Birth for some women in Pakistan

Defining and defiling

Margaret Chesney

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The University of Sheffield
Faculty of Medicine
School of Nursing and Midwifery

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7 Chapter: Findings

7.1 Introduction to the findings

This introduction to the findings provides the context to the main theme, and the subsequent seven sub-themes. A time has come in the analysis of the data to weave the existing theory and knowledge into the emerging concepts from the women's stories. This is within the context of the women's lives across two continents, two decades and three generations, yet all with the experience of birth in Pakistan.

Current discourses on birth in Asia, Jeffery, Jeffery and Lyon (1988) Chawla (1999, 2000) and Sizoo (1997) are almost exclusively about life and birth in India. In order to study childbirth Roger and Patricia Jeffrey and Andrew Lyon (1988) undertook research in the Bijnor district of Western Utter Pradesh Northern India. As a research team they based themselves in a disused government dispensary between two villages, Dharmnagri whose population was mainly Hindu and Jhakri who were predominantly practising Muslims. The initial research took place in 1982, this was a survey of women who had recently given birth. The researchers returned for two months in 1985 to conduct semi-structured interviews with key informants, (41 couples, 22 in Dharmnagri and 19 couples in Jhakri). The overall aim of the research was to study childbearing as socially organised phenomena. Throughout the research there was extensive contact with dais. Jeffery, Jeffery and Lyon's (JJL) findings told of dai practice that could be classified as 'dangerous'. In their ignorance, dais were undertaking vaginal examinations without washing their hands (JJL page 3). They were pushing on the woman's belly in labour (JJL page 104): wrapping a ball of dry mud in a rag to absorb the postpartum blood (JJL page 5): asking for the dispenser to give an injection to make the baby come when the head was in the transverse (JJL page 115).

Whilst there are many similarities in rural living and birth practices between birth in India and Pakistan, there are also differences. The main differences being that only 30% of Jeffery Jeffery and Lyon's sample were Muslim. Jeffery Jeffery and Lyon (1988) focused upon the 'dangerous' practice of the dai with little mention of any positive practice. Whilst the staff at the Maternity hospital agreed with Jeffery Jeffrey and Lyon (1988) the

women who had given birth in the home spoke strongly of the positive presence of the dai.

Other text linking to birth in Pakistan is limited to research on maternal morbidity and mortality, Awan 1996), or specific issues relating to maternal and child health: anaemia (Chapple, 1998), divorce (Carrol, 1997), and abortion (Fikree, Jafaray, Kureshy,1998). Further discourses on women's health arise from conference proceedings, (Khanna 1996, Qureishi (1995) and Kamal (2000) National Committee for Maternal Health (2002) It would appear that there is little ethnographic research into women's life and birth in Pakistan.

I laboured for some time under the belief that the women's stories alone would convey the important message as they did for me. I rationalised that if the stories were told, word for word as I had heard them, adding in the context as I saw it, the message would then be as clear and powerful to others as it was for me. However, realisation hit first that the message I received was incomplete, as it comes from only a snapshot or a brief research encounter with the women and their lives. Second, the message only had clarity for me laid upon and with my past experience. Third, it is important to relate the women's life and birth experiences alongside other women's stories across the world. Fourth, the application of existing discourse will serve to enhance the content and understanding through multiple perspective application.

Many contextual issues from the women's lives and my experiences in Pakistan have proved difficult to articulate. Extracts from the women's stories did not convey the important context or emotion that was evident at the time of the interview. Searching for a more effective mode of communication as a way forward was eventually found through a dual process. First, I had to declare the context, written as the context stories then focus on the birth story of each woman (Chapter 6). Discourse has been applied throughout the whole text, as the comparisons, parallels, contradictions or juxtapositions arose. Some duplication was unavoidable as reference was made back and forth in the text. The purpose was to make the whole text pivot on the women and reflect the complex milieu of their lives in the existing limited discourse on birth in Pakistan.

I held a fear that the individual women would be lost if a collective reductive analytic strategy was employed. This fear was ameliorated when I realised there was the opportunity to give the women's words more power. Presenting the women's words attached to a theoretical perspective could do this. Thus the women's words would not be lost, misrepresented or generalised by concept formation from the narrative analysis. Instead they would be strengthened, honoured, confirmed or refuted. The words would be stronger by the aggregate and powerful in the application and contribution to existing knowledge. Thus instead of lone voices repeated in the telling, an opportunity existed for the women's words to contribute and build new theory to shape more sensitive interaction between women and midwives. Within the dialectic framework (Tolman 1983), the move towards a greater knowledge through debate will symbolise some of the major influences upon women and childbirth in Pakistan. Finally, and very importantly, the women's words will be honoured and revered by a wider audience than me alone.

Realisation that woman from Pakistan and the UK (generally)[45] are more alike than different dawned slowly. Similarities came from the unique. Each woman has a life and birth experience that is unique to her. However, we only learn of the uniqueness by listening to each other, juxtaposing differences, telling stories that have a meaning and create impact. Listening, thinking, empathising, and observing are the keys to unlocking the uniqueness. From this concepts emerge such as, women's knowledge, work, power, relationships and trust. Women's birth experiences do not take place in a void, but in a social, religious and cultural dynamic life hotbed, with peri-contextual issues that influence women's lives across continents and indeed the world. The whole serves to generate multiple similarities of concept, from wildly differing contexts. These range from the position of women in the society to the need for support, trusted care and a feeling of safety, with a broad construct of women's knowledge and in the context of the prevailing superior, medical knowledge.

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[45] The insight of the similarities, differences and uniqueness, in and between the two groups of women interviewed, myself and other white western women was unexpected.

It should be emphasised that this research is not a comparative analysis of birth, birth practice or the birth attendant. Such an exercise would be absurd. It is, however, relevant to describe the known, to highlight the different. Both the macro and the microelements within the two societies are poles apart. At a macro level, the differences are in politics, the welfare state, (or lack of thereof); the organisation of health care, the role and status of health professionals and, importantly, the legislation and economic systems underpinning the infrastructure of both countries. All are at opposite ends of a continuum or at different stages in evolution. Microscopically, attitudes, symbols, general life ways, beliefs, views and expectations of the populations in Pakistan and the UK are equal in their divergence only.

My experience as a researcher, midwife, mother and grandmother spans both societies; however, my culture, race and socialisation as a white western English speaking woman, served to separate me, yet perversely allow me into the lives of Pakistani women. I have been conscious throughout that the pathway 'in' may have been paved by the colonial past. This has been a source of some discomfiture to me. I only became aware of my own culture when I experienced another. It has to be acknowledged that there is an unavoidable difficulty in cross-cultural research,

Further exploration is offered prior to reading this chapter on the use of the terms midwife and dai. Much of my early thinking linked the two together, simply because they were both with the woman at birth. Also the women used the terms inter-changeably; it was common to call the untrained dai the midwife, but usually not vice-versa. The synonymous cross-use of the terms dai and midwife appeared to be more than a slip of the tongue. It was as if the meaning 'with woman' was more important and better understood than the differential or indeed any importance given to the issue that the midwife had some training and the dai had not. The 'sameness' may also be linked to the position and regard in society.

Living, working, studying, sharing and reading of other women's life and birth experiences begins a journey of learning with no end; a journey that serves to gather understanding and shed prejudice along the way. If an end had to be stated, for me it would be satisfied women.

Women satisfied that I had been responsible for their words, given with trust, treated gently without prejudice or judgement and with honesty and humility. Satisfied readers, who will be mostly women, more likely to connect with the text in a position to judge whether the women's words and concepts smell of reality, brought alive through vivid vocabulary and discourse, then they too are more likely to be satisfied.

The aim of the research was to create a synaptic cognitive leap from ignorance, uncertainty and error, to a qualitatively different state of knowledge. I reflected whether this was because I had seen the whites of their eyes; lived in their world, sampled their lives. The words did not just smell real: they were real. The stories were thought out, shaped and delivered with careful consideration. I was amazed when some of the stories paralleled my experiences, thousands of miles away and in awe at the different lifestyle. Seeing the life and birth experience of women from a different culture and continent took me on a journey into my own birth and life experience, a journey into rediscovery, towards seeing the obvious from a different perspective.

> *"Rediscovering the obvious becomes exciting when it proves to be more relevant than originally thought"* (Sizoo 1997:243)

An expectation I took with me on my very first visit to Pakistan was that birth for most women would be physiologically the same, perhaps more 'normal', than in the UK and USA. Despite vast social differences, I reconciled that the woman's reproductive system held few major structural differences and that the woman's body would behave in parturition the same across continents and cultures. I hypothesised that birth in Pakistan would involve the women working, either in the fields or in the home; they would take temporary respite from one means of labour to undertake another. Labouring at home supported and cared for by other women, then the home birth would take the women into a very important social role in Pakistani society, that of mother.

> *"It is the moment when she becomes a mother that a woman first confronts the full reality of what it means to be a woman"* Oakley 1976: 17)

The women's birth stories confirmed some of my expectations and initiated a re-discovery of my own birth experiences.

Revisiting my birth experiences made me realise how I had been socialised during my nurse and midwifery training to be 'objective', In the mid 1970's the use of ones own 'subjective' life or birth experience was strongly discouraged, even when trying to relate to the experiences of women. One did not 'get involved', empathise or use reflection as a means of learning. I did learn to disengage, control my emotions, hide in the sluice to cry, say I had sore eyes because of an allergy, and in short I learnt to bury my emotions. It took listening to the birth stories of the women from Pakistan to awaken and give voice to my experiences (Appendix 1). Strong parallels as well as the expected differences became evident. Moreover, our joint connected birth and life experiences appeared to be related.

Birth for me in the 1960's and 70's corresponded with the care that I saw given in S... in the late 1980's. Similarly, the experiences as a community midwife in the UK in the late 1980's and 2000 plus, held many similarities with the content of the birth stories from the women who had given birth at home, cared for by the dai in the 1950's through to the 1970's.

To clarify, in the 1960's I went into hospital in spontaneous labour, my husband was told to stand in a corner. I was starved in labour after being given a pubic shave and an enema. The position I maintained throughout the labour was semi-recumbent; I was dripped, exhorted to PUSH and threatened with possible brain damage of my baby if I did not. Thereafter, I had an episiotomy and eventually delivered from a stranded beetle position. The baby was given nothing orally for the first twelve hours, water for the first feed, and then attempts were made to attach her to the painful, engorged breasts.

In 1989 in S... Pakistan, a hospital birth for women involved being laid flat, dripped and labour accelerated with drugs on admission, no matter what stage or progress the labour was taking. Relatives were banned from the labour room, multiple hands pushed on the woman's fundus, the lithotomy position assumed whilst the person between the woman's legs manually dilated her vulva. An elective episiotomy was performed for the first birth, the cord left attached until the placenta is delivered and colostrum discarded whilst the baby was given sugar water for the first three days.

Home birth in Pakistan between 1950 and 1970's saw the dai called to the home, women and relatives take decisions, the labouring woman given 'special' drinks and nutritious diet, move around in labour and adopt a squatting posture for the birth.

From 1990 to 2002 in the UK, with the continuity of the community midwife and a caseload model of care, however still very few are given the choice of venue for the birth. The service cannot supply the midwife and the midwife no longer has the skill or the confidence for home birth. The woman may be ambulant in labour, when she is not being electronically monitored, or rendered immobile by an epidural. She may be 'allowed' to give birth in a position of her choice; however, this choice may be limited by technology and or social expectation.

Although I had not foreseen the multitude of influencing factors that affect birth in Pakistan, rediscovery of the obvious was both exhilarating and depressing. Exhilarated by the strength of women and depressed by the intervention and pervading highly prized technology that surrounds birth in hospital in Pakistan. Further excitement was derived from applying the knowledge gained to relevant midwifery care in the UK in order to increase understanding.

7.2 Summary

This introduction to the findings chapter began with exploring the concept of message power and the need to explain the emerging themes from the women's stories. The emerging dialectic of positive and negative factors that influence birth in Pakistan is woven into the historical obstetric influences seen over half a century.

The omnipresent person in the life and birth stories of the women interviewed was the dai

7.3 THE MAIN THEME 'THE DAI'

7.3.1 Introduction

> *"The dai is seen as indigenous specialist in women's well being"* (Chawla 2000) yet she is considered as *'ignorant'* (Naz) and is blamed for *'mis-handling'* women. (Naz's daughter and Dr Q)

Most of the women interviewed about their birth experiences in Pakistan agreed with Chawla's (2000) definition. The dai is the person called in labour. The women did not use the term 'specialist'; more often the descriptor that was attached to the dai was that of 'family'. It was evident in both the frequency of referral to the dai and in the positive reverence, that the dai was as important to the childbearing woman as the close female relative. The importance of the dai being a relative, or part of the family, with or without blood or kinship links had clear emphasis within the narrative. As such, the dai, her practice and her relationships with the woman and her female relatives serve as derivatives of the major theme, which is the dai. Further sub-themes are explored in chapter 8.

Initially I was uncomfortable with extracting discrete categories or packets of information from the life stories of the women. Holding important context in my head and no vocabulary with which to communicate it, I judged that the women and doctors would have the same internal problem. Consequently, there was a strong sense of superficiality and a fear of doing the dai a disservice. I was also aware that this important chapter was mainly written from the perspective of the woman and others and not the dai herself. The only dai to contribute spoke of her social position, not feeling safe to give her name and from her knowledge appeared to have been influenced by western practice. However, there is no way of knowing whether she is typical without listening to other dais. The perspective of the women, my own interaction with dais over a 10-year period and existing discourse would suggest that she was atypical.

The women's words have been honoured and portrayed with the maximum context and the minimal researcher bias. Throughout the text, the women's words have been applied to existing discourse. However gaps or emptiness in the context can only be highlighted when seen. By virtue of the subject and the 'subjects', many such gaps will be hidden, some purposefully to keep strangers out, and some because of the lack of an appropriate mode of communication.

The next part of this chapter explores who the dai is and where she fits in the provision of health care in Pakistan in the context of other trained birth attendants.

7.4 Who is the dai?

Alongside the women participants' interchangeable use of the terms dai and midwife, there are common misunderstandings world wide around the definitions and roles of birth attendants. The title, dai, is often synonymous with traditional birth attendant (TBA) (Fleming, 1994; Maine, 1992; Manglay-Maglacas, 1986; Murray, 1996; Minden, 1993). Such global confusion around terms and definitions of traditional birth attendants (TBA) led to a study by WHO (1992), which did little to clarify the issue. Literature from Pakistan (UNICEF 1989) further confuses, as it classifies 'trained' dais and midwives collectively, with no mention of the TBA. Later research in Pakistan and India (Chawla 2000) clearly recognised the untrained dai as being 'with women' and defined her as an '*indigenous birth attendant'*. Further differentiation comes through reference to the midwife as '*being trained for 12 months'*, thereafter introducing yet another descriptor, '*the auxiliary midwife'* (Kamal 2000). If the definition of midwife is taken literally, from the old English '*wif* (with) *woman*' (Collins 1994), then the following text will show that the dai is indeed a *'midwife'* as she is '*with woman'*. The statistics to uphold this are recorded by Fikree, Jafarey and Kureshy (1998), Chawla (2000), Kamal (2000) and Kasi (2002), each confirming that between seventy-five and ninety per cent of women who give birth in Pakistan are attended by the dai. Further clarification of the definition that links to the role of traditional midwife describes her as being '*a woman skilled in aiding the delivery of babies* '(Kamal, 2000, Kasi, 2002)

The skill of the untrained dai comes from indigenous empirical knowledge. This skill may have been enhanced or contaminated by biomedicine in the form of some kind of training or touching of practices. This will be explored later in more depth.

In the mid 1960's fifty-eight out of sixty-four societies globally provided elderly women experienced in matters pertaining to birth, to attend other women McClain (1981: 25) confirmed that;

> *"It is the minority of societies that train young women who have never experienced childbirth to be with woman"*

At that time, Pakistan would have straddled the minority and the majority societies, the majority, through the provision of elderly women (dais). This is largely through government default as the dais are unpaid, undervalued and with no social position. Pakistani society would also be in the minority position because the government (and some charities) uptake of places to undertake midwifery training are from young women with an age range of seventeen to nineteen (Pc, Personal.communication, Lee). Married women are not usually recruited into midwifery for multiple cultural reasons. Following marriage the midwife's family must take priority on her time and the role of wife and mother carries a more socially valued position. Most student midwives reside in the hospital hostel, following marriage it is unusual for a woman to work away from home.

Changes are occurring. I know of a Pakistani trained nurse who has come to the UK to work (after retraining and recognition through the Professional Body). She has brought her husband with her but has had to leave very young children in Pakistan. It would appear that it is acceptable to leave the children for work but not the husband.

In a bid to bring the home to the hospital and encourage women to continue work after marriage, the L... D... Hospital in Karachi is now offering the qualified midwife and her husband hospital accommodation. However, she will be expected by her husband's family to become pregnant in the first year following marriage and to be available to give care to any sick member of the family as a priority over her work.

Consequently, it is usual for the young, unmarried student and qualified midwife to discontinue working after marriage. This results in a relatively young, inexperienced and

ever changing midwifery workforce. Family needs and marriage accounts for the high attrition and sick leave taken during training. (P.c. Lee). Due to the desperate shortage of newly qualified midwives, following qualification the hospital that trained the midwife tries to tie them into employment at the hospital for a minimum period of one to three years.

This shortage has continued at least since the 1950's when Naz had her children in Pakistan. Naz had the first four of her nine children in Pakistan in the 1950's and 60's in a small town in the Punjab. Naz said there were no qualified midwives when she had her children. Contrary to this assertion, there were indeed midwives in Pakistan in the 1950's. The presence of some midwives at that time was confirmed through the interview with Ina.

> *"I was 18 and unmarried when I started training in Yalcot (Sind) in 1956. I did one and half year,*[46] *... I had to have twenty-five witnesses and twenty-five operations, I worked from 1956 to 1981 as a midwife* (Ina Chapter 6).

Ina's midwifery training had similarities to the two year midwifery programme in the UK at that time. However, Naz's statement served to highlight the lack of any national infrastructure or realistic national provision for midwifery training in Pakistan. Then, as today, there are relatively few training institutions and midwives in Pakistan. Although the Pakistan Nurses Association (PNA) register is unreliable, Saleem (1992) declares there to be only seventy nurse and midwifery-training institutions with an estimated seventeen thousand midwives[47]. When one considers that Pakistan has a population of one hundred and forty three million people, the shortage of midwives can be understood.

Chawla, in her study of 'indigenous health knowledge systems of dais in India (2000), found that even the most competent and active dai did not have an apprentice. This led to the conclusion that '*the tradition of becoming a dai is dying from neglect*' (Chawla

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[46] The programme was over two years; however, Ina arrived late because her brother would not give his consent for her to start.

47 In the same text Saleem (1992) declares there to be 19,000 nurses and states that many of the 17,000 midwives do not work as midwives.

2000). Confirmation of this came through Shad's interview and her declared preference to do cleaning jobs, rather than become a dai like her mother. In addition, the village that we visited in 2000 had seen the need to support the training of a dai, because there was no relative of the old dai prepared to take over. In exploring the unpopularity of becoming a dai, it would seem relevant to examine the characteristics of the person and role.

7.5 Characteristics of a dai

Hunte (1981) studied forty dais in six urban regions of Afghanistan and came to the conclusion that:

> *"Dais' are usually widowed, of low economic standing, illiterate, but experienced".*

Table 6 The characteristics of the dai as told by the women interviewed.

UNTRAINED, UNEDUCATED, (IN A WESTERN SENSE) YET INFINITELY SKILLED AND EXPERIENCED
OLDER (OFTEN) WIDOW WOMEN, SOME ARE BLIND
FROM THE LOWEST SOCIAL CLASS
WITH NO SUPPORTIVE FAMILY

The women interviewed were in no doubt they did not want themselves or any of their relatives to be a dai or a midwife.

The dai's role involves her being called when the woman goes into labour, or if a female relative 'attends' the woman for the birth, the dai may be called to cut the cord, deal with the placenta, clean up the floor and mop up vomit, faeces or waters (liquor) only. Massage also was considered an important part of the dai's role. There was some difference of opinion as to whether the dais would give injections. Some would (Naz Chapter 6), others said it was a doctor's job (Dai no name Chapter 6). The reasons they

were given were *'to make the pains stronger'* or if requested by the mother (Sha Chapter 6). However, the dai who would not give her name accused other dais of giving injections to '*increase the bill'*.

The role and practice of the dai has not been of interest to the medical profession (Chawla 2000) except to say that the dai needs to be 'trained'. How that training is organised, planned and implemented has never been agreed nationally. Short term training programmes supported by government or overseas aid agencies have evaluated poorly (Jordan, 1989). The major finding or effect of TBA training programmes has been no lowering of the mortality (Maine, 1992). Largely funded projects have been piece-meal and concentrated upon problems, not on the use or possible advantages of the current indigenous dai system.

As a consequence, trained health personnel in Pakistan attend only 13.6% of births (Save the Children's Fund 1992, Kamal 2000), midwifery is a much misunderstood and neglected profession in Pakistan and this is reflected in the unclear definitions. TBA, dai and midwife are used synonymously. The dais lack of formal training, but great familiarity with birth, puts them in an opposite situation to that of many doctors and reflects the values placed upon education rather then the familiar.

Some of the doctors who have been employed at the maternity hospital have not undertaken any gynaecological or obstetrical training. They have done the theory-based degree in medicine, followed by a year in clinical practice, then a year in a 'house job'- in any speciality that can be acquired. Following this they are then placed at the maternity hospital in charge, undertaking obstetrical interventions such as tubal ligations, forceps deliveries and caesarean sections. It is a most unpopular placement and is looked upon only to gain experience before setting up a private clinic or employment in a teaching hospital. That is, until marriage. Male doctors would not be posted to the Maternity hospital, they would not be accepted, as women would not attend.

7.6 Midwifery training

There are three categories of midwife in Pakistan, the nurse midwife, the health visitor and the non-nurse midwife (Kamal 2000). Currently all three undertake the same twelve months course using a National Curriculum, which was last revised in 1994. The training institutes are regulated by the Pakistan Nursing Council and the system in place states that each training institute should be inspected every three years (Saleem 1992). However, there are instances where no one could remember the last inspection (Kamal 2000, P.c.Lee).

Within midwifery training in Pakistan, there are limited opportunities for supervised practice. The student, (referred to as 'pupil' in Pakistan, as they were in up until the late 1970's in the UK) midwives are required to observe five and conduct twenty births in the hospital, with five being in the home, during their twelve-month course. However, the reality is that in order to 'protect' the student's reputation, she is not allowed into the community[48]. Consequently the students do not see home births. Supervision and/or mentorship is also a problem, as in the smaller hospital the student may be totally unsupervised and used as a member of staff. In the larger hospitals, there are such large numbers of medical and postgraduate students; the student midwife is unable to get the required experience.

The woman giving birth in the home is attended by her relatives and the dai. The criteria for attendance are that they must be married and have experienced birth themselves. The student midwife would not be allowed to attend, as most are unmarried. Even if the relative were a midwife, nurse or lady health visitor, she would attend as a relative the dai, would assess progress and assist during the birth. The woman would either call the dai or, as usually happens, they would take her to the hospital (P.c Lee). However, the ward assistant in the maternity hospital did practice as a dai in her day off in her own village (P.c Lee.).

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48 There is no organised community midwifery service in Pakistan, various projects have 'outreach' schemes, but a planned home birth attended by a qualified midwife is considered an anathema. The hospital trained midwives consider it dangerous to give birth at home (Pc).

With a national home birth rate averaging two per cent in the UK, (DoH 1993) very few student midwives have the opportunity to attend a woman giving birth in her own home. However, home birth still constitutes an important part of the curriculum in the UK, albeit theoretical for most students.

In Pakistan, I asked a group of very young student (pupil) midwives why they were doing the course. Their blank stares and generally confused response was followed by the answer that they had been sent by their mothers/families. This provided them with the opportunity to provide for their families until marriage and potential earning power if the marriage does not work out. As a consequence, they will survive in a society where there is no financial or social support system outside the family.

Student (pupil) midwives in Pakistan are not a motivated group (P.c. Lee). Firstly, they have not chosen to be there, secondly, once there, it is only a stopgap to marriage, not a career pathway and thirdly, the pay and status of the midwife is extremely poor. The rationale behind the pupil midwives being resident in the hostel is for their protection, as they are at the most vulnerable age and time of their lives, post-pubertal and pre-marriage. Their families choose the training institute based upon its reputation for ensuring the safety of the young girl. This places a huge burden of responsibility on the training institute, a watchful eye and strict rules of segregation and chaperoning are adhered to in order to maintain the girls' honour and the school and institute's reputation.

The social and cultural norm for post-pubertal, pre-marriage girls in an Islamic society is complete segregation from men. Although many of the midwifery students are of Christian faith, the Islamic social norms, if transgressed, bring shame upon the whole extended family, from which the stigma will burn into the marriagability of both men and women, even siblings.

There is low priority given to midwifery in Pakistan. Although almost every nurse undergoes midwifery training, very few practice midwifery (Kamal 2000). This midwifery training does not prepare midwives to practice midwifery, let alone function independently. The private and public sector employs midwives who have been trained for twelve months some from the age of fifteen, with no previous nurse training. Nurses

train for three years and lady health visitors for two years, which is made up of one-year midwifery and one year public health. The latest government training programme (2001) is a three-year public health nurse programme. This training (note not educational programme) sits in the context of extremely low educational entry requirements, matriculation plus a science for midwifery. Conversely, the status of the doctor in Pakistani society is high, although their pay is still low compared to the other 'professions', such as lawyers, architects or engineers.

The current debate in the National Assembly (P.c.) has been around the number of women who train as doctors and do not practice. The sequel of this social dynamic results in an inverse ratio of nurse/midwife to doctor compared to the UK. It is the doctors who will provide the high dependency care, supported by a very small cadre of poorly trained nurses and midwives. These midwives act almost entirely as doctors, nurses and health visitor assistants, or conversely act as doctors themselves rather than autonomous practitioners. Dais act as advisors to relatives and support the women, yet they are not considered part of health care provision.

7.6.1 Monitoring and regulation

Not only is the clinical learning environment a problem for the doctors in Pakistan, it constitutes a grave problem for midwives. The Pakistan Nursing Association (PNA) continues to set national examinations and should visit and approve each training institute and clinical placement every three years, yet it is common knowledge that this is a theoretical paper exercise. In the UK, the UKCC - now the Nursing and Midwifery Council, has devolved the examination process to the training institutes since the middle of the 1980's. The professional body did however retain the very important and rigorous validation and monitoring visits to the clinical areas[49]. Assessing and approving the

49 In the past the clinical visits by the ENB ensured that the clinical areas met the needs of students, ie had enough experience and the appropriate ratios of trained mentors. I have experience of a clinical area (ANC) being removed from student midwife placement, because the practice was likened to a conveyer belt. This monitoring has been taken over by QAA since 1991

clinical learning environment is given high priority in the programme approval process. In Pakistan however:

> *"The absence of any regulatory mechanism for the practice of midwifery is a source of encouragement for the dai and TBA and of professional insecurity for the licensed midwife"* (Kamal 2000*).*

The regulation of the nurse and midwife is through the Pakistan Nurses Association (PNA), which has Boards in each Pakistan Province. Unfortunately registration as a midwife is not monitored in a systematic way. As a consequence, even if a midwife completes the one-year, [50]programme, registration with the PNA may not take place. Employment is given on the certificate of education alone and not professional registration (P.c.). The usual reason given for failure to register is financial because there is no restriction on employment if the health professional does not bother to register. Monitoring standards or removal from the PNA register for malpractice does not happen. If a midwife's practice is found wanting she is sacked and moves to another hospital, perhaps in another Province, to continue working. Thus the rules become rhetoric, as it is in the regulations of the Pakistan Nursing Council, laid down in the 1973 PNA Act, "*that unregistered persons should not practice as nurse or midwives, the penalty for fraudulent registration is six months imprisonment* (Saleem 1992).

Without registration or any formal checking system for authenticity of the certificates, it is possible for anyone to call herself a nurse or midwife and to practice for a lifetime without any updating or monitoring of standards of practice. There is no comprehensive record of the numbers of midwives practising.

It is within this context that the dai attend between eighty and ninety per cent of the women at birth.

In the UK the traditional untrained midwife practitioner was outlawed as a result of the 1902 Midwives Act. Thus, the infrastructure that the Pakistani midwife trains and works in, i.e. undertaking birth in hospital only, with the dai attending all the home births, bears no resemblance to the infrastructure that the UK midwife trains and works in.

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[50] Some midwifery programmes are now fifteen/eighteen months in length e.g. L D, Karachi (2002).

Compounding this difference is the lack of rigour within the Pakistan Professional Body, which is responsible for training midwives, plus the very poor social status and pay of midwives. All result in the belief that midwifery is not a suitable occupation, especially for educated women. Consequently, it is easy to see the cleavage between midwifery in Pakistan and the UK. Recruitment into midwifery from a society that in the first instance does not support women working, seeing employment as a stopgap to marriage must constitute a major problem.

7.6.2 Traditional birth attendant (TBA) /dai training

Evaluations of the variety of traditional birth attendants training throughout the world have been mixed. Fleming (1994) showed few significant differences in the TBA's knowledge and practice between trained and untrained TBA's.. However, Maine (1992) found TBA's could make appropriate referrals. Maine (1992) claims that no studies have demonstrated the direct effect of TBA training on maternal mortality or morbidity. One of the main reasons for the failure is the nature, content and style of delivery of the biomedical programmes (Jordan 1989). Most TBA's learn their skills through the use of indigenous knowledge and imitation with tools that are conceptual and practical, earthy and human; as Chawla (2000) describes, '*elegantly simple yet effective*'.

Jordan (1993:178) was concerned about the transferability of knowledge acquired in the verbal mode to real life situations, as biomedicine is taught. There is some evidence to support that what is learned in this mode is used again in the verbal mode only and is unlikely to be transferred into behaviour. This has been corroborated by my own experience of teaching both in Pakistan and the UK.

There has also been in recent times (1998), a short three month dai training or traditional birth attendant' training programme in Pakistan. This was a Government sponsored scheme that has since been discontinued. This course involved the dai becoming the servant of a Lady Health Visitor (LHV) for three months, answering some questions (orally) paying some money and getting a certificate (license to practice). As the courses (and most of the work of the LHV) take place in the suburbs, the dai from the rural areas

will not have access to these programmes. However, some dais work in the maternity hospitals across the country (Red Crescent). Their role when employed will not be to take responsibility for the labour and birth, unless there is no one else available, especially at night, but to undertake the 'dirty' part of the work, picking up soiled linen, dealing with the placenta, mopping up faeces and vomit. However, this work is sought after as it pays regularly and attracts much more money than attending births in the village.

In a situation analysis of midwifery training in the Sindh province of Pakistan Kamal (2000) revealed that seventy-eight per cent of births take place at home, attended by untrained dai or, as described, traditional birth attendants. Within this study major problems were found with the midwifery training, and a recommendation was made to the Ministry of Health that a policy decision should be to train an 'auxiliary' midwife to provide basic midwifery services for safe delivery with the goal of replacing the TBA. (Kamal 2000)

Little can be said about the content of apprenticeship training of the dai at her mother's knee. This may be because the dai and birth have not been considered interesting research material, or there are no words that can describe the knowledge that is passed on mainly by observation. The practice of the dai is hidden while also serving to protect the dai and the woman from the critical gaze of obstetric hegemony.

7.6.3 Poor health care provision

Although becoming a doctor is a highly prized social achievement signifying high family status, few women doctors practice after marriage and men choose to work in the high technological hospitals in the large cities, rather than live and work in the poorer rural areas. Both the private and public (government) health provision is unattainable for the majority of the population residing in the rural areas. All services make a charge and transport is expensive, both are beyond the means of the poor women in the rural community and as a consequence, the dai is called for the birth.

A further layer in the (poor) health care provision in Pakistan is the (popular) non-governmental organisation system, some charity driven. It is one such organisation where

the research was undertaken. My nine visits to work in this hospital have been the source of much of the information for this study.

Current government sponsored training programmes cannot meet the needs of childbearing women. There are only seventy Nurse and Midwifery training schools in Pakistan, population one hundred and forty million (Saleem 1992). There are however, Christian organisations in most towns known as Mission hospitals[51]. Some of these hospitals undertake training for health care professions. However, they are very reluctant to take any Muslim students and although their standards appear to be higher than the government schemes, (P.c.) they train to meet their own needs only. They charge on a means tested system for the hospital services.

7.6.4 Dai a problem not a resource

The major difficulty in recruitment of midwives is the status of midwifery as a profession. Saleem (1992:75) admits candidly.

> *"Ours (Pakistan) is a society where economic status determines ones position in society and a profession with a poor salary is not supposed to garner respect"*

The pay is extremely poor even in relation to the cost of living, (sixty pounds per month for the midwife in charge of the labour ward (P.c. 2002). If a family had spent money educating a girl they would not want her to be a midwife. Saleem (1992) stated that the educated peoples' mindset in Pakistan hesitate to take nursing as a career, because of the stigma of inferiority that is attached. The prevalence of illiteracy amongst rural Pakistan women is also a factor disqualifying girls from induction in the 'nursing' service. Fundamentalist Muslims may scorn women who want to work or have a career, believing that according to Islam.

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[51] The Mission hospitals throughout the Punjab are supported by Canadian charities (CEDAR).

> *"A woman is not required to work in order to earn her living and if working affects the family, especially the children, then her husband has the right to prevent her from working* (Salahi 1993).

This is evident in an extreme way in some fundamentalist Islamic countries that do not allow the women to work.

To fill the gap between the few midwives, who all work in hospital[52] and women's need to be attended by a trained person, it has been the government strategy to sponsor programmes to train the dai and/or traditional birth attendant. These programmes have in the past been given recognition through a licence to practice on completion (Leedham 1985).

Women's health initiatives have been mainly biomedically orientated and have not seen the dai as a resource, only as a problem. Maine (1992:66) looked at why the Safe Motherhood Initiative (SMI) had stalled. One of the drivers within SMI was the philosophy underpinning the following statement: -

> *"The best strategy is to assume that all pregnant women are at risk of serious complications and efforts should be focused on improving the quality of, access to, and utilisation of emergency care services"*

The difficulties surrounding this strategy may have contributed to the stalling of the SMI. Other factors include the cost and problems of referral to hospital from the outlying rural areas and the assumption that all pregnant women are at risk. The philosophy reveals a strong biomedical, modernist, downstream approach that relies on training the person to pick up the pieces after the event instead of preventing it happening. The strategy reflects the politics of the policy developers at the time.

Nowhere in the SMI strategy does it take account of the positives of indigenous knowledge of the dai in overcoming some of the health problems of poor rural women. "*Dai practice is accessible, affordable, sustainable, popular, effective and culturally appropriate*" (Chawla 2000). Yet, the medical research fraternity has not shown any

52 They work in hospital because the training is medically dominated consequently the Pakistani midwife fears birth outside the hospital setting, much as most doctors do in the UK. There is no organised community placement in training because of the safety of women out alone (Pc Lee 2002).

interest in researching the beneficial elements of dai practice. Funding for research programmes has been linked to solving 'problems' after they have occurred; short–term, quick-fix projects with limited budgets and impossible outcomes have been popular, instead of focussing upon strengths in the system or building on what exists that is effective. Meanwhile, continuous politics and policy change result in constantly altering priorities that are exacerbated by short termism.

7.6.5 Empowerment project

One project that we became aware of during the last visit to Pakistan (2000) was funded by a Christian organisation. This organisation supported village people to improve services to their community. This was done by means of an interest free loan, the villagers had to collectively support a project and make an agreement to pay back the loan. This one village decided that they wanted to pay for a dai to undertake 'training' at the maternity hospital in the nearest town. There was an old dai in the village, however, she did not have a female relative to hand down her skills to, and neither would she share her skills and knowledge with anyone outside the family.

The village women were delighted at the prestige of the arrangement between the hospital doctor and the dai and the project was held up as an example of progress. However, I was left feeling distinctly uneasy. The practice of the doctor in the maternity hospital is was strongly interventionist. If the dai models on this type of practice and returns to the village using the methods seen in the hospital, the safety of the women may be in jeopardy.

The introduction of the medical model of intervention would undoubtedly be detrimental to the women in the villages. An example of such practice could be repeated vaginal examinations that would precipitate intra-uterine infection or excessive fundal pressure in order to push the baby out of the birth canal (Chawla 2000). The introduction of the medical model into traditional practice as superior and modern would potentially precipitate the demise of hands-on skills and the belief in the woman's ability to birth normally. Also the reputation of the dai in the hospital (referred to later in-depth) was so

poor that the dai in training at the hospital may find her confidence affected, as Jordan (1993) found when medical personnel attempted to train midwives in the hospital environment.

> *"Midwives who in the environment of the hospital-based training courses often appeared stupid, illiterate and inarticulate showed a completely different face when engaged in doing their work in their own communities where their skills were acknowledged and respected"* (Jordan 1993: 149).

It is ironical that the post–modern move towards alternative medicine, complementary therapies and spiritual healing with an emphasis on energy in developed countries, has parallels and some grounding in the use of indigenous knowledge and health tradition. This is evidence of a move away from the mechanistic biomedical scientific dominated, "injection pill medicine cure all era". The dai health modality of high touch and massage, the application of heat or cold, isolation, protection (from domestic and sexual obligation) are now recognised in contemporary midwifery practice as being beneficial and valued by women in the UK (Edwards 2001).

It can be extrapolated that the dai is the 'true' midwife, with woman. However the social status of women, the unpopularity of midwifery as an occupation, and the social norm of women not working after marriage, contribute to the continuance of eighty per cent of women being attended for birth in the home by the 'untrained' dai. Not only is midwifery as a profession unpopular but the findings from this study confirm Chawla's conclusion (2000) that the next generation of dai are not at their mothers knee as apprentices. This is at a time when dai practice and ethno-medicine (indigenous knowledge) is becoming recognised as beneficial in developed countries (Edwards, 2001). In line with most developing countries, there appears to be a time lag for development, which would explain why Pakistan currently is at its peak of biomedical popularity. However, this speaks for the educated who can afford the modern medical technology.

In summary, this part of the chapter began by exploring who the dai is and her position in the current health care provision. It is evident she has not been perceived as a valued resource to the country's health. There are worrying signs that the apprenticeship model

for next generation dai is not popular. Who will then be 'with woman' in Pakistan and will the mortality rates sore even higher?

The next part of this chapter on the dai examines in some detail the practice of the dai.

7.7 Situating dai practice

In order to situate the dai as the birth attendant for women giving birth at home in Pakistan; it is proposed to focus upon, comparative historical parallels, legislation and the link to colonialism.

Although the registered/trained midwife became compulsory through statute in the UK in 1902, it was some 30 years later women in Leap and Hunter's (1993) study of the oral history of the transition from handywoman to professional midwife, when reference is made to the 'handywoman' as, *'the woman you called for'*. India was still at this time one of many British Colonies ruled using British law. As such one would then have expected the legislation from 1902 to be on statute in Pakistan at the time of independence in 1946, however, this does not appear to be the case.

The process that recognised the handywoman as 'bone fide' midwives in the UK has not taken place in Pakistan. The acceptance of the untrained midwife as bone fide in the UK allowed space and time for training to be introduced for all midwives and the introduction of statutorily registration.

The dai in Pakistan is not trained, (except for a few who have undertaken a short traditional birth attendant (TBA) programme). This did not involve any registration so in that respect cannot be compared to the bone fide midwife. However, the role has many parallels with the handywoman. Both were married women who had experienced childbirth, both were 'uneducated', had acquired their skill through many years in an apprenticeship system, both practised in the homes of women, paid for in kind by the women and her family. Both were usually from the same community as the women.

Following legislation, regulation and registration handywomen were removed from the birth scene in the UK. It then became the organisation that was 'called for'not the person. However, in Pakistan it is still the dai who is 'called for' for eighty per cent of births

In the History of Nursing in Pakistan written by Saleem (1992), there is no mention of the 1902 Midwives Act or the bone-fide midwife. She does, however, record the neglect of the British as rulers pertaining to nursing.

> *"The British Government made no comprehensive arrangements to ensure the nursing service continued in the post independent period (1946). An outcome of this neglect on the part of our previous rulers found the very fabric of nursing service severely damaged"* (Saleem 1992 p14).

Pre 1946, the English medical superintendents and matrons in charge of hospitals in India were said to be 'contemptuously against' the idea of training a 'native nurse', preferring instead to bring compatriot nurses from the UK. This was on the basis of annual contracts with handsome 'emoluments' and attractive working conditions (Saleem 1992). It took until 1934 before the first Indian nurse was admitted to the Mayo Hospital, Lahore. Prior to that, during the days of the Raj, only European and Anglo Indian ladies were privileged to be taken in for training. When training started to accept 'native' students, Saleem reported that inducements were made to the poverty stricken families to send their daughters, on condition of their (families) conversion to Christianity.

Because the poor women needed inducement to become a nurse, protection and money might have been a greater incentive than a change of religion. It is significant however that dealing with body fluids (Chapter 8) presents as a disincentive for a Muslim woman to undertake nursing or midwifery, as does mixing with men (who are not family members).

The remnant of this historical context may still exist today as the majority of nurses and midwives in Pakistan are from the very small (one per cent of total population) Christian communities.

Flora Thompson quoted by Leap and Hunter (1993) in their text on the oral history from handywoman to professional midwife in the UK, spoke of the 'new' trained district

nurses (midwives), identifying issues that arose from the increased status training brought.

> *"The trained 'district nurses'[53] when they came were a great blessing, but the old midwife also had her good points, for which she received no credit. She was no superior person, coming to the house to strain its resources to the utmost and shame the patient by forced confessions that she did not have this or that. But a neighbour, poor like herself, who would make do with what there was, or if not knew where to borrow it"* (Cited in Leap and Hunter 1993:2)

It is apparent from this quotation that the new training created space or a divide between the women and the midwife; a space that was filled with superiority and a cost that accentuated the poverty of the woman. This resulted in women being ashamed of their situation and different to the midwife. The midwife was no longer 'with' the woman, particularly in a social sense. Her education set her apart and made her different.

Without training, the dai has stayed 'with' the women in a social sense and retained 'hands-on' empirical knowledge. As stated earlier, the dai practice was based upon empirical knowledge gained through personal experience and observing other women, then being with woman, using a holistic approach. These are the descriptors that would be words used in the twenty-first century, however, at the turn of the century in the UK, for the poor women the 'handywoman' would come to the childbearing woman's house and do what was necessary during the labour and after.

An alternative picture of the untrained midwife of the time (1890/1920's in the UK) was as a drink-sodden old hag portrayed as Sairy Gamp in Dickens' Martin Chuzzelwit. She was lacking in hygiene, ignorant and unkind. There is no evidence, except in fiction, of the drunken midwife in the UK, as there is no evidence to suggest such dai (without alcohol) exist in Pakistan. However, it is reasonable to expect that dai would be anywhere on the continuum from competent and skilled to incompetent and ignorant. Also the women relatives that are with the woman during her labour and birth in Pakistan may appear anywhere on the continuum from kind to cruel. Mother-in-laws (sas) in

[53] At that time being a district or community 'nurse' meant the midwife, as this was before district nursing became a speciality.

Pakistan have a certain reputation and in the UK are commonly displayed in the media as bossy and interfering, forming the butt of comedian's jokes. The important relationship of the sas to the birth process will be explored later.

From my experience at the hospital in Pakistan, dais send or accompany women to the hospital when they are concerned and unable to 'facilitate' the birth, (some of the issues around transfer to hospital are covered later). 'Facilitate' is an old English term used by the staff in the hospital when the dai is unable to deliver the baby. This is one of the many 'old' English terms that are a constant reminder of the Pakistan's colonial past. The connection between the dictionary meaning of the term 'facilitate' as *'make easy, 'promote', 'help forward', 'assist the progress of'* (Collins 1994), is especially appropriate to childbirth and the role of midwife, yet is not in common use in the UK.[54]

Another example of an old English term related to childbirth is 'issue', the dictionary definition of, '*the act of emerging, outflow, a person, offspring or progeny* (Collins (1994). Common usage in the UK is not in this context, but in the sense of 'giving out'. In Pakistan I have heard 'issue' in the negative more times than the positive. This has been when referring to women who have never had any children, '*she is issueless*'; it is a kinder phrase than 'banhj' which means 'unproductive' as a sterile field would be and is spoken harshly. It seems ironic that women in Pakistan have stayed with the old English sense of certain terms and we in England have moved on to a different interpretation. Raising this as is example of the potential differences in understanding of terms and the divergence in the use and behaviour around terms such as 'care'.

7.7.1 'Dai handled'

The reputation of the dai stands or falls through the media of gossip in the close knit rural communities. Such social control is pervasive and is monitored and controlled through fear. My childhood was hung with the fear of breaking particular social norms that existed to retain the family's standing and reputation in the community. For example, not

[54] Facilitate is a common term used in education relating usually to group work.

consorting with certain families who did not adhere to the same social norms and standards, like attending church. The reputation of the dai, who is from the lowest social grouping in Pakistan, is particularly vulnerable.

In the hospitals in Pakistan (Lahore and Karachi) the phrases "dai handled" and "dai practice", were both synonyms for poor unsafe practice. Dais were accused of stretching the woman's perineum and/or cervix, pushing on the fundus and giving Oxytocin indiscriminately by inappropriate route at the wrong dosage, and not referring women to the hospital (Chesney 1994 b). Indeed women were admitted to the hospital when they had been in labour for days, babies dead inside the mother, who was often febrile and occasionally moribund. Women would arrive at the hospital on the verge of collapse, their wombs (uterus') either on the verge of rupturing or ruptured. Women generally had no resistance to infection due to chronic anaemia as a result of a poor nutrition. They were overworked, physically worn out from frequent repeated pregnancies and chronic infection. The dai was often blamed for the woman's poor condition on arrival at the hospital, when the decision for the woman to come to the hospital was often not the dai's to take. It is often the mother-in-law, in collaboration with the eldest son, who make the decision when to seek medical help or transfer to hospital.

Paradoxically the clinical practice of the doctors and the midwifery staff[55] at the hospital, observed personally, was in my opinion equally as unsafe as that described as the dai practice, but for different reasons. (P.c.) has confirmed that the dai, the woman and her relatives are afraid of being 'hospital handled' so are often reluctant to go to a hospital for the birth. The staff - doctors and midwives, generally treat the woman with disdain and the midwifery practice was far from evidence based.

In 1989 all the women were put in the lithotomy position for the birth, their abdomens were pushed upon and the person delivering the baby would manually dilate the vulva and pull on the baby's head before it had chance to negotiate the birth canal. In technical

55 Lady Health Visitors (LHV), undertake deliveries in the absence of the doctor and in preference to the midwife. The midwife would only conduct a delivery when neither the doctor nor the LHV was available, in the hospital in S....

terms - restitution or rotation had not taken place (Chesney 1994 b). During the early visits to Pakistan all women had intravenous fluid in situ containing Oxytocin to stimulate the uterus. It was custom and practice for the woman to lie flat on the bed in labour and then assume the lithotomy position for the birth. All women having their first baby were given an episiotomy.

The practice seen in this hospital may not be reflective of that undertaken in other hospitals or in the home. In fact the dai is unlikely to embrace this practice at home, as she encourages the woman to walk about in the first stage of labour and adopt the squatting position for the birth, the position alone may mitigate against pushing on the fundus and manually dilating the vulva. However, there is always the exception, as told by Taz. (Chapter 6) when the dai pushed.

Because I had not been familiar with the practice of pushing and pulling by hand I immediately judged this practice as being 'unsafe' This stance is documented by Jordan (1993) as being typical of superiority and she coined the phrase 'moral requiredness' (thinking one's own practice is the right one). Logically, I could rationalise and understand the thinking behind the need to 'help' birthing women, by the attendants pushing on the top of the abdomen[56]. I have seen women do it to themselves both in the UK and Pakistan. However my 'training' included knowledge that is considered authoritative in the western world of the physiology of childbirth. This knowledge underpinned my midwifery practice of not pushing on the abdomen. Contrary to logic, pushing on the abdomen does not help, but may serve to inhibit the birth process by interfering with normal uterine contraction. Pushing on the abdomen also theoretically has the potential to inhibit the birth process by separating the placenta from the uterus. Pulling on the fetus may also inhibit the natural passage of the fetus through the birth canal. The shape of the woman's internal structures guides the fetus out of her body. Thus it would seem that by forcing the birth has the potential to damage both the fetus and the mother.

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[56] I have seen Pakistani women in both the UK and Pakistan intuitively put both hands on the top of their uterus and apply pressure.

On reflection, a parallel practice of pushing and pulling with drugs and instruments, not hands became evident within practice in the UK. As a midwife trained in the late 1970's, I had accepted without question the practice of a thirty per cent induction rate (pushing with drugs) and the current instrumental and operative delivery rate of between twenty to twenty-five per cent (pulling with instruments) as part everyday practice. It was evident that I had been socialised in the belief that 'educated' doctors and midwives could make the decision to push and pull with drugs and instruments and the practice was considered safe, thus given an authoritative status. Yet the easier to control and less invasive practice of pushing and pulling with hands was abhorrent to me. A difference also lay with who was undertaking the pushing and pulling. In the hospital in the UK it was the employed midwife and doctor with loyalty and accountability to the organisation. In the home in Pakistan it was the dai and female relatives, who were all known to the childbearing woman, who had strong loyalty and accountability to the family.

Reviewing the rationale that underpins the reputation of the dai, whether this is in the village or in the hospital, highlights certain parallels with the current blame culture in the UK, particularly relating to the NHS and its employees. This is a reflection of the 'moral requiredness' that supports one's own practice to be the best and above reproach. Yet the parallels of pushing and pulling to get the baby out within a time frame set by theoretical knowledge of the population average, with no account of the individual, occurs both in the UK and Pakistan hospitals. Such 'knowledge 'over-rides the natural process of events that drives the individual woman in her birthing.

7.7.2 Shared decision making

Ami's story of her labour portrays the negotiated decision making when birth takes place in the home in Pakistan. It does, however refute the belief that during the first birth the woman is considered inexperienced in childbirth so unable to contribute to the decision-making (Chapter 6 Ina). However, the emphasis Ami placed upon her action of lying down when the dai and her mother-in-law were encouraging her to walk is making a statement about her difference and strength as a woman.

Decision-making as a family concept is covered in more depth later. It is noteworthy that the role of the sas and close relatives play a far greater role in the care of women during labour and birth in the home than the hospital, although a relative will stay with the woman (cooking and caring) all the time she is in hospital. When the birth takes place in the hospital, relatives may not be allowed to be with the woman, let alone make decisions on care. Shad's mother and sister were on the hospital premises but not allowed into the delivery room (Chapter Shad 6).

Similarly, in a western managed labour, the woman herself may be perceived to play little part. However, the labour is not socially but medically managed. The role of mother and/or mother-in-law is less clearly defined. It is also improbable that the woman in the western delivery unit would ever refuse a treatment recommended by the doctor. This principle was upheld by a recent review of informed choice (Kirkham and Stapleton, 2001). The decision when to summon medical assistance in the UK has the clear-unclear 'abnormal' boundary. When to send to hospital in Pakistan appears to be taken by the mother-in-law or female relative.

7.7.3 Position for birth

"Squatting is dai practice" (Dr Q)

The position a woman adopts for birth in the hospital in Pakistan is a symbol of educated practice. It is the practice that all women were put into the lithotomy position for the birth. The purpose of the woman assuming the lithotomy position is for the benefit of the person undertaking the delivery only[57]; it allows them to observe the woman's perineum. Midwives, in the UK are/were taught that they could 'control' the fetal head and thus prevent the perineum for tearing in this position. However, it has since been realised that

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57 The supine position for birth is said to have originated from, Louis 17th (Wilson, 1995) who wished to view the birth of his heir. Wilson (1995 p36) recorded midwives in the 17th Century using different methods for a swift and safe delivery. One of the methods was the birth posture, which varied by region. In the UK Midlands kneeling was popular and in London the birth stool was commonly used. In Taunton women liked to stand and in Manchester, sitting in another woman's lap to give birth was a common posture (Wilson 1995)

the lithotomy position, as well as being unnatural and acutely dehumanising, stretches the perineum, making it more likely to tear (Goer, 1995, Borgatta et al 1989). The natural position that facilitates gravity and widens the outlet of the woman's pelvis would be squatting or kneeling and leaning over; the latter allows the midwife to view the perineum.

As stated in the hospital the women in labour were laid flat on their beds and put in the lithotomy position for the birth. The women interviewed told of the positions they were in when giving birth in the home. Fari said that she thought she was in the upright position for her labour:

> *"I think straight...walking... I was having pain in my back, ...then I could not walk any longer, then I lay down, ...I think I was lay on my back, I think the dai massaged me...I cannot remember the detail...I think I was sitting or lay on my back...on a charpoy (string bed)...."* (Fari Chapter 6).

The pain in Fari's back is suggestive of the fetus being in the posterior position whereby again the upright position would be especially beneficial. Being upright in labour allows gravity to assist descent of the fetus into and through the birth canal.

Many research studies have been undertaken on the optimum position for birth. Lupe and Gross (1986) undertook a review of the studies up until the middle of the 1980's. Later reports of the evidence by Goerr (1995) and confirmed by Wagner (1994: 153):

> *"Pregnant women should not be put into the lithotomy position during labour or delivery. They should be encouraged to walk about freely and each woman must freely decide which position to adopt during delivery"*

The research that has influenced midwifery practice in the UK has been Sutton's (1994) work on optimal fetal positioning. As referred to in Dr Q's interview I showed the doctor Jean's article and because it was a 'midwifery approach', it just confirmed to her that my practice was no better than dai practice.

7.7.4 Push on the fundus

Pushing on the woman's fundus in second stage of labour is not practice condoned in the UK. As such it would be considered a 'form of care that is likely to be harmful' by Enkin Keirse and Chalmers (1989). However, this was common practice in the Pakistan hospital, if not by the staff by relatives, or as reported the woman herself is instructed to do it. Taz (granddaughter Sam) described what the dai did at the delivery:

> *"The dai...push (demonstrating with hands on top of the abdomen). But when my uncle was born, ...do you know when my uncle was born...do you know the contractions...she suffered them 3-4 days and when the dai pulled...she broke his arm...it is OK now though"*
> (Sam, Taz's granddaughter)

This statement militates against Taz being in the squatting position for the birth. For when one is in a squatting position, the forearms rest on the thighs and if the woman is leaning forward (for balance) very little pressure can be applied to the top of the uterus (fundus). The position serves to widen the outlet of the pelvis making pushing externally less likely to be needed.

7.7.5 Moral analgesia

Analgesia in labour did not emerge as a key issue from the data[58]; it was evident that analgesia was not on offer at the hospital in Pakistan. In fact there was no analgesia given for extremely painful procedures such as dilatation and curettage when a woman had an infected uterus for a missed abortion (personal experience). We were informed by the doctor at the hospital that:

> *"The women are strong and they do not need anything; they have moral analgesia'.*

[58] Analgesia constitutes a major component of the western model of labour care.

This belief correlates with the notion promulgated in the 1950's, which is that birth was 'easier' for primitive societies than 'civilised' because they were used to hard work (Freedman and Fergusen 1950). The doctor in Pakistan was of the opinion that because women worked hard this gave them strength to cope with the pain of labour and birth. Such women were strong and had a toughness that was not evident in women who would need analgesia; however, this is not to say they did not want analgesia. The suggestion was that some women had moral fibre and were hardy and were able to self generate a toughness in order to get them through labour and birth. If they could bear the pain then they had the moral fibre, if they could not they were seen as weak.

The corollary to the doctor's statement is that women who ask or need analgesia do not have the moral fibre to endure. However, she did admit that she herself would need analgesia, not because she was weak but because she was not used to the hard work in the fields. Labour in the fields was seen to be preparation for the labour of birth. In the west, we revere the woman who does not need any analgesia, which suggests those who do are the weaker.

In Jordan's (1993:53) study the Mayo (Yucatan) women expected some pain as part of the life process in general. The women were told labour was painful, and that:

> *"some distress is normal" and "it will pass, as it did for other women".*

Shu, who was interviewed on the bus between L... and S..., was asked what role the midwife played during her birth experience:

> *"The midwife did not do anything... I was on the verge (delivering)...did not give any injection...but did press on here (stomach) a little...the baby came soon...I walked around and then lay down"* (Shu)

As stated previously Shu added *"all the midwife did was to hold her stomach and made the pain go away"*

The midwife's skill of '*making the pain go away*' (by holding Shu's stomach) would be greatly valued by a western midwife or mother; however, it seems to be taken for granted in Shu's story. This may suggest that Shu regarded the pain as to be expected or

insignificant and that she has a high expectations and confidence in herself to bear the pain and the midwife's skill to relieve it:

> *"I had no injections or tablets, nothing..."* (Fari)
>
> *"They give us an injection after delivery and the muscles go flabby and the 'dirt' that has to come out, doesn't...they should leave nature alone..."* (Chapple 1998: 203)

The interpreter who accompanied us during our ninth field trip to Pakistan found the reaction of the women to pain in labour astonishing (she had herself given birth to five children in the UK):

> *"They (women) do not make any sound in the labour...I remember shouting (screaming) as the baby was delivered, the women in Pakistan do not make a sound, I find this strange"* (Bal interpreter).

Taz (Sam's granddaughter who acted as interpreter) stated;

> *"The doctor was brought to give injections...these were to speed up and make the baby come...because there was no pain relief she suffered..."* (Sam, granddaughter of Taz)

Reports of childbirth in the 1960's in India and Sri Lanka stress the importance of silence (Gideon 1962, Lucjnski 1962). Women are criticised for shamelessness if they make a noise audible to people outside. I have direct experience of a member of staff at the hospital putting their hands over the woman's mouth and deriding her for calling out in pain. It is however acceptable to moan and pray quietly to Allah. There are no analgesics administered in labour at the hospital in Pakistan, even though Syntocinon is commonly used (known to exacerbate the painful contractions of labour, as the pain does not build gradually). The staff tell the woman the pain is 'for your child', which connects to Jeffery Jeffery and Lyon (1988) declaration that there are no remedies for reducing the pain that women experience, indeed intense pains are thought to ensure a speedy delivery. Women are told to *'endure the pain* (dard khao), rather than take in too much air, they should swallow back their breath and are asked, *"how can a baby be born without pains?"* They should *"just accept the pains, calling on God's name"*. I can confirm that this is current thinking and practice in a small hospital in S... in the year 2000. A statement from Bal (interpreter/advisor) highlighted the empathetic feelings of a mother for her daughter in labour (Chapter 6 interpreter during 2000 field trip):

> *"My mother would not come in (to the delivery room) when I had my children (I was alone) she (mother) was crying... that made me worry, am I really in that much pain (danger)"* (Bal)

Bal's mother's tears and fears for her daughter kept her out of the birth room. Bal interpreted this as.

> *"There was something wrong".*

Although Dil said that she did not have anything for the pain (of labour) when I asked if her mother massaged her, she said:

> *"Yes on my back...my sister do (massage) my front and my mother would talk...in these days they don't do that, but in Pakistan they do...here they give medicines and ... the more medicines we will get the more disease we will have. I don't know this in my mind, either I am right or I am wrong, in my mind I take herbal things that cure me and don't give me side-effects, but if I take tablets that give me side effects..."*(Dil)

Continuing with the exploration of what the dai does at the birth, Riz told the story (she interpreted for her mother) of the dai who looked after her mother:

> *"The dai looked after her...when she started in labour...no antenatal care.... Everything was Okay; she would stop at the later stage. Most of the time she would sit in the corner with a hookah pipe. Towards the later stages they (dai and mother-in-law) would squeeze and support her ...tell her she was doing well and check her (pointing to the abdomen) to see if the baby was going down. The midwife used to do internals to determine goodness knows what...and press really hard on the (Ami's) back, put a lot of pressure..."* (Chapter 6 Ami)

Again, it is interesting to note the interchange of the title between dai and midwife, both perceived as the same person. The care given by the dai focused upon the labour, being summoned when the pains started, then coming and going until the later stages[59]. This is practice common in the Dutch system (Jordan 1993) and links to women feeling strong and confident in their body function to give birth that helps them cope with the pain of

[59] This is practice I am familiar with from the 1970's when the community midwife would keep 'popping back' to a labouring woman, until such time as birth was imminent. This was before mobile phones, often we would leave the labouring woman with an idea of where we would be,' just in case'.

early labour. For most of the time, the dai in the corner with the hookah had both a physical and emotional presence providing the woman with the space and minimal disturbance, undertaking a watchful patience. Thereafter followed what could be described as exemplary midwifery care. The squeezing (massage) and supporting came as a joint effort from both the dai and Ami's mother and most important, the positive encouragement, and monitoring of progress (head going down). The extra firm pressure on her back would serve to ease the pain from the pelvic floor and cervix (Bennett and Brown 1999)

7.7.6 Delay in transfer

Thaddeus and Maine (1994) undertook research in Morocco on the effect that the time interval has between the onset of obstetric complication and the outcome. The outcome is most adversely affected by delayed treatment. They examined the delay in three phases. The first involved the decision to seek care, the second the delay at the arrival of the health facility and thirdly the delay in the provision of adequate care. Phase one involves the delay in deciding to seek care on the part of the individual, the family, the midwife or the dai. Examples of such factors that influence this decision are; the status of the women, dai and relatives, the characteristics of the labour, distance from the health facility, financial and opportunity costs, previous experience with the health system and perceived quality of care at the facility. Phase two delay included physical accessibility, travel time, availability and cost of transportation and condition of the roads. Phase three involved the delay in receiving adequate care at the facility. Relevant factors include adequacy of the referral system, shortages of supplies, equipment and trained personnel, the competence and attitude of the personnel.

Distance exerts a dual influence as long distances can be an obstacle to reaching a health facility and can be a disincentive to even trying to seek care. UNICEF (1989) found that only thirty-five per cent of the rural population in Pakistan lives within an hour's walk of a health facility. The woman's mobility will be affected because she needs permission to travel firstly from her mother-in-law and then maybe the elders of the village.

Pregnancy and childbirth are ubiquitous events and although acknowledged as potentially risky, are commonly considered natural, normal work for women. In most cultures or societies, childbirth is not seen as an illness, which would justify admission to hospital. Other reasons for hospitalisation may be an obstetric complication that cannot be resolved through medical intervention. There are beliefs that support the retribution theory; whereby what is happening in the labour is a result of previous behaviour, either in the current or another life. Consequently, whatever is introduced to counteract what is happening will not be effective against the cause.

As stated, the reputation of the health facility may also be the source of the delay in making the decision to take the woman. If the hospital has a reputation for unfriendly staff or includes services that are judged to be humiliating, the woman herself may refuse to go because of specific procedures they dislike or fear, such as exposing their genitals and being put into positions they do not like. Finally, a concept that links closely to the reason why women are reluctant to be referred to hospitals is that of time, (Chapter 7). Time spent getting to and waiting for treatment, time that is lost from other more productive activities, such as farming, fetching water and fuel, herding and cooking.

Multiple factors influence the decision to take a woman to hospital when there is a problem in the pregnancy or labour. Firstly the problems inherent in the decision about whether the referral is necessary, then the journey distance and cost, compounded by the reputation and practice of the hospital. These factors are complex enough; however, it is possible to add one more that is not recorded by Thaddeus and Maine (1994) and that is fear and mistrust. Fear of retribution from the staff at the hospital to the woman, towards the dai or her relative for not coming sooner, accused of being the cause of the problem rather that the solver of the problem (Chapter 6 Dr Q). Commonly there is fear and distrust of hospitals and their personnel, for example, stealing or swapping a healthy child for a sick or dead one, or swapping a boy for a girl (Chawla 2000).

Birth in the home in the rural villages is clear in that it is relatively untouched by medical hegemony (excepting the Oxytocin). However, birth for the undernourished, physically debilitated woman is doubly complex and dangerous. Childbirth mortality and morbidity is appallingly high (Chapter 3). Because of the women's health, the policy-makers'

solution has been to implement traditional birth attendant training, focusing on detecting the problems early so the women can be transferred to hospital care. My experience confirms that of Davis Floyd (2000:2), women get poor treatment when and if they get to a hospital:

> *"...they expose you, shave you, then they cut you, they leave you alone and don't come back when you call...and they won't allow your relatives in"*

But the dais apparent inability to recognise when to send a woman to hospital is only one facet of a much greater problem. The women know that when they get to hospital they will be treated badly by the staff. The initial problem however is transporting the women to hospital. There are no ambulances, transport is costly and the women in rural areas are well below the poverty level and low priority in the family system for spending what meagre finance is available. A quotation from a TBA in Mexico articulates the major problem:

> *"Do not blame us for failing to transport women. We know when we should transport, but none of us have cars, nor do our clients. The buses run very irregularly, there is no ambulance service and if there were, our clients wouldn't be able to pay for it and the only taxi driver in out town charges more than the women can pay. How do you expect us to get our clients to the hospital in a city one hour away? No we can't we just have to do our best..."* (Davis Floyd 2000:4)

7.7.7 Medication

Western practice influence and specifically Oxytocin injections was one of the major concerns that formed the seed to begin this research on birth in Pakistan.[60] Making the womb strong, by whatever means, is thought to aid the birth, even though it may be more painful or dangerous. When pain is seen as the inevitable, borne with acceptance and stoicism, any means of enhancing the pain will be seen as effective. There was some reluctance from the dai (Chapter 6.) to give injections (seen as the doctor's job); others

[60] In 1989, the first visit to Pakistan it was the policy at the hospital for all women admitted in labour to have an IV Oxytocin infusion, regardless of contractions and stage of labour.

took it as an addition to the new (Chapter 6 Naz) or emergent role (Landy 1974). This may mean that some dais have seen and experienced the potential effects of the drug (ruptured uterus, intra-uterine death) when given indiscriminately. Or as we were informed by one dia," *if we do not give the injection, they would send for another dai'* (P.c.)

Previous research (Chesney, 1994 b) reported that out of a sample of twenty-four women giving birth in a hospital in Pakistan, all but two of the women had received injections, which made the pain 'worse'. Pakistan legislation, like the UK, states that only a doctor can prescribe drugs but, in reality, anyone who knows the name can buy any drug from the bazaar. Ahmed (1991) declared:

> *"The laws of Pakistan, criminal, civil or justice, just do not apply"*

McConvillle in Bangladesh (Kitzinger 1989) reported that TBA's administer intra-muscular injections of Oxytocic drugs, causing the uterus to rupture. Jeffery, Jeffery and Lyon (1988:111) confirm *a 'glaring misuse of Oxytocin with fifteen per cent of women in the villages being given it*'. Women regard the injections as beneficial, since it gives 'strength' to the uterus the local term is 'dard barhana' (amplify the pain). It is ironic that the temperature of the drug needs to be kept at less than four degrees centigrade to maintain its potency (WHO/DAP/93.6). As there are no refrigerators in the rural areas, nor incidentally in the small maternity hospitals, the concern may be that the drug does not work when it is needed in an emergency[61].

The following section introduces the possibility of there being a 'moral requiredness' around the effects of drugs and/or medication.

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[61] In the UK a synthetic Oxytocin may be given in a diluted form via calibrated IV to stimulate the uterus either to induce or enhance the contractions of labour (Syntocinon). This also may be given mixed with Ergometrin as Syntometrin post delivery to stimulate placental separation. If the latter is given antenatally it may stimulate prolonged sustained contracts of the uterus potentially cutting off the blood supply through the placenta to the fetus. If given antenatally when the uterus is weak or scarred, there is the danger of uterine rupture with the subsequent death of mother and baby.

7.7.8 Social construct, active management of labour

Dil's story of her first birth:

> *"...It (the baby) was not coming, the opening was small so that is the reason my mother had to cut, she did not stitch she put on elastoplast and later applied Vicks"* (Chapter 6, Dil)

My western culturally specific biomedical knowledge of this internationally available product Vick may be considered symbolic of the cultural diversity of knowledge and practice. My knowledge of Vick was as a vapour rub applied externally to serve as a decongestant for the upper respiratory tract. This is clearly a social construct that I had come to believe was the universal effect for a commonly used medication. I had never considered that it might have other actions or effects. My understanding queried that if Vick does have other actions why are these not marketed in the UK. This is typical of a superior western position; I made a sweeping judgement that I had all the knowledge that was available about the product.

However, the use of this product in a way not familiar to myself, initiated reflection on fact that Dil was educated and had worked as a health worker Pakistan. Whilst I acknowledge that the effectiveness of any medication is not entirely dependant upon its constituents alone, I did not consider that the product may be used for an entirely different purpose in another country. However, I had accepted without question the healing properties of other vapour-laden product Tiger balm, during a holiday to Malaysia. This is so recommended for rheumatism and lumbago. Also, Nutmeg balm is applied to insect bites and the temple for headaches and stomach for abdominal pain. Thus it is evident that the effectiveness, measured in biomedical terms, by relief of the presenting symptom, may be limited by the lack of understanding and consideration of some other important factors. Such factors may be previous experience, personal recommendation, individual response and sensitivity, compliance, belief and confidence in the dispenser/practitioner and the knowledge of the properties of the product to name but a few.

The utility of Vick as a medication is used as an example to portray the varying ethno cultural world in which the dai practices and the women in Pakistan give birth.

The unnamed dais interaction with the women she brought to the hospital was primarily to act as her advocate, to watch over her and protect her from the hospital staff. It is my considered opinion that the women who give birth cared for by the dai and female relatives in their own home appear to be in a greater place of 'safety' than the women who attend the hospital for normal birth[62]. The largely biomedical practice in hospital can and does save lives through the use of appropriate intervention. However, the proponents of hospital practice, whether it is in Pakistan or the UK, appear to operate a system that denotes if intervention is good for one group (those in need), then it should be good for all[63]. As the term intervention implies it is interference with what would be normal. Interventions and technology propose the notion that the normal is not good enough, following which a dependence then develops on the intervention, with a possible sequel being loss of belief in the woman to be able to manage birth unaided. This results in a potential loss of self-esteem and feeling completely disempowered.

Such a process of interference in normal labour was well documented in the 1970's and 80's in the UK and was aptly named the 'cascade of intervention'. Intervention was inherent in O'Driscoll, Meagher and Boylan (1993), active management of labour protocol. Whereby the promise was made to women that they would give birth within 12 hours of labour starting. This was achieved through interference, namely hourly vaginal examinations and Syntocinon IV therapy (synthetic Oxytocin). O'Driscoll et al (1993) developed this protocol to overcome the most commonly asked question of midwives by women in labour "*how much longer?*"

O'Driscoll's promise of a time limited labour was at the expense of women handing over their bodies own timing for labour, in receipt for the much more painful contractions induced by Sytocinion. Once the technology and protocols supporting intervention are built into the training and examination process of student midwives for which practice

62 This opinion may be derived from my firm belief that the place for normal birth is in the woman's home, whether this is in the UK or in Pakistan.

63 Intervention has become the norm in the UK, women receive hormones to induce labour, their membranes are ruptured, perineums' cut and the placenta pushed out with Oxytocin and still the midwife may call this a normal delivery.

has to be gained. Subsequent practice is enforced in such a way that those who do not comply are seen as ignorant.

This practice of episiotomy for primigravid women was common in the UK in the 1970's when it was felt that a surgical cut healed better that a tear and that the pelvic floor benefited from less stretching (Goer 1995). However, the evidence from research in the early 1980's (Enkin, Keirse and Chalmers 1989) did not support this assertion and such practice was discontinued in the UK in the middle of the 1980's. In 1989 labouring women at the maternity hospital in Pakistan lay flat on a bed in labour[64], the position for all births was lithotomy;

However, it would appear that the research and recommendations of the 'experts' have not influenced teaching and practice in Pakistan. The delay in knowledge transfer and or practice based upon current evidence is typical of the gap between developed and developing countries.

7.7.9 Careless, risk taking and ignorant

The path to the present authoritative, medically dominated, interventionist practice in the UK was laid in the 1970/80s through government reports (HMSO, 1970 and 1980). These reflected the prevailing orthodoxy of the time, which was that technology, held the answer to the population's health needs as it could improve on nature. The recommendation for all births to take place in a hospital was made under the spurious rationale of safety, when the health of some women and unexpected pre-term birth at home were the reasons for most maternal deaths, rather than the birth place (Tew, 1985). Midwifery in the UK and Pakistan is now in the position where childbearing women value the medically dominated, technocratic, interventionist practice, with home birth seen as outdated, traditional and unsafe. Supporters of home birth are seen as careless, risk taking, ignorant women. During the peak period of medical dominance in the UK (1970 to date), few home births took place and consequently, some midwives have lost

[64] This practice was not evident in 2000.

the skill and confidence to support a woman during birth at home. Such orthodoxy is being challenged in the UK, where the evidence from some European countries and New Zealand is being taken into account and some educated women and midwives are recognising the benefits of home birth (Edwards 2001).

As stated, midwives in Pakistan are not exposed to home birth neither during nor after their training. Therefore, they judge birth at home to be on a par with dai practice and 'unsafe'. Student midwives in the UK still cover home birth in the curriculum even if they do not get first hand experience. Midwives in both countries have been socialised into accepting intervention as the norm, the sequel of which is operative delivery (Thomas and Paranjothy, 2001). This results in midwives dual loss of confidence that spreads like a contagion to women. The first spur to loss of confidence links to a question mark being placed over whether the woman can birth normally. Secondly, the belief strongly voiced by some midwives and most doctors, is that the sequele of the intervention, unbearable pain, epidural anaesthesia, ventouse or forceps delivery, perineal trauma, caesarean section, possibly postpartum haemorrhage, could never be managed in the home. However, it does not appear as evident to these midwives and doctors that if the intervention did not take place in the first instance, many of the consequences mentioned would not occur. Somehow it is seen that it is the intervention that benefits the woman. Midwives and women recoil further from home birth as a feasible 'safe' birth option 'because these sequele could happen at home', instead of analysing the root cause, which is likely to be the intervention rather than the place of birth.

The simplicity of the delineation of home and hospital birth is complicated in Pakistan by the health of the women and their choices are economically limited. Most of the women in the villages would probably be a high risk by UK standards. This would be by virtue of their poor physical condition. Anaemia is endemic, most women have some form of infection (Chapter 3 Awan 1989 and 1996) for which they have no resistance because of the anaemia. It would appear that the social cultural and economic deprivation that has also served to destroy the women's physical health paradoxically has protected and preserved their confidence and belief in the body's ability to give birth. The continuance

of women giving birth in the home in Pakistan has served as the vehicle for the dai and the woman to retain the confidence that the woman's body can birth normally.

The inverse of this has occurred in the UK; women appear to have lost confidence in their body's ability to birth normally. Believing that it is technology that will ensure birth happens safely. Birth assisted by technology takes place in hospital; many midwives have never attended a home birth, so do not have the confidence to practise outside the hospital environment.

7.7.10 Defiling and unique

Keeping the labouring woman concealed, Jeffery, Jeffery and Lyon (1988, 103) reported that:

> *"the dai...does not wash herself.. but touches the woman's genitals and inserts a hand inside her body.. which is defiling work. Other women would be appalled to do this"*

The care provided by the dai in Pakistan includes touch through massage; keeping everyone's spirits high by creating laughter and masterly inactivity. "*All she did was sit in the corner with the Hookah*" (Ami). Some dai performed domestic duties, but the major specific dai role is to deal with the placenta. Although dai practice is of low status and highly polluting it could be classified as highly skilled, as they perform the vaginal examination that reveals important information about the progress of the labour. However, Jeffery Jeffery and Lyon (1988) found the dai was left with the low status menial demeaning tasks, such as inserting vaginal pessaries, this was confirmed by Ami, Riz's mother:

> *"...Of course we must call the dai (for the birth), none of us can cut the cord. The cord is cut only after the placenta is delivered, otherwise it could go back inside, back into the tubes and the poison would spread and kill her".*

> *The dai does not have control over the birth or any decision making, nor is she a sisterly or supportive partner (*Jeffery and Jeffery 1988: 105*)*

Contrary to this, I have observed a sisterhood between the women and the dai in Pakistan, both in the words of the women about the dai and observing dai who have brought women to the hospital.

Ros Bryer (1995) portrays a theory of midwifery, which bases its philosophy upon women centredness and the belief in the women's knowledge of self and her ability to give birth unaided. The dai base their practice on women's knowledge, from those women attending the birth and her own experience. She uses basic senses such as, sight, smell, hearing and touch. The women and the dai assess progress and actions are negotiated. Although current education for midwifery in the UK includes in the curriculum the midwife's use of her senses, she may not have the role models in practice to build the skills. Electronic fetal monitors are used in practice and are considered 'more accurate' and without human frailty, but also without human sensitivity. Machines confirm normality and detect abnormality and the human skills are not valued as highly as the technology in the technocratic hospital. Thus in the UK the students are not seeing in action a midwifery theory or model of care.

All UK students do not see midwives using intuition. Intuition is knowledge obtained without perception. An inner gazing and instinctive knowing that develops through experience of the understanding of underlying meaning (Alvesson and Skolberg 2000) Intuition involves connected knowing (Belenky et al 1997) and sensitises the midwife to the women's needs; she reads body language, she feels mood, detects atmosphere and communicates a genuine empathy. Previous knowledge of the wider family group offers the right components for intuitive knowing. Intuition combined with in-depth theoretical, practical sensual knowledge can help the midwife develop her clinical skill. These skills can be learnt through an apprenticeship model of observing the midwife with intuition and experience in action. This approach builds through relationships of mutual trust and respect and upholds the belief that woman can birth normally, no matter what birthplace.

Some skills have become redundant in the face of technology; ultra-sound is one example, this can 'see' inside the woman, what Foucault (1980b:1) called the 'clinical gaze.' In the visualisation of the individual organ tissues and body there is a metaphorical

blind spot to the whole person, which includes the spiritual and emotional synergy of mother and fetus.

The technocratic way of birth, and the belief that the mother's body works as a machine with the midwife as technician, is the predominant belief in both the UK and in hospitals in Pakistan. The technician has replaced the intuitive experienced midwife. However, the evidence from the women interviewed suggests the experienced intuitive dai still exists in Pakistan. Despite this and due in part to her social position and role involving body fluids, which are believed to contaminate her, the dai is devalued by all but the women.

The polluting parts of the role of the dai link to the chapter on behaviour and blood (Chapter 8). The person who 'deals with' the placenta in Pakistan is the dai:

Sam (Naz) "*she* (dai) *used to bury it* (placenta)..." Taz interrupted saying "*nahee* (no) *they* (dai) *throw it in deep water and tie something hard to keep it at the bottom...*"

During this interview with Naz there was a query whether the dai was Christian or Muslim, and it was clear that it was usual for her to be a Muslim. Following on from this the conversation went onto body fluids being considered unclean; it is stated that Muslims regard menstrual blood as dirty and polluting, this concept is upheld by Chapple (1998) in her qualitative study of Asian women with anaemia.

Jeffery Jeffery and Lyon (1988:3), in their study of women and childbearing in India, found that the work of the dai is mainly that of "*clearing up'*. They tell the story of a woman who urinated on the dai during a contraction, to which the mother-in-law retorted "*What is there for you to fuss about, isn't all of a dai's work defiling*". This statement is based upon the belief that:

> *"Childbirth pollution is the most severe pollution of all, far greater than menstruation, sexual intercourse, defaecation or death. Consequently, touching the amniotic sac, placenta and cord, known collectively as pindi or lump – and delivering the baby, cutting the cord and cleaning up the blood are considered the most disgusting tasks"* (Jeffery Jeffery and Lyon 1988:106).

The women interviewed did not relate especially to the polluting nature of the dai role, concentrating instead upon the position of the dai in relative terms and her actions during

labour and at the birth. However, the dirty (ghunda khoon) nature of blood was discussed at length during Naz's interview,

Naz confirmed the placenta's dirtiness by using the analogy of eating dog.

Fauz, in a subdued tone, as if the topic was untouchable with words, said:

> *"Yes we have a problem with that...those things we are talking about, yeh placenta, she say... it come from not being allowed to drink blood, not allowed to eat or drink... The Masai people in Kenya, East Africa, they drink blood of live animals, they cut hole in the neck and blood spurt and they fill their bowls to clot and then they drink...milk and blood is their staple diet...God help them..."*

It was due to the disgusting (haram) qualities of the placenta and cord that the dai is called to the birth:

> *"This is why the dai is called to deal with the cord and placenta..."* (Sha Chapter 6) .

Jeffery, Jeffery and Lyon (1988: 106) confirmed this:

> *"Of course we must call the dai, for none of us (family) can cut the cord"*

7.7.11 Invisibility of dai practice

It is complex to compare the similarities and differences in the care provided by the dai even across the same continent. Fari was most complimentary (Chapter 6) yet Naz's daughter and daughter-in law stated categorically that 'dai were ignorant' (Chapter 6 Naz). The women participants told of the dai 'doing massage' and 'dealing with the placenta'. The dai who talked openly about her practice was proud of not having to admit women to the hospital and honest about the injection she knew of, but never gave. She knew about eclampsia, had some knowledge of the symptoms,[65] (but named it polio); she could talk through the safe birth of a breech and resuscitation of a baby who did not

[65] She demonstrated an eclamptic fit by jerking her own body.

breathe at birth. Very importantly, although it was wrapped up in finding fault with other dai, she knew the importance of patience (Chapter 6).

It is interesting to note that female relatives feature as strongly as the dai in the women's birth stories. It was not always clear whether the dai were blood or kin relative of the family. The term 'family dai' (Chapter 7) did not necessarily link the dai as a member of the family, but as a member of the community, or as my mother used to talk about the 'family grocer'

In order to analyse the interface between the women and the dai, it is fitting to apply Landy's (1974) concept of 'role adaptation'. Landy introduced a tripartite typology of the kind of roles the traditional birth attendant may bring into play in a modern pluralistic medical setting. First Landy hypothesised that there was an 'attenuated' role, which involves an acceptance of diminishing influence and co-existence with a 'higher status' biomedically dominated health system. Secondly, Landy describes an 'adaptive' role, whereby the dai adopts some of the trappings of the biomedical practice, for example 'injections' The third 'emergent' role would apply to the dai now accompanying the woman into the hospital, instead of sending her or handing her over. I have noted an increase since 1989, in the number of dai who come with the women and stay when they come to hospital.

It has become apparent to me that good dai practice is largely invisible. As stated previously, I have undertaken nine field trips and have spoken to many dais about birth, but have yet to observe a birth in the home in Pakistan. When the dais are called and the birth is normal, the story about the birth stays within the family behind closed doors. Good or bad dai practice is only actually seen in the event of transfer into hospital and this heralds the likelihood of the dai being blamed for the poor condition of the woman. She is unlikely to be praised for her care in labour or her good practice in transferring the woman to hospital. In the hospital the practice of the dai is then scrutinised and judged by other's who were not present to witness the good or bad practice in the home. Consequently, best practice goes unnoticed and understated.

A parallel can be drawn with midwifery practice in the UK. Assumptions are made when a woman booked for a home birth is received at the hospital that the midwife or the woman has failed. Failed in two ways, first by accepting the woman as a home birth (when obviously she needed the hospital), and second by not being able to deliver the baby. Yet the real issues are ignored, the woman and midwife's relationship, knowledge and belief, the relationship of trust, the belief in the woman's body and the naturalness of the process. Transfer to hospital is not a failure - it is a success in the detection of assistance that may be needed.

The health of the women directly correlates with poverty and not dai practice (Chawla 2000).

When situating the dai in the context of birth for some women in Pakistan, a more powerful understanding emerges from the multifaceted complex context around the dai and how she performs her role with women at birth. The analysis of who defines the dai raises issues about the people with the words to do this, as it is clear that neither the dai nor the women have contributed to the definitions. In this thesis a dai has defined her work, however it is clear that she had had contact with western practice.

The substantive inter-relationships that exist between the dai, the childbearing woman and the woman's relatives will be explored in the next section.

Further analysis across the women interviewed, identified both subtle and overt links with dai practice and the links to health care work not obvious at first sight. Naz had the dai knowledge, saying her elder sister was the dai, yet her relative Farn said it was Naz herself who was the dai. Farn's daughter was a nurse, Riz, the daughter of Ami, was a nurse and student midwife in the UK. Dil worked as a family welfare worker and Ina (the midwife) had trained and worked for over a decade in Pakistan. Finally, the dai interviewed in Pakistan, who although would not disclose her name, talked openly about her practice at birth for which she was paid.

Table 7: Positive comments from the women concerning the dai.

" *The dai massaged*" (Fari)
"*The dai put a sachet (herbs) in the vagina*" (Ami Riz's mother)
"*The dai sat in the corner with the hookah" (Ami Riz's mother)*
"*The dai sent the doctors out, you have done (tried) now it is our turn*" (Ria)
The dai made us laugh" (Woman in the preliminary focus group)

7.7.12 Blame and distrust

Blame and distrust, and death of children were two important concepts in Shu's context and birth stories (Chapter 6). Not only is there distrust of women in the midwife or hospital staff, but also the hospital and its staff distrusts the dai. As stated previously (Chapter 6), the phrase 'dai handled' was a statement made by staff when things had gone wrong and the labouring woman was admitted to the hospital. A further example of this was recorded in the fieldwork log (14.11.97:6). The staff held the dai responsible for the stillbirth yet the relatives upheld the view that it was Allah's will and the dai had done what she could (Chapter 6 Kad 6, interpreter).

Following the incident of the stillbirth, I had the opportunity to chat with the relatives who had brought the woman to the hospital. They said that she had been in labour since the previous day and the dai kept saying the baby was coming. However, during the journey to the hospital (four hours on a horse and cart), the baby had stopped moving inside the mother. The family did not hold the dai responsible or judge the delay to be linked to the death of the baby; they said simply 'it was Allah's will'.

Whilst the data does not contain direct quotations from the women that are critical of the dai, some are positively critical of the staff 'trained' in the hospital. This may be attributed to the belief that dais are considered part of the extended family. Shu, the woman who was interviewed on the bus from Lahore to S..., had a very poor opinion of the midwives in the hospital:

> *"The midwives at the hospital were no good; they complicated cases to get money"* (Chapter 6 Shu)

Also Dil stated that she was anxious not to be blamed when she took on the care of a dying women,

> *"all right don't blame me, I am not saying it is a fact...I will try that is all to cure her"* (Chapter 6 Dil)

However, Hunt in a study of dai in Afghanistan reported:

> *"It must be remembered that in some instances, where the dai refers a 'case' with complications and the woman and/or infant subsequently dies, the biomedical trained practitioner often receives the blame".* (Hunte 1981:14)

Such batting back and forth of blame provides evidence of competing ideologies around childbirth. Doctors and mothers/relatives often have a qualitatively different way of looking at the nature, context and management of reproduction (Currer and Stacey 1986). The different frames of reference encompass a system of values and attitudes that had strikingly divergent views. The doctor or trained person is held accountable and 'promises' to 'do no harm'. This is interpreted by the women and relatives as 'putting everything right', when there may be times when this is not possible. Thus it is not surprising that when things go wrong, the trained staff are blamed as they are not members of the extended family, where the dai is positioned. However, in the full knowledge that the qualified staff are unable to 'put everything right' instead of admitting fallibility, they reflect the blame back onto the untrained and the woman. It is my observation that the trained staff and not the women blame the dai. If the dai's role is to 'facilitate' (help the progress) of birth, she is not acting in a decision making capacity and she may not be to blame. However I have experience of women being manually stretched vaginally and been told by the women that the dai tried to make the way for the baby, so the dai may be responsible for mishandling the woman.

A story that has exemplified personal retribution concerned a member of staff at the maternity hospital being brutally beaten by a relative because she had administered 'bad blood'. The woman was given blood of the wrong grouping. This had been bought by the relative from the bazaar where a terrible mistake had been made, however, it was the 'trained' midwife who had put the drip up, and she was held responsible for the woman's

death. The person who put up the 'bad blood' had performed an action, so thus could be held responsible and blamed.

When blame is apportioned, it may be more acceptable that someone outside the 'family' is held responsible such as in the biblical story of the serpent being held responsible for Eve taking the apple from the tree and giving it to Adam. Holding a family member responsible for a poor outcome may be too painful to contemplate and would result in family disharmony. It is better that the family stands together to blame another. The 'other', who is the butt of blame, when a woman was admitted to the maternity hospital with complications, was the dai; clearly the hospital staff held the view that the dai was not a family member.

In summary, this part of the chapter on the dai told of her practice, beginning with the comparison with handywoman, then moved on to explore in some depth specific dai practice in the context of current evidence, finishing with the relative invisibility, yet indispensability of the dai and her practice. The former has lead to ignorance and blaming of dais for the wrongs inherent in the health of women.

7.7.13 Poverty kills, not the dai

Chawla (2000:14) confirms the poverty related poor physical condition of women in India and Pakistan.

> *"We discovered the extent to which childbearing women's health is compromised by poverty, lack of nutrition, overwork, ecological degradation and unavailability of resources. Communities and families lack resources and childbearing women suffer...."*

A story is told of a woman who died in childbirth and the cause was attributed to the dai

> *"The woman S... had eaten only rice and salt throughout her pregnancy"* (Chawla 2000:14)

During the field trip in 2000 we visited some rural villages. In one of the villages we met a woman who was being castigated by other women for being heavy with child, yet her other two children could not yet stand. The woman told us that she could not remember

the last time she ate meat or drank milk; she lived off flour and water. The milk from her family's buffalo had to go to the market. To attribute her health or complications in pregnancy to the dai's practice seems ludicrous, to use Chawla's (2000) words, it serves to "invisibalise *the quiet violence of poverty*".

The introduction of the medical model of interference, as referred to in (Chapter 7), would undoubtedly be further detrimental to the women in the rural villages. As would the dai being trained by the doctor in a hospital would potentially lead to modelling on what would be seen to be 'modern practice' (Chapter 7). Examples of medical practice that may be injurious if introduced by the dai into a birth home could be:

- Repeated vaginal examinations, which if introduced in the home would be likely to precipitate intra-uterine infection.[66]
- Clean water is at a premium and the lack of knowledge around germ theory means that the importance of hand washing prior to examinations is not considered necessary[67].
- The lithotomy position for normal birth, which adversely influences the positive effect of gravity on descent of the fetus and reduces the space available at the outlet of the woman's pelvis, created by pressure on the woman's coccyx.
- Widening of the birth canal damages soft tissues, delaying the healing process. This practice was observed and was undertaken in the hospital in Pakistan. Willughby 1773 (cited in Wilson 1995 :36) called this 'meddlesome midwifery' but was known to undertake such techniques because it was effective in stimulating the labour pains[68]

66 Frequent vaginal examinations, even in supposed sterile conditions will predispose to intra-uterine infection.

[67] Or as identified by Hunte (1981) the dai wore dishwashing gloves to keep her hands clean. She became known as "*the dai who wears sacks on her hands*".

68 Dai may have also have undertaken such practice in the homes, (see Ria's account of how her aunt and the dai pulled her baby out (Chapter 6). However the position of the women, either kneeling or squatting would mitigate against such interventions, as it is only when the woman is lay on her back or in the lithotomy position that the vulva can be viewed or reached.

The introduction of the medical model into traditional practice as superior 'modern' practice would potentially see the demise of hands-on skills and the belief in the woman's ability to birth normally. Also, the reputation of the dai in the hospital may be so poor that her 'training' may result in her confidence being affected. As Jordan (1993) found when medical personnel attempted to train midwives in the hospital environment: -

> *"Midwives who in the environment of the hospital-based training courses often appeared stupid, illiterate and inarticulate showed a completely different face when engaged in doing their work in their own communities, where their skills were acknowledged and respected*"(Jordan (1993: 149*)*.

Robinson (1999) in the UK similarly voiced concern with regard to hospital practice being introduced to the home situation. Parallels can be drawn with the community midwives of the 1950's-70's in the UK, when up to thirty per cent of women had their babies at home (Smith, 1997, Allison 1999). However, in the late 1970's, the same community midwives who had the skills and confidence to attend women to give birth at home, were brought into hospital to 'update' (personal experience). The skills that were judged as needing updating were, the use and interpretation of a cardiotocograph for monitoring fetal well being and 'top up' for epidural. Neither of these hospital skills would be needed within the role of the community midwife. Moreover, the skills that the dai and the community midwife excelled in were not seen to be necessary for updating the hospital midwives at the time, which provides clear evidence of the underpinning dominant medical model pervading hospital midwifery practice then and now.

> *"The dai plays a precious role within her community, wishing her to disappear or ignoring her would represent a real danger for the women. On the other hand if she is imprisoned in her traditional role, she risks, by using dangerous practice, endangering the woman's life, she would disappear spontaneously because the other women would not seek her out"* (Altaf 1992:3).

Whilst this statement suggests that the women have a choice, the scarcity of dais may mean that there is only the one dai to call. It is my experience that if the outcome is poor, it is not the dangerous practice of the dai that is attributed to, but the will of Allah. Conversely, if there is a choice of more than one dai then the dai that has been linked to any adverse birth event, will be blamed whether it is due to her dangerous practice or not.

The dai's reputation will suffer and she will spontaneously disappear. However, a stronger argument emerges of the rationale for the ongoing reduction in the number of women wanting to become dais because they are no longer prepared to take the risk of being blamed. (Chapter 6 Shad).

In summary situating dai practice has traced parallels and difference to that of the UK handywoman, explored the positive and negative elements of dai skill, knowledge and practice, considering the invisibility of good practice and how it 'touches all'. Acknowledging that is it poverty that kills and not the dai, links to the blame that is apportioned and the social status of her position with the polluting elements of her work. As the dai's good work is largely invisible, her skills and any subsequent benefits go unrecognised.

The next part of the dai chapter focuses upon the all-important relationship she has with the family, both her own extended family and the fictive kin to whom she belongs when conducting her business.

7.8 Dai a family thing

The third and last part of this chapter on the dai explores the relationships between the childbearing woman, her female family members and the dai. It was clear from the narrative that the current birth system in Pakistan was based upon economic need and trust, the next generation's choice not to follow in their mother's footsteps presents as a concern. Learning how important the dai and the family are to the childbearing woman in Pakistan has served to highlight how the western birth system excludes the family, especially around decision making.

The dai is likely to be from the same community as the women she is called for, so will probably share the same cultural values and social norms. Whereas the midwife in Pakistan or the UK is educated and of a higher social class and so distanced from the women they care for. The midwife may also have travelled away from her own community to undertake training and continue her work in the hospital. Educated women

can afford the services of a doctor and the cost of travel to a health facility. This is seen to be the 'best' option by virtue of the charges made and the education of the midwife. However, it is the mother-in-law who would make the decision who to call or where to go for the birth[69]. Even if the family could not afford to pay for the 'educated personnel', services may be bartered for, as Shad's mother did (Chapter 6).

> *"My mum used to take her cases there (to the doctors) so she did not take anything from us...just for the medicines..."* Shad[70]

Within the community, there will be differing social groups and it is usual for the dai to be from the poorest and lowest group. As a working woman the signal to the rest of the community is that she does not have the support of a man. The accepted social norm of segregated gender roles exists within the family grouping. Men go out into society to earn for the family and the woman's role is within the home, bearing and caring for children, maintaining the home and cooking for all. There is a stigma that is attached to the whole family when a woman works.[71]

The decision making during labour appears to be grounded in a community of women, discussing what is to be done. Jordan (1993) found that decisions about labour and birth are made jointly between the woman, her helpers and the midwife. Decisions such as, whether the woman should have something to eat, which position she should adopt when she should push, whether she was pushing hard enough, what constitutes reasonable effort, what is unsatisfactory progress and what should be done about it. The decision emerges as a negotiated consensus. The sas or aunt and the dai may, as they did for Ria, make the ultimate decision to take over from the doctor. As it was Ria's first birth, and she was under the influence of the drug, to stop her vomiting she was aware, but not

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69 I have direct experience of a mother-in-law insisting that the dai deliver her son's wife; "because she delivered her son" The family were the land lords in the village and had educated their son to be surveyor.

70 These two experiences (births in hospital) served to frighten Shad so much she could never take a case and become a dai.

71 Even in 2002 Bal needed the permission of the family elders to work after marriage. Her husband and his brother were not supportive of her working even though neither of them had jobs themselves. It was a family friend (elder, man), that persuaded Bal's husband to let her work. He said it was the way to keep her as a good wife.

involved, in the decisions being made. However, with subsequent births she may be included or consulted. Contrary to this consensus decision-making Jeffery, Jeffery and Lyon (1988:108) believe that the mother rarely features in the decision making.

> *"Birth is a socially managed process, the labouring woman plays little part in the discussion about how her labour is progressing or any intervention...she might refuse a chosen treatment, whether hot sugar water or squatting on bricks, but management of the labour is not in her own hands. Usually the labouring woman's sas (or other senior attendant) calls the dai only once she considers labour to be well established. Before that she (sas) may have examined the labouring woman's belly or tried to hasten the delivery through various domestic remedies"*

It is noteworthy that the role of the mother-in-law (sas) and close relatives is much more important for birth in the home than the hospital. Although a relative will stay with the woman (cooking and caring) all the time she is in hospital. When the birth takes place in the hospital, relatives may not be allowed to be with the woman, let alone make decisions on care. Shad's mother and sister were on the hospital premises but not allowed into the delivery room (Chapter 6 Shad).

Similarly, in a western managed labour, the woman herself may be perceived to play little part. However, the labour is not socially but medically managed. The role of mother and/or mother-in-law is less clearly defined. It is also improbable that the woman in the western delivery unit would ever refuse a treatment recommended by the doctor. This principle was upheld by a recent review of informed choice (Kirkham and Stapleton, 2001). The decision when to summon medical assistance in the UK has the clear-unclear 'abnormal' boundary. When to send to hospital in Pakistan appears to be taken by the mother-in-law or female relative.

> *"Familial bonding – where there is a lot of commitment and affection, but also the avoidance of conflict"* (Chawla 2000:14)

Families can be both supportive and oppressive; examples of both are evident in the narrative (Refs. Taz, Ria, Dil,). Chawla's words describe the bonding and commitment that holds families together, this is especially visible between the female members of the family at the time of childbirth. The family in Pakistan is a clearly defined extended unit; the extension appears to include the dai.

An exploration of the relationship between the dai, the woman and the woman's relatives, opened up concepts that were outside my own life experience as a midwife, mother and woman in the UK. Even though as a child in the 1950's I was familiar with the neighbours being auntie and uncle and them being called to care for the family at times of birth, illness or death. Behar (1993) gave non-relatives as family a sociological descriptor of 'fictive kin'. The, strange (to me) concept was around the importance of the female relatives in decision-making and direct care of the woman in labour.

On reflection I realised that I may only be one generation away from the relative as decision-maker concept. My mother often told me the story of my own birth in 1946. This included how a neighbour looked after her when she was in labour and when the birth was imminent the neighbour and my mother jointly decided to call the midwife. When the midwife arrived she administered 'twilight sleep'; my mother awoke to find she had given birth to not one, but two babies. The neighbour was not of our street but from the village. She 'looked after' women in labour. The arrangement was set up between my mother and the neighbour, not the midwife and neighbour, although the midwife knew and trusted the neighbour well. The neighbour performed the role of supporter not deliverer.[72]

It could be argued that the role of neighbour parallels that of the female relative in Pakistan. Although the Pakistani relative and not the labouring woman would make the decision when to call the dai (Chapter 6 Fari, Farn). The difference appears to be that the Pakistani relatives continue to make decisions on care throughout the labour and birth, even in the presence of the dai. The neighbour in the UK 'handed over' to the midwife, when she arrived, although some of the decisions taken were as a result of shared discussion (P.c.[73]) The 1902 legislation made the midwife accountable in law for decisions made, especially when to summon medical aid.

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[72] The doula in some countries would undertake the 'neighbour 'role (Mander 1991)

[73] Personal contact with a retired midwife (my mentor) who worked from 1950-70 in the community

Analysing the decision trail has raised awareness of just how much the medical profession and the midwife in the UK have taken away, replaced or put to one side, the woman and her family's autonomy and responsibility for decision making during childbirth. Much as the (UK) took away the autonomy of the countries we ruled as the British Empire.

The complex relationships between the relative as a dai or midwife and the childbearing woman emerged when women told in glowing terms of the infinite benefits of the mother, mother-in-law or other female relative also being a dai (Dil Ria Shad Chapter 6). The main advantage that was derived from this arrangement was trust, which is covered in more detail later (Chapter 7). Other facets of the relationships include the necessity for those present at the birth, including the dais, to have experienced birth themselves. Although Bas (Chapter 6) refers to the blind dai's unmarried daughter who was assisting her mother and Ria's statement that it was not necessary to be married.

The findings include the recognition that there was a no-go area for relatives, whereby certain tasks were never undertaken by a relatives and were for the 'non-true family dai' only to perform. If the dai is also a kinship relative of the woman giving birth another dai may be called (P.c. Bal) to undertake the polluting work.

After exploring the women's positive feelings that came from knowing those present at the birth there emerged one family whereby the antithesis of Chawla's (2000) affirmation that '*familial bonding avoids conflict*' was evident (Taz)[74].

7.8.1 The dai , special and influential

It was evident from the women's narrative that dais are trusted, special and influential members of the extended family and community. Her role was clearly understood by the women; the focus of this was her coming to the woman's home when she was called and

74 Taz's daughter Rob felt her daughter (Sam) had committed some terrible transgression that had brought shame on the family, "*if she had done in Pakistan the police would have brought her back and the relatives would have killed her*" Rob (Chapter 6).

performing duties that no one else was prepared to undertake. The mother-in-law or other female member of the family had already made the diagnosis of labour, based upon observation of a change in the woman's behaviour (Chapter 6 Fari).

This emphasis on the dai in the women's stories may well have been influenced by my declaration that I was a midwife and that I was especially interested in the person(s) present during birth. However, the stories were there to tell. There was one notable exception to the generally positive opinions of the dai; this was Naz's daughter in-law, who spoke with some disdain about the dai (Chapter 6 Naz), in apparent ignorance of the fact that her mother-in-law had been one. The dynamics of this hidden knowledge will have contributed to the family relationship and possibly to Naz's chronic ill health.

Naz's daughter's words highlight the complexity of relationships between the dai, the woman and the woman's family. Birth at home in Pakistan, no matter what social class or caste, would probably involve calling the dai; additionally she may be a relative or an honorary member of the family.

The relationships with other women present at the birth may differ if the dai was attending as one of her own family. As she may well be the 'other' special person present at the birth, which could be the mother or sister-in-law (sas). However it was still necessary to call a dai to undertake the defiling work of touching the genitals (undertaking vaginal examinations) cutting the cord, dealing with the placenta, cleaning up the blood. The best dais appeared to be the woman's mother or mother-in-law (Dil, Ami, Ria Shad Farn)

The mother as the dai, only delivering family members, is one of the many complexities within the social fabric of the Pakistani community. The subsequent effect upon the dai (not a family member but summoned anyway) is outlined by Dil:

> *"My mother was a dai, but only for the family "*

Farn's dai was also her relative. Farn was safe and secure in the relationship and the knowledge that the dai was caring for her, "*she looking at me*". Living in the same street, same community, even the same family would suggest the dai's knowledge of Farn was much more than any professional could ever achieve, again changing behaviour as

referred to by Fari, would be evident. The 'relative' care would engender confidence and mutual trust, providing a firm grounding for a normal birth.

> *"It is inappropriate to regard the dai as the expert midwife in the contemporary western sense as it is the senior relative, usually the sas (mother-in-law), who manages and directs the actions of the dai"* (Jeffery Jeffery and Lyon 1988: 108)

This quotation directed my thinking towards the power relations during a home birth in Pakistan. My experience of talking to dais and women upheld the belief that the dai was the expert in a 'midwife' practical hands-on sense (Chapter 6 Dai, no name). Many opportunistic discussions with dai (who may also be the senior female relative) have served to impress me with not only their knowledge and skill of midwifery practice, but also the provision of tender loving care to the women.

The dai, by being 'of the family' would be much more likely to have an understanding of the holistic needs of the childbearing woman. Shared family norms and values create a bond of knowing that does not need to be articulated, reduced or altered in meaning through the use of words that at times may not fit. Feelings are communicated much better through non-verbal behaviour and importantly received and understood through implicit common knowledge, values and beliefs. Control and responsibility shared with Allah, as a religious priority, constitutes one of the major shared belief systems that bind together a relative acting as dai and the childbearing woman. Such joint belief systems have the potential to change priorities for action in labour. If the woman, her relatives and the dai all believe that the labour is being prolonged due to the will of Allah, none of them would consider themselves above Allah's will, so acceptance will be the unquestioning action rather than to seek further help.

The relationship between the dai and Dil's mother showed the hierarchy in the birth setting. The dai was nervous in the presence of Dil's elderly experienced mother who, despite her advancing years, 'took over' and 'did it (birth) herself'. Whilst the dai performed the vaginal examination's, it was Dil's mother who *'cut* (Dil's perineum) *with a blade'* This would involve touching the genitals, so would be classified as polluting work. It may be speculated that the former may have been too personal an act for a mother to undertake. The latter, however, has parallels with Landy's (1974) adaptive

role, whereby the perceived higher status and the trappings of a biomedically dominated system, the surgery (cutting with a blade) and the sterilisation of the implement were remembered by Dil as important (or important to tell me). Dil had complete faith in her mother's knowledge:

> *"She know everything, you know, my mother, even though she was uneducated"* (Dil).

Dil's concept of her mother's knowledge, 'knowing everything' includes knowing about Dil and the biomedical (Chapter 6 Dil). Dil was a family health worker in Pakistan, with this background she was in an unusual position for a Pakistani woman. Knowledge of Dil's background as an educated health worker in Pakistan led me to make an assumption that she worked with western knowledge that was in tune with my background culture and experience. This belief was refuted when I learnt of her mother's treatment to aid healing was Vick referred to previously.

Table 8 : Comments from the women interviewed on the dai.

"The dai was my dad's auntie...she live in our street, only a few homes away...she is looking at me "Farn
"My aunt (dad's sister) is also my mother-in-law...she is the dai" Naz
"The dai was very kind, she delivered all my brothers (I got six and one sister) "Fari
"..Yeh... they (dai) looked after her (grandmother)...the family system,...most of the family used to look after her when she was in labour" "The women in the family...because it was quite a big family they looked after her..." (Sam granddaughter of Taz
"She, the dai is in the same village, her mother was also..." Bas
"My sister became a dai, it was the only way to get some money" Naz
"The dai was a family thing " Ami Riz's mother

Although happy to 'own' the dai as a member of the family, there was a strong feeling that the women did not want the low social status of the dai to be attached to their family.

"It is not something you would like your family to do...it is in the family, but not every family allows it...the families that do are on the poor side or may have no husband...being a doctor, now that's something else"(Chapter 6 Taz)

The presence of a mother who is a dai (only for her family) brought with it a reassurance that appeared to temper the fear (of childbirth) for Dil;

"she (mother) never 'do it ' for other people, only family and grand-children...I trusted... I knew although I was frightened. " (Dil.)

Amongst the many concepts that emerge from Dil's story of her life and birth experiences, one stands out as memorable. this is the 'loving' Dil received from her mother: A loving that took away the necessity for Dil to think of anything else but giving birth. Absolute trust comes as a result of knowing someone is thinking for you. This could be a very safe haven to be in during a vulnerable time when thinking for oneself may be an added burden.

When significant persons are the caregivers the potential for providing holistic care increases exponentially. The parallel that immediately comes to mind is that of a mother, who is also a midwife, providing care during the birth of her grandchild. Some groups of UK midwives, managers and supervisors frown upon a midwife 'midwifing' for relatives or close friends. They use the argument that 'being too close' can affect rational thinking (personal experience). This nervousness has spawned a protocol for use in some hospitals. This argument appears to ignore the huge benefits derived from the childbearing woman who knows and trusts her relative to make the decisions, giving up herself to the care and supervision of the person who either gave birth to her or has known her from birth.

7.8.2 Trust

Although trust appeared to be family defined by the women interviewed, paradoxically they trusted me as a cultural outsider with sensitive and intimate details within stories of their life and birth experiences. If a trusting relationship had developed, then awarding proxy family status became the norm. The manner of address then became as a relative,

sister, auntie, or uncle. This was evident when Vez elevated me to honorary bahjee (elder sister). It was not culturally acceptable to have a friendly relationship, as Pakistani man and western woman, unless I became a member of his family. This honour was further extended to me being his eldest sister who, next to his mother, would be the one he would most take notice of. This principle also applies to the dai; many of the women spoke about the dai being a relative.

If the dai is not directly related to the woman, yet she is from the village and is always called to attend this family, she is known as the 'family dai'. Although not connected by blood, marriage or kinship, the connection is through the community and her role. The term bhajee (sister) and the strong statements about the dai being a 'relative', may originate from politeness linking to respect and how one addressed elders, much as I did as a child when referring to my mother's friend as 'auntie'. Or as one would have used the term 'family' referring to the 'dai one always called'[75]. However, it is also possible that the trust is a vestige of that commanded from the white western colonialist prior to independence.

Trust is a major determinant in developing a therapeutic relationship; lack of trust is one of the major reasons for the woman/doctor/hospital staff detachment and dissatisfaction. In Pakistan, women who came to the hospital were always accompanied by at least one other woman. The rationale for the accompaniment was to protect, speak and generally represent and be the advocate for the woman. This acknowledges the vulnerability of the woman, unable to speak for herself, and that there will be a need for protection. However, the relatives who accompanied women into hospital were unable to act as advocates. Staff removed them from the birth room (Chapter 6 Shad). The presence of another woman, equally as powerless in the setting, may act as subliminal support to the woman, but not able to protect or advocate. The presence of another and ourselves as visitors did not stop the staff objectifying women, sanitising them, treating them mechanically without feeling, judging them to be unworthy, hopeless, ignorant, shameful, disarmed of

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[75] It is also respectful not to call an elder by their first name without the prefix madam or ma'm.

identity, humanity and sexuality[76]. It is tragic that such treatment of women by women has also seen observed in other developing countries (Davis Floyd 2000).

The concept of a therapeutic relationship, or consideration of the women as people, does not appear to exist in the hospital in Pakistan. I have reflected that with so much tragedy and suffering, perhaps the distancing is a defence mechanism for the staff.

In Pakistan, the trust and confidence between the dai and the woman arises from mutual knowing, shared values and socialisation over time, often through generations. Leap and Hunter (1996) explored the confidence that a midwife inspires in childbearing women in the UK; a confidence that the woman can give birth and the ongoing belief that she can be a mother. Midwives and women in the UK often have only a short time to build up the mutual trust and confidence in each other; it is rare that they ever really know each other as relatives within an extended family network.

What was observed and heard in the women's stories was that of trust in the birth process. A believing and trusting in the woman's body and its capability to give birth, upheld the view that birth was what women's bodies were designed for. As Naz's granddaughter stated "*we are gifted*". Trust is reciprocal, it has a symbiotic growing edge, and my mother had a maxim '*to be trusted is to be trustworthy*'. If the body is trusted to give birth normally then this will happen. Edwards (2001) in her study of women who had home births in Scotland, found women wanted to be able to trust the decisions of the midwives and what made the difference between trusting and not was having someone who had similar views on birth. It was important that both the midwife and the woman trusted the woman's body to birth. The beliefs and views of the women in Pakistan do not differ from those of the dai or their relatives because they are all from the same social grouping with common values and beliefs; there are no other allegiances, no other master to serve. As Chawla (2000: 15) observed:

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[76] The woman doctor in Pakistan judged that the woman who was being cared for by the UK student midwife should have delivered sooner. The doctor took a glove, did not speak to the woman and proceeded to undertake a vaginal examination. As the woman backed away, the UK student gently took hold of the doctor's hand saying '*please don't do that*'. The doctor stormed out.

"Their ways of being in the world tell of a joint reverence for the natural world..."

The sense of security that emanates from trust speaks of a trust that disappears if the woman feels undermined or unsupported. The dai and women's relatives stand side by side with the women giving birth, as Ria's story beautifully depicts. They all have the same lived experience - they know each other's personalities, weaknesses and strengths. They all emanate a confident belief, comfortable with the naturalness of birth. This was evident in Farn's answer to the question - did she go to the doctor to confirm her second pregnancy?

"No, I know now" (Farn)

Farn admitted *'not knowing'* she was pregnant with her first child. However, having experienced pregnancy and birth for the first time, she then had the confidence to 'know', she had grown in confidence through her first experience. This is in direct contrast to some women who experience the biomedical, technocratic world of birth in the UK. Their confidence may be shaken by the terms, 'failure to dilate or progress' and the belief that the machine knows more than they do. Woman's knowing is not valued, women are kept 'unknowing' by the system, the midwife, the scan, the doctor who all speak of their superior knowing.

The groups of women at a birth in Pakistan not only present a joint belief and confidence in the female body and the naturalness of birth, but also create a social and gender boundary that says, 'this is the women's domain'. Keeping 'professionals' out protects the belief system. The ritual of certain women being excluded continues. Young unmarried women are not included in talk about sexual matters, so would not be allowed in a birth room.[77] Women who have had problems conceiving or who have disfigurement may also be excluded. Men (unless they are doctors called for a reason) are also excluded. There is no need for medical intervention or consideration of external political

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77 Unmarried girls are not included in women's talk on menstruation or birth matters, this is confirmed by other text (Harcourt 1997), and begs the question, how do they find out about such matters. If it from friends at school (as in the UK), yet not all girls attend senior school in Pakistan and the level of knowledge is not experiential or evidence based, so ignorance is perpetuated and can be shameful (Dil). Learning from peers also perpetuates ignorance. Elder sisters or sisters-in law are the usual source of information.

positioning, no government policy or standard setting body has laid down rules to control birth[78]. The privacy of the home birth is strictly maintained by not allowing any stranger, observer or researcher to observe birth in the home. As a consequence, the ethnic knowledge and skills used by the women are hidden from view, kept out of the media and remain untainted and unchanged, only passed on through oral history. The boundary that keeps out the world of medicine keeps in the woman-centredness and states clearly that women can 'do it' (give birth), the woman is strong, birth is within their gift from God (Naz's granddaughter Sam). It is interesting to note that the body is related to in the medical mechanistic terms, as a special design feature, yet wrapped in the strong cultural norm of all women wanting children.

The next part of this chapter explores the inter-relationships between the labouring woman, female relatives.

7.8.3 Marriage, mother and daughter dai

Bas referred to the dai who was blind and her daughter became her eyes The dai's daughter was not yet married (as Bas says if marriage does not take place she will be able to earn a living).

> *"She (dai) is in the same village...her mother was actually a 'midwife' as well as her daughter. Because she (mother) was going blind...she said she will teach her... and after she dies she will be able to carry on...that was if nobody does marry...you (daughter) will be able to support yourself "* (Bas.).

Bas identified a dual purpose and benefit to the daughter carrying on in her mother's footsteps as a dai, thus passing on skill knowledge and expertise through family generations. This was considered necessary in order to support the ailing mother and to provide a backup source of earnings in case the daughter does not marry. Bas's justifications for the dai's daughter following in her mother's footsteps do not appear to

78 Dai practice has not changed in the rural areas, however in the urban areas where women are asking for the *'women's drug'* Oxytocin *'to make the womb strong'.* dais were able to purchase the drug from the bazaar, providing she knew its name and could give injections.

fit the assumptions and beliefs that young unmarried girls, without birth experience, would not be included in discussions about childbirth, let alone be allowed to take part in a birth. Harcourt (1997:101) describes this as the '*silence on sexuality*' whereby before marriage, Pakistani girls are not included in women's talk. The concepts of attaining a skill that will be a potential source of income should marriage not occur or fail reveals a dark (often hidden) part of Pakistani women's' lives. This comes with the contextual knowledge of Bas's story, whereby the death of her father had a detrimental effect upon her own marrigability that would offer security for the future.

There is a clear responsibility for the male members of the extended family to arrange the marriage of daughters and sisters (Ina's daughter, Chapter 6). The choice of which family to marry into is especially important if there are no relatives available at the right age (Chapter 6 Shan). Some marriages are arranged soon after the children have been born. Marrying within the same class or caste is a strong social norm in a Muslim society. The influence of the family in the decision is still varied[79].

The daughter of a dai who is undertaking one of the most menial roles in Pakistan society, especially if she does not have a man in the family to arrange marriage, may well have grave problems attracting a husband. It is not acceptable or common practice for a woman to work outside the home, except rarely in domestic roles for which the pay is very poor. Women only undertake this option when there is no other way to get money to feed the family. Women's economic dependence on the man in the family, whether husband or brothers is absolute. Spinsterhood and widowhood are shameful burdens for the family. Family feuds based upon who should marry whom, ill treatment of the new wife by her husband and/or in-laws, or subsequent marriage breakdown are common occurrences in a Muslim society.[80] However, if a marriage fails, for whatever reason,

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50 Muslim children would never disobey or dishonour their elders. Although parents are involving the children in the decision of who to marry, the choice is often Hobsons's as the parents would have to 'find another' which may not be easy. This was exemplified by Ami's daughter who said "*they (parents) do ask if it is OK, but this is not a choice*".

80 Visits to S... prison to talk to women on remand have been made in 1990 and 2000,.Most of the women informed us the root cause for their imprisonment could be traced to family feuds, typically the mother-in-law no longer wanted her son to be married to the woman in goal, so accused her of some crime.

those who set it up are held accountable and will provide food and shelter for the daughter/sister when she returns home. More commonly, the young woman remains silent and perseveres in order to save the family from the shame of her being sent back or being divorced.

The issue of a woman becoming a dai without having given birth herself was raised with Ria, *"(emphatically) No, it would not matter... if it ran in the family then she would carry on..."*

It seemed to be accepted that daughters would follow in the family tradition of the mother and become a dai[81]. "*As a means of survival*" (Chapter 6 Bas) the daughter would learn the skill by accompanying her mother. However, this was taken to be after the daughter had experienced birth herself. Prior to this she would not be allowed into the birthing room, yet the daughter would be more likely to need the means of survival if she had been unable to find a husband or conceive and birth children, her childlessness may serve to prevent her becoming an effective dai.

Childlessness is not a choice that would be made by Pakistani women (Chapter 6 Naz). However, as stated, infertility may make the woman vulnerable to divorce and then she may need to earn a living. Ria's criteria appears to be linked to whether a woman has 'run the family' rather than the need for the woman to have given birth, attended and assisted at birth or been a mother. When extrapolating Harcourt's (1997:101) concept that young, single women, *'maintain a silence on sexuality, and are excluded from any sexual discussions'*, it may be safe to assume that dai would need to be married to be present or included in birth decisions. However, there are always exceptions; the ill health of the mother, who is a dai, needing the assistance of her unmarried daughter may constitute such an exception Bas (Chapter 6).

The silence around sexuality (see also Chapter 8) is maintained until after the young woman's first birth experience, whether delivering her first baby at home or in hospital.

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81 Shad did not want to follow her mother and become a dai, she was *'frightened to take a case'* - her own birth experiences had been in hospital.

The woman is not part of the discourse or decision-making, as covered in Chapter 7. Female relatives who have had the experience undertake decisions, led by the mother-in-law.

Taz was clear on the issue of not allowing her daughter or granddaughter to become a midwife (Taz Chapter 6).

Not allowing a daughter to become a midwife, yet acknowledging there is a dai in the family, appeared to be linked to the low status being a dai. If the family were educated and wealthy, the status would be a contradiction in terms. A high status family would not allow any of the women to work in such a lowly profession. Even highly educated female doctors tend not to return to work after marriage due to family pressures. According to Islam (Salahi 1993:78)

> *"A woman is not required to work in order to earn her living. Her husband is responsible to ensure a decent standard of living"*

Financial dependence on the husband is usual, i.e. single, divorced or widowed women are not required to work and return home to be supported by their fathers or brothers. If the family could not afford to support the women or there were no male natal relatives, then the option of becoming a dai may be forced upon the women by economic necessity[82].

Bas, according to her daughter Siaq, (who had applied to become a midwife in the UK) held a different viewpoint that linked to education in general, although it is interesting to note that Siaq had not told her mother of the application.

> *"I have mentioned it to her...but I have not told her that I have applied... She says it is a good job as well...it is about getting the girls educated...like the people from the villages did not really want...they thought they are going to get married and have children..."* (Chapter 6 Bas)

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[82] Social conditions differ from one community to another. There will be no comparison between a tribal nomadic or rural community to that of the urban employed.

Wanting to become a dai or a midwife arises from a myriad of motivational factors, each one unique to the person. However, not wanting to become a dai speaks volumes about the conditions, the satisfaction and the frustrations. Becoming a dai as we have heard is becoming unpopular (Chapter 7) and the tradition is dying. Becoming a midwife in the UK is still popular. In the University where I work, there are three hundred and fifty applications for forty places per annum.

In contrast to the role of the dai in Pakistan, the western midwife's role is much narrower. The economic, occupational and professional aspects of being employed limit the latter. Within which are conflicting demands; to provide a woman-centred service whilst being an employee bound by statutory rules and a professional code of practice. With a multitude of constraints on behaviour, not least that of time to care, the demand is for bulk care, at the loss to the individual[83].

Wilkins (2000) identifies the paucity of the professional paradigm that locates the woman and the midwife on different planes of being in terms of social dimension. This gives rise to inevitable shortcomings. First it alienates the midwife as a professional from herself, consulting the personal, denying the social self and the potential for using/applying experiences of life-ways of knowing. Second, it denies the connection with women.

Whilst the dai may not always be of the same family group or caste as the woman they attend, she brings to the birthing room knowledge of the family, a certain empathy from lived experience and considerable practice wisdom, a connected knowing (Belenky et al 1997). The connection with the woman shapes the nature of the relationship (Pairman 1998). Just as importantly the dai is not constrained by being 'professional'. It is my belief that the most restricting limitation to the relationship is that of time, covered in more depth in Chapter 8, women's time versus institutional time.

[83] An example of the internal conflict is when a woman wants a home birth, professionally the midwife should attend, yet her employer may say they do not have the resources to allow this.

The normal life event of giving birth involves the support of people who are in the social network. When there is need for other than a dai and relatives, the process then becomes abnormal.

Farn's experience of birth the first time brought her to the stage of knowing (Chapter. 6) she had the experience and has learnt from it. This reminded me of a story told to me by a GP in Pakistan. He said a particular village collected the money to pay for a man to attend the local health facility to have haemorrhoids treated - haemorrhoids were a problem for many of the villagers. The man who had been paid for came back to be the 'haemorrhoid' expert in the village. They had invested their minimal resources in 'training' him (experientially) so that he could come back and treat others in the village.

Farn's 'knowing' upholds the belief that pregnancy and birth is a learning experience, with each event there is a confidence in the knowing. Some UK birth experience has been known to shatter the woman's confidence. This may be due to the promises made by technology that it cannot keep. Technocratic birth promises that if the woman attends for antenatal care no harm will come to her or her baby, yet technology cannot always prevent, merely sometimes detect. If the woman gives birth in hospital then there is a promise that a caesarean section or birth through intervention can be done quicker. Yet a hospital birth increases the chance of needing the intervention. It would appear that birth with technology may not be a learning experience for women, but may be a dispiriting experience of promises unfulfilled.

7.8.4 Summary

There are varying opinions and views on the dai, the value of her role and her practice Although the data revealed widely divergent views; it is the opinions of the women interviewed that have driven this chapter and thesis. They saw her as a vital and essential part of birth in the home. The opposing viewpoint came from the staff and doctors in the hospital. The dai role at a home birth was clearly articulated by the women interviewed, with little blurring of her role and that of the other important persons present, the women relatives. It was with the women relatives that the power of the decision making lay yet the staff at the hospital held the dai responsible for the outcome based upon these

decisions. Despite the recognition of the importance of the dai, there was a distinct reluctance to consider the job of dai as a decent working option for women. The low status of her work far outweighed the necessity of her role or any monetary benefit. The debate between the dai as essential and the dai as dangerous will continue, with the latter lasting or being heard because it is the educated that articulate this position. These opposing views on the dai are examples of the dialectical debate that follows in Chapter 9. The next chapter explores some of the eight sub-themes that emerged from the rich data.

8 CHAPTER: SUBTHEMES

8.1 Introduction to the sub-themes

This section of the thesis charts important contextual issues that arose from the women's stories. These issues are classified as sub-themes, the first sub-theme is gender preference, exploring how this influenced women's lives. The second issue covers the omnipresent medical model and how it articulates with women's knowledge. The third sub-theme explores the birth systems that influenced the women when they gave birth in Pakistan. There follows an important facet from within the women's stories; that of how their lives are affected by blood. This links to the next sub-theme, which had a much broader impact on women's lives, that of maintaining family honour and the link to marriage. Moving on through the life of the women interviewed in R..., the woman told how their lives were influenced by 'coming to the UK. This was felt important enough to include as a sub theme as it influences their memories of birth back in their homeland. The last two sub themes bring us into the present to explore how modernisation has influenced women's lives. Especially saved to be the last is the sub theme that threads its way though the other sub-themes; that of how birth can make women strong.

Although it is never going to be possible to formulate a complete picture of what life and birth is like for women in Pakistan, the following chapter serves to provide depth and colour to the major theme from within the data; that of the dai and her influence on birth in Pakistan.

8.2 SUB-THEME Boy Popularity[84]

Preference for boy children emerged as a theme from the women's stories within this a generation difference was evident; the younger generation felt that '*their elders wanted sons so they could be looked after in their old age*'. This linked the boy preference to the social and cultural norms within the extended family. In Pakistan the pattern of marriage is exogamous and the post-marital residence is typically patrilocal. The norm is for the sons to bring their wives to live in their mother's home. The practice of marrying into an extended kin household of strangers physically and psychologically isolates the woman from her natal kin. The source of power for the new bride is the ability to produce children, especially sons (Dyson and Moore 1983). Discourse on the corollary to this, is the daughter being on loan and the concept that '*bringing up a girl is likened to watering another's garden*' (Aziz 1990) serving to exacerbate the social popularity of boy children and casting a shadow on the life and role of Muslim girls. Living in this shadow and with the relative literary silence around women's lives, has meant that text has concentrated upon the injustice of boy preference (Prahbhjot M and Jerath J, 1997), to the exclusion of exploring the value role and life of girl and/or woman. Nevertheless, the debate on Islam and women reveals a discourse that is characterised by opposition, contradiction and negation. Jamal al L-lail (1996:99) states that:

> *"Islam perhaps more that any other religion has developed a well integrated view of women in terms of sexuality and their proper place in society"*

whilst Rafiqul-Haqq and Newton (1998 :5) say:

> *"...woman was made to bear and feed children. Therefore she is emotional and she is forgetful, because if she did not forget how is it is to give birth she would not have another child. That is why she is not as reliable a witness as a man"*

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[84] The issue of gender preference is widely used in anti Islamic text and as such there is an abundance of literature and propaganda on the Internet which speaks loudly of the inequality of the sexes and the deficiency of women (Rafiqul-Haqq and Newton 1998).

The perspective depends upon the interpreter of the Qur'an (Ibn Kathir Qu'ran 4.34, cited in Haqq and Newton 1998:1)

"Men are superior to women and man is better than woman"

Reflecting back, it is easy to recognise the negative perspective taken in the past (Chesney 1994 b). From this starting point a new non-partisan position was aimed for by exploring both the positive and negative discourse on gender preference.

Abedin (1996) traces the Islamic theoretical perspective of the gender divide in her paper to the Fourth World Conference for Women. Stating that there has been an uninterrupted history of discrimination against women in all societies and acknowledging the vigorous reaction in some societies through feminism. Malhi and Jerath (1997) argue that there is little empirical evidence on sex preference from India, which is a country where preference for sons has often been sited as an important factor sustaining high fertility. Most of the available evidence is based upon anecdotal information or the results of small sample surveys. However, the Indian National Family Health Survey 1992-3 had a sample of 89,777 married women from 16 states, which offered the opportunity to analyse, gender preference. The findings were framed around the use of family planning by sex composition of living children. The acceptance of contraception was found to be higher amongst women who had one or more living son.

8.2.1 The birth of a son -actualisation

Much is at stake in birthing a male child, not only for the mother who can consolidate her position in the family, but also the father who in the absence of male descendants runs the risk of extinction of the family, putting the families social position in jeopardy. Generation differences of opinion on gender preferences exemplified the dynamic position held by the Pakistani women interviewed. These came to the fore during interviews with up to three generations of women, discussing topics that are not usually shared across generations.

I have known Shan (Chapter 6) for over a decade and she presented as a demure, quietly spoken, humble submissive person, always taking others' opinion above her own. That is until she gave birth to her son, when immediately her persona changed. Her new role as the mother of a son (she already had two daughters) heralded a confidence that showed in a total transformation of her character and subsequent worthiness. Overnight Shan became confident, strong and powerful. The resonance in her voice changed from being breathy and hesitant to being strong and confident. No longer did she tone down her opinions with 'perhaps', or 'may', or 'probably' what Coates (1987) describes as *'epistemic modality'* which are linguistic forms used to indicate the person's confidence.

Shan had now met the requirements of a 'good wife' - to give her husband and his family a son. She now had status in the community and society and very importantly *'protection for life'*. Her son will take over the responsibility for earning and 'keeping' his family, as the other men in Shan's life had done previously. Despite Shan being the only working person (earning as a midwife) in her extended family, the 'keeping' was more in a society protection sense than a financial sense. Without a son, Shan's husband may have chosen to divorce her and marry another woman to beget a son. Her daughter would marry into another family and Shan would be left without security for her old age, albeit, in the true Islamic sense men should treat both wives equally.

Polygamy has been permitted in Islam 'as a solution to social problems' (Salahi 1993), the example given of such a problem being when a woman has a chronic illness which makes her unable to satisfy her husband's needs. Rather than divorce her, her husband is allowed to have a second wife. Shab was a second wife; the problem was of a familial genetic origin between Vez and his first cousin first wife. Fari had to be reminded by her friend of the possibilities if she agreed to be sterilised.

> *"My mother never said she was pleased my daughter was healthy...my mother-in-law say you must have another (baby). When I came here (UK), we had another girl and my husband said, 'these are our boys, so we don't want to have any more. He said have an operation...I did not know what to say, I told my friend and she said why can't he do that (be sterilised) ... if he had operation ...so in case he needed more children he can't blame you. I wasn't very clever enough to tell this until she gave this idea. He kept saying to me have an operation.... He asked me to go to the doctor to arrange*

...the doctor would not do his (husband) operation (sterilisation) just in case my death then he needed more (male) children..." (Fari)

Multiple layers of oppression are deeply embedded in the culture that finds a woman less valued than a man. Men must have their needs satisfied, even though his wife may be chronically ill. The older generation uphold the belief that it is the woman's responsibility for the birth of a son and the consequences for the wife (second marriage) if this does not happen. The woman's strength and power of not being sterilised is tinged with the consequences of the remaining option, continue to get pregnant until a son is born.

If the way to confidence and power for a woman is through the birth of a son, what happens to women who have daughters or are unable to conceive? (Chapter 6 Fari, Naz, Ami) However, generations change. Bas's daughter tempered the radical view with a half way perspective:

"There are fewer babies these days and providing there is one of each, the girl is valued" (Bas).

However, Naz was clear about the situation for her:

"With each girl mother-in-law treated me worse"

Ami's daughter Riz said,

"She (mother Ami) had a lot of grief when I was born (a second girl)...the second time a girl is a disaster...they used to dress me as a boy, cut my hair and my nickname was Popu, which is given to boy"

Actualisation on the birth of a son moves the woman onto the important role of mother and mother-in law, and could be described as birth metamorphism. The final rite of passage that takes the woman from birth as a mere girl to pre-marriage and being devalued and of no consequence even considered a potential burden. Through to the exquisite and vitally important role of mother, especially of sons, is achieved through the support of other women in the extended family and community. So, as the society oppresses women, it also venerates them for being able to conceive and bear sons.

Many of the stories the women told surround the rituals that were undertaken during life's passage to actualisation (or not). Fari did not give birth to a son and, although a

teacher in the UK, felt that she was too tired to take up her love of reading and study. Naz's life had been blighted in her latter years by perinatal morbidity, although she did eventually give birth to a son and so her mother-in-law stopped treating her badly. However, there was no love lost between Naz and her fundamentalist husband (Chapter 6. Naz), who brought her unwillingly to Britain, leaving behind her four daughters and a mother who died before she saw her again. After her first traumatic birth experience in Pakistan, Ria lived her life through supporting other women in the community. Shab, as a widow and second wife, knew she had been selected as a second wife to bear a son, who was then to be given to her husband's first wife. She did this willingly, thankful that her second husband had rescued her from the non-person role of widowhood.

Siaq was in her early twenties and sat in on the interview with Bas, her mother. The aim was to help her mother with English. Siaq's strong opinion demonstrated the generation difference and ontological change with just one generation's difference

> *"How do I feel (about boys being more popular than girls), it is silly, because the attitude of my generation has changed a lot. I think the older generation are thinking about their old age and how boys will look after them"* (Siaq, Bas' daughter)

This statement included how Siaq felt she would have behaved when she herself eventually would go to live with her mother-in-law.

> *"My attitude will have to change, (when I live with in-laws) I will have to obey orders, I would expect to work around them, not expect them to work around me. I think it is nice to live with your in laws initially, so that you can get to know them a little better and then decide when to start your own family". (*Siaq Bas' daughter)"

This latter statement held multiple meanings. Siaq was admitting that her attitude with her mother/parents would have to change to be acceptable for her in-laws. This suggested that daughters and daughter-in laws were treated differently, that the daughter-in-law would be expected to be more respectful of her in-laws. Despite this, Siaq was accepting and looking forward to living with her in-laws (initially), identifying the importance of the extended family when starting a family. This is suggestive of the supporting role that the in-laws may play with grandchildren and reflects the lack of support her mother, Bas, received when she came to Britain compared to when she gave birth in Pakistan (Bas)

Siaq's reference to attitude change, both of herself with other elder family members and of her generation and her parents' generation, provides some insight into the dynamic social and cultural influences on gender preference and modernisation which is explored later.

There were three generations present during Naz's interview. This provided the opportunity to get an intergenerational perspective on boy preference. Other connected issues raised were, fertility and the responsibility of conception on women only, the total unacceptability of, '*no children by choice*' and the cruelty of the mother-in-law with the birth of girls only. Naz's first five born children were girls and as stated her mother-in-law treated her worse with each girl that was born.

This burden on women of giving birth to yet another girl is that she will undoubtedly have to become pregnant again and this will be repeated until a son is born. Bal the interpreter had to 'keep going' until after four girls she had a son, then she could start using contraception and building up her strength. In hospital in Pakistan (P.c.2000), we helped a woman give birth to her fourth girl and the atmosphere was as one would expect at a funeral and she begged us not to save the child (who was sickly). Neither the mother-in-law nor the mother would hold the baby. Both awaited the father of the baby saying, "*I will clothe the baby*" before they would take hold of the baby. Staff at the hospital were adamant that no mother had ever abandoned a baby girl at the hospital, but leaving a sickly child to die was a potential reality.

Naz relates the pressure to conceive and the anxiety this creates for the Muslim wife

> *"The pressure from the family... they always say it is the woman's problem, after a few years he will bring a new wife saying 'she' cannot have a baby...I know somebody that has been in and out of hospital, her husband is dominant and macho.... He was eventually persuaded by his mother, (to go for tests) who had blamed the daughter-in-law for all the years and they actually find it was him..."*
> (Chapter 6 Fauz. Naz's daughter-in-law)

The suggestion that some married couples may choose not to have children was considered preposterous. However, this was for current and past generations.

> "...*Big joke...no definitely not...maybe for a couple of years...not for ever, maybe the next generation...they are not going to sterilise themselves without having kids...I cannot imagine...*" (Fauz Naz's daughter in law)

Surprisingly it was Naz, who is a generation older than Fauz that presented the alternative view, conceding that the future may be different.

> "...*But people want choice, don't they really...if they want to have a child there should be choice...*" (Chapter 6. Naz)

Naz's generation did not get any choice; the pressure to conceive soon after marriage was enormous.

Sai, Naz's granddaughter, rounded up the topic of 'fertility with no choice' with total resignation, introducing the dialectic of passivity and acceptance with that of specialness and uniqueness. These appear to be 'givens' in the life of girls and women, who are socialised from a very early age to become a hostess, wife and mother. There is clear delineation the roles of men and women in Pakistan society. Women displayed pride in 'keeping house' and a 'good table'.[85] This was confirmed during visits to families where girls from the age of five served guests with food. Women pride themselves in the smooth running and cleanliness of the home and delight in cooking for guests and family. The greatest pride and achievement appeared to be in the number of healthy chubby babies and children. The women's life was the home and family. Third generation Pakistani girls were born and educated in the UK, a group that Sai, Naz's granddaughter belonged to. Sai saw clearly the specialness of the woman's capacity to conceive and birth in the context of a social void. However, apart from feeling restricted socially, not being allowed out socially as her cousin of the same age, there was no resentment in the following statement:

> "*Nothing else to do really, we have the special mechanism...* (Chapter 6 Naz)

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85 A further parallel with my own childhood, it was the family's joke that mum would spend her whole holiday gazing in a butchers shop window. She also ate last, taking the left overs and eating only the fat from the bacon, because that was all that was left.

Ina the midwife simply stated that if a woman only had girls, the husband would divorce her and then she would have to return to the family and her brothers would look after her. Ina's daughter explained that her father did not leave her because of daughters or because she was a midwife, but because he had met someone else.

> *"My father did not leave her because of us, (daughters) or being a midwife, he went to college to study complementary therapies to work together (with Ina) he met someone else and married her..."* (Ina's daughter Chapter 6)

Ina however, expressed her concern about her own daughter having four girls.

> *"I have two girls, she (daughter) has four, when she got two girls the family were anxious to have the boy...but we called the second girl Rani (Queen)"* (Ina Chapter 6)

Dil proved again to be different; she gave birth to three boys, trying the third time for a girl.

> *"I prefer one girl, I would like a girl, this is the reason I try for the third time. I prayed for a girl, but we did not have a girl...I thought I might have a girl, of course you know now I can't work properly in the house, all the mess, I can't pick up all the time. If I clear this table, go the other side, clean the other side, when I come back it is mess again. If it was a girl she would help me you know...The other thing is 'cause I have survived a lot of things, what I have I don't want my daughter-in-law to suffer the same thing..."* (Dil Chapter 6)

The rationale for Dil wanting a girl appeared initially to be to help with the housework. Diamant (1997) in her text on the lives of women pre-Biblical times identifies the importance of daughters easing the burden of the mother and the endless task of looking after the boys. However, a very strong theme through this book is the importance of daughters in keeping memories alive, passing down family folklore orally through generations (Norris 1998).

Family influence on the way girls were received appeared to depend upon the gender mix of the husband's family, although some contradiction was evident. Farn's husband has seven sisters.

"It is not in our family to prefer boys to girls, my dad got seven sisters and two brothers and I got five daughters, my mother and dad look after very much, they do food and everything all the time. Sister-in-law very good they look after, you know our families, you know sometimes... they like this boys..." (Chapter 6 Farn*).*

The mention of the girls in the family getting food '*do food and everything*' is suggestive that others may not be given food. Food is the symbol of caring and the supply of food to the family is the man's responsibility, as the family and the home are the woman's.

Although gender preference was not always evident in the women's words the wider social implications of giving birth to a second girl becomes evident in Fari's story (Chapter 6). Fari's friend warned her that her husband's request for Fari to be sterilised might precipitate him taking another wife or divorcing her because they only had girls. The GP (a man) would not support Fari's husband being sterilised because he may want more children if Fari died.

So many facets within Fari's story reflect the context and givens of the lives of Muslim women in Pakistan. The disappointment that Fari felt when her mother in-law did not express pleasure on the birth of her granddaughter is remembered thirty years after the event. The birth of a second daughter evoked Fari's husband response '*they were their sons*'; denying the very gender to which Fari and her children belong and suggesting their daughters were not on a level with sons.

Further to this, Fari's husband's request for her to be sterilised and her friend's suspicion of Fari's husband's motives, introduced a lack of trust into the husband/wife relationship and as Fari stated a sense of naivety. The suspicion around motive appeared to be gender divided, as the male doctor refused to sterilise Fari's husband (at the suggestion of Fari), due to the possibility that he may need to remarry if Fari died. This accentuates the importance for the man of having children and introduces the idea that some men may choose divorce, or take a second wife, if the first gives birth to daughters only.

It would have been interesting to know how many women the doctor had referred for sterilisation and not considered the possibility of them being widowed and wanting to get remarried. Remarriage for a widow is unusual. Fari's father died when she was young

and the question about her mother's remarriage was met with an astonished '*no way*'. Re-marriage was an option for Shab, saved at a cost.

Shab was a widow with a young daughter, living back in her natal home with no status and '*destined for a life of drudgery as a servant to the family*' when Vez heard about her from a family friend. Vez and his first wife Hus had two children both with a genetic syndrome affecting mental development and together they made the decision that Vez should take a second wife, who would conceive a 'normal' child which would be given to the first wife. Shab was chosen and her health and potential fertility screened. As a widow, Shab saw this option as being rescued from a life with no position. When asked how she felt about giving her child away, her answer was that she would do anything to make her husband happy. Vez could not understand my question about being 'unfaithful' to his first wife whom he adored. However, Vez's first wife clearly did not like it when Vez showed affection towards Shab.

A further example of re-marriage after widowhood arose when we were staying with a GP friend in Pakistan. Their gateman (chokador), a widower, offered to marry a woman who had been put out to fend for herself after her husband died of a fever. Her five children were kept by her sas. However, the gateman would only agree to the marriage if the woman would 'give him', conceive a child. The woman came to us to ask if the operation she had after her fifth child was a hysterectomy or a sterilisation; she had heard that a sterilisation could be reversed and was hoping he would pay. Marrying the chokador was her only alternative as she was illiterate and could not work outside the home.

Riz, the student midwife, was present during the interview to help her mother with the spoken English. She told a graphic the story of how she, as the second girl, was treated as a boy by her father.

> *"She had a lot of grief when I was born as the second girl. They tried to keep their emotions to themselves, but on the whole what Pakistani's do if they have a daughter, they think, Oh it would have been nice to have a boy, the second daughter is a disaster, because she (Ami) had trouble conceiving they (family) were grateful. She says, 'we were all liked and looked after', having said that, I*

> *remember my granddad used to dress me as a boy. He had my hair cut like boys do, he also called me Popu, which is usually given to boys, I was treated as boy, so they did not make it obvious, but they wanted a boy...*" (Ami)

Anyone else may say that it was fairly obvious that the family wanted a boy when Riz was born, however there is no obvious resentment, bitterness or cry of unfairness underpinning either Riz's story or the stories of the other women. Even the treatment of Naz by her mother-in-law was a statement of fact not emotion, ie how Naz felt about it. The acceptance of different gender value communicated a whole family need to have a son or boy in the family. The disappointment of the family at yet another girl linked also to the health of the woman, which is compromised by recurrent pregnancies (Malhi Jerath 1997). Mothers appeared to be more concerned about the number of mouths to feed than their own health. It would please a woman more to fill her husband and children's belly than her own. As stated. I recognise this as a norm for my own mother's generation, the first half of the twentieth century in the UK. The women's stories appear to accept and not resent what Islam dictates is their 'proper place in society', their vital role in and for the family gives women complete satisfaction. Yet western feminists would see this as typical of an oppressed group.

Ironically the oppressor, seen to be man in Islam, may also be oppressed. Men have also been victims of violence, inter-ethnic, inter-tribal and internationals. They equally suffer the consequences of poverty and economic deprivation, ill health and malnutrition. It is a well known general observation in health research that women have more illnesses but live longer than men (Rosenberg and Wilson 2000).

Education was an issue also for Farn; she had a very quick mind and an amazing memory for dates. However, because she was a girl, her education had to be curtailed when her mother became too ill too care for the other children in the family.

> *"I didn't go to secondary school you know, when I was twelve. I was going to primary school, then my father bring for me a book and everything. Then my mother very ill then my first brother (I am the eldest) then she nearly dies and there is nobody to look after my brothers and sisters. My mother said 'sorry you cannot go to school I need you to help me then I help others' and look after my brothers and*

sisters'...hard working, cooking and cleaning...I like it..." (Chapter 6. Farn).

Farn was not aggrieved that she had to give up her education to take on the mother role and responsibilities. She was proud that her father acknowledged her scholarliness by purchasing a book for her. Housework and caring for siblings are the commonest reasons for a girl to discontinue education in rural Pakistan (Scott 1989 and P.c Lee). By the time the eldest girl is ten her mother will have been pregnant six to eight times, will have become chronically anaemic and suffered recurrent infections. With her mother's health seriously compromised, there will be no option but for the eldest daughter to continue what her mother was unable to do. This starts the cycle of ill health before childbearing worsens it further, then her daughter will take over and the cycle goes on.

8.2.2 Summary

The women's stories were shot through with the segregation of men and women and the importance of men in an Islamic society. It would appear that from birth the value of women hangs on the birth order and gender of siblings. Once there is a son in the family, then a daughter is welcomed and valued. The woman's special role in fertility and childbirth is so strong it is not underpinned by choice; there is the view that '*this is what women are designed for*'. Although Islamic culture places pressure on married couples to bear a son it gives the man the option though taking a second wife to achieve this. Within the women's words there was no sense of shame in a woman not having a son, there was the sense that life would change for the better as the mother of a son.

8.3 SUB-THEME Omnipresent medical model

The relationship dais have with the family is not one of power, but as a servant. Ironically, Cronk (2000) advocates that the most empowering relationship a midwife can have with a family is one of professional servant. The assumption of 'power over' takes away the feelings of responsibility, on which good parenting depends. Cronk (2000) recommends midwives should give professional advice and not orders. The dai offers her opinion but, as already mentioned in chapter 7, her recommendation may not be acted upon.

8.3.1 Critique of intuitive practice

Davis (1996) explored 'inner knowing' and what constitutes a primary source of knowledge for women who give birth in the home. She explored the midwives' use of intuition as a guide to action and decision-making, as Shab did when she knew her 'time' had come to go into labour. It is particularly difficult to define intuition. Collins (1994) states *"it is knowledge or belief that is obtained by neither reason nor perception."* Shab may have perceived a change in her body, which in its purest form could not be defined as intuition; she was using perception to listen to her body. Women in the UK are not encouraged to 'listen' to their bodies, because someone else can do it 'better', more objectively. It is especially difficult to record intuitive, spiritual, connected prepositional knowledge in a system that does not have a vocabulary of appropriate terms, using instead, rational, reasoned technocratic knowledge and terminology as the standard, within a culture that values the scientific as superior.

However, Paul and Heaslip (1995:20) critique intuitive nursing practice by reviewing its relationship to expertise:

> *"When performed automatically without care, vigilance and criticism, intuitive practice can result in prejudice and patterns of practice which are misinformed"*

This quotation could clearly be applied to any nursing or midwifery practice. Any act that is performed routinely, without care or thought, results in misinformation. A more substantial argument to uphold the value of intuitive practice is that of Bastick (1982) who isolated a number of positive characteristics of intuition. These include confidence in the process, the sense of certainty of the truth of insight and the suddenness and immediacy of awareness of knowing. The association of fact with insight, the non-analytic (non-rational non-logical) and gestalt nature of the experience, the empathic aspects of intuition, the preverbal and frequently ineffable nature of knowledge. Some of these characteristics would be outside the definition of intuition. There may be a reason or a inner feeling that cannot be verbalised, either because there are no words, or what words there are do not convey the appropriate meaning, or if the words when recorded or spoken would be ridiculed and not valued by the audience.

The unreliability of words to convey meaning is identified by Oakley (2000:5) using a Herbert Spencer quotation: -.

> *"Every word carries with it a cluster of associations, often inappropriate to the particular case in which the word is being used, distort more or less the image it calls us"* (Spencer 1904: 300)

However words, whether written or spoken, with all incumbent inadequacies constitute the main media for communication to carry knowledge to the next generation. The written being especially important in this 'visual' age.

There are other issues around the lack or misuse of words, which may inhibit a practitioner acting upon intuition. One may be that past intuitive feelings and action may be found to be spurious (as if medical knowledge is always correct). The use of intuition has the potential to leave practitioners who are steeped in medical hegemony, by virtue of their institutionalised training and employment, to value only the measurable, scientific and tangible facts; to ignore or lose confidence in the messages of the body, the intuitive, bodily inner knowledge. It would appear that there is a positive in the strongly negative issues around the lack of education for Pakistani women and as long as the dais and women in Pakistan remain 'uneducated ' in a western sense, they will not lose their confidence in their strong intuitive knowledge.

8.3.2 Dual ignorance and hierarchy of value

The egalitarian collective use of women's intuitive, holistic, connected body of knowledge wisdom and skills passed on orally through generations of women, is valued by women when giving birth in the home in Pakistan. The belief that hospital is a place to go to as a last resort, or to die originates from indigenous knowledge based on past experience, or on fear of the unknown. This perspective is at one end of the continuum of ignorance as the other end is occupied by the lack of understanding and belief that there are benefits to the non-interventionist care a woman receives when birthing at home. Such dual ignorance combined with a 'moral requiredness' that each believe their position to be right results in stalemate and a lack of development, that is evident in Pakistan today.

For those women for whom choice is an option (can afford it), it would appear that they are opting for the western valued medical model. Three out of seven of the women interviewed in Pakistan could afford to pay for a hospital birth,[86] (Aia, Shu, Mrs A,) and did. As opposed to all ten of the women interviewed in the UK who could afford to pay for a hospital, yet all delivered in their homes. However, there is a time difference; the women interviewed in the UK had their babies between 1950 and 1970. The woman interviewed in Pakistan had all given birth in the 1990's.

8.3.3 Blame the dai and intuitive knowledge

Some educated women (Dr Q and Naz's daughter) believe that dais practice and home birth are for the 'ignorant and poor'. Blame is apportioned to the dais for outcomes that directly arise from the general poor health of women (pre-term small babies, anaemia, and haemorrhage, intra-uterine death) and not home birth or dai management. Such

[86] This is a value judgement based upon the estimated income and status of the family.

blaming of the dais serves to heighten the division between the birth practice in the home and hospital.

The woman giving birth at home in Pakistan, cared for by women relatives and the dai, is not monitored or measured in the same way as in the UK. Records are not made, thus the care is not scrutinised using a standard designed from a diametrically opposite paradigm. This does not mean that it is free of criticism. Dr Q and the staff at the hospital repeatedly make sweeping judgements, blaming the dai's for the poor condition of women referred to them (Chapter 7). The phrase 'dai-handled' has become synonymous with poor practice. Blaming the dai for the condition of the women raises the question as to how much knowledge the doctor has about the real issues that affect women's health, such as poverty and starvation. This is recognisable as *'scape-goating'* defined by (Collins 1994) as 'a person/s made to blame for others'. This phrase originated in the Old Testament of the Bible, where a goat was used in the ritual of Yom Kippur at the Day of Atonement (Leviticus 16). The goat was symbolically laden with the sins of the Israelis and sent into the wilderness to be destroyed.

Policy makers (Scott 1989:103) advocate a western model of care, *'because it is simply the only model available'* yet this further drives indigenous birth practice underground. Chawla (2000) and Kamal 2000 (Pc) have recognised that the use of consultants who advocate 'foreign' practice when they are unfamiliar with national traditional patterns, cultural values and religious beliefs..

A way needs to be found to value intuitive inner knowledge, retain confidence to the benefit of women, offer birth at home to women who are healthy, fit and well and direct the sick to a place which will make them well. This applies to all nursing and midwifery practice worldwide.

The western midwife's practice is monitored (and controlled) through Statute, Supervision and Management vis a vis Regulation (UKCC 1998), through Codes of Practice and Standards for Record Keeping. However, changes are occurring. Like Wilkins (2000) I have noted a wind of change in that British midwives are beginning to redefine the role, policy and practice of the midwife and are developing an awareness of

the importance of intuitive practice, recognising times when they cannot justify actions taken in logical rational terms. Some UK midwives place value upon connection, in the context of holistic model of birth and health care and this leads them to listen to their 'inner voice', rather than operate according to protocols alone. This can create a dissonance between what their heads tell them, evidence-based rational knowledge and what their hearts feel, inner knowledge, *'this is not right for this woman, in this situation'*. Current medical hegemony mutes the midwife's 'inner voice' (which may not have appropriate words). The culture and higher status of the authoritative evidence silences the inner voice.

8.3.4 Communicating practice

In the omnipresent medical model the 'fear' of not knowing (in words) can influence relationships with women and students. Some midwives feel like they ought to know the evidence-based answers to the students' questions, by virtue of seniority and experience, yet do not, at times through no fault of their own. The outcome of this scenario is a break in communication and as a consequence the student loses confidence in the midwife. What the student needs to learn from the midwife is what thought processes the midwife goes through to make her clinical decision (often difficult to articulate), not necessarily what evidence. The student and the midwife can jointly seek out the 'hard' evidence. This particular complicated dynamic does not exist in the home in Pakistan. However, the key relationship between the mother-in-law and the dai may be just as complicated (Chapter 6 Dil).

It is evident that the women interviewed in R... believed firmly in the intuitive knowledge of the dai, their mothers/in-law and themselves. This correlates with midwifery practice in the UK in the 1950's (Smith, 1997, Murphy Black, 1995) whereby thirty per cent of women gave birth in the home cared for by a district midwife. From personal experience, the district midwife resented the shift of authoritative knowledge to the medical profession that underpinned the UK Peel Report (HMSO 1970).

The UK Peel Report (HMSO 1970) advocated that all pregnant women had a right to a hospital bed, recommending also that one hundred per cent of births should take place in hospital. The report's findings were based upon spurious evidence which was built up using statistics that were skewed because of high risk women, giving birth to pre-term babies before the midwife could attend or the woman could get to hospital (Tew, 1985). Midwives in the UK in the 1970s did not question the evidence, even though most of them had an inner knowledge that home birth for low risk women kept them low risk. However, the midwives had no knowledge of how to get their voices heard in a system that utilises academic argument based upon statistics to make decisions. It took a statistician (Tew 1985) and an anthropologist (Kitzinger 1989; Kitzinger 2000) to put the evidence into the academic arena of the relative safety of home birth for low risk women.

The position of the Pakistani women interviewed overlapped with gender norms in culture and exposed parallels with history and across other cultures. Each woman's individual birth experience contrasted and blended in the telling. The omnipresent western medical knowledge was evident at one end of the continuum and humanistic, intuitive knowledge at the other end. Dichotomous thinking is not always helpful and although it should be accepted that one knowledge is not entirely untouched by the other, the bipolar positions are easier to visualise in Pakistan than in the UK. The boundary around the practice of the dai has high conceptual walls, made up of the strong differentiation between the 'educated' and high status of the doctor, the low social status of the dai and the fact that medicalisation has not yet reached the villages. The economic restriction on the latter has been the lack of any organised health system in the country.

At a time when the medicalised domination of birth is being questioned in the UK (Edwards 2001), there is the concomitant changing values from medical to women centred knowledge. It is paradoxical that 'educated' women in Pakistan and other developing countries are seeing the western technocratic paradigm as a model of good practice. It is argued that the medical system is a contributory factor towards a decline of maternal, perinatal and neonatal death rate in the UK. Dr Q. used this argument (Chapter 6). A counter argument could be that it is women's nutrition and health along with improved environmental and public health infrastructure that has improved and

influenced the decline in the mortality rates in developed countries and not the medically driven midwifery care or technology.

Collectively, the defining edge that offers strength and support of women for women includes empathy, connection and an emotional bond. The distancing and objectivity that medical hegemony upholds as 'professional' behaviour militates against any bonding. Medical ideology does not speak the same language, have the same meaning, and provide the same assistance that women say they received from other women from their own social group. Women in Pakistan make decisions together. At the birth of Ria's son, Ria's aunt and dai took the decision to take over from the doctors, who had 'given up':

> *"My aunt and the old lady dai got worked up and they pushed them (doctors) out of the way, you have had your mind, you said you cannot save the child...the child is gone anyway...what harm can come...?"* (Ria Chapter 6)

There are discrete boundaries around birth ideology. Ria could afford to have a doctor come to her house; the doctors used their 'higher level' knowledge, which was considered superior to that of dai care, however, was ineffective out of the hospital environment. It was only after the doctors' were given the first chance to expedite delivery and failed, that the dai and relative' practice was given a chance. Ria's aunt and the dai were very careful to adhere to the values and norms of the family and society (because they were the same as their own) by seeking the permission of the men in the household before 'trying' to help Ria give birth.

> *"We asked our father's permission (to expedite birth)...my father said she is wife now, so my husband's direction was sought to save my life..."* Ria

The demarcation between normal and abnormal is complex (grey swampy lowland of practice (Benner 1988). In the hospital in S... Pakistan in 1989, most of the women were given the same treatment. All (by virtue of their poverty) already had health problems, as well as being pregnant or in labour. Estimating whether the woman's labour was 'normal' when the fetus was thirty-two weeks size, when the norm was for very small babies, has a parallel with the western induced 'normal' labour. Normal and usual have become confused in both Pakistan and the UK.

An intra-uterine death is not in the swampy low land, it is clearly abnormal, but is quite usual at the maternity hospital in S.... The doctor diagnoses and treats, thus it is the doctor who determines the cause and frequently apportions blame to the dai (Dr Q Chapter 6). Some of the women who came to the hospital in S... with an intrauterine death told of being given injections back in the village. The women were not able to say what drug they had been given, sometimes by the dai but mostly by the dispenser. The inappropriate use, dosage and route of administration of Oxytocin is discussed by Head (1990) Kitzinger (1989) Jeffery and Jeffery (1988) Jordan (1993) and Chesney (1994 a). Oxytocin is commonly known in developing countries as the 'woman's drug'.

The dai told me that women ask them for an injection *'to make the womb strong or make the baby come'*. Some dais have been taught by other dai to give it (Chapter 6 Naz), some do not give it (Chapter 6 dai). Ironically the potency of the drug is attenuated by high temperature and refrigerators are not widely available. However, the potency for its appropriate use (for haemorrhage) is also affected by it improper storage.

It appears to be a recent phenomenon that healthy women from wealthy Pakistani families partake of private hospital services, believing in the superiority that the dominance suggests. In the past (1950-70) there were women (Ria, Ami, Bas, Dil, and Naz) who gave birth at home, with the care of relatives and the dai, even though they could afford the medical intervention. This is suggestive that the dominant medical ideology has taken over the traditional holistic care and practice provided by the dai and female relatives, as evidenced by Shu, Mrs A, Dr Q, who gave birth 20 years later.

In order to achieve dominance there has to be something to dominate - domination is usually achieved by discrediting the alternative. The educated doctors and the staff at the maternity hospital consistently denigrate the dai and her practice. As stated, they blame the dai for the poor condition of the women. Women today (2002) who are from the wealthier families would not normally contemplate a home birth (either in the UK or Pakistan), as this care is provided by the lowly (to doctors) 'untrained, ignorant midwife or dai'. This has the potential to create dissonance within families as the mothers and grandmothers tell stories of their birth experiences of birth at home attended by female relatives and the dai (Naz). Recently (2002) a woman was telling me her daughter had

two elective caesareans. The mother said that she had her four children in hospital in the 1960' and 1970's, yet her mother had given birth to ten healthy children at home attended by the dai; the woman asked, what it was that had made women's bodies weaker.

One of the major strength factors is the woman's nutritional state, which if compromised in younger life further deteriorates with each pregnancy. Survival through childbirth is also dependent upon the knowledge of the women attending - knowing when to refer to hospital and what to do in an emergency. But, as discussed, this is not as straightforward as women in the rural areas are stranded by their poverty. Even if the dai can deal with an emergency and recognise the necessity for medical intervention and the mother-in-law agrees, the cost of getting the woman to hospital may be out of reach. Quality life and or death for women in childbirth is thus out of the woman's control, this sits well with the health belief model that another (Allah) holds life's destiny in his hands. This may be better than blaming each other; no link is being made to another possible culprit, the political systems and respective government.

8.3.5 Victim blaming

Medical dominance across most cultures attaches blame for any deviation to the individual, this is known as 'victim blaming'. A story that demonstrates this concept came from an educated Pakistan woman (solicitor) who had given birth only eight weeks previous (2001) in a medically dominated private hospital in the UK. It is a story that will be familiar to many women and midwives: -

As she was overdue by ten days Nadia (not her real name) was happy to take up the suggestion of her consultant for labour to be induced. The pain of induction was shocking, so she gladly accepted the offer of an epidural, this counteracted the contractions so a stimulant of exogenous intra-venous drugs was 'needed'. Twenty-four hours later, without sleep for two nights, an attempt was made to deliver the baby by ventous (suction) because the mother was too tired to push. This failed, due to the lack of skill of the doctor, so forceps were applied in order to deliver the baby. Seven weeks later Nadia still could not sit down without pain in her perineum. She had to give up

breast feeding as her baby cried all the time, especially when Nadia held him. Nadia has left her husband and returned to her mother, she is on the verge of a breakdown.

The story held a different meaning for me, when talking through her birth Nadia felt that she had failed utterly, even though she had a beautiful child. She was "*too soft*", (pain) "*too tired,*" (no sleep) and *"not big enough*" (needed instruments). and "cannot *even heal myself*".

Nadia clearly blamed herself, she had **failed** to go into labour spontaneously, and her contractions were **inadequate**, yet she **could not bear** the pain and **could not bear** the child, and furthermore she **could not feed** him. Nadia's birth experience had stripped her of any vestige of confidence. She was determined 'never to go through that again' so if needs be would have an elective caesarean. The moral of this story is to avoid induction, however when I mentioned home birth to Nadia she was horrified and I saw the look in her eye, which said 'you must be mad'. There is a body of knowledge that recognises the harmful effects of unnecessary induction, however, the reluctance to share this with the general public means that women are still requesting induction for social reasons.

Nadia was eager to comply with the authority of the medical advice. Compliance is a term that suggests authority. It is often used in the medical hegemony and its meaning relates to conforming to the medical professional prescription or treatment. This is an effective way to ensure personal or individual responsibility is undermined. The responsibility for assessing the effectiveness of the treatment within the medical hegemony is the professionals' and not the person in receipt of the treatment. However, the factors that affect the compliance and effect of the treatment are personal and linked to culture and belief systems. Confidence in the person who prescribes/recommends the treatment is of paramount importance. The drug and or treatment is less likely to be effective if the person in receipt does not trust, respect or believe in the person prescribing, recommending or administering it (drug and/or treatment).

The emotional/psychological involvement of the person in their symptoms and how they may change their social position in the family is also paramount, for example if they get more attention when ill, will influence the response to treatment. Prior expectations of the

treatment may also influence efficacy, as will past experience or contact with other users that have responded positively or negatively.

Compliance may be an effective oppression mechanism for a number of reasons. The current value system of medicine with the women interviewed appeared to be hierarchical. Advice was better than nothing, a pill better than advice, and an injection better than a pill and an operation better than an injection. This may of course be because the advice is not culturally acceptable, understood, valued or applicable in the first instance. However, the responsibility for response to treatment is still personal. I do not have evidence to support a parallel blame culture in Pakistan that is as endemic in the UK. This may be due to the belief system that upholds Allah as the benefactor (or punisher). Unlike the UK and USA, whereby if a birth experience is less than perfect, midwife, doctor or more usually the hospital is held responsible and must be to blame and pay. There is no litigation against midwives in Pakistan, simply because as yet there is no medical insurance or professional indemnity cover from employees. The pay is not enough to support the premium.

As with any society norms there are the exceptions, people who take out personal retribution; this is exemplified in the story of the anaemic woman being transfused the wrong blood type (Chapter 7).

8.3.6 The authority position

Women's lives are complex, textured, and multi-layered with responsibilities to Islam, society, others and self, in that order. In Pakistan the boundaries around birth between male and female are expansive and impeachable.

The majority of women in Pakistan live in the rural areas where over eighty per cent (UNICEF 1989) of the births takes place unattended by any 'trained' personnel. The authorities, UNICEF, government, politicians, wealthy upper and middles classes do not accept or value the years of hands-on apprenticeship practice wisdom that the dai uses in the care of women. Yet it is this relationship that undoubtedly contributes to women being strong and confident following childbirth. The valuable empirical, pragmatic,

experiential, intuitive knowledge of the dai and female relatives saves many lives (Ria Chapter 6) and provides social structure (Steinberg 1996). However, this knowledge when juxtaposed with the western dominant abstract medical knowledge carries no authority, on the contrary, as mentioned, the dai is blamed for birth tragedies (Jeffery, Jeffery and Lyon 1988), that are a direct result of the women's poor health and poverty. In the villages, the women call the dai when they go into labour (Chapter 7), whether this is because women recognise the benefits of such action or because yet there is no choice can only be speculated. The worrying prospect is, whilst one would wish women to have the resources to have such choice, such choice will mean that women may walk the road of post-modernity, with the apparent loss of the woman power and confidence that currently childbirth in the villages in Pakistan heralds.

Practice wisdom is still in evidence in the rural villages in Pakistan. The emphasis in current midwifery practice in the UK is on evidenced-based practice and theoretical knowledge. Attributes such as honesty and belonging to a 'respectable profession' and working within codes to provide consistency are held above practice skill; midwives are paid to behave in a 'professional manner' at all times, provide empathy and respect or otherwise the professional status can be removed. To get too close has the potential to lose objectivity and with it goes professional. There are still some midwives who believe that a relative or close friend should not help a woman give birth, yet how objectivity improves practice has not been documented. There are however many stories in the literature that stress the importance of knowing to the women (Edwards 2001; Pairman 1998; Cronk 2000; Flint and Poulangeris 1987, Wilkins 2000).

The picture painted is of two extremes and reality dictates that these are but the parameters within which the dai and midwives working within the medical model operate. Each is somewhere on a continuum between the extreme. There are dais whose practice may do harm to women and there are doctors who provide women centred intuitive care. There is however only one perspective that is authoritative.

8.3.7 Western for illness and traditional for health

In a study of birth systems in Tamil Nadu India (Steinberg 1996), the women's ability to interact with each other and their freedom to be employed outside the domestics spheres gave them a greater command over their lives in terms of their physical movement. They had a strong faith in western medicine for the treatment of illness, however in striking contrast they stay with the traditional methods for childbirth. This was achieved through resilience and a network of friends, neighbours and relatives; they had limited involvement on antenatal programmes, dai undertake ninety-four per cent of the births. The reluctance of Indian women to have a hospital birth lay not just with the costs but in the fear of an unfamiliar and hostile environment, Steinberg (1996) also remembered the practice for compulsive sterilisation in the 1970's and did not trust the hospital service. Another fear a hospital birth brought was that the baby born to them, especially a boy, would be exchanged for a 'worse' one, generally a female from a more influential mother.

Professionals and/or educated women in Pakistan would never be seen to uphold women's intuitive knowledge as superior or even on the same level as the 'educated' medical model (Dr Q Chapter 6). There was, however, some evidence of the acceptance of the place of both types of knowledge, when women were aware of both (Shu Chapter 6). Medical knowledge maintains its primacy and dominance. Western society gives authoritative status only to the higher level inductive and deductive reasoning. The devaluation of non-authoritative knowledge as defined by the 'educated' is achieved by hierarchical systems that support formal education.

Bourdieu (2000:8) a French anthropologist states:

> *"Formal schooling succeeds in obtaining from the dominated classes a recognition of legitimate knowledge and know how, entailing the devaluation of the knowledge and know how they effectively command (craft and folk lore)"*

When I challenged the dominant formal 'education' knowledge (in the field of childbirth) and upheld the women's intuitive 'know how', I was seen as backward, ignorant, naïve (Dr Q Chapter 6).

Davis Floyd and Sargent (1997) give an account of the historical transformation of authoritative knowledge in America. They point out that well into the twentieth century, medical care was provided by multi-stranded, pluralistic medical systems within which the knowledge held by the barber surgeons, homeopaths, folk healers, midwives and other empirically based practitioners was considered authoritative by different parts of the population. This is covertly evident in Pakistan (Shu Chapter 6) where the women in the villages exclusively call the dai for the birth. However, as stated, they are not yet in a position of choice as the alternative is denied them through their poverty.

Women in the west have been socialised to expect 'professionalism' from the midwifery service. The midwives (middle class, authoritative, self-appointed leaders) chose in 1902 to lobby for registration and regulation that took midwifery down a pathway to medical hegemony. Control and domination by the medical profession through the regulation could be described as the start of the decline in the art of midwifery and women-centred care (Cowell and Wainwright 1981). Such care was based upon embodied knowledge gained from oral tradition and experience, intuition and a holistic approach that could be described as practice wisdom.

Professionalistation may be considered a hospital phenomenon, (especially in Pakistan). It does not link to the dai or birth in the home. Medicalisation when it happens, for those with problems that can afford it, overrides women's knowledge; women are treated objectively (by other women), judged to be hard working, tough, ignorant, unfeeling - no womanly connection. The dominant obstetric ideology, which is evident in the hospital, is of professionals who are received knowers who respond to each other and to women in ways typical of those oppressed: they oppress others.

Further analysis around the theme of the paradox of the womanpower within patriarchy leads one to consider the belief systems of men and women. In Pakistan, as in many other cultures, men's belief systems are grounded in rational thought and women in emotional liability. However, there are exceptions (Chapter 6 Shab and Dr Q).

Women in the main maintain spiritual, emotional and bodily integrity; also there is a unity, with no sense of the individual only the collective. Strong power networks that are

gender specific perpetuate matriarchal power wielded as the mother of a son. A woman will control her son's family, their coming and going, often with ultimate say on the division of the finances; power exerted within the family home, but extends outside. For example, a surveyor colleague who had been educated in the UK would seek his (illiterate) mother's permission to undertake a business trip and it was her decision that allowed his wife to accompany him or not. Such was the power of the mother of a son. However, the segregated gender roles within the family may mean that the female and male members of the family live virtual separate lives outside the bedroom. They may meet when the women serve the men's food; men will eat first, then the children and lastly the women. Although there is a strong culture of unity, within each family gender group there is a strict hierarchy, with the eldest son's wife being next in authority to her mother-in-law.

However, it should be remembered that the son's wife, as her husband's cousin, may also be her mother-in law's niece, and have been brought up in the extended family, living with her husband as a brother or cousin. Life long enculturation and strong enforcement of social norms makes the family a very strong supportive or oppressive group.

8.3.8 Social underpinning to medical model

Throughout the research, the social context of the women's lives was embedded in a unitary, Islamic, phallocentric, dominant, patriarchal culture. (One way of thinking/living/doing that is dominant by men and male supremacy). However, the women appeared to know how to manage this effectively (Fari and Dil Chapter 6) and through women networks they shared strategies to overcome the gender or mother-in-law oppression (Naz Chapter 6). The rules of Islam and society are gender biased; whatever the female does, it is in relation to the man. Patriarchy is overtly evident in all public and social life, but still hierarchical. Family life is strongly matriarchal, woman centred with women groupings that achieved through collective connecting. Often contriving to get what they want, not unlike midwives in the West who contrived to do good by stealth (Kirkham 1987) in the medical hegemony of the hospital birth. However, most of the

women, except Dil, Shad and Fari, did not see a need for societal recognition of knowledge. Each, for different reasons, did not want to work outside the home. Ami's daughter saw her ideal life as being cared for (financially) by her husband. Women devote all their energy to the family and children. Running a home and providing a 'good table', and caring for children were seen as the most important role of the wife and mother (Shab, Farn, Bas Chapter 6). These were also strong values upheld in my mother's generation 1940-1970's, UK. Focus on children (especially boys) and marriage for the girls (thinking and planning ongoing from birth); the position of women in the family is hierarchical. Without family, women do not exist and may be destitute.

8.3.9 Summary

The sub-theme omnipresent medical model began by recognising the relationship of servant that the dai has in the family in contrast to the power relationship between the UK medical system and the 'patients in the NHS. Moving on to the lack of definitive terms for intuitive bodily knowledge which makes traditional models of learning (through the written word) more difficult. Dai practice relies upon oral and empirical transfer of knowledge (without the written word) which is given little value in the presence of the more expensive composed medical model. As a consequence the monitoring and regulatory systems for effectively are different. In the UK they are national and formal and in Pakistan they are personal (word of mouth , reputation) and local. UK interest is being shown in the traditional intuitive models as the dominance of the medical is being questioned. The lack of personal and the demand for compliance in the medical model is becoming unpopular in the UK but at its peak in Pakistan. Tamil Nadu's resolution brings the benefits of both systems together even within a hierarchical patriarchal Islamic society.

8.4 SUB-THEME- Birth systems

The birth systems that both perpetuate the oppression of women, and take them on the journey through the important rite of passage to self efficacy as a wife and mother, and maybe actualisation as the mother of a son; are explored through the words of the women as they apply to current theory.

Campbell Roland and Buetow (2000) suggest there are two principal dimensions of quality of care, access and effectiveness. Effectiveness is then further sub-divided into two components, effectiveness of clinical or personal. The measure of quality of care is a concept that is most meaningful to individuals what may suit one, may not be acceptable to another. Access to care provided by the dai in the villages is dependent upon the family social network, status and whether they can afford to pay, although the dai may only require payment in kind. Access to organised health facilities for most women in the villages is denied; women can only make the long uncomfortable journey to the hospital if the family agree it is necessary and can amass enough money for the transport and to pay for the service.

There are free beds and care in the Red Crescent Hospital, however, registration, drugs, and all treatments are charged for. For those women who can afford the alternatives, there is a totally unregulated private sector that flourishes and the district general hospital that maintains that charges are means tested, but one cannot get beyond the chokador (gateman) without beginning the long line of palms to grease. Midwifery practice in both the private and the public institutes mirrors that of the 1950's in the UK, except for some of the medication and the tests available. Also excepting any form of 'tender loving care' which is not part of the role of the professional. The responsibility of the relative is to administer all care and provide bed cover, food, drugs and dressings. A female relative (and often a few children) will stay with the woman throughout her stay in the hospital. They will camp out in the hospital grounds cooking over an open fire, or buying food from the bazaar.

The women interviewed cannot be taken as a representative of women in Pakistan, any more than twenty women selected conveniently in the UK would be. The average village

woman in Pakistan does not have access to antenatal care, as undertaken in the UK, which is that of a systematic monitoring of women' physical health in pregnancy. Thus the monitoring function of the western dominant medical model does not get the opportunity to alter the course of the pregnancy or improve women's health, for the better or worse. In Edward's (2001) study of home birth in Scotland, the women considered monitoring as surveillance and described a loss of the ability to gauge their own health. Unlike Farn (Chapter 6), who reported that she attended the doctor only once for advice antenatally but made the decision herself not to return, even though this was requested by the doctor.

> *"She (doctor) told me that womb open little bit, every night you should sit like this (kneeling all fours) for few minutes.* (Farn)

None of the women interviewed, either in Pakistan or R..., were plunged into the medical ideology (or any subsequent benefits) underpinning antenatal care. Although Dr A's wife attended a medical colleague for checks, the ownership of the normality was clearly her own:

> *"I go to there (Dr S...s) every month to check myself"* (Mrs A Chapter 6)

If there were no problems detected by the woman or a close female relative, she did not attend a doctor, thus the normality of her pregnancy and birth was confirmed by women's knowledge of her self and the belief in pregnancy and birth as a normal event.

The norm for health and the issues around availability of medicalised care form the context antenatal care provision in developing countries. Poverty denies choice, thus even when in dire need of medicine and/or treatment, it is not affordable or accessible (Awan, 1996, 1989, Chapter 3).

Issues on women's health and seeking treatment too late are bound up in the general health, position and agency of women in society, enmeshed as they are in the societies' strong religious and cultural norms. Acquisition of agency through core social roles, such as work, the family, marital and civic roles, are essential pre-requisites for successful personal regulation in strengthening a sense of self esteem, self efficacy and belonging (self integration). Siegrist (2000) argues that the loss of core roles brings a threat to the continuity and confinement to non-reciprocal exchange, which impairs personal

regulation and triggers 'social reward deficiency'. Examples of this are evident in the women's stories (Ami, Dai, Shab and Fari) when women who do not give birth to a son are widowed or divorced. The women's duty is to look after the house and the children; men should look after the external affairs of the family (Salahi 1993:143).

There is no concept of the midwife or dai being a buffer between the medical model and women. Women, except some women doctors are positioned together and men, medicine, technology, doctors and hospitals are positioned together, the latter carrying the status and position of working with and from societies' sanctioned knowledge. The former uses women wisdom, working behind closed doors, in ignorance as defined by patriarchy, and out of view and thus control of medical dominance; that is until problems occur. When referrals are made and the cost of transport is met, treatment of all women in hospital is totally devoid of any psychological or emotional support, understanding or respect. This results in the objective management of women (personal observations) and sweeping judgements made on the work of the dai.

As stated in Chapter 3, it is ironic that at a time in the UK when some women are rejecting the dominant medicalised childbirth culture; women in Pakistan, who can afford hospital and doctor care, would choose it and consider it to be superior (Dr Q Chapter 6). Paradoxically Reid (1993) and Nelson (1993) identify that women from the lower socio-economic classes in the UK tend not to oppose medical intervention. The women in Pakistan who receive the non-medicalised care are the lower socio-economic groups in the villages. Some of the women interviewed gave birth in hospital in Pakistan (Aia, Shu, Mrs A, Shab, Chapter 6). They had given birth in Pakistan more recently. Machin and Scamell (1997) explored how women become vulnerable when they moved over a boundary of a domain (from non-medicalised to medicalised or vice versa). As normality is interrupted, the norms, rules and values of every day life become suspended; the power of the setting (hospital) takes on a new dimension. When birth takes place at home the setting supports normality (Fari Chapter 6). The women interviewed in R... who had given birth over a decade previous in Pakistan, upheld the ideological belief that home was the appropriate place to give birth (Dil, Ria, Naz. and Bas Chapter 6).

A common strand throughout the thesis has been birth venue; this is covered in some depth (Chapter 8). Home birth in Pakistan is real, yet ignored, visible yet invisible and very much denigrated by the educated wealthy. It is my belief that if the women were well nourished and the dai given simple instruction, birth would be safer at home than in the hospital where birth systems and practice are influenced by the medical model. Home birth and dai practice is not (as yet) contaminated by hospital practice (Dai Chapter 6). However, very recent changes are to be seen whereby a village empowerment project seconded a woman from a village to 'train' with the doctor at the hospital, as a dai. My fears are for the transfer of hospital practice into the home, trespassing over the previous boundary of domain, covered in the previous paragraph (Machin and Scamell 1997).

Home birth in Pakistan does not challenge medical ideology, it does not have a standardised written body of knowledge, is not regulated or monitored by any controlling body in the name of protecting the public (Dr Q). The dai and the women who are present at the birth do not have the same conflicting agendas with the women that western midwives have. They work with their *'in the head'* knowledge, learnt at their mother's knee, through an apprenticeship type training passed on orally. The authority is with the woman, not scientific knowledge (Ina Chapter 6). There is no institution in the care, no protocols, rulebooks, codes of ethic and significantly no medically dominating ideology. It is so easy to write what dai and relative care is not and more difficult to articulate what it is. Because, as stated, the words have not gone before, there are no published articles to uphold, refute, critique or quote:

Home birth in Pakistan is simply women wanting to do the best for women, not through *'text book kindness'* (Edwards 2001) but by knowing each other to include what matters. This could be life's pleasures and tragedies, personality, likes, dislikes, fears, anxieties, nuances of relationships, family history and knowledge of what has gone before in the woman's life. This is at the opposite end of the continuum of knowing, to western stranger care and discontinuity. Knowing of the process, systems physical even psychological and social, cannot compensate this lack of woman knowing that can be built up over ten antenatal visits (the best of continuity offered in the UK). Two decades ago community midwives knew the women in a particular geographical patch. She had

been at the birth of whole family's even generations of families. Her care included many of the benefits of 'knowing' yet these were sacrificed at the altar of medical knowledge when she was brought into hospital for 'updating' and another midwife undertook her clinics and labour calls (home births).

The 'knowing' of the woman in labour can lead to many positive elements in the care, whether relatives or professionals provide it. If the woman and birth attendant share the same beliefs, choice is less of an issue, it becomes more a question of knowledge sharing, the weighing up of diverse concerns to arrive at the best course of action through action, through dialogue or consensus based on trust. Edwards (2001) reports a positive aura of silence in the relationships whereby words are unnecessary, a stillness that provides a space to allow the woman's body to birth uninhibited by extraneous events, noise/words or interference. This is absent in the UK, replaced by a stranger in a strange room, albeit with a notice on the door.

However, knowing may have to deal with two realities; the first concerns possible romanticising and idealising traditional birth systems (Jordan, 1993, Davis Floyd 1996). When a woman's health is poor and poor growth or disease affects her physical development, the risks involved in home or indeed any birth are considerable. Thus labour and birth needs to take place in a place that provides the facilities for speedy instrumental or operational intervention. The second reality surrounds the concept of continuity of care; it cannot be satisfactory for a woman to receive continuity of care from a midwife, dai or relative that is unkind to her.

I did not 'like' the midwife who cared for me in labour. However, I was afraid of offending her and I did not have confidence in myself or the system to be able to speak of my dislike, or tell her not to do the things to me that I did not like. The power she had over me was absolute, I saw her as representing a system that I was not big or strong enough to buck. However, there was trust in the context of this fear. I trusted because others had been through the system and survived. I judged that if I behaved and was compliant then I would be rewarded with a live healthy baby. Somehow I felt that my compliance would control whether my baby would be healthy. I would be responsible when things went wrong, but the staff and hospital would take the credit for the healthy

baby. This was very scary and served to shatter any confidence I needed to care for the young baby. Yet later I am aware that it was in defence of my young that I became strong and confident. I sought out and dealt the bully, the teacher who did not treat all equally, the dinner lady who force fed. I could do for my children what I could not do for myself, speak up.

Traditional birth systems can be harsh, judgmental or subjective. Care may be based upon poor practice (Davis-Floyd 2000, Jeffery Jeffery and Lyon 1988), such as stretching the woman's vulva with a high fetal head, telling the woman to push throughout labour, pushing on the fundus, being unkind and denying women support or analgesia. Mostly, however, the women had someone to speak for her. The women interviewed in R... referred to the dai in positive terms, for example her kindness, and multiple women referred to the dai as a family member. Edwards (2001) used the term 'engaging' rather than just doing a job. Engaging may be one of the fundamental differences that enable women in Pakistan to overcome an oppressive society and emerge strong. Normal birth in Pakistan does not take place in an institution but in the home, where there are people that are known and trusted. Even though sincere attempts have been made to make some institutions in the UK more homely, (Price, 1995, Cronk, 2000 Flint and Poulengeris 1987). If the midwife does not 'engage' with her role, or the woman does not engage with the place for birth, she will not engage or trust the person who practices there. Institutions as a place of safety do not have a proven track record in history, even with the technology. They can be an 'unsafe' place for birth. From the 1960's onwards, when transfusions and some drugs were seen to save lives, institutions and their personnel owned the drugs, thus owning by proxy the person receiving them. This owning met needs of the institution and those working there, not the person visiting and for whom the institution was established. One of the major needs or demands of the institution involved time.

8.4.1 Women's time versus institutional time

Frankenberg (1992) refers to women's time versus institutional time. In the west, women pass from their daily domesticity of pregnancy and their own social time to being hospitalised with the beginnings of labour and a transition to institutional time. The individual woman loses her body time and becomes totally submerged in institutional time, Frankenberg (1992) maintains the logic of the many in the institution prevails over the logic of the individual. The woman in Pakistan does not place any technology time estimations i.e. scan estimates of EDC on the event of birth "*the pains come*" (Bas Chapter 6) In answer to my question, how does the mother know when the baby is due? The reply was tinged with indignation and disbelief that I was a supposed educated woman and did not know the obvious answer. The woman giving birth at home in Pakistan stays with her own body time. The bodily signs connect with the progress of pregnancy; labour and birth are muted by the authoritative knowledge of technology. No longer does the quickening (first fetal movement) hold the same marker for gestation that it used to do. This is because the ultrasound scan is taken to be more accurate. The 'lightening' produced by the fetal head engaging in the mother's pelvis at thirty-six weeks (with the first baby), no longer heralds the time of birth nearing. Without the technology the woman and birth attendant listen to the woman's body. There is a place for technology; the problem lies in its assumed superiority to all other information sources and its widespread use for all.

Shab knew her time had come, even though she was *'touched by technology'* she had been socialised back home in Pakistan to 'listen' to the body signs and they signalled time. Murphy-Lawless (1998) confirm that in the west "*time is the medium through which women's bodies are controlled*", particularly in pregnancy. Gestational length and labour stages are two critical examples. When pregnancy and birth is medicalised, midwives become machine minders, reading the signs on the monitor, estimating chemical reactions through microscopes and probes. The woman's sounds and behaviour are ignored. The woman's sense of her body is relegated or considered no longer important. The same time controls do not operate in the villages in Pakistan, gestation is calculated

according to the lunar month, time of day according to the sun and moon and the stages of labour according to the woman's behaviour (Fari Chapter 6).

8.4.2 East and west time

Time may have very little meaning in a culture that believes that God sets the agenda. In Pakistan the saying when arrangements are being made is, 'in shala', meaning, 'with God's blessing'. However, this statement has come to mean 'only if God wants it to happen' and is used to frame the 'maybe' with arrangements. There is a subtle different between God's blessing for all that may happen and God being responsible for it happening or not. Both are within the belief systems of Pakistani women so need to be understood by western carers.

When time is out of the control of the individual (Allah is in control), it ceases to have the same meaning. No shame or loss of credibility occurs if appointments are not kept, as God has willed the 'other' to happen. The story I tell that links this concept with the strong cultural norm to value visitors relates to the woman just about to leave her house to attend her antenatal appointment. As she gets to the door, visitors arrive. The visitors take priority and the woman will take her coat off and provide hospitality to her visitors by feeding and entertaining them. This has implications for a hospital time controlled system. The woman fully intended to keep the appointment; she was not missing it purposely. Her priority lay with the social norm of community reputation based upon hospitality and God's will. A further example of the responsibility for hospitality, even in the hospital, arose when Vez and Shab received a neighbour as a visitor just prior to the birth of their son. Neither of them could ask her to leave even though she was interfering in the birth process (my opinion).

Time was also found to be an important theme in Pairman's study (2000) into the relationship between midwife and woman in New Zealand. However, this was in the sense that a relationship takes time to develop and for trust to build, not in the sense of opening out time, placing no other call on time between the woman and the dai/midwife. The professional, employed midwife in the UK has, even in the 'ideal' situation, one-to-

one midwife/woman ratio on a labour ward (RCOG and RCM 1999), many potential time limitations that may come between the labouring woman and the midwife. Shift changes meetings and other responsibilities of being employed, as well as family life, childcare, running the home can all detract from the 'giving of all'. In a society that has a clear priority - the birthing woman, where other women give support, time may not have the same limitations.

The dai may also have multiple calls on her time, elderly relatives, grandchildren, housework; however, in an extended family set up, these responsibilities are more easily shared. Geographical distance or death of in-laws and supportive relatives can create extra pressure upon a family. It is usual for the men to travel away to work. Most of the women interviewed in R... told of their husbands working away from home. It was more unusual for the women to be away from home, although Mrs A lived with relatives whilst she studied medicine. For the menfolk to travel to seek work was seen to be an economic necessity, whilst the extended family supported those left at home. For women who had neither a supportive extended family nor a husband, the need to earn was vital, as there is no infrastructure of social or economic support in Pakistan. The paid work available and acceptable for the uneducated woman appeared to be limited to cleaning or becoming a dai.

New generations of women are confronting multi-level, multi-generational knowledge acquisition, moving towards a more questioning less accepting culture. However, this can precipitate intergenerational friction. An example of such conflict and clashing of generations was evident in Taz's story. Taz's granddaughter Sam had breached an important religious and cultural norm (in her mother's opinion); however her daughter Sam had been educated in the values and norms of a different generation. All three concepts of time within the same historical moment and the individual differences in a collectivist society can result in a micro intergenerational anarchy.

According to Kristeva (1982) a French philosopher, female subjectivity appears to be linked to cyclical time (repetition) and monumental time (eternal). Both offer ways of conceptualising time from the perspective of motherhood and reproduction; cyclical from the menarche and through biological rhythm, menstruation to menopause and the

monumental changes these bring. Further time differences could be linear, for example over history. The birth experiences for the women interviewed spanned three decades in history, from the 1950's to the 1990s. Three generations of women were involved in some interviews (Naz, Ina the midwife, Taz and Aia). Kristeva's (1982) explicit aim was to emphasise the multiplicity of female expressions and preoccupations so as not to homogenise 'women'. She stresses the word generation and distinguished between two generations using feminism as the example. The first generation of feminists focused upon egalitarian principles, the second emphasises the difference of women from men (a counter ideology which may be considered an inverted form of sexism). Applying Kristeva's theory to time (linear) and the feminist ideology as it pertains to the three generations of women involved in the interviews, takes the findings to a theoretical perspective that can be applied to the women in the study

The new generation of western women is indeed confronting the dimension of multi-level, multi-generational knowledge and technology with the inevitable friction. Given choice with information some women may choose quality time for motherhood, if the option is available. Home birth is rapidly receding as an option due to lack of expertise and low numbers of midwives available, whereas in Pakistan, choice is not an option for rural women. Although Shad exercised a choice not to become a dai, if her choice is representative, it leaves women without the expertise of the dai to attend a woman in labour. Relatives will be practising unadvised without the expertise gained from attending many births. This is the time for Pakistan to review its policy around the birth attendant. Kamal (2000:2) is known as 'the senior most midwife of Pakistan' with a stated aim of promoting midwifery education. She would like to model on Sweden's practice:

> *"Two hundred and fifty years ago Sweden was the first country to provide professionally competent midwives. Evidence exists that countries that have utilised competent midwives to provide maternal health services have brought down the death rates much more than those who did not. ..."* She recommends *" reducing the categories of midwife to two (auxiliary midwife and trained midwife) and better preparation of midwife teachers and establishing Midwifery Boards*

responsible for preparing competent midwives and regulating practice "[87]

Starhawk (1990) found erasure of spirituality to be the bedrock of patriarchal oppression and the cornerstone of the structure of domination. Such oppression and domination through and by women on women is evident in the hospital in Pakistan. The dehumanisation of women was carried out even in the presence of us as observers, with the covering statement "*we know the women, you do not*". In this instance such 'knowing' was a paradox of judgement, cruelty, control and oppression. Green, Coupland and Kitzinger (1998) found that women wanted to avoid being controlled but this did not mean they wanted to take control themselves and did not want control to be exerted over them. Campbell and Macfarlane (1994) confirm when birth takes place at home the woman is in control.

When birth takes place in the home in Pakistan all those in the room are known to each other and share the same beliefs. Close female relatives are able to respond to the woman's needs, needs that do not need verbalisation. The woman's desires are known the connection is spiritual, there is engagement and trust. It is not surprising that the latter experience empowers and the former (hospital birth) disables. It follows then that if most of the births take place in the home in the villages, the women become strong through childbirth, they have achieved against incredible odds. They may be physically ill through poor nutrition and recurrent childbirth; birth releases the spirit of womanhood, the birth of the mother happens through her own birthing experience, becomingness.

I made a connection between my own ideology as a UK midwife to the dai practice and beliefs of valuing, knowing, working with intuitive knowledge, based upon years of experience. However like other employed midwives in the UK, all my working life has been spent in a medically dominated care system. I am aware that I can be strong in my spoken and written word supporting intuitive, woman centred non-medically dominated practice. In Pakistan my practice upholds this ideology. Why then do I fall down, weaken and crumple in the face of the oppression created by the medical majority and its

[87] The time may be right for such a clear thinker to lead the way, the problem is linear time is running out for Imtiaz, she is 79 years young.

superiority when I am back working in Britain. Is it that I am over-awed by the heady theoretical terminology, facts and evidence and the use of complex statistical measurement? Do the theoretical concepts, judged as the gold standard in research, make me feel second best, or an impostor? With over twenty-five years of socialisation it is difficult to shake off the reverence to the medical. My hope is that the students and newly qualified midwives who have not had the same prolonged socialisation will not be mesmerised as I and many of my colleagues have been. I can hear the students reply "*you could not do it (challenge and change the medical dominance), now you expect us to*". They are right but changing values, thinking and the written word alone does not happen overnight and changing practice takes longer. I hope I am not wrong in feeling and seeing a change away from medicalisation towards women, led as it always has been in history by the women (and not the midwives), however a critical mass of midwives must believe enough to move with the women and not against them. During adversity, collective thinking (knowing others' feel the same way) creates stronger, more resilient and confident women to care for families and midwives to attend women practitioners.

8.4.3 Summary

The sub-theme birth systems opened out many of the issues that surrounded birth in Pakistan for the women interviewed; the venue for birth, the trusted knowing attendants, and the relative lack of surveillance that provided a space in which women grew strong. The previous themes focused upon some of the macro influences the women spoke of. The next two sub-themes centre on two micro influences the women found important enough to tell of in their birth stories. The first is the effect blood has upon the life of women, the second relates to sharm and honour.

8.5 SUB-THEME, Behaviour and blood

Childbirth occupies a central position of symbolism in religion and religious beliefs have proved a powerful influence upon the cultural development within humankind (Norris 1998). The woman is often portrayed as the miracle worker in a supernatural sense, the giver of life, sustenance, warmth and caring. The man on the other hand, has been portrayed as the soothsayer, the strong protector, the giver of life and fundamentally the interpreter and the scholar who passes on the wisdom to the next generation. These are simplistic generalisations that effectively cover the work and strength of women, largely because the work of women is unpaid. Such generalisation perpetuates the myth of male supremacy.

Mernissi (1991:32) believes that male supremacy is the manifest message of human history. Islam is known as the bedrock of Pakistani culture, it is based upon the word of Allah and the text as written in the Qur'an. The words and interpretations of the prophet Mohammed are written as Hadiths (words of the prophet) and set the standard for life for all Muslims. There are however many interpretations of the original Arabic text. One of the interpretations links to equal rights of women Sura (1990: 228) of the Qur'an.

> *"Women have rights similar to those (of men) over them in kindness and men are a degree above them".*

Equal rights would appear to be subsumed by the acceptance that men are a degree above women. Mernissi (1985) states that she is tempted to interpret the first part of the sentence as a simply stylistic device to bring out the hierarchical content of the second.

Further debate raises the question why women are considered a degree below men when clearly in the biological sense women possess uniqueness bound up in menstruation and childbirth. Samuel Johnson was asked by a woman to define the difference between men and women. "I can't conceive, madam" he replied. "Can you?" (Mernissi 1985). This statement equalises uniqueness, the process of reproduction is not one-sided, and the antecedent condition is the fusion of ovum and sperm.

Male supremacy over women is also apparent in the Old Testament:

> *"And the rib which the Lord has taken from man, made he a woman, and brought her unto the man"* (Genesis 2:22*).*

The creation of Eve as a subordinate to Adam and God's curse to Eve *"thy desire shall be to thy husband and he shall rule over thee"* Gen3: 16) point to discrepancies between men and women. The idea of a person fashioned out of a rib has an element of the ridiculous and is transparent in its bias. However, Norris (1998:20) believes it is the translation of the story from Hebrew that places Eve as subservient. An alternative translation would have Eve as a *'companion corresponding'*, in other words a person with the same status as Adam. Any interpretation brings with it the values of the time. The way we see and the language we translate could be judged as equivalent to the cultural lens with which the world is viewed. Specific to the moment, past experience is influenced by the individual and not generalisible.

Islamic menstrual laws focus upon the responsibility of the woman to protect men from the pollution of menstrual blood. Norris (1998:69) portrays how:

> *"It is the woman's duty to maintain menstrual rules for her husband's sake, rather than to preserve her own purity"*

Her statement would seem to confirm male dominance. Yet other bodily emissions, for example ejaculate are covered in the ancient (Second Century AD) purity laws. However, while the menstruating woman may be considered unclean, her body acts as the receptacle for man's emission when she is not menstruating; this has the potential to make her doubly soiled. The subsequent effect on women of being labelled 'soiled' may contribute to feelings of shame. Altered behaviour norms at the time of menstruation extenuate what may otherwise be a hidden occurrence. Social constraints placed upon a menstruating woman involve separating siblings who have, prior to puberty and onset of menstruation, been part of a warm, supportive network of friends and relatives. Banning menstruating women from the preparation of food and segregation from the family during consumption of food may be seen as a mixed blessing - either a relief from the work of preparation, or the joy of social food sharing. The controlling effect of the Islamic menstrual laws on the household is pervasive, even in some 'modern' households (Naz).

Notwithstanding Islamic menstrual laws the concept of female pollution is a strong belief in wider society (Shildrick 1997:35). A comparison of women's leaky bodies with men's self contained controllable torso relates back to the 14th century. The post-modernist humoral theorists believed women were excessively cold and moist and thus weaker than the hot-blooded 'perfect' man. Sexual intercourse itself is polluting (Jeffery, Jeffery and Lyon 1988:29); man can cleanse himself by washing whereas a woman is internally defiled after intercourse. Katbamna (2000:131) found many contradictions within the issue of pollution, located as it is within male dominated practices. Ironically it would seem that men have a fear of the pollution menstruation denotes:

> *"...It will kill the garden (if you, a menstruating woman) go near..."*
> (Petchesky and Judd 1998:286).

Many fundamentalist Muslim men believe that women are impure and that if they touch even the palm of a woman not legally bound to them, they will suffer red-hot embers applied to their own palms on judgement day. It was reported that the prophet Mohammed refused to touch any woman who did not belong to him and many hadiths (interpretations of Mohammed's word) around this action exist. Sasson (1999:59) states:

> *"A praying man may interrupt his prayers if one of three things should pass in front of him, a black dog, an ass, or a woman "*. A further saying from a Muslim man is *"I would rather be splashed by a pig than to brush against the elbow of an unknown woman"*

However, fear of becoming polluted by the unclean is not just gender based. Brooks (1995:105) relates the ancient Muslim fear of Jews in Iran:

> *'It is so strong that once long ago before the Islamic revolution, the government passed a law requiring Jews to stay indoors during rain or snow showers, lest water that had touched their bodies flow into streams that Muslims might use to wash before prayers'.*

It may be argued that some women collude with the subjugation of menstruating women, perpetuating certain beliefs to safeguard their own status and influence within the family. Menstruation has been referred to as *'the curse'* and when a woman is bad tempered the statement *'don't lose your rag'* may be used. However, women have been known to manipulate the knowledge of men's fear of menstrual blood to their benefit. Petcheski and Judd (1998: 311) describe how some women feigned menstrual periods to avoid

unwanted sex. Thompson (1981) confirms that many pollution rules are interwoven with strategies to avoid sexual relations with husbands or to allow women to recuperate after childbirth. They are also used to facilitate 'privileges' of food and enhance status within the family. It could be argued that for women to use knowledge in this way is a demonstration of underlying inequality in the first instance.

The link with food is not peculiar to Pakistan. Research undertaken by Standing (1980) in South Wales unearthed beliefs around the poisoning quality of menstrual blood. Women who were told not to touch red meat because it would 'go off', or to make bread dough because 'it *would not rise'* (Currer and Stacy 1986:204) confirmed the superstitious belief of people in a working class street that meat handled by menstruous women would go bad.

Different cultures have taken a variety of attitudes towards menstruation. A common feature across western cultures appears to be women's discomfiture. Women are not overtly ashamed but are socialised to hide the monthly occurrence.

> *"Women are consumed with embarrassment during 'their time'; they will go to great lengths to conceal the activity especially from men, but also from other women. So much that they are attracted by products that will hide the 'offending act', thinner, more absorbent, deodorised disposable products"* yet we say *"menstruating is not shameful, no more than eating or sweating, sneezing or urinating. It is a normal process that happens to all women"* (Wingfoot 1999:1).

The blood from a traumatic event does not induce embarrassment however, in a world and time of knowledge that blood is a contagion of deadly disease; traumatic blood evokes a major fear element. Yet menstrual blood brings with it an added 'excreta reaction'. Grosz (1994) paints a graphic and depressing picture of the ways that menstrual markers of young women's puberty are enmeshed in significant stains, loss of control and leakage, drawing her back into the dependency and inadequacy of infancy, rather than pushing her forward into self-contained adulthood. My own daughter's plea at her menarche was –

> *"'People will be able to tell',* my reply was not *'so what? '* but *'can you tell when your friends are menstruating?'*

However, the latter part of Wingfoot's quotation does not apply to traditional women in Pakistan. Menstruation is a common and much wanted and revered event the very first time, as it signals fertility and the onset of womanhood. However, as a recurrent event in Pakistan it is not common, married women without contraception are likely to get pregnant as soon as ovulation recommences after childbirth, thus may only menstruate once or twice in their reproductive life.

The notorious and controversial suggestion that women should taste their own menstrual blood to show it is not dirty was one proposal cited by Brook (1999:53). A further suggestion to fit the consumerist society involved the proposal that puberty should be celebrated by society - this concept may spawn an industry, paralleling the current western 'wedding industry'.

Standing (1980) made the observation that landmark rites of passage have been medicalised into extinction, to the extent that they have lost both social and symbolic significance. Blumenkrantz and Gavazzi (1993) more recently linked the absence of initiation rituals in contemporary society to teenage antisocial behaviour such as alcohol and drug abuse. A solution based upon this hypothesis, in one state in the USA, has been to introduce into the curriculum *Rite of Passage Experiences* (ROPE) to transmit and preserve belief, attitudes and skills central to individual growth and functioning. This is run as a longitudinal randomised control study of four hundred and ten students over a five-year period and has resulted in significantly higher levels of family involvement and lower delinquent activity (Standing 1980).

The demise of rite preparation ceremonies in the West came with clinical reductionism and there may be certain parallel's drawn between western medicalisation and ritualisation in other cultures. Both appear to have the same purpose - to categorise with a view to control. They appear to have the same aims - to protect the unborn child in order to control the unknown and provide an explanation if things go wrong. The medical model reduces people so they are controllable, a necessity from a medical professional's point of view. In this way it ignores the social experience and any implications thereof. Within some cultures the social experience of menstruation is ritualised and symbolic, where fertility and creation are celebrated on the one hand but treated as dangerous and

polluting on the other. Body waste is considered defiling, not simply in a hygienic sense but in a sacred sense (Standing 1980). For this reason a cluster of taboos are often found around the menstruating and post-parturient woman.

Of all the rituals in the preparation for transition, communication between generations is not given any credence. Harcourt's (1997:186) study of the intergenerational transfer of knowledge between women from countries as far afield as Tanzania, Ghana, Sri Lanka, Italy, Switzerland and Pakistan found:

> *"In terms of knowledge of bodily health young girls are not well informed and there are few places that they can find information. Unmarried women are basically ignorant of their maturing body and sexuality is kept so as a sign of chastity, which is strongly linked, to family honour and marriageability. Menstruation is not discussed even within the family and the pretence of illness during menstruation is maintained, with women expected to hide all signs of bleeding."*

One further taboo that surfaced in the research findings is one that I remember from my own formative years, not washing one's hair nor having a bath.

Naz's granddaughter said:

> *"...My mother told me not to wash my hair or have a bath".*

Petcheski and Judd (1998:286) reported respondents in their survey as saying: -

> *"And if you told em (parents) they tell you that you can't go swimming and you can't do this... if on a period"*

Undergoing a ritual cleansing bath, including a massage, at certain times following childbirth is common practice. 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 she is excused from household work, especially anything to do with preparing food. This practice is shared by many other cultures round the world (MacCormack 1982, Blanchett 1984). Although this restricts the woman's movement it also has the potential to ensure the mother gets much needed rest following the hard work of birthing. Jackson

(1993: 30) recommends further 'protective' action for women who have recently given birth:

> *"Avoid touching a cold floor with bare feet or undressing in a cold room"*

Following menstruation, the purpose of maintaining modesty and purity, and the rationale underpinning seclusion is to segregate the now potentially 'provocative' women. Man's inability to fight the temptation of women and their incapacity to resist the sexual impulse may be interpreted as a weakness. A woman thus has the potential power to protect a man. She does this by taking responsibility for the man's apparent inability to control his sexual urges, by veiling and removing herself from the man's company. Mernissi (1985:31) concluded that Muslim women are better able to control sexual impulses than men are and that consequently sexual segregation is a device to protect men not women. When considering why Islam fears the power of female sexual attraction it is suggested that the male cannot cope sexually with an uncontrollable female. Muslim society is characterised by contradiction around this issue. This may be examined using explicit and implicit theory of female sexuality. The double theory of the sexual dynamic shows the man to be aggressive and the woman passive. The implicit theory driven further into the Muslim unconscious is epitomised in some of the classical works (Ghazali 1964). Mernissi (1985:33) saw civilisation as struggling to contain women's destructive all-absorbing power:

> *"Women must be controlled to prevent men from being distracted from their social and religious duties"*

Such theory, with its antagonistic machismo vision of relations between the sexes attempts to describe the male-female dynamics as they appear in the Qur'an. Muslim social order views the female as a potent aggressive individual whose power can, if not tamed and curbed, corrode the social order (Mernissi 1985).

One of the main obstacles western women have been dealing with is the society view of women as passive inferior beings. The fact that generations of University-educated women in both Europe and America have failed to win access to decision making posts is due in part to the deeply ingrained image of women as inferior. The Muslim image of

women as a source of power is likely to make Muslim women set higher and broader goals than just to get equity with men. Mernissi (1985) says the most recent studies on the aspirations of both men and women seem to reach the same conclusion. The goal is not to achieve equality with men - they see this as not worth having. Women's goals are phrased in terms of the global rejection of established sexual patterns, which are frustrating for males and degrading for females.

Martin (1987:52) highlights the conventional (male) description of menstruation as waste, the negative *'uterus crying for a baby'* image. Martin proposes positive images, such as that of renewal and regeneration, focusing on the menstrual mechanism for protection against harmful microbes. Instead of useless and disgusting debris, menstrual blood should be viewed as an important part of women's flexible and responsive immune system. A radical description of menstruation as waste Steinem (1981: 14) describes as politically charged with the potential social changes that would need to be made if men could menstruate:

> *"Menstruation would become enviable and boast worthy. Men would brag about how long and how much...Street guys would invent slang ('he's a three-pad man') Men would convince women that menarche equated to manhood"*

8.5.1 Dirty blood

The picture around menstruation emerges as complex and contradictory. Douglas (1966) raised the question of why it is that menstrual rather than other bleeding is perceived with disgust or feared, out of proportion to its actual ability to harm or infect. Kristeva (1986) distinguishes between bodily fluids that are polluting and those that are not, linking menstrual and post delivery blood to excrement (Naz Chapter 6). Ironically it would appear because men in traditional societies have a fear of contamination from pollution, they have been content to leave the managing of childbirth in the hands of women. Blood, especially the loss of blood without injury, is what makes menstruation appear so powerful; the power conferred upon women by this blood is the source of fear and/or joy. Fears and constraints around menstrual and post-delivery blood are not specific to the

developing world - it remains one of the few areas of women's bodies to be almost unspeakable and unrepresentable. Soaps and melodramas that purport to represent the real world do not raise menstruation as a topic or an issue, even though teenage pregnancy and painful birth is a popular story line. It would appear that the evidence of teenage sexual activity is preferable to mentioning the rite of passage she must have undergone in order to conceive in the first place.

Male authority over female sexuality is reflected in the importance of a woman being a virgin. Women remain alienated from their sexuality, silenced by the shame of it, segregated from the family.

> *"I could no longer sit on my fathers lap"* Petcheski and Judd (1998:286).

The following parable epitomises the 'ownership' and responsibility of the father and husband for their daughter and wife (Parable - lock up your daughters Norris 1998: 70).

Norris (1998: 70) quotes how the sages spoke in parable about women:

She is like an unripe fig, or a ripening fig, or a fully ripe fig,

> *"While she is yet a child, and a 'ripening fig', these are the days of her girlhood, and during these times her father is entitled to ought that she finds, and to the work of her hands and he can annul her vows. As a fully ripe fig she is past her girlhood, when her father has no more her rights over her (Mishnah, Niddah). Her husband then takes on these rights"*

Further to this Ben Shira recounted in Norris (1998:71)

> *'The only value a daughter can offer is negative, she is the treasure of sleeplessness' worrying over her prospects and his (fathers') reputation. In her youth, lest she pass the flower of age, and when she is married lest she be hated, in her virginity lest she be seduced, in the house of her husband lest she prove unfaithful, in her fathers' house lest she becomes pregnant and in her husband's house lest she becomes barren. So much that marriage does not bring relief"*

Shira's quotation depicts the vulnerability of the family when there is a post-menarche daughter living at home unmarried. In Pakistan a daughters' first menarche directs the parents' thoughts towards marriage. Until married the girl is potentially able to bring shame on the family; this would be considered unforgivable and would affect the

marriageability of other members of the extended family (Bas and Dil Chapter 6). This window of vulnerability has the potential to be extended when the family live in the UK, as the marriage is not allowed until the age of sixteen and a girl may have reached puberty some years earlier.

Menstruation is a sign of womanhood and the beginning of sexual isolation (Petcheski and Judd 1998:286). The passage from one social status to another universally involves changes in the life that guides the passage. These may be linked to physical separation (seclusion), transition and re-integration. Physical separation may take place around and following menarche. It is my experience that the preparation for the very different roles in life begins as soon as infancy is over. In Pakistani households, girls as young as seven are expected to bring food and serve visitors, whereas boys will sit with the visitors and be served by their sister. Changes in behaviour are combined with a preparation for the new life and the responsibilities of the eventual lifetime new role.

Jeffery Jeffery and Lyon (1988:72) consider that pregnant women restrict their movements outside the domestic area to avoid being seen. Fari, although not referring to when a woman is pregnant, upheld the concept that just being out in public may be judged as potentially sinful.

> *"...a girl going out you were gaining sins...I don't know it was the idea in those days that you should be married so there was no chance of..."*(Fari)

After a long pause I added, "*meeting a man*" to which Fari nodded. When asked what she did between the age fifteen (her menarche) until she got married aged nineteen, Fari's reply demonstrated the responsibility her mother took to prepare her for her new role.

> *"sort of... went to a centre. ...we used to learn Arabic and the meaning of the Qur'an...my mother bought lots of embroidery and sewing and cooking..."* (Fari)

Once menarche occurred, Fari was restricted from 'going out' and the final preparation for her new role as wife, housekeeper and mother took place. The segregation of women from men in the household was never more apparent than when visiting a home in Pakistan. 'Mixed company', that is women and men unrelated to one another socialising was frowned upon and the practice has been to show me into the women's quarters

(usually at the back of the house) while my husband is entertained by the men in another room. If women are to go out of the house, a chaperone was seen to be essential. Recognition of the separation and difference in gender maturation rites that restrict and control social behaviour are exemplified by the grand-daughter of Naz

> *"Even in our family (enlightened)..., now the boys...of... you see Afiz...he is the same age as me...all the girls, even Sabrina at sixteen ...she is so much mature than the eldest...it is so obvious in the family... he will be running up and down in his car and everything...the girls are just sort of...'sat there"* (Nazir's granddaughter)

Although the term enlightened was added (by me as the researcher), Naz' granddaughter's as attitude and her ability to speak freely in the presence of her mother and grandmother, led me to judge the family as open and progressive. My belief was that the family accepts yet questions tradition. The advanced maturity of teenage girls compared to boys was acknowledged. Social restrictions and the need for limitations on mobility appear to be accepted by Naz's granddaughter, there was no underlying resentment in her statement.

The stage of enlightenment may proceed questioning. To be able to question one needs further knowledge of alternatives or comparisons. Naz's granddaughter has been educated in a totally different culture, which is made up of views and beliefs that are at odds with her own. How she will balance this knowledge will depend on a myriad of factors and certain influences that are beyond the scope of this work and would be deserving of further in-depth study.

> *"...we never eat in front of our family when we are having a period and ...that men even our brothers. Five girls are living in the house with my two brothers, we never ate with them when we were menstruating... as well ...it can be very embarrassing... you know you cannot fast...even I don't know...I do it out of respect..."* Naz

The segregation and subsequent behaviour within Naz and Sai's family served to highlight the 'happening' of menarche and menstruation to the rest of the family. This is in direct contrast to the need to hide and no-one-must-know norm within my own culture, the shame of 'dirtying', displaying, staining crosses cultures. Whether this is linked to the concept of blood as defiling and contaminating would need further analysis.

Anthropologists have noticed that in most societies a person in transition between two social identities is considered somehow ambiguous, dangerous and abnormal (Standing 1980). Rituals that surround these transitional states can even provide a metaphor for expressing the concerns and sometimes the conflicts of the whole society. Ritual action and taboos serve to control the unknown and to reduce anxiety at a crucial time.

During the course of a lifetime, an individual passes through a number of social statuses, the content of which is defined by certain expectations, such as 'adult' behaviour.

> *"I don't know...my mum...she said... right... just put this (sanitary towel) here and sit down and behave like a lady..."* Naz' granddaughter

> *"My daughter will sit there something like that (with her legs splayed) and I will say, close your legs, it does not look nice, or, don't keep touching your knickers...it would not look nice in public to be doing that..."* Naz

The maturational gap - that of the physiological preparedness of the body for conception and the maturity of the mind to cope with childbirth and motherhood was seen as a major problem by Naz

> *"Even though my daughter is.... (Unable to verbalise the rite of passage her daughter has reached)...like her body is changing, but mentally she is a child...so we tell her to sit properly or, when she run...you know... cover her body... (her breasts do not show) that is a part of growing up...preparing her...she does mentally become prepared...I think I changed over night..."* Naz

The latter statement suggests that the physiological and maturational gap is new knowledge and was not around when Naz herself started to menstruate. She remembered changing overnight from a girl to a woman. This change over a generation may be linked to education and questioning. Naz's inability to articulate puberty and the changes this brings translated instead into instructions for behavioural changes and can be juxtaposed with intergenerational silence. A silence hung where intimate details of the body - how it works and the changes it undergoes - should have been. Smith (1997) in her study on having a baby before the birth of the NHS gave examples of how mothers did little to prepare daughters for the fundamental changes to their bodies. This has a direct parallel with Naz's statement:

"My mother never talked about periods... You'll know soon enough... started menstruating when I was ten and I was a green as grass". When one woman was asked why she had not asked her reply was "I did not want everyone to know I was ignorant". Naz

Further experiences demonstrating the widespread lack of information available to the young pubertal girl about the ensuing life event is outlined by Petcheski and Judd (1998):

> *"Most respondents did not learn about menstruation until it happened to them, their mother (or guardians) then taught them accepted methods of hygiene, above all how to conceal the blood, above all there was a shameful aura surrounding the onset. I felt anxious, I felt bad because I had not been told, I did not like it, I wept, it was a terrible experience, I thought I was sick, I had no knowledge of it, I felt afraid, embarrassed, sad, ashamed, uncomfortable and I wept" (*Petcheski and Judd 1998:193)

However, the strongest message from mothers and guardians, after the onset of menstruation, was one to beware of men and the dangers of premarital sex, which leads to a whole complex area of misunderstanding.

Petcheski and Judd (1998:166) in their study on negotiating women's rights in Mexico give a dramatic example of a woman's lack of knowledge of her body and her sexuality:

> *"Once, I saw a young woman had blood on her feet, and they said she had been raped, that a man had abused her. I did not know how this could happen; I mean I did not even know they put their thing inside you. Then when I got my period, I started to cry. My sister asked me what had happened and I said I had been raped, so they started beating me and asking who was it and I said nobody. Then they said 'how were you raped?' I did not know, but blood was coming from me..."*

The linking themes of menstruation and intergenerational silence on the topic of menstruation run through the transcripts of all the women interviewed about their birth experiences in Pakistan.

> *"I did not talk to my mother...I talk with my friends but NOT my mother"* Ina's daughter.

> *"...she (daughter) learn from friends that were older, not her sister...it is like a protected subject...you just did not talk about it...it is taboo, when I started my period I was afraid because I would leave marks...it was an embarrassment..."* Naz's daughter in law

> *"...you know when I am fifteen, I think I start my periods (whispering) I didn't know what...about a thing...I don't know I call my mum...I said I didn't know I want to go to the toilet all the time and bleed (the word bleed almost indiscernible)...then my mum said you can do everything...I am sorry for to talk my mother like this (as if it was disloyal finding fault with her mother)"* Farn.

When asked if she had talked with her older friends Farn replied:

> *"As the eldest in the family and ehm I am busy all the time".*

Dil told a long and detailed story about her menarche based upon her ignorance of the expectation. This is referred to in the case-study on Dil. Shame appears to arise from three sources, the intergenerational silence (not being told), the lack of the woman's ability to control the bleeding and the defiling nature of the blood itself. The interview with Naz, her daughters, daughter-in-law and granddaughter depicted the Ghunda (dirtiness) of blood and the different generations of thinking.

> Naz *cried in horror* "Hieee" *when her granddaughter said she had read that some women eat their placenta....: "We would consider that Haram...it is disgusting, like eating a dog...it is the body's waste"*

However, Sai's reply is evidence of a change in thinking for the third generation:

> *"How can it be dirty if...that very interesting that because if it is I find really interesting...I do not think it is dirty...I think it is an old wives tale...what do they do with the placentas that are not eaten?"* Naz's daughter-in-law.

Naz had believed implicitly for such a long time that blood was so dirty it was almost defiling to discuss. This would constitute a firm fixed belief. Although the definition of a delusion is a firm fixed belief, I did not judge Naz to be deluded and respected her very strong feelings about blood. Naz's granddaughter was not of the same belief, even questioning the source of her grandmother's feelings. She used her knowledge of biology, reflected and questioned the concepts of her revered and much respected elderly relative and presented her with an alternative perspective. This was a fascinating experience to have as a researcher, a time when I faded into the wallpaper, observing the interaction and the boundaries of age merge and shift. Naz's granddaughter sat at her grandmother's knee using lots of touch and eye contact, testing how far she could go and checking out

with her mother and aunt if the step was one too far. It was evident that this was not the usual topic of conversation:

Why then are women, and such a natural and vital bodily function, endowed with so many varied and contrasting cultural taboos and beliefs? Could it be these beliefs rest alone on socialisation imbued through religion? Or are the cynical theorists right? Montague (1999:82) rationalises:

> *"By making women objects of fear and something to be avoided as unclean, it is possible to reduce the cultural status of women. Any biological advantages are demoted to the state of cultural disadvantage; once this is achieved they are then converted into biological disadvantages".*

Across cultures and from an early age females are conditioned to believe that menstruation is a curse and a handicap (Salzman 1967). I maintain that these beliefs are almost wholly unsound. Current knowledge tells women menstruation is neither mysterious nor malignant but perfectly healthy. Menstruation makes women different yet we behave by concealing the 'happening' and not talking about it. Perhaps it is the opportunity that is lacking. Pakistani women, when talking about their birth experiences, saw it as important. This may have been because of my direction and linkage of the topic with childbirth alone. Even if this were true, the content, the direction and the themes were entirely their own.

Further study upon the effect menstrual and postnatal blood has upon the mind and consciousness of both men and women is needed. It is fascinating to analyse the cultural differences in society's behaviour around menstruation. The event of menstruation is highlighted in some cultures and hidden in others. A paradox exists between the UK and Pakistani cultures. As the UK culture and media virtually ignores menstruation yet is open about pregnancy and birth, Pakistan culture and media virtually ignore all aspects of women's lives. It would appear that the myths surrounding appropriate behaviour during menstruation or postnatally do have cultural specificity, generations will be surprised at the previous or the next generation's behaviour around blood.

8.6 SUB-THEME-Shame and izzat (honour)

The next sub-theme involves moral rules for propriety that are especially pertinent in Islamic countries. Religious and cultural belief systems are central to norms of behaviour. What is seen as woman's 'proper' behaviour in Pakistan surrounds such concepts as modesty, shame and bashfulness (Jeffery, Jeffery and Lyon 1988:29). Thompson (1981) when studying a small Indian village discovered the often-used term 'sharm', which can have negative and positive meanings depending upon the context used.

Thompson's translation of sharm was appropriate to use for the women in Pakistan, as it offered an explanation for the possible lack of guilt or blame that may be attached to shame. Also it fitted into the dialectical theoretical framework used in the next chapter, as it opened out both positive and negative connotations on the concept of shame. As stated, sharm can only be ascribed according to the context when such a term is used. For example when it is related to women's behaviour, can be either good sharm, which is being bashful and respectful, conversely bad sharm evokes a feeling of embarrassment, which follows a breech of the moral rules of propriety set within the culture of the society, e.g. divorce in the family. Young men will display positive sharm through obeying their parents. Woman's negative sharm is often related to sexuality.

The depth of social control of behaviour, not just women's, is epitomised in a quotation from one of the many interpreters of Qur'anic principles:

> *"Women's status and dignity is not a matter for negotiation in the Islamic context. Not only are all forms of exploitation of the women's image directly prohibited, but are indirectly discouraged by imposition of rules of modestly in dress, behaviour and demeanour, which applies to men as a well"* (Abedin (1996: 73).

Ria, the gatekeeper and leader in the community in R.., attempted to use sharm to influence the women at the over-fifties group. Common phrases she used were *' shame on you'* and *'I am only doing it for you'* However, Bal our interpreter on the field trip to Pakistan in 2000 could see behind what I judged to be Ria's paternalistic bullying tactics.

> *"Ria wants the women to role model on her, not to be down trodden, represent themselves, she has had to fight all the way...it is not easy in*

our community, whereby gossips are always out to destroy family honour.." (Bal Chapter 6)

There are multiple examples of both positive and negative sharm that can be drawn from experiences in Pakistan and R... Two have been selected - the first is linked to the next concept of izzat. When we stayed with a GP and his family in Pakistan, a relative of the interpreter who had travelled with us came to visit her. He had journeyed for a whole day and night from a distance, yet he was not allowed into the house. He was of a much lower class and status to the GP's family and they had a marriageable daughter. Letting a stranger in the house, even though he may not see the daughter, would still be a source of gossip that could ruin the daughters reputation, (lose her izzat) she would then be without sharm and less marriageable.

A further example of sharm both in a negative and positive context can be seen in the relationship between Vez, Shab and me. When I assisted Shab to give birth to their son, Vez could only be friendly with me by calling me his elder sister bhajee. The only relationship that retains the positive sharm and prevents the man or women being sharmless is between family members, what Behar (1993:7) describes as 'fictive kin'. Even this is restricted. Jeffery Jeffery and Lyon (1988:29) state that the daughter-in-law should be respectful towards her husband and his father and mother, "*slow to offer opinion and obedient*". This also explains Siaq's concern (Bas Chapter 6) about living with her in-laws after marriage and how she will have to obey orders and her attitude will need to change.

Ultimately it is the women's sense of sharm that maintains boundaries between groups and constitutes a powerful way to divide men and women's worlds. As such, Thompson (1981:44) has described it as '*psychological purdah*'.

In exploring the relationship of izzat to shame Thompson (1981) said that if someone does not have a positively evaluated sense of sharm, then he or she would be said to be 'without izzat.' Fundamentally it is a concern about reputation. For a woman it is particularly about ensuring how she does not become the subject of public criticism or censure, as stated previously when the GP's family would not allow a visitor into their home. The implication of the vulnerability of the woman's izzat is that she should be

more sensitive to criticism from the community than men and that she attracts more unwelcome exposure and should take care to avoid it.

Gossip and family dispute based upon maintaining the family izzat and retaining the public private division became evident in the women's stories. As previously discussed, the loss of honour (izzat) for women if their husbands divorce them has a ripple effect through the extended family, mainly affecting marrigability.

Riz told a story of the tragic death of her mother's brother and the family division this created. The negative sharm and loss of izzat this brought to the family resulted in Ina being ostracised from her sister-in-law's family, this was distressing Ina because her nieces and nephews were not allowed to visit her.

We visited S... prison in 1989 and 2000 to find that out of the sixty-eight women on remand (in 2000), most of them were in prison following family disputes followed accusations of that they had sullied or flouted the izzat of the family.[88]

Negative sharm and loss of family izzat can lead a mother to wish her own daughter dead (Taz Chapter 6). Sam's mother accused me of not understanding shame and honour.

> *"You in the West do not understand the importance of family honour, what someone has done shamed the whole family..."* (Sam's mother, Taz, Chapter 6)

The media describe such action as 'honour killing'. Sanderson and Self (1999) published a story of a mother and brothers killing their sister/daughter for getting pregnant before she got married. The mother was a widow and loved her daughter dearly. It was the community elders who pressurised the family to avenge the loss of izzat. They told the mother that this would only happen if they killed the daughter for her sin. Insulted honour is the ultimate disgrace in Pakistani community; unfortunately it goes hand in hand with the act of revenge.

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88 The prison was visited on information that very young women were being detained and prosecuted for being raped. Their izzat has been lost according to Thompson (1981), the punishment for fornication in Sharia Law is either stoning to death or seven years imprisonment, unless the woman has seven witnesses that it was not her fault.

8.6.1 Gaining sins

Honour (izzat) and its potential loss of, as it linked to Pakistani girls' behaviour and the multiple negative connotations of sharm, constituted an important sub-theme that emerged from the women's words. The post-pubertal daughter of a GP friend in Pakistan was chaperoned at all times because her parents believed that her honour (and marrigability) would be lost or affected if she was seen in the 'wrong company'. Fari's preparation for marriage involved her not being allowed out into mixed company,

> *"...because my mum when she was married she was very young fourteen or fifteen...used to think that if a girl goes out you were gaining sins...I don't know...it was the idea in those days that you should get married...."* (Fari Chapter 6)

Despite being the next generation Fari was still kept under virtual home arrest/guard in the interim period between menarche and marriage. Her mother took this opportunity to continue Fari's preparation for her future role as wife and mother.

> *"My mother bought lots of embroidery and sewing and cooking"* Fari

Thompson (1981) states that it is possible that negative sharm and the consequential loss of izzat gains some of its emotive force from its association with physical modesty. Almost from the time a child can talk, great stress is laid on girls concealing their genitals; this is the first way they are taught to express sharm Naz.

Sex and reproduction are considered 'shameful' and they are rarely talked about, particularly between generations (Harcourt 1997, Thompson 1981). Menstruation and bleeding postnatally are considered impure (Chapter 8). Women conceal the signs of their condition as far as possible and the menstruating women will not help prepare food or eat with the male members of the family at this time" Naz.

It would appear that family honour, negative sharm and loss of izzat, whilst being the responsibility of the community, both men and women, it is the women that are held to account, with the community and the men considered liable for the monitoring, protection and the punishment. Jeffery, Jeffery and Lyon (1988), Harcourt (1997) Petcheski and

Judd (1998) Abedin (1996) emphasise the negative sharm, and it does appear that the evidence is skewed this way. However, using the ideology underpinning dialectics and actively seeking out the opposition and contradiction, it would be the positive, protective and provider responsibility of men and the community that has to be raised. One example emerged from the narrative and that was Ina's brother took on the responsibility of arranging the marriages of her daughters when her husband divorced her. However, I have reflected upon the numbers of Pakistani men who are unemployed in the UK and considered how they feel not being able to fulfil the role of provider to their family. Also sending a daughter to Pakistan to arrange a marriage may be perceived as protecting her from western societies' norm and the promiscuous behaviour of western teenagers. It is true also that although young men appear to have freedom to socialise in their teen years, they stay at home after marriage taking on the responsibility of caring in monetary terms for their elders and the marriages of their sisters. They do not have any more say in the selection of a marriage partner than young women do (Jeffery, Jeffery and Lyon 1988). Marriage choice has emerged as a classical dialectic characterised by contradiction and opposition.

An agreement must be made between the couple before they come forward for marriage, no one can force them to get married (Salahi 1993). The marriage itself requires a commitment by the bride or her guardian. However, it is inevitable that there will be times when opinions differ. The bride to be is required to have retained her chastity and her future husband must retain her honour. It is not permissible for a man and a woman to be alone in a closed room if they are not related (Salahi 1993: 90). Choice does not always have other options, as Ina the midwife identified.

> *"Nobody gave me a choice, they do ask if it is OK, this is not a choice...you have to say yes because if you say no they have to find someone else..."* Ina (midwife Chapter 6).

Ina's perceptive knowing that, although her parents sought her opinion on the suitability of a marriage partner, this did not mean that that she had a choice. Positive sharm is predominant; respect for parents/guardians choice takes precedence over her own. the midwife, qualified this norm with an age condition. (Ina, midwife Chapter 6)

Often from the very birth of a girl, the family begins to look for an appropriate marriage partner. Some families look first within their own extended family. A colleague midwife Shan, who had come to the UK when she was aged five, said:

> *"We knew there was no-one in our extended family of an appropriate age...so my parents had to look outside the family to friends of relatives*[89] *"My parents gave me a choice of three, I said I wanted someone who had lived in the UK. Subsequently however, my father's eldest sister in Pakistan, wanted a distant relative, so I had to take her choice, I would not upset my mother and father. We have already arranged that my husband's younger brother is to marry my sister (they are both aged eleven now)"* Shan

Yet Ami said that:

> *"We do not believe you should marry in the family, we have come across this but they started to have abnormal babies... "* Ami [90].

An arranged marriage does not come with a guarantee of success. Breakdown can create reverberations through a whole extended family network, especially if the couples are related. Dil told a graphic story about how her eventual marriage was affected by her sister's divorce (Dil Chapter 6). Also convoluted family relationships evolve in proportion to the number of wives the husband takes.

Riz answering for her mother, Ami said:

> *" she laughs when you ask...she has not had a good marriage...it is a joke...it has gone past...he is her first cousin...her mother and his mother are sisters...it is all so complicated...he has always been coming and going,....he went to Pakistan and got divorced there and sent mum the divorce papers...he came back and wanted to live with her and she said no way...he has done before, ' married two other wives and she has taken him back...he now lives with me...he has divorced his third wife...he is a sad man, he used to be popular at one time he had lots of money and his own business...the women*

89 Jeffery, Jeffery and Lyon (1989:26) say that it is the groom's parents that make the first move, however, for Shan (Chapter 6) aged twenty-nine years, following qualification as a nurse and a midwife, her parents had received only two expressions of interest, Shan had turned them both down so Shan's parents had to look amongst the family in Pakistan.

90 The belief that consanguineous marriage increased the risk of congenital abnormalities is upheld by Proctor and Smith (1992).

> *only married him for his money, when he had no money he came back to mum and she always accepted him...now if she cooks she will send some round (to our house) for him....He could never cope with Sima (severely disabled 21year old sister) who is cared for entirely by my mum...he left her to it"* Ami.

Bas admitted that having one troubled marriage in the family affects the marriages of the other women. However, she also very clearly said that it was not her responsibility to be concerned. The men, father and brothers take on that responsibility.

Siaq speaking for her mother Bas said:

> *"it was very late (when her mother Bas got married) aged twenty-eight years, this is because her father died when she was thirteen or fourteen, her mother was scared what might happen...they were still worried with what happened to my aunt..." (*Siaq, Bas's daughter Chapter 6)

Ina the midwife was also divorced from her husband; '*he went to classes for complementary medicine and met someone else'*. This meant that Ina's daughter's marriage was arranged and paid for by her uncle (Ina's brother).

The social and economic significance of marriage and the marital relationship was confirmed in the words of the women and marriage was indeed a very important part of their narrative. This importance is a reflection of the Islamic faith. '*Marriage is the chosen practice of the Prophet* (Salahi 1993:239) Stopping short of making marriage obligatory there is a strong encouragement or recommendation for Muslims to follow the example of the Prophet. Consequently it is unusual for a woman to stay single. On reflection I have often reflected on the sadness felt when talking to some women who have never been married nor had children when this has not been their choice; they just have never met the right one. Had they been born into the Islamic faith they would have had families and brothers to help them to find a husband.

For the second and third generation Pakistani girls and women in R.., living and retaining a religion and culture that is radically different to the country of residence creates many challenges. Some of the first generation immigrants to the UK, who followed their husbands, had no need to learn the language because they stayed within their own community, shopping and socialising within the community. However, the second and

third generations were educated in the host culture and would often be living and socialising across a dual cultural system with confounding norms and values. This created a problem for the first generation elders who found it difficult to understand the norms and values of the school and social environment of their children

Debold et al (1996) outlines the conflict between a girl's own experience and their increasing knowledge of cultural expectations at early adolescence. This knowledge may lead girls towards developing methods for knowing and in doing so either accept or reject what authorities, parents, and/or school say as true. Sai, Naz's granddaughter, made two statements; the first rejected the authoritative knowledge of her mother, aunt and grandmother, the second accepting of her role as a young woman

> *"I do not think it is dirty...it is an old wives tale...how can it be dirty...it feeds the baby"* Naz's granddaughter.
>
> *"...nothing else to do (*other than childbearing"Afiz (cousin*) is the same age as me'...he will be running up and down in his car and us girls are just 'sat there'...* (Naz's granddaughter Chapter 6)

These contradicting statements, the first questioning the knowledge of her elders the second accepting of a restrictive gendered role, reflects the relationship of opposites that exist for a third generation Pakistani girl. Her life spans two cultures and three generations. Thus she will be living in a home where cultured values, roles and rules depict that she cannot go out on her own and must not socialise in mixed company for fear of losing the family izzat in the community. She must not question elders and accept the family choice of a husband; thereafter she will live with her in-laws, obeying their rules. She will not have to work outside the home or be responsible for the family's income. The parents of children educated in a society which has values that are considered immoral, must suffer agonies of worry that their children may be drawn into the culture of western youth which accepts showing large parts of the body, drinking alcohol, having pre-marital sex. It is not surprising that some parents choose to send their children back to live with the families in Pakistan. This seems ironical when most of the women who came to England (UK) came to give their children a better education and chance in life.

8.6.2 Summary

Sharm and izzat play an important part in the life of the Pakistani women as portrayed by the women's stories. Maintaining family honour and reputation has a vital part to play in the girls' upbringing and the subsequent arrangement of any marriage. Each marriage success or failure has an impact on all family members, especially the unmarried.

The importance of marriage to a Pakistani girl/woman comes even before childbirth, as the former requires the latter. Living in a culture that does not operate from the same code of honour can create dissonance. The stories told by the R... women about their emigration to England constitute a short but important sub-theme that brightens the context of the life and birth stories of the ten women who were interviewed in R...

8.7 SUB-THEME- Come to England

Coming to England would seem to be an obvious theme to emerge from the narrative of the women interviewed in R.., as they had all made that journey. This took place mainly in the 1950's. R... was a very different place to that of today. Today it is a lively, multicultural town with a multitude of Asian food shops and whole communities of Pakistani and Bengali people. There were two major differences to cope with, the first was and still is the climate and the second is the language, although the latter became easier as more families settled here.

Ria told stories of when she came to England in the 1950's and because she could speak English became the interpreter for other families with the schoolteacher, doctor, health visitor, midwife and police. She was one of few women (Farn) who went out to work when they came. Ria went to work in the smartest shop in the town and Farn to work alongside her husband in the cotton mill. Mostly, and to this day, women did not work outside the home; this served to increase the isolation and decreased the probability of learning and having the confidence to speak English.

In the 1950's there was no established Asian community in the town, the strange health and education systems, plus widely divergent social and family cultural norms further compounded the isolation and unhappiness for the women. However, the major cause of the unhappiness came from leaving family behind in Pakistan. They had come from extended, supportive, closely-knit family networks to live in a strange world, knowing their husband only and he spent most of his time at work.

Mostly the men emigrated in the 1950's and started work in the cotton industry, returning to Pakistan to marry some years later. The women were brought by their husband to live in R... (Bas, Fari Farn Naz).

Khan (1999) undertook studies of women who had settled in Bradford, and proposed that settlement in another country may lead to modification of belief and values, but found when the communities became established and supported each other, some women still did not speak English, even after living in Bradford over twenty years. This was evident

in the over-fifties group as Ria was cajoling women into being interviewed. Some of who had been in the UK considerably longer than 20 years. The reason given for not wanting to be interviewed alone was the lack of confidence with spoken English. Three examples of this are Bas, Ami and Naz. Each had spent between twenty and forty years living in R... However, they had no real need to speak English, the family norms meant that their husbands interacted with the community and they cared for the house and family.

Of the ten women interviewed in R... Ina the midwife and Taz did not live in the UK, but were in the UK on holiday. Ria, Dil and Fari felt confident to be interviewed without someone to help with English. Farn, Bas and Ami had been here since 1960, Naz 1950 and Shab 1990's. All had difficulty with spoken English. Ria spoke in Urdu to the women at the over-fifties group; Shan translated this.

Bas's husband had lived in England for five years before returning to Pakistan to marry her. Following marriage, Bas stayed in Pakistan with her husband's relatives. It was four years later that she eventually brought her daughter Siaq and came to live in R... The young girl, who had never before met her father, remembers the first meeting vividly (Bas Chapter 6). The reason that Bas came to England was for Siaq and subsequent children of the marriage so they could be educated.

> *''She (Bas) came to England for me, more than herself...she used to cry a lot and was homesick.... It was five years before she returned to Pakistan to see her mother...you cannot imagine that can you, five years, it must have been heartbreaking...she would have stayed (in Pakistan) but because my father was here...she came...he went for work in Karachi and he met someone who said go to England there is work there and he came..."* Siaq, Bas's daughter

> *"When I came (to R...) no help no rest, wash towelling nappies, hard work, no washing machine ..."* Bas

Bas's obvious distress and isolation was exacerbated by the fact that she was unable to return to see her mother for five years. Naz was also in a similar position as she was 'brought' to England against her will in 1960, leaving four daughters and her beloved mother whom she never saw alive again.

Naz pined to return to Pakistan and had been unable to due to her husband's political position and her own physical condition.

Naz was the eldest of the women interviewed, she was born in 1930 and it was evident that she commanded great respect in the over-fifties group. When Naz was brought to England she did not know where she was coming to and had no idea that she would never return. Because Naz was so obviously depressed and in an attempt to explore the reason I asked her what she would like most in the entire world. Her reply was that she would like to come to Pakistan with me. She was still homesick after nearly forty years in the UK.

I realise that whenever I think or write about Naz I take on her sadness. She becomes the symbol of unhappy Pakistani women for me. Perhaps the emotional connection is through her previous covert life as a dai. Her close family did not know of her dai activity so Naz denied it by telling us that it was her sister who was the dai. However I had a sense that her knowledge of childbirth was not just that from personal experience. Naz's daughter-in-law told me in front of Naz that "*dais' were ignorant*"

Not only was Naz hiding her background, forced to leave her young family but she also suffered terrible morbidity from the subsequent five more children she went on to give birth to in England (Naz Chapter 6). Life in England surrounded by her new family could in no way compensate for her not being in Pakistan, her home.

Farn's husband had come to the UK to work and then returned to Pakistan to marry. This was and still is common practice. Following marriage, Farn's husband came back to Britain alone. He worked and supported his family back in Pakistan. It was two and a half years after marriage that Farn joined her husband in the UK. Farn worked in the mill on shifts when she first came to England, returning for her first visit back to Pakistan some six years later.

> "*I keep two children there (Pakistan) he send me money for them, everything you know, house rent, everything, he sent rupees ...*" (Farn Chapter 6).

Similarly Fari's husband was already working in the UK and returned to Pakistan to marry Fari when she was aged nineteen. Two years later, after their first child was born in Pakistan, Fari came to join her husband. Since arriving in the UK she had trained to be a

teacher of Maths and Urdu and was currently employed in the local community centre. Fari' education in Pakistan was up to matriculation.

> *"I am sad to come to England, but I am pleased that I am with my husband...we know we have to live with our husband...we did not live with my mother-in-law we went to a different city we went for my husband work*" (Fari Chapter 6*).*

Although Fari had undertaken a career in teaching she did not feel that she had achieved her ambition. She blamed having children and working for this.

> *"...women have to sacrifice a lot more than men..."* (Fari Chapter 6).

When I said it was never too late she replied that:

> *"She was too tired now she had the freedom*" (Fari Chapter 6).

The freedom Fari was referring to was independence from childcare.

Dil spoke with passion about her reluctance to come to the UK and her constant wish to return.

> *"...I did not have time to think anything, honestly, because when I came to this country there was.... (I was) so shocked...I had to live in a room, one double bed, one microwave and one chair...in Barking...when I came I started crying...(whispering) one day when he came I said 'you can stay I am going back to my job (as Family Health Worker)' your relatives are here mine are not, I said I came on leave I can go back I am sick of them. Even now...I know, even though my husband doesn't give me... because I have a skill I am proud of that, I can teach over there., I can do Family Welfare Course I cannot starve. My husband struggle for ...because they were not giving visa. Although I had British passport my son born in Pakistan at that time I wasn't clever as I am now, I didn't know how to cope, our circumstances were that way we never used to go out, once a blue moon for weddings and parties and that is all, otherwise I wasn't allowed to go..."* (Dil Chapter 6).

Dil's unhappiness was plain to see. She was rushed both into the marriage, her first betrothal was called off because the family found out her sister was divorced.

None of the women would have chosen to live in England of their own volition. They came because of marriage and to ensure a better education for their children. When they

contrasted the support of the extended family that was received in Pakistan with the isolation in R.., it is surprising that there were not more than three (Naz, Dil and Bas) who experienced symptoms of depression.

Fari classed herself as lazy when her sister cared for her baby in Pakistan, giving Fari the chance to rest after childbirth. However, when Fari had her second baby in R... there was no support available, as she did not live in the same town as her mother and sister-in-law. Lazy was also a term also used by Mrs A. Fari and Ria (Chapter 6)

Mrs A referred to her being lazy in connection with returning to work shortly after giving birth, (Chapter 6) Mrs A's early return to work was because her husband said British women only had a short absence from work for pregnancy and birth.

Fari also considered herself lazy because her sister helped her with the baby.

> *"Actually I was very lazy, my sisters did not let me do anything, my younger sister was bathing the baby, clothing the baby, cooking and cleaning and everything I did not do anything...no help or support (in R..) as soon as I came home from hospital..."* Fari.

Bas went on to have three more children in R.., without the help she received in Pakistan when she gave birth to Siaq.

Ria called the women in the over-fifties group lazy because they did not speak or practice their spoken English.

Consequently women were being compared unfavourably with English norms; the lack of support following childbirth from the family, the early return to work after childbirth and the pressure to speak a second language that they obviously had no need for.

8.7.1 Summary

The women's stories about coming to England contain the underlying regret that it was necessary; necessary to improve either their husband's work opportunities and/or the children's education. The women did not seem to gain from coming at all. The impact upon the lives of the women when they came to England was abject isolation from family

and the support this offered in Pakistan. Also they appeared to be judged by spurious standards of a western work ethic.

The next sub-theme to emerge from the women's narrative takes in multiple context issues that show how fast the pace of life is moving and in doing so it highlights how much the rural poor have been ignored.

8.8 SUB-THEME-Modernisation and change

In Pakistan, from the baby girl's first breath begins a clear pathway that is mapped out for life. She will be fed and nurtured by her natal family and they will diligently prepare her for the role of wife, hostess and mother. After marriage, she will become a member of her true family, her in-laws. During her life, she will carry the weighty burden and responsibility of retaining the family's (natal and true) positive sharm and izzat. She will conceive within twelve months of marriage, giving birth to between five and seven children, with at least one son. This relatively unchanging life package sits inside a world that is modernising at a pace that is hard to measure or comprehend, yet the rural poor live as if the rest of the world does not exist, equally so the rest of the world pays scant attention to their needs.

Over the years there have been a number of studies on modernisation in developing countries see for example Randall and Theobald (1985). In 1947 Pakistan was given back its independence and actively sought re-development. However, in the year 2000 Pakistan is still struggling with the remnants of an infrastructure left by the British. Conflict and confusion are the predictable outcomes of this, grafted on democratic political systems underpinned by ideological belief systems such as socialism; challenge traditional values based upon Islamic convictions, hence the revision of the Sharia Law in the mid 1980's. It could be argued that the imposed Colonial systems had some benefits. The evidence to support this is measured in terms of development, railways, irrigation systems and some industry. However, it must be remembered that colonialist rule was a military and commercial regime, not a Welfare State (P.c.Sean Lang). Some elders in Pakistan argue that the Britishers deliberately did not construct a major sewerage system as was done in Victorian Britain. This was in order to control the population by disease. There was also the argument made in the chapter on the dai about politically ringfenced education and roles for British nurses and doctors in Pakistan.

An interview in Lahore with a pro-British ninety year old man who incidentally was still working by putting the dhobie (washing) away and sleeping by the gate 'to keep out dekoyts (robbers), was very interesting.

> *"They (Britishers) were strict but fair...we had laws that were upheld when the Britishers were here"*

Confirming this belief, a GP colleague in Pakistani, who was fond of telling stories with a meaning, compared basic law and order during and in the post colonial period.

> *"When the British ruled there was a law that bikes had to have lights at night, now there is no law that even cars have to have lights at night."*

New technologies have been imported and better educational facilities are available in the urban and city areas of Pakistan. Yet the traditional and the new seem to be discrete entities, there is no merging or blurring at the edges. This may reflect the contrasting wealth and poverty of the country. One of the major differences will be between the wealthy and the poor. The girl born into a poor rural home will know unpaid work as soon as she is able to walk. After leaving a katchiabadi (mud hut village), whereby only a very small proportion of the women had been able to access education, it was incongruous to drive through Lahore and see a neon sign advertising test tube babies.

The Qur'an expresses the equality of the works of the sexes and the oneness of the origin of the sexes, however many interpretations of the Qur'an's words '*naqisatan; alan wa dinan*' are literally translated to mean deficient in intelligence and religion and relates to women. Thus an obvious dialectic emerges from the words of the Qur'an, alike yet weaker.

Change that takes place as a part of the modernisation comes into direct confrontation with existing traditional values that are underpinned via the Islamic Sharia Law. This blatantly violates the status of women (Zia 1990). However, since 1988 there has been special provision for female representation in the National and Provincial Assemblies. The women in the National Assembly are rarely in the media. It is more often the women lawyers raising equal rights issues that represent women in the press. This voice has latterly come from women lawyers. The women politicians appear to conform to the

subdued, reserved behaviour expected of Muslim women (personal observation in the National Assembly Islamabad 1999)[91].

Deference and submission are the bedrock of the Islamic culture and religion. Submission however, is to Allah, for all Muslims and not specifically to men by women. Modernity taken loosely to encompass *"the transformation and possibilities traceable to western scientific know how"* (Lukere and Jolly 2000) presents the idea that one can continue to think, write and speak of ones culture as representing a continuous development of progress. The idea that it is the women in the West that are progressing towards emancipation and self-realisation, through not being submissive or showing deference, produces rather than surpasses the traditional male–female divide and is suggestive of an equality that simply does not exist. Although more women work outside the home in the West, mostly they still carry the responsibility for home and family.

The dialectic of 'specially designed' yet 'deficient' has the potential to leave women once again reduced to her body and to silence. This is in contrast to her being culturally shaped, complex, evolving, rational, and naturally leaky. Judged to be deficient in relation to the male standard, Islam completely separates any masculine-feminine cultural intercourse. The Islamic culture keeps the world of men and woman separate, except in the bed to procreate. The separateness set by Islam has ensured that patriarchy has not been allowed to influence the woman's world of birth, family or home, as has happened in the West. However, that is not to say that patriarchy has no influence on women, in Pakistan, for it does so strongly, through state control, Sharia law and societal norms

Islam quite spectacularly reveres the female gender and what it stands for. Conversely it is often argued that the emphasis on the female body and its reproductive and erotic potency simply reinforces patriarchy and its underpinning conceptions of gender difference. Some feminist writers (Jamal al- L-lail 1996) confirm the traditional assumptions that the nature of feminine thought and writing emphasises the dearth of irony, the fulsome self-congratulation and resistance to objectivity, the senitmentalisation

[91] I attended only one session in the National assembly and it may be misleading to make this assumption.

of love and friendship and the tendency to reduce relations to their sexual. This ignores the woman's ability to multi-task; to lead and work against enormous social difficulties, all demonstrated by women in the UK during the two world wars.

Jamal al- L-lail (1996) maintains that there is no conflict between the basic teachings of Islam, particularly with regards to the role of women and modernisation; rather it is argued that the conflict is between traditional values and modernisation. Traditional values are at variance both within and out with the Pakistan populace in Pakistan and UK R... There is a popular belief that immigrants stick with the time and cultural values that were strong when they left Pakistan. However, this may be relative to the amount of contact between the relatives in Pakistan and the UK. Ironically the more contact the more contemporary the thinking. Personal experience tells me that the ties with home are still strong and journeys back to Pakistan are saved for continually. Grandparent will name the new baby and permission is sought for choice of occupation or any major decision. Also, very importantly, marriages are arranged often with relatives in Pakistan and R... The strong family bonds often extend to financial support, whereby the extended families in R... support whole families back in Pakistan. This is due to there being no social support or government benefits system in Pakistan.

Whilst modernisation has been widely accepted by the West, it has been criticised by theorists. Jamal al- L-lail (1996) suggested that the process of modernisation is accompanied almost always by the adoption of what are particularly western cultural traits or westernisaton. Ram and Jolly (1998) coined the term 'westoxification'. Black (1996) suggests that the spread of modernisation involves a dynamic blend of traditional and western influence. These assumptions have since been challenged; for example Saudia Arabia lacks formal political parties and instead has Majlis, a traditional form of interaction between the rulers and the ruled. It could be argued that women are oppressed in this Islamic traditional society. However, the alternative system of the rulers holding informal meetings in the homes to discuss social, political and economic concerns and aspirations, challenges the western values practice and validity of political participation, it also generates the 'emperor's clothes' reaction.

My experience in Pakistan has been that anything western is perceived as modern, for example a mother proudly showed me that she had a feeding bottle for her baby, presumably because she has heard that we are a bottle feeding nation. Drugs are bought to induce labour, because they are 'modern', the corollary of this is that traditional practice is paralleled with ignorance.

Pakistan reflects the inner struggle between modernity and tradition or what Binder (1974:21) called,

> *"The synthesis of modernity as an idea and tradition as an empirical, historical configuration".*

This has been approached dialectically rather than dichotomously to focus on the dynamics and interacting elements central to the process of change that will value both the traditional and the modern.

8.8.1 Summary

This chapter contributes to the ever expanding discourse on the life and birth of women in Pakistan by exploring some of the contextual issues that emerged from the narrative of Pakistani women as they told their life and birth stories. Islam as a way of life is the thread that holds the garment of women's lives together. Their lives can be illustrated by using a dialectical framework that can be prefixed by the term ' the most'

The most exploited yet the most resourceful; the most ignored yet the most indispensable, the most vulnerable yet the most valuable, the most exploited and resourceful, the most ignored yet most indispensable. These descriptors were used by Abedin (1996) to describe the situation of Islamic women. As such they exemplify life for most Pakistani woman. However, like most matters of life there is the usual and the unusual, Dil challenged many archetypal ideas of what was usual for Pakistani women.

As I began the research experience in ignorance and uncertainty, after listening to the women's life and birth stories, not only did I become acutely aware of my own inadequacies and strengths, but also gradual and significant change occurred. The

research process drove this change, dialogue conversation and debate with the emerging discourse on birth in Pakistan, characterised as it was throughout by opposition and contradiction. An example of this is where I started, by considering Pakistani women as poor, powerless and pregnant. Some five years later I also view Pakistani women as strong, knowledgeable and supportive.

8.9 SUB-THEME – Strong women

In a society and culture that is accused of oppressing women (Sarin 1991), it would appear that birth and motherhood act as a catalyst to overcome such oppression. In doing so it provides women with the agency to be strong, positive and powerful. This research is a story about strong women, who may not be strong in a physical, political or academic sense, but in a womanly achievement capacity. This statement and the title of this section emerged from the feelings and words of women interviewed about their life and birth experiences in Pakistan and my own empirical observations of birth in the UK and Pakistan. Certain factors frame the issues that contribute to the strength and power women displayed after their childbirth experiences. These could not be separated out from other factors in the women's lives, however they contrasted starkly with the position of women who were born and grew up as a second sex (De Beauvoir 1993). It was as if women with no agency in society achieved this very important power to influence through the experience of childbirth. The ultimate factor in achieving position and power relates to the strength that women derive from becoming a mother.

Yet another very important factor involves influences in the context of birth and specific birth practices that dais, midwives and women display in Pakistan. A further factor emerged through the women's stories which captured what makes a difference between birth contributing to a woman's confidence or not; this was seen to be women's knowledge and the practice wisdom demonstrated by women at childbirth. In contrast to the effect medical dominance is having on women and childbirth in the West, whereby women feel they cannot 'make it happen' or survive without the professional and technology. The final factor that denotes the strength of women lies in the systems that link into the place for birth. In Pakistan, birth is a place for women, with women, by women. The absence of any male medical framework to contribute to women being strong ties in with the absence of time frameworks onto the behaviour of the woman's body. This latter factor is seen as a negative when it is associated with prolonged labour due to obstruction. However, many women in the UK are delivered artificially without proper assessment of the size of the pelvis in relation to the fetus or the opportunity to let labour take its natural course.

It would appear that although women in Pakistan are considered oppressed, this may only be comparative to what women want in the West, that is to be free to come and go in society, to be able to work outside the home[92]. Childbirth, its venue and the women in Pakistan showed a way for women to emerge as strong, yet in the West childbirth has been accused of dissempowering woman (Edwards 2001).

When considering whether adversity makes women strong and has the capacity to bring out the power to overcome, I drew upon the history of women in the UK during the Second World War to illuminate the metamorphosis of Pakistani women, from being oppressed to strong powerful. This exposed the parallel between the *'group feeling and purpose'* that women have about the 'problem'. Women 'crewed the boat' during the war, women supported other women by caring for their children, whilst some women worked on land or in the munitions factories. In Pakistan, women support each other in childbirth, the extended family care for each other's children and homes. Taking the analogy one step further it could be said that women in Pakistan have kept the sides of the boat too high to enable the professionals to climb in. Following the Second World War the women were asked to jump out of the boat and the men got back in.

It would appear that negotiated decision making, alongside a clear value in the purpose and role of life after childbirth that has yet to be touched by medical hegemony, are all pieces in the jigsaw that make up the picture of women's strength in the presence of social oppression.

Robinson (2001:289) related a conversation she had with a woman doctor who was involved in low-tech midwifery care in South America. The doctor said:

> *"They were women who had nothing, no education no respect, no self esteem, no money, yet after having their babies they were somehow more powerful, they could cope they could do things, they had confidence "*

Clarke, Callister and Vehvilainen-Julkunen (2001) also found in their research into Finnish women's birth a strong sense of maternal confidence or self-efficacy. These

[92] Some western male partners and husbands do not want their wives to work outside the home. This was more common fifty years ago.

feelings were elicited when women were asked how they felt when they first saw the baby. Feelings of self-actualisation were articulated, as women successfully negotiated life's most challenging event, birth.

Robinson's (2001) words and Clarke Callister, Vehvilainen, Julkunens' (2001) research findings resonated and contrasted with my experiences of working with women in Pakistan and the UK. Women in the UK, who in comparison, materially, educationally and culturally appeared to have so much, could be flattened, lose confidence and be totally disempowered by their birth experience (Edwards 2001). Like the women in South America, the Pakistani women interviewed had nothing, no money, no education and no respect from the strongly patriarchal society, yet they did not position themselves as downtrodden or oppressed. On the contrary, following childbirth they emerged strong, confident and sure of their vital position and role in society.

It is evident that birth is a life-changing event, for the better or the worse. The evidence suggests that women who have nothing, who are at the bottom of the social pile, can emerge strong and confident through the most natural of events, birth. Yet other women through the same process, who materially want for nothing, are educated, access all that is up to date in medical technology and are accorded social status, may emerge lacking in self-esteem and confidence. It seems reasonable to explore the major influence in the experiences of birth to try and capture the important factors that contribute to making the difference.

Women in Pakistan villages were poverty stricken and often malnourished, but in contrast to their dependant physical weakness, some of them projected an inner strength and confidence in their womanhood. This strength, conviction, determination and faith culminated in a glowing power, this emanated from the strong belief that they could do that which only women can do - give birth.

> *"Only a woman can give birth"* (Naz.) *and "women are specially made"* (Taz) *"women have a special mechanism"* (Fari)

The support from other women and women's knowledge, confidence in achieving 'that which no other can do' shines with humility from the words and actions of the women. Such confidence and self-actualisation was heard in the voice of a Pakistani woman

friend on the birth of a son, this story exemplifies the surge of strength and purpose her life now held as the mother of a son.

Much is written about Pakistani women being poor, powerless and pregnant (Sarin 1991, Pachauri 1989, Ali 1990, Sather 1990). Little is documented about the bittersweet paradox of birth giving women power in an oppressive society. This is a story narrated through the discourse of the women and the literature exploring in-depth the experience of childbirth in Pakistan under exclusive female control, using women defined knowledge. It further relates how the collective solidarity of women's knowledge and midwifery hegemony serves to transform the shy, modest, demure, devalued young woman into a mother with the power and confidence to protect her young and rule the family home.

The position of women in Pakistan is often viewed as ultimately dependent upon male members of the family, especially for social and cultural identity. However this offers a stark paradox to the relative independence that is achieved through the birth process. In the segregated family roles the interdependence of women with women left some women vulnerable and others supported. Naz was vulnerable - her mother-in-law treated her badly (Naz Chapter 6), whereas Farn, although she did not have a mother-in-law, her sister-in-law took on this role and supported her through childbirth (Farn Chapter 6). The interdependence has the potential to insulate the women against the strongly patriarchal society and gender oppressive culture.

The time frame spanning the women's stories and experiences makes up half a decade (1950 to late 2000). During this time there has been a knowledge explosion, a volcano of technology and satellite communication that makes the world a global village. None of this has touched the women in the rural areas of Pakistan, yet the women interviewed are along a continuum from the rural at the one end (Sha Chapter 6), to Shu, travelling alone from town to town at the other end. Multiple cultural layers of social and birth experience, plus midwifery practice are included within the research. Layers are formed from multi-social multi-ethnic women participants, including a doctor, dai, a midwife, and a professor. All are telling of birth practice and their birth experiences, underpinned by myself as a mother, researcher and midwife, supported by interpreters and fellow

midwives, all interpreting and analysing the woman's words in the context of our own experiences. It is surprising that there has been any consensus.

Working as a midwife currently in the pathologised western medicalised midwifery service, places a contemporary time frame to the findings. Also having observed hospital birth in Pakistan through the late 1980's and into the late 1990's reveals multiple parallels with midwifery in the UK during the 1950's and 60's. These parallels were validated through my own experience of childbirth which took place in the North of England in the mid 1960's (Appendix 1). The evolutionary (linear) timing of the interviews and the women's birth experiences took the research into birth stories that jump in and out of multiple historical contexts relating to knowledge, fashion and practice. However, many of the practices the women recalled are tied into birth practices that were reminiscent of midwifery before any regulation of midwives in the UK occurred. For example, little value is placed on antenatal care, the woman and her family choose the midwife and the birthplace is the home. Yet another time dimension links to discourse thought to change the balance of influence from women to men in midwifery and subsequent medicalisation. This masculinisation of birth started in the mid-eighteenth century recorded by Donnison (1988) Marland (1993) and Wilson (1995) in the UK.

The previous paragraph highlights the complex similarities and the differences of dai care across what was once one country and with a difference in time of ten years. To hypothesise parallels with the dai and the handywoman midwife in the UK may be spurious and purely for historical realism. The possible links are firstly they both work/ed outside any formalised system autonomously, second both had personal experience of birth and gained further experience through a hands–on apprenticeship way of learning and neither were/are regulated. Lastly and very importantly, the women who called them to attend knew both the dai and the handywoman. The only common parallel that linked directly to care is a perceived hardness or lack of compassion that some of the dais and handywomen are recorded as displaying:

> *Ruby and Molly (who delivered before the second war) reported 'Being bossed and it being agony,'* Ruby and Molly said:

> *" I think we've probably got a very small quantity of Sairy Gamps and even with good training you always get the bossy midwife with the best of intentions but totally unfeeling in everything she says and does"* (Leap and Hunter 1993: 144, 189)

This may have arisen from a feeling of helplessness, however, it is a truism that there are and always will be good, bad and indifferent doctors, midwives and dais in every society. Some who would bully women and others that were classed as angels (Leap and Hunter 1993, Smith 1997, Cowell and Wainwright 1981). Although I contend that the angels cannot be angels unless they stop the bullies, (even though this is very difficult in a hierarchical organisation), the angels are only angels in relation to the bullies - all women deserve kindness.

There is one major difference which made me realise that I may not be comparing like with like. Although the dai were practising outside the system in Pakistan, there was/is a system for training and registration of midwives. There are midwives in Pakistan (Ina Chapter 6) who are trained, who did and do work in an organised, if poorly unregulated, systems of health provision.

Pakistan was a British Colony up until 1946 and the 1902 and 1936 Midwives' Acts (that regulated the practice and training of midwives) did not appear on the Pakistan statute books (P.c. Vez). There is a Pakistan Nursing Council that issues certificates. In the UK, handywomen of good character were given bone fide midwife status until they undertook a midwifery course of three months duration, then they could go on the Midwives Register. This was how the current system of formalised training, registration and monitoring began.

Therefore, even though the legislation was not evident in Pakistan, midwifery training in the 1950's was as post 1902 UK. Ina provides one example of the decline in the enactment of legislation, around training of the midwife in Pakistan. She started her two-year midwifery training in Sind in 1952; the duration and content of the curriculum and requisite experience paralleled that of the UK at that time. The age of entry was eighteen years.

Currently (2002) the midwifery programme in Pakistan takes twelve months, (S...) (fifteen months at the L D in Karachi). The entry criterion is matriculation and the age of entry fifteen years. Some courses (not the L D) can (and have) been completed without a placement on a delivery ward, as a consequence midwives are qualifying without undertaking a birth. Standardisation of experience is not monitored by the PNA.

It would appear that in the differences there are also similarities, the bone fide midwives were working delivering the babies in the home and the dai continue to work at the birth of babies in the home - both are (were) unregulated and untrained.

The most obvious differences between the dai and the UK midwife lie in the birthplace and the involvement of men in birth. Men do not get involved in home birth in Pakistan, (except in rare circumstances like Ria's) whereas in the UK only two per cent of births take place in the home compared to over eighty per cent in Pakistan. Thus for ninety-eight per cent of births, medical men are part of midwifery in the UK, they influence antenatal care, take part in birth decisions and are currently involved in the delivery of over thirty per cent of birth (forceps, ventous and caesarean section). Because there is very little antenatal care for women in the rural areas of Pakistan (who will be the ones having a home birth), doctors and/or trained midwives and/or other health professionals do not get involved in childbirth.

Wilson (1995) addressed the question, why and when did women desert the traditional midwife in the UK? He maintained the two drivers for this change were fashion and forceps. Fashion was first adopted by the merchants who sold their wares to the wealthy at the top of the social scale; others aspired to afford such luxuries. Men came in to midwifery when they saw the potential of a lucrative income, they charged more for their services than the midwife and professed to be educated, thus the wealthy and the gentry who could pay thought they were getting better quality care from men midwives. This belief diffused downwards through the social scale by a process of 'envious emulation'. Wilson (1995:3) used the analogy *"like drinking tea, taking snuff and or wearing wigs"*. Contrary to this Wilson (1995) argued that the application of forceps, initially to extricate a dead baby, began among the poor (Cases in Midwifery 1734 in Wilson 1995).

Men midwives transformed childbirth from a female dimension into a part of medicine. However, this change was not assimilated to wider medicine, but came with a history of its own.

Although Pakistan was a British Colony until the middle of the 1940's the main religion was and still is Islam. The strictly segregated lives of men and women may have discouraged men from stepping into the world of women and birth. Although man midwifery and the wealthy choosing to call a man midwife occurred in Britain in the mid 1700's in other European countries such as Spain, Italy and Holland the man -midwife at a birth was rare and the midwife's hegemony over normal birth remained unchallenged.

Currently in Pakistan, the attention of a doctor appears to be out of the grasp of women who give birth in the home. This may be due to multiple reasons, governmental lethargy, norms and mores in the patriarchal society, or it is not lucrative enough. In order to draw the doctors to work in the rural areas they have to be paid sufficiently and the living conditions need to be attractive. It is ironic that in the UK it is fashionable to live in the rural areas, although with current transport difficulties this may be changing. In Pakistan, it has never yet been fashionable to live in the rural areas. Limited living facilities such as basic clean water, electricity, gas and sewerage do not make rural living an attractive option.

With the difficulties attracting trained doctors to work in the rural areas of Pakistan, it is not outside the realms of possibility that the government may decide to train up men (technicians, mini doctors), to undertake forceps or ventous deliveries. They have social mobility and are in the employment market and could be paid less than doctors. This parallels the pattern in history and the rising popularity of the man-midwife in the 17th century, bringing with him the real possibility of men taking over or interfering in the normal birth process. Whilst this is a possibility it is improbable that Muslim women, and especially the husbands would allow a man to 'attend' their women in childbirth.

A further option would be to follow the UK example (late 1800's) and give some training to the dai, offering them bone fide status they may then after some 'training' become midwives. This has led to the present situation in the UK. a position whereby midwives

have lost the skill and confidence to attend women who wish to give birth in their homes. One further option would be to provide a national programme that values the skill of the dai for normal non-interventionist birth. Build on these skills with a basic course in safe birth and how to deal with emergencies, employ one expert midwife per village to support the practice of the dai and who can deliver with ventous.

None of these options may be selected. The current policy makers have invested in the training of public health nurses. These nurses have a twelve week midwifery placement (observing but not undertaking deliveries) so they can work in the rural areas as generalists. With such limited birth experience, it is probable that the dai will continue to attend the women.

The dai is called to the births of over eighty per cent of women in Pakistan (UNICEF 1989). I am not privy to the knowledge that would answer the question, if the women could afford the services of a trained midwife would they call one or go to the hospital? I would suggest that if the question were asked, many women would not choose an option they know little about. Although the villages now have at least one television, men predominantly watch it and the programmes are gender biased and politically controlled. The limited health education programmes concentrate on population control through contraception, which fall wide of the cultural norm that values large families. The major problems around women's health and education are coming into the literature (National Health 1990). However, as only 7.3% of women are literate in the rural areas it may take decades and/or major government policy changes to see any change.

When listening to the women's (including two dai) testimony on what the dai does at a birth in Pakistan, there are as many parallels with the birth practice of England in the mid 1600's as there are with birth practice just prior to 1902. The bone fide midwives were working in a system whereby the woman had only one (more costly) alternative and that was to call the doctor, whereas the choice women have in Pakistan are multiple, if they have the means to pay.

The women from the wealthy business class who reside in the suburbs of the large cities in Pakistan (Vez and Shab) would travel to Britain, Europe or America in order to access technology and a very expensive medicalised model of birth - caesarean section.

The upper middle class (Mrs A and Aia) would access the totally unregulated private sector in Pakistan. Doctors, who undertake the delivery supported by either midwives, lady health visitors or untrained dai using a medical model of often unnecessary intervention, offer this.

The ordinary townswoman such as Shad (Chapter 6) has two jobs cleaning jobs. They may call the dai and if needed may access the Red Crescent Maternity Hospital or less likely the District General Hospital. Alternatively they may seek out the services of the private sector or a trained midwife who has another job in a hospital (private or public - both charge) and is prepared to deliver the woman at home. Whilst there are no stories of women who have chosen the trained midwife to deliver at home, staff working at the Red Crescent told how they practised 'privately' on their days off or holidays when they returned to their homes.

The wealthy woman however, may be living in a strongly traditional matriarchal family. Her mother-in-law will tell her that the dai who has delivered the rest of the family must be called. Even though this family can afford the transport to the town or even a developed county, the matriarchal belief is that the family dai who has delivered other children in the family must be called. I have noted a decline in this option over the last decade. This may be because older matriarch are visiting western countries (America, UK) and are influenced by the media and western practice.

The village woman would call the dai for the birth, even if there are problems that may require a doctor's intervention, the family may not be able to afford the transport (Sha, where both her babies died because the family was poor). It is interesting to extrapolate and apply the choices for birth venue and attendant made by the women interviewed in R... The families of these women were sufficiently well off enough to arrange marriages to men who could afford to come to Britain to work; yet the popular option was birth at home attended by a relative and a dai. It has to be remembered that these births largely

took place in the 1950's and 60's when the West was moving radically over to the medicalised model.

In Pakistan, the alternatives to dai and relative care are exclusive to those who can pay. It is my experience that the same practice occurs in the private rooms of the doctors as in the hospital (it is usually the same staff).

There are obvious immediate benefits to being cared for in labour and at birth by a relative and a dai known to the family in a familiar environment. The outcome of such a birth shifts the women from being powerless to being strong and powerful. This cause and effect is so obvious, yet it is smothered in the perceived benefits of technology and medical intervention possible when the birth venue is the hospital. Authoritative knowledge has the power to stifle or label alternative practice as unsafe. To be able to turn the tide of knowledge, communication systems need to be established, words are needed (in print) to both describe and uphold the intricacies and subsequent benefits of care by a known skilled person. Changing Childbirth (Dept of Health 1993) held up continuity of carer as a standard and then the government failed to fund the concept.

Immediately prior to the regulation of Midwives in the UK in 1902 and until the start of compulsory midwifery training for all midwives, doctors largely documented knowledge of the good or bad practice. Women's knowledge was kept in the head for sharing orally and not recorded. This was especially so in Pakistan where literacy rates for women were as low as 3.7% in rural areas (Ali 1990). However, as far back as 1680, Wilson (1995) found that in London midwives had acquired some literacy skills when fifty per cent of women were able to sign their names. Almanacs for women appeared in 1690. Wilson further suggests that it was literacy and leisure (of reading) that broke the bond that united women as a common culture. One would think that with women reading and writing it would be possible for the authentic voice of women to be heard. However this was not the case, the new literacy culture was saturated with the presence of men; this brought a new form of dependence on men. Also the knowledge in the head of the dai and/or midwives in history never have been considered authoritative and thus not recorded.

In the search for what factors around birth in Pakistan would contribute to the 'catalytic converter' that takes women from being oppressed to strong and positive, it is vital to address what counts as knowledge; where the knowledge originates, the form it takes and the application of the knowledge. Childbirth knowledge in the rural villages in Pakistan is in the domain of the women relatives, the dai and the childbearing women herself (after her first birth experience). The value of inner, intuitive knowledge (Farn Chapter 6) "*I know now*") is often silenced in the presence of the higher status medical knowledge. It is much easier to describe (and critique) a knowledge that has been recorded than one that is being passed on orally. The dai are unable to communicate their inner knowledge in the written word, leaving observation by others as the only way of communicating. 'Others' do not have the appropriate cultural or experiential lens or vocabulary to describe, so the inner knowledge of the dai is silenced.

The pervasive dominance of medical knowledge is built on scientific, mechanistic principals of measurement and singularly judges itself as authoritative and is uppermost in the practice of midwifery in the UK in the twenty-first century. It has the potential to devalue women's own knowledge by treating all women as the same, inferior. It judges outcomes on risk factors and probability estimations via complex statistical decision making. It is devoid of emotion and ignores the psychosocial cultural influences of the individual. This is diametrically opposite to the post-modernist needs of the individual women in the UK today. In the medical hegemony, no room or time is apportioned for woman to woman support; this has been squeezed out of the busy work and life schedule into a planned finite time for operative, technocratic intervention. Birth has become pathologised (Wagner 1994).

There is evidence that contamination from the West has weakened and replaced the belief, practice and benefit of woman to woman empowerment (Smaje 1996). As the ensuing medical hegemony ascended to its current position to be the knowledge of the educated, it is emulated by the lower classes. An example of this in Pakistan comes from Ria who expressed her concern about the increasing number of her relatives opting for the expensive caesarean sections, thinking that quality costs the much cheaper (and safer) option of normal vaginal birth is 'for the poor'. Emulating the rich, the poor aspire to

have that which money can buy and devalue the cheaper option; an example being pop stars, the idols of the young who may choose to have a baby by caesarean section. This gives the message to the young followers that this way of birth is better. The expensive way of birth that invades the body with instruments, wielded by detached unknown professionals, in the highly organised and formalised hospital services and undertaken by professionals who would be seen to have failed if they became subjectively known or involved with the 'patient'.

Wilkins (2000) in her study of the mother/community midwife relationship in the South East of England found a profound lack of 'fit' between the professional paradigm and the viewpoint of the mothers. In defining the professional paradigm, Ruth stated that the medical masculine paradigms preferred the concepts of rationality, objectivity, and formal knowledge. Ruth further states the professional outlook as blind to the processes that make a relationship. Campbell, Roland and Buetow (2000) in their theological text introduce a thought provoking perspective to professional care. They maintain there is a deep dishonesty in the notion of power status and income being gained from other people's ill health, confusion and social disadvantage. This somewhat cynical perspective fits that of Ivan Illich (1977) who accuses professionals of disabling clients by accumulating inappropriate authority. Dai and female family members are clearly outside the professional domain.

8.9.1 Summary

As I move through my own mental landscape, I have listened and applied the words of Pakistani women, reviewed the concepts of others, moved back and forth through time, across continents, cultures and birth practices. I have examined how hegemony and patriarchy score through the lives of women, unpacked some of the complexities underpinning the life worlds of women and opened out the togetherness around and childbirth. The journey has brought me to a place where women can be strong, positive and fulfilled.

We, in the western so called 'developed' nations, have a great deal to learn from women who can achieve so much with so little. My own learning has greatly benefited by using dialectics as a system of inquiry.

9 CHAPTER: DIALECTICS DEVELOPMENT THROUGH CONFLICT

9.1 A DIALECTICAL PERSPECTIVE ON THE FINDINGS

9.1.1 Dialectics as a framework

> *"Dialectics is a system of scientific inquiry that denotes movement from one state of ignorance, uncertainly and error to a qualitatively different state of knowledge by means of a process, dialogue, conversation, debate which is characterised by opposition, contradiction and negation"* (Tolman 1983:320)

Tolman's definition of dialectic provides the theoretical framework to address some of the key issues that emerged from the findings. Analysis of the data and related literature was like passing through day and night with no obvious beginning or end. Taking me from a state of almost blind ignorance (dusk), towards a realisation of the depth of my ignorance (night darkness), then onto an eye opening position (dawn) with the application of some theory, and a promise of a day with more knowledge. However clouds brought shade of misunderstanding, back into the dusk with the realisation of the expanse of knowledge and that the crucial may be missed. The night and day analogy also depicts the sadness and joy experienced in the ever changing search for knowledge and understanding.

Knowledge emerges through dialogue and debate that is shot through with contradiction. As night and day are a part of the same twenty-four hour period, contradictions, refutations and negation may be considered part of the knowledge on birth. If it can be viewed in this way then the dichotomy of right and wrong can be caste aside as there is a continuum. This analogy also recognises fashion, what is considered politically correct and authoritative at one time, is in the sunlight, but may be with changing knowledge taken into the night, to be left or emerge again at another time.

I realise that I am at a different state of knowledge, having passed through many nights and days, still on the upward spiral of learning, to that of yesterday, or during my first visit to Pakistan. The research has taken me into my own knowledge store (my life experiences) which shifted me from thinking the research began when I started to collect the data. In the dark of night I see only my own ignorance, realising just how much I do

not know, however, with each perspective opened through discourse or reflection, another day comes.

It is from this position of relative ignorance that I continue to extend the dialogue and debate on some key issues in the findings using Tolman's description of dialectic as a framework. This is undertaken in order to reach a qualitatively different state of knowledge. A truly dynamic process, exposing the contradictions and strong relationship of opposites and recognising that they are on a continuum which includes dawn and dusk.

The women's words have taken me into a world unknown and unfelt by anyone but themselves. I have 'ingested', nurtured, analysed and interpreted their stories. This has been done through my own culturally coloured heart, head, eyes, hand and pen. I have applied and critiqued existing discourse, celebrated parallels and reflected on the contradictions. I intend within this chapter to go one step further up the spiral that may take us through more dawns, days dusk and nights. Five conceptual contradictions are explored in some depth; others are identified and may warrant future research.

Table 9 Title: Dialectics

Outsider, insider to the research
Pakistan, conquered or developed
Birth, defining and defiling
The dai, essential but dangerous
Strong women through oppression

Table 9 Dialectics (continued)

Other dialectics for future study
Coming to England, isolation for education
Islam's view of women, equal yet deficient
Social control through positive shame
Women, vulnerable and valuable

9.1.2 Dialectic not dualistic

Prior to the exploration of the identified contradictions, it is pertinent to explore in more depth dialectics as a system of inquiry. It clearly is not dualism, working entirely with the extremes of the good or the bad, the two ends of a spectrum, polar positions, right and wrong. As Tolman (1983) states it is about development through debate, wholeness through conflict, completeness through process, the relationship of opposites, the process of constructive interpretation towards patterns of agreement, a synthesis into a higher abstraction, a route to resolve, wholeness (Moccia 1985). Taking a spiral journey towards a different state of knowledge.

Researching dialectics took me back to ancient history and the origins of science; this seemed like the dark night, as it was my first taste of philosophy, enlightenment and the nineteen-century theory scholars. Although there is no daylight shining yet, internal debate was informed and a basic level of understanding is beginning to emerge. At one dawn I realised science and education has been considered as synonymous and if the principles of science were not applied, ignorance was assumed. Science as the systematic study of nature and behaviour (Collins 1994) is a process constantly changing; with new thinking building on the old, the old renewed, new hypotheses become thinkable.

The nineteenth century rise of social science was directly related to the emerging dialectical worldview (Tolman 1983). Marx and Engels (1970) fully recognised the nature and significance of the intellectual revelation and undertook to apply a fully

conscious dialectic to the study of history, sociology and political economy. The history of dialectic is one of a gradual realisation of the developmental nature of all existence.

Plato's contribution to the development of dialectics was to include logic and metaphysics (non-physical) into the science of first principles. Aristotle is identified with differentiating between dialectical reasoning from generally accepted opinions to conclusions. Hegal (1964) develops the dialectic as an intellectual method integral with the world process of wholeness. It is towards Hegel's conception of the dialectic that this research leans.

Although greatly influenced by Kant's criticism of metaphysics, the common interpretation of Hegal's dialectic is movement from a thesis to an antithesis to synthesis; this would suggest a linear and additive process, yet this is not intended. Hegalian dialectics is a route to wholeness and not a series of steps (Tolman 1983). Georgoudi (1983:77) further defines wholeness as,

> *"The essential nature of reaching completeness through the process of its own development, never static continuously 'becoming', the innovative movement of knowledge"*

The underlying assumption of harmony in diversity is postulated as a relationship of essential opposites, a structure or pattern in which what appears antagonistic is merged into a qualitatively different possibility through synthesis into a higher abstraction (Stepelvitch 1990).

The pattern may be visualised by applying the warp and weft analogy as an alternative to the spiral of night and day. The warp and the weft carry opposing strands of knowledge; yet, together they interweave and produce new knowledge the cloth is developed by harmony through opposition. To add to this the colour and pattern of the new cloth will change as the process of new knowledge develops.

The work of scholars in defining the dialectical approach to knowledge offers a framework that fits particularly well to the findings from the research on birth in Pakistan. The development of knowledge through the describing, explaining and predicting that includes the relational warp and weft or the spiral night day process

constitutes a productive and harmonious nutritive approach that connects with the underpinning humanistic philosophy of the research.

Science also involves rules and players and is based upon deductive reasoning allowing universal claims. These claims can be tested and are repeatable. Scientific thinking rests upon the concept of control - humans manipulate resources and control outcomes giving pretence of objectivity. The concept of deductive and inductive research is now being questioned. Schmuttermaier and Schmitt (2001) state that at the onset all research is deductive, yet once the data commences to be interpreted and conclusions manufactured it then proceeds to a deductive inductive dialectic. Schmuttermaier and Schmitt (2001:2) use the metaphor of a carpenter.

> *"The furniture is the product of the carpenter/researcher and not the tools used"*

As stated science and education have been considered synonymous. However, scientific thinking can exist without education, as we know it. This is evident following my direct experience of asking a grandma why she was giving the new-born baby what looked like dirty water from a spoon. When asked why she was not advising her daughter to give the mothers' milk the grandma replied:

> *"We have tested the mothers' milk by putting a fly into it and it died, the milk is poisonous"*

Although grandma had never attended a school for her education, life had taught her to question, to test and to problem solve all scientific principles. Her obvious lack of knowledge (to us) around drowning made me reflect upon the gaps in my own knowledge.

Science makes the assumption that 'the basic stuff of the universe' exhibits two fundamentally different kinds of properties: matter-energy and mind spirit. Birth is uniquely concerned with both these properties. Contrary to traditional scientific beliefs, post-modern science allows, even encourages acceptance of subjective experiences as reasonable data (Harman 1988). Science has moved on from the theory then research epoch, into the research then theory process, as a simultaneous ongoing dialectic spiral leading to new knowledge

The process towards new knowledge development, research then theory, acknowledges that many research topics are out of human control and if control is attempted it can encourage a state of disconnection from the context. Context is especially pertinent in a discipline that is devoted to a holistic perspective such as midwifery.

Women's individual birth experiences could be one such topic where scientific rules would not apply. To the post-modernist, birth without the context would be rendered meaningless. There is a strong belief that science and the scientist are inseparable, as such the theorist; the researcher and the research are inextricably woven in the fabric of science. The defining judgement on the quality of the research is whether the research findings can offer defensible interpretations of multiple realities of interest to the discipline (De Groot 1988).

Dialectics as a system of scientific inquiry not only includes the situational context that leads to the development of knowledge, but, it also assumes that the observers/researchers are contextually situated in a dynamic inter-relationship with the observed. The former situational context is covered in Chapter 6. The latter inter-relationship context can be found in Chapter 3. Thus the ecological, social and spiritual context is inherent in the debate on women's birth experiences in Pakistan.

9.1.3 Ollman's framework of a dialectic

One example of a dialectical framework has been tentatively applied to unpack the contradictions in the findings, is that of Ollman (1985). Ollman judged the dialectic to have four functions.

> "**Outlook,** *a way of viewing entities as phases in their own development*
>
> ***Inquiry,*** *an approach to the study of problems that focuses on the search for relationships between entities both in the present and over time*
>
> ***Exposition,*** *a method that explains the organisation of a topic and the terms selected to accomplish this*
>
> ***Intellectual*** *reconstruction, the activity of incorporating what is learned through the dialectical inquiry into what is already known, in the process of expanding and changing the original understanding"* (Ollman 1985:9)

A further function that I would add would be Necessity.

> **Necessity**, *'to ensure the approach and development includes the two opposing perspectives. It must be seen to be a necessity for the dialectic whole to contain evidence from the contradicting perspectives, even if this is simply to acknowledge the starting point'.*

The utility and virtual unpacking of Ollman's (1984) dialectic served as a vehicle to synthesise some of the issues from the research on women's birth experiences.

9.1.4 Outlook

The first function Ollman said the dialectic had was outlook. Viewing the themes within the findings (Chapter 9), the opposing standpoints create the right environment for development to a new position. This new position will not be a conclusion, although some form of wholeness may be reached over time. Simply recognition of the contradiction may be considered a new position. Wholeness comes from further debate and a process of constant adjustment towards a new ever-changing knowledge.

Seeing the knowledge development as a process and not an ending served to remove or re-distribute the pressure I had been feeling to create new original knowledge for the sake of gaining a PhD. The need to 'discover' something new dissipated as I realised it was enough to document the spiral learning journey.

The value in the emerging concepts from the women's narrative came from both the exclusivity and the oneness within their lives. Thus the colour and texture of the 'cloth' changed not just with each woman but also with each moment in history. The more women's lives are explored, listened to and charted, the more knowledge will emerge to be shared with other women. Thus, previously unspoken, unheard and undervalued, women's life and birth experiences coalesced, then divided, then moved on up the spiral.

9.1.5 Inquiry

The second function Ollman (1985) said the dialectic had was inquiry. From first interview until present day, the relationship of opposites emerging from the data has been a challenging journey. The hardest part has been to swim against the flow of existing knowledge. Such knowledge has gained legitimacy by being in print. As Davis Floyd and Sargent (1997) identified, those who have dared to espouse an alternative knowledge system have been viewed by the authoritative opinion leaders as backward, ignorant, naïve or just trouble makers. Placing the women's words in the same weave as the previously dominant authoritative opinion makers exposes the lack of cultural authority that this viewpoint had. This is labelled by Bourdieu (2000) as 'misrecognition', whereby socially constructed coercive knowledge can be perceived as natural, legitimate and in the best interest of all parties whilst being oblivious to the other viewpoints.

The purpose of the dialectic is to value the alternative in order to resolve the differences, to achieve a higher abstraction and not simply lurch or react to one authoritative side then the other. It has been valuable to uphold each viewpoint, whilst always keeping the opposite in sight, moving both towards a synergistic completeness.

9.1.6 Exposition

The third function Ollman said the dialectic had was exposition and this was the one with the most utility to the research. This was because it offered the opportunity to establish a framework to present the opposing perspectives without discrediting or devaluing either. Exposition provides the opportunity to influence each opposing perspective, not simply cleave or separate them. Weaving the two opposing viewpoints into the debate values the contradictions, which may go on to produce a third substantial view. An example of this comes from considering the dai as essential but dangerous. The third view has to take account of the current position of the dai in society. Some lives are saved by the dai (Hunte 1981); this is also my experience after talking with many of them and discussing their actions in emergency situations. However, they do not get recognition. Is this because they are women in a patriarchal society and they have no social status? Also the

women whose lives they save do not have a political voice and the life saving takes place behind closed doors, the stories are for women's ears only. The dai's position in the future health care system needs to be acknowledged, changed and developed in some constructive way before the dai dies out, potentially leaving a much worse position for women, their health and the country's future.

9.1.7 Intellectual construction

The final function Ollman (1985) said the dialectic had was intellectual construction. This was similar to exposition and has enabled the themes within the findings to include the previously unheard women's words. The words of the women have been placed upon the same line as authoritative knowledge, questioning the latter when there was disagreement, strengthening the women's word when there was divergence. This has served to expand and change the original understanding, to bring a more innovative movement to existing paradigms of knowledge. Such a process of constructive interpretation of the opposing perspectives from a non-partisan perspective exposes development through conflict. Reconstruction of my thinking emerged from all the women's words; however, the analysis raised the powerful dialectics. Those with major impact upon my learning are the ones that are included in this chapter.

The intellectual construction by Ollman's functional dialectic has served a purpose to this research. This has been through opening out the utility of the dialectic to hear the women's words in the context of existing knowledge and facilitating constructive interpretation. Dialectics as a system of inquiry has also moved me to a different knowledge position and I am still moving.

The next part of this chapter explores the contradictions introduced at the beginning of this chapter. These are but a selection from the many contradictions that emerged from within the research.

9.2 Insider, outsider dialectic

The developmental nature of my own knowledge on birth in Pakistan began with observation as an outsider in culture and as an insider to birth. Being an outsider who was granted insider access afforded me the luxury of seeing the usual as unusual. This was evident within the preliminary focus groups whereby the women saw their lives as '*Tikhey*' (usual, no problem) yet later during the in-depth interviews revealed life experience that held fascinating stories of events. Because it was familiar to the women it was not considered interesting to tell. This may have parallels with not seeing our own culture or as the saying goes, 'fish cannot see the water in which they swim' (Wagner 1994).

It was a revelation to me that an outsider may be more acceptable to the women to entrust their life and birth stories to. I had judged that someone from the same culture and community would have been more accepting and understanding of the women's lives through their knowledge of the language and culture. However, lack of trust 'not to gossip' appeared to override the problems that any cross-cultural researcher brought.

I felt this trust was given almost without question on the back of my being a midwife who had visited and worked in Pakistan. However for some time I laboured under the assumption that I was selling the women short by being a cultural intruder. I was ultra-sensitive to the 'voyeur of an oppressed society' accusation. Although I cannot pinpoint the exact time when my position changed, I think it was when I started to see the women as strong with the power to withhold or share their stories to whosoever they wanted. This is not to say that I ever felt the power dynamic was equal. I was still the white western educated woman, asking questions with all the connotations this brings.

I am aware that there are gaps in the knowing that my culture and outsider position prevented me from seeing, I am happy with this as I feel I have no right to see them. I have moved from thinking that the research should only have been undertaken by an insider (Chesney 2000/2001) to the position that an outsider undertaking cross-cultural

research brings a perspective that may not be seen by the insider providing this is undertaken in a culturally sensitive way. The women should be the judges of this.[93] Through a process of insight channelled into constructive interpretation the dialectic of researcher as insider or outsider a new position was reached.

The wholeness theme or recurring standard within the internal debate on the emerging dialectic must be that the new position from the data remains true to the women.

The next dialectic explored encompasses the ecology of the research, the environment that takes account of the colonialist history.

9.3 Pakistan conquered or developed

A thread running through the narrative that emerged as dialectic linked to Pakistan's history as part of the British Empire. Colonialist rulers imposed or introduced, (depending on which perspective was taken), imperialistic western ideology into an eastern social system. Stories relating to both the developments (Johnson 2000) and accusations of inhibiting progress can be found in the text. However, the greatest influence was Britain's introduction or imposition of scientific knowledge.

Science has become the dominant worldview of the educated west. This developed historically with Bacon and Descartes with the Cartesian split of mind and body upholding men (researchers) to be separate and different from those they study. At the same time in history (1700's), the educated west was exploring and conquering 'under-developed' countries. Imperialist notions developed in the context of an interdependent mix of philosophy, technology, politics and religion and were underpinned by the view that those who were dominated were inferior. The dominant scientific worldview became the sword with which the west slew the dragon of the east, bringing the message of cowering inferiority. Anyone questioning the dominant worldview was judged as

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[93] This is why I wanted the women to be one of the thesis audiences. Four women have asked me to provide them with a copy of the thesis. One midwife teacher in Pakistan has read and commented on the content validity and three other Pakistani women have read and commented.

ignorant or infantile. This was a source of conflict and antagonism that came from colonised countries.

Following Pakistan's independence in 1946, a tension arose between the dominant scientific world view, left by the west and espoused by the educated, and the holistic beliefs of the indigenous uneducated majority. Evolutionary time differences between developed and developing countries and their methods of generating and disseminating knowledge can be juxtaposed with ever changing values underpinning research philosophy and methodology. The whole may contribute to the opposing worldview. Developed countries are beginning to undertake, publish and disseminate more ethnographic research, which brings a new perspective to sit alongside and challenge the popular (in Pakistan), scientific hegemony.

A Marxist perspective of imperialism would be one that judged the British to have plundered and taken over countries throughout the world, conveniently naming them part of the British Empire. The indigenous population was judged to be backward and as a consequence the educated west sought to 'improve' ways of living. One way was to introduce the link to disease from poor hygiene (the germ theory) into a post-enlightenment cultural belief system that upholds the dictum, God gives and God takes all, very much evident in the women's stories (Sha and Shad Chapter 6). The resultant clash of knowledge saw the indigenous knowledge driven underground, believed, but not spoken of, with the imposed given superficial credence.

The ensuing discourse from some Pakistani elders spoke both for and against the British rule, or what came to be known as the Raj. One old man told a story symbolic of when the British were ruling Pakistan. They were fair but strict; *'at least there were some laws'*. This was compounded by a story told to us by a GP, who was fond of stories with a morale meaning, about how the law was upheld when the British ruled (chapter 8).

Johnson (2000:67) introduced the positive side to imperialism:

> *"The Empire was not a sordid tale of greed, land grabbing massacres and cruelty. Creating and running the Empire was a vast exercise in political and economic experiment, scientific discovery, exploration and cultural analysis. It was about the creation of*

> *wealth and knowledge. The Empire was the greatest single historic force in binding the world together into one society under the rule of law. Although it had to be kept together by guns and warships the Empires most visible products were ports and roads, railways, canals, lighthouses, oilfields, hospitals, universities..."*

In negotiating a route to wholeness that contains the relationship of opposites, conquered or developed, there undoubtedly existed a negative dissempowering effect upon the nation over-ruled. Yet the British Empire was displayed with pride on the Pathe news of my youth. Juxtaposed to the dissempowering effect of colonialisation there was as Johnson outlines many infrastructure developments.

Colonised countries were plunged into 'alien' changes in their infrastructure, the introduction of 'developments' such as railways, roads, irrigation systems and democratic socialistic legislation. The implementation made possible only by the cheap labour of the indigenous country, not necessarily by monetary investment from Britain. These changes were planned in and for the west and not the east. Such different perspectives will not now be resolved. However, they demonstrate that there are truths even in opposites, as they all can contribute to create a liberating non-blaming wholeness that allows movement forward.

The dominant worldview of science left by the imperialist rulers of the colonies was and still is in the domain of the educated, inherently gender biased and reductionist. This serves to side-step women and knowledge of their life world. The development of credible research methods that present and value the participants' viewpoint, such as phenomenology and ethnography, has been slow to gain momentum in the west and are still considered by some to be *'unscientific'* (Dr Q chapter 6). From this vantagepoint, research undertaken with women, on a subject that has been publicly forbidden and hidden, using a method that has little credibility, it is inevitable that contrary opinions emerge.

The challenge faced within the research was to deal with the vastly contrasting opinions in a constructive but not dualistic way. However, the evidence from this text suggests that women's stories were 'protected' from the male dominant ideology by cultural norms of segregated gender roles and the polluting nature of childbirth. This had a dual effect, first,

in a true patriarchal way, it rendered women and birth invisible to the wider society and secondly, it served to keep out the interventive practices of the dominant medical model. Good dai practice at birth was particularly invisible.

9.4 Birth, defining and defiling

A contradiction in the text that stimulated dialectic debate came through the relationship of opposites associated with woman and birth, identifying birth as both defining and defiling. The terms linked to the opposing positions on blood as life giving, yet dirty (haram), menstruating and postnatal women are widely viewed in Islamic society to be a source of contamination. Subsequently the dai who deals with blood is considered of low status, unclean and only from the poorest lowest social class/caste.

Childbirth pollution is the most severe pollution (Jeffrey, Jeffrey and Lyon 1988: 106) women regard their bodily functions with distaste and as a source of embarrassment (Naz's chapter 6).

"I just thought I had dirtied my undies... it can be so embarrassing"

This introduces an interesting gender linked paradox inherent in Pakistan society. The doctor, surgeons and female obstetricians also 'deal with' blood yet all doctors are highly trained and respected, they are not considered fouled by the handling of blood. Their position in society is in the high status group. The obvious difference between the dai and the doctor is education[94].

The religious and social norms associated with blood have served to keep men out of childbirth. Davis Floyd (2000) says that the bleeding woman and the dai are a threat to male dominance. In Pakistan most, if not all the obstetricians are women. Muslim women and their husbands' prefer the woman to be attended by a female doctor. Although a strongly patriarchal society, the door to a woman's life and birth is kept firmly closed to men.

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[94] In the hospital the doctor steps aside for another to deliver the placenta, however, I have been in theatre when the doctor has had to remove a placenta praevia.

The debate around menstruation emerges as complex and contradictory. Menstrual bleeding denotes the change from child to woman and is confirmation of yet another dialectic: fertility. Fertility is a much-revered state for women in Pakistan. However, the blood of menstruation is considered dirty and shameful. It is given a label 'Haram' in Punjabi or 'Narak' in Hindu. Both terms loosely translate as dirty. The menstruating woman is thus considered by Pakistan society to be dirty. Yet following menarche the young woman moves into the sacred position by being fertile and capable of conceiving a son. Pakistan society rates being the mother of a son as the pinnacle of womanly achievement (chapter 8). The transition period through the rite of passage to becoming the mother of a son was termed by Van Gennep (1960:78) as the '*fertile sacred position of liminality*'.

Douglas (1966) raised the question of why it is that menstrual rather than other bleeding is perceived with disgust, or feared out of proportion to its actual ability to harm or infect. Kristeva (1982) distinguishes between bodily fluids that are polluting and those that are not, linking menstrual and post delivery blood to excrement. Ironically it would appear because men in traditional societies have a fear of contamination from pollution they have been content to leave the managing of childbirth in the hands of women. Blood, especially the loss of blood without injury, is what makes menstruation appear so powerful; the power conferred upon women by this blood is the source of both fear and joy. Joy that womanhood and the rite of passage that will lead to motherhood and in Pakistani society, a new family and much revered position. The fears and constraints around menstrual and post-delivery blood are not specific to the developing world; it remains one of the few areas of women's bodies to be almost unspeakable and unrepresentable.

In Sanday's (1981) view isolation protects and honours, with menstruation being a potential source of female power that takes the woman to motherhood, is not one often portrayed. Giving voice to both perspectives does not establish one as truth or right, but contributes to a further abstraction and understanding.

The linking themes of menstruation, intergenerational silence, the desirability of at least one son, are threads that run through the transcripts. The young woman's life is defined at

the onset of menstruation, she is then deemed to be fertile. The defiling part of her menstruation linked to society's beliefs about body fluids, especially blood. Socialised in a void due to intergenerational silence increased the fear (Ina, Bas, Farn and Dil chapter 6).

In summary herein lies yet another night- day dialectic spiral. The woman's position in Pakistan society moves from the non-person position of a prepubescent, unmarried daughter without 'true' family (dark night), through the spiral of defining and defiling of menstruation (dawn) to become defined at childbirth as the mother of a son within her own family (sunlight of day).

9.5 The dai essential but dangerous

In the chapter on the dai, (chapter 7) two very different viewpoints were presented. The women's perspective of the dai, as an essential and important member of the group assembled for birth. The second, contradictory opinion was from the trained professional staff, which was that the dai was ignorant and that her practice during labour and birth was dangerous and harmful to woman and her unborn child. Such divergent views need not be seen in a dualistic way as good or bad, but considered from a perspective that contributes to further knowledge.

Authoritative knowledge is not necessarily right; however it counts (Davis Floyd and Sargent 1997, Jordan 1993). The view of the dai as dangerous upheld by Jeffery, Jeffery and Lyon (1988) is linked to her profoundly polluting role, that of cutting the cord, touching the genitals and inserting a hand into the vagina. Dais also handle the placenta and clean the floor. What I would consider to be 'dangerous practice' was carried out by 'trained' staff in the hospital, yet attributed to the dai. Examples were; instructing the woman to push when her cervix was not fully dilated, applying fundal pressure in the second stage of labour and stretching the woman's vulva manually.

Women were admitted to the hospital, supposedly *'dai handled'*. One woman had a badly bruised vulva when the baby's head was not in the pelvis. Another woman was in extremis from obstructed labour because the baby lay in the transverse and she had been

in labour many days. Many other women were admitted with their babies dead inside them (IUD intra-uterine deaths) with histories of multiple injections and long labours.

However, there was no proof that dais were responsible, the woman did not say the dai had stretched her or delayed their transfer to hospital. It is probably that the dai did the stretching, as a relative would never touch the genitals. The dais however may have been under instruction from the mother-in-law. In addition, any delay in transfer is likely to have been due to decisions made by the mother-in-law or senior relative not the dai.

Chawla (1999:164) in her text on maternity in colonial and post colonial countries reports that dais would continue:

> *"To practice in dangerous cases when there is no other alternative, if the family did not blame them". This was confirmed in both* Ria and Dil's stories.

There does not seem to be any contradiction over the dai as essential (Jeffery, Jeffery and Lyon 1988 and Chawla 1999) and the findings within the current research. The dai is the person essential for birth. The contradiction is with the label 'dangerous'.

Chawla (1999:167) questions whether trained TBA's can be expected to reduce overall mortality and morbidity rates '*in the presence of poverty, illiteracy and discrimination.* When exploring the expectations placed upon the untrained dai it is evident that she is not in control of the decision to transfer, it may be to her credit that she does not abandon the woman.

In the context of the belief system that considers dai as essential for birth, it would appear that this is a pragmatic solution to ensure someone undertakes the dirty work. However, the dai is monitored by external standards such as mortality and morbidity rates and is subsequently blamed for the appalling high rates. It would seem that the wider public health measures such as poverty are not factored in.

I am aware that emergency management of birth in the home has been the basis of most TBA training programmes (P.c.). However, it is my observation that such programmes have mainly been designed, planned and delivered by hospital trained staff who may have themselves never worked in the rural areas. This may account for the programmes being

largely unsuccessful in changing practice or improving the mortality rates (Brasseur, 1992). Furthermore, efficacy is compromised because of a relative lack of knowledge about the needs of the rural poor, a lack of consistency in the training message or any understanding of the dais indigenous practice (Chawla 2000).

Training programmes also assume an infrastructure that does not exist. Without statutory professional registration or regulation, standards of training and practice cannot be attained or maintained.

There is a belief that the risk of death can be reduced if fully trained and supervised midwives were placed in villages (Kamal, 2000:2) reaffirmed this at the International Conference held in Karachi to celebrate the day of the midwife in 2000 that:

> *"Professionally competent midwives can bring down the maternal death rate. The evidence exists to show that the countries who have utilised competent midwives to provide maternal health services brought down their maternal death rates much quicker than those who did not"*

There are yet insufficient trained midwives to meet the workforce needs in hospitals in Pakistan (P.c. Lee) let alone supply the rural areas. Even if the cultural safety issues could be resolved to enable students to have a placement in the villages and the curriculum included community midwifery, there is no one to teach or mentor the students. There is also the additional problem of working after marriage being socially and culturally unacceptable.

Meanwhile the dialectical debate encircles the dai who is undoubtedly essential, by virtue of her undertaking the defiling tasks at birth that no-one will do; accused of dangerous practice that she may or may not have undertaken and if she has she may have been coerced into. Finally, the dai is rapidly becoming scarce, due to the social repugnance of her work.

For the time being, dais continue to provide a service, untrained, unpaid and unrecognised by society and the State. Reversal or resolution of this situation could begin by concentrating upon the dai's good midwifery practice and counting the times when she gets it right. These times were referred to by the women in the research, her presence,

support, massage, and knowledge of progress and traditional means of assisting birth. Not blaming her for the times when it goes wrong and counting the deaths that are largely due to the women's poor health. Lastly, legislation for an infrastructure that provides culturally sensitive programmes that would develop women who wish to be with women at birth providing a decent wage, would seal the future for the dai and the health of the nation.

Davis Floyd (2000) identified that social interaction was such that knowledge may be produced and displayed in one setting and yet in another it was not allowed to emerge. Dai knowledge can be heard in the women's part of the home, yet is muted in the hospitals and corridors of power. The dialectic then is influenced by the environment. The dai is seen to be ignorant in hospital and essential in the home.

The relationship of opposites is as much a part of the equation between the state, the population and the dai as the relationship between the dai and the woman. Each has a particular opinion, perspective and position. The relationships have not been analysed in a dialectical way previously. More often only one side is heard or published, that of the educated. The women's voice is silenced through lack of education. Taking account of the complexities in the ever-changing spiral process towards the development of new knowledge is exciting when the thoughts of those directly involved are put into the dialectic. To be able to do this it is necessary to view each contribution to knowledge as valuable, understanding the complexities of its source without favour or judgement. Rather than establish one view as authoritative, dialectics allows exposure of the contradictions in order to resolve differences.

Exposure of the contradictions reaches in to more understanding, further knowledge spirals towards wholeness when it is juxtaposed with the contradictions of strong women through oppression.

9.6 Strong women through oppression

A major sub-theme of the research is entitled strong women (chapter 8.) therein lies the current state of knowledge and a possible rationale for why women in Pakistan can be strong, even though they may be oppressed by culture, religion or society. Development within the debate has begun by recognising the strength of some women. I began this research believing that women were singularly oppressed, stuck in the one sided biased position that came from the popular media and comparing my own life and position in a very different society. My state of ignorance mirrored that of Sarin (1991:13) who said that Pakistani women w*ere 'poor, powerless and pregnant'*. Additionally I believed that Islam made women the property of men.

I did not stop to ask whether this was what the women wanted. I was certain they deserved better but judged the better to be what I wanted and had, such was my ignorance and arrogance. The movement towards a different knowing, a real eye opening came with the opposite position to that of oppression, which is strength. This was a concept in the narrative but became especially clear after meeting two women in Pakistan. Both had nothing materially, were from the poorest villages, worked exceedingly hard yet their eyes sparkled with strength and they emanated womanpower.

One of the women who changed my thinking agreed to be interviewed Shad (chapter 6); she was the mother of nine children who had taken many knocks from family disputes between her husband and his family. She currently had three cleaning jobs and wanted us to find her another. A request to take further control of her life was for us to give her the contraceptive pill.

The other woman was the trainee dai in the empowerment project village, who was a young widow who wanted to be trained by the doctor at the hospital to be the dai for her village. The rest of the village had borrowed money to pay for her to travel to town and observe the doctor. She was bright, keen and determined to succeed against incredible odds. The old dai in the village would not share her knowledge (as the trainee was not a relative). The village was one of the poorest we have ever visited, everyone was undernourished and there was no health facility within travelling distance.

I realise that the strength of both of these women arose from wanting to work and being physically and socially in a position to work, whereas many women are not physically able or in that position. I reflected whether the link with work and my perspective of the strength connected to my own Victorian work ethic.

Close encounters with women in Pakistan (living in their homes) had been with the upper middle class (GP and businessman's wife). Their work was in the home, they were completely satisfied by keeping a good house and home, even though they had 'help' the work was in organising and running the home. They devoted all their attention towards their husbands' needs and educating their children to ensure good marriages. It was fascinating to learn that the 'preparation' for future life of a daughter was directed towards attracting a good husband. This preparation began with educating the girl (if the family could afford it) followed by teaching her how to cook and clean, appreciate poetry, develop the art of good conversation, play at least one musical instrument and learn to sing and dance. The latter was in order to entertain both herself and her 'real' family (in-laws). This was alongside the necessary formal education, not with any intention of applying this to work, but with the purpose of attracting an equally educated husband.

I realised that the vast majority of women in Pakistan are denied a formal education. Or, as Farn and Bas (chapter 6) experienced, they only attended school for a short time (four to five years) before having to leave and care for their younger sisters and brothers because of their mother's illness and father's working away.

The majority of women in Pakistan are at the opposite end of the social scale to the ones we stayed with. The GP's son referred to the 'dark side' of the society when I commented upon the obvious malnutrition of their cleaner's child. The destitute live in tents at the roadside and uphold the image on the charity posters. This image is of a woman slumped at the side of the road, holding a baby wrapped in rags who has flies collecting round his infected eyes; the woman is begging for food. If the child has a deformity, this is shown to passers by. There are indeed women who are forced to beg in the towns and suburbs[95]

[95] There is no-one to beg from in the villages.

as there are women whose children cannot stand because of starvation (chapter 7). Until I met Shad and such village women as the trainee dai in the empowerment project village, I had not seen how the poor could possibly be strong. This began the debate that moved my thinking and subsequent knowledge away from the dark one-sided perspective of the dialectic spiral that all poor Pakistani women were oppressed.

Moving on through the debate took me into a realisation that as strong as I am physically, I would not be able to cope with living as most women do in Pakistan. I would not be able to work from morning until night whilst pregnant. I would not be able to breast feed a child until the next one was born. I would not be able to support and feed my large family without monetary support. This realisation shook me into asking the question, who is the strong one? This led me to the answer that it most certainly is not me, even though I am the educated one with a voice. The life that women have to endure may contribute towards their strength. However, I have only ever considered its effect on their weakness. Their resistance to infection in the hospital is derived from an immune system that has developed based upon the Darwinian principal of survival of the fittest. Further to this, I have yet to meet a negative, dissatisfied poor woman at the hospital. Although they perceive England to be very rich, they have never bemoaned their position or resented mine, simply achieved what they can with what they have got. The opportunities for women's strength are almost exclusively linked to childbirth. Only women can conceive and nurture a child, most births take place without technology. The home as the place of birth is a no-go area for men and consequently the practice of the dai is, as yet, non-interventionist. The positive group feeling and support reported by the women during their labour and birth is a source of confidence. The role of mother has been observed and prepared for since childhood. Becoming a mother and birthing at least one son guarantees the position of mother-in-law, which is the most powerful position in the family.

9.6.1 Summary

The dialectic spiral through the 24 hour day led me away from a one sided position, which was to consider Pakistan as a conquered and abused country, birth as a polluting and defiling event, and the dai as an unsafe and dangerous practitioner. This biased perspective culminated in a potentially jaundiced judgement of Pakistani woman *being 'poor powerless and pregnant'* (Sarin 1991). Thus dialectics moved me into the present position of alternatives and possibilities which is that of Pakistan being a country of opportunity, birth as defining, the dai as essential and finally, how women can become strong in a patriarchal society.

As stated in the beginning of this chapter dialectic is not a tool to explore dichotomies or polar opposite positions to find one right or another wrong. It is about a process through dialogue and debate, towards a different knowledge state (Tolman 1983).

The debate has opened my eyes to the contradictions within the social and cultural norms and values of Pakistan's society, seeing in the light of day has served to reveal my previous position as prejudiced and uninformed. However, I am well aware that although I am at a qualitatively different state of knowledge to where I started, I am not in a position to disregard one perspective and rigorously substantiate another. The spiral cyclical nature of dialectics as a system of inquiry is in constant motion.

When I began to study birth as it is for some women in Pakistan, I only saw the culturally strange, negative and shocking. The darkness caused cultural blindness that inhibited me from reflecting in any depth. The spiral dialectic debate has served to resolve the differences and has been an effective tool to explore the context of birth in Pakistan.

Throughout the analysis of this research I had an inner discomfort and dissonance with the reductionist feel that came as a result of taking the women's words out of context and extracting quotations or themes. The research was never meant to be casual or mechanistic, manipulating the women's words felt like a distortion. I was aware that I was analysing them from a western stance, applying discourse that was not always

critical. The only way I could reconcile this was to declare it. Using the dialectic as a system of inquiry took me through the contradictions and negation within myself and the text. On reflection, I felt that by bringing to the fore the opposite position I moved towards seeing a fuller picture and out of this came a qualitatively transformed position. I take this more confidently into the next and last chapter.

10 CHAPTER: LEARNING

10.1 Learning transformation

The aim at the onset of this research was to expand knowledge on birth and the entire text has been crafted towards this aim. The quality of the knowledge that has come through memorable stories and the narration of personal experiences could never have been imagined or predicted. Stories from the women's lives and of their birth experiences took me into another learning dimension. In order to emphasis the learning from the stories. Initially I intended to write the stories as parables with a message for midwives to apply to their practice. However, after reading Plato's allegory of the cave, a Gestalt light came on. The allegory would be used to explain some of what I had found particularly difficult to articulate, i.e. dissonance around interpretation and the learning I had undergone by undertaking the research. Using the allegory as a framework applied to some of the themes in the findings has served to highlight what is seen and heard, women's stories are interpreted from our own limited sight and hearing challenged position.

The format will be firstly to outline Plato's allegory of the cave, then apply this to the major themes from the findings to show the learning transformation that I have undertaken whilst undertaking this research.

10.2 Plato's Allegory of the Cave

Plato realised that generally humans can think and speak without knowledge. The converse of this may also be true - knowledge does not always have a language. Plato likens people to prisoners chained in a cave, unable to turn their heads. All they can see is the wall of the cave. Behind them burns a fire. Between the fire and the prisoners, there is a parapet along which puppeteers (other people) can walk and talk. The puppeteers behind the prisoners hold up puppets (their stories or life objects) that cast a light on the wall of the cave. The prisoners are unable to see or listen to the words and pictures of the puppeteers, but what they see are shadows, images or an illusion. What the prisoners hear are echoes. It is not until they see the light at the mouth of the cave that they realise that they had been deceived by an illusionary shadow on the wall. The light however had the

potential to blind eyes that were not accustomed to the light. This results in the prisoners disbelieving what the light had shown them

Such prisoners would mistake appearance for reality. They would think things they saw on the wall were real - they would know nothing of the real causes of the shadow.

So, when the prisoners talk, they talk about what they think they see, but they are really talking about a shadow and the words heard will be as if the shadows are reality:

> *"and if they could talk to one another, don't you think they'd suppose that the names they used applied to the things they see passing before them"* (Plato cited in Grimes 2002: 1)

Plato's point in this statement is that the prisoners would be mistaken, for they would be using the terms in their own language to refer to shadows rather than to the real things casting the shadows. In terms of our language, the names of physical objects are descriptors that we can see and already know. They are other names of objects or phenomenon we cannot see, things we have no experience of.

Plato sums up his views in an image of ignorant humanity trapped in the depths and not aware of its own limited perspective. The rare individual who escapes the limitations of the cave through a long tortuous journey discovers a true reality. Such a person is best equipped to govern having knowledge of what is ultimately worthwhile in life.

The importance of the allegory lies in Plato's belief that there are invisible truths lying under the apparent surface. Used to the world of illusion, the prisoners at first resist enlightenment as students resist education. Plato said that education is not a process of putting knowledge into empty minds, but making people realise what they already know. When the prisoners in the cave are liberated and compelled to stand up, turn the neck, and walk towards the light, they will suffer sharp pain, the glare will distress and the realities will not be clear. When informed that what was seen was an illusion at first they will not believe; the shadow will be truer than the reality, then turning an eye toward reality, the vision will be clearer. However, pain in the eye may make the prisoner take refuge in the illusion until such time they will be able to see the sun, not mere reflections. Bewilderment of the eyes is of two kinds and arises from two causes; either from coming out of the light or going into the light which is true of the mind's eye also.

Plato says what is necessary is reflective understanding.

In order to utilise reflective understanding to the stories women have shared on their life and birth experiences in Pakistan, it is necessary to consider that I have received each as a perception through a shadow on the wall of the cave. The woman telling each story has been behind the parapet using visual and language from a reality not of my understanding or world. My eyes were indeed blinded by the sun light when I stepped out to observe this reality, not undergo their birth experience, but observe other women giving birth from the UK social and professional paradigm. So I turned back to the dim firelight reflection on the cave wall to face the familiar reality of birth, my own birth experiences and work as a midwife in the UK.

It could be argued that I am both creator and interpreter of the images on the wall in the cave, which in a dialectical sense is acceptable, but requires in-depth reflection and understanding to articulate. My own experiences have been woven into the tapestry of the woman. My (in) capacity as a researcher borders at times on torment, reality pain in the eye and soul, brought about by the flash of the sunlight when finding out that reality within cross cultural research will only ever be a blurry shadow on a wall. Gaps in knowledge and the probability that the large silent spaces are present even in the shadow are just as important and relevant to the reality and have to be acknowledged by the reader. Whilst in the cave I had a strong feeling of dissonance, which precipitated a loss of confidence in my perception of the shadows. Yet I still could not turn my head, I knew my vision was faulty or incomplete but could not articulate why. The allegory of the cave has helped to explain why I only had confidence to write about myself. Goldberger et al (1996:85) understood the basis of this dilemma when he stated:

> *"I do not know anything is true outside myself"*

The recognition that the reality of life and birth was not within my vision brought with it a sense of release. Even if I was freed from the cave, was able to turn my head to listen and get over the pain in my eyes and eventually became accustomed to the light, it would not be shining on my reality. The allegory helped me to see that the reality was the women's. The illusionary shadow would be the interpretation and analysis of the prisoner (myself as researcher). However, the field work and observation method used in

anthropology and ethnography does allow the prisoners' own reality to complement the people under study through fieldwork diaries and reflection.

Anthropological research is based upon personal experience and indeed on personal capacity. Such capacities are the same ones that allow people to engage in social life, to experience the reality. Standards for such engagement are learnt in the first place as children and new standards or forms of life are adapted in adulthood. There is a need for the anthropological researcher to live the life of reality from the position of informed prisoner. I did not live the life of women in Pakistan, yet as an ethnographer I tried to learn my way in the host society, just as the men and women did when they emigrated to the UK. It is possible to learn to understand a new way of life, however in research parlance one then risks stepping over the border of objectivity by 'going native' Hammersley and Atkinson 1992: 98). Perhaps in Plato's allegory all one does is change position in the line of prisoners. The point I am trying to make is that fieldwork is a minor variant of a great theme in life. It represents a continuing encounter in the flow of events with new and unprecedented social circumstances from the vantagepoint of the prisoner.

The question arises, what is the nature of the knowledge the ethnographer produces from the research encounter? It is a very complex set of concepts made up of partly the knowledge of an everyday sort, such as body language, reading and narrative, and for this research, specific knowledge of the influences on the individual life and experiences of women who gave birth in Pakistan. Interspersed thoughout is an infrastructure of multi - paradigmatic knowledge, underpinned by an exploration of the researcher as biography, personal motivation and influence.

Using the allegory, the trustworthiness of what ethnographers learn in the field is questionable. All that can realistically be hoped for is an account, a plain observation or a description of the images represented on the cave wall. However, the words of participants (puppeteers) are more reliable, if only they can be interpreted. Herein lies the dilemma of interpretation mentioned previously. Reproducing exactly the women's words (tape-recorded and verified by them) in the text was essential. However, this still left the dilemma of what to include or leave out, as mentioned previously. The puppeteers

speak a different language and are from a different culture, further blurring the vision and distorting the echoes of the prisoner researcher. The puppeteers are also likely to have a minimum number of puppets (words or objects) available to make the vision anything like the reality.

The conceptual framework for this research was made up of the preliminary focus groups. The prisoners could not discern the shape of the objects or understand the words of the puppeteers and so gave up the show. Participant observation (within the R... women's group and at the hospital in Pakistan), whereby the prisoner was trying desperately to listen to the echoes and understand the image on the cave wall, without realising that she was tied up and the fire was nearly out. The in-depth interviews with a pragmatic convenience sample of women were experiences for the prisoner that brought some clarity to the images on the cave wall and some of the words spoken by the puppeteer connected with the reality in the head of the prisoner. The findings from the interviews were subjected to simple content analysis as well as analysis of the narrative that involved asking questions of the text. These questions were mainly answered from the prisoner perspective so whilst they broadened the image it did not take the prisoner any nearer reality.

Thereafter, one major theme and multiple sub-themes emerged. The selection of main and sub-themes was based upon the frequency the images shown by the women. The dai was shown by the puppeteer woman to the prisoner most often, not surprisingly the emerging themes exposed multiple contradictions. The women were trying to show objects that represented their individual experience. In a bid to prevent the fuzzy image from the diverse object shadows in the poor light of the cave wall from being lost to the limited vision of the prisoner, a lens or coloured screen of dialectic was inserted. An analogy of this could be the coloured glass put in the spectacles of the dyslexic person to prevent the words jumping around. Not with a view to establishing one clear object or truth, but as a catalyst to make the vision of opposing objects that come in to the frame, albeit from opposing ends of the spectrum. This would facilitate a process of constructive interpretation, allowing synthesis of the shadows into deeper resonance to present a new wholeness, bearing in mind that the opposing images both had fuzzy edges:

"The *dai is illiterate and half baked"*

The main (most frequently seen) theme that emerged from the women's life and birth stories involved the dai - who she was, her position in society and the community, relationships with other women and her role at birth. Although the National Committee for Maternal Health, under the Chairmanship of the Secretary of Health for the Government of Pakistan (2002), describes the dai as '*illiterate and half baked'*. I believe this is in the context of an artificial imported scientific knowledge with western practice as the norm from a prisoner's perspective.

The women puppeteers in the research were not critical of the dai; they saw her support as essential to the birth process, the person to call for when labour starts, the handyman who "*washed, cooked, cleaned and performed rituals*" (Kamal 2000). There were multiple common themes, or more clearly defined images of the dai role at birth, for example she cut the cord, disposed of the placenta and cleaned up the blood.

Images of the dai undertaking these tasks are interpreted from the UK prisoner's perspective only. The woman in the research did not hold the dai responsible for any decision making on progress of labour. However, some dais did conduct examinations. The dai's influence around decision-making and provision of care was dependent upon the experience of the other women, especially the mother-in-law who was also present at the birth. Mostly the mother or mother-in-law made the decisions, such as when to summon others, the dispenser or doctor for an injection, transport to hospital, change the woman's position or give her nutritious drinks or food. Women helping other women in childbirth are seen as an extension to the skills of mothering (Kitzinger 2000: 108) so women without children were not encouraged to attend.

Unlike the puppeteers (women) in this research, the women interviewed in India by Jeffery, Jeffery and Lyon (1988) were highly critical of the practice of the dai. This reflects the expectations of her to work as a midwife and is the prisoner's interpretation of the shadow. As a dai she was given the responsibility for mortality and morbidity, allocating blame when things went wrong, but without apportioning value to the important preventative elements of her support when all went well. Plato's allegory states

that reflective understanding and inner knowledge comes from the sunlight, the light has shone on scientific knowledge only. The light from intuitive knowledge appears to blind the scientist's eyes.

The puppeteers have been medical wo/men who have distorted the images of the dai, upholding their reality as in the light of education. The dai is found guilty of '*handling*' the woman, doing '*unsterile vaginal examinations*' and offering unhelpful comments such as, *"what baby is ever born without pain, just endure, taking the name of God"* (Jeffery Jeffery and Lyon 1988: 3*)*. Although Jeffery, Jeffery and Lyon (1988) had a stated aim, which was to correct the negative view of the dai so often presented in the literature, the image they continually saw was the one they knew. The light may have been too strong or they may have preferred to stay with the image on the wall.

My shadowy image of the dai equated with my 'reality', my literature view of the untrained midwives; some with developed skill and experience, some not so good, and both unregulated. It took constant staring at the shadowy image and listening to the echoes of the women (puppeteers) stories, before I saw the shadowy edge clear to show the shape of, in my vocabulary, the doula[96]. As an experienced (by virtue of her own birth) supportive woman, the doula has built up a repertoire of skills to be able to assist the woman give birth. The midwife is the skilled person, charged with the responsibility to assess and manage the labour and birth process. There is the argument that the midwife should be in a position to provide the service that the doula offers, however, because most midwives in the UK are employed, the may find themselves restricted by organisation policy.

Only a few of the trained midwives work as midwives in Pakistan.

> *"There are 10,000 trained midwives in Pakistan, however, the few that practice work in hospitals. The traditional birth attendants that have been trained have reverted back to old ways because there has been no monitoring or support. The little that has been invested has had no impact on mortality rates" (*Kamal 2000:2).

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[96] Kitzinger (2000:126) defines doula's as *women who give time to support women in childbirth, not as midwives but as sisters sharing the experien*ce"

This has spurred the prisoners to blame the dai, whereas if one takes the evidence from Guatemala, has shown a reduced morbidity and mortality when the doula is present at a birth. It can be deduced that the mortality rate would be much higher without the dai presence at birth. So, instead of blaming the dai for the high mortality she should be venerated for the service to humanity. Often, as happens, this knowledge (the prisoner is released to see the light) comes too late. Becoming a dai is rapidly becoming the last resort as an occupation choice for rural women in Pakistan. It is such an unpopular and poorly paid job that it is difficult to attract even destitute daughters to carry on when the dai relative is too old or sick. Dai knowledge and skill is not passed on in the written word, the 'objects' do not have a name even in shadow form. A traditional apprenticeship type learning takes time to integrate the 'working with' and the oral tradition of story telling. The value of this type of learning is now being recognised in the professional education arena.

> *"The time is right to revive and celebrate clinical story telling as a method for professional education and development. The stage is surely set for a new improved and lasting way of learning"* (Greenhalgh 2002).

In the allegory of the cave, the prisoners (clinicians) hear the stories of the puppeteer and may still be unable to turn their head and visually convert the 'objects' into reality. However, reflecting on and applying further knowledge may liberate the prisoner to turn towards the light and reality. In this way, learning from clinical story telling can prove to be an effective method of professional education and development, seeing but not experiencing. Story telling has earned the reputation of having impact on clinician behaviour (Freemantle, Harvey and Wolfe 2000; Wyat 2000). For a significant and sustained change in clinical behaviour, knowledge of the best evidence must be combined with debate, discourse and insight with a change in attitude and motivation, real evidence of liberation from the cave and seeing the light.

A number of studies by educationalists (Eraut, 1999; Macnaughton 1999) have thrown light on the process by which clinical experience accumulates. We start by learning detailed rules (seeing, and believing only what is on the cave wall) and as we gain knowledge, we convert these rules to stereotypical stories. Recognising the sequence of

what is seen on the wall; we then refine our knowledge by accumulating atypical and alternative stories (seeing the sequence and the differences by turning to look at the source of the reflection on the wall). Through experience, in-depth knowledge and reflective understanding can be gained from debate, discourse and oral tradition - the light is visible, albeit it may temporarily blind some people. There is evidence that clinical knowledge is stored in our memories as stories rather than structured collections of abstracted facts (Hunter, 1996).

Studies on the development of expertise in clinicians confirm the Dreyfus and Dreyfus (1986:31) taxonomy of problem solving: "*the more experienced the clinician gets, the less logical the decision making processes becomes*". Although the same object on the wall will be perceived by each prisoner in the context of their past experience, repeated experience may precipitate insight that inform knowledge and action.

Whilst there is a now a substantial and profoundly important scientific evidence base to midwifery practice, there is also an indefinable artistry. The importance of the woman's story as a learning tool is no longer in doubt. According to MacNaughton (1999: 202):

> *"The patient 'woman's' narrative interpreted by the skilled clinician (midwife) (has turned to see the light) provides relevance and context and offers insights into their beliefs and priorities and life choices".*

The unique, individual, contextual, interpreted story provides insight into what might happen and as such constitutes the raw material from which clinical decisions can be anticipated or reached.

Plato's allegory says the reflection on the cave wall does not bear any resemblance to reality. The sunlight figuratively speaking is reflective of understanding gained from education. It is important to recognise that the educated light comes from many types of knowledge. Two forms of knowledge contribute to learning: evidenced based and intuitive.

The dichotomy between evidenced-based and intuitive knowledge would appear to be typical of dialectic. In relation to midwifery, the polarity of allegiance to evidence or intuition may be perceived as an adversarial relationship, with one side being those who

see themselves as humanistic, woman centred intuitive midwives and those who support the rational explicit and systematic delivery of care. However, as Greenhalgh (2002) highlights, this is not a zero sum relationship, that is, more of one implies less of the other. The dialectic is between the deductive steps of evidenced-based medicine (the science) and the subjective interpretation of the woman's story (the art). The latter is advocated by midwives who often assume that at a philosophical level it is impossible to integrate the science of evidenced based practice with the intuitive art of clinical judgement. The polarity continues with the belief that evidence can be taught, yet intuition is unfathomable and simply happens with some midwives and women but not others.

Using intuition to inform evidenced based knowledge and vice versa would appear to be one route to wholeness. The route began with what appeared initially as antagonistic concepts, then along the way merged into a qualitatively different position, to eventual synthesis and higher abstraction learning. Thus, the combination of intuition and evidence applied to real life scenarios makes for dynamic learning enlightenment.

The prisoners in the cave are of both sexes, all cultural and occupational groups. The inability to discern the meaning of objects being shown by the puppeteers on the parapet is grounded in past life experience. Socialised, as we all are to recognise our own cultural shapes, we see them as the 'right' ones and use them as the measure of validity. When we turn around and face the light at the mouth of the cave, after initially disbelieving and judging, our eyes get used to the light and then we see that our own familiar objects are amongst many different shaped objects. Such is the realisation and reality that it drives light into the soul. Perry (2002) talks about this experience being the transition from sleeping to waking. I woke up in the process of analysing the women's experiences of life and birth in Pakistan.

11 CHAPTER: CONCLUSION

11.1 Shortcomings

The limitations of this research in many respects link to the cross-cultural methodology. This is referred to in some depth in chapter 9 when considering the 'insider, outsider' influences of a white western researcher undertaking research in a previous British Colony, across a language and culture barrier. One of the shortcomings arising from this is the potential gap in knowing and understanding. An attempt to fill some of the gaps was through the support and guidance of some very capable Pakistani advisors. However, for future research it would seem appropriate to partner a Pakistani midwife researcher.

Another limitation to the quality of the research has been the use of a relatively inexperienced interpreter, who, whilst having the interests of the women uppermost was limited by her age and unmarried status. The choice of interpreter (chapter 5) must in future take account of the interpreter's age, social status and personality, as well as language skill and knowledge of terminology.

Limitations to the sample size and social range of women interviewed were generated by a fixed time frame that is inherent with part-time un funded single–handed research. A longer time spent in the field would open up opportunities to interview more women, especially dais and mother-in-laws. It would have been really interesting to observe dais practice and to discover first hand the relationship issues in the birthing room. It may also have added value to be able to observe the births of women then interview them soon after. This would have introduced yet another time dimension to the research

11.2 Contribution to knowledge

It is hard to draw to a conclusion to what has become a lifetime study. It is however important to take stock at certain times and this PhD thesis serves as a way marker in a continuous process of learning.

When asking oneself the questions, 'for what' and 'will it make a difference' it is tempting to justify verbosely. However, words can be just that; words; action or deed

may never follow. It is hoped that this study will prompt action; provoking insight that can change thinking and subsequent interaction and care. Tandon (1989:7) says how alternative research such as this contributes to knowledge production by answering certain questions like, what is life and birth like for women in Pakistan. He also opens out the purpose of research beyond seeking truth.

> *"The dominant system of knowledge describes its purpose and answer to the question, 'For what?' as the pursuit of truth. In contrast, alternative systems of knowledge production are involved in answering questions of daily survival and providing insights into the daily struggle for life and living, or ordinary people in a struggle..."* (Tandon 1989:15)

This conclusion is underpinned by the aims of the research and personal growth and offers aspiration for the future.

Despite global technological advances, knowledge on birth in developing countries is still sparse, especially in Pakistan. Consequently, this research has had to draw significantly on text from India (Jeffery, Jeffery, Lyon 1988; Chawla, 2000, Sizoo, 1997) and use existing theory from the Americas (Davis-Floyd, 2000; Jordan, 1993; Behar, 1993, Lukere and Jolly 2000).

Certain points of interest emerged from within the total contributions to discourse. Although not intended to represent the whole, these are set out below as highlights to exemplify some of the contributions to the discourse on birth worldwide.

Prior to these findings there appeared to be little or no evidence to support the positive side of dai practice, yet, clearly the women in this study found her essential as she emerged as the pivotal person in their birthing experiences. This research uncovered some unsafe dai practice, but revealed much safe, traditional, woman centred, therapeutic non-interventional practice from dai and relatives as dai. Chawla's (2000) recent study of dais practice in India supports this.

A strong theme in the women's stories confirmed an ongoing gender preference for boys. This supports existing knowledge, (Aziz, 1990; Jamal al L-lail 1996). However, generally the women were not resentful of this preference, rather they basked in the 'specialness' of womanhood, knowing that until they became the mother of a son, they would continue to

have more babies (Biribili 2000). Economic and physical implications seemed secondary to the strong cultural need to become the mother of a son.

It would seem unfortunate that there continues to be emphasis on the dominant western medical model of intervention, within professional education, with little regard for the positives within the traditional model. These findings suggest that this is a continuation of colonialist influence.

The birth systems of the women interviewed were largely outwith this medical model. This made the comparison to the technocratic system obvious, showing the benefits of the traditional model. For example, for birth in the home the women had a firm belief in birth as a normal event, recognition of the process and acceptance of the time birth takes, against the highly interventionist western model that exists in both the Pakistan and UK hospitals.

Symbols of power within the Pakistan society are evident when blood is used as the controller of behaviour. Entwined in the cultural belief that blood, especially menstrual and postpartum, is the dirtiest product imaginable; puts the women, who are the repositories and contaminated into a position in society that is feared. It is especially interesting to note that it is women that perpetuate this 'dirtiness belief' and to explore the role and position in society of the person who deals with the blood, in the home, the dai, in the hospital the midwife.

The emergence of strong women in the face of adversity and oppression was enlightening. Such a realisation served to shock my western complacency and view of the propensity for dissatisfaction that is common in the affluent western world differently.

Further contribution to discourse in the text of this thesis comes also from the undertaking. Considerable learning has taken place in the unique methodological journey. A humbling example of this is the move from looking for answers to the realisation that there are only more questions. Further eye opening learning is the recognition that each methodology is unique and squeezing them into existing theoretical frameworks has the potential to restrain not release. However, it is only when seen in the context of existing

theory that its value can be judged. Dialectics as a combined philosophy and method provided the dynamic towards constructive interpretation and a type of wholeness.

A measure of whether the thesis has met the stated aims will be the interest shown by the editors of journals, conference organisers, readers, midwives, other health professionals, internationally and nationally. Also, this work presents a challenge to the policy makers in Pakistan.

The data from the women's stories will be used to inform midwifery teaching. The stories provide real life scenarios, experiences of birth over half a century, told in the women's words, with their own emphasis, in true context. These will provide a rich source of material for triggers to learning, to be used in problem based learning (Savin-Baden 2000).

My wish for the future would be that the policy makers in Pakistan take heed of the women, in their future decision making around who should be the 'midwife', to consider carefully the good practice of the dai, whilst working to abolish all unsafe practice.

When the ethical protocol was devised there was a challenge made to inspire, prompt and provoke a revision of thought and practice and to develop a new understanding. As the researcher the women's words have inspired me, changed my thinking and led me to a new non-judgemental position. I judged knowledge to be theoretical and found it to be personal. I judged Pakistani women to be passive and I found them strong. I judged birth to be weakening and found it empowering. I judged the dai to be dangerous and found her protective. I judged blood to be life-giving and found it feared. I judged research to be easy and found it hard.

The final quotation by Perry offers the way forward to understanding.

> *"When we all understand each other we will no longer worship our own routines. We will stand together when we transcend our cultures and recognise the capacity of all citizens of every nation, tribe and culture to grow, that is when we waken to the possibility of waking up"* (Perry 2002).

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Appendix 1 My life story

Born at home, the second of undiagnosed twins in the year the Second World War ended, must have been a shock to my parents. My mother was admitted to hospital in pregnancy with anaemia. She 'pinched her cheeks to look well' in order to be discharged to care for my older brothers and sister. Under the influence of 'twilight sleep' she was told that the midwife only realised I was in utero when my brother was born. He was *only* six poundish and 'Mrs Hamer did not have small babies' - my eldest brother had weighed in at thirteen pounds. A Mrs Stelfox was with my mother throughout the labour, dispersing the rest of the children to neighbours. It was the neighbours that rallied round for clothes and my cot was a drawer.

My twin brother and I were the youngest of five and I was the second girl. As my sister was ten years old when I was born, she became my surrogate mother. My sister's death at the age of twenty-one with leukaemia was a major traumatic event, as I remember the 'specialness' with which I was treated. I also remember being excluded from attending her wedding and funeral due to lack of decent appropriate clothing. Inevitably, as most pubescent children do, I blamed myself for not being able to save her, or at the very least, enhancing her death by rocking the bed when I visited her in hospital (she asked me to stop as she was in pain). My poor sister had got pregnant and married a totally unsuitable (in my father's view) man at the age of sixteen years. At aged eighteen she delivered a brother for their two year old. He died aged three months from a *blood disorder*, so was our ignorance. Up to the day she died, my sister had never had a holiday, a fact I remember every single time I am jetting away for yet another exotic holiday (the parallels with women in Pakistan hit me more each time I recall my early life).

Both my mother and sister were warm, kind, generous gentlewomen, who worked extremely hard until the very day they each died. My father was a typical Victorian disciplinarian. I quaked and obeyed. Neither of my parents ever had to resort to punishment by smacking. My father provided our food and shelter and was distanced from us, his children, by his mind. He was an active member of the Manchester Literary Club and a lay Methodist Minister. We children were clearly the responsibility of our

mother. Mother had an account at the local grocery store and we knew at the end of the month when we saw her crying that father had shouted because the bill was too high. Although a brilliant writer and orator (the only time the chapel was full was when he was speaking), we children did not appreciate this; his words both written and spoken soared above our heads. We never opened the leather bound classic books that were stacked neatly behind the glass bookcase in the 'house'.

My teenage years were spent engrossed in sport (netball) and the youth club. My brother and I left school at the age of fourteen years (June 1960). None of the leavers took any examinations or went on to College. It was felt important that my brother get an apprenticeship, as he would need to work for all his life. I started work on my fifteenth birthday in the local woollen mill as a weaver on shift work, safe in the belief that once I met my husband I would become a housewife and mother, or maybe work part time.

In the beginning, I was proud to take home what was then a good wage, tipping it all up (unopened pay packet) for board and having ten shillings a week for 'spends'. I remember the first shoes I tried on and bought from a shop when I was aged sixteen years. Previously we had been clothed and shod from jumble sales or catalogues. I also ate out for the very first time around that age. At work, my mother's friend and neighbour who took me under her wing spoiled me. I used to look round to the Polly's and the Freda's who had worked in the mill all their lives, and wonder if that was what life had in store for me. There was a time when I felt it was penance for a crime committed in a previous life. Never was it an option to look for alternative employment, escape was not possible, I did not know how. As I filled the shuttles and pulled back the loom arm, I dreamed of meeting a man who would sweep me off my feet.

My best friend got engaged on her sixteenth birthday to a grammar school boy whose parents owned the tobacconists in the village. He went off to the army, leaving Helen behind. Both Helen and I had a whale of a time (ten pin bowling and dancing in the rock and roll clubs) on money her husband was sending home to save for a house. On his leave he brought home a friend, who I became engaged to. He stayed on leave at the only Inn/hotel in the village. In 1965, during one of my fiancé's stays at the hotel, we both met the new manager. My first impression was of a 'middle' aged man; dark, arrogant and

'*greasy*' with a white apron tied over a paunch. This was the first meeting with the man I was to marry six months later and have recently celebrated my thirty-eighth wedding anniversary with. The hysterical trauma story of breaking off the engagement has been a tale told many times. My 'husband' got my ex-fiancé drunk, drove him to Manchester airport, put him on a plane to Dublin and he has never been seen or heard of since.

Escape from the hard work in the mill was only temporary. I worked in my new family's catering business just before and after marriage. This truly was hard work. We had our first daughter nine months and five days after marriage. I was only just nineteen, my husband twenty-eight years old. The birth was typical of the 1960's in hospital. I was cared for by someone who, when I asked if the baby was all right, replied 'that is for me to worry about'. Further to this, on my timid inquiry as to whether she was a mother, I was met with, 'What me go through this? Not on your Nellie!' I was told, as many women were, that I was 'not pushing hard enough' and if I chose to give up it would be me and my baby that suffered no one else. The woman doctor suturing me uttered 'don't know which bit to stitch to which'. Ten long-suffering days later I returned home to live with my in-laws. My husband had the mortgage on their house.

It was both my husband and my mother-in-law's belief that I was the mother and I should 'know what to do'. I remember crying and praying for the 'maternal instinct to come' and I would then know what to do with this baby. Surprisingly she survived, which was a meagre source of confidence, however when she was five years old, it was decided that we would 'try' for a brother or sister.

I was always thin, but for the first two years of my daughter's life I began to lose more and more weight. I was also plagued by dull abdominal pain constantly. After twelve months of a variety of treatments and weighing an incredible five and a half stones we decided to pay for a referral to a consultant. I had a hemi-colectomy for Crohn's disease in 1968.

Our second daughter was born in 1973. I worked right up to the day of the birth for both children and each time took only two weeks off work. Working in the family business meant that I was needed for the busy times and used to take the baby with me. I never had

any independence whilst living with my in-laws, my husband became a town councillor and we lived nine miles away from my mother. Following the birth of our second daughter and my in-laws' retirement, we bought my husband's parents out of the house. It was wonderful to have our own house; the only drawback to it was that I felt as if I had pushed them out.

I had dreamed recurrently of becoming a nurse, probably because of a tonsillectomy at aged five years. For the ten days I was in hospital, as was the practice then, my mother was not allowed to visit me. I had no idea if I could 'make it to be a nurse' either academically or psychologically. My family had labelled me 'highly strung' after my sister's death. I lived up to the expectations by being 'sensitive', 'timid and 'easily upset'.

With one child aged seven and the youngest only ten months I spoke to a neighbour who was a nurse about 'getting in'. She set up the interview with two 'old school' hospital matrons (one a teacher). Whenever I see the police interviewing criminals, I think of this interview. One played the good 'guy' the other was determined to slay me. I was told in no uncertain terms that I was a *risk to employ*. I had two young children and would no doubt have recurrent bouts of illness and time off from the Crohn's. The 'good guy' convinced '*Godzilla*' that perhaps I should be given a chance to prove them wrong. Due to that experience entirely, I have yet to have my first day off sick in the twenty-nine years of working. Like others, I know sickness hits on holidays and days off.

In my student years (I was given the two year EN course as test) I became known for my inquiring nature. In fact I incurred the wrath of one of my teachers when she dressed me down for asking questions, telling me that I should go and find out. I took her advice. Having excelled in all fields, I received the Gold Medal for the best SRN student during the two years it took to convert from EN. For the first time ever I was proud of myself, yet I was unaware that I had set myself a very steep path to climb. In the late 1970's, once one had 'qualified' it was experience that gained promotion, yet the one course that secured 'double qualification' and almost guaranteed a sister's post was 'midder' (midwifery). I heard the rumours that the EEC was making it necessary to lengthen the training by half again to eighteen months. This fact alone spurred me to switch from Intensive Care Nursing to student midwifery.

My midwifery student days were pure misery, I was no longer 'needed', and the women looked beyond me to who really mattered - the midwife. Although I had an excellent mentor on community, the hospital midwives and their practice convinced me that I did not want to be one of them. Routine ruled, induction was the norm, consultants controlled, the hierarchy-quashed innovation, but worst of all, one was ridiculed for supporting women who wanted birth to be a satisfying experience. After only twelve months and certainly not fit to practice, I passed the theoretically inappropriate examination and immediately applied to work back in nursing. On my way to hand in my notice, I bumped into my community mentor. That conversation changed my whole life. After only ten months in the hospital, I applied and was shocked to be offered a community midwifery sister's post. Again, I was being put to the test. The Director told me that I was to take over the largest and most difficult practice in the district. Three different community midwives had tried to run the practice in the preceding year and begged for out. A colleague said that every new community midwife should start with that practice to teach him/her what work was about. Without much support from the community midwives initially (because I was a 'rookie' in midwifery terms). I sallied forth into the happiest five years of my career. I found the role demanding, satisfying, rewarding and challenging. I enjoyed working with students yet, on reflection, for the first six months on community I was lonely; I missed the banter of my colleagues in the hospital, especially sharing the responsibility of decision making. However once I became *independent* the job satisfaction piled in. This was when my love of the profession and the women I cared for was born. I wanted to know more to help the women and improve care, so enrolled for the ADM (1985). It was then I realised just how much I did not know and also how to communicate it, which required certain academic skills that I had never mastered. My first assignment, History of Midwifery, was a mass of fascinating facts with no structure (except time), extremely bad grammar and dubious punctuation. I failed and began to climb the steep hill of academia that still looms like a mountain above me today.

I thought I would burst with pride when I passed the ADM., my clinical confidence rose to a peak, colleagues sought out my opinion and even the GP I worked with treated me differently. I have vivid memories of an ENB Midwifery Officer coming to the clinic and

sitting in with me whilst I booked in a woman. The GP came in and told her that I was the practice's senior partner for midwifery. We had by then built up a very good rapport, I only called him when I was concerned and on the odd times I did that, he really listened.

Because the Director of Midwifery Service had done the ADM the old way, combined with the MTD, she did not fully understand the new way. She felt that I had only done half a course and persuaded me to do the MTD (Teachers Certificate). Another motive was that at the time, the service could be reimbursed for my fees and salary. I spent a miserable academic year doing the certificate, never really understanding what group I was in or what the names of the groups meant. I followed others like a sheep, not knowing what I was supposed to be doing, reading but not understanding. This was not midwifery; it was full of strange terminology like taxonomies, educational and psychological theory and research. I hated it, I cried driving home, I felt trapped and wished I had never given up community midwifery or 'my' practice. My husband gave me a masculine alternative after another miserable red-eyed journey; "*You either pack it in or get on with it*". The latter was the only option, as I could not face the Director and say I had failed. So I limped through two teaching practices, both over the Pennines in winter. One was a nightmare, the other a painful learning experience with some really kind people. The assignments were nothing short of mediocre and the time dragged. The whole experience confirmed the view I had of myself. I had outstretched my ability, this was the limit and my place was with the women not the books. With jubilation and surprise, I graduated as a teacher. The most surprising factor was that I enjoyed teaching the students and they appeared to enjoy my teaching. What I did not like was the rigid, hierarchical, austere, patronising way I saw students being treated, especially by the compulsory obstetric lecturers. I remember in my training asking a consultant, who was teaching us posterior position, how long it had been since he had cared for a woman in normal labour and he reported me to our teacher.

When I went to inform the Director of my impending return, she informed me that Miss E. was retiring on ill health grounds. I was to take up my place in the school on the day of my return. My heart sank, I had lost my practice, and I had trained myself out of the job I loved. Teaching was standing in a classroom quoting the text, models, diagrams,

lists, spoon feeding and cramming. Theory was a textbook and practice beckoned me every minute. The teaching unit was attached to the labour ward, so, when there were no students in school I would help on the unit and do some 'proper work'. The textbook laid down the rules for passing the exam, watching the 'good ones', dodging the harridans and being in charge (even as a student) picked up the practice. Consultants came to do statutory lectures from notes made ten years previously. There was a meeting once a month, the senior midwife teacher wrote the curriculum and we worked from lists of content to deliver a 'hotch potch' of topics in a stilted way, all without mentioning or thinking of the woman's needs. For those who remember these as the good old days, I question their sanity.

Three years and I had had enough. I then turned to an era in my life where I learnt most about women, not pregnant women but menopausal midwives. Twenty-nine point six, whole time equivalent, community midwives constituted my caseload. As their manager I learnt what motivated them, how close and how cruel they could be to each other; each one with their own specific needs, each one with varying degrees of commitment to the job. I felt like a juggler with all the balls in the air, batting them back up but afraid they would all come tumbling down together. Sickness ran in peaks and troughs, as did satisfaction and tragedy. Change was constant; challenges continuous, but the camaraderie, the belonging, the pulling together and the support leave me with a warm longing to return. Why did I leave? A dark cloud gathered. Our Director got her much longed for retirement package, I acted up for twelve months and then they appointed from a nearby Trust. I felt hurt, deserted, humiliated; they knew me, I would lay down my life for the midwives and women I knew so well. After seventeen years they would have stood on their head for me, yet the management did not want me as their Director.

I rationalised that I should give the new Director a chance. It was not her fault *they* did not want me. Six months later, after having my integrity questioned, being totally confused by her behaviour - sweet words yet sour non-verbals, I begged my ex-boss in teaching to take me back. She welcomed me with open arms and until the day I retire I will give her my loyalty, commitment and hard work. By then I had my first degree gained at Huddersfield; three years with a terrific multidisciplinary group and a

supervisor who had the warmth of a favourite uncle, the skill to make one feel ultra special and the direction and understanding of the perfect research supervisor. I look back upon my life since starting nursing and realise that I am an epitome of the life long learner. I have likened it to a hunger, the more you eat the bigger the stomach becomes. Each bout of *indigestion* and I consider going on a *diet,* however, much as I struggle to limit real food, I cannot control my appetite for knowledge, and on it goes...

Completing the Masters at Surrey was especially painful because it meant time away from home and family. It felt like a selfish act, only thinking about myself in the evenings, the freedom to think, to study, to eat when I was hungry. I realised just how much I had juggled home and work, squeezing in at the bottom of the priority list, reading time. The luxury of time to read during the three, two week blocks away from home is such that I yearn inside when I think of it. I have always used every spare minute to read but have always felt that I have to read twice as much as 'an academic' to ingest the same information due to my poor basic education.

Although I had worked for four years with Pakistani women in R.., it was only after visiting Pakistan that I realised how blind I was to their needs. The very first visit to Pakistan was not only a culture shock but it removed the ground from under my feet. I could not stand by and let women and children suffer in the way I had witnessed. On my return, I wept helpless tears, night after night, nothing had any meaning. I alternated between walked around in a daze to burying myself in thought blocking work. Whenever I stopped to think, I shook my head, disbelieving the pictures imprinted on my inner eye. I hoped that I would wake up and it had been an unreal nightmare. The only way I rationalised *knowing* was to do something about it. Hence the return visits. With each subsequent visit my eyes opened a little more. Like peeling an onion, each visit stung my eyes, as the next layer was uncovered with more shock and disbelief. Was it that I had become accustomed (sensitised) to the previous layer and found pain the new previously unknown? Yet, it was on the fifth visit that I experienced the acute discomfort of being different. The midwife who accompanied me had the experience and the language skills to communicate with and for the women. I was superfluous, a misfit. What right did I have to think that I could possibly help when my help had the potential to do more harm

than good? Not being able to communicate serves to create problems. I began to dwell on the times when I got it wrong:

The classroom teaching

Trying to get transport for the health visitor

Helping with the application for a salary rise

Anaesthetic machine - never used.

Shoes for the village children

It was not enough to want to get it right. It was not enough to smile, nod and hug. Communication was the key. I did try; I did attend Urdu classes every Saturday morning for two years. These did help me to understand more but no matter how I try, they cannot understand me. There is only one way to learn and that is to live there for a long period. It is not the time in my life to be able to do that yet but maybe in the future.

The last four years has seen recognition of achievement in an academic institution and I still awake every morning with the feeling that I will be 'found out' and shown the door for not being academic enough. I have been for the last two years the Director of Midwifery Education at Salford University. Being elected to this position by the midwife teachers I manage was an accolade. I still have to pinch myself to believe. I am privileged to work with a brilliant team, for a boss who is sensitive, understanding and fair. The organisation is culturally strange compared to the NHS. However, I prefer the working practice, as it is egalitarian and not hierarchical. There is still the drive to be recognised as an academic (in the full knowledge that I am not and never will be). From my present position, getting a PhD would be the zenith of my career. It would be the marker to Pakistan doctors that midwives can be equal and should be respected.

Appendix 2 : Information for women

The University of Sheffield---SCARR

Sheffield Centre for Health & Related Research

'Research into the birth experiences of Pakistani women'

Research project whilst completing Phil/PhD– Margaret Chesney

INFORMATION FOR WOMEN

Thank you for agreeing to be interviewed, an experience I hope that you will find enjoyable and worthwhile. Your contribution will help towards building a more complete picture of the birth experiences of women. You have been invited to participate in this research because you have experienced birth in Pakistan.

The interview will take approximately 45 minutes to an hour. If you are in agreement I would like to tape record the interview as it is the only way I can accurately recall everything you have to say. If there is information you would like to speak "off the record" then please feel free to turn the tape off. Although I hope you will not find it necessary, you are at liberty to terminate the interview at any point.

Both the site where the research is being done and all the participants will be annonymised, no personal information such as your name, address or area of work will be recorded. The tapes will be kept in a locked filing cabinet accessible only to me, the content will be transcribed word for word by me, except when needing translating from Punjabi to English, this will be undertaken by a trusted Midwife colleague. The computer on which the data will be stored is my own personal property and not used by anyone else. Once the project is complete the tapes and the computer records will be wiped.

To protect the privacy of others taking part in the project, I ask you to maintain confidentiality and to agree not to discuss any part of the research with other participants.

This study will help provide a better understanding so that policy makers and midwives may provide more culturally sensitive midwifery care to Pakistani women in the future.

If you know of women who are eligible and would like to be interviewed please ring:

Mrs Margaret Chesney, 7 Haugh Fold, Newhey, R... OL16 3RF Telephone Number – 01706 841520

Appendix 3: Participants in the research

The names have been changed, brief descriptor.

Aia	Vez's mother
Shan	Midwife who translated tapes form focus group
Ria	Gatekeeper over 50's women's group
Shad	Wife of gardener at the rest house
Farn	Farn had a my picture of me with her daughter
Naz	Three generations was a dai family did not know Naz was a dai
Bas	Mother of Siaq chiropodist wanting to be a midwife
Dil	Family health worker and different
Ina	Retired midwife from Pakistan
Ami	Riz (student midwife)_mother
Bal	Interpreter visited Pakistan 2000
Fari	Teacher from the over 50's group
Shut	Interviewed on the bus
Sha	Mother of two, interviewed at the hospital
Shab	Shab, second wife of Vez
Vez	Vez, friend with two wives
Taz	Taz, religious daughter and son
Dot	Retired midwife from UK who acted as research assistant
Riz	Student midwife who is the daughter of Ami

Fran	Daughter of Farn who had a picture of me
Lee	Midwifery teacher in Karachi
Kad	Interpreter nurse, data collecting field trip 1997
Mrs A	Dr A.'s wife
Jan	Student midwife from UK
Fauz	Fauz, Naz's daughter-in-law
Hus	Pervez's second wife, who came to the UK to give birth to her second child
Dai	Dai who would not give her name
Dr Q	Doctor at the hospital in Pakistan
Siaq	Bas daughter
Sam	Taz's granddaughter
Farz	Midwife in Pakistan who came to work in the UK
Irs	Midwife from Pakistan who came to work in the UK

Appendix 4: A sample of Concepts from analysis of in-depth interviews

Birth practice

- Dai in the corner (Ina, Riz)
- Morbidity (Naz)
- Advice on position (Fara)
- The birth of a son (Ria)
- Hidden labour and pain (Fara)
- Position for birth (Ina)
- Mother as dai for family (Dil)
- Kind dia (Fari)
- Home is the best place (Fari)
- Push and pull no analgesia (Taz)
- No antenatal care, everything OK (Ami)

Boy preference

- With each girl treated worse (Naz)
- Boy popular (Bas)
- Responsible for being the mother eof son (Dil)
- Boy preference (Fari

Authoritative power

- He is a doctor I am a nobody (Ria)
- Intergenerational silence (Taz)
- Women special mechanism (Naz)
- Silence and multi-level helplessness (Naz)

Others

- Time and dates important (Fara)
- Unclean (Taz)
- Pale fat baby (Fari)
- It was like mud (Dil)
- Heavy work (Fari)
- Opportunistic visitor
- Not clever enough to be suspicious

Appendix 5: Examples of key issues, over fifties group

- Gatekeeper Razia
- Did not tell I was coming (word and deed)
- No wish to be a 'taker'
- Purpose – to build relationships
- *"you are lazy you can speak perfectly good English"*
- Afraid and too shy to tell her mother she was pregnant (32 years ago)
- *" My experience would be out of date".*
- An elderly woman living alone
- A broken hip but not immediately taken to hospital as the family had no money.

Focus group 3.3.97 (Transcribed by Shah)

- Who and where information (on pregnancy and childbearing) could be acquired, though friends or relatives who had themselves had babies.
- I felt accepted as part of the group, someone shouted "hello Margaret"
- A chair was brought over for me with the comment "here you are Margaret"
- "*I am a different Pakistani*" telling me that she came from Kenya
- I had already eaten and was not hungry, however I felt it would have been churlish to refuse the food.
- I knew the rule (social/group norm) pay 80p
- My roller coaster of emotions took a nose dive (I asked the same woman the same question twice)
- Rescued by a story of being at the birthing of a sister's baby, which was dead.
- I was jubilant, the bland 'no problems' norm had been had broken. I felt a trust growing
- No children because of TB, 'Allah's will', husband angry when children move newspaper so it meant to be.

- She had pleaded with her husband (her cousin) to take another wife
- Upset over talk of children
- It felt right for me to assist the women in the kitchen.

Fourth Field trip to over fifties group 10th March 1997

- GPs wife who had worked as a midwife in Pakistan.
- Within two minutes she was weeping, 24 year old son died in Pakistan.
- Woman, care assistant for the Social services, liked to care for Roman Catholic people
- Electioneering local MP came to speak to the group
- M and N, names mixed up N insulted
- I was a 'regular' although I still asked for Ria (permission to be there)
- Women did not care if Ria came or went
- Dull eyes –depressed because children were independent
- Barriers down when eating
- Fasting when pasta served
- Cooking – charity (social) work
- Resuscitation, quiet
- Blowing on hands, stroke the body – blessing
- Returned transcript, 'marked' in red
- "I keep going dizzy"
- Advice to go to doctor felt like I was fobbing her off
- "Hated weight" just listen

Appendix 6:Published work

Dilemmas of Self in the Method

Margaret Chesney

In this article, the author focuses on the researcher in research. Challenged by the theory and criticism of self-indulgence, the author has, as the researcher, come out through reflection and self-scrutiny to address some of the dilemmas the research process has held for her. Dilemmas concerning interviewing women from Pakistan using interpreters have been covered previously. The dilemmas discussed in this article concern the position of the researcher and honesty, the criticism of Western dominance, and how the research process has changed the author.

As a British-trained midwife, I have since 1989 made a total of nine field trips to work in a Red Crescent Maternity Hospital in Sahiwal, Pakistan. The work involved teaching and supporting midwives, doctors, and lady health visitors and dais. An evaluative study of the teaching input was undertaken in 1993 (Chesney, 1993). The sample for the current research comprises two groups of women. One group (7 women) was interviewed during a field trip to Pakistan in November 1997. Participant observation of birth practice in Pakistan was undertaken. The second group of women has also given birth in Pakistan, but the women are currently living in the Northwest of England. Prior to interviewing the second group, participant observation was undertaken with an over-50 Pakistani women's luncheon club. It is from this group that 10 women agreed to be interviewed.

This superficial background tells the reader little about the researcher within the research process. Real subject knowledge comes from knowing the people as well as the topic; yet there are many veils within methodology that hide the researcher. Although none of the qualitative research text overtly depersonalizes the research process, there is a consistency in the text that the researcher should not engage personally with the processes of the fieldwork or declare himself or herself in the analysis. Researchers are exhorted to neutralize or hide themselves behind a veil of objectivity, not to declare themselves. Putting the researcher in the research has been called self-indulgent, exhibitionist, even narcissistic (Coffey, 1999, p. 3; Okely & Callaway, 1992, p. 2), but it is not the unmediated world of others but the world between ourselves and others that adds reality to the field (Okely & Callaway, 1992, p. 1).

PURPOSE

In this article, I explore the dilemmas that arose when reflecting, analyzing, and writing the research concerning birth for some women in Pakistan. The "me" in the

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research influenced the choice and focus of topic, the relationships in the field, and the content and analysis of the data and finally writing up the research. I judged that it would be immoral and deceitful to ignore the initiator and fundamental shaper of events. For the readers to accept the research as valid, they must be able to scrutinize the integrity and philosophy of the researcher so that the findings are trusted. Okely and Callaway (1992) support rejecting the division between subject (in this case, women) and researcher in the field of investigation. Coming out as the researcher involved honesty, openness, and also acknowledging how one has changed and continues to change over time and with experience. Coffey (1999) acknowledges that "ethnographers rarely leave fieldwork totally unaffected by their research experience" (p. 7). How I changed and developed through the fieldwork and the analysis has affected my relationship with the women, the content, and myself. To hide this knowledge behind an unspoken veil, not to lay it open for scrutiny, is to deny its presence, which constitutes a gap in the research, what Coffey calls the "silent space" (p. 8).

As the research is about examining the birth experiences of women and how they interplay with the private, personal, and social worlds of women, my role as the researcher is to place this private world in the public domain for academic and professional audiences. For the research to have credibility with this audience, it is important for more than past experience and qualifications to be laid open for scrutiny. Consequently, I focus on the dilemmas experienced as a researcher, with women, for women, that came with me as researcher and how they impinged on the research process and the relationship (partnership) with the women. I also discuss how the fieldwork changed me as a midwife, woman, and researcher. This builds on the previous work (Chesney, 1998), in which the dilemmas of interviewing women using interpreters and the subsequent effect on the relationship triad was discussed.

THE RESEARCHER AS SELF

With all practitioners undertaking research, their approach to the research process will have certain parallels. However, as Reed and Proctor (1995) point out, methodological texts reveal little about the complexity experienced by the practitioner-researcher: "We are our own subjects, how our subjectivity becomes entangled in the lives of others is and always has been our topic" (Denzin, 1997, p. 27). The primary focus of the research is and will remain the birth experiences of women in Pakistan. The subjectivity of myself as researcher and my interest and involvement in their life could be described as the lens or analytical filter through which the women's birth experiences pass. Contrary to theoretical assumption, addressing the me in the research does not, in my opinion, detract from this; rather, it adds a quality dimension. With this in mind, coming out as a researcher constituted a vital part of the data and analysis. What else does (should) one do with the feelings from research (fieldwork) but apply them to the analysis?

Lofland and Lofland (1995) address the self in research by labeling the researcher as an instrument that has a direct influence on many issues, the choice of topic being not the least. Their chapter on getting along in the field discusses issues of emotion, includes the roles and relationship of the researchers, and acknowledges the emotional and stressful elements of fieldwork. However, they say that even if it were

possible to catalogue the stress (feeling), doing so would not be epistemologically useful and may discourage potential field researchers. Such a shortsighted and blinkered approach will do little to prepare or help future field workers. Hammersley and Atkinson (1995), in reference to "impression management, their guide for fieldwork practice," request the researcher to pay attention to "identity" in the field, stating, "We do not refer to donning a persona totally at odds with your natural demeanour" (p. 55). The suggestion is that the researcher constructs a research identity as part of the fieldwork. However, little guidance is given to how these identities should be established, shaped, or reproduced, much less to how to prepare the researcher for the way identities can be challenged or change the fieldwork process. It could be argued that words are inadequate to describe the unique and totally individual process that underpins the development of a research persona. The lack of guidance, beyond dress and overt behavioral advice, suggests that there may be more subtle indescribable elements or signals that shape the researcher in the field. Cross-cultural norms had a major influence in shaping the me that I judged would be acceptable and successful as an ethnographer. Experience in the culture taught me, for example, that a comforting hand on arm at times of distress might not be acceptable. Learning in one culture what is acceptable in another is not a static concept; it is a continual trial and error, sensitive tightrope-balancing act. I found it uncomfortable to construct a persona as I thought the women would see through the disguise and suspect I was deceitful or had something to hide. I also struggled with the idea that a falsely constructed self could be maintained over time.

The necessity of constructing a false identity is an underlying theme in the writings of the ethnographic gurus (Hammersley & Atkinson, 1995, p. 83; LeCompt & Preissle, 1993, p. 92), which they feel protects the researcher from becoming too subjective. The researcher is cautioned to stand apart from social and political issues and is expected to have no personality or culture much less the capability to develop idiosyncratic insight. I would argue that such behavior would amount to putting a veil between the researcher and the researched. Certain parallels can be seen with professionalization and power, whereby constructing a distinct body of knowledge ensues a separateness through the use of its own terminology and behavior.

THE RESEARCHER'S POSITION

"Going native" is a euphemism for being too involved. This is believed to limit fieldwork by potentially introducing bias from over-rapport with the researched, in this case[1] women. Hammersley and Atkinson (1995) suggest that overidentifying can lead to tunnel vision and flawed and limited findings (p. 98). Nowhere is it mooted that acknowledging, documenting, learning from the transition from objective to involved, and then applying this information to the research findings may enhance, enrich, and increase the validity of the research. However, Hammersley and Atkinson declare that "the complete observer generally escapes the danger of going native, risking failure to understand the perspective of the participant" (p. 100), the implication being that the process inhibits the content. To become too comfortable is seen as losing one's perspective: "Ethnographers should strenuously avoid being 'at home' " (Hammersley & Atkinson, 1995, p. 102). Lofland and Lofland (1995) suggest a more or less marginal position to gain creative insight, quoting

Powdermaker's (1966) recommendation to be "intellectually poised between stranger and friend" (p. 15). Although acknowledging that Powdermaker was the first to document and accept that the researcher's position could be on the cusp, it could be argued that this position was (is) a dynamic balance, not a static midposition. In maintaining the balance, there would be the potential to confuse the researched because the researcher might, at the same time, lean toward friend and toward stranger. Positioning became a dilemma for me when I developed a connective bond of friendship with some of the women. This happened when a woman I had interviewed asked me out socially. I felt churlish when I said no, and she clearly felt that I had let her down by my refusal.

It seems that for the researcher to be scientifically accepted and for the findings to be credible, it is important not to reveal oneself in the research. Lofland and Lofland (1995) confirm this by saying, "The norms of scholarship do not require the researcher to bare their souls, only their procedures" (p. 13), emphasizing that they do not encourage writing self into the text. However, they do support a sense of connectedness through emotional engagement. Reed and Proctor (1995) state that "it is almost as if experientially gained knowledge and understanding is something which is an embarrassment rather than a source for research" (p. 4). Yet, Malinowski's diaries (1967) reveal many times of stress and anxiety and his intense absorption and preoccupation with his own well-being. His need to come out as a researcher was evident.

Lofland and Lofland (1995, p. 6) note a sense of schizophrenia in the ethnographer when they engage and disengage, also emphasizing the sensation of comfort as a danger signal. In total contrast to this, I distinctly recall a strong feeling of comfort when the woman (and family) became oblivious to my presence. This was not a source of danger but a rich source of information; the acceptance and fitting in of the real me advanced the research considerably.

Although Lofland and Lofland (1995) do not question the idea of total commitment, they say there should always be some part held back. They feel that it is in this space that ethnography gets done, and without this, ethnography becomes an autobiographical account of a personal conversion, adding that although this would be interesting, it would not be ethnography. This should not be interpreted as "omit the personal" because delving into the personal, into the prejudices, shortcomings, and values of the researcher, allows for scrutiny of the shape and color of the researcher's analytic lens. However, Lofland and Lofland believe that the lens needs to be at a certain distance to be able to focus with any clarity. A parallel to this concept is the position of midwife as professional friend. A certain holding back from the total involvement that would be expected of closest kin ensures that professional judgment and decisions that need to be made are not influenced by the personal.

Everhart (1977) describes the blurred vision that can result from being too close: "Saturation, fieldwork fatigue and just plain 'fitting in' too well culminated in a diminishing of critical perspective, events were escaping me, the inquisitiveness had been drained form me" (p. 13). This example suggests that researcher burnout may or may not be related to being oneself and fitting in; however, denying analysis of self by reflecting on why the inquisitiveness or interest has waned would add a dimension to the fieldwork. It is of concern to me that the space recommended by Lofland and Lofland (1995) is for the researcher only and is denied to the researched. If we as researchers hold back, then it can be expected that the researched will also hold back. The denigration of "autobiographical account" as "interesting personal

conversion" denies the powerful insights gained from analysis of self and its positive influence on the research.

ME IN THE RESEARCH

I support the autobiographical analysis of self, not as separate from or in competition with the ethnographic words of the women but as a nurturing bed to place the research findings in and as a part of the transparency of the research process. Reflecting honestly and openly has helped me retain some integrity and develop insight and self-awareness, and it has given me a certain confidence. Ignoring, suppressing, or falsifying the self places the fieldwork on shifting sand and sets a bad example for the researched. Autobiographical data have been dubbed "self indulgence" and labeled "narcissistic or exhibitionist" (Okely & Callaway, 1992, p. 2). Beynon (1983) felt he was too old to adopt the now familiar ethnographic persona, declaring it best to be honest (p. 41). However, he did not analyze how this honesty influenced the research.

THE RELATIONSHIP WITH SELF

Goffman (1955) suggests that we develop, create, and establish a personal front within our identity for certain situations—that we become social actors. I do recognize a change in me for certain situations, and there is no doubt that I have subliminally devised a strategy to manage the crossing of cultural norms. However, whether out of ignorance or instinct, I did not devise a persona for the fieldwork or interviews. I introduced myself honestly, sharing my background both as a practitioner, researcher, and woman. I answered all questions truthfully, holding nothing (personal) back. I did draw a thick line at confidentiality and at what I judged to be coercion by the gatekeeper. Placing myself, feelings especially, in the analysis brings a life to the context and content and sparks insight and understanding. An example of the complex interactions that took place within the research occurred when I interviewed a woman who had a photograph of me with her daughter (a nurse) taken a decade earlier. The photograph was taken only weeks before her daughter committed suicide. I was totally oblivious to all this when the interview was arranged. A further example of the insight gained through analysis involved the indefinite answer of several women to the question every woman should know the answer to: How many children have you given birth to? The insight came with the analysis of why women chose to be vague. It appeared to have parallels with why some pregnant women or mothers do not like to talk about stillbirth or cot death: That is, this might tempt fate and put their baby at risk.

I cannot pinpoint the time when my confidence as a researcher allowed me to question current text and opinion. Confidence evolved gradually, evidenced by the increased feeling that I could safely question and celebrate connection. Confidence to be different (from theoretical opinion) comes from support, praise, and the nonjudgmental acceptance of ideas and ways of being. I have gained confidence from my research supervisor's unconditional positive regard, academic challenge, and ever-rising standard for academic rigor. I can, however, pinpoint the time of diffidence,

(between midwives in the United Kingdom and birth in Pakistan) constitutes social reality. Gubrium and Holstein (1995) call this a "lived border" (p. 101) that serves to make reality come alive.

HOW THE RESEARCH CHANGED ME

Lofland and Lofland (1995) address some of the changes the field-worker goes through over time, moving from being a lay novice to acceptable incompetent. The former does not have the ethnographers' self-awareness of what has been learned and the social transactions that inform the production of knowledge. This has parallels with life: The experience gained over time, along the way, serves to make us reflect on how we could have done it better. Reading the interview transcripts and field notes has raised many questions that need further fieldwork to answer. Drawing together and using the women's words to create themes or key concepts mitigates against misrepresentation; however, when out of context, dialogue can be corrupted. This is where the integrity of the researcher has to be laid open for scrutiny.

Bowen (in Coffey, 1999, p. 18) documents personal and emotional difficulties and how she came to terms with the estrangement (culture shock) of being a competent independent woman to being a novice in the culture she studied. She considered this integral to the process of learning but documented nothing further about how she managed her feelings. My management strategy centered around the support of peers, advisors, my supervisor, and other women.

With the analysis and interpretation came an acute sense of my self, my Whiteness, and my culture background, and difference became much more obvious. I focused on parallels, looking for convergence of views, so that I could be considered culturally and academically credible. I felt much more visible than I was as a practitioner, midwife, or researcher. Dipping my toe into a discipline that has a long history of research made me unsure of my views and arguments. Since beginning the research, I have become more politically conscious and doubled my sense of social responsibility. My interpretation and my words in the analysis will be the bearers of another's experience; this feels like a huge responsibility. Suddenly, the method by which I had obtained the women's stories became acutely significant, and I needed to come under rigorous self-scrutiny. This scrutiny of self was the underpinning rationale for writing this article.

ME IN THE RESEARCH: CONCLUSION

Although my confidence ebbs and flows, the dilemmas experienced, faced, scrutinized, reflected on, and analyzed have culminated in learning and a change in me as researcher, woman, and practitioner. Opening up for public criticism is the next part of the learning process. Knowing that I just want to be a better researcher for the women I represent seems crudely altruistic; however, this is not entirely honest. I bring with me the principle I learned the very first day I started on my midwifery career, that is, to care for others as you wish to be cared for yourself. I would want to scrutinize the researcher who was interpreting my words.

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Margaret Chesney has been a nurse and midwife for more than 25 years, with experience as a midwife and manager of community midwifery services. She continues to carry a small caseload with students. Since 1991, she has held teaching positions and currently is in the final stages (analysis) of a Ph.D. study titled "Birth in Pakistan (for some women)," supervised by Professor Mavis Kirkham, Sheffield University.

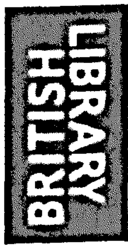
Issues in research

Dilemmas of interviewing women who have given birth in Pakistan

Margaret Chesney recounts her responses to the challenges posed by interviewing women from an ethnic group.

This paper focuses upon dilemmas that arose when Pakistani women were interviewed about their birth experiences in Pakistan. The dilemmas are grounded in issues from my own background and research stance and the methodology used. These factors expose issues from my white Western heritage and entry to the research field, as well as dilemmas ranging from power within the method to the sensitivity around the role and accountability of the interviewer. The over-arching dilemma involves the heavy weight of responsibility incumbent upon me to interpret the women's words accurately and leave them unharmed by the experience of being interviewed.

I have made seven field trips, as a midwife and teacher, to the Red Crescent Maternity Hospital in Sahiwal, Pakistan. My visits have been part of a unique twinning of towns, linking Sahiwal with my home town of Rochdale. I have worked closely with the Pakistani community in Rochdale for over 17 years. This, combined with my professional role, has fuelled my avid interest in Pakistani women's birth experiences. In previous research (1), I evaluated the changes in midwifery practice after my first visit to Pakistan. The purpose of the current ethnographic/oral history research, is to study the



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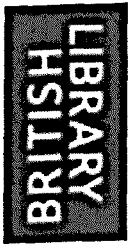

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experience of women who have given birth in Pakistan. The knowledge gained will serve to increase the understanding of birth in other cultures, building on the work of Jordan (2). The research sample is made up of women in Pakistan and Pakistani women in Rochdale.

This paper focuses on the dilemmas that presented when the group of women in Rochdale were interviewed. It is set in the context of my own background and research methodology.

Researcher as outsider

As a white, Western woman, mother and midwife, I have developed an ambition to transform thinking through knowledge and to act for justice and equality. Never is this more evident than during, or just after, visits to Pakistan. I become angry and incredibly frustrated when I see women or children suffer. In the interest of the research, I felt it was essential to suppress the strong urge to defend, and be the advocate of, Pakistani women, as I realised that this would only serve to perpetuate the imperialist tradition of paternalism.

The basis for a British midwife to study birth in Pakistan may be criticised, however, contrary to my own and others' experiences (3), there are beneficial elements to being an 'outsider', in terms of culture and race, as opposed to an 'insider', when sharing information for research purposes. I was told that, had I been a Pakistani woman from within the community, the door to the research field would have been firmly closed. The reasons given related to lack of trust. The women told me that an insider would not respect confidentiality and would use information to gossip. I realised that, as long as I did not upset a key member in the community, or unwittingly betray a trust, the door to the research field would remain open. It became clear to me, however, that the greater involvement I had in the community, the more likely the women were to tell 'stories' about me; consequently the more precarious my position as a researcher would be. In this respect, my

colour, or the trust they have placed in other white people in the past, may have protected me. However, such trust may have been earned or imposed under the banner of white supremacy and this makes shedding the burden of supremacy particularly difficult.

Gatekeeper/recruitment

The gatekeeper of the women's group came to Britain in the 1950s. Atypical of the Pakistani woman's demeanour, her strong, outgoing personality underpinned her role as link person to Western ways. From her strong power base, she guarded the women from being exploited, in a disempowering way. She regularly chided them for not learning to speak English (as she had), yet perpetuated their ignorance by speaking for them. My dilemma involved feeling acutely uncomfortable with her philosophy. The strategy to overcome this was to use basic humanistic principles in all my interactions with the group.

The pattern for conducting the interviews was as follows: I spoke to the over-50s women's group, introducing myself and my work in Pakistan and the research. I then gave prepared seminars on health-related topics, for example, breast examination, the menopause, and resuscitation. Following these, I shared a meal with them that had been prepared by the group leaders. During the meal, I asked women, who had given birth in Pakistan, if they were prepared to be interviewed. Those who agreed were given the research protocol, with my telephone number to allow them to withdraw from the study if they changed their mind. I did not request signed consent as my previous experience, and other work in the field (3, 4), showed this to be potentially intimidating and offensive. This is based on the belief that, where a culture values the spoken word as a binding contract, written consent may imply mistrust. I already had credibility with the women, from their knowledge of, and interest in, my work in Pakistan and from the complex internal 'press'. The origins of this lie in my past, when I worked as a community midwife in the Pakistani community. It was evident then that the women were willing to trust a professional aligned to their highest

status occupation, the doctor.

Covert feminism

An ongoing dilemma is my confusion over the particular research stance. I subscribe to the Collins English Dictionary definition of feminism which states that it is 'a doctrine or movement that advocates equal rights for women', particularly since I have experience of a culture which is so obviously unequal. However, I do not assume, as other feminist researchers have (3), to have an automatic affiliation with the women by virtue of shared gender alone. The woman's role in Pakistan, her social class, culture, religion, and family structure is so different to my own, such an assumption would be absurd. I do, however, openly declare a bond with Pakistani women through the birthing experience, both from the mother's and the midwife's perspective. So, in the differences, there is a core of shared experience.

Oakley (5) identified the lack of 'fit' between the theory and practice of interviewing that is especially likely to be evident when a feminist interviewer is interviewing women who may not be feminists. In my experience, Pakistani women do not uphold the doctrine of equal rights for women: to have some rights outside the home would be a quantum leap. Consequently, they may not be described as feminists, however, they are nurtured and socialised in an almost exclusively woman's world. Mixed company (being in the presence of men who are not their relatives) is actively frowned upon. Because of this segregation, men also appear uncomfortable with women. I have direct experience of men behaving like pubescent young people, giggling and showing off, which is very disconcerting, especially as they are mature men holding powerful, influential positions.

'More windows, better view'

Interviewing was one part of a journey or process through change,

for myself, the women and possibly the other family members present. Unstructured interviews, participant observation and an autobiography, written as a reflective diary, framed a 360-degree view of Pakistani women's experiences of childbirth. Such triangulation of method was defined by Denzin and Lincoln as, 'a multi-method range of interconnected methods, which hope to get a better fix on the subject' (6). Jick (7) maintained that this serves as a check on reliability and adds to validity, serving also as a holistic approach to improve completeness. Jick's belief, however, is founded in the positivist paradigm, using qualitative and quantitative methods, whereas this research uses qualitative methodology only. Cegalowski (8) believed that writing from multiple vantage points opens up windows to the issues. These provide a viewpoint, like a crystal illuminating different angles, colours and dimensions, of understandings. It is envisaged that the birth stories from the women, superimposed upon my observation and experience of birth in Pakistan, will provide a window into their lives and birth experiences. However, this is in the full recognition that the view is not static but ever changing.

Misinterpretation/accuracy

A huge dilemma when interviewing the Pakistani women was the potential for misinterpretation of the responses or taking out of context what was said. The probability of this happening is greater across a cultural divide. Oakley (5) has been criticised by Nijhof (9) for incorrect, inconsistent interpretation. Theories drawn by Oakley are stated to be 'partial truths', her interpretation of the examples challenged. Using Oakley's seminal work (10) as a model – I did not want to misinterpret or take out of context the word of the women – I gave all the transcripts back to the women to read, with the option of changing or deleting any part. This constituted a huge commitment on their part and was out of my control. The feedback was enlightening; women have asked for issues to be erased that I did not expect and contrary to this have been happy with certain aspects that I anticipated would offend if repeated. This certainly

accentuated our cultural differences. However, there was always the potential for some women to be uneasy with finding fault or disagreeing with the written transcript, as culturally this may be considered impolite. I was always very pleased when amendments were made.

Questions will undoubtedly be asked concerning accuracy of interpretation if the researcher cannot pick up on the nuances or the political underpinnings of relationships. The validity of information from the interviews, removed from social context many years later, may also be questioned. Because childbirth is a major life experience, its importance as a rite of passage aids accurate recall. In the social rehearsal, telling the story many times, certain aspects of the birth story are remembered vividly. However, other aspects may not have been verbalised at all before. For some women the interview situation served as a trigger for those 'forgotten' memories or issues not spoken to anyone before, surprising the interviewee on recall.

Power

Maguire (11) suggested that one purpose of inquiry is to tweak the status quo. The power associated with this is daunting. The status quo is where the information lies, hidden in the minds of those who have experienced it. To lift the lid on that requires dealing with the feelings it arouses. The experiences women have gone through in childbirth are so profound that unearthing them may require counselling support long after the time given for an interview. Leaving the women 'high and dry' after reliving a traumatic experience, not always the birth, but divorce, death of loved ones, or in one instance, a disabled child, constituted acute ethical dilemmas that had to be faced.

The interviewee-interviewer relationship is undoubtedly hierarchical. I was seeking out the respondent and as such, was very sensitive to hesitation or reticence when gaining informed consent,

even to the point of feeling good when a women declined to be interviewed. Interviewing has a value itself, yet I had to remind myself that I was not a social worker or professional counsellor when in the home. However, I did not leave my Code of Professional Conduct (12) at the door. If I could help with information or contacts, I considered it a moral obligation to do so.

Zealot or reporter?

The next dilemma involved my role as researcher and concerns what Oakley (5) described as 'fundamental to the role of interviewer', that of 'being a reporter and not an evangelist'. I constantly have had to remind myself, as I become more deeply imbedded in the lives of the women being interviewed, that although not strictly a zealous advocate of a cause, I do seem to experience a greater personal responsibility towards helping the women. I have used the analogy of the women being pregnant and needing my service as a midwife. Superimposed upon this is a conscience that will not allow me to experience satisfaction in the study if I do not attempt to help them. I also feel an unparalleled gratitude that I live and work in England and not Pakistan. Aware that these factors could easily build into a type of evangelical zeal, I have to remind myself of what Chenail (13) said: 'Instead of having a righteous missionary zeal, researchers should approach the land of research with respect, openness and curiosity.' He also added: 'If such practice (openness) is embraced, researchers can move beyond this period of colonialism into a new era of community, co-operation and the advancement of research.' In this way he has formulated a more positive stance when making a case for clinical research.

Convention

Convention requires researchers to write of the venue, number and length of interviews conducted, the question format and how the information was recorded. Issues that are not always commented upon include; the interview environment; the social/personal characteristics of those doing the interviewing; the quality of the

interviewer-interviewee interaction; or the interviewees feelings about being interviewed. I consider these to be fundamental to this research. Sensitive to the words of Krieger, 'when we discuss others, we are always talking about ourselves' (14), I chose, in collaboration with the advisors (a Pakistani midwife and a Pakistani mother), to adopt a method tested by Cegalowski (8) of 'story writing'. This was a supplement to other methods and to replace the researcher's diary. Stories were written contemporaneously and contain my own and, where appropriate, the women's emotional and physical memories associated with the interview, plus an in-depth description and analysis of the interview environment.

Oakley (5) stated that: 'Interviewing women is like a marriage, everybody knows what it is, an awful lot of people do it, yet behind each closed front door there is a world of secrets.' As Denzin and Lincoln (15) highlighted, the quality of data generation is largely dependent upon the skills and expertise of the interviewer. Yet training in interview skills focuses on screening out bias and learning certain rules of behaviour (16). The style, standard and quality are largely hidden until one becomes the interviewee in another research study. The researcher needs to be flexible and adapt to the interviewee's individuality, however, this in itself may constitute bias. A personality conflict or communication breakdown can be the result of myriad factors, some of which are never identified. As Thompson (17) found, good interviewers develop a variation of the method which brings the best results and suits their personality as well as that of the interviewee.

I recognise my interview skills are grounded in the interrogative style that antenatal interviews were conducted in during the 1970s. Limited time and the women's responses to mainly closed questions left no space for knowing. Thankfully, over the resulting decades in midwifery practice, I have developed more of a sense of when communication is effective and a 'knowing' when to listen and when to speak. Active listening is easy when the topic is of interest.

However, on reflection I realise that I tend towards being a 'rescuer', helping quickly with prompts or suggestions, saying I understand, because I want them to feel supported. Building up a tolerance to silence is my greatest challenge, yet I am wonderfully aware of the benefits when this is achieved. Thompson (17) stated that the strongest argument for a completely free-flowing interview is not to seek information or evidence of value in itself, but to make a 'subjective' record of how the interviewee looks back on their life as a whole; how they speak; how they order it; what they emphasise; what they miss out; the words they choose. These factors are all important in understanding. He considered that the less the testimony is shaped by the interviewer's questions, the better.

In reality, this completely free interview cannot exist. The social context must be set up, the purpose explained and at least an initial question asked. All these combined with unspoken assumptions create expectations which shape what follows.

'Friend or researcher?'

A recurring dilemma that I encounter in common with most midwives is that I value all the information, so identifying extraneous material is difficult. I have not mastered Oakley's recommendation (5) of 'being friendly but not too friendly'. Nor have I achieved the balance of sufficient warmth to develop a rapport and the detachment necessary to see each woman as an object under surveillance. I know that I 'feel' too much. I was uncomfortable with manipulating the women to being 'objects of the study/sources of data'. As professional researchers, interviewers are exhorted not to lose themselves in being friendly. Moser (18) warned of the danger of 'over rapport' after finding slightly fewer satisfactory results from the sociable interviewers, who were 'fascinated with people'.

One further aspect of behaviour that is to be discouraged, is for the interviewees to ask questions of the interviewer. Yet, when this happened, I felt much happier and relaxed. I felt accepted, safer

knowing that the situation was being equalised. It has also been considered inappropriate to provide the interviewee with any formal indication of the interviewer's beliefs and values. I recognise that the women's values may be 'shaped' to be in accordance with mine when stated, so tried to reserve facts about myself until after the interview. An open value acceptance, devoid of judgement is my preferred stance. Selltiz *et al* (19) gave a more explicit recipe for solving the dilemma of 'friend yet researcher'. They stated that the interviewer's manner should be friendly, courteous, conversational and unbiased, 'she should be neither too grim nor too effusive, neither too timid nor talkative'.

Interpreter

Although I have studied Urdu and can follow a conversation, I cannot speak and be understood. This has meant that I have had to use interpreters for the interviews. The services of a fellow midwife and family members were used with different ramifications.

The traditional role of the trained interpreter is to work towards being invisible (20). However, working with members of the family acting as interpreters took the interview towards a totally different dimension. This had strong positive and negative aspects. The positives include the potential protection the family member provided their relative with, by acting as their advocate. There were real benefits to other family members hearing, sometimes for the very first time, stories about their loved ones' experiences in life. This has acted as a catalyst to understanding behaviour. Interviews stimulated discussion between the family members.

The negative side may have involved family members not consulting the woman, giving their side/version of the events as they know it. The women may also have been uncomfortable revealing certain experiences in front of family members. Maintaining confidentiality was vital (21). When arranging the time and venue for the interview, I explained to each woman that she

may have whosoever present at the interview she wished. Without the 'safe environment' of home and family, it is doubtful whether depth and quality of information gleaned could have ever have been achieved

Among the references in research to the use of an interpreter (3, 20-22), the one common element is reassurance that it 'slows the interview', providing time to reflect on the previous response and carefully prepare the next. For both focus groups and in-depth interviews, this was more an ideal than a reality. The tendency was for the women to become bored or to lose the thread, starting their own discussion, and it was then difficult to get back on track.

Flow and ethics

A further dilemma that involved me being so engrossed in the women's story was, when a concept arose that I needed to explore in more detail, I tried to hold it mentally to bring up later, then inevitably lost it. The obvious solution was to jot it down, however, when I tried this, it created a hiatus in the flow, so I discontinued the practice.

As a check to the validity of the interpreter's translation of my questions, I asked a midwife friend who speaks fluent Punjabi to transcribe some tapes, asking her to focus specifically on the informed consent, the manner the questions were put and the reliability of the interpretation. It occurred to me that the women/respondents were not aware that their chat between questions and answers was going to be translated literally. I then questioned the ethics of my hearing what the women may have thought was 'private' conversation, 'private' by virtue of them thinking I was unable to understand their language fully. The only way I knew to overcome this was by asking my friend to make a judgement on the 'privacy' elements on the tape and leave that out.

'Walk inside without breaking anything'

A dilemma linked with the safety of the home environment for the interview is that of potentially exploiting the hospitality of the

women and their families. This made me even more conscious of a minor, but nagging, dilemma of whether to take along a gift. My advisor reported that they do not expect this and the women may feel they have to reciprocate in some way. I partially resolved the issue by taking along a 'thank you' card and small plant when I collected the transcript of the interviews (returned to them for review).

The ethical issue of taking and not giving is an ongoing source of discontent for me. I view the research at times as a selfish process, yet in some ways I am a servant. I offered to help; provide advice and education if needed. Yet I still feel that I imposed my presence in their own homes or their group taking up valuable family time, asking what may have, to them, seemed quite impertinent questions, delving into sometimes painful memories. Yet as their servant, I listened attentively and empathetically, giving them much valued commodities in today's busy world, time and undivided attention. Inquiry has value in itself, but ethically I feel it must benefit the women also or I could not continue. I concur with Swantz (23) when she stressed the importance of the inquirer gaining the confidence of the community/respondents and how one can only reach the centre of human existence if there is common trust. Swantz (23) used the phrase 'walk inside without breaking anything'. I have been sensitive to the responsibility and ever cautious of the potential for harm as well as good during interviews. Although looking at things entirely from the women's point of view may not have been entirely possible, listening, respecting and honouring the stories told will serve to limit potential damage.

Conclusion

Within the context of one woman looking into the lives of others from a totally different world, it is not surprising that there are many dilemmas that perplex and challenge. I recognise the interview itself as a social event, heavy with ambiguity and suffused with efforts of presentation, for both myself and the women interviewed. This is underpinned throughout by contradictions between the need for rapport and the pretence of neutrality. Facing and coping with these dilemmas is made worthwhile as debate is opened up, giving these women a voice, and increasing and moving knowledge in the direction of respect and equality, for this is the ultimate aim of the research.

Margaret Chesney BSc(Hons), MSc, RGN, RM, is Senior Lecturer, Midwifery Department, Salford University, Bury.

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Interaction and understanding: 'me' in the research

The author of this article adopts a radical approach by focusing on herself as the researcher, in the context of research with women who have given birth in Pakistan. She formulates a justification for the reflexive autobiographical approach and then reveals how factors in her life have influenced current personal values, thinking and philosophy. Last, some themes from her life are analysed in the context of their importance to the interaction between herself and the women in the research.

Field and Morse (1985) maintain that the understanding that emerges from research is based on the interaction between the researcher and the researched. In order to understand what happens between the researcher and researched it is pertinent to examine both the researcher and researched. However, autobiographical data has been dubbed self indulgent, narcissistic even exhibitionist (Okely and Callaway 1992). Consequently research findings are more likely to present only one half of the equation, the researched. The following article breaks that mould and focuses upon myself as the researcher, in the context of research with women who have given birth in Pakistan. This took place in Pakistan (first cohort of women) and in Rochdale, both groups of women had given birth in Pakistan. First, I will formulate a justification for the reflexive autobiographical approach, continuing on to reveal how factors in my life have influenced current personal values, thinking and philosophy. Last, a selection of the emerging themes from my life will be analysed in the context of their importance to the interaction between me and the women in the research.

Reflecting back upon and writing the story of my life fulfilled many purposes. First, it was a cathartic exercise and also highlighted the chasm of differences and some powerful parallels between the women and myself. Importantly, it also demonstrated how I influenced the research and also how conducting the research changed me.

Ourselves and others

It has not been specified how this 'interpersonal experience' should be written up but Scholte (1972) advocated a reflexive approach prior to analysis. Reflexive in this context involved using a reflexive model (Gibbs 1988) to write up a diary at the end of each day in the field. It would also seem pertinent to note what Hastrup (1987) identified as being a peculiar reality in the field. Hastrup noted: 'It is not the unmediated world of others, but the world between others and ourselves that is important.' Thus, by exploring and exposing the two, the 'join' can be better understood.

Why is an autobiography important?

My past experience of both quantitative and qualitative methodology brought a feeling of confidence that there is no ideal research method, only methods that are not appropriate. This knowledge led me critically to examine the factors influencing choice and type of method. While there is no doubt that the subject under study will direct the method, it is the researcher who selects the subject. Consequently the researcher's background, philosophy, values and beliefs form the bedrock on which the choice of method is based. The study of oral history (Thompson 1996; Dunnaway and Baum 1996) confirmed that ethnography was the most appropriate method. Although the interviews with the women were within the framework of their life history, the key purpose of the research was to contribute to knowledge on birth in other cultures, for midwives to read and learn from; not as an oral history project purpose would be, to contribute to the picture of life as it was for the women. Having reached this decision I felt it was important to address the influencing factors therein; the first, as mentioned, was myself as the researcher

Myself

Okely and Callaway (1992) say that there should be an autobiographical element in ethnography. The purpose is to work through the self in order to contextualise and transcend it. This is what I have tried to do, without making the 'I' an 'ego trip'. As I began, the 'I' was a voice of diffidence, in the face of academia and science. It is in this sense that I nervously open my work to critique. Wax (1971) advocates ignoring the self and the gender of the researcher. I cannot support this statement as the research on birth involves gender, women's work private lives and knowledge. A man simply could not conduct research on birth in Pakistan, as he would not be allowed entry into this very personal private world of Pakistani woman.

Philosophy

A total commitment to honour and respect the women's words and to 'create a sense of openness', as identified by Kirkham (1997), formed the cornerstone of the research. Asking each participant to read and comment on the interview transcript ensured that this happened. My personal philosophy hinges on 'women centredness'. This is achieved by ensuring that the person I am interacting with at that moment is the most important person in the world to me. This gives credence to my commitment and belief.

The relationship

The relationship between myself and the women would be considered a dynamic intermingling of cultures, sometimes clashing sometimes merging. This intercultural experience is built on a journey in which each step is tentatively taken, always with the sense that I may have to retreat because a boundary or norm has been crossed. The women and I are, without doubt, at different points on a cultural spectrum, socialised in different worlds, but are in the same age bracket and of the same gender. Our life experiences are so familiar to ourselves yet may be shocking to others. Some of the women interviewed have

lived in Britain for a number of years; yet they view the town they live in and its culture through their own cultural lens. Others will have never been out of their hometown or village in Pakistan and the very presence of a white woman leaves them in awe (interpreter's comment). Without exception, the women share a common bond – their faith: Islam. As a Christian brought up in a small, strongly Methodist community, some, if not many, of my basic values and beliefs are shared with the women. Strong family ties, standing together and defending each other, particularly at times of strife, obey thy father and thy mother and respect one's elders, have been the basic tenets of my socialisation. In many ways the Ten Commandments parallel the code of conduct within the Qu'ran. A good Muslim will be called upon to pray five times a day; fast during the month of Ramadan; make a pilgrimage to Mecca (Haj) at least once in their lifetime; make a declaration of faith and make a payment to Zakaat annually (2.5 per cent of net savings which is to be distributed to the poor and needy). However, as with any faith there are the fundamentalists at one end of the spectrum with the non-practising believer at the other.

More than words

A reflexive approach has been used to shape the autobiographical 'connection' between the researcher and the researched. I have written simply as a human being. The truth that I have tried to tell includes the rational development in myself that comes from the immersion in another, previously alien, world. Jackson (1987) cited by Okely and Calaway, (1992) identified that when anthropologists become immersed in another culture (or, in their own, as a participant observer) they learn not only through the verbal and the transcript, but through the senses, through movement, through their bodies and whole being in a totality. This total knowledge is used to make sense of the experience; field notes are then used as a trigger for bodily and subconscious memories. Fardon (1990) says we cannot write down the knowledge at the time of experiencing it. I would add that we cannot hope to write it all, ever, but each time recalled, re-written, re-read, a differing perspective emerges.

Bourdieu (1977) also notes how the body can be treated as a memory, these words validate my own experiences and the feelings that surface as I recount the words of the women, the observations made, or the experiences lived. Flashbacks to the interviews, triggered by various stimuli, jolt the senses to reveal yet another possible different perspective. Why this was not seen at the time, is a mystery of the mind. It is almost as if the seedling had to grow darkly nurtured by other hidden memories from experiences, or, as I suspect, attached to emotions that may not have been appropriate to reveal or deal with at the time. This could be classified as 'emotional grounded theory'.

As stated, there is infinitely more 'in the head' of both the researcher and the researched than words can depict. Indeed, words may actually serve to reduce feelings not describe them. Kirkham (1997) highlights a lack of appropriate language to express the experiential, intuitive and creative dimensions of midwifery practice. An attempt to overcome this was made through sharing my thoughts with other midwives and women and recording the 'feelings' as they erupted–at times raw, confusing, painful, and insightful. Insight can be used to see further than the situation and often arose when least expected. I became aware of a sixth sense. A feeling that there was more than the word alone, this approach served to develop a greater awareness of the unconscious in influencing issues.

Behaviour

One is challenged as a researcher to act as an objective scribe, devoid of influence or judgement, to adhere to strict moral and ethical code, to do no harm. These words have the potential to become protective, rhetorical words that impress the reader. We only know if there is potential for harm by asking the respondent or her representative, an advisory member of the community or an appropriately trained advocate, whose sole purpose in the research is to protect the respondent. The bare minimum ethical principle for the midwife will be to translate with integrity and absolute honesty, accepting the

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

Ethnography autobiography

A fundamental aspect of ethnography concerns the relationship between cultures or groups. The women's relationships with each other, their families and the society they are living in are indeed fundamental to the research. It is however important to consider that the autobiography of the field worker/ethnographer does not exist in a cultural vacuum. Some of my cultural norms and values can be gleaned from the synopsis of my life to date (life story). I am a white, female, working class, middle-aged woman with a strong work ethic and old fashioned traditional moral values. I have been, without doubt, grossly ignorant of the cultural needs of others – at least until recently. This is hardly the profile of an ethnographer studying a life experience in a different culture. As a consequence there is a lot of ground to be made up. The positive factor in my ignorance (of culture) may be a lack of any pre-existing prejudice.

Fieldwork practice is always concerned with relationships (Campbell 1964). The ethnographer has to form long term links with others across the cultural divide, however problematic. The relationships with the women are crucial to the research. Some of the problems that arose are addressed in Chesney (1998), where the dilemmas of interviewing women through interpreters have been addressed. In my low times I castigate myself for even thinking that ethnography can be conducted across a language barrier. I justify it and carry on by remembering the words of more than one woman I interviewed who said: 'We would not have told anyone else our story'.

The autobiographical experience of fieldwork requires the deconstruction of the relationship with the women in the field. Derrida's (1967/76) deconstruction theories were based upon the belief that in Western countries, speech is considered superior to the written word and that the latter has been taken to be an unproblematic record of speech. Derrida argues that the written text is a construction of its own. His insights have made us more self-conscious about the production of text. Okely and Callaway (1992) call for this deconstruction to be conducted with rigor. The autobiographical account undoubtedly embodies, at an individual level, the discredited practice of the 'others'. I anticipated the others in the research to be the dais (untrained traditional birth attendants). However, although the women were often happy to discredit their husbands and mother-in-laws, without exception, they did not find fault with the dais. Whether this was because I was a midwife needs to be explored further. As a researcher/ethnographer the objective was to be self-conscious, critical and reflexive throughout, ever conscious of the possible power relations that inevitably exist.

Western cultural ethnography.

Reflecting upon my initial judgement that the labour and birth I first saw in Pakistan was dangerous, I see now that my reaction demonstrated what Jordan (1993) called 'superior knowledge'; I became acutely aware of how

this served to affirm a Western/Northern dominance. Ironically the source of the 'dangerous practice' was previous Western influence and dominance. Once aware of the predilection to Western dominance I had no wish to exacerbate this by using a research method of inquiry, (ethnography), that rests upon Western ethnocentric traditions. Dodd (1986) stated that autobiography is associated with Western individualism and is not found outside our cultural area, it expresses a concern peculiar to Western man that has been of good use in the systematic conquest of the universe. This 'great white man' tradition draws upon pre-existing western assumptions that not only conclude with dominance over the Third World, but dominance over certain research methods (eg 'women's stories'). Juhasz (1980) expounds the theory that women's stories show less of a pattern of linear development towards a clear goal, more of a repetitive cumulative, cyclical structure: never a conclusion, always a process, the perception being immersion not distance. In direct contrast to the cyclical women's stories, yet paralleling the immersion, information and insight, Malinowski's posthumous publication of his diaries (1967) exposed the 'people side' of fieldwork experience. He treated his diary as a place for himself, separate to the 'official' publications that he was required to produce. Using this as an exemplar, the perspective of the women in the research will be better represented by my immersion in the culture, superimpose this upon the dynamic process that so clearly exits, then the information an insights gained will have more credibility. Thus, there seems no doubt that field work and subsequent analysis of the findings constitutes a unified praxis that will feed into an upward opening cylindrical model. With each insight dialectical links with the knowledge gained from experience or theory serve to widen the perspective and increase understanding about the interaction between the researcher and the researched (women and myself).

The ethnographic situation (birth experience) is defined not only by the 'native situation' (the women) in question, but also by the ethnological tradition 'in the head' of the ethnographer (myself). The complex dynamic of the researcher- researched interface are as stated vital to the credibility of the findings of the research. To ensure these are better understood, the important influencing factors should be opened up

for scrutiny. As the women are asked to put their birth experiences in the context of their life story during the interviews, as the researcher I am opening up my life story for examination, with specific relevance to my own childbirth experience and work as a midwife.

Emerging Patterns from Autobiography: Love and respect for women

I had two very influential role models to shape my deep respect and love for women. These were underpinned by segregated gender roles within my childhood home parallel those that are current in many Pakistani homes' today. The religious values and norms formed the bedrock for acceptable social behaviour, potential shaming or disappointing my parents formed effective deterrents to pre-marriage sexual relations and controlled the peers I consorted with. The choice of a caring women-centered profession serves to reward me with incredible satisfaction. However, juxtaposed to this I can truly empathise with a culture that, outside the home, in the world of work and academia, the woman is considered an 'also ran'. Gender differences and boy preference come as major themes, both in my autobiography and through work with Pakistani women. My personal dogged determination and stubborn will to succeed is grounded in showing the men in our household that 'I can'. This background served to form my personal strategy to overcome the gender difference, which was control, of both environment and self.

Control

A wish to please, to prove myself, to overcome, to take control, both with what I perceived to be a poor basic education and also with a 'weak, sickly body and/or mind', i.e. labelled highly strung and sensitive following the death of my sister. I was virtually ignored by three older brothers to the point of wondering if I existed. I cannot pinpoint the exact time the determination to show them surfaced, and thus the beginnings of a working strategy to control, but I can

remember the surprise in their eyes and voices when they were told I was to go into nursing. One of the women interviewed was a Pakistani midwife, Amina. Her life story paralleled mine; however, her brothers had the cultural support to place real obstacles in her way. The real crunch in taking control for me as a young woman came during my interview to become a nurse. Being told 'You are a risk to employ', set me on a path that some might see as evidence of a pathological need to exert control. I would not – I could not – ever have time off sick. Next came the assessors who rightly challenged my fitness to be what I wanted to be, more recently within academia. These really did touch my Achilles' heel, my academic capability. I flush with acute embarrassment and shame if anyone at work queries the grammar of a sentence I have constructed: I must surely be out of my depth or a fraud and should not be a senior lecturer in a university or undertaking a higher degree with grammar so poor that I cannot construct a sentence properly. This trait, arising from socialisation in a male dominated household and having a non-academic background, could be seen to be highly beneficial to the current research. This makes me remember my mother's words of 'your day will come'. There is undoubtedly a bond with the women I interview; I used to consider this was entirely because I am a woman, working in midwifery with a history of being a community midwife for Pakistani mothers. These factors are all important but I realise there is more. Completing the autobiography has been the catalyst to the recognition of this.

Ignorance of culture

The lack of prejudice (or am I just kidding myself?) towards different cultures, I believe has its origins in ignorance. For a major part of my life, probably for over 20 years, I had no contact or experience of people from other cultures. When I listen to the racial prejudice through the media and the horrific stories from our hometown I am shocked and almost disbelieving. I have to register the facts as the statistics reveal there are major problems. However, when one has never experienced first hand, believing has a different quality. Just recently my awareness has being raised by my daughter in another public sector (police). She

works in a town similar to Rochdale with a higher than average ethnic mix population. From her, as yet minimal, experience, there is indeed prejudice both from within and without the service. I know of others who have studied inequalities because of experience of racial discrimination. This makes me think that I am taking on an ostrich stance. I cannot stir emotions with racial prejudice that bubble immediately to the surface if I just think of women or child abuse.

Summary

Writing the story of my life has served to open up a theoretical window to shed light on the vital relationship between myself and the women in the research. Clearing the view to myself has served to help me understand others. However, this is a dynamic process and as such this exercise should be carried out periodically throughout the research.

Margaret Chesney is Senior Lecturer Associate Head of School (Research), Dept of Midwifery, University of Salford, Salford M6 6PU
m.chesney@salford.ac.uk

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Chapter 7

A Three-way Relationship

Margaret Chesney

Introduction

My work as a midwife with Pakistani women often required the presence of another, an interpreter. This chapter explores issues arising from this triad relationship that influenced my relationship with the women. The experiences described originated from my work as a community midwife in my home town of Rochdale and as a visiting midwife researcher to a maternity hospital in Sahiwal, Pakistan. This chapter will focus on four areas central to the relationship between the midwife, the interpreter and the woman. Pseudonyms have been used, and permission has been obtained from the people mentioned.

First, I will outline the context, background and experiences, and their effect on the relationship. Second, I raise issues from my findings in Rochdale. Following this, I will focus upon my dealings with individual interpreters during the field trips to Pakistan. Finally, following this very personal journey of learning from experience, I will examine some issues surrounding interpreter training so that a better relationship can be established when midwives and women are of a different culture and speak a different language.

Context and cultural ignorance

I was brought up in a village in the Pennines where I knew of no ethnic minority families. During my midwifery training, I recall 'role-playing' a woman who had just arrived from Pakistan, attending a booking clinic. This was the sum total of my formal education on cultural awareness.

Culley (1997), in her critique of what she describes as the 'conventional culturalist approach', identified a lack of awareness of cultures other than our own. She states that while cultural awareness education is essential for all health professionals, it must go beyond conventional awareness-raising if it is to benefit professionals and clients. Balibar (1991) renames the culturalist approach the 'ethnic sensitivity model' and says that characteristics of the distinct cultures can be captured to explain health differences. This was confirmed by Stubbs (1993), who further identified a prevalence of the 'ethnic sensitivity models' within which a conceptual framework is developed, focusing on the differences between the ethnicity of minority groups and that of the majority 'white' culture.

I interpret the culturalist (sensitivity) approach to be the recognition of cultural differences yet acknowledge the potential to reduce the differences to problems, the consequence of which may be to ignore the power relations that exist between cultural groups. I wholeheartedly agree with Davies (1997:219) when she says that 'one cannot care for and be with women if there is a lack of understanding about their lives'. Essentially, the health professional must take this knowledge of both the distinguishing characteristics and the political power influences beyond the understanding the health beliefs and behaviour stage and into a critical evaluation of the complex ways in which ethnicity, socio-economic status, gender, age and geographical location may intersect.

When I began working with the Pakistani women in 1980, I was without doubt culturally ignorant: I did not even have the basic 'culturalist approach'. I was, however, without prejudice. I did not judge the Pakistani women's 'different ways' as being any less important than my own. Since then, I have kept that stance and, with eight visits to Pakistan and a significant study of the culture, I hope to be moving beyond the culturalist approach to what Gillborn (1995) calls 'plastic', fluid yet moulded, in which race and ethnicity continue to be of critical importance, their precise form and interaction with other variables, however, remaining amorphous. My aim in gaining knowledge and understanding is unambiguous: to provide what Leininger (1991) describes as 'culturally congruent' care.

The clinic

As a relatively inexperienced midwife, I was promoted in 1980 to the level of Sister and given a community midwife post. My 'challenge'

was to sort out a busy GP practice. Twenty per cent of the women giving birth in the hospital at that time originated from either Pakistan or Bangladesh. The clinic I was given was an all-Pakistani caseload with 15–20 women booking per month. The midwife who handed over the practice had held it for six months, having been the third that year, said, 'Every midwife should do a minimum of six months with this practice; then they would know what work was about.' I worked there for five very happy and satisfying years. The women would bring their sick children to the clinic; that was sometimes why they came. The doctor used to attend at the end of the clinic, and the women would wait hours for him (the clinic starting at 1 pm with as many as 30–40 on the list).

At first, 30 per cent of the women on the list chose not to attend, this figure being consistent with the available evidence (Hayes 1995). However, this was very simply addressed once I realised the confusion the women were labouring under. They were required to attend the GP clinic in one place, another hospital for the antenatal care, then a different hospital still to give birth. When I visited their homes and asked why they had not kept their appointments, they had no idea where to go: further to this, they did not understand why they needed to attend. If it were convenient for them, I would conduct the antenatal examination in the home. I remember a colleague saying that she had no intention of 'starting that, as all women would want it and purposely not attend the clinic'. This did not, however, happen. The norm was to attend clinic and the women wanted to be 'the same', so once they knew where to attend and felt that there was a purpose, they did. The confusion decreased as communication and attendance improved.

Continuity

Continuity of care and carers for the women, both before and after birth, was the norm. Most women would see only between one and three midwives in the antenatal and postnatal period. Because I lived locally to the hospital and (initially for my own convenience) in order to reduce the initial loneliness of being the new community midwife, I called into the hospital every morning. I would visit each of the areas, talking to the staff and woman from *my* practice. Although I have to admit that it was not initiated for this purpose, I soon realised that this daily contact with the women served as the cement of trust

for the relationship with the women. It was as if we 'connected'. Halldorsdóttir (1996) relates to this concept, using the metaphor of a bridge, symbolising the openness in communication that takes the relationship onto a 'professional intimacy'. This is developed in the presence of mutual trust, respect and compassion.

The women's eyes would light up at my familiar face. This would reflect on me and it felt good. If necessary, I would call the interpreter (who worked on the wards in the morning) from our clinic and ask her to check whether the women needed anything. This visit also enabled me to provide extra information to the hospital staff on the women, usually of a personal, social or psychological nature, the type that is difficult to commit to paper, for example, 'This woman is having a hard time with her mother-in-law.' I could see that such information brought the woman 'alive' to the hospital midwife. So they saw not only the 'outer' physical woman, but also the inner, hidden, silent, often neglected one. Through 'seeing' the whole, the hospital midwives could then offer an 'extra' smile and gentle warmth, which crosses all cultural communication barriers.

'Bad care days'

During my visits to the women's homes, I developed a 'patter' of pidgin Punjabi and learned to *talk* with my hands, face and body, developing a virtual, designer sign language. Although this was developed on a trial and error basis, if it served *my* purpose it was reinforced, and if not I sought alternative means. The effectiveness was judged by my getting the answers I wanted. It is only in retrospect and with embarrassment I recognise this and other strategies that I used to employ on Tuesdays, when the antenatal clinic began at 1 pm and finished at 6 pm. I sometimes had to assist with another clinic from 9 am for an hour or so, and in between there were often eight or more antenatal and postnatal visits. There was no concept of necessary or unnecessary (selective) visits. I carried out the ritual visits twice daily for the first three days, then daily for ten; only thereafter could visits be as needed until the 28-day watershed.

The quality of the visits on Tuesday must have been different. Now I recognise them as 'bad care days'. My strategy was to pray on the doorstep that there were no problems. If it was a visit for my colleague's practice and non-Pakistani women, I would pray for the woman not to be in, but the Pakistani women would always be home.

I would breeze in chirpy and cheerful, with the pidgin 'OK Tak-haï', 'no problems', an effective 'blocker' for any problem. The obligatory top-to-toe examination of mother and baby was conducted, using my agenda, at a speed that I judged the woman would not detect as being rushed. If I had a student, this was wonderful, as both 'top-to-toes' could be conducted simultaneously. If there was a problem that I had initially 'looked through' on arrival or that arose during my swift record-keeping, I would move into superefficient mode and deal with it quickly, with little thought.

I look back and recognise that I was using what Foucault (1980) describes as the 'professional gaze'. According to the time I had, that is, how much 'work' I had on, I would use this gaze to enable or disable the women. As the women were always pleased to see me, I used to kid myself that I did not need an interpreter, and, when my conscience told me otherwise, I would rationalise that it was the way the women wanted it. The women, however, knew no different; they did not have an expectation of me being able to understand or help them. Speed certainly does not allow time for really listening or for the provision of essential psychosocial care. On reflection, I had nothing to listen to because I could not understand. On non-clinic days, I tried to make up for the care shortfall. This must have been very confusing for the women as I probed and actively listened one day and was professionally distant the next.

While we had the good fortune to have an interpreter at the antenatal clinic one half-day a week, there was throughout the rest of my working week no-one, other than family members, to assist with communication. An on-call rota for volunteer interpreters (paid when called) was briefly set up, but the service was poorly funded and, not surprisingly, unreliable. If ever there was a dire need for an interpreter, such as the times I wanted to admit a mother or her baby to hospital and she did not understand, I would ring the GP's surgery and ask the Pakistani receptionist or the doctor to explain to the woman. On rare occasions, I arranged with the interpreter from the antenatal clinic to meet me at a woman's home. I am ashamed to admit that this situation lasted for the five years I worked there and to my knowledge continues today.

Those five years were the happiest and most satisfying times of my midwifery career. I spent many long interesting visits asking anyone who could speak English about the Muslim culture and learnt as many Punjabi phrases as I could. I admired the strong family ties and values; I saw unconditional love, and children given priority. This was very refreshing compared with my own life, which involved full-time

work with others caring for my (at the time) young children. The latter provoked feelings of guilt and inner conflict. For the first year in the community, I was lonely and missed the support of my hospital colleagues. I remember being thrilled to be allocated a student so we could chat between the visits, share our feelings and views on practice and the women, and learn from each other.

Parveen was the very first interpreter whom I worked with; she was attached to the GP clinic referred to above. Parveen was based at the hospital on the postnatal ward, as an auxiliary, and then came to the clinic for one half-day a week. In the hospital I had not noticed her attitude towards the women but in the clinic I was shocked by her authoritarian manner. I listened horrified as she berated the women, chastising them if they had forgotten their sample of urine, ordering them to the chair or the couch to lie down. The final straw came when I asked her what she had said to one women and she blandly informed me that she had told her to 'speak when she was spoken to'.

I learned that Parveen lived in and was part of the community of women attending this antenatal clinic. When I informed Parveen that I would like her to speak to the women kindly, she became surly, withdrawn and unhelpful. Her power in the triad relationship revealed itself clearly as she failed to facilitate the communication between myself and the women. The worst scenario I suspected her of was distorting the message. It was evident that the cultural conflict and the power relationship lay not between the women and me but between Parveen and me. It became an issue of great concern as I was aware that my reputation in the community would rest with Parveen. Her power as the gate-keeper to the community neutralised in one stroke any control I had of the situation.

An opportunity for change arose when Parveen's pregnant sister attended the clinic. The difference in Parveen's attitude was palpable. I took hold of this and informed Parveen afterwards that that was how I wanted her to be with all the women. Her reply was, 'the women did not want or expect this' and 'I would not be accorded the respect I was due, by virtue of my professional role, if I continued this way.' She made the comparison with the doctor, who, like their husbands, must be looked up to and obeyed (Rafiqul-Haqq and Newton 1996). As such, she considered her authoritative behaviour to be entirely appropriate.

Our differences were initially and superficially resolved in an authoritative way. As I was 'in charge', she would do my bidding, yet she made it abundantly clear that I was 'going about it the wrong way'. This solution to our cultural conflict only served to fuel her

existing cultural and socially inculcated reaction to power and authority. Her belief system upheld the view that the only way to gain respect was to command it. My belief system was based upon the principle that one cannot command respect, it has to be earned. Earning respect, however, takes more time.

Following the birth of her sister's baby and my visits to their home, there was a distinct change in Parveen's attitude and behaviour. Parveen's acceptance of my methods became evident as she used her links and extensive knowledge of the community in the care of the women. My role as a detective, tracing families that had been rehoused, or women who had gone home to their mothers, became much simpler as Parveen shared with me information about the community. Her insider knowledge of important issues such as family feuds, second wives or abusive husbands became crucial to my understanding and subsequent care of the women. I knew I had passed the acceptance test because she trusted me with this information. I was, however, very 'careful', despite some very clever questioning from some women, never to divulge any information. I had earned Parveen's trust and respect, and she saw and experienced an alternative belief model in operation.

The relationships blossomed from then on; Parveen began to address the women as *Baji* (sister); she was able to be 'kind' to the women when she made them honorary members of her family. Consequently, through the process of my using my position in the hierarchy and wielding power and authority, including ingredients such as persistence and kindness, a change in Parveen's attitude to the women was achieved. Parveen and I became a team working for the benefit of the women in her community. On reflection, I was aware that I had imposed my values and was in no doubt that the motive behind Parveen's action was to protect and guide me.

Ethnocentricity, power and authority

Contrary to the role of the interpreter in most codes of ethics (Kaufert and Putsch 1997), Parveen did not show 'neutrality or objectivity'. Whether neutrality is a realistic expectation for interpreters has been debated by Solomon (1997). She found that principles easily slip over to dogma when they are applied ethnocentrically (in believing in the superiority of the cultural group from which one comes); this can create sterility in the triad relationship, which itself becomes a barrier.

It could be argued that both Parveen and I were applying ethnocentric principles dogmatically. The situation was initially resolved, albeit not satisfactorily, by the use of power and authority. My 'do it to prove it' approach possessed an ethnocentricity, but the clinical damage and potential sabotage might have continued without the key learning opportunity brought about by Parveen's sister attending the clinic. Friedson (1985) focuses upon issues of power and dominance in clinical communication, but he refers specifically to health care providers and clients rather than interpreters and health care workers. There is much value to be gained from morally sensitive persons in a particular situation bridging the cultural gap, in this case initially via the interpreter. It should be remembered, however, that the right to the moral high ground must always remain in question, especially cross-culturally.

Policies that restrict the role of the interpreter, and emphasise cultural neutrality and invisibility, may ignore the important other dimension that Parveen and others bring to their role of interpreter, that of broker or mediator. There are many important issues that surface when the interpreter takes on this role, not least the ethical dimension. It would not be possible to gain the consent of the community prior to Parveen's divulging information, but it should have been a consideration for the individual. In the early 1980s, a utilitarian approach was instituted, but almost two decades later it would be important to consider the rights of the individual more carefully.

Parveen's story provides an example of problems that occur outside the woman when the interpreter and midwife do not share the same culture. It does not, however, highlight another fundamental issue surrounding the interpreter–midwife–woman triad, that of demonstrating how interpreters make sense of the uncertainty surrounding the direct translation.

Interpreting: more than just words

In my naïveté and ignorance, I believed and trusted that Parveen had interpreted my words verbatim. Neither Parveen nor I had received any training for this part of our role, and I often asked why it took so many sentences to effect the translation of a single sentence. Kaufert and Putsch (1997) found that some interpreters introduced a bias into the messages they gave. It was only after I had worked with different interpreters and had myself studied Punjabi and the Islamic culture

that I realised how a straight verbatim interpretation might not get the message across.

In the provision of a straightforward interpretation, Kaufert and Putsch (1997) confirm that interpreters often need to extend upon or adapt the message so that it is understandable in a different language or culture. This is often conducted in a mediating way to prevent conflict or to protect both parties. Managing the information to the benefit of both parties involves what Schott and Henley (1996) identify as cultural brokerage. However, there is the potential for suspicion (from either the giver or receiver) around this cultural adaptation. The interpreter as the carrier of the message may suspect direct translation is inappropriate, or the owner of the message may suspect the interpreter of altering the meaning of the message.

Trust is needed on all sides; the interpreter, who has worked and lived in both cultures, who has a knowledge of the topic and culture, and who also possesses the skills of a good communicator, may be the best person to make a judgement on how the information is best managed. There are also other factors that need to be considered – the interpreter's standing in the community, personality, gender, religion, dress and attitude – which all have the potential to make or break the vital link to effective communication.

The status of interpreter

The literature about communication has emphasised language and culture as 'barriers'. Kaufert and Koolage (1984) found that interpreters or bilingual health workers were usually represented by ancillary members of the health care team. Thus, despite the importance of the interpreter's role, the power structure, the culture of the health service and the low status of the women can easily lead to interpreters being marginalised. There is the ever-present potential for misunderstanding, leading to a breakdown in communication. Schott and Henley (1996: 94) quote a community midwife who said, 'I am never sure what she [the interpreter] tells them, she seems to make their decisions for them... I feel she looks down on the women as uneducated and stupid and feels she knows better.'

It is understandable that the interpreter identifies with the 'higher-class' health professional, which further emphasises the disparate elements of class. Parveen considered herself 'a cut above' the women who came to the clinic, even though they were of her community;

until she elevated them to being a member of her family, she did not treat them as equal. The major issue that set her apart was her education, which ultimately accorded her access to the health system, a freedom denied to most Asian women generally (Hayes 1995). As discussed, Parveen worked as an auxiliary in the local hospital so some of the terminology would be familiar, but the concepts, importance and relevance might not have been understood. There is also the ever-present possibility that there may not be a linguistically equivalent term for the interpreter, which presents her with a dilemma. This is especially important if it is superimposed upon a total lack of understanding of the true meaning in one language. Tests for screening fall into this category.

Bad news

This is a direct translation of an untrained interpreter's interaction with a woman following the confirmation by scanning that her baby was abnormal (Rizwana, personal communication, 1998):

> Your baby is handicapped and ill; how are you going to cope in looking after it? It will be a burden to you and your family, and you must think of them; you can always have another baby. The doctor wants you to have an abortion.

This approach is incredible to believe, yet it took place in an antenatal clinic in 1998. The woman had conceived this, her much-wanted, eighth child, while visiting Mecca to pray for one last chance at motherhood. This conception was a 'blessing from Allah'. The psychological effect upon this woman following this interaction was devastating, 'her world fell apart' and she was left feeling that the health service and all its personnel had failed her.

Giving bad news through an interpreter is a cultural double-edged sword. Truth as a concept may not be upheld or valued, especially if it has the potential to do harm or hurt someone's feelings. This generates a culture that supports an 'emperor's new clothes' value system and is reminiscent of my own upbringing with regard to the maxim 'If you cannot say anything good, do not say anything at all.' However, a problem denied cannot be one solved. This has been evident to me many times during my work with Pakistani women and their families.

One example of this occurred when a child born with a severe heart defect was transferred to a distant regional unit. The mother did not want to visit or learn of the child's problem; all she asked was whether a child with this condition had ever lived.

There seems no doubt that one's use of language affects one's perception of reality. Carrese (1995), working with Navajo Indians, found that their core values prohibited the discussion of bad news. Protecting a relative from bad news is a common value in many cultures (Felema and Teklemarian 1992). It is interesting to note that other groups hold a parallel belief that telling the truth may be considered disrespectful and has the potential to attract harm by tempting fate.

This belief underpins the true story of a woman attending a GP in Pakistan with severe anaemia. When the GP asked how many children she had had, she replied that she did not know: 'five or six maybe...'. The GP subsequently learned that she had given birth to nine children in eight years. He rationalised her reluctance to tell the truth by saying that it was her belief that if she spoke about her success and luck in having nine live children, she would be tempting fate and some harm might come to them. A parallel to this is the Western woman who is afraid of discussing cot death just in case she 'makes it happen'.

There is also the unfamiliar (to English) polite and impolite/respectful and non-respectful terminology in Urdu and Punjabi. A small parallel can be made with the English language. I have heard other midwives use (and indeed have myself used before I knew) the term *pishab* when asking a Pakistani mother for her specimen of urine. When I learnt that this word translates into a rough common term likened to 'piss', I realised the potential to offend.

Interpreters in Pakistan

Following on from the examination of the cultural context, the stark realisation of the effect that interpreters and interpretation have upon the relationship between the women and the midwife, I propose to explore experiences that I have had with different interpreters in Pakistan. It is not my intention to 'dramatise' and thus increase the potential to stigmatise the interpreters, the women or their culture. Some of the information has been collected systematically through ethnographic study while the rest has come through practising as a midwife. Davies (1997) might refer to this as 'practitioner observa-

tion'. I would like to make it very clear the findings can in no way be generalised as each relationship was unique.

The interpreters allocated to us during the early field trips to Pakistan came from a multitude of backgrounds: a lady health visitor, a civil defence worker and a GP's wife. We had no choice in the selection as it was made by officials from the town, the Chairman of the Town and Municipal Councils and the Chief Engineer. This occurred because the twinning was between town councils. The relationship with each of the interpreters had its own uniqueness. The success (from my perspective), or otherwise, of the triad relationship with the women–staff was dependent upon trust, and whose agenda was being served.

There was no doubt that the Pakistani council officials required feedback from the interpreters on our behaviour and the questions we were asking, and it was inevitable that the loyalty of the interpreters lay with these bureaucrats. We were treated with reserved suspicion. I was even asked whether I was an evangelist trying to convert women to Christianity. Discussions with the elder men of the community at social events left us in no doubt that Western women are considered to be decadent and of loose morals. They took the statistics on teenage pregnancy and divorce as a proof of this. As a consequence, we were aware of the 'fear' felt by some of the men that we might lead their women astray into decadent Western feminist ways.

They could not, however, have been further from the truth. My strict Methodist background gave me a grounding similar to theirs. In addition, I have a high regard and respect for all cultures. Communication through an interpreter, however good, is never likely to be as effective as direct communication between a midwife and woman who share the same language and culture (Schott and Henley 1996). This is undoubtedly true, but in research on birth in Pakistan, the women agreed to be interviewed only because I was a Western women and midwife (Chesney 1998a). The reason given was that they trusted me not to gossip. Whether this is trust or subservience from the colonial past is a matter for further analysis. Mumtaz and Rauf (1997), in their study of the silence surrounding reproductive health in Pakistan, found a reluctance to talk to other women from their own community or background, especially about private matters such as childbirth. This further extended to a division between married and unmarried women. The latter would never be included in any discussion that involved reproduction.

Although each of the indigenous Pakistani interpreters proved fluent in written and received spoken English, their ability to understand our northern accent, cope with the speed of our spoken English and follow our terminology caused both them and us great difficulty. This lay outside the sensitivity of the topic, that of birth. After a particularly frustrating third visit, I informed the twinning group that we would return if we could take an interpreter from Rochdale.

Razia

The first of the interpreters to accompany us from Rochdale was Razia. She was 'allocated' to us by the town hall in Rochdale, her name having been proposed by one of the members of the twinning group. Razia was a single girl who was doing voluntary work with a youth group in the town.

Our first mistake was to meet her for the very first time at the airport, although I had requested a meeting many times before. On reflection, this should have raised my suspicions. During the flight we discussed her role. I tried desperately to overcome her passive, subservient demeanour, but it seemed that I did not have the key to free her to be my equal, so I changed role to that of 'maternal protector'. I did not know whether this was natural shyness or a fear of me or of the situation. It is almost impossible to build a relationship of trust during a 10-hour flight to a 'mission of fear', which was how I perceived Razia to feel.

Unfortunately, Razia's premonitions were realised. To summarise the key elements of a particularly frustrating field trip, we were first met at the airport by her relative (a male cousin slightly older than Razia), who had been instructed by the family to chaperone her throughout the trip. I explained that he would not be allowed to be present in the maternity hospital, but he was not happy to let Razia out of his sight. He even insisted that Razia stay with the family rather than with us in the rest house. Naturally, I did not want to offend any cultural norm and gave Razia the choice of where she wished to stay, understanding her wish to please the family.

Razia (along with her chaperone) accompanied us on our first 'official' function. A politician called her over and asked her who her father was and what was he doing allowing her, a single girl, to be in the mixed company of women and men. I spoke to the politician but the damage had been done and Razia was frightened. The only time we saw her on the trip thereafter (until the return journey) was when we went to visit her at her aunt's house to check that she was not being kept there against her will.

Not being able to communicate freely with the women and the staff at the hospital was the most frustrating part of our work together. I had studied Punjabi, and although this helped a little when combined with pidgin, signing and body language, no-one was able to understand me fully. In sheer frustration, we would end up smiling, nodding, shrugging our shoulders and moving on to the next equally frustrating experience. This formed a web of communication that was frequently devoid of common words, but over the seven visits we built an abundance of common experience. This served as an umbilical link containing veins and arteries of mutual respect and admiration. We cared for and looked out for each other, as women would do in a war situation. For example, one time when I was upset over a stillborn baby, the staff, despite being surprised at my reaction, comforted me. Another time, one of the staff had been transferred, and we pulled out all the stops to get her back.

In a bid to span the language gap and prevent a recurrence of Razia's unfortunate experience, I informed the co-ordinator at the town hall that I would select the next interpreter to accompany me. As it happened, we self-funded the next trip in order to conduct the evaluative research for my MSc. This was primarily to free us of the social commitments that the town-twinning arrangement required of us. Such civic duties, for example prize-giving at the local schools, took priority, in the official's eyes, over our work in the maternity hospital.

Nadia

When I was a teacher in the West Pennine College, Nadia was a student midwife. Before I seriously considered her offer to act as interpreter, I asked her to confirm her parents' permission. They asked to meet me and the others in the team who were to accompany Nadia to Pakistan, and after only a brief introduction we were served a delicious meal by Nadia, ate alone and left. We had been vetted, and Nadia was given permission to travel with us and act as our interpreter. Her own student group raised money for Nadia's fare. We had frequent meetings about the trip; Nadia was involved in the piloting and development of the interview schedule, and we role-played the interview situation. The relationship built into one of mutual respect, with a clear focus and direction.

In total contrast to the previous visit, our pre-existing relationship made the trip a resounding success. Nadia had a warm, non-

judgemental, humanistic approach and she bowled everyone over with her serene 'mother Theresa' presence. Even the socially sensitive GP and his wife who provided our accommodation were impressed with her, when she asked the GP whether she could possibly move the Koran in her bedroom to another place as she was not happy to sleep with her feet pointing towards it. She was, in everyone's opinion, the epitome of a good Muslim girl, yet she was breaking the social norm by being in our company. To overcome this, we took on a parental role. We totally avoided the political and social scene, and as a consequence Nadia did not suffer the male prejudice that Razia had encountered.

Nadia was undoubtedly the ideal interpreter, whispering in my ear, filling me in with conversations that she felt were appropriate to the research, yet managing to maintain everyone's trust. When I asked a question that could not be directly translated, she would check any adaptations made with me and explain the relevance to me. Her thinking was woman centred, and she knew the aims of the study by heart; in addition, because she was halfway through a 78-week midwifery programme, she had a firm grounding of the terminology and practice. We spent some time working on the wards, and together we experienced emergencies such as shoulder dystocia and a fresh stillbirth. These experiences, although extremely traumatic, built the relationship between us and the staff in the hospital. On reflection, the relationship with the women was transient, almost secondary.

By then (our fourth trip), the staff had come to accept our different 'sisterly' care of the women. It was ironic that the staff were insatiably hungry for our knowledge, yet the one thing that they could give within their own resources was 'care' – which did not appear to be valued. However, Nadia and I agreed that the tender loving care we saw given by a mother to her daughter, first day post-caesarean section, could not be matched by that of any nurse or midwife.

Nadia and I reflected upon the need for the staff to protect themselves psychologically from the tragedy that went with their daily work. I thought of the women who asked me to remove my (as I saw it) comforting hand from their arm in labour: they had built a wall of protection and did not want it breaking down by my touch; or perhaps, because I was a white person, they were suspicious of my presence and 'odd' behaviour. Further reflection took Nadia and I into an analysis of the camaraderie and relationship with the staff following major incidents: no angry black cloud of litigation hanging over us, making us defend our individual practice, just an honest, genuine desire to do it better, try something different next time.

Although this fourth field trip was the most traumatic and challenging in a midwifery practice sense, it was, paradoxically, without doubt the most satisfying. The reasons were multifaceted:

1. our relationship with the staff, made possible by a more effective communication system
2. the oneness (philosophy) of the interpreter (Nadia) and myself
3. trust built through working together
4. separation from the male bureaucracy.

I consider attaining these goals to be essential before effective care can be given. What is considered 'effective' is, however, culturally determined. Saving lives is clearly cross-culturally valued, but dealing with the psychological as well as the physical trauma is not yet on the agenda for the poor women or the staff in this hospital. On a Maslow (1969) type hierarchy, the basic level of survival has to be achieved before considering morbidity, either physical or psychological. As a consequence, in this hospital and in Pakistan, we are at the opposite ends of a cultural continuum. The relationship with the women remains in limbo: they neither wanted nor understood our tender loving care. The relationship with the staff, however, has moved onto a different plane. They observed holistic care, saw the women's reaction, so did not value or emulate it for the women, but did admit that they would like to receive it.

Amrith

Nadia was unfortunately not available for the sixth field trip as she had by then qualified as a midwife, was married and was pregnant. I thus considered myself very fortunate to have Amrith offer to accompany me as my interpreter. We held a similar position in higher education and had studied together at undergraduate level.

My lasting memory of this field trip is of a huge, painful learning curve; being in a minority group, I realised just how uncomfortable a situation that is. My relationship with the women and the staff took a downward spiral as my confidence was sapped. I was no longer the one with the knowledge – someone else had that and possibly more understanding of the culture – but most importantly, she had the means of communicating it, in a warm, friendly, empathetic way. I felt helpless, and the very same useless invisibility that engulfed me as

student midwife returned with a vengeance. The women looked through me to the person who could help the midwife, or in this case the interpreter, who was also a midwife.

A multitude of feelings and thoughts sprung from the uncomfortable position in which I found myself. I felt marginalised as the women grouped around Amrith. I felt a failure when I had to ask her to explain what the women were trying to say, and I knew that I was not needed for the answer as Amrith could give it. I experienced grave reservations about my role within the project. I had been happy with the communication through a non-informed interpreter or a student, who did not know as much as me – how inflated my ego must have been. This field trip made me think for the first time that it was not good enough. I had been selling the women and the staff short when what the women and the staff needed was what Amrith could give them and I could not. A mother must feel this way when her child is on a special care unit. I recognised my feelings as being those of jealousy: I wanted to help the women whom I had come to care for but I could not. I had compromised the women, given them second best, and they deserved more.

I recognised, however, that the culture would not allow Amrith to address the men (the bureaucrats) in the town as I did. I was able to challenge them and at times shame them into taking on their responsibilities, such as clearing the hospital drains and decorating the hospital. I had built a long-standing, trusting relationship with the staff at the hospital, and they often asked me why I did not stay longer or come more frequently. Perhaps my cultural difference could complement a partnership, if I could overcome my jealousy.

The partnership was not to be, however. I had detected reluctance from the twinning group when I proposed Amrith as my interpreter, their reluctance being based upon the issue of her coming from the Indian Punjab and on her religion as a Sikh. I told the group that they were bigots. However, I lost the bid to return with her, not because of Amrith's religion but on the issue of her not originating from Rochdale!

Nasreen

Nasreen's father was a founder member of the twinning group and he proposed his second eldest daughter, Nasreen, to be the interpreter for the eighth field trip to Pakistan. My personal aim for this trip was to interview women on their birth experiences in Pakistan. I really did

need a reliable interpreter, and I knew that Nasreen was also a Registered Sick Children's Nurse (RSCN), which I initially saw as being beneficial to the project. I had known Nasreen's mother and father for many years as I had been their midwife for the last four of their 15 children. I was, however, suspicious of Nasreen's father's offer as I knew that Nasreen had never visited Pakistan before. As such, I made it very clear that she would not be able to spend time with her relatives in Pakistan. I insisted that Nasreen come to visit us at home before I agreed. Nasreen visited us a number of times. She was 25 years old, both her RGN and RSCN had been completed in the north west of England, and she had recently graduated with the Open University.

It was a shock when we met Nasreen, as she was articulate, very forceful and politically opinionated. Her nervous, high-pitched laugh belied her maturity, and she had a somewhat naïve perspective on life. She jumped into a defensive paternalism with a protective stance towards the Pakistani population of Rochdale without apparent provocation. It was almost as if she did not believe us when we talked of caring for the women in Pakistan. The source of this might have been the strong 'caring' extended family network. Nasreen had a likeable openness about her; she would joke with my husband but then sulk like a teenager. We never knew what she was really thinking. I had never come across a more complex young woman and wondered whether this was a result of living in one culture and being educated in another, yet Nadia had had an almost identical background but was quite different. I came to the conclusion that this must have arisen from personality and social differences. On reflection, I was disgusted with myself for expecting them to be similar as it showed that I was thinking in absolute categories, demonstrating what Rattansi (1992) called a 'culturalist approach', which has the potential to collapse diversity and complexity into a destructive stereotype.

It was Nasreen's expressed wish that we were not to let her out of our sight in Pakistan as she herself was suspicious of her father's and other relatives' intentions in Pakistan. We had discussed Nasreen's role as interpreter, stating clearly my requirements during the trip. I did not have to wait long before I saw the effect that Nasreen had upon the relationship with the women. We hit a problem that had not been anticipated during the very first interview. This was with an older woman who did not speak any English. Following the introductions and purpose of the interview, as a part of the woman's 'life story', I asked Nasreen to enquire how old the woman was when she started menstruating. Nasreen turned to me indignantly and stated, 'I can't ask her that, it would be disrespectful; she is my elder.' I was taken aback. We had discussed the interview questions and they contained more personal information on life and the birthing experience in general. How on earth was I going to conduct the interviews if the interpreter could not ask the questions? I explained to Nasreen that it was not she asking the questions but me; reluctantly, and with some embarrassment, the question was asked.

I had never experienced difficulty with the non-acceptance of young students caring for Pakistani women before. Thus, I had never considered the age of the interpreter or midwife relevant before this incident. However, I have since then read Gatrad's (1994) study on the attitudes and beliefs of Muslim mothers towards pregnancy, which confirms that Muslim labouring women prefer to have older female attendants. (This may contribute in part to the difficulty experienced in recruiting Pakistani student midwives.) The incident also made me realise the difference between asking a mother about her child (a familiar occurrence for Nasreen as a children's nurse) and asking a woman across a generation gap about personal matters. This also accentuates the bad practice of using a younger member of the family as interpreter.

Schott and Henley (1996:101) say that using children to translate matters that are distressing or highly personal can cause long-term damage to both the children and the family relationships. Yet I am ashamed to admit that, when there has been no other possible alternative, I have had to resort to seeking the help of relatives who have accompanied the women. Most parents wish to shield their child from distressing or sensitive information, as with the woman who was advised to abort her 'blessed child' (Rizwana, personal communication, 1998), whose eldest daughter, aged 15 years, accompanied her for the antenatal booking interview. When the question of consanguinity arose, the woman was embarrassed: she did not want her daughter to be influenced against her extended family wish and the norm of marrying her cousin.

'Get it over with'

A further difficulty with Nasreen's lack of understanding of midwifery and with her background was exposed when she stated that she could not see a problem with 'getting the labour over with as quickly as possible' and thought that induction and the use of oxytocin was 'modern midwifery practice'. All her brothers and

sisters had been born during the 1970s and 80s, and she had undertaken her maternity placement during her RGN training in a regional high-technology maternity unit. Nasreen had grown up in a world steeped in the medicalised model of midwifery, with induction and intervention as the norm. I learned later that she considered me 'way out' and 'radical', much like the doctor at the maternity hospital in Pakistan, who judged my non-interventionist approach to be on a par with that of the untrained, uneducated *dai*.

One interview that stands out as being the most successful, in terms of really communicating with the woman and feeling the relationship between us build exponentially, was with a women whose husband was the gardener at our accommodation. On reflection, and with an analysis of the chemistry that gelled the relationship, a multitude of factors emerged. The key one over which I lingered was the acceptance of the woman by Nasreen and vice versa. I feel that this came from the initial exchange of information prior to the interview when we explained the purpose of our being there, our personal interests and professional backgrounds, and, very importantly for this particular interview, our personal backgrounds.

I had noticed in previous interactions, not just with interviewees, that Nasreen avoided answering the inevitable question 'What does your father do?, as well as the next most asked question of how many siblings she had. Whenever it could not be avoided, I always added to her almost whispered reply that I would have loved such a large family, sensing Nasreen's diffidence. There was undoubtedly a prickly defence reaction in Nasreen when she felt she had been cornered into replying. When we asked the gardener's wife how many siblings she had, her reply matched Nasreen's in both number and gender. There was an immediate snap of acceptance, a common empathic experiential bond. I had sensed and experienced this so clearly only once before, when observing a student midwife book a woman who had had a previous stillbirth, and the student saying, 'This also happened to me.' Thus, it was apparent to me, but too sensitive to discuss with Nasreen, that she had become ashamed of the size of her family, much as I am reluctant to 'tell'the truth' about my daughter cohabiting with her boyfriend when I am questioned in Pakistan. It is almost as if I am confirming their belief that Western norms and values are decadent.

Interpreter training

My experiences working with different interpreters, in both Rochdale and Pakistan, directed my thinking towards getting it right more often. To achieve this, specific training must be the key. I have been involved in the training of link workers who have a primary interpreter role. What information could or should not be given was a major theme in the training. Because of their link worker status, basic health care information on hygiene and child care, plus information on whom to contact and where, was included in the content of the training. The screening tests and the different pathways that women would tread through the childbearing continuum were covered in some depth, but the other very important elements of what to do with bad news and problems in translating medical terms were not addressed. The training also involved trying to get the interpreter to accompany the women through the antenatal clinic to act as their advocate. Despite clear directions, this has never been achieved. The reason given was that the interpreters wanted to be separate from the women and sit in the staff room until summoned by the midwife or doctor; this was a recognition of their status. Indeed, this training was superficial compared with that outlined by Solomon (1997), Zimmerman (1996) and Woloshin (1995) currently offered in some states in America. Although they identify the lack of nationwide standards for language interpreters, some states have training programmes and certification. Similarly, they further maintain that the goal of the medical interpretation should not be maintaining a distant neutrality but building a shared meaning.

Following training, Kaufert and Putsch (1997) suggest that interpreters should be given the freedom to interpret, to provide the additional context, to say more than the professional has said, or to ask questions of the health professional that *patients* may not have asked. These authors recognise the potential for harm, that is, crossing the line into inappropriate persuasion or how interpreters may avoid conveying critically important information, particularly if the message is considered rude or improper.

Wasongarz (1994), cited by Solomon (1997), recommends a 'transparency' rule. Such a rule requires the interpreters to explain to the health care professional whenever it is difficult to make the required translation, revealing what they have omitted, changed or added. On reflection, the relationship that developed with Nadia and myself embodied such transparency, and it is apparent that we had

developed a practice standard that is validated by research. The responsibility now is to create an educational programme to disseminate this through education.

Professional interpreter

It is possible, but may not be practical, to overcome some of the language and interpreter dilemmas by employing midwives (professionals) from the cultural group being served. However, to achieve this we would need successfully to recruit many more ethnic minority nurses and midwives. This would seem to be an oversimplistic solution to the problem as conflict may arise between the roles of midwife and interpreter.

French *et al.* (1994) examined factors that are influential in the choice of 'nursing' (as a lead-in to short midwifery programmes) as a career choice. They identified the importance of the family in any career decision-making. The primary reason identified within my own ongoing work (Chesney 1998a) points to the status of midwifery, not in Britain but in Pakistan, as an influencing factor. The bond between the branches of families in Britain and Pakistan is very strong. Thus, when a Pakistani family in Britain write to their relatives in Pakistan about their child's career aspirations, wanting to become a midwife is taken by the extended family as entering a lowly 'dirty' profession that no 'decent' family would condone. Another obstacle is the issue of unmarried Pakistani women being forbidden to discuss sexual activity or reproduction. Mumtaz and Rauf (1997), in their study of intergenerational knowledge transfer, found an imposed silence on issues of sexuality between generations.

Murphy and Macleod Clarke (1993) reported that health service staff consider cultural barriers to be largely of language origin only. They argue that staff are less likely to be aware of the structural constraints within which the communication operates. Such structural constraints include a uniculturally designed health service. Bowes and Domokos (1995) found other barriers, including gender, class and racialisation. Similarly, the King's Fund study (1990) of racial equality and the nursing profession found an overemphasis on culture and language, rather than equal opportunities and antiracism.

In the first instance, I considered the major issue inhibiting understanding to be the absence of a common language. I naïvely felt that if we communicated, women's needs could be met. However, following

my experiences working with interpreters at home and in Pakistan, I now see that the issue is much more complex and needs to be addressed holistically. This could be demonstrated in a model using the onion skin analogy, with the core of culture or language being encircled by gender, age, class, personality, attitude and racialisation as the outer layers of the onion. To put this in context, each person has these (and more) layers as the organisation and environment will have their own; the complex whole is dynamic and may never be describable.

Conclusion

Such was my ignorance that I practised hypocrisy and self-deception. Reviewing my past experiences caring for Pakistani women in Rochdale has enabled me to address my previous complacency, cultural blindness and imperialist approach to care. The spark that ignited the fire of change came from being deposited in the minority position myself. Unable to articulate my needs, being the lone *different* served as a shock to open my eyes and increase my awareness of how Pakistani women may feel receiving care from a British midwife imposing a British system of care. For the women in Rochdale, living in a strange country, passing through a major life event and being processed in a service not designed for them is surely bad enough, but to superimpose on this the inability to understand, or be understood, is persecution.

Moreover, there is a definite complacency surrounding the provision of care of ethnic groups in the NHS. This is evidenced by the lack of priority and resources to train link workers or interpreters. I have recognised that providing care through a third person, an (untrained) interpreter and/or a relative, increases exponentially the potential for problems. Caring for women across a language and cultural difference is beset with problems at the outset. Even if there is no language difference, the cultural values and norms related to childbirth are the strongest in any society. Some of the problems encountered have been uncovered in the text: conflict, power, control and ethnocentricity provide some evidence for the complexity of this area.

Care provided through a third person requires specialist knowledge and at least some training and preparation. In the UK, there is a void where this training should be. As a consequence, professionals and interpreters muddle through, much as I have done, and are lucky, as I have been, to get it somewhere near right the odd time. This is,

however, not good enough; the women are casualties of this, and their lives and those of their families are affected by it. Good maternity care requires intimate and sensitive communication between women and those who care for them (Hayes 1995). To work effectively, however, the midwife may not be required to become an expert in the ethnocultural group, or the interpreter need not necessarily be a midwife. It is essential, however, to have cultural flexibility, acceptance and understanding, and to perceive the woman as an individual, as well as to develop a self-awareness and openness to cultural diversity in relation to our own beliefs, values and culture.

Interpretation needs may not be immediately evident, but communication is the key to the success or failure of the therapeutic relationship between midwife and woman. A woman's needs are, as stated, individual and unique to her. Thus communication needs will be broad and complex, but solutions must be found to provide the care that all women deserve. *The Patient's Charter* states 'there should be respect for privacy, dignity, religious and cultural beliefs' (Department of Health 1995:6). This care should undoubtedly encompass information so that choices can be made; the very best form of information is 'people attached' and context framed. Paper information should supplement this. It is, however, apparent that many sections of the community are denied both.

These are the key learning experiences that arose while working with professional, but untrained, interpreters. They demonstrate the uniqueness of and effect that each person has on the relationship with the other. When there is an interpreter, this will increases the potential for disharmony by a third, but, as I have suggested, one simple but unrealistic answer would be to have midwives who can communicate through a common language. Until such time, trained interpreters are an essential component of health care. Zimmerman (1996) identified an agenda for action, which involved three simple steps:

1. There is a need for a rigorous review of education with the development of a core component on ethnicity and health, race- and culture-specific health problems.

2. Models and frameworks of care need to be adaptable, and the assessment of need should include the use of a cultural assessment tool (Tripp-Reimer *et al.* 1964, Giger and Davidhizer 1990).

3. A rigorous programme of research is required to establish the needs of ethnocultural groups.

It is every policy-maker's and professional's responsibility to take Zimmerman's steps beyond the 'words' stage and into action.

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