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Pregnancy and childbirth are the most significant events in the life cycles of most women, irrespective of social class, culture and ethnic background. This book is about the experiences of pregnancy and childbirth in Britain of two groups of South Asian women with roots in the Indian subcontinent.

In western industrialized nations, advances in medical technology and the dominant role played by medical professionals have had a major influence in determining trends in childbirth practices. In the process, a biological and social event, traditionally supervised and managed by females, has been transformed into a medical emergency. The inexorable rise in the medicalization and hospitalization of childbirth witnessed in the west has become an important consideration for childbearing women, women’s organizations and those who have an academic interest in the subject. This is evident from the large volume of literature within the field of social science and medicine, which has examined the impact of current childbirth practices on women’s lives.

To date, much of the research effort has been confined to exploring the experiences of white women. Women from minority ethnic groups, who constitute a substantial part of the female population of childbearing age in Britain, have received relatively little attention in the literature. This lack of interest is particularly striking given that women from minority ethnic groups in Britain are not immune to the vagaries of current childbirth practices as they have little alternative but to accept the care provided by the National Health Service (NHS). The invisibility of minority ethnic women is particularly worrying given that their own experiences are often very different from those of the mainstream: most recent arrivals will have been exposed to a traditional model of managing childbirth in which female relatives play a very influential role. These differences provide further arguments for much needed research which will contribute to our understanding of how minority ethnic women negotiate care when faced with conflicting models of childbirth. Although cultural values and traditions are constantly evolving,
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some values and belief systems survive despite external pressure (Bhopal 1986; Drury 1991), and the issues they raise will continue to influence the behaviour of women from these communities for the foreseeable future.

Although a small but growing body of literature has begun to address this situation by involving South Asian women in research, the subjects of this research are often treated as if they are a homogeneous group, disguising the enormous variations in experience which can be attributed to age, religious belief, socio-economic and educational background, language and patterns of migration.

People from India, Pakistan and Bangladesh are sometimes referred to as Asians or South Asians in the UK, and as East Indians in a North American context (Birbalsingh 1997). These terms often cause confusion because they are sometimes used imprecisely to describe a complex population (Bhopal et al. 1991). To add to this confusion, people from the Indian subcontinent are also referred to as ‘coloured’ and ‘ethnic minority’; even though about 50 per cent of people of ethnic minority origin are born in Britain recent research sometimes also refers to them as ‘immigrants’ (OPCS 1991).

The presence of people of South Asian origin is not a recent phenomenon as small numbers have lived in Britain for the last few centuries (Visram 1986). However, the bulk of the South Asian population is made up of people who arrived in Britain from India and Pakistan after the Second World War, followed by a second wave of immigration from East Africa in the late seventies and later from Bangladesh (Walvin 1984; Adams 1987; Ballard 1994). Estimates from the 1991 Census suggest that 3 per cent (around 1.43 million people) of the total British population is made up of people whose roots were in the Indian subcontinent. Of these, 823,000 were Indian, 449,000 were Pakistani and 157,000 were Bangladeshi (OPCS 1991).

One of the major differences between the various South Asian communities is that they do not speak the same language. For example, in India there are more than 150 languages, none of which is spoken by more than 30 per cent of the population (Edwards 1994). In Pakistan, Urdu is the national language but other major regional languages, including Pushto, Punjabi (and Mirpuri), Baluchi and Sindhi are also spoken (Lewis 1994). In Bangladesh, dialects such as Sylheti are also spoken in addition to Bengali, the national language (Katzner 1977; Hussain 1991).

The people of the Indian subcontinent also differ in their religious beliefs. The main religions practised in the region are Hinduism, Sikhism and Islam. Islam is further divided into two main groupings, Sunnis and Shias. Within each of these two groups there are still further divisions into sects (Lewis 1994). Hindus are also divided not only into different religious sects but also into distinct caste groups (Burghart 1987; Dwyer 1994). Sikhism, likewise, is characterized by diversity.

In addition to the significant differences in patterns of migration, length of settlement and educational and occupational backgrounds, the huge disparity in economic status sets these communities apart from each other (see, for instance, Modood et al. 1997).
It is evident that the superficial homogeneity of people from the Indian subcontinent not only masks many important differences between the main South Asian communities in Britain, but also further differences within and between subgroups. One of the main objectives of this book is to explore some of these differences in relation to childbirth and, more pertinently, to examine the impact of traditional and medical models of childbirth practices from the perspectives of two groups of South Asian women. The women whose experiences of childbirth are the subject of this book were drawn from predominantly Hindu Gujarati Indian, and Muslim Bangladeshi communities.

**Gujarati Hindu community**

Although the Gujarati Indians originate from the state of Gujarat in the north west region of India, their history of immigration is highly chequered, sometimes involving settlement in more than one continent before arriving in Britain. For example, while many Gujaratis migrated directly to Britain in the 1950s, some first settled in east and central Africa and later migrated to Britain in the late 1970s. Despite the different routes of migration and settlement patterns, many features of Gujarati culture and traditional values have survived and are strongly adhered to in Britain. For example, many Gujaratis are followers of the Hindu religion and Gujarati remains the first language for many, particularly older people. Similarly, despite the influence of British culture, their dietary habits and their mode of dress have largely remained unchanged. Other features which have been retained are the organization of the community into various caste groups and the structure and composition of the family. Although by no means universal, the extended family is still an important aspect of the Gujarati community 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. The Gujaratis, particularly those from East Africa, are considered to be among the most successful South Asian immigrants to Britain (Robinson 1996; Modood et al. 1997).

**Bangladeshi Muslim community**

The migration of the Bangladeshis from the then East Bengal or East Pakistan, and now Bangladesh, to Britain runs parallel to that of Gujaratis. The migration from East Bengal was predominantly from Sylhet – a district in the north east region of Bangladesh. The early migrants to Britain from Bangladesh were men who worked on cargo ships as sailors and cooks who later gave up their seafaring careers and settled in sea-ports around Britain (Adams 1987; Eade 1990). Unlike the Gujaratis, the migration of wives
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and other dependent members of the family has been a very recent phenomenon prompted by the increasing desire of many Bangladeshi men to make Britain a permanent home for themselves and their families (Carey and Shukur 1985). Because the migration of the whole family has been a relatively recent event, the Bangladeshi community has retained much closer physical and emotional links with Bangladesh, particularly as many family members have been permanently separated by the strict immigration policy introduced in the post-1970s period. The fragmentation of families across continents has had serious repercussions on the tradition of the extended family system and on informal social support networks.

All Bangladeshis are predominantly followers of Islam. Bengali is the national language but people from the Sylhet district speak the Sylheti dialect. Evidence suggests a low level of education and professional qualifications, particularly among women, and a generally low level of literacy in Bengali and English (LMP 1985; HEA 1994). The unusually high rates of unemployment and underemployment experienced by people in the Bangladeshi community make it one of the most deprived communities in Britain (House of Commons Home Affairs Committee 1986; Modood et al. 1997). It has also been reported that of the main South Asian communities, the Bangladeshi community has the lowest level of home ownership, with a majority renting their homes from local councils. Bangladeshi families are often housed in substandard homes lacking many basic facilities (Owen 1994; Eade et al. 1996).

About the book

The main text of the book is based on in-depth interviews with 15 Gujarati and 15 Bangladeshi women in the third trimester of pregnancy and within six weeks of birth. Additional interviews were conducted with key informants from the Bangladeshi community, namely community liaison workers and maternity hospital interpreter/link workers. The interviews with the Gujarati women were carried out by the author in Gujarati. Interviews with the key informants and two of the Bangladeshi women were also conducted by the author, but in English. The remaining interviews with Bangladesh women were carried out by bilingual interviewers who were given training in conducting in-depth interviews. Hospital obstetric notes for the Bangladeshi women were used to augment information given during face-to-face interviews.

The women were aged between 18 and 40 years and included both primipara and multiparous women. Although the individual circumstances of women in each community varied, the sample reflects the general characteristics of the communities in question. For example, the majority of Gujarati women had lived in Britain from early childhood; many had professional qualifications and were in full-time employment, owned their homes and were in a financially secure position. In marked contrast, with the
exception of two women, the majority of Bangladeshi women had lived in Britain less than ten years, and lived in rented accommodation, including temporary hostels. Very few Bangladeshi women were literate in Bengali or in English and none of them had any experience of working outside their homes.

The material in the book is organized in seven chapters which trace the progress of the Gujarati and Bangladeshi women from the third trimester of pregnancy to six weeks after birth. Chapter 2 opens with a brief overview of literature on the health of South Asian women drawing on research literature on maternal and child health, access and uptake of maternity services and recent development in research on women’s health issues. Chapter 3 examines women’s attitudes towards conception and pregnancy and highlights the social, cultural and intergenerational differences in attitudes towards pregnancy and motherhood, and the struggles women encountered in coming to terms with pregnancy. Chapter 4 explores the women’s experiences of negotiating care during pregnancy and the strategies they used to cope with the medical and traditional management of pregnancy. Chapter 5 examines differences in the women’s attitudes towards, and participation in, parentcraft classes and provides an insight into their experiences of giving birth in hospital. It also discusses the extent to which knowledge of the medical procedures involved in managing labour and delivery in hospital helped or hindered the women’s decisions. Chapter 6 contrasts the women’s experiences of postnatal care in hospital with traditional approaches and examines the impact of the differences on the women and on other members of their families. The tension between medical and traditional models of childbirth and differences in attitudes towards pregnancy and childbirth which form central themes of the preceding chapters are developed and explored in case studies of childbirth in two Gujarati extended households. The final chapter provides an overview of the position of South Asian women in the context of British culture and current ideology surrounding childbirth practices in Britain.

Annotated bibliography


This collection is based on the fourth national survey carried out by the Policy Studies Institute and it provides a comprehensive account of the experiences of ethnic minorities since the 1960s. The series of papers covers a range of key issues which have had a major impact on the experiences of ethnic minorities. Some of the most significant changes reported relate to changes in demography, family and household structure, socio-economic position, cultural identity, health, education, employment and experiences of racial harassment.