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Maternity services in multi-cultural Britain: Using Q methodology to explore the views of first- and second-generation women of Pakistani origin

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ABSTRACT

Objective: to explore first- and second-generation Pakistani women's experiences of maternity services and the inter generational differences/comparisons.
Design: a retrospective Q methodology study of Pakistani women following childbirth.
Setting: two Children's Centres in an inner city in the West Midlands.
Participants: women self-identified following distribution of information leaflets at Children's Centres. Fifteen women took part in interviews (Stage one) using a semi-structured design and 16 women participated in the completion of the Q grid sorting (Stage four).
Methods: a standard five-stage Q methodology process took place: (1) initial data were gathered using a combination of individual face-to-face and focus group semi-structured community-based interviews (developing the concourse); (2) transcribed interviews were analysed for 'themes'; (3) the themes were reduced to 'statements' that reflected the overall content of the concourse using an unstructured evolving approach (giving the Q set); (4) participants were asked to sort the statements (Q sorting) according to a pre-designed distribution grid providing individual participant response grids; and (5) the response grids were factor analysed using PQ Method (V2.11), which generates clusters of participants rather than clusters of variables. Factor loadings were calculated using factor analysis by principal components with varimax rotation. This produced a list of factors, each of which represents a 'story' of women's experiences of maternity services. Throughout the process, an Urdu interpreter was involved.
Findings: six factors were identified: (1) confidence and empowerment of women who had attended higher education and had family support; (2) isolation of some women from both family and maternity services; (3) women who had poor experiences of maternity services but good family support, and wanted opportunities to be involved in service development; (4) women with positive experiences of maternity care and influenced by traditional cultural practices; (5) importance of information and support from health-care professionals; and (6) importance of midwifery care to women.
Conclusion: there were no clear inter generational differences identified, but a breadth of opinion and experience that seemed to be influenced by level of both education and social support was found. Whereas some women had few demands of maternity services, those who had less support and those with language barriers had additional needs.
Implications for practice: care given should be based on individual need but given within a wider collaborative context in order to support women effectively. Increased maternity service user involvement would also be welcomed for future planning of maternity services.

Introduction

Britain is a multi-cultural society with ethnic minority communities making up 7.9% of the population. This figure is significantly higher in many inner cities, with ethnic groups making up the majority (Scott et al., 2001). Women of Pakistani origin in Birmingham form the largest group of ethnic minority

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maternity service users (Taylor and Newall, 2008). However, other than recent studies by Richens (2003) and Hirst and Hewison (2002), very little research has been carried out into Pakistani women's experiences of childbearing in a British society and the National Health Service (NHS) maternity services. Research has been conducted regarding the apparent needs surrounding ethnic minorities (Onozawa et al., 2003; Atkin, 2004; Stewart et al., 2006). It could nevertheless be argued that if women are not asked directly, these 'needs' could be often misrepresented, thus increasing stereotyping and discrimination (Douglas, 1998).

Pakistani women are considered vulnerable service users (Department of Health, 2004). One reason for this is an increased maternal mortality rate, which is three times higher than that for White women (Confidential Enquiry into Maternal and Child Health, 2007). Pakistani women also have 35.7% of stillbirths within the Birmingham primary care trusts compared with 25.1% of births, whereas European women have lower risks with 33% of stillbirths and 43.6% of births (West Midlands Perinatal Institute, 2010). It was thought that after the first generation, the morbidity and mortality rate would reduce; this has not been the case (Margetts et al., 2002; Harding et al., 2004). The reasons for this are complex and are thought to include poverty, consanguinity and discriminatory practices (Power, 2002; Gennaro, 2005).

Maternity services do not provide equitable or effective care to vulnerable women (Cross-Sudworth, 2007; Gardosi et al., 2007). In order to address this, it could be argued that services should target those who are more at risk. 'Enhanced social care' (where there are additional home visits in the perinatal period with access to an interpreter where necessary) is a model of care that has proved to be beneficial and well liked, especially with immigrant communities (Parsons and Day, 1992; Oakley et al., 1996; Martinez-Schallmoser et al., 2003). Additional support has also had some positive effects on measurable outcomes (e.g. increased birth weight). However, this model has yet to be researched and implemented widely, although currently there is a Pregnancy Outreach Worker pilot scheme being undertaken in the most deprived areas of Birmingham, UK, offering additional support and information to those with identified risk factors (Birmingham Health and Wellbeing Partnership, 2007).

A vital but challenging addition to finding effective models of care involves service users in the planning and evaluation of services, including those from vulnerable groups (Department of Health, 2004, 2007a, 2007b, 2007c). Vulnerable women's inclusion, however, may be challenging, particularly for those unable to speak English or those unused to formal meetings (e.g., Maternity Services Liaison Committees: Department of Health, 2006).

Maternity care is construed as a partnership between the woman and health carer, which places a bilateral responsibility on both parties to engage with care provision. While the focus of this paper is the role of the maternity services, it is nevertheless recognised that the women involved also have a role to play in ensuring optimum outcomes throughout the pre-, peri- and postnatal periods. Ethnic minority groups have, however, traditionally been considered part of a 'hard-to-reach' group that has not wanted to engage with services or research (Douglas, 1998; Atkin, 2004). While there is evidence that ethnic minority women are less likely than European women to have their pregnancy booking appointment before 12 weeks (Gardosi et al., 2007), there is also the suggestion that where services are accessible, specialised and service orientated, women's engagement as well as overall experience is improved (Department of Health, 2005).

While working with women of Pakistani origin as a community midwife, there appeared to be a breadth of life experience and social standing as well as cultural and religious opinion within the Pakistani community; all factors which may influence a woman's experience of childbearing. For example, a woman who has recently arrived from rural Mirpur is likely to negotiate the NHS in an inner city very differently compared with a mother with Pakistani parents whose formative experiences and education have been in Britain. However, there is a gap in the research on inter generational differences within ethnic groups.

The aim of this study was to explore the maternity experiences and views of both first- and second-generation women of Pakistani origin. For the purposes of this research, 'first-generation' refers to women born in Pakistan and 'second-generation' refers to those born in Britain but who are ethnically Pakistani. The intention was to make recommendations to maternity services, raising awareness of issues faced by a diverse Pakistani community. This exploration of their experiences within the context of their cultural needs may increase understanding and improve the partnership between service providers and service users leading to more accessible, equitable and appropriate care.

Previous research

A literature search was carried out on south Asian women's experiences of childbearing within Britain and negotiating NHS maternity services. A search criteria limitation of only English-language articles was given with terms including 'ethnic minority', 'service users' and 'maternity services'.

Research exploring ethnic minority women's experiences of maternity services commenced in the 1990s. This had the effect of raising cultural awareness as well as exposing racism (Bowler, 1993; Woollett et al., 1995; Bowes and Domokos, 1996). Key issues identified were poor communication, a lack of respect and restricted choice (Harper Bulman and McCourt, 2002; McLeish, 2002; Martinez-Schallmoser et al., 2003). In addition, Hindley (2005) also found that women wanted good continuity of carer, believing that this would overcome some of these barriers.

Bowler's (1993) groundbreaking research used non-participant observation of south Asian women in hospital in conjunction with interviews with hospital midwives. This ethnographic study identified stereotyping, discrimination and a lack of cultural awareness by midwives, resulting in a lack of empathy as well as poor care.

Ellis (2004) also used non-participant observation, resulting in similar findings to Bowler (1993), strengthening the reliability of the original research. However, unlike Bowler (1993), Ellis (2004) only sampled second-generation south Asian women who were generally well educated and spoke English. However, these women also felt powerless and ignored by midwives.

Bowes and Domokos (1996) reiterated the juxtaposition of the powerful health professional and the powerless Pakistani woman in their research, stating that Pakistani women were 'muted' and isolated. There was no control group for comparison of care, but there were more barriers to effective care and perceived support than language alone.

Hirst and Hewison (2002) compared White indigenous women's views with those of Pakistani women, but only concerning hospital postnatal care. These interviews identified worse communication, staff attitudes and continuity towards Pakistani women in comparison with care given to indigenous women.

Richens (2003) comprehensively explored Pakistani women's views of the overall care they received using focus groups in the postnatal period. The findings showed that women believed that poor communication between themselves and their midwives