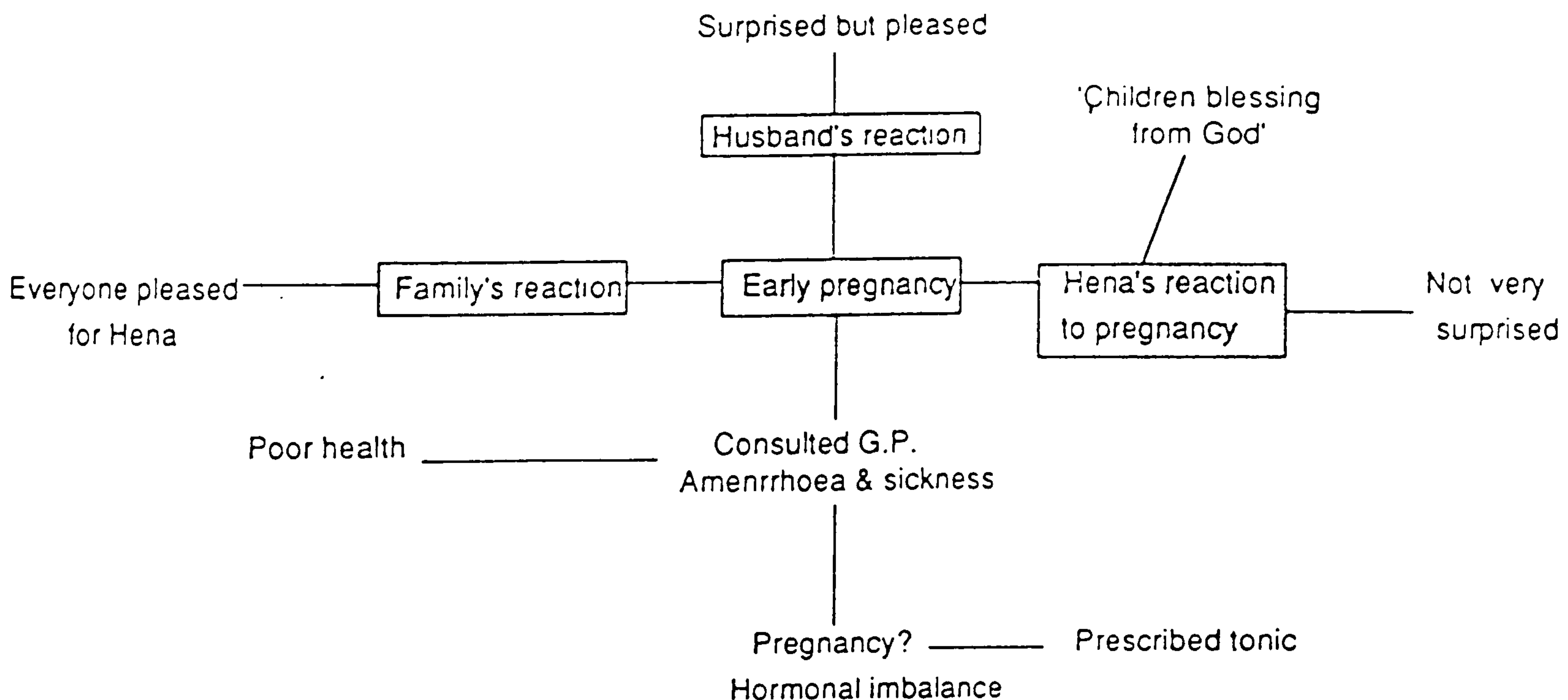
that she was prepared to override her husband's displeasure:

"I did not tell my husband when I came off the pill because he was not keen to have a third baby so soon while our second daughter was just a year old."

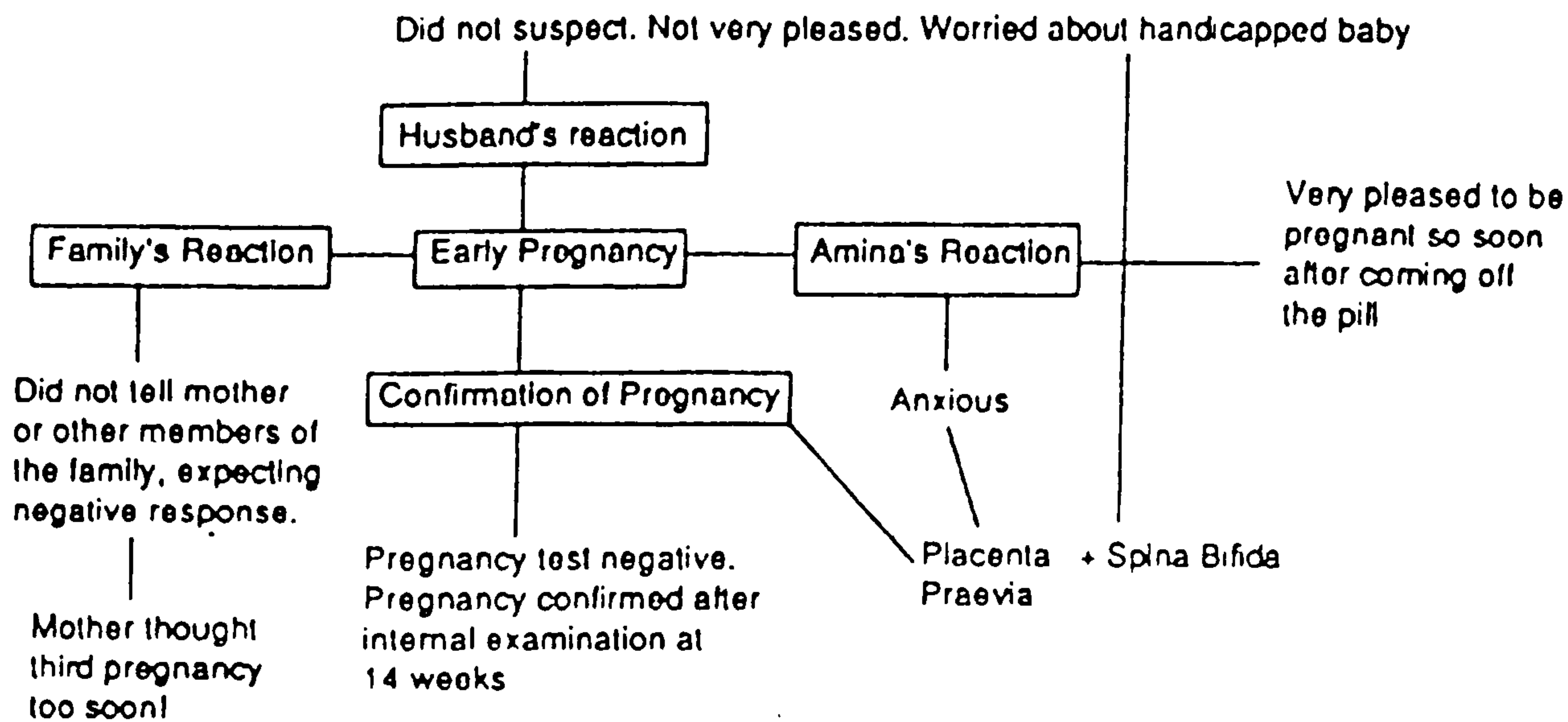
It would seem that although Hena and Amina were able to take control over their fertility their desire to fulfil their religious and cultural expectations outweighed any implication for their baby's and their own health.

Reactions to Pregnancy

In Hena's case, reactions to the confirmation of her pregnancy were more predictable than those of Amina's. Whilst Hena's husband and other members of the family accepted her pregnancy without question, in Amina's case, announcing her pregnancy to her husband and other members of her family was complicated by the fact that she had not involved her husband in the decision to have another baby. See Charts 10B(i) and 10B(ii).



10B(i) Hena's Early Pregnancy Experience



#### 10B(ii) Amina's Early Pregnancy Experience

"I told my husband when I missed my first period. I dropped hints that I might be pregnant. I didn't want to shock him because we had not planned it together. He kept telling me that I would get my period. When I missed my second period he started to believe me. He was not pleased at first because our second daughter is very young. He would have preferred for us to have waited for a few more years. It took him a while to accept that we were going to have another baby."

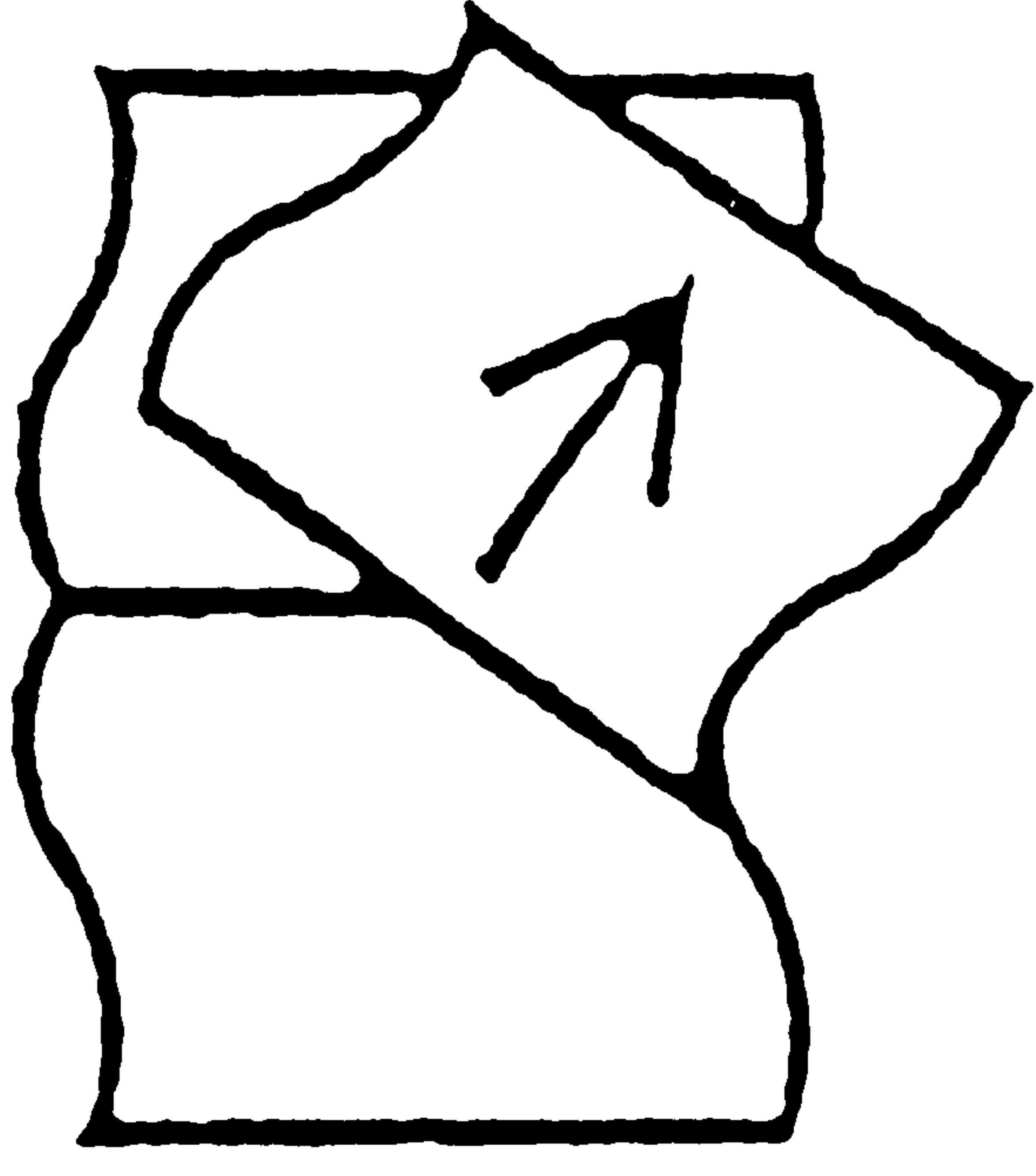
Although Amina was initially very pleased to become pregnant so quickly after coming off the pill, she had not expected her happiness to be marred by complications in her early pregnancy. Her situation was exacerbated by the fact that she was not able to share her anxiety with other members of her family because she had not told them about her pregnancy. Amina's husband was too upset to be able to offer her any support. Amina left it as long as possible before she announced her pregnancy fearing family's members' negative reactions:

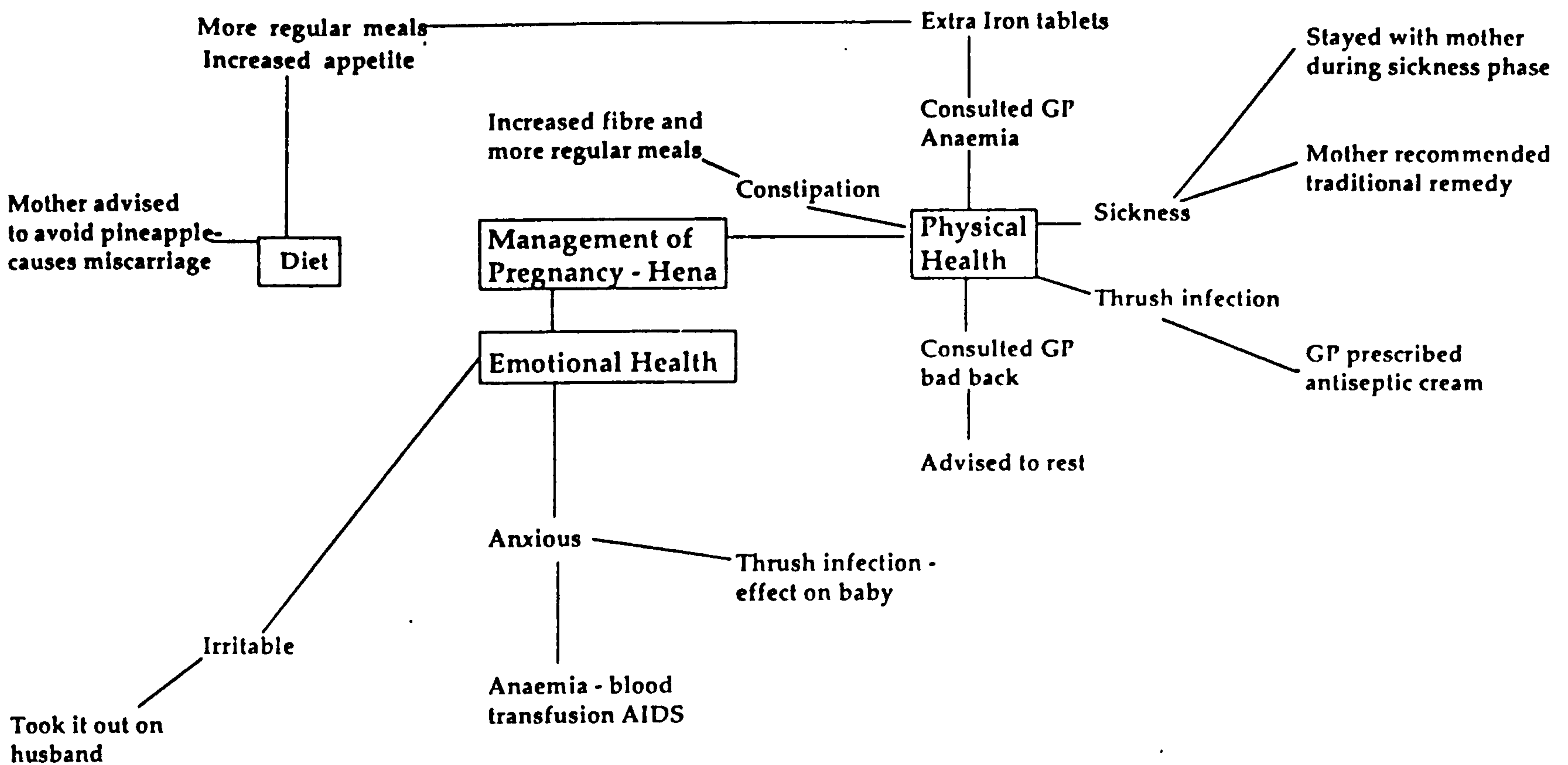
"I did not tell my mother and my sister until I was over three months pregnant. My mother's reaction was the same as that of my husband. She was not pleased and told me that I was mad to be pregnant so soon after my last pregnancy. By this time I had had my first hospital appointment and I was told that my placenta was located too close to the cervix and there were traces of protein in my urine which indicated that the baby might have Spina Bifida. As my mother was not pleased with my pregnancy I



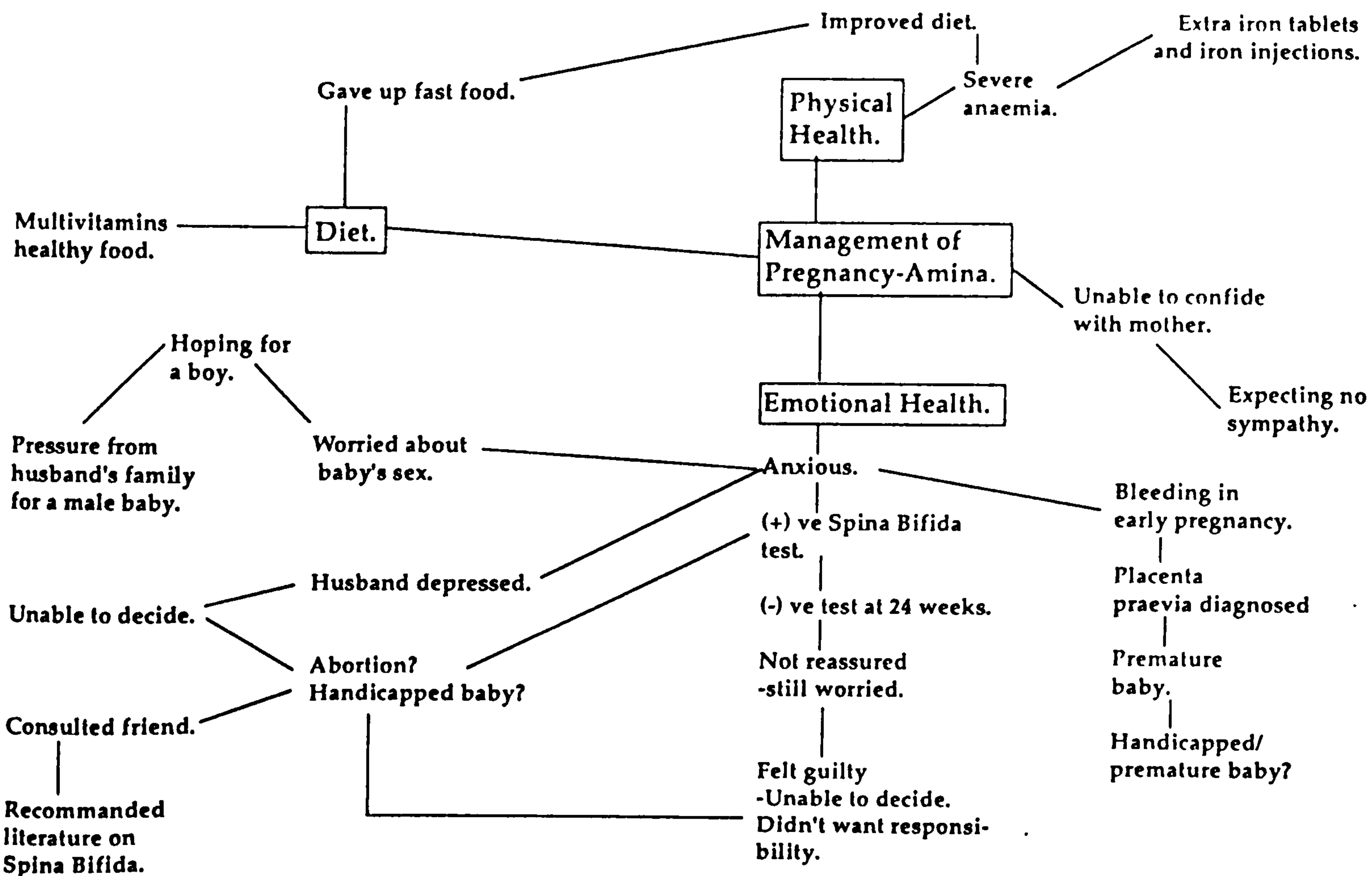
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10C(i) Management of Hena's Pregnancy



10C(ii) Management of Amina's Pregnancy

In Hena's case, her pregnancy put extra strain on her already impoverished health. As a result some of the common discomforts of pregnancy became exacerbated. Unlike the Bangladeshi women in the main study who tended to avoid consulting their general practitioners during their pregnancy, Hena freely sought medical advice of her doctor and also took the advice and physical support given by members of her family. For instance, Hena's fear of contracting AIDS through blood transfusion, made her take medical and dietary advice seriously so as to cure her anaemia. Besides acting on the medical advice for her anaemia, Hena was also following the advice of her doctor to cure a thrush infection:

"I have had a problem with anaemia for the very first time during this pregnancy. I have been advised to take extra iron tablets to improve my blood count. In spite of extra iron tablets, my blood count is not what it should be and the hospital is still concerned about it. I am really worried in case I need a blood transfusion. Because of AIDS I do not want a transfusion."

Hena also took the advice of the hospital dietitian and changed her eating habits to cure her anaemia and constipation:

"I eat more balanced meals and keep more regular mealtimes than I used to before I became pregnant. I am following the dietary advice by including more milk and fresh vegetables to improve my blood count. I eat more foods containing high fibres to reduce constipation."

Hena found the emotional and practical support provided by her mother very valuable to cope with sickness and tiredness in the early months of her pregnancy:

"I suffered from sickness and extreme tiredness for nearly four months. I used to go over to my parents house from early morning and only came home to sleep. My mother used to do everything for me and my children. I used to just eat and sleep. My mother used to offer me grapefruit juice and beetlenuts to chew to obtain relief from the nausea and sickness."

Although Hena received a lot of support from her family, her poor state of health continued to cause her anxiety right upto the end of her pregnancy:

"Because I have been feeling very weak, I worry about having enough strength to cope with labour. I can't wait for the pregnancy to end because I am really fed up. I can't stop thinking about anaemia and the thrush infection

which might affect my baby. I often feel irritable and depressed about everything."

Turning now to Amina it became apparent that whilst her physical health, especially her anaemia, was a serious cause of concern to her and her obstetrician, her physical health problems appeared to be insignificant compared to the mental anguish she experienced about the health and the sex of her baby. Although the initial positive test for Spina Bifida turned out to be wrongly diagnosed, the concern about foetal abnormality and abnormal location of the placenta continued to cause Amina and her husband anxiety throughout her pregnancy:

"It is very hard to describe how I felt when I was given the positive results of the Alfafoetoprotein tests. I started to blame myself for becoming pregnant. I kept looking for things to blame. I didn't want the responsibility on my shoulder - I was torn between termination and having a handicapped baby, neither of which provided any comfort or answers."

Having given birth to two daughters, and especially after the birth of her second daughter, Amina had been made to feel inadequate for failing to produce a son. This pressure for Amina to produce a son came from her husband's older brother. Although the sex of the third baby was a constant source of anxiety, the feeling of inadequacy was increased by the prospect of possibly producing a handicapped baby:

"When our second daughter was born, I must say, I was hell bent on having a son. I did feel some disappointment. A few members of my family from both sides were disappointed and even voiced their disappointment openly; saying well it is another girl and it is another Caesarean. The next birth will also be a Caesarean and if the third baby is not a boy then they will have to arrange the marriages of my daughters with their cousins so that my husband's inheritance would not go outside the family. They made me feel very depressed, even my husband felt low. They made us feel inadequate because we could not produce a son. I am aware of the comments that will be made by certain members of my family if this baby is a girl! One of these people is my older brother-in-law and we can't retaliate in any way."

In order to find out more about Spina Bifida, Amina confided in a friend who was able to guide her to other sources of information on Spina Bifida:

"In the beginning I had no one who I could turn to for help except a close friend. She was very supportive. With her help I read all the available literature to find

out what I had done in my early pregnancy which could have caused spinal deformity in the baby."

Amina's husband was unable to offer her much support as he too found it difficult to accept the idea of having a handicapped baby:

"My husband took it very badly. He became depressed and withdrew completely - blamed himself for it. He wouldn't talk to me. He wasn't able to help in taking any decisions. He wanted me to decide on my own. I felt very depressed because I couldn't talk to anyone."

Since Amina's family did not have a previous history of Spina Bifida, a second blood test was done. Amina and her husband found the waiting for the results of the second blood test a most testing time, especially for Amina who was preparing herself for termination of the pregnancy if the second set of results were positive:

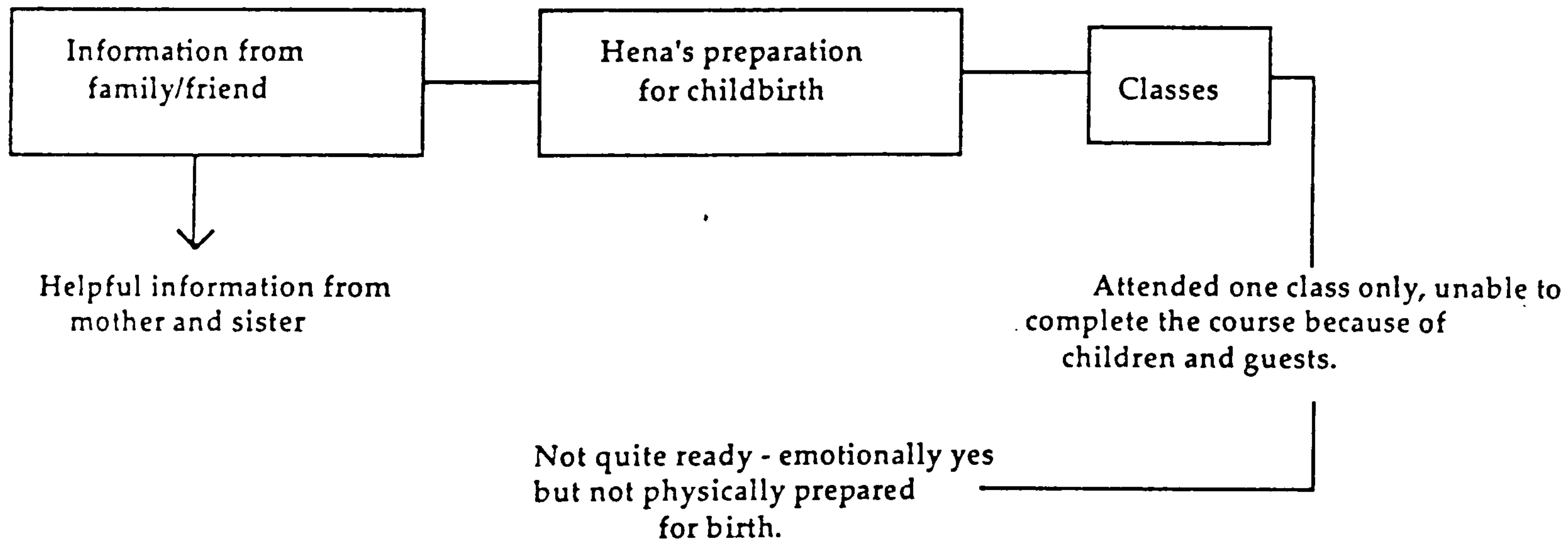
"The second lot of tests took a long time to come and waiting for the results was most traumatic. At the same time, the time limit to request abortion was approaching very fast. I knew I could not get an abortion after a certain number of weeks and I would end up having to carry a handicapped baby to full term. There was no one I could turn to for sympathy or who could understand the dilemma I was in. My mother was not very pleased to learn that I was pregnant so there was no way I could share my problems with her. It was a very depressing time until I was told that the results of the second set of tests did not show up any trace of Spina Bifida. Even now no one except my husband and a close friend knows about the Spina Bifida."

Despite the fact that the results of the second set of tests turned out to be negative, Amina had lost confidence in the ability of health professionals to make correct diagnoses. Amina's anxiety was further heightened when she was admitted into hospital because she developed bleeding problems half way through her pregnancy:

"Although it was a relief to be told that the baby had no abnormality, I still have nagging doubts. I am not assured because they could have made another mistake. I became more depressed when I started to bleed because of the placenta praevia. I was so frightened. I didn't want to face it. I just wanted to close my eyes and hoped that it was just a nightmare. I felt I was being punished because not only might I have a premature baby but it also might be deformed. I honestly don't know how I would cope. I don't know how I would react but at the same time I am not totally offended by the idea of having a handicapped baby."

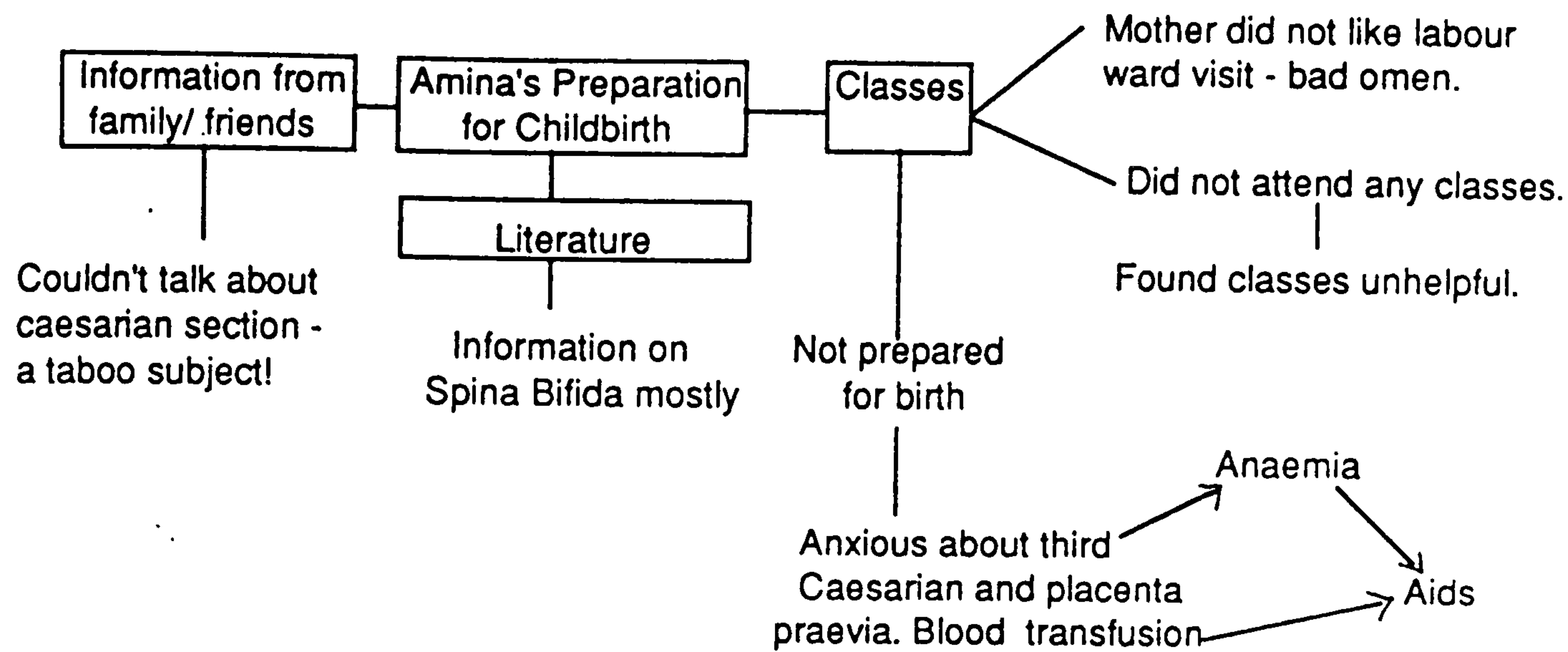
It is apparent from the experience of Hena and especially Amina that whilst they were able to draw attention to their physical symptoms for which they were offered appropriate advice and treatment, their emotional problems did not seem to attract much attention. Although Amina's case was an extreme example, it showed that not all Asian women living in an extended family are guaranteed emotional support. Furthermore if articulate women like Amina and Hena fail to receive emotional support it only highlights the plight of other Bangladeshi women who are effectively silenced by their inability to communicate with the health professionals. Since this inability to communicate had also determined to some extent other Bangladeshi women's access to antenatal classes and other sources of information, I am going focus on whether or not Hena and Amina had taken advantage of antenatal classes and other sources of information on childbirth.

#### Antenatal Preparation



#### 10D(i) Hena's Antenatal Preparation

Hena had not attended any classes during her previous pregnancies because she was studying for her law degree and in her present pregnancy she had attended only one class [see Chart 10D(i)]. She was unable to complete a full course because she was busy with her children and guests from Bangladesh.



#### 10D(ii) Amina's Antenatal Preparation

Amina, on the other hand, had taken advantage of a full course of classes with her first pregnancy but during her second and third pregnancies she declined the invitations to the classes. After Amina realised that she could not have a normal delivery, she decided not to take up the offer of a refresher course:

"After my first daughter was born with an emergency Caesarean I decided not to attend classes with my second and third pregnancies because they would not be much use to me. From my experience of attending classes during my first pregnancy, I found that the classes are geared for women with a normal pregnancy expecting a normal birth."

Unlike most Bangladeshi women in my main sample, Hena and Amina had made use of printed literature and television programmes to obtain information on pregnancy and child-birth. They had also benefitted from the discussions they had had with other women. However, Amina found that some Bangladeshi women who had Caesarean sections were either reluctant or unable to share their experiences with her:

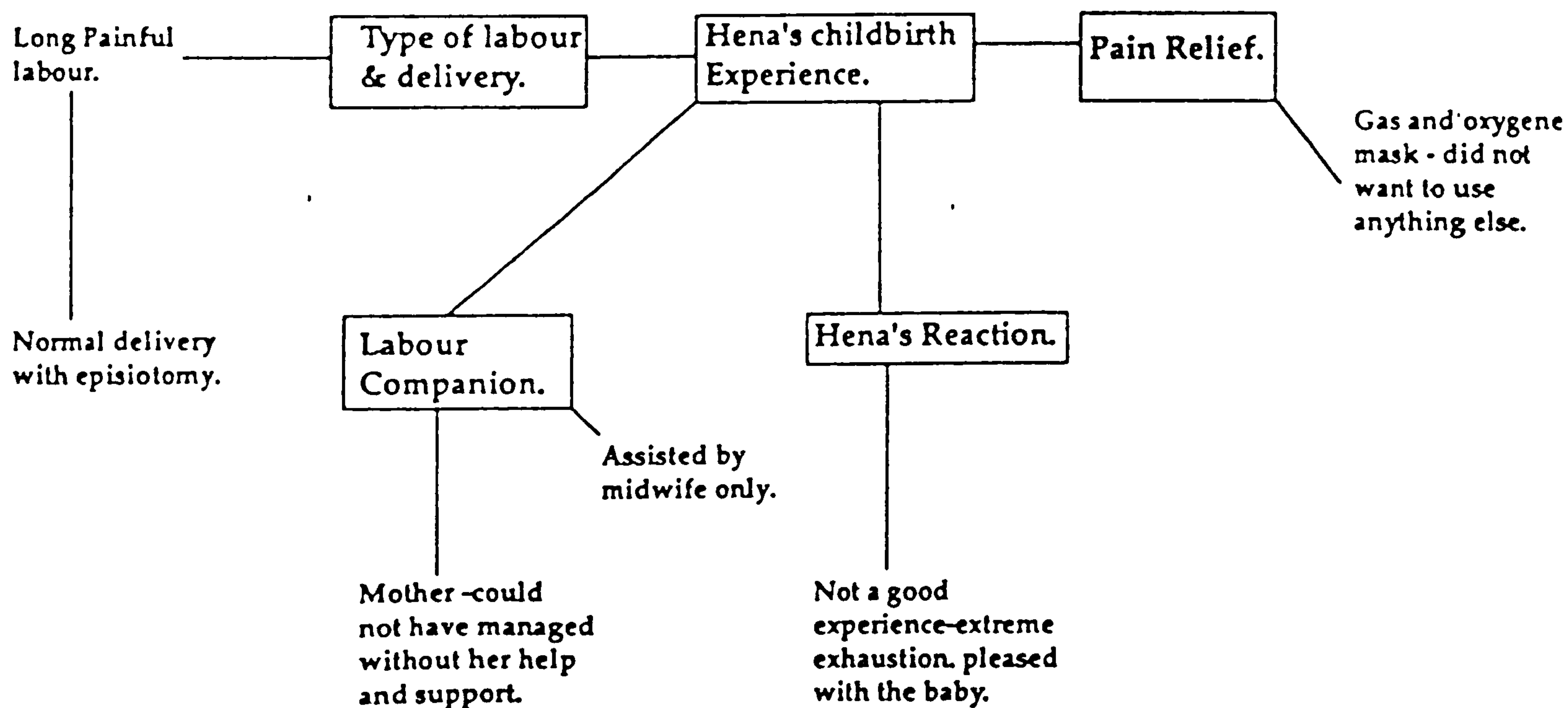
"I found that other women from my country were not willing to talk about their Caesarean sections. Some women did not really understand anything about sections or why they had one, especially those women who had normal deliveries in Bangladesh."

Despite the fact that both Hena and Amina had previous experiences of childbirth, each of them had reasons for believing that they were not fully prepared for birth. Whilst Hena's main concern was for her own health, Amina's was concerning the uncertainty about foetal abnormality, the pressure to produce a male child and the fear of contracting AIDS through blood transfusion:

"I have become more apprehensive as my pregnancy has advanced. I am terrified to think that the baby might be physically repulsive to look at. I don't know if I can cope with it. My feelings are so confused; at times I am desperate to get over with it and at the same time I want to put it off as long as I can. I am also worried about having another Caesarean and blood transfusion because of the risks they carry."

### Childbirth Experiences

Hena's experience of childbirth is represented in Chart 10E(1) below.



10E(1) Hena's Childbirth Experience

Hena had a normal delivery with an episiotomy. Hena found her labour was painful and lasted a lot longer than her previous two labour. Hena had decided not to use anything except the gas/oxygen mask for pain relief:

"When the contractions became unbearable I used the



gas/oxygen mask to take the edge off the contractions. I had decided I was not going to accept any other forms of pain relief. During the birth of my first baby, I had accepted pethidine which had made me feel completely out of control and I ended up with a forceps delivery. That is why, no way was I prepared to use anything else."

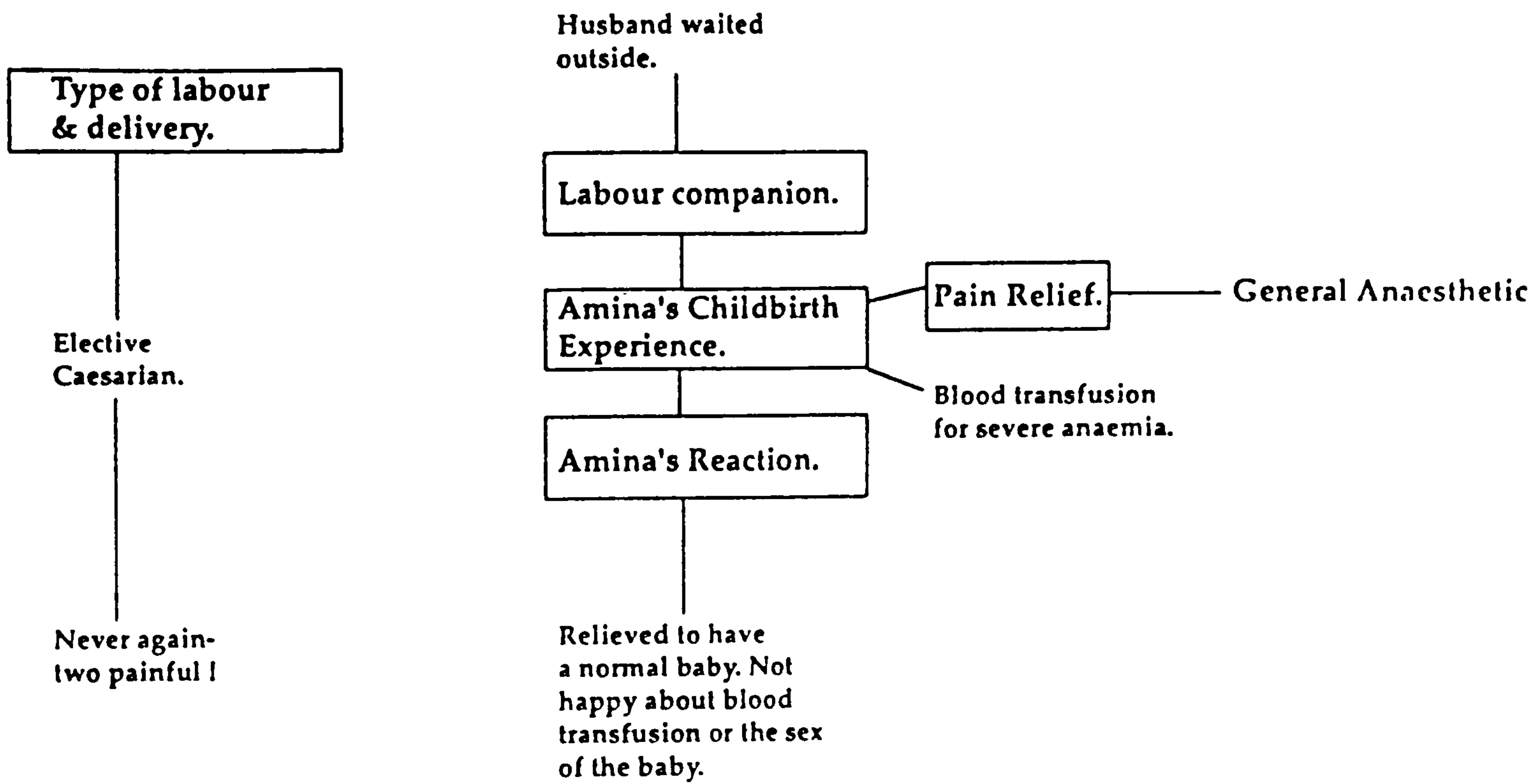
Hena felt that she was too exhausted even before she went into labour to cope well and if her mother had not given her support she would have found it very difficult:

"Looking back I do not think it was a good experience compared to my last two labour. I felt I was in labour for too long. My labour lasted for about sixteen hours! I don't think I could have managed without my mother's help. She gave me physical and moral support throughout my labour. Just her presence made me feel better. My husband feels nervous about hospital and in any case, in my country, it is always a female relative who supports a woman in childbirth. My mother was also present during my last two deliveries. My mother assisted the midwife as much as she could. She also made sure that I did not end with another retained placenta as it had happened with my first labour."

Hena had requested that during her delivery she should be assisted by female obstetric staff only:

"At my first hospital visit I requested to be placed under the supervision of female doctors during my pregnancy and for delivery. The only time I would agree to be examined by hospital male doctors was in times of emergency. Throughout my labour I was helped by a midwife and my mother."

In Amina's case, pregnancy was terminated by Caesarean section five weeks before the expected date of delivery because of placenta praevia and to avoid further weakness in the scar tissues surrounding the site of the previous Caesarean sections. Since Amina had a general anaesthetic with her previous sections, she had decided to use general anaesthetic again. After the operation, Amina was given a blood transfusion because she had suffered from severe anaemia during her pregnancy. Amina's childbirth experience is represented in Chart 10E(ii)



#### 10E(ii) Amina's Experience of Childbirth

After the birth of the baby, Amina's reactions were mixed:

"I felt terrible as the effect of the general anaesthetic wore off. At that time I thought I would never go through another section again. When I regained my senses the first thing I asked the nurse was if the baby was alright and if she was normal. The minute I heard that she was normal all my worries disappeared. It was a relief to know that she was normal. I don't know how I would have coped, perhaps while she was a baby but not as she grew older. I don't think my husband would have coped at all, emotionally and physically. I am pleased she is okay but I would have been more pleased to have had a son. For the first two or three days I felt depressed and dejected. I blamed myself and assumed it was my fault although it was irrational I just couldn't help it."

The experiences of Hena and Amina suggested that Hena and Amina appeared to be more at ease in their dealings with the hospital. This was particularly so in the case of Hena who was able to determine the kind of care she required during her pregnancy and at the time of delivery. Hena had also decided the type of pain relief she would use based on her previous labour experience and stuck to her original choice despite the fact that she had found her labour unbearable. Although Amina's experience was not unlike many other British women who undergo Caesarean section under general anaesthetic, her anxiety about the welfare and the sex of the baby seemed to colour her perception of her childbirth experience.

## Postnatal Experiences

In this section, I am going to focus on Hena and Amina's experiences in the postnatal period at hospital and at home. Since their health was a major problem during their pregnancies, I am specifically interested in looking at their physical and emotional health after childbirth and at the role of their relatives in the postnatal period.

### Hospital Confinement

Unlike many Bangladeshi women in my main sample, Hena and Amina did not find it difficult to adjust to hospital routine because they had previous experience of staying in hospital and had no difficulties communicating with the hospital staff. However, as far as hospital meals were concerned, Hena and Amina appeared to be just as dissatisfied as some of the women in my main sample. Amina who was kept in hospital for almost two weeks after her third Caesarean section commented:

"I managed as best as I could eating hospital meals. It was difficult for my husband to bring food from home because he was busy looking after my two daughters at home. In the wards Muslim patients were served so called 'halal' meals which in fact were really vegetarian meals because there was no meat in them. I was in hospital for eleven days and at the end I was desperate to go home."

Hena who had her baby in another London hospital also found the hospital meals unsatisfactory:

"Fortunately I was able to come home after four days. I was not able to eat the hospital meals because I was worried in case the meals which we were served were contaminated with 'non-halal' foods. I survived on bread, milk and vegetables. I was not able to receive food from home as I had done with my previous deliveries because my mother did not have time to bring food for me."

Hena and Amina's experience of hospital food suggested that their attitudes towards dietary restrictions in keeping with their religious beliefs had not altered as a result of growing up in Britain.

Although Amina found the care she had received from the hospital staff was very good, she felt that some members of the hospital staff did not really appreciate the cultural or personal reasons why some women refused to be sterilised:

"I have been asked if I will have more children. I don't know about it but I shall not be sterilised. I might try for another baby in five or six years time. At one point I was going to be sterilised but I have lots of doubts. For example, what if my children died?..What if my marriage fails and if I remarry? I might want children. The people who were advising me to be sterilised were only interested from the medical point of view and ignored the emotional side."

### Postnatal Convalescence At Home

#### Health of the Mothers

Six weeks after childbirth, it appeared that Hena and Amina's emotional and physical health was still a cause of concern. Although Amina was recovering from a Caesarean section and receiving treatment for anaemia, her physical health appeared to be causing her less concern than her emotional health. The comments made by Amina suggested that her feelings of dejection and depression were linked to the attitudes of the family towards the birth of her third daughter:

"There was a mixed reaction from the rest of the family. My mother was pleased but my husband's elder brother was definitely not pleased because I had a third daughter. My husband's cousin was displeased and he even asked me if I had undergone sterilisation or if I would try for a son next time. My brother-in-law has been asking if my husband would find a second wife or would he remain a 'goolam' (servant) to me. There has been this kind of talk about me which has hurt me deeply. First few weeks I felt very inadequate - why me? why could I not have a son? It was always implied that I had a daughter and therefore by implication it was my fault and there was something wrong with me. I felt very alone and depressed. I don't feel threatened by the prospect of my husband's remarriage but it does hurt when other people point a finger at me, it hurts when my brother-in-law taunts my husband."

Hena, on the other hand, found that six weeks after the birth of her baby there was no significant improvement in her physical health. Hena was also receiving treatment for anaemia which was making her very irritable with her family:

"I felt very tired when I first came home because I was anaemic after the delivery. I felt very weak. I am still taking iron tablets. Unfortunately I don't remember to take them regularly. I felt very depressed on and off. I am more aware of feeling low this time than with my previous births. I just cry a lot and take it out on my

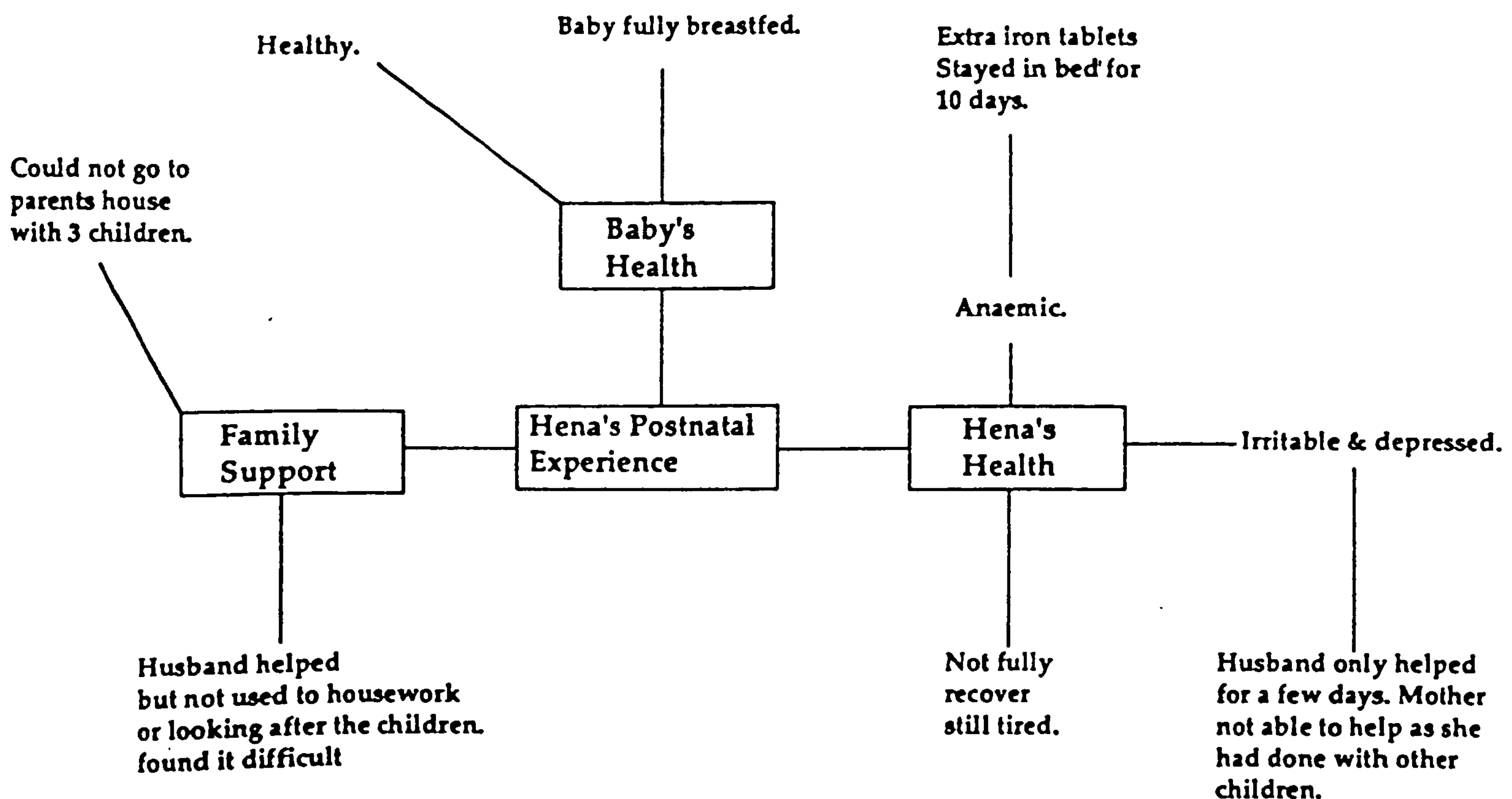
husband and the children. Because I am feeling so tired I just became more irritable about everything."

The emotional trauma and disappointment experienced by Amina are shared by many other Asian women who fail to give birth to a son. Unfortunately many of these women internalise their guilt and shame and fail to get the support they require. It would be unusual for women in a similar situation as Amina to speak so openly as she had done.

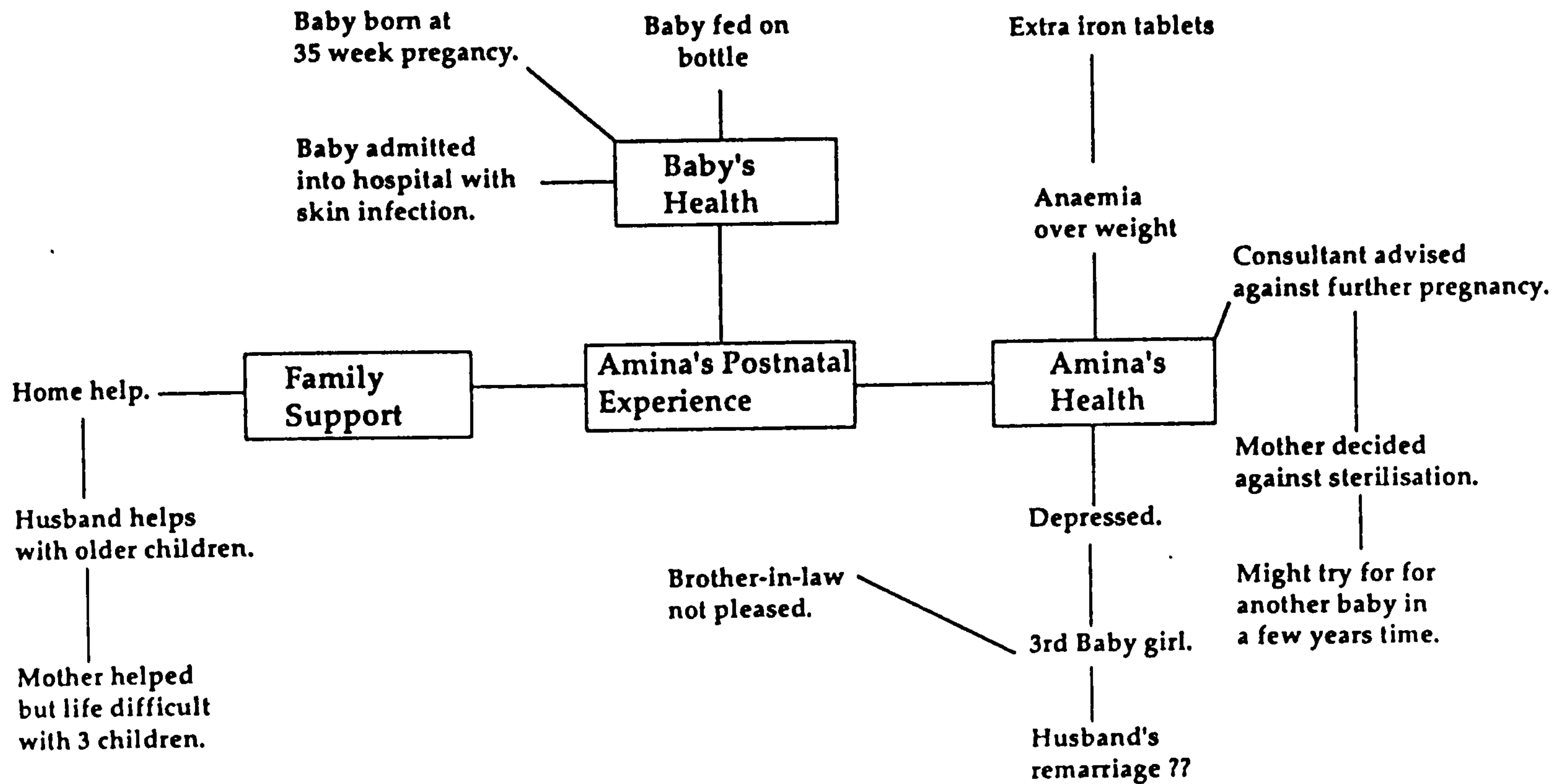
### Family Support at Home

After Hena returned from the hospital, she had to rely on her husband to look after her and her children. Hena's mother who had provided support after the birth of her first two children was not able to offer her any help because Hena could not go to her parents house:

"For the first ten days after I came home I stayed in bed. My husband did the housework and looked after the children. He had never done anything like this before so he found it very hard and the children played up a lot with him. I could have gone to stay with my mother but I did not want to go because it is a lot harder to organise everything with three children. It would have been too unsettling for the children."



10F(1) Hena's Postnatal Experience



#### 10F(11) Amina's Postnatal Experience

When Amina returned from hospital, her mother who was living with her provided help with the housework and helped to look after her other two daughters. In addition, Amina also had a home help to do shopping and laundry as her mother was not able to go out on her own. Despite the amount of support which Amina had, she found it very difficult to cope with two children under five and a new baby:

"I am slowly going mad trying to cope with my two daughters and a baby. My older two are still young enough to require individual attention. Some days when the baby and the older two start crying all together, I want to sit in the middle of them and cry as well. My mother helps a lot and I have a lady who comes to help twice a week but I still feel I can't cope."

#### SUMMARY

On the whole, Amina and Hena's experiences of pregnancy and childbirth suggested that despite their educational attainment and the length of time they had spent in Britain they had maintained strong ties with their religion and culture. This was evident in their attitudes towards conception and producing a male child. However, on other cultural issues such as Purdha restrictions they had adopted more liberal

attitudes towards male medical practitioners. In this respect their behaviour and attitudes differed significantly from the Bangladeshi women in the main study who either delayed medical consultation or sought advice through the intermediaries i.e. usually through their husbands. Other important factors which determined the quality of medical care and attention received by Amina and Hena were ease of communication and familiarity with the maternity services.

As far as their attitudes and behaviour towards management of pregnancy and childbirth were concerned, their experiences appeared to be similar to those of Gujarati women of similar social and educational background. However, it was interesting to note that whilst some Gujarati women's experiences suggested that they were confronted with the clash of two cultures, Hena and Amina's experiences appeared to be free of such crises.

Another interesting observation which emerged from Hena and Amina's accounts was the apparent lack of the kinds of conflicts found between the older and younger Gujarati women. However this does not mean that the older relatives did not have any influence on the younger Bangladeshi women. Although it would seem that generally women who lived with their husbands' family were more affected than those who did not, Amina's in-laws who did not live with her still had an influence over her as demonstrated by her determination to produce a male offspring to satisfy them.

The amount of stress experienced by the women in the case studies suggested that neither group of women were spared. It would seem that certain factors such as an unplanned pregnancy particularly in the case of multigravidae women, Caesarean section, anxiety about the sex of the baby, especially - in the case of women who already have daughters and need a son, and finally women who have been trying/waiting for a number of years before conceiving all can be sources of great anxiety and stress. Whilst some women may be able to share their anxiety with others, those women who are either isolated or have the fear of being ridiculed by those who do not share their cultural beliefs may not feel free to express their fear and anxieties. Amina's experience is a case in point and adds weight to the earlier assertion that just because Asian women live in extended families, it does not necessarily follow that they have the emotional support they need.

An important conclusion to emerge from the case studies is that individual circumstances interact with cultural expectations in certain ways, producing feelings, needs and behaviour which many health carers may not be sufficiently aware of in order to be able to respond in a sensitive way.

## CHAPTER 11

## CONCLUSION AND RECOMMENDATIONS

In undertaking this project, my main objective has been to provide some insight into the experiences of childbirth from the perspective of Asian women. In doing so, I hope I have raised some of the issues which confront Asian women. In concluding this thesis, I would like first to discuss the position occupied by Asian women within the current childbirth debate in Britain. In particular, I would like to focus on the attitudes and behaviour adopted by the two groups of Asian women included in this study. After discussing these more theoretical issues, I would like to focus on more practical questions, putting forward suggestions as to how concerns of Asian women might be addressed by the policy makers and the health professionals in the National Health Service.

However, before proceeding any further, it is necessary to place these women's experiences within the context of the wider British society. This is important for two reasons - firstly, as has been demonstrated in the empirical chapters, Asian women do not live in a cultural vacuum: they are affected by childbirth practices in both their own and the indigenous culture. Secondly, it is necessary to draw parallels between the views and experiences of Asian and British women to ensure that the perspective of Asian women is neither overlooked nor marginalised.

Whilst it is misleading to make broad generalisations about the attitudes and behaviour of Asian women towards childbirth, the concerns voiced in this thesis raise important questions both for women generally and for those involved in providing maternity care. In many respects the worries of Gujarati and Bangladeshi women mirror those of indigenous women. There are, however, many differences in behaviour between the two groups of women.

It is apparent, for example, from the discussions in Chapter 2 that questions of control over childbirth are related to the wider social control of women and in particular, to the medicalisation of childbirth and the influence exerted by male medical professionals in the management of childbirth. The way maternity care is organised and managed does not encourage women to take control of decisions affecting the management of their childbirth. From the accounts of Gujarati and Bangladeshi women it is evident that the impact of social control of reproduction and the medicalisation of childbirth implicitly and explicitly affected their decisions and behaviour concerning conception, management of pregnancy, antenatal care and antenatal education, and the management of delivery and post-partum care.



For Asian women, however, the conflict between their own cultural expectations and the expectations of the health professionals makes this situation more complex still. For instance, the circumstance under which the women became pregnant was greatly influenced by whether or not the women were able to exercise control over their fertility. This in turn depended not only on their cultural and religious attitudes to birth control but also on who had the responsibility for taking precautions against pregnancy. In the case of many Bangladeshi women the decision whether or not to have a baby was out of their control because of religious beliefs, whilst for many Gujarati women who were keen to follow advice about family planning from the health professionals, the ability to put family planning advice into practice depended on their partners' willingness to take an equal share of the responsibility.

Similarly, women's ability to exercise control over decisions affecting the management of pregnancy was determined by how much they were influenced by the medical management of pregnancy and how much by the traditional management of pregnancy supervised by other women. Whilst traditional female-centred management of pregnancy placed greater emphasis on traditional diets, remedies and rituals to enable women to make a safe transition from pregnancy to motherhood, medical management of pregnancy required the women to have their pregnancy confirmed by their doctor, and required them to attend antenatal clinics for routine tests and examination and to avail themselves of antenatal education and follow dietary and health advice given by the medical professionals.

For Gujarati women, the two very different managements of pregnancy created a great deal of conflict. Because many women were fully conversant with the western medical system they were more open to persuasion to accept the medical model of care during pregnancy. At another level Gujarati women who were living in an extended household were expected to follow the advice given by their older female relatives. Gujarati women who faced this dilemma appeared anxious to reject the influence of the older female relatives but did not openly question the control exercised by the doctors.

The accounts of Gujarati women expecting their first baby suggested that they placed greater faith in western medicine and were very eager to seek medical confirmation of the pregnancy. They had a better record of attendance at the antenatal clinic and antenatal classes and took medical advice very seriously compared with Gujarati women who had had previous experience of childbirth in Britain. This pattern of behaviour was continued by many first time mothers right upto the time of delivery including in the post-partum period.

Bangladeshi women, on the other hand were not only anxious to observe purdah restrictions but also appear to be guided by their previous knowledge of the traditional management of pregnancy. As a result many Bangladeshi women did not worry unduly about obtaining medical confirmation of pregnancy nor did they consider it necessary to attend antenatal clinics early in pregnancy or attend antenatal classes. In fact, some women with previous experience of antenatal care in Britain deliberately delayed reporting their pregnancy to avoid attending clinics more than was necessary. Therefore, one could conclude that whilst Bangladeshi women were glad to receive medical care, they nonetheless determined how soon they availed themselves of it. Although Bangladeshi women did not openly set out to defy medical control, their decision to delay seeking medical advice is nonetheless a form of resistance to medical control. It is, however, important to stress that the Bangladeshi women's reluctance to come forward for antenatal care was also due to other reasons such as difficulties in gaining access to clinics, communication problems and the lack of childcare facilities.

Even if women succeed in resisting medical control of the management of their pregnancy, when it comes to choosing a place of delivery, only the most well-informed and determined women can arrange to give birth at home instead of hospital. With almost 100% hospitalisation of birth together with the increasing use of modern technology, most women find it difficult to resist medical control. Neither the Gujarati nor the Bangladeshi women appear to put up any resistance against hospitalisation or the medicalisation of birth overtly, however, Bangladeshi women relied on their previous knowledge of childbirth and delayed their admission into hospital as long as it was possible and inadvertently delayed coming under the control of obstetricians and medical technology. From the accounts of a majority of Bangladeshi women it was evident that on the whole they spend shorter time in labour wards and had far fewer medical interventions compared with a majority of Gujarati women.

When the current debate about control over childbirth is examined in the context of Asian women in this study, a complex and contradictory picture emerges. On the one hand, this contradiction seems to be located in the issue of pollution and female-centred childbirth practices and on the other hand it is located in male dominated medical practices. Ironically, it would appear that because men in most traditional societies have a fear of contamination from pollution, they have been content to leave the responsibility of managing childbirth in the hands of women. At one level it would seem that the older women were colluding with the subjugation of women by perpetuating beliefs about pollution. At another level they were keeping the pollution belief alive to ensure that men were kept out of childbirth

and also to safeguard their own status and influence within the family.

The attitudes and behaviour of some women, particularly Gujarati women, seem to suggest that in their attempt to reject the pollution taboo and the influence of their female relatives they inadvertently ended up accepting western child-birth practices dominated and controlled by men. However because of different patterns of immigration, most Bangladeshi women do not form part of such family groupings in Britain and are therefore less likely to be subject to such pressures.

Although, neither Bangladeshi nor Gujarati women appeared to be entirely satisfied with the treatment they had received from the medical professionals, their criticism was not directly linked to the lack of control they had over decisions affecting the management of pregnancy and child-birth. In fact, there was very little suggestion from either group of women that they objected to medicalisation, hospitalisation or high-tech birth or that they equated such practices with a form of female oppression. Whilst it is true that many women, particularly Bangladeshi women, expressed concern about receiving care from male health professionals and about difficulties in gaining access to health services because of language problems, they did not openly question the hospitalisation or the medicalisation of childbirth.

Such ambiguous attitudes on the part of Asian women to western childbirth practices might lead one to conclude that Asian women are less favourably inclined towards traditional childbirth practices than to the western medical model, and that they do not share the concerns of indigenous women regarding the lack of control over childbirth. I would like to suggest that such conclusions represent only a superficial view. To fully understand the reasons why the women appeared so well inclined towards western childbirth practices, it is necessary to take into account additional factors, such as institutionalised sexism and racism within the health service.

In the present climate, when women are expressing a concern about the power male health professionals have over women's bodies, it is perhaps surprising to find that Asian women are not expressing a similar concern. And yet in the early sixties indigenous British women also believed that the doctors' judgement should not be questioned because their superior knowledge was based on specialist training. In fact, even women's organisations such as the National Childbirth Trust and the Association for Improvement in Maternity Services, which were set up to represent the interests of childbearing women, did not fully appreciate the danger of placing so much power in hands of the medical profession.

Jenny Kitzinger (1990 :105), writing on the history of the National Childbirth Trust, points out that whilst the organisation's main aim was to promote natural childbirth, the Trust took great pains to woo the medical profession. At the time, antenatal teachers trained by the National Childbirth Trust were instructed to encourage pregnant women to place their trust in the medical profession and to obey doctors' orders. The Association for Improvement in Maternity Services' early campaigns were to demand hospital delivery for all women and pain-relieving drugs in labour to be made more freely available to all women regardless of social class. These demands were made with the best possible motives, and the implications of the lack of choice in the place of delivery and the disadvantages of pain-relieving drugs were only realised much later. In response to the dissatisfaction and alarm expressed by women about the lack of freedom to make their own decisions, both these organisations are now actively involved in campaigns to restore control over childbirth to women.

It would seem that the women who have gained most from the organisations which have challenged medical authority are predominantly white middle class women. The interest of working class women and women from black and ethnic minority communities have not been adequately addressed by these organisations. As a result, the information which enables white middle class women to take control over decisions affecting childbirth is not so readily accessible to other women. Therefore in the case of women who do not have any information other than that which promotes the medical management of childbirth, it is not surprising to find that most women, including Asian women, are in awe of medical professionals.

Another reason which makes it difficult for black and Asian women to question the authority of the medical profession is that it is dominated by predominantly white middle class men. For black and Asian women who have been brought up under the shadow of western imperialism, it is difficult to challenge overt and covert racist attitudes which cast aspersions on different beliefs. Very often it is not only difficult to recognise covert racist attitudes but, worse still, there is tremendous pressure to internalise them. The most obvious examples of how racism affects Asian women are demonstrated by the attitudes of Gujarati women both towards the medical profession and towards traditional childbirth practices. At one level Asian women, in common with other British women, have to struggle with the sexist ideology which places male health professionals on a pedestal. At another level, Asian women have to cope with racist attitudes in British society. Very often the way to cope with the stress of racist attitudes is to internalise the racism, to

accept the medical model and to reject traditional practices.

This position is not difficult to understand, given the historical tendency for the dominant culture, in this case British culture, to devalue any other cultural beliefs. It was quite obvious from the women's accounts that they experienced the greatest pressure to reject their cultural ideology when they moved outside their community to obtain maternity care. Women were often worried about attracting derogatory comments from health professionals if they observed traditional diets or remedies or rituals. They were exposed to hostile comments from the nursing staff in the postnatal wards about traditional diets after childbirth.

As the argument presented in chapter 1 suggests, traditional beliefs also come under assault from the numerous research projects specifically undertaken to unearth facts which can than be blamed for poor outcome of pregnancy.

There is also a tendency on the part of the health professionals to discredit the advisory role of anyone except those who receive medical training in the West. It would appear that Asian women, particularly older women, pose the greatest threat to medical authority because many of the traditional practices are promoted and supervised by older female relatives. This particular threat posed by older Asian women and the central role they play in supervising traditional practices is not unique. Jordanova (1980 :51) suggests that male health professionals often express negative attitudes towards traditional cures and ceremonies which were devised by women to restore health. She asserts that the arguments male health professionals have used for dismissing such practices were based on sexist ideology which not only regarded women as irresponsible people but also charged them with irresponsible behaviour for passing their knowledge to the next generation.

This thesis has, then, attempted to examine and understand how Asian women living under the influence of two cultures make sense of their childbirth experiences. It has highlighted the fact that Asian women, far from belonging to a homogeneous group, are individuals with a wide range of ways of coping with giving birth in Britain. Given that Asian women who have recently settled in Britain face struggles on numerous fronts, it is not surprising that their fight against western childbirth practices does not take precedence over their effort to adjust to life in a new country. Their struggles are compounded by belonging to a different race and class and culture. Furthermore, for a majority of Asian women, the main struggle is to gain access to health services rather than question the sexual politics of reproduction within their own culture or in the indigenous culture.

### Ways Forward in Improving Maternity Services for Asian Women

In the light of the concerns and the dissatisfaction expressed by Gujarati and Bangladeshi women in this study there is clearly a need for assessing/evaluating the delivery of maternity care to Asian women. Since the women's concerns with the services were related to difficulties in gaining access, lack of appropriate information for making informed decisions and dissatisfaction with obstetrics and midwifery care, I hope the suggestions outlined here will be of particular interest to policy makers and health care providers in the National Health Service.

In summarising the findings of this project and making recommendations for improvements in the maternity services offered to Asian women, attention will be focused first on Bangladeshi women and then on Gujarati women. In both cases, the findings of the main study will be supplemented by those of the more detailed in-depth case studies.

### Issues raised by Bangladeshi women's experience of

#### pregnancy and childbirth

#### Attitude to Conception and Pregnancy

In the chapter concerning attitudes to conception and pregnancy, the opinions expressed by Bangladeshi women were clearly a reflection of how women are socialised from the early childhood to accept control over their sexuality and, in particular control over their fertility. The views on conception of a majority of Bangladeshi mothers who had recently left Bangladesh were an indication of their own experience of marriage in the late teens and followed shortly by a pregnancy. The view that conception was highly desirable as soon as possible after marriage was shared by these women, including those who were expecting their first baby.

The Bangladeshi women's attitudes to their pregnancy were thus strongly influenced by cultural traditions which favoured conception and also by their religious beliefs which considered a pregnancy as a gift from God. The views expressed by Amina and Hena in the Bangladeshi case studies suggested that they also shared similar views about conception. Their experiences also indicated that the influence of culture and religion concerning conception had not been affected a great deal by changes in social circumstances, education or length of settlement in Britain. For instance, the attitudes to conception of both women, but particularly of Hena were very positive in

spite of being aware of the possible risks to their own health. In short, the Bangladeshi women in the sample were favourably inclined towards their pregnancy and for them fertility control was not a major issue.

However, most but not all of the Bangladeshi women shared traditional views on conception. The attitudes to pregnancy of women who had tried unsuccessfully to control their fertility, were less favourable. This had serious consequences for women whose pregnancy posed a threat to their health. The accounts of other Bangladeshi women, whose pregnancy had resulted in a miscarriage or a still-birth, suggested that their ability to control their fertility was also undermined by a lack of a full and clear explanation about the contraceptive pill.

Any attempt to improve maternity services for Asian women must bear in mind that those women who seek advice on family planning need full and clear information about the range of contraceptives that are available so that they can make their own informed decision. The unfortunate experiences of women who had a miscarriage or a stillbirth also suggested that many women were not alerted to the inherent risks posed by an improper use of the contraceptive pill. There is thus a need for a review of the way health education messages are disseminated since current methods seem to have had only limited success. One solution may involve the setting up of informal health groups in the community. This method would ensure that the information was provided in a language and form which was sensitive to the needs of the community.

### Management of Pregnancy

Many of the difficulties experienced by Bangladeshi women in the management of pregnancy were related to the tension between traditional and western approaches.

Since a majority of the Bangladeshi women had very recently left Bangladesh, their perception of the management of pregnancy was based either on their own personal experiences or those of other pregnant women in Bangladesh. For a majority of the women, this area was largely the concern of older female relatives who supported and advised a pregnant woman throughout her pregnancy. The help of medical professionals was only sought in cases of extreme emergency.

The experiences of many Bangladeshi women suggested that some aspects of the way pregnancy is managed in Britain raised a number of issues for them. The hospitalisation of childbirth means that women have to have their pregnancy confirmed in order to obtain assistance during childbirth

and to qualify for maternity benefits. One of the major issues which confronted many Bangladeshi women was this alien concept of medical confirmation of pregnancy. The women who had previous pregnancies in Bangladesh reported that in Bangladesh they had not found it necessary to seek medical confirmation of their pregnancy.

Although most women accepted the need for reporting their pregnancy, their experiences suggested that not only did many of them encounter difficulties gaining access to a general practitioner because of language problems, but some women also found it culturally unacceptable to consult a male doctor. As a result some women had delayed reporting their pregnancy as long as possible and a few had avoided consulting their doctor personally, conveying the symptoms of their pregnancy to their general practitioner via their husbands.

In addition to the difficulties encountered at the beginning of the pregnancy, many women found that attendance at the antenatal clinic was also problematic because of transport problems, the responsibility of other children and the need to rely on their husbands to accompany them to antenatal clinics. Additionally many women found the long wait at the clinic and the antenatal examination involving unfamiliar tests very stressful.

Another interesting observation concerning health during pregnancy was that many women accepted the distress caused by some of the common ailments such as sickness, tiredness or digestive disorder as a normal part of their pregnancy and did not consider it necessary to seek advice about them, whereas for symptoms such as headaches, burning hands and feet and a lack of sleep they sought medical advice. It would appear that whilst some attempt was made to investigate the physical symptoms presented by the women, this was done without paying sufficient attention to the psychological needs of the women.

This is also a function of treating physical and emotional problems as two separate branches of medicine as well as the general tendency to pay more attention to physical symptoms presented by a pregnant woman than to her emotional problems. Some of the women who complained about headaches and lack of sleep were suffering from isolation or socioeconomic deprivations and often their conditions were exacerbated by their poor housing conditions. It was therefore not very surprising that the investigation of physical symptoms did not reveal the real cause of their problems.

Another worrying consequence of not fully appreciating the difference in perceptions of health is the impact this can



have on the outcome of the pregnancy. For instance, Bangladeshi women who were suffering from severe anaemia and high blood pressure during their pregnancy appear to have been unaware of the seriousness of their condition. This would suggest that the medical staff had not considered it necessary to share with these women their concern about either condition. The failure to provide adequate and simple explanations has serious implications for the success of any treatment recommended. It was also reported that dietary advice to cure some of the physical conditions such as anaemia and constipation or nutritional deficiency often did not bear any relation to their traditional diet. As a result the dietary advice was ignored or followed for a very short period.

These difficulties, however, are by no means universal. Hena and Amina, for instance, did not experience problems negotiating antenatal care. Although neither women had any objections to consulting their own male general practitioners, Hena, did have the some reservation about being examined by male obstetricians. In this respect, Hena's objection were not unlike those expressed by many other British women who also prefer to be examined by female obstetricians during pregnancy and childbirth.

Another major difference which set Hena and Amina apart from the Bangladeshi women in the main study was their perception of health and illness. Their attitudes and concern for their own and those of their baby's health suggested that their perceptions of health were a lot closer to the western model. However, in spite of this, Amina allowed cultural pressure to override any anxieties she may have had about the medical inadvisability of becoming pregnant.

Amina's case also indicated that being conversant with British culture and practices does not necessarily mean that one would automatically obtain emotional support from health professionals. In this respect her experiences were no different from the other Bangladeshi women who suffered similar anxieties.

One of the main issues to emerge from the women's experiences of gaining access to maternity care during pregnancy is the urgent need to recruit more female, preferably bilingual, medical practitioners in the areas where there is a high concentration of Asian people.

The marked difference in the perception of health and illness of Bangladeshi women also has implications for the training of health workers. Unless health workers have an appreciation of how women from different cultural and social backgrounds perceive their health, they may not be

fully effective in providing care for women from non-western backgrounds. Whilst health advocates and interpreters perform a vital role, this clearly is not enough. What is most urgently needed is a real commitment to the appointment of trained bilingual staff in all professional grades including doctors and consultants of both sexes.

The degree of effectiveness of any medical advice or treatment depends on the cooperation of the women. In order to ensure that the advice or treatment is acceptable, it is essential that clear and adequate explanations are provided to involve women in the decision-making process and to enable them to act on that advice. It is also important to recognise that just because a woman does not speak English, information about her health should not be withheld from her. On the contrary, sharing of information may increase the acceptance of advice or treatment.

The significance of the change in the sex roles for Bangladeshi men in Britain is often not fully appreciated. The fact that many Bangladeshi men were having to take on additional responsibilities of acting on the behalf of their wives during medical consultations, having to take time off work escorting their wives to the clinics and taking care of the younger children also needs recognition since, traditionally, they are not required to play an active role during pregnancy.

Finally, it is important to recognise that women who have recently settled in Britain may be suffering from additional distress during their pregnancy because of social and economic deprivation and poor housing but may not be able to articulate their anxiety or be able to seek help. One should also not assume that these women do not need professional help because they live in an extended family. Amina's situation is a case in point. Even though her mother was living with her, she was not able to share her anxiety with her.

#### Preparation for Childbirth

In Britain today, the hospitalisation of childbirth with the increasing use of modern technology has meant that women are not only required to prepare emotionally and physically for childbirth but also to be prepared to consider the use of modern technology. Thus preparation for childbirth involves attendance at antenatal preparation classes and the ability to make use of the information disseminated through the mass media.

For a majority of Bangladeshi women, preparation for childbirth in their own cultural context did not involve any

formal preparation because delivery took place at home assisted by a midwife or older female relatives without the use of modern drugs or technology. Emotional and physical support was also provided throughout the pregnancy and childbirth by female relatives.

The experiences of Bangladeshi women who had recently settled in Britain, suggested that formal preparation for childbirth was a new concept for them. Women who had assisted other women during childbirth or had personal experience of childbirth in Bangladesh were often of the opinion that preparation for childbirth was not necessary. Nonetheless, many of these women reported that they were unaware of the existence of antenatal classes because they had not been invited to attend.

A few who had accepted the invitation to attend classes found them unhelpful; some found any references to the female anatomy or the childbirth process embarrassing. It would seem that it was not only the women's perception of what was covered in the classes which prevented them from attending. For many women, the general difficulties of gaining access to medical services also extended to attending classes. Whilst many women considered attendance at the antenatal clinic to be important despite the difficulties encountered, they did not perceive attendance at antenatal preparation classes in the same light.

In contrast, the experiences of Hena and Amina suggested that they encountered fewer difficulties attending classes. Hena and Amina were also able to make use of other sources of information. Their experiences also suggested that whilst they had retained links with their cultural beliefs and traditions, their familiarity with the health service and ability to negotiate care gave them an advantage over women who had recently arrived from Bangladesh and who were not conversant with the British culture or language.

The fact that so few Bangladeshi women claimed to have received an invitation to attend classes or to have any knowledge about their provision, suggests that women who do not speak any English are not encouraged to participate in such preparation classes. Also the few Bangladeshi women who did attend in the beginning were put off from going again. Their experiences suggested that perhaps the teaching method designed to suit the needs of the indigenous women was not appropriate for the Bangladeshi women. Those responsible for antenatal education should develop courses which are sensitive to the cultural and social backgrounds of the local Bangladeshi women. To encourage more Bangladeshi women to attend classes, it is important that the classes should be offered in mother-tongue by a suitably trained person who understands the cultural and

traditional values of Bangladeshi women.

Although a variety of information is disseminated through the mass media, very little seemed to reach the Bangladeshi women. Since many Bangladeshi women were not literate in Bengali, there is a need for the production of health education material on video cassettes.

The experiences of many Bangladeshi women suggested that attending the hospital antenatal clinic was a difficult and stressful experience. An alternative venue such as a local community centre or health clinic within walking distance of their homes may be more attractive for women who find a hospital environment stressful.

### Childbirth Experiences

The Bangladeshi women's experience of childbirth highlighted a number of important points. Their experiences were a reflection of how women who are new to the management of childbirth in a hospital setting cope with labour and delivery. Their experiences were also an indication of how women who have additional difficulties of dealing with hospital staff from a different cultural and linguistic background cope with delivery in hospital.

When labour starts the timing of arrival at the hospital can have an important effect on the management of labour and the degree of control a woman is able to exercise over them. For a majority of Bangladeshi women the kind of childbirth experience they had had much to do with the time of admission into hospital. Although none of the women indicated that their main reason for delaying their admission was to avoid medical intervention, their admission into hospital in well established labour meant that the need for either pain-killing drugs or acceleration of labour was avoided.

Although most of the Bangladeshi women had a relatively straightforward labour and delivery, some of the women appeared to be confused about how their labour and delivery were managed. This was found to be so particularly with women who had no previous experience of hospital delivery and were therefore not familiar with some of the routine procedures such as the administration of drugs. As a result some women who had been given pain-killing drugs such as pethidine believed it was routinely administered to all women and others who had an injection of syntometrine (routinely administered in the final stages of delivery to prevent haemorrhage) mistook it for a pain-killing injection.

On the other hand, Hena's and Amina's accounts of child-

birth experience suggested that they had not encountered any difficulties understanding how their labour and deliveries were managed.

Although husbands are encouraged to act as labour companions, traditionally men are not expected to play an active role during childbirth. Whilst Hena was able to arrange for her mother to act as her labour companion, a majority of the Bangladeshi women in the main sample had to manage on their own. Since many Bangladeshi women were accustomed to the traditional emotional and physical support provided by their female relatives, an absence of this support was reported to cause additional stress to the women when they were confined in a strange environment of a modern hospital labour ward.

Whilst delayed admission into hospital in this instance worked in favour of most of the Bangladeshi women, women who reach hospital in the last stages of labour could be exposing themselves and their babies to some risks. Since some of the main reasons for delaying their arrival at the hospital were to do with the fear of being in a strange hospital environment and fear of being not understood or able to understand, Bangladeshi women need reassurance and trained interpreters should be provided to alleviate distress caused by communication problems.

Unless and until it is possible for all women to arrange home delivery, it is important that women are familiar with the way labour is managed in a modern hospital with its attendant technology. The accounts of the childbirth experiences of the Bangladeshi women make a strong case for the training and employment of health workers from the Asian communities. In addition, the provision of antenatal classes run by a trained Bengali woman and the provision of appropriate health education information is essential if Bangladeshi women are to be given the same opportunities as are available to other British women to make informed decisions.

Although it has become a common practice to expect husbands to act as labour companions, it must be recognised that traditionally Asian men are not expected to play an active role during childbirth. Therefore not all women or their husbands find it acceptable for men to act as labour companions. Instead all maternity hospitals should have a policy which actively encourages women to bring any companion of their choice.

### Postnatal Experience

For a majority of the Bangladeshi women coming to terms with childbirth in a hospital did not end with the delivery

of their baby. The comments made by the women concerning their experience of the time spent in the postnatal wards suggested that some women found their stay very stressful for a number of reasons. Some women had reported that the nursing staff were not very sympathetic or helpful. This was partly to do with the women misunderstanding the status of the nursing staff and the role which they played. Since many Bangladeshi women were familiar with the traditional support provided by their relatives, they believed that the nursing staff were there to give the kind of support usually provided by their relatives.

The other reasons for their less than happy memory of postnatal stay in the hospital was a feeling of isolation and the difficulty of getting used to the hospital routine which was exacerbated by having to deal with hospital staff who were from a different social, cultural and linguistic background. Those women who were confined after a Caesarean section or those whose babies were in a special care unit, reported that they suffered from a lot of anxiety because they were not able to express their concern about themselves or their babies.

The postnatal experiences of many Bangladeshi women suggested that whilst they were very appreciative of the advantages offered by modern medicine and the facilities provided in a maternity hospital, gaining access to them was complicated by language difficulties and by having a different perception of the management of care for new mothers and their babies. As a result not only did some Bangladeshi women find it difficult to adjust to being confined in a hospital for childbirth, but some also found adjusting to normal life after their hospital discharge difficult. This adjustment was most difficult for women who had the responsibility for other younger children and for running the home without the help of relatives to give them the traditional support after childbirth.

The two major issues which were raised by the Bangladeshi women concerned their difficulties in adjusting to hospitalisation after childbirth and their different perception and expectation of nursing staff. It highlights the case for improving communications between the mothers and the nursing staff so that the women know from the outset what kind of care they should expect in the postnatal period.

Secondly, since the nursing staff and the women did not share a common perception of postnatal care, training courses for midwifery staff should include discussion of the way postpartum care is managed in other cultures.

Finally, it must be recognised that many Bangladeshi

families have been fragmented because of migration, and consequently it would be wrong to assume that they all have adequate support at home after they are discharged from the hospital and therefore do not require support from the health professionals.

Issues raised by the Gujarati women's experience of pregnancy and childbirth

Many of the issues raised by the Bangladeshi women applied equally to the Gujarati women. However the Gujarati women's experiences highlighted a number of issues which were linked to their level of educational attainment and the length of settlement in Britain and the degree of assimilation into British culture and society. In addition to focusing on some of the salient points raised by the Gujarati women in the main study, the material from the two Gujarati case studies will also be used in order to illustrate in greater detail the impact and involvement of the family during pregnancy and childbirth.

Attitudes to Conception

In many respects the Gujarati women's views on conception were similar to those of the Bangladeshi women i.e. a majority of the women believed that they were expected to have children but conception was only permissible within the context of a marriage.

Whilst Gujarati women recognised the social and in particular 'family' obligations to procreate, a majority had also been influenced by the western concept of family planning. There were many indications that relatives do have an influential role in ensuring that couples fulfil their obligations, for instance, in the case of women who were expecting their first baby. The fact that a majority of the couples had used some form of contraception after their marriage indicated that they were keen to exercise control over their own fertility.

However, the women's attitudes to their pregnancy suggested that the circumstances under which some women had found themselves pregnant were a lot more complex than might appear at first sight. With the exception of those who had consciously set out to become pregnant, the rest of the women's attitudes to their pregnancy were determined by how much control they had been able to exercise over their fertility. The issue of lack of fertility control and an ambiguous attitude to pregnancy was not confined to women who were expecting a second or subsequent baby but applied equally to women who were expecting their first baby.

The ambiguous attitudes were also reflected in the negative reactions to their pregnancy. It was perhaps not surprising to find that the men's reaction was more positive than their wife's since the effects of the pregnancy are more directly and immediately felt by the women. It might be expected that the newly married women who are under pressure to prove their fertility would be pleased with their pregnancy. However for some first time mothers in the main study as well as in the case of Kiren and Meera in the case studies this was not the case because they gave their career development and improvement of their financial position greater priority than starting a family.

The case of Gujarati women who not only had ambiguous attitudes towards birth control but also did not want to continue with their pregnancy highlighted the struggles some women experienced coming to terms with their pregnancy.

On the other hand, with the exception of a few relatives, the reactions of the majority of relatives was very positive. Since most of the relatives were of the generation who had not practised birth control it was understandable that they did not share the mixed attitudes of the women towards conception or pregnancy.

The mixed feelings expressed by the Gujarati women expecting their first baby are perhaps surprising given that most women are expected to prove their fertility as soon as possible after the marriage. It would be wrong however, to assume that first time mothers experience fewer difficulties in adjusting to their pregnancy and are not in need of emotional support.

It is also important to recognise that although a majority of multipara women had small families, an unwanted addition to the family can affect the women's attitude towards the management of their pregnancy and childbirth.

As many Gujarati women live within an extended family it is often assumed that these women do not require any additional support from any outside agency because all their emotional needs are fulfilled by their relatives. The case of the women who had considered termination of their pregnancy, indicated that this type of support is not always automatically available.

### Management of Pregnancy

The management of pregnancy for Gujarati women involved resolving the conflict between traditional and medical expectations. Since almost all the Gujarati women were



living with their husband's family, the management of their pregnancy was inevitably influenced by traditional practice as supervised by the older female relatives. This traditional practice was based on rituals and ceremonies and dietary restrictions. The rituals and ceremonies were considered necessary for avoiding any mishaps in pregnancy. It also involved regulation and maintenance of a dietary regime according to Ayurvedic principles. Traditional management of pregnancy, passed on by women from one generation to the next, had an added significance for some women because it also fulfilled the psychological needs of both the pregnant mothers and their female relatives.

On the other hand, since many Gujarati women had also lived in Britain for a number of years, they had become accustomed to the western medical system and had adopted some of the values promoted by orthodox medicine. Aspects of medical management of pregnancy such as confirmation of pregnancy, and antenatal care were recognised by the majority of Gujarati women in the study as an essential part of maternity care.

Some of the older female relatives found the idea of seeking medical confirmation of pregnancy quite strange when the symptoms of the pregnancy were quite obvious to them. However the women themselves were more inclined to trust medical confirmation. This was illustrated by some of the Gujarati women in the case study: compare, for instance, the accounts given by Geeta and Meera. The experiences of a majority of the Gujarati women suggested that the medical confirmation of pregnancy and the negotiation of antenatal care were not major issues for them because they encountered fewer difficulties gaining access to medical practitioners. Although very few Gujarati women had expressed a preference for a female practitioner, it was apparent that in Harrow it was possible for the Gujarati women to find a female doctor if they wished. This made it easier for women who might not otherwise have been favourably inclined to receive care during pregnancy.

The relative ease of access to medical services and the women's more positive attitudes to the western medical system meant that unlike the Bangladeshi women, more Gujarati women had consulted their doctors for some of the common physical symptoms such as sickness and heartburn. However, the Gujarati women's experiences suggested that they were less keen to seek help with their emotional problems.

In this respect, the Gujarati and Bangladeshi women's experiences were similar to indigenous women who cannot find support within their own family network to express

their anxieties about an unplanned pregnancy, the sex of the baby or the fear of high-tech birth.

The Gujarati women's experiences suggested that certain aspects of the traditional management of pregnancy caused some difficulties for them. Some of these difficulties were the restriction on washing hair, the restriction on consuming certain food items and the requirement to keep away from women who had recently delivered. Observation of such restrictions had a special significance to the older women because they had observed them in their own time and believed in the value of such traditions. In expecting the younger women to follow in their footsteps they were trying to keep the family traditions alive.

However, for some of the younger women such a course was difficult because, unlike their older female relatives, they were not confined within their own communities. In addition, some of the women's attitudes to such beliefs had changed because of the influence of western culture. As a result restrictions which involved interactions with people outside their own community, were observed reluctantly or under duress. This was the case with many Gujarati women in the main study but the impact of restrictions was particularly significant for Meera and Kiren and for Kamla and Geeta in the two Gujarati case studies.

On the other hand, most Gujarati women seemed to be quite happy to placate their families by taking part in ceremonies which took place within the confines of their homes. For instance, 'Khoru' ceremony was regarded by most women as a pleasurable social event which gave their pregnancy an added status. Although the 'khoru' ceremony is a social event to celebrate the pregnancy, rituals of this ceremony also prepare a couple for their new role in life.

Whilst the significance of the ceremonial rituals in the traditional management of pregnancy did not directly clash with the medical management of pregnancy, the traditional perception of health in relation to dietary habits did. Traditionally, the Gujarati Hindus are lactovegetarian, however many younger women have adopted a western diet and are not strictly vegetarian. Many medical workers believe that vegetarian diets are insufficient and have linked the incidence of low birth weight babies to the so called inadequacy of the vegetarian diet. As a result some of the women found that the dietary advice they received from their own family members clashed with the advice from medical workers who promoted diets based on the western concept of a balanced diet with its emphasis on consumption of animal protein.

Although the Gujarati women in this study were less

disadvantaged in terms of gaining access to medical services and were able to find a female doctor, it is important to recognise that many Gujarati women in other parts of the country may have greater difficulty in finding a female doctor.

It is also important that care is taken when dietary advice is given to women who have to observe vegetarian diets at home. When inappropriate advice is given it is more difficult for women to maintain it and may induce guilt in those who are not able to follow it or are not able to change their diet as it involves eating unaccustomed foods. It also must be recognised that the traditional vegetarian diet is nutritionally sound and therefore any advice should be based on it and positively reinforced to make dietary advice more acceptable.

It is often wrongly assumed that a woman who lives in a joint family can rely on her family for support, whereas the experiences of many Gujarati women suggested that they did not find it easy to share their anxiety about the unplanned pregnancy, the sex of the baby or fear of having a baby with physical disability.

#### Preparation for Childbirth

The Gujarati women's familiarity with and their relatively easy access to maternity services were important factors in enabling a majority of them to take advantage of antenatal preparation classes. This was reflected in the number of women who had attended some classes either during their current pregnancy or during their previous pregnancy. Unlike the Bangladeshi women, Gujarati women were not prevented from attending classes except when the classes were offered in the evening or when they were invited to attend with their husbands. Whilst the women were not discouraged from attending classes, the involvement of husbands was discouraged and was frowned upon by older female relatives who believed that it was shameful for men to take an active role in what was essentially a woman's concern. This was clearly seen in the account given by Geeta in one of the Gujarati case studies.

Besides the involvement of husbands in preparation classes the tour of the labour ward, which is often an integral part of the preparation classes, was problematic for some Gujarati women. As a result some of these women had to resolve, on the one hand the cultural restriction of pregnant women coming in contact with persons or places associated with childbirth and on the other hand their need to take advantage of classes to prepare for a hospital birth.

Although many women were able to defy this restriction by keeping their female relatives ignorant of what they were doing, women whose childbirth experiences were less positive suggested that open defiance caused them mental anguish in retrospect. This was clearly seen in the account given by Kiren in the Gujarati case study.

With regards to the use of alternative sources of information Gujarati women did not appear to have taken full advantage of what was made available through the mass media. This is contrary to expectations, in view of their level of educational attainment which was higher than that of many Bangladeshi women.

The fact that so few Gujarati women had made use of additional sources of information raises the question about the appropriateness of the information disseminated through the mass media and how effective the mass media are in reaching Asian women.

The women's reluctance to attend classes organised in the evening or where they were required to bring their husbands with them should not be interpreted as their lack of interest in such classes but that evening classes or couples classes may not be appropriate for some women.

It would also seem that in spite of attending classes and having had previous experience of hospital labour experience, many multipara Gujarati women were more anxious and less confident in their ability to cope with labour and childbirth. This suggests that the present method of preparation besides providing information about the management of childbirth in a hospital does not boost women's confidence to take control over decisions affecting the management of their labour and delivery.

### Childbirth Experience

The main issues to emerge from the childbirth experiences of Gujarati women suggested that for a majority of women who were unaccustomed to home births, delivery in hospital was considered to be more safe. Unlike the Bangladeshi women, most Gujarati women were very eager to be admitted into the hospital as soon as the labour started. This was partly because some women felt safe inside a hospital and others were keen to follow the instructions given by the hospital.

It would seem that the timing of their arrival at the hospital was a crucial factor in determining to some extent the type of delivery they had. For example, the accounts of birth experiences given by Gujarati women suggested that once they were admitted they were unable to cope with

their labour and needed pain relieving drugs. It would also seem that once these women lost control in labour, they were unable to avoid further surgical procedures.

Whilst it is misleading to make any generalisation from the the subjective experiences of childbirth of Gujarati women, their experiences suggested that even those women who had attended preparation classes were not able to exercise any more control over decisions concerning the management of their labour and delivery. Thus mere possession of information about how childbirth in hospital is managed does not equip women to make independent decisions concerning the management of labour and delivery when confronted with medical advice and medical experts.

### Postnatal Experience

There were a number of issues highlighted by the women's accounts of their postnatal experience. A number of these were related to the confinement of women in hospital after childbirth. Some of the difficulties encountered by the Gujarati women were to do with nursing care and hospital catering policy.

One major concern expressed by the Gujarati women was the sudden shift in attitude towards women once they had given birth. Many women felt that while they were pregnant they were given a lot of attention and could not understand why suddenly they were expected to behave as if there was nothing wrong with them. It would seem that there was clearly some mismatch concerning the expectations of the postnatal care. This may have arisen because traditionally Asian women are expected to receive a lot of personal care after childbirth. Although the Gujarati women had fewer difficulties accepting the idea of hospital birth, after childbirth their perception of desirable postnatal care was closer to the traditional practice.

The other concern expressed by many Gujarati women was regarding hospital meals and the restrictions imposed by the hospital on receiving food from home. Although Gujarati women were provided with a vegetarian choice on the menu, the women found that it was inappropriate and often inadequate to meet their needs. Many women expressed a desire for the traditional diet especially recommended for newly delivered mothers which the hospital was unable to provide. Some of the women's relatives were very willing to supply food from home to satisfy this need. Also preparation of this food served the need of the family to show that they cared for the mother and the need of the mother to feel that she was cared for.

Many hospitals in Britain have become aware of the dietary

needs of the Asian population and are catering for their different needs. However the experiences of Gujarati women suggested that imposing a diet which the hospital believed served the needs of the local Gujarati population was found by women to be totally unsuitable. Once the women were discharged from the hospital, the difference in expectation of postpartum care disappeared as in most cases the family members took over the responsibility of providing care.

It would appear that the difference in perception of nursing care and the different expectations were also a cause of dissatisfaction amongst some Gujarati women. It is essential that the hospital's policy on the management of postpartum care should be explained fully in the preparation classes. At the same time the hospital policy on the management of postpartum care should note that hospitalisation of childbirth is responsible for the apparent contradiction that exists between the medical management of pregnancy and the management of the postpartum care. It is therefore not the fault of the women to expect the same kind of attention that they had been given antenatally.

Additionally, it is important that a maternity hospital should make every effort to provide suitable meals for Asian women. The experiences of Gujarati women suggested that the hospital catering policy did not sufficiently take into account the importance the women and their relatives attached to the traditional diet. It suggests that without proper consultation with the community in question, however well intentioned the hospital may be, it may still fail to serve the real needs of the community.

#### Role of Family in Childbirth

The role played by relatives throughout pregnancy and childbirth was an indication of the fact that pregnancy and childbirth were a social event and not merely the concern of the couple expecting a baby. The different stages of pregnancy and childbirth were marked by rituals and ceremonies in which the older female relatives played an important role in preserving the traditional childbirth practices.

The influential role played by the female relatives in many aspects of pregnancy and childbirth management were clearly obvious. The accounts given by the women in the two Gujarati case studies gave further indications of the role played by older female relatives. This role was also very significant as the traditional methods of managing childbirth extend a few weeks after the birth of the baby.

It would also seem that women were sometimes caught in

between the traditional and the medicalised childbirth practices. This conflict became more apparent because in trying to preserve the traditional values and beliefs the older female relatives were challenging the male dominated medicalised model of childbirth.

It is important to realise that for Gujarati women and other Asian women, pregnancy and childbirth is a family event and traditionally the role played by female relatives fulfils the psychological needs of both the women and their relatives. Although some disagreement may exist between the younger women and their older female relatives, younger women's respect for and expectations of their relatives outweighs any difference in opinions that may exist.

#### SUMMARY

To sum up, the issues raised by a small group of Gujarati and Bangladeshi women indicated that the way a woman copes with her pregnancy and childbirth is a very unique and personal experience. At the physical and emotional level the experiences of these women were not unlike those of other British women trying to cope with a male dominated medicalised model childbirth. At another level for some women retaining some aspects of traditional childbirth practices was also an important issue.

It must be emphasised that the findings presented in this thesis are not necessarily representative of the views of all Gujarati and Bangladeshi women in Britain. However, some of the findings do indicate that culture, social organisations, religion, traditional childbirth practices and medicalised childbirth practices in Britain affect, to a greater or lesser extent, all women from these groups. The diversity of language, culture, religion and differences in approach to childbirth were reflected in the views expressed by the two groups thus confirming earlier assertions that Asian women are not a homogeneous group and should not be treated as such.

Therefore, there is a need for greater sensitivity on the part of health carers when disseminating health education information and secondly when structuring provision for culturally diverse groups. However, it is necessary to stress that Asian women are not making a demand for special treatment but for treatment which meets their different requirements.

The findings also point to the need for health carers to be educated as to the perceptions of childbirth and expectations of women from different cultural backgrounds.

As we have seen, Asian women are not a homogeneous group. The experiences of Gujarati and Bangladeshi women are clearly very different. Nonetheless, a close examination of their experiences of pregnancy and childbirth demonstrates the failure of health professionals to perceive or respond to their very real need.



ABSTRACT

This thesis is about the pregnancy and childbirth

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APPENDIX A

## GUIDED INTERVIEW SCHEDULE

The interview schedule is divided into two parts: the first part deals with antenatal experience and the second part deals with postpartum experience. The questions contained in the interview schedule were used to guide the conversation between the respondent and the interviewer. The interview schedule is divided into two parts: the Part I deals with antenatal experience and the Part II deals with postpartum experience. Part I and II consists of open ended questions followed by specific questions under each topics.

PART IAttitude to Conception and Pregnancy

Can you tell me what it has been like to be pregnant?

Were you surprised when you became pregnant?

How did your husband react to the pregnancy?

What were the reactions of the other members of your family?

Can you tell me if you had given much thought about becoming a mother when you were young?

How soon did you realise that you were pregnant?

How did you feel when you found out that you were really pregnant?

How long did you wait before you told anyone about your pregnancy?

How long did you wait before you saw your doctor?

Specific Questions

Were you using any birth control before you became pregnant?

If yes, what method?

How many weeks pregnant are you now?

How many times have you been pregnant before?

How many children do you have?

Health in Pregnancy

How healthy were you before you became pregnant?

Have you enjoyed good health in your pregnancy?

Have you had any difficulties in your in pregnancy?

What did you do if anything to cope with your health problems?

Did you ask anyone for advice, if so who?

Is there anyone in your family with whom you would be able to speak freely about pregnancy, if so who?

Is there anything concerning your pregnancy you would be reluctant to tell anyone in your family?

Is there anything about your pregnancy you would be reluctant to tell your doctor?

Have you been prescribed any medication in your pregnancy?

Did you use any herbal or traditional remedies in your pregnancy?

Have you at any time felt anxious or worried in your pregnancy?

Have your feelings towards your pregnancy changed since you first became pregnant?

Some women have vivid dreams about their babies in their pregnancy, have you had similar experience?

Specific Questions

Have you suffered from any of the following ailments?

Morning sickness

Constipation

Heartburn

Cramps

Tiredness

Depression

If yes, what remedies if any did you use?

Diet in Pregnancy

Have you changed your eating habits in anyway since becoming pregnant?

Do you eat the same food as the rest of the family?

Have you had any craving or dislike for food?

Have you observed any dietary restrictions in your pregnancy?

How do you feel about such restrictions?

Who has been advising you to observe these restrictions?

Specific Questions

Are you a           vegetarian,  
                      non-vegetarian,  
                      vegan,  
                      lactovegetarian

Antenatal Care - Specific Questions

Where do you go for your antenatal care?

How often do you go for your check-up?

Have you missed any appointments? If yes, give more detail.

Ceremonial Rituals

Can you tell me about any ceremonies you have taken part in during your pregnancy?

Can you tell me if you had to observe any religious restrictions in your pregnancy?

How do you feel about such restrictions?

Antenatal Preparation for Childbirth

Have you made any preparation for coping with childbirth?

Have you talked to anyone about their experience of labour?  
If yes, did you find it helpful to talk to others?

Have you ever witnessed childbirth or watched it on TV ? If yes what did you think about it?

Specific Questions

Have you been invited to attend parentcraft classes?

Have you attended any classes?

If no, what were your reasons for not attending classes?

Have you attended any other classes?

Did you find the classes useful?

What type of pain relief would you consider using in labour?

How do you intend to feed your baby?

Multipara Only

Can you tell me about your previous labour experience?

Can you tell me if you are more prepared this time to cope with childbirth?

Specific Questions

Where did you deliver your last baby?

How long were you in labour?

How did you cope with labour pains?

What type of delivery did you have?

BACKGROUND INFORMATION

Country of Birth

Date of Birth

Religion

Caste

Respondent's Occupation

Husband's Occupation

Respondent Educational Attainment-

None

Primary

Secondary

Higher Education

College Degree

Length of Residence in Britain.

Family Composition.

PART II

POSTPARTUM EXPERIENCE

Childbirth Experience

Can you tell me how you have been since the first interview?

What was your health like before you went into labour?

How is your baby?

What has it been like having a baby in the house; is it how you expected?

Labour Experience

Can you tell me about your labour?

When did you go into labour?

How did your labour start?

What did it feel like to be in labour?

Was your experience of childbirth as you expected?

Specific Questions

How long were you in labour?

Did you have anyone with you to keep you company when you were in labour?

Did you use any pain relief in labour, if so what?

Did you find the pain relief helpful?

What type of delivery did you have?

How did you feel immediately after the baby was born?

Can you tell me about your experience of postnatal stay in the hospital ?

Was it as you expected?

Specific Questions

How long did you stay in the hospital?

After you were discharged from the hospital did you

i) go straight home

ii) go to stay with your mother?

How long did you stay with your mother?

What was it like staying with your mother?

Diet in Postnatal Period

Have you changed your diet in anyway since the birth of your baby?

Do you eat the same foods as the rest of the family since you returned from the hospital?

How do you feel about eating the traditional diet?

Specific Question

How long have been eating the traditional diet?

How long do you intend to continue eating the traditional diet?

Postnatal Confinement at Home

How have you been managing since you were discharged from the hospital?

What kind of help have you had since you returned from the hospital?

Has it been easier or more difficult to cope than you expected?

Now you have been home for few weeks, have you noticed any change in your feelings about your experience?

Specific Questions

How old is your baby today?

How are you feeding your baby?

How long do you intend to breastfeed your baby?

How soon can you go out with your baby?

FOR THE INTERVIEWERS

Please give your impression about two interviews. Indicate whether the mother was shy, intimidated or ready to answer questions. Give detail of anyone else present during the course of the interview and if they made any contribution to the interview ?



APPENDIX B

ଆହୁତାହୁତା ବିନିମୟ

ଏହି ଆହୁତାହୁତା ହେଉଛି ଏକ ବିଷୟ। ଏହା ଏକ  
 ନିର୍ଦ୍ଦେଶିତ ଅବସ୍ଥାରେ ଅଧିକାରୀଙ୍କୁ ଏକ ନିର୍ଦ୍ଦେଶ ଦେଇ  
 ଉପାଦାନ ଏକ ବିଷୟ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ଏକ ବିଷୟ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ  
 ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ

ଏକ ନିର୍ଦ୍ଦେଶ  
 ନିର୍ଦ୍ଦେଶ

- ① ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ② ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ③ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ④ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ⑤ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ⑥ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ
- ⑦ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ ଏକ ନିର୍ଦ୍ଦେଶ

- ⑧ ଅନ୍ଧାର ମର୍ଦ୍ଦୀ ସମ୍ପର୍କ କେନ୍ଦ୍ରୀୟ ଏବଂ ଅନ୍ଧାର ଏବଂ ଅନ୍ଧାର ସମ୍ପର୍କ ଅନୁସନ୍ଧାନ କର ?
- ⑨ ଅନ୍ଧାର ସମ୍ପର୍କ ସମ୍ପର୍କ ଅନ୍ଧାର ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?  
ଅନୁସନ୍ଧାନ କର ?
- ⑩ ଅନ୍ଧାର କି କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ ଅନୁସନ୍ଧାନ କର ? ଅନୁସନ୍ଧାନ କର, ଅନୁସନ୍ଧାନ କର ?
- ⑪ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?
- ⑫ ଅନ୍ଧାର ଅନୁସନ୍ଧାନ କର ?
- ⑬ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?

ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ ଅନୁସନ୍ଧାନ :-

- ⑭ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ ଅନୁସନ୍ଧାନ କର ?
- ⑮ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?
- ⑯ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?
- ⑰ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?
- ⑱ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?
- ⑲ ଅନ୍ଧାର କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କେନ୍ଦ୍ରୀୟ ଅନୁସନ୍ଧାନ କର ?

- (20) ਅਫ਼ਰੀ ਸਮਰ ਯਕੀਨ ਅਸਰ ਰੋਕ ਅਸੂਰਿਓ  
ਅਸਰਿ ਲੋਠ ਯਕੀਨ ਯ ਅਸਰਿ ਅਸਰਾ  
ਪਕਿਰਾਓ ਅਸਰੁਓ ਰਾਓ ਕਰਾਓ ?
- (21) ਅਫ਼ਰੀ ਸਮਰ ਯਕੀਨ ਅਸਰ ਰੋਕ ਅਸੂਰਿਓ  
ਅਸਰਿ ਲੋਠ ਯਕੀਨ ਯ ਅਸਰਿ ਅਸਰਾ  
ਯਕੀਨ ਰਾਓ ਕਰਾਓ ?
- (22) ਅਫ਼ਰੀ ਸਮਰ ਯਕੀਨ ਅਸਰਿ ਠਿ ਰੋਕ  
ਅਸੂਰਿ ਯਕੀਨ ?
- (23) ਅਸਰਾ ਅਫ਼ਰੁਓ ਠਿ ਰੋਕ ਕਰਿਓ  
ਅਸੂਰਿ ਰਾਓ ਕਰਾਓ ?
- (24) ਅਫ਼ਰੀ ਸਮਰ ਯਕੀਨ ਅਸਰਿ ਠਿ ਰੋਕ  
ਯਕੀਨ ਕਰਾਓ ?
- (25) ਸਮਰ ਰਾਓ ਅਸਰਾ ਅਫ਼ਰੁਓ ਯ ਅਸੂਰਿ  
ਕਰਾਓ ਠਿ ਰੋਕ ਅਫ਼ਰੁਓ ਕਰਾਓ ?
- (26) ਅਫ਼ਰੀ ਸਮਰ ਯਕੀਨ ਅਸਰ ਅਫ਼ਰੁਓ ਕਰਾਓ  
ਅਸੂਰਿ ਕਰਾਓ , ਅਸਰਿ ਠਿ ਰੋਕ ਅਸੂਰਿ ਕਰਾਓ ?

ਵਿਸ਼ਵ ਪ੍ਰਸ਼ਨਾਵਲੀ :-

- (27) ਅਸਰਿ ਠਿ ਰੋਕ ਅਫ਼ਰੁਓ ਅਸੂਰੁਓ  
ਕਰਾਓ ਕਰਾਓ ?  
ਕਰਾਓ ਕਰਾਓ , ਕਰਾਓ ਕਰਾਓ , ਕਰਾਓ ਕਰਾਓ  
ਕਰਾਓ ਕਰਾਓ , ਕਰਾਓ , ਕਰਾਓ  
ਕਰਾਓ ?  
ਕਰਾਓ ਕਰਾਓ ਕਰਾਓ ਠਿ ਰੋਕ ਕਰਾਓ

ସାଧାରଣ ମାନବର ସାଧାରଣ ଜୀବନ ସାଧାରଣ-ସାଧାରଣ :-

- (28) ସାଧାରଣ ମାନବର ସାଧାରଣ ମାନବର ସାଧାରଣ-ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ?
- (29) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କି ?
- (30) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କି ?
- (31) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କି ?
- (32) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କି ?
- (33) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କି ?

ସାଧାରଣ ମାନବର :-

- (34) ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ?  
 ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ?  
 ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ?  
 ସାଧାରଣ ମାନବର ଜୀବନ ଅନିବାର୍ଯ୍ୟ କିମ୍ପାକ୍ତି କି ?



ଲେଖାଯାଇଛି, ଯଦି କେହି ଆଜ୍ଞା ଅଭାବରେ ଅନ୍ୟାନ୍ୟ ଓ ଅସୁସ୍ଥତା ଘଟାଇଛି ?

ବିଶେଷ ପ୍ରଶ୍ନାବଳୀ :-

- (୫୫) ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟ ଲୋକଙ୍କ ଅନ୍ୟାନ୍ୟ କ୍ଷତ୍ରୀୟ ଅସୁସ୍ଥତା ଘଟାଇଛି କି ?
- (୫୬) ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟ ଅସୁସ୍ଥତା ଘଟାଇଛି ? ଯଦି ହାଁ ତେବେ ଆଜ୍ଞା ଅଭାବରେ କି ?
- (୫୭) ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟ ଲୋକଙ୍କ କ୍ଷତ୍ରୀୟ ଘଟାଇଛି କି ?
- (୫୮) ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟ କ୍ଷତ୍ରୀୟ ଅନ୍ୟାନ୍ୟ ଘଟାଇଛି କି ?
- (୫୯) ଅନ୍ୟାନ୍ୟ ଅନ୍ୟ ଅନ୍ୟ ଅନ୍ୟାନ୍ୟ ଘଟାଇଛି କି ?
- (୬୦) ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଘଟାଇଛି କି ?
- (୬୧) ଅନ୍ୟାନ୍ୟ ଅନ୍ୟ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଓ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଘଟାଇଛି କି ?

ବିଶେଷ ପ୍ରଶ୍ନାବଳୀ :-

- (୬୨) ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଘଟାଇଛି କି ?

- (53) ଅମଳି ଘରର ମୁଖ ଦେଖିବା ଜିଲ୍ଲା?
- (54) ଅମଳି ମୁଖର ଗୁଣ 16 ଯାଏ ଅନ୍ୟ କଣ?
- (55) ଅମଳିର ଗୁଣର ଅନ୍ୟ 16 ଯାଏ କଣ?

ଅମଳିର ଗୁଣ :-

- (56) ଅମଳିର ନାମ
- (57) ଅମଳିର ଗୁଣ
- (58) ଶର
- (59) ଅମଳି
- (60) ଅମଳି
- (61) ଅମଳିର ନାମ
- (62) ଅମଳିର ଗୁଣ
  - ଅମଳି
  - ଅମଳିର
  - ଅମଳିର
  - ଅମଳିର
  - ଅମଳିର ଗୁଣ
- (63) ଅମଳିର ଗୁଣର ଅନ୍ୟ କଣ ?
- (64) ଅମଳିର ଗୁଣର ଅନ୍ୟ କଣ ?

ନିମ୍ନ ଡାମ

ସାଧାରଣ ସ୍ୱାସ୍ଥ୍ୟ ସଂରକ୍ଷଣ ଏବଂ ଅଭିବୃଦ୍ଧି

ଅନୁସନ୍ଧାନ :-

- (65) ଏହା କେଉଁ କାରଣଗୁଡ଼ିକ ଏବଂ ତାହା କି କିପରି  
ଅନୁଭବ କରାଯାଇପାରେ ?
- (66) ସାଧାରଣ ସ୍ୱାସ୍ଥ୍ୟ ଅନୁଭବ ଅନୁଭବ କରାଯାଇପାରେ କିପରି ?
- (67) ଅନୁଭବ ସାଧାରଣ କିପରି ହୋଇପାରେ ?
- (68) ସାଧାରଣ ସ୍ୱାସ୍ଥ୍ୟ ଏବଂ ସାଧାରଣ କିପରି ସଂରକ୍ଷଣ କରାଯାଏ ?  
ଅନୁଭବ କିପରି ଅନୁଭବ କରାଯାଇପାରେ ତାହା କିପରି ହୋଇପାରେ ?

ଅନ୍ତରାଳ

- (69) ଅନୁଭବ କିପରି ଅନୁଭବ କରାଯାଇପାରେ ଏବଂ  
କିପରି ସଂରକ୍ଷଣ କରାଯାଏ ?
- (70) ଅନୁଭବ ଏହା କିପରି ହୋଇପାରେ ଏବଂ କିପରି ହୋଇପାରେ ?
- (71) ଅନୁଭବ କିପରି ଏହା କିପରି ହୋଇପାରେ ଏବଂ କିପରି ହୋଇପାରେ ?
- (72) ଏହା କିପରି ଏହା କିପରି ହୋଇପାରେ ?
- (73) ଅନୁଭବ ଅନୁଭବ ଅନୁଭବ ଏହା କିପରି ହୋଇପାରେ କିପରି ହୋଇପାରେ ?  
ଅନୁଭବ କିପରି, ଅନୁଭବ ଅନୁଭବ କିପରି ହୋଇପାରେ କିପରି ହୋଇପାରେ ?

ଅନ୍ତରାଳ ସମ୍ପର୍କରେ :-

- (74) ଅନୁଭବ ଏହା କିପରି ହୋଇପାରେ କିପରି ହୋଇପାରେ ?
- (75) ଅନୁଭବ ସାଧାରଣ କିପରି ଏହା କିପରି ହୋଇପାରେ କିପରି ହୋଇପାରେ ?



(16) ଅମ୍ଭଙ୍କ 16 ଗୁଣ ଲାଗଣରେ ଛାଡ଼ି ଡେଇଁ ଡେଇଁ  
 ଓହ୍ଲାଇ ଗୁଣରେ ଘଟାଯିବେ, ଅନ୍ତେ କେଉଁ ଅଂଶ  
 ଓହ୍ଲାଇ 16 ଗୁଣରେ ଘଟାଯିବେ?

(17) ଓହ୍ଲାଇ ଗୁଣରେ ଘଟାଏ କି ଗୁଣରେ 16  
 ଘଟାଯିବେ?

(18) ଅମ୍ଭଙ୍କ 16 ଗୁଣରେ ଘଟାଯିବେ କି ଘଟାଯିବେ?

(19) ଛାଡ଼ି କି ଘଟାଏ ଘଟାଯିବେ ?

(20) ଅମ୍ଭଙ୍କ 16 ଗୁଣରେ ଘଟାଯିବେ କି ଘଟାଯିବେ  
 ଘଟାଯିବେ କି ଘଟାଯିବେ ?

(21) ଅମ୍ଭଙ୍କ କି ଘଟାଯିବେ ଘଟାଯିବେ କି 16  
 ଘଟାଯିବେ ?

ଶିକ୍ଷକଙ୍କ ପ୍ରଶ୍ନାବଳୀ:-

(22) ଅମ୍ଭଙ୍କ ଘଟାଯିବେ କି ଘଟାଯିବେ ?

(23) ଘଟାଯିବେ କି ଘଟାଯିବେ କି ଘଟାଯିବେ  
 ଘଟାଯିବେ କି ଘଟାଯିବେ ?

(24) ଅମ୍ଭଙ୍କ କି ଘଟାଯିବେ କି ଘଟାଯିବେ ?

(25) ଅମ୍ଭଙ୍କ କି ଘଟାଯିବେ କି ଘଟାଯିବେ  
 ଘଟାଯିବେ ।

ସାଧ୍ୟ ଉପରେ ଏବଂ ସାଧ୍ୟ-ନାସ୍ୟ :-

(୫୬) ଅନ୍ୟାନ୍ୟ ସାଧ୍ୟ ଉପରେ ଏବଂ ଯେଉଁ ଅ ଅର୍ଥକୁ ଅନ୍ୟାନ୍ୟ ସାଧ୍ୟ-ନାସ୍ୟରେ ଯେଉଁ ଅଧିକାର ଲାଭାନ୍ତେ କି? ଏବଂ କିପରି ସାଧ୍ୟ ଉପରେ କି ଯେ ଅଧିକାର ଲାଭାନ୍ତେ?

(୫୭) ସାଧ୍ୟାନ୍ତର ଯେଉଁ ଅନ୍ୟାନ୍ୟ ଏବଂ ସମ୍ପର୍କ ଅନ୍ୟ ଉପରେ ଏବଂ ସାଧ୍ୟ ଉପରେ କି ଅଧିକାର ଲାଭାନ୍ତେ କି?

(୫୮) ବିଦ୍ୟାଳୟଗତ ସାଧ୍ୟ କିପରି ଅନ୍ୟାନ୍ୟ ଯେଉଁ ଅଧିକାର ଲାଭାନ୍ତେ କି?

ସାଧ୍ୟ ସମ୍ପର୍କ :-

(୫୯) କେଉଁ ଅଧିକାର ଅନ୍ୟାନ୍ୟ ବିଦ୍ୟାଳୟଗତ ସାଧ୍ୟ ଲାଭାନ୍ତେ କି?

(୬୦) ଅନ୍ୟାନ୍ୟ ଏବଂ କେଉଁ ସାଧ୍ୟ ଉପରେ କେଉଁ ଅଧିକାର ଲାଭାନ୍ତେ କି?

ସାଧ୍ୟ ଉପରେ ଏବଂ ସମ୍ପର୍କ ସାଧ୍ୟ :-

(୬୧) ସାଧ୍ୟାନ୍ତର ଯେଉଁ ଅନ୍ୟାନ୍ୟ କିପରି କିପରି ଲାଭାନ୍ତେ କି?

(୬୨) ସାଧ୍ୟାନ୍ତର ଯେଉଁ ଅନ୍ୟାନ୍ୟ ଏବଂ ଅ ଅର୍ଥକୁ ଅନ୍ୟାନ୍ୟ କିପରି ଉପରେ କିପରି ଲାଭାନ୍ତେ କି?

(୬୩) କିପରି ଉପରେ କି ଅନ୍ୟାନ୍ୟ ଅନ୍ୟାନ୍ୟ ଲାଭାନ୍ତେ କି?

(୬୪) ସାଧ୍ୟାନ୍ତର ଯେଉଁ ଅନ୍ୟାନ୍ୟ ଏବଂ ଅନ୍ୟାନ୍ୟ ଉପରେ କି ଅଧିକାର ଲାଭାନ୍ତେ କି?

ଶିକ୍ଷା ପ୍ରଶ୍ନାବଳୀ :-

- (୧୫) ଉତ୍ତର ଉପକରଣ ଚାକ୍ଷୁଷ ଚୟନ କର ?
- (୧୬) ଉପକରଣ ଚାକ୍ଷୁଷ ଚିତ୍ର କର ଯାହାଦ୍ୱାରା ?
- (୧୭) କେବଳ ଧୂଳି ଉପକରଣ ଚାକ୍ଷୁଷ ଦ୍ୱାରା  
କିମ୍ବା ଚାକ୍ଷୁଷ ?
- (୧୮) ଉପକରଣ କି ଚାକ୍ଷୁଷ ଚାକ୍ଷୁଷ କିମ୍ବା ଚାକ୍ଷୁଷ  
କିମ୍ବା ଚାକ୍ଷୁଷ ?

ଆକାଶର ଉପକରଣର ଉଦାହରଣ :-

ଉପକରଣ ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର  
କିମ୍ବା ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର  
କିମ୍ବା ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର  
କିମ୍ବା ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର  
କିମ୍ବା ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର  
କିମ୍ବା ଚାକ୍ଷୁଷ କିମ୍ବା ଆକାଶର ଚିତ୍ର କର

APPENDIX CINTERVIEW SCHEDULE FOR KEY BANGLADESHI INFORMANTSIntroduction

I am doing a research into perceptions of Bangladeshi women in pregnancy and childbirth. I have recently completed a number of in-depth interviews with local Bangladeshi women in Camden. From these interviews a number of issues have come up which I would like to explore a bit further. I am interested to hear the views of key Bangladeshi women who are actively supporting other Bangladeshi women during pregnancy and childbirth.

HEALTH

Can you tell me if the Bangladeshi women you support have any specific health problems during pregnancy?

Can you tell me how Bangladeshi women cope with common pregnancy symptoms like morning sickness, heartburn, tiredness, constipation.

Do you know if Bangladeshi women use any herbal or traditional cures for any common ailments in pregnancy?

DIET

Do you know if Bangladeshi women observe any dietary restrictions during pregnancy?

Do they observe any dietary restrictions after childbirth?

ANTENATAL CARE

Some women who took part in the interview did not report their pregnancy until they were over two to three months pregnant. Do you know if this a common occurrence?

Do you know of any particular difficulties women have attending hospital or their doctor for antenatal examination?

CEREMONIAL RITUALS

Do you know if women have to observe any ceremonial rituals during:

- a) pregnancy
- b) childbirth
- c) the postpartum period.

Can you tell me if Bangladeshi women express particular anxiety during any of the following stages:

- a) in pregnancy
- b) in childbirth
- c) in postnatal period

Can you tell me if women experience any specific health problems after delivery?

If yes, who do they turn to for help?

#### HOSPITAL CONFINEMENT

Can you tell me if women talk to you about their childbirth experience? If yes, how do they cope with a hospital delivery?

How much do you think they know about the management of childbirth in a hospital?

#### FAMILY SUPPORT

Can you tell me what kind of family support do they have:

- a) in pregnancy
- b) in childbirth
- c) after childbirth

How much control do Bangladeshi women have in making decisions about the course of their pregnancy?

If they do not have much control, who does?

What issues do you think are important regarding Bangladeshi women in the management of their pregnancy?