

**MEETING THE HEALTH AND SOCIAL NEEDS OF
PREGNANT ASYLUM SEEKERS; MIDWIFERY
STUDENTS' PERSPECTIVES**

A critical discourse analysis of language use by midwifery students in their social constructions of the health and social needs of asylum seekers accessing maternity services

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Meeting the health and social needs of pregnant asylum seekers- midwifery students' perspectives

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Abstract

Current literature has indicated a concern about standards of maternity care experienced by pregnant asylum seeking women. As the next generation of midwives, it would appear essential that students are educated in a way that prepares them to effectively care for pregnant asylum seekers. Consequently, this study examined the way in which midwifery students constructed a pregnant asylum seeker's health and social needs, the discourses that influenced their constructions and the implications of these findings for midwifery education. For the duration of year two of a pre-registration midwifery programme, eleven midwifery students participated in the study. Two focus group interviews using a problem based learning (PBL) scenario were conducted. In addition, three students were individually interviewed and two students' written reflections on practice were used to construct data.

Following a critical discourse analysis, dominant discourses were identified which appeared to influence the way that pregnant asylum seekers were perceived. The findings suggested an underpinning discourse around the asylum seeker as different and of a criminal persuasion. In addition, managerial and medico-scientific discourses were identified, which appeared to influence how midwifery students approach their care of women in general, at the expense of a woman centred, midwifery perspective. The findings from this study were used to develop “the pregnant woman within the global context” model for midwifery education and it is recommended that this be used in midwifery education, to facilitate the holistic assessment of pregnant asylum seekers’ and other newly arrived migrants’ health and social needs.

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“Hold my hand. Let’s leave this land of winter where the sun refuses to shine. Smiles are frozen, flowers have no scent, and love, the great savior is only a tale. Son, hold my hand; take me home. Promise I never seek asylum again.”

Houri Ghamian cited in Dumper (2002)

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Chapter 1: Introduction

1.1 My starting point

In 2004 a number of events prompted my interest in the topic of asylum seekers. First, I was reading some current midwifery literature when a particular article caught my eye. It was referring to a study undertaken in 2001 by the Maternity Alliance, a charity championing equality in maternity care. The study explored asylum seekers' experiences of maternity services in the United Kingdom (UK) (McLeish,2002). Although this was a small local study, half of the women interviewed reported that they had experienced rudeness and racism and indeed considered that professionals appeared indifferent to their situation. They considered that personal prejudices were impacting upon professionals practice (McLeish,2002).

As a midwife educator I am involved in preparing midwifery students for clinical practice and part of this practice could include providing midwifery care for asylum seekers. One of the recommendations from the McLeish (2002) study was the need for appropriate training and support for health professionals working with asylum seekers in maternity services. My interest in facilitating this training and support for midwifery students began to grow.

Following this, I began to explore in more depth the topic of asylum seekers and their health and social needs. I submitted an abstract to a conference concerned with developing cultural competence. This was accepted and I presented a workshop to an audience who were predominantly university academics with

health and social care backgrounds. Part of the workshop included a quick quiz about asylum seekers, their health and social needs and current initiatives and policies focused on meeting these needs. There appeared to be large gaps in the knowledge of the audience about a number of issues related to the health and social needs of asylum seekers and I was left questioning whether this would be the case for health professionals working in clinical practice.

A few weeks later, I was reading my local newspaper and came across a letter written by an ex-police inspector commenting on the “gangs” of asylum seekers hanging around the city centre in expensive designer clothes. She believed that they were provided with newly furnished homes, clothing and plenty of cash to spend (Ball,2004). I was surprised to read such comments from a professional person and wrote a letter in response to the issues she raised, which was published the following week. Another letter appeared in response to mine, this time written by a nurse working in the outpatients department of the local hospital (Stokes,2004). She or he described the NHS as “doomed” and referred to the “amount of diseases asylum seekers are flooding this country with”. This response reminded me of the McLeish (2002) study and the need for training and support for health professionals working with asylum seekers. I was left wondering if this training actually took place anywhere and how midwifery students could be targeted. At this point, I felt the need to follow my interest in the topic of asylum seeking childbearing women, with the focus of my study on how midwifery students could be facilitated to meet their health and social needs. This chapter will now discuss the focus of my literature review including

relevant background theory around asylum seeking and the main theoretical perspectives relevant to this topic.

1.2 Literature search

To explore this topic in depth and focus on the intended research area, a literature review was undertaken over a period of time, covering a range of issues. The literature review spanned a number of different disciplines, including nursing, midwifery and other allied health professions, medicine, social sciences, health service management, media studies and social policy. Generally, the literature selected was restricted to the past ten years but some seminal pieces were also included. They were identified when they were frequently referred to within recent publications. In addition, the University library stock was searched for relevant articles from reference lists and paper journals that were not available electronically.

Initially, electronic databases were searched using the university system. A combination of the following terms was input in the search engines:

1) Asylum seeker/ refugee/ minority groups/ immigrant/ migrant

And

2) Pregnant/ maternity care/ health care/ economic recession/ public attitudes/ social exclusion/ racism

Or

3) Health care education/ midwifery education/ nurse education/ training

The following data bases were searched:

- National Library of Medicine (Medline)
- Midwives Information and Resource Centre (MIDIRS)
- Cumulative Index to Nursing and Allied Health Literature (Cinahl),
- British Nursing Index (BNI)
- Applied Social Sciences Index and Abstracts (ASSIA)
- British Humanities Index

In addition relevant websites were accessed including the Department of Health, Home Office, Royal College of Midwives, Nursing and Midwifery Council, Quality Assurance Agency, relevant Non Government organisations and relevant refugee and asylum seeking charities.

Using the same search terms, the university library catalogue was searched for relevant books and other material held in print form.

1.3 My philosophical perspective

An in depth exploration of my philosophical perspective will be provided in chapter three. However, it is important to summarise my position at the outset of this thesis as it influences how the issues raised throughout the study will be viewed. This study is being approached from a social constructivist and a feminist perspective, which have been interpreted as viewing reality as socially constructed, influenced by discourses within the context of an individual's social, cultural and historical position in the world (Burr,2003). Social groups are exposed to different discourses around a social phenomenon, in this case the

asylum seeker and therefore construct varying versions of social reality. Furthermore, Holloway and Wheeler (2002) discuss how social reality is constructed in a different way for women than it is for men, because women have a subordinate position in society, originating from oppression and exploitation by men. However women are not a homogenous group in society and gender is only one construction of identity (Ramazanoglu and Holland,2003). My interpretation of a feminist perspective is to examine subordination and oppression in society, be it men or women, due to the social construction of their identities due to gender, age, sexuality, disability and social class.

Burkitt (2000) argues that power will influence an individual's construction of social reality. Dominant discourses develop and are (re)produced from social structures which influence the way in which individuals view social phenomena. An individual's construction of the asylum seeker will depend on the particular dominant discourse influencing her/his life. This construction is not static and will change with time as events evolve and discourses change. This idea will be explored further in this chapter in relation to literature around the asylum seeker (see 1.5)

1.4 Critical discourse analysis

Chapter four and five will provide a detailed discussion of research methods used for this study. However, it is important to consider my approach to data analysis as arguably, this is congruent with the social constructivist and feminist perspectives outlined above. Critical discourse analysis (CDA) is an approach to

data analysis which aims to understand and address what is constructed by society as a “serious social problem” (Van Dijk,2009, p. 63). In this case the problem is the asylum seeker; an interpretation which will be justified throughout chapter one. CDA aims to critically examine discourses focusing on how they are reflected in the language used in interactions. Social inequality resulting from social power abuse is at the heart of CDA, with powerful discourses influencing the way people think and act in relation to a phenomenon (Van Dijk,2009). Using CDA, this study aims to focus on connections between knowledge and power from a feminist perspective, as constructed in spoken and written texts. In this context, it will focus on discourses influencing students’ construction of the pregnant asylum seeker and how this influences their perceptions of the woman’s health and social needs.

1.5 The asylum seeker

The United Kingdom Border Agency (2011a) describes asylum as the protection given to an individual who is fleeing her/his native country in fear of persecution. The UK is a signatory to the 1951 Geneva Convention. In accordance with this convention, the UK has an obligation to offer protection to those seeking asylum. The individual has to apply to the UK Border Agency who subsequently decides whether the fear of persecution is well-founded and whether or not to grant the individual refugee status. A refugee is a person whose asylum claim has been accepted and who has been granted permission to remain in the UK (Ashton and Moore,2009).

A failed asylum seeker has had her/ his claim rejected and is excluded from the asylum system with no legal recourse to gain the right to stay in the UK (United Kingdom Border Agency,2011a). She/ he has no access to welfare benefits, housing, healthcare or education and no right to work. The failed asylum seeker is expected to return to her/his country of origin. However, there is perceived to be a growing group of such people in the UK who are afraid to return to their country of origin. They are driven underground having no contact with authorities (Ukoko,2007). When this occurs, they then become redefined as an illegal immigrant, together with those people who enter the country illegally or overstay their visa (Somerville and Sumption,2009).

The UK receives the second largest number of asylum applicants in the European Union (EU) after France (Aspinall and Watters,2010). In 2008, the biggest proportion of asylum seekers, 13% of the total number, arrived from Afghanistan, a war torn country which was invaded by Western allies in 2001 and therefore arguably responsible for the displacement of people. Although every year, there are a large number of people applying for asylum in the UK, according to the Home Office (2009), the actual numbers are slowly reducing. The latest figures for 2009 showed there were 24,485 applicants for asylum. This was a drop of 6% on 2008 (Home Office,2009). In 2009, only 17% of the total number of asylum applications were accepted (Home Office,2009). This had dropped from 37% in 1999. In 2009, of the 17%, 37% of those who appealed were allowed to stay. Theoretically, after an unsuccessful appeal, the remaining applicants would be returned to their native country. However, as

highlighted earlier, the fear of returning to the situation that they escaped from drives a number of failed asylum seekers underground.

Aspinall and Watters (2010) criticise the home office statistics on asylum as it considers only the principal asylum applicant in a family. There is little data available on dependents who accompany them. In addition, there is no official data for women or pregnant asylum seekers arriving in the UK, or failed asylum seekers, now categorised as illegal immigrants, who have not returned to their country of origin.

Although the term asylum seeker is clearly defined, there is public confusion between the numerous different terms related to immigration; asylum seeker, economic migrants, refugees, bogus asylum seekers, illegals, clandestines and health tourists are all terms used interchangeably in the popular press, usually with negative connotations (Aspinall and Watters,2010; Gedalof,2007; Mulvey,2010; Somerville and Sumption,2009). In addition other terms have been found in the academic literature instead of the asylum seeker such as humanitarian immigrant and forced migration (Dwyer and Brown,2005; Mulvey,2010). Undocumented migrants are a category of people who are not recorded as being in the UK, encompassing the illegal immigrant, economic migrant and failed asylum seeker (Wiseman,2011).

The popular press perceives that there are “good” and “bad” migrants (Mulvey,2010). “Good” migrants are those who are either highly skilled and come to the UK to work or students who come to study. “Bad” migrants are

those who are perceived as relying on the welfare state for income, including the asylum seeker. In reality, asylum seekers are a heterogeneous group of people of different ages, countries and backgrounds who share the commonality of fleeing from atrocities that they have experienced (Ashton and Moore,2009). The term asylum seeker should therefore be considered in the context of situation rather than the identity of the person (Squire and James,2009).

1.6 The turning tide

As I began to explore the range of asylum seeker related literature, I realised that around the time that my interest in this topic was sparked, public discourse around asylum was changing and the asylum seeker was beginning to be constructed as a serious social problem in the UK. In the early 1990s, the asylum seeker had been constructed as an individual who deserved sympathy and understanding (Sales,2002). At that time there were no specific policies in the UK around asylum (Hynes and Sales,2010; Mulvey,2010). The welfare system provided support to asylum seekers should it be required. Hynes and Sales (2010) discussed how the Kosovo crisis had a major influence on public perceptions. The government backed an effort to transport large numbers of Kosovo Albanian refugees into the UK, for their safety and this was represented in a positive way by the media (Audit Commission,2000). However, following this, the number of asylum applicants in the UK increased dramatically and the number for 2002 peaked at over 80,000 applicants compared to 32,500 in 1997 (Home Office,2009).

At this point, the then Labour government was starting to be criticised by the popular press. It was believed that the generous benefits being offered encouraged bogus applications from economic migrants (Greenslade,2005). This negative discourse was exacerbated after the September 11 terrorist attacks in America in 2001 and then the 7th July attacks in London in 2005 (Aspinall and Watters,2010; Sales,2002). There was an increasing public fear that there was a link between asylum seeking and terrorism.

In response to the increase in asylum applicants and the discourse around tackling “abuse” of the asylum system, (Lewis,2005; Mulvey,2010) over the next few years, the government introduced a number of new asylum policies which added to existing legislation and incrementally reduced entitlements (Gedalof,2007). These were designed to reduce the “pull” or attraction for illegitimate immigrants to come to the UK and thus reduce the overall number of asylum applicants (Mulvey,2010). The first of a series of Immigration and Asylum acts was introduced in 1999 (Home Office,2009). These acts included a number of measures, which Sales (2002) believes increased the visibility of the asylum seeker in society, consequently leading to a discourse of public hostility. This mirrors the hostility that I had encountered through my experiences with the local newspaper.

The policy measures included the use of accommodation centres and hostels to house large numbers of asylum seekers. They were no longer permitted to work whilst awaiting their asylum decision. This has led to the image of “gangs” of

bored asylum seekers hanging around near to these accommodation centres (Hynes and Sales,2010). In addition, a new policy of dispersal was introduced where asylum seekers could be moved to any area of the UK designated as a dispersal area. These areas often had no history of minority ethnic groups. In addition, temporary housing was often located in deprived areas with high unemployment (Sales,2002) and asylum seekers hanging around in groups fuelled local tensions. This has led to widespread conflict and incidences of violent attacks and even murder (Hynes and Sales,2010).

The new asylum policies included changes to welfare provision and in 2000 the national asylum support scheme (NASS) was established to provide social support to asylum seekers. Part of this was a new voucher system, which was introduced instead of cash benefits. These vouchers, to the value of only 70% of income support had to be collected in a post office then spent in designated shops. It is argued that this had a negative impact on the public perception of the asylum seeker. There were increased waiting times in busy post offices and separate counters were opened segregating asylum seekers, leading to an impression of privilege at not having to queue with the public (Eagle, Duff et al.,2002). The voucher scheme was amended in 2002 to the entitlement card system, which still required the services of the post office, but this time using a credit type card to access cash which was handed out at the post office counter.

Whilst these changes were occurring to the asylum system, media coverage of asylum seekers was becoming increasingly negative. In 2003, the infamous "swan bake" story emerged on the front page of The Sun. It discussed how

callous asylum seekers had been caught stealing the Queen's swans which they intended to barbecue and eat. This story was found to be completely untrue, with no police reports being written in relation to the alleged incident (Greenslade,2005, p. 29).

In the same year, a similar story was published in the Daily Star. This story described how Somalian asylum seekers stole and ate donkeys which were kept in Greenwich Park. In reality, again there was no evidence for this crime and indeed, strict Muslims will not eat any meat that has been improperly raised and prepared as it is forbidden under Islamic law (Greenslade,2005). Although both these stories were found to be fabricated, they stressed how “negative, inaccurate, distorted reporting on a large and frequent scale is bound to awaken feelings among readers that may otherwise have lain dormant” (Greenslade,2005 p. 29).

In 2004, the Information Centre about Asylum and Refugees (ICAR) undertook a review of a sample of London newspapers over a two month period. The centre examined representations of asylum seekers and refugees within newspaper articles. Fifty eight articles were found to include the term asylum seeker or refugee in the text or headline. All of the articles then went on to describe them as bogus, false or illegal. No articles could be found that represented asylum seekers or refugees in a positive light. (Information Centre About Asylum and Refugees,2004)

1.7 Public opinion

There is a wealth of published research examining public opinion about asylum seekers, the discourses around the negative perceptions and the impact of this on asylum seekers lives. The studies found were qualitative in nature and most involved focus group interviews with members of the public and asylum seekers to explore in more depth their understanding and opinions of asylum seeking.

A study by Lewis (2005) was the most extensive study undertaken by the Institute for Public Policy Research (IPPR). Thirty two focus groups were undertaken with 227 men and women of different ages, ethnic groups and social classes in five areas of the country. The majority of participants expressed hostility towards asylum seekers but did not understand the different categories of migrants. Many participants classed any non-white person in the UK as an asylum seeker. They also over estimated the numbers of asylum seekers living in their area. Hostility was higher amongst the participants with the lowest incomes who felt they were competing for jobs and benefits. The main reasons given for the hostility was the fear of population explosion, loss of British culture and the economic impact of migration. Although participants expressed distrust in the national press, they often used the same language and frequently gave examples of stories from the press in their discussions.

Other more local studies had similar findings, including The Equality and Human Rights Commission (2010) which undertook a study in Wales and found significant hostility towards asylum seekers. Asylum seekers believed that this hostility was inflamed by them not being allowed to work and the media depicting them as taking resources from British people. Some asylum seekers

had experienced harassment, bullying and abuse. They believed that they had useful skills and qualifications which they wanted to utilize.

Ward (2008, p. 25) found that the public mostly believed asylum seekers were not genuine and were really economic migrants and that Britain should “look after its own”. It was perceived that asylum seekers received better housing, health care and jobs. There were comments about the way they dressed, including expensive designer clothes, their habits and manners. The participants in Ward’s (2008, p. 26) study stressed that they felt intimidated by groups of male asylum seekers “hanging around in groups”. Interestingly, 57% of refugees and asylum seekers who participated in Ward’s study also felt intimidated, but by the local population and had experienced harassment and even violent attacks.

All these studies have highlighted the lack of knowledge the general public have about who an asylum seeker actually is. Indeed Pearce and Stockdale (2008) found that when comparing understanding of members of the public who have had little or no contact with asylum seekers and those who worked with them, there was a polarization of opinion. The lay group had more negative discussions about asylum seekers, such as describing them as lazy, sponging and criminal, draining the economy and taking resources. The sample who worked with asylum seekers was more positive, considering them mainly to be genuine, fleeing from persecution or life threatening poverty. Perhaps there is a need for more education of the public and integration of asylum seekers into the wider community through employment and housing. This certainly does not fit

with the government agenda of detaining, dispersal and unemployment which in turn, arguably impacts on negative media discourses around asylum seeking.

1.8 The current context of asylum

In 2005 the UK Government introduced a new five year strategy for controlling asylum and immigration (Home Office,2005). Part of this strategy included the new asylum model (NAM) to replace NASS in 2006. The aim was to speed up the asylum process with rapid removal or integration. Each claim is classified into five types depending on the perceived credibility of the applicant. Those considered less credible are detained on arrival, then fast tracked through the system and can be deported within seven days of arrival if they do not appeal (Hynes and Sales,2010).

Mulvey (2010) discusses how current policy has been reactive to public opinion and the focus has been on setting targets for numbers of asylum seekers arriving, how fast they are processed and sent home again. In addition, juxtaposed UK border controls in France and Belgium have prevented would be asylum seekers even reaching the UK to claim asylum (Aspinall and Watters,2010). It could be argued that the number of arrivals should reflect disasters around the world rather than increasingly restrictive policy within the UK. By restricting access, the government is not maintaining its obligation under the Geneva Convention to provide a safe haven to people fleeing persecution. Instead, the government could be perceived to be reacting to the negative discourses around bogus asylum seekers fuelled by the “powerful” popular press.

Crawley (2010) asserts that current policy in the UK is underpinned by the assumption that asylum decision making is motivated by economic gain and that the choice of destination is based on knowledge of asylum systems in different countries. She undertook an independent study, commissioned by the Refugee Council and interviewed 43 asylum seekers and refugees to look at the decision making processes, in choosing the UK to seek asylum. She found that were most people had no time to plan their journey. In most cases, an "agent" helped them to escape from their country of origin. They didn't know where the UK was or know much about the country and didn't know where they were until their arrival. Many stated that they would have not chosen the UK and were not happy to be here. Most respondents had employment in their home country and expected to find a job and support themselves in their host country. Of the few participants who chose their destination, access to generous welfare benefits played no part in the decision making process.

The current worldwide economic crisis is impacting on people's lives in the UK on a number of different levels. Firstly, the cuts to public spending threaten the employment of thousands of public sector workers (Stuckler, Basu et al., 2010). This is in addition to the large number of workers in private industries who are becoming unemployed due to the decline in output across the whole economy (Somerville and Sumption, 2009). The cuts to the public sector will have an impact on the provision of public services, including the National Health Service (NHS), with cuts to funding being imminent. Despite the promise not to affect frontline services, the cuts will impact on users of the services and public health in general. In addition, the current government has increased Value Added Tax

(VAT), a regressive tax which impacts most on the poorer people in society (Stuckler, Basu et al.,2010).

The public construction of asylum seekers continues to be negative with them being viewed as recipients rather than contributors to the welfare state (Aspinall and Watters,2010). It can be argued that this is exacerbated during the current economic climate. Somerville and Sumption (2009) discuss how, during times of economic stress, there tends to be a backlash against immigration in general, due to job insecurities. There is the concern that immigrants will take jobs away from the indigenous population. Somerville and Sumption (2009) undertook a literature review, published by the Equality and Human Rights Commission. They analysed historical data from the previous economic recessions in the 1970s, 1980s and 1990s and concluded that the current crisis is likely to not impact upon the number of asylum seekers arriving in the UK as they are fleeing persecution rather than migrating for economic reasons. Therefore, whilst there are still negative political events, leading to the abuse of people, occurring around the world, there will likely to still be asylum seekers arriving in the UK.

Yorkshire is one of the top dispersal areas in the UK for asylum seekers (Home Office,2008). By the end of September 2009, there were 3,795 asylum seekers dispersed to this area. Some of these will likely be pregnant women, who require good quality maternity care, which meets their needs. This chapter will now explore the context of woman and asylum seeking women who are pregnant and potentially what their needs are, before moving onto chapter two and the asylum seeker in the health care context.

1.9 Women asylum seekers

The media portrayal of the typical asylum seeker in the UK is the young male (Dunne,2007; Gedalof,2007). Women have been considered as the dependent with a male head of household, but in reality, this is not always the case.

Dumper (2002) undertook a large study of 149 asylum seeking and refugee women living in the UK. 75% of these women were young, under the age of 35 and two thirds of these were asylum applicants in their own right, being either alone or with their children. However, 37% were alone, as they had to leave their children behind in their native country.

As a consequence of this discourse around the young male, women are often perceived as invisible within a male dominated asylum system (Aspinall and Watters,2010; Dunne,2007). Women can claim asylum for the same reasons as men, but often have experienced gender specific violence which is not considered within the asylum policies, such as sexual violence and rape, domestic violence, female genital mutilation, forced abortion and sterilisation (Reed,2003; Ukoko,2007). Women may also have been the victims of human trafficking, forced prostitution or slavery (Dumper,2005). The UK government has a list of "white" countries which it believes to be safe and therefore women from such countries claiming asylum for gender specific violence are unlikely to have a successful claim. In relation to political persecution, they may be safer than other countries, but in relation to violence against women this may not be the case.

The refugee council established the Vulnerable Women's Project in 2006. Of the women that have attended the project, 75% admit to having been raped and 15% of these had become pregnant as a consequence. Many of the women originated from countries in conflict where "war rape" had become endemic. In Rwanda up to 50,000 women were systematically raped. Many women had been raped on passage to the UK and many raped on arrival in the UK. (Refugee Council,2009).

The gender specific violence described above suggests that asylum seeking women are in an even more vulnerable position than male asylum seekers and Squire and James (2009) describe refugee women as amongst the one of most marginalised groups of people in society. In addition, Burnett and Fassil (2004) state that women are more seriously affected by displacement. They may be unsupported and 50% of refugee women in the UK have taken on the unfamiliar role as head of household (Refugee Council,2009). If they are supported, women are more likely to be the care giver in a family and are less likely to speak English, increasing their social isolation (Bruna,2003; Reed,2003). In addition, the stress associated with the asylum process is thought to increase the risk of domestic abuse for women (Sales,2002).

A number of studies have highlighted the difficulties that women asylum seekers can experience once they arrive in the UK, with an increase in women being detained in male dominated initial assessment centres and immigration removal centres once their asylum claim has been rejected (Dunne,2007). Women have also had poor experiences of being dispersed, including being placed in mixed

sex accommodation and sharing intimate living space with asylum seeking men. A third of the women in Dumper's (2002) study said they felt unsafe in such centres and 28% admitted to having experienced verbal and physical abuse.

1.10 The pregnant asylum seeker

In addition to the problems experienced by women discussed so far, the pregnant asylum seeker has all the added issues related to being pregnant, as well as being female and an asylum seeker. Squire and James (2009) identify that a large percentage of women asylum seekers arriving in the UK are pregnant. This may be due to a lack of available contraception, or due to rape. As highlighted earlier, asylum seeking women are often pregnant on arrival to the UK following rape (Refugee Council,2009). These women may have even experienced gang rape (Squire and James,2009). In addition to the psychological distress caused by the asylum process, these women have to cope with the impact of carrying the child that is a consequence of violence. It may be culturally inappropriate to discuss the issue of rape and a woman may be shunned by her husband, family and community. She may feel ashamed and unclean (Burnett and Fassil,2004).

McLeish (2002) discusses how asylum policies in the UK, with the aim of deterring "bogus" asylum seekers, ignore the special needs of minority groups such as pregnant women and their children. Indeed, Aspinall and Watters (2010) highlight that pregnant women are often amongst those women detained in immigration removal centres, sharing living accommodation with male strangers of different ethnic backgrounds. Reynolds and White (2010) undertook

a small qualitative study interviewing eleven professionals working with pregnant asylum seekers in an initial assessment centre. They believed that the health and wellbeing of pregnant asylum seekers was seriously damaged by the asylum process itself. This included poverty, sharing accommodation and frequently being moved at short notice.

Pregnant asylum seekers are identified as a vulnerable group in society and there are specific concerns related to their health and wellbeing (Aspinall and Watters, 2010). Carolan (2010) undertook a systematic literature review around the health of African refugee women of childbearing age and found that their general health was poor. In particular, they were found to be more vulnerable to malnourishment, iron deficiency anaemia, malaria, HIV/AIDs, tuberculosis, sexually transmitted infections and psychiatric disorders. This has massive implications for health professionals, including midwives caring for these women in the NHS.

Bollini, Pampallona et al (2009) undertook a systematic review of sixty five international studies of immigrant pregnant women and found that they were more likely than native women to have a pregnancy ending in an unfavourable outcome. This was attributed to the social and psychological problems resulting from living in poverty and from social exclusion. In addition to this, it can be argued that asylum seeking pregnant women may feel anxious due to the uncertainty of their asylum claim and therefore their future life expectations, as well as possibly being traumatised by the violence and rape that they have experienced.

Karlsen (2007) highlighted how chronic stress including racism can lead to internalised anger and raised blood pressure. In pregnancy, prolonged racism increases the risk of prematurity and low birth weight babies (Cross-Sudworth,2007). The latest CEMACH report (Lewis,2007), identified that asylum seekers and newly arrived refugees in the UK are six times more likely to die in childbirth than other pregnant women in this country. There were 36 maternal deaths among refugees and asylum seekers representing 12% of the total of maternal deaths. About 20% of the total number of deaths was directly or indirectly related to late booking or poor/no attendance for antenatal care. Failed asylum seekers are in an even more vulnerable situation. Dumper (2005) highlights that pregnant asylum seekers who come to the end of the asylum process and fail to achieve refugee status are charged for their maternity care. Bragg (2008) discusses how this is ignored in the CEMACH report. If women are expected to pay for their maternity care then this will be a real barrier to attending for care. In 2009, the Department Of Health clarified that immediate necessary medical treatment, including maternity treatment, must never be withheld for any reason. However, a retrospective charge will be made for the maternity care failed asylum seeking women receive (Aspinall and Watters,2010).

In addition to this lack of maternity care, failed asylum seekers who are receiving no welfare support will be likely to be destitute. This will impact on their ability to maintain good health in pregnancy, including a nutritious diet, which in turn will influence both maternal and fetal health, leading to poor birth weight and weight gain in the neonate (Ukoko,2007). These women are also likely to

be living in stressful circumstances and in order to receive some form of income, research shows that these women may be forced into prostitution (Refugee Action,2006).

1.11 Conclusions

This chapter has presented literature which suggests that asylum seekers in the UK are living in very difficult circumstances, with increasingly stringent welfare entitlements and only a small chance of being successful in their asylum claim. In addition, it is argued that negative discourses around asylum, fuelled by government policy and the popular press has led to examples of hostility and violence by some members of the public, towards asylum seekers. The literature suggests that asylum seeking women, in particular those who are pregnant, are in an even more vulnerable position. They may have experienced gender specific crime and be pregnant as a consequence of rape. In addition, they may be alone, living in a country where they are experiencing hostility from the general public. These women are likely to be in poor physical and mental health and have a significantly increased risk of both maternal and infant morbidity and mortality than UK citizens who are pregnant.

When considering all these issues, it can be argued that it is essential that pregnant asylum seeking women receive good quality maternity care and support from knowledgeable and caring midwives. Chapter two will argue that this is not always the case, some asylum seeking women reporting negative experiences of maternity care. One way of addressing this issue, is to ensure that the next generation of midwives are well prepared in their education

programmes, to meet the health and social needs of pregnant asylum seekers. The overall aim of this study was to facilitate this education, by exploring midwifery students' perceptions of pregnant asylum seekers and their learning needs, in order to become knowledgeable, supportive and caring midwives. This thesis will report on this study and the key issues which arose from it.

1.12 Structure of the thesis

Chapter two critically examines the literature, including contemporary research around asylum seekers, in the context of health care service provision in the UK. In particular, it focuses on the poor experiences that some asylum seekers report, specifically when accessing maternity services. It also explores the research around health care staff and in particular some midwives' negative perceptions when caring for pregnant asylum seekers. Finally, it reviews the current context of midwifery education and how the standards set by both the Nursing and Midwifery Council (NMC) and Quality Assurance Agency (QAA) infer that asylum seekers should receive good quality maternity care. It concludes by presenting the research questions constructed from identifying gaps in the literature. These questions address the way in which midwifery students construct a pregnant asylum seeker's health and social needs, the discourses that influence their constructions and the implications of these findings for midwifery education.

Chapter three explores the underpinning philosophical perspectives informing the way that this study was designed. It introduces Mason's (2005) "five important questions" which were found to be useful in ensuring that the topic

area, the intellectual puzzle, the aims and purposes of the study and the resulting research questions were consistent with my ontological and epistemological position. It focuses on a feminist, social constructivist perspective, considering knowledge to be contextual and how this perspective links with the use of critical discourse analysis (CDA) to examine how power, knowledge and ideology are implicit within social interaction. By examining language use, dominant discourses, which influence the construction of social reality, can be identified. It concludes by revisiting the research questions in light of the philosophical underpinnings, to demonstrate congruence between the way the questions are worded and the philosophical perspective of the researcher.

Chapter four provides an overview of the research strategy implemented to design the specific methods for this study. It explores the congruence between the principles behind a case study approach, social constructionism and critical discourse analysis and how the principles behind the case study approach were adopted during the different stages of the research process. The “case” was identified as volunteers from a cohort of midwifery students, using an embedded design to identify subgroups to further investigate the research questions. The case study is argued as supporting the use of multiple methods of data construction to develop knowledge that is context specific, detailed and perspectival. It also supports the social constructivist interpretation of methodological triangulation and the principles behind the use of critical discourse analysis; looking for patterns in the data which identify underpinning discourses. Finally, this chapter explores the concept of theoretical

generalisation and how this is congruent with the principles behind a case study approach and social constructionism. It discusses how this concept was adopted in the way that literature was used throughout the research process.

Chapter five provides an in depth exploration of the specific methods used to undertake this study. It discusses issues around quality and how the concept of credibility was interpreted, in the context of this study, as assessing the researcher's trustworthiness and believability in the research process. It also provides an exploration of reflexivity and how this was implemented in this context. Throughout the chapter credibility and reflexivity are considered in the context of the specific sampling, data construction and data analysis methods. In addition, the methods are justified from a philosophical perspective, aligning their use with the principles behind a social constructivist, feminist perspective and case study approach to research. This chapter identified difficulties that arose in the research process including securing a sample and on the second attempt, the subsequent use of a sample located in the institution in which I work. The epistemological and ethical impact of potential biases that could have occurred, have been explored and how these issues were addressed in practice. In addition, the use of PBL focus group interviews, individual interviews and documentary evidence were explored and how potential biases, on the part of the researcher or the sample, were addressed. A detailed account of the critical discourse analysis of data was presented and how issues around credibility were addressed. Finally, this chapter explores research ethics, using the four ethical principles; autonomy, beneficence, non-maleficence and justice to address potential ethical issues that could have become apparent in the

context of this study. The difficulties with gaining ethical approval are addressed due to the potential conflict of interest that the researcher may experience, if substandard care of pregnant asylum seekers in clinical practice was identified.

Chapter six presents this study's key findings. It focuses on the three research questions and presents quotes from all the data sets, to illustrate the key discourse strands and the underpinning discourses that were identified from the verbatim and written sources. In relation to the way that the pregnant asylum seeker was constructed, this chapter discusses the underpinning dominant discourses around the asylum seeker being foreign or different and of a criminal persuasion. In addition, this chapter explores the dominant underpinning medical discourse, influencing how midwifery care is approached and how this was revealed in the data. This chapter also highlights the apparent confusion when approaching maternity care and whether to consider the woman on an individual basis, or within her context, when assessing her needs. Finally, this chapter explores the findings which appeared to reveal prejudice in the informal "talk" occurring in the NHS, but also findings demonstrating how some participants appeared to question dominant discourses, after they had engaged with the literature, between the first and second PBL focus group interview. This chapter presents these findings in relation to the research question addressing the implication for midwifery education.

Chapter seven returns to the intellectual puzzle developed for this study and discusses the findings, together with underpinning literature to develop an argument around possible reasons why some pregnant asylum seekers may

have negative experiences of maternity care. It focuses on the influence of dominant public discourses around difference and criminality and the impact of these on midwives. It discusses Foucauldian theory around power and how these discourses are (re)produced through powerful political, media and social locations. The complex relationship between political and media locations is explored and how they work together to (re)produce these dominant discourses, which are diffused and (re)produced through social interaction in different societal contexts. It then discusses how these issues can be partly addressed through education of both the general public and midwives, to facilitate them to challenge dominant discourses and construct an alternative version of asylum seeking.

Chapter eight again returns to this study's intellectual puzzle, but this chapter argues how some pregnant asylum seekers may have negative experiences of maternity care, partly due to the way that midwives approach their care provision. This chapter discusses the findings, together with supportive literature, to argue that there appears to be a power struggle between underpinning medico-scientific, managerial and midwifery discourses, within the maternity services. It argues that this manifests in the clinical area through midwives rigidly adhering to policies and guidelines at the expense of providing a woman centred approach to care. This chapter describes how the findings demonstrated participants' apparent confusion around the inconsistent messages, as to how midwifery care should be approached and how dominant conflicting discourses impact on the current context of maternity care. This chapter then discusses how these issues may be already partly addressed,

through midwifery education; using PBL as a teaching methodology and the integration of case loading into the curriculum. However, it also focuses on the way forward in relation to issues around knowledge and power and how theories such as "women's ways of knowing" (Belenky, McVicker Clinchy et al., 1997) and viewing knowledge as contextual, from different sources and in different forms could be useful in informing midwifery education.

Chapter nine explores how a new model for midwifery education; "The pregnant woman within the global context" was developed from the key findings and theoretical concepts, which have emerged from this study. This chapter explains how the model works to assist midwifery students, when learning how to assess the needs of pregnant asylum seekers and other newly arrived migrants in the UK. It identifies the three layers of the woman's environment; micro, macro and global and factors in each layer which need to be considered, in conjunction with the woman, to work out her individual holistic needs, when accessing maternity care. The model includes how the concept of power and the dominant negative discourses around asylum are considered within the macro layer and how the student can address these in order to develop an understanding of how inequality and oppression can be addressed by the midwife. This chapter argues that the new model incorporates the requirements of the NMC and QAA in relation to midwifery education, embraces the relevant principles around education for sustainable development, is congruent with social constructivist and feminist educational principles and respects "women's ways of knowing".

Finally, chapter ten concludes the thesis by returning to the research questions and providing an overall impression of how they were addressed, within the context of the findings from this study. This chapter then moves on to discuss how the new knowledge constructed from this study around using CDA in midwifery education, approaches to midwifery care, using PBL as a research method and the “pregnant woman in the global context model” can be shared through conference presentations and publications. It discusses the limitations of this study; due to the social constructivist philosophical perspective, the changing context of asylum in the UK and due to limitations around undertaking insider research. It then makes recommendation for changes including pre-registration midwifery education, post-registration education, and clinical practice and also recommends potential future research projects that could be undertaken.

Chapter 2: The Asylum Seeker in the Health Care Context

2.1 Introduction

This chapter begins at the same starting point as chapter one; the McLeish (2002) Maternity Alliance study, which highlighted that half of pregnant asylum seekers reported having had negative experiences whilst accessing maternity services. However, this study is now nearly ten years old and has methodological limitations, which will be discussed further (see 2.6). The aim of this study was to explore how midwifery students can be well prepared to meet the health and social care needs of pregnant asylum seekers. In order to develop specific research questions, a thorough review of the contemporary literature relating to the asylum seeker and health care was undertaken; in particular maternity services and midwifery education (see 1.2 for literature retrieval strategy). This chapter will critically analyse the literature to develop appropriate research questions and inform the theoretical basis for this study.

2.2 The history of midwifery

Traditionally, midwifery was rooted in the female healing role, within a social model of care (Oakley,1984). Women were supported during childbirth, within the context of their own home and by female supporters (Kirkham,1999). Midwifery was therefore predominantly a female activity, undertaken by women with women. Midwives were perceived as knowledgeable and were highly respected by the local community (Oakley,1984). However, during the 17th to 18th centuries, in the UK, childbirth began to be controlled by male medical practitioners who became obstetricians (Oakley,1984). Although at this point

childbirth began to be considered as potentially pathological and in need of medical surveillance to avoid complications occurring, from a Foucauldian perspective, this control of childbirth became an extension of the need to control and regulate women's sexuality, through taking over the pregnant body (Kent,2000).

With the increasing medicalisation of childbirth came a gender and class division between midwifery and obstetrics. Wealthy women began to turn to medically trained male obstetricians and male midwives to attend them during childbirth, whilst poor women continued to be attended by female midwives. These female midwives were excluded from the medical profession, being prohibited from a university education. A dominant medical discourse was evolving, leading to the male medical profession controlling childbirth at the expense of midwifery, which was becoming marginalised (Bates,2004) .

The medical discourse around childbirth continued to evolve over the course of the century, influenced by inventions such as analgesia in labour and forceps. These shaped the way in which wealthy women were cared for during childbirth. This control over midwifery practice culminated in 1902, with the passing of the first Midwives Act, which was apparently focused on protecting the public from unskilled lay midwives. Midwives were regulated through the central midwives board (now the NMC) and had to undertake an educational programme, underpinned by obstetric knowledge, before they were allowed to register and practice as midwives. However, Way (2010) considers that the passing of this act had massive implications for midwifery practice. Indeed, it can be argued

that this instigation of midwifery training was key in (re)producing the already powerful medical discourse around childbirth, which began to control how midwives practiced.

In 1948 the NHS was established and it can be argued that with this came the institutionalisation as well as increasing medicalisation of childbirth. The medical profession was more powerful and in a better organisational position than midwives and were therefore able to influence decisions about the organisation of care, which involved "bringing the women to the experts" (Kent,2000, p. 19). Whilst maternity care was being moved into the hierarchical hospital setting under the control of obstetricians, general practitioners began to be paid for providing antenatal care to women, which further undermined the role of the midwife (Bates,2004). From a Foucauldian perspective, Kent (2000) argues that power and knowledge were central to the establishment of the NHS. An example of how this power was exercised was through open Nightingale style wards, which made it easy for the surveillance and assessment of pregnant bodies by the medical profession (Kent,2000).

As the twentieth century passed, various government policies compounded this medical and institutional control over midwifery. Since the 1980's, government policy has focussed on the modernisation of the NHS by increasing market forces, with a climate of competition between service providers evolving. With this came increased managers from business management backgrounds, to improve the efficiency and cost effectiveness of services (Clarke, Gewirtz et al.,2000; Kirkham,1999). The concept of consumerism started to infiltrate

modern health care and the increased involvement of service users in decision making about the management of care (Barry and Yuill,2010). The concepts of quality assurance and clinical governance evolved, which influenced existing policies and guidelines and further regulated midwifery practice (Holmes, McGinley et al.,1996).

In addition, government policy compounded the medicalisation of childbirth. Bates (2004) describes the most controversial as the 1970 Peel report and ten year later the Short report, which both recommended that to increase the safety of childbirth, all births should occur in the hospital setting and that modern technology should be embraced within maternity care. With this came increasing institutionalisation for midwives, the majority of whom were moved into the NHS, where they remain employed today. The Short report also identified a need to increase the safety of childbirth in the NHS and consequently, obstetricians began to oversee some of the traditional midwifery roles in normal birth. Midwives became assistants in childbirth rather than the lead professional caring for women. However, since then, Bates (2004) argues that obstetricians have distanced themselves from normal birth, as it was perceived to be time consuming and mundane caring for women in labour. This role was adopted by midwives who are still responsible for leading normal midwifery care today and referring to obstetricians “where a deviation from the norm which is outside her current sphere of practice becomes apparent” (Nursing and Midwifery Council,2004, p. 18).

The concept of safe childbirth began to be associated with medical and NHS control of maternity care. This had a powerful influence on both women's experiences and the midwives' role in maternity services. Care became fragmented and regimented, as power was exercised by both the NHS organisation and the medical profession (Kitzinger,2000). Women who had experienced care in that era described it as "feeling they were on a conveyor belt" and that the care was organised for the doctors convenience, rather than the needs of the pregnant woman (Kent,2000, p. 18). Within the hierarchy of the NHS, midwives were considered semi professional, undertaking medicalised care and working under the control of obstetricians (Kirkham,1999).

In the 1990's, changes were made to the rules around legal aid, which increased public accessibility to funds, resulting in an increased number of claims against the NHS, particularly maternity services, for negligence and substandard care. This led to an increasing fear of litigation and consequently a number of organisations were developed to exercise control of practice including NICE and the Clinical Negligence Scheme for Trusts (CNST). The concept of risk management was introduced to reduce the cost of high litigation rates in the NHS (Battersby and Deery,2004). Rigid guidelines and policies were developed to standardise care (Bates,2004), which Fleming (2006) argues had the agenda of increasing defensive practice to reduce insurance premiums. This further reduced the autonomy of midwives, who were expected to follow policies and guidelines when caring for pregnant women.

The development of rigid policies and guidelines were based on what Kent (2000) describes as medico-scientific discourse. Western medicine was beginning to be informed by science; scientific research being valued above other sources of knowledge informing clinical practice (Wickham,2004). The randomised controlled trial was developing as the gold standard of medical research and the best available evidence on which to base the plethora of policies and guidelines being developed to standardise practice (Hunter,2006; Rolfe,2002). Because of their apparent superiority over other research approaches, randomised controlled trials began to receive huge amounts of funding from the Department of Health, at the expense of other research methodologies. However, Wickham (2004) argues that medicine is not a true science as it is based on theories and not proven facts. In addition, there is always an uncertainty about midwifery practice and the outcome of pregnancy cannot be based on absolute facts, as there is always the exception to the rule (Wickham,2004). The evolving of this medico-scientific discourse can be argued as further undermining the autonomy of the midwife in her approach to care, due to a lack of recognition of other sources of midwifery knowledge, which may be used when approaching midwifery practice (Hunter,2006).

2.3 The National Health Service (NHS)

The NHS was established with the intention of providing a comprehensive health service to improve the physical and mental health of the whole population. It was free at the point of use and based on need and not the ability to pay. According to the current coalition government, this is still the aim of the NHS today (Department of Health,2010, p. 7). However, this is only for British

citizens. As highlighted in chapter one (see 1.5), failed asylum seekers, a vulnerable group in society, are not entitled to free health care and can be charged for services received (Aspinall and Watters,2010). In addition, Ellis (2004) argues that the NHS was established to meet the needs of the majority population and despite increased immigration, current health services are still aimed at white people. People from black and minority ethnic (BME) groups including asylum seekers do not receive the same standard of care.

The 1976 Race Relations act and more recently, the 2000 Race Amendment Act make it an offence to discriminate against a person because of their racial background, either directly or indirectly. This includes women accessing maternity services (Dimond,2003). The Macpherson report (1999), which followed the Stephen Lawrence enquiry, highlighted the issue of institutional racism and how large organisations, including the NHS, discriminate against people from minority ethnic groups, which would include asylum seekers. The new Equality Act (Government Equalities Office,2010) is designed to consolidate a number of other acts aimed at preventing discrimination against different groups of people, described as having protected characteristics, including pregnancy, race, religion/ belief and sex. This suggests that the pregnant asylum seeker should be protected from discrimination, as she would fit some, if not all of these characteristics. However, the Equality Act does not consider the process of asylum seeking itself, as a characteristic in need of protection and this chapter will consider contemporary research, providing examples that support the argument that discrimination against asylum seekers does exist in some contexts.

Over the past twenty years the Department of Health has introduced various white papers designed to address the needs of women accessing maternity services. Changing Childbirth (Department of Health,1993), the first paper of its time to recognize a link between socioeconomic factors and maternal health, was criticised as focusing on the opinions of white middle class affluent women (Hart and Lockey,2002). Since then, a number of papers have highlighted that maternity services should be targeted at meeting the need of disadvantaged women, which would include asylum seekers (Department of Health,1999; Department of Health,2007; Department of Health and Department for Education and Skills,2004). However, Hart and Lockey (2002) were critical of the policies up to 2002 arguing that there was a mismatch between the policy visions and their operationalisation in practice partly due to a lack of resources. Indeed, it could be argued that this is still the case now.

Maternity Matters (Department of Health,2007) recommended that resources be channelled into reducing health inequalities in pregnant women. However, at a time of an economic downturn, there are going to be massive cuts to public spending (Stuckler, Basu et al.,2010). It is unlikely that resources will be sufficient to address the issues raised by the Labour government in relation to disadvantaged pregnant women. Indeed the most recent report by the current coalition government discusses the importance of maternal and child health and how this can be influenced by social, cultural and economic factors , but pays little attention to women from minority ethnic groups including asylum seekers (HM Government,2010). However, at the time of writing, there are imminent changes to the structure of the NHS (Department of Health,2010). How these

will address the needs of vulnerable women accessing maternity services will need considering once the changes are implemented.

2.4 Healthcare research

When reviewing the literature around asylum seekers' experiences of health care services, most studies were found to be qualitative using individual and focus group interviews to generate the data. Qualitative research aims to explore an issue in depth and to illustrate this issue for the reader to decide the value of the findings (Mason,2005). Therefore, the research article or report must be written with enough detail for the reader to make this decision. When critically analysing the research, I was searching for examples of where asylum seekers experiences were well illustrated through an appropriate sample with enough depth of data to support this illustration.

Initially, research was found that explored the experiences of asylum seekers in accessing health services in different areas of the UK. O'Donnell, Higgins et al (2007) undertook a qualitative study but with a diverse sample in Glasgow, interviewing fifty asylum seekers from sixteen different countries. Their findings were mixed, some asylum seekers having positive experiences of both hospital and primary care settings, while others felt they were discriminated against because they were asylum seekers. Bhatia and Wallace (2007) undertook a similar, but smaller study in London, with eleven asylum seekers who had attended a drop in centre. Their findings were more negative, most participants feeling unwanted and a burden on resources. They felt that the discrimination that they experienced from staff in the health services reflected discrimination by

the general public in wider society. However, I would argue that these findings may have been particularly negative because people may have accessed the drop in centre as they were experiencing difficulties that they were seeking support for and therefore may not have felt as positive about their healthcare experiences.

Robinson and Phillip's (2003) study focused on the staff caring for asylum seekers. They interviewed sixteen clinical and non-clinical staff working within three different general practitioner (GP) practices. They found that the staff frequently negatively stereotyped the patients from minority ethnic groups who attended the practices. They assumed that the patient would behave in a certain way because they were from a particular ethnic group. Although this research was aimed at people from minority ethnic backgrounds, this may have included asylum seekers attending the surgery. Some of the staff referred to patients "playing the race card" to get what they want (Robinson and Phillips, 2003, p 291). They may have been referring to the social construction of the bogus asylum seeker coming into the UK to claim generous benefits, described in chapter one (see 1.5).

2.5 Women's experiences of maternity services

National surveys are widely used to assess women's satisfaction with their childbirth experience (Care Quality Commission, 2010; Redshaw, Rowe et al., 2007). However, they do not distinguish between whether women are recent migrants, asylum seekers, refugees or UK citizens. In addition, they tend to be written in English, therefore excluding a large number of women from minority

ethnic groups who cannot read English. Despite these limitations, one of the findings from the survey undertaken by Redshaw, Rowe et al (2007) was that women from minority ethnic groups often felt that they experienced poorer levels of maternity care than "white" caucasian women.

The experiences of maternity care of minority ethnic women has been a well researched topic over the last twenty years, with a seminal study (Bowler, 1993) examining the perceptions of London based midwives about women of South Asian origin. Robinson and Phillip's (2003) study ten years later supported Bowler's findings. In both studies, stereotyping was common with health care staff classifying patients as belonging to a particular ethnic group and expecting them to behave in a particular way because of this. Other more recent studies had similar findings. Ali and Burchett's (2004) study, undertaken by the Maternity Alliance, found Muslim women felt discriminated against when accessing maternity services. Kirkham and Stapleton's (2004) study was around informed choice in maternity care and how the socioeconomic status of women and not just their minority ethnic background influenced the choices they were given. Interestingly, this study found stereotyping to be an issue for women regardless of their ethnic background, which suggests it is a wider issue impacting on women accessing maternity services.

2.6 Asylum seekers and maternity services

The major focus of this literature review related to pregnant asylum seekers' experiences of maternity services. As already identified, studies were mainly qualitative using focus group and individual interviews to construct data. In

addition, it was noted that most of the studies used interpreters for the non English speaking women. This is an important methodological issue as language barriers are likely to have a negative impact on women's experiences of maternity services (Gaudion, McLeish et al.,2007) and it is important to understand these women's perspectives.

As stated earlier (see 2.1), the McLeish (2002) study was the trigger for this particular subject for my PhD. However, the study was confined to the South East of England and the sample developed through snowballing. This is a useful technique for accessing participants that are hard to reach, for studies that may be considered sensitive (Magnani, Sabin et al.,2005), which could include asylum seekers. However, word of mouth usually leads to a sample with similar motivations and characteristics and it could be argued as introducing sampling bias (Polit and Beck,2004). Consequently, it is important to consider other literature when formulating a theoretical basis for this study.

A number of other more recent studies had similar findings to the McLeish (2002) study. Lockey and Hart (2004) undertook interviews with disadvantaged women, including asylum seekers and refugees and the midwives caring for them. Most women had negative stories of their experiences, one woman saying that she felt she was treated "like a dog" by the midwives caring for her (p. 786). Similar findings came from Gaudion and Allotey (2008) who undertook a study of the maternity services in Hillingdon, close to Heathrow airport, where newly arrived pregnant asylum seekers were referred. There were some positive examples of good practice. However there were also significant examples of

negative experiences. Midwives made comments about the women accessing services directly from the airport and felt that they had to pay too much attention to “these people” at the expense of the “white British population” accessing maternity care (p. 23). The asylum seeking women interviewed felt that unfair stereotypes and generalizations were made about them whilst they were receiving care. There were similar findings in Harper Bulman and McCourt, (2002) study of Somali refugees in West London. Some women described the midwives as “cruel” and disinterested in them (p. 373). They also felt that they were stereotyped because they were from Somalia. For example, they were perceived as not needing as much pain relief in labour due to their ethnic background.

Whilst there are many negative experiences described in these studies, there are studies showing positive examples of maternity care. Nabb (2006) interviewed nine asylum seeking pregnant women who were based in emergency accommodation. The women’s perceptions were mainly positive, health professionals being described as kind and nice. However, one woman believed her experiences were good because both she and the baby were alive. Similarly, the participants in a study by Dumper (2002) expressed that they were just grateful to have access to Western medicine and still be alive. It could be argued that these individuals have different expectations of what they should receive from health care services. Consequently, this could make it difficult to judge the quality of care that they received at any one given time.

The studies reviewed so far were all small, local qualitative studies and it is possible that pockets of poor practice existed in the areas studied. However, other more widespread studies were reviewed which support these findings. The National Institute for Health and Clinical Excellence (NICE), an independent organisation that makes recommendations to the NHS based on systematic reviews of the evidence, states that women with complex social problems, including asylum seekers, are deterred from attending antenatal appointments because of negative attitudes of healthcare staff (National Institute for Health and Clinical Excellence, 2010). Also, Downe, Finlayson et al (2009) undertook a meta-synthesis of eight published research papers examining access to antenatal care for marginalised women, including asylum seekers in the UK, USA and Canada. As found in the other UK studies discussed above, some health professionals were perceived to be kind and attentive, while others were perceived as disrespectful and judgmental.

Kennedy and Murphy-Lawless (2003) examined the experiences of refugee and asylum seeking women in the Irish republic. Sixty one interviews were undertaken with women from a range of countries. Many women had experienced some form of discrimination in the care they received. However, there were limitations with this study. Whilst they were being interviewed, the women became distracted from the focus of the interview and wanted to discuss the wider issues around their lives which they considered difficult such as poor living conditions, hunger and prejudice in the local community. Similarly, in another study by Briscoe and Lavender (2009), the women wanted to discuss housing, policy and financial issues rather than their maternity care experiences.

Despite this, the findings from these two studies reflected the other studies discussed above, suggesting that there is a strong argument that some pregnant asylum seeking women have poor experiences of maternity care.

2.7 Educational needs

The literature so far suggests that the education of midwives about asylum seekers is essential to address some of the negative stereotyping, prejudice and discrimination that is reported as occurring in maternity services. This suggestion is supported elsewhere. Suurmond, Seeleman et al (2010) undertook a systematic review of the literature and found that health professionals do not feel competent to care for asylum seekers. Also, the NICE guidelines recommend more training for maternity staff caring for pregnant women with complex social factors, including pregnant asylum seekers (National Institute for Health and Clinical Excellence,2010). Following a review of the literature, Feldman (2006) identified the need for further training for health care professionals in order that myths around asylum seeking can be challenged. As the future midwifery workforce, targeting midwifery students could be considered essential to bring about positive changes in practice. No research could be found examining midwifery students' perceptions of asylum seekers. However, literature was found addressing young people and university students' perceptions, as discussed below.

In 2003, UK refugee organizations commissioned a MORI poll which examined the views of 289 young people aged between 15 and 24 about asylum seekers (Amnesty International UK,2003). The results reflected the public discourses

identified in chapter one, around genuine asylum seekers. Only 51% of young people believed that asylum seekers in the UK should have the same rights to education, work and freedom as UK citizens. Over half of respondents believed that asylum seekers are not genuinely in need of safety and 23% believed the UK should not offer a safe haven.

Wray, Walker et al (2007) undertook a quantitative study using likert scale questionnaires to examine attitudes towards asylum seekers and refugees of 160 pre-registration nursing students, before and after taking a twelve week module on social inclusion. Although, after taking the module, attitudes towards asylum seekers did improve, only 3 out of 37 statements were found to be statistically significant. More students believed that asylum seekers belonged in the UK and deserved the same amount of care as UK citizens. However, there were still a number of students unsure of whether asylum seekers and refugees should have equal access to health care. Although it is useful to identify that providing education to young people can improve attitudes to asylum seekers, both these studies are quantitative with no exploration of the reasons that young people may hold these beliefs. Consequently, it is difficult to evaluate how this superficial data could assist in the education of midwifery students.

Goodman and Burke (2010) undertook a qualitative study in a university setting using focus group interviews with psychology students, to examine how they talked about asylum. Generally, students were negative when discussing asylum seekers in the UK for three main reasons which mirrored the findings from the Lewis study (2005) in chapter one (see 1.7); economic reasons,

terrorist threats and the loss of the British society. Although this is helpful in illuminating the issue for these students, the findings may not be transferrable to midwifery students who could have different perceptions, because they may have already met and cared for pregnant asylum seekers whilst on clinical placement. Therefore, it is argued that research focusing on midwifery students' perceptions of asylum is important to identify their educational needs.

2.8 Midwifery education

Pre-registration midwifery education in the UK is governed by the Nursing and Midwifery Council (NMC), which sets standards for students to achieve, which have to be written into educational curricula (Nursing and Midwifery Council,2009). In addition, the Quality Assurance Agency (QAA) reviews the quality and standards of higher education in universities and has subject benchmark statements and a code of practice framework against which institutions are assessed (Quality Assurance Agency,2001; Quality Assurance Agency,2011). Both organisations have a similar philosophy in relation to how midwifery education should be framed. They both discuss the concept of providing women centred care. Within this, it is important to respect a woman's beliefs and cultures and overcome communication barriers to provide informed choice (Nursing and Midwifery Council,2009; Quality Assurance Agency,2001). Practice should be anti-discriminatory and the QAA goes further, to say anti-oppressive, with midwives being able to challenge unacceptable practice. In addition, the QAA discusses how midwives should be able to understand the political and ideological factors that influence inequalities in health. The NMC highlights that midwives should have knowledge of relevant legislation related to

equality and diversity which would include the Race Relation and Equality Act (see 2.3). At the point of registration, midwives should always “act professionally to ensure that personal judgments, prejudices, values, attitudes and beliefs do not compromise the care provided” (Nursing and Midwifery Council,2009 p. 35).

Following the review of literature around maternity care provision reported earlier, (see 2.6), it can be argued that there is a dichotomy between the principles of non judgmental, women centred care written into midwifery curricula and the way that some midwives are practising when caring for pregnant asylum seekers. Consequently, it is important that midwifery education re-addresses the curriculum, in order that midwifery students are well prepared to practice in a way that meets the standards prescribed by the NMC and QAA.

As identified in chapter one (see 1.7), public discourse around asylum seekers appears mainly negative and some young people, including university students may be influenced by this discourse. It is important to identify whether this is the case with midwifery students in order that pre-registration education can address this and facilitate appropriate learning opportunities. Consequently, the following research questions were developed:

- 1) What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?
- 2) How do midwifery students construct the pregnant asylum seekers health and social needs?

- 3) What are the implications of students' constructions for midwifery education?

2.9 Conclusions

This chapter has presented an indepth exploration of the health care services in the UK, from the perspective of an asylum seeker. It has identified how despite legislation to protect minority ethnic people from discrimination, many asylum seekers have reported poor experiences when accessing health care services. In particular, the literature suggests that asylum seeking women have experienced prejudice, discrimination and stereotyping when accessing maternity services. Despite the NMC and QAA setting standards to ensure these women receive non judgmental, women centred care; in practice some midwives appear to have negative perceptions of asylum seekers, influencing the quality of care they provide. A number of government policy documents have identified the need for women from disadvantaged and vulnerable backgrounds to experience equality in maternity services, however, to date, without extra funding, these appear to only be paying lip service to a widespread problem.

Research suggests that young people, including university students, are influenced by the negative public discourse around asylum seeking. No research could be found to identify whether this is the case for midwifery students. Consequently, the research questions for this study focused on this issue, in order that midwifery educators could revisit the curriculum and identify

how midwifery students could be best facilitated, to meet the health and social needs of pregnant asylum seekers.

Chapter three will move on to explore how the research questions identified above, became embedded into the study's methodological approach. It will explore my philosophical position as the researcher and how social reality is constructed and new knowledge developed from this construction. These ontological and epistemological positions will then be considered to ensure the research questions are consistent with the philosophical underpinnings of the study.

Chapter 3: Knowing Where You Stand

3.1 Introduction

To ensure consistency between research stages and to prevent a mismatch of theoretical perspectives, a literature review was undertaken which included a text called "Qualitative Researching" (Mason,2005). This has been very useful and informative in helping me to think through key issues in designing a research project as it poses difficult questions to consider for each stage. For these reasons, I have used it as a foundation on which to build the next few chapters of this thesis; philosophical perspective, research strategy, research methods and to focus the findings. Consequently, I will refer to relevant sections at different points of these chapters.

This thesis so far has identified a topic arguably worthy of further investigation; how midwifery students can be well prepared to meet the health and social needs of pregnant asylum seekers. According to Mason (2005), the next challenge is to design a project with a "clear, relevant and intellectually worthwhile focus to explore the topic" (p.13). To achieve this, Mason (2005) discusses five important questions which can be addressed to ensure that the research strategy is philosophically consistent. These questions will be used to provide a framework for this chapter, to explore the research strategy in more depth and to demonstrate how the research questions evolved from my philosophical perspective. Chapter four will then move on to discuss how the underpinning theory from this chapter was used to design a research strategy

for this study and how this maintained congruence with my philosophical position.

3.2 Ontology and epistemology

The first two questions relate to the philosophical beliefs of the researcher and how these will influence the design of the study (Mason,2005). Although these are addressed as separate questions, they will be discussed together as it could be argued that they are terms that are implicitly linked, epistemology being concerned with the generation of knowledge to address the ontological perspective of the researcher.

Mason (2005) describes ontology as the nature of social reality and in relation to research, the nature of the phenomenon being investigated. It is concerned with what the researcher believes creates social reality. Epistemology relates to how the social world can be interpreted and knowledge generated to contribute to the understanding of social reality. Mason (2005, p 15) provides a table of suggested ontological perspectives from which researchers can pull out those terms felt to be relevant to their philosophical beliefs. This I found useful to clarify my thoughts. The terms "social constructions, multiple realities" located in "discourses, accounts, language," were all terms I felt reflected my key beliefs about what constitutes social reality. In addition, gender identity will form a key component of this discussion, as will be explained through the course of the chapter. My ontological perspective therefore, is that a woman's reality in the social world is socially constructed within the context of her social, cultural and historical position in the world and through discourses influencing this context.

This chapter will explore this perspective in more depth to demonstrate the congruence between the research questions (see 3.4) and philosophical position.

3.2.1 Social constructionism

Social constructionism is an approach to understanding social reality which assumes that knowledge is constructed through groups of people, in a particular context, interacting to develop a shared account of reality (Burr,2003). In this case, the group of people was all female students as there were no male students enrolled on the programme at this time. The context was midwifery education, constructing a shared account of reality about the pregnant asylum seeker and her health and social needs.

A discourse is “a group of ideas or patterned ways of thinking which can be identified in textual and verbal communications and located in wider social structures” (Lupton,1992, pp 145). This pattern of thinking is influenced by discourses originating from sources of power in society (Jager and Maier,2009). Groups of people are influenced by different discourses depending on their social, cultural and historical position in the world. Therefore they will construct multiple accounts of reality depending on what discourses influence them. By examining patterns of thinking in accounts and tapping into discourses, knowledge about a particular social reality can be constructed.

Traditional feminist theorists believe that social reality is constructed in different ways for women than for men, which in turn constructs gender identity. Holloway

and Wheeler (2002) argue that women have a subordinate position in society, originating from oppression and exploitation by men and this will influence their social reality. However, it could be argued that identities change as discourses evolve and that women are not a homogenous group, having different identities depending on their location in the world (Ramazanoglu and Holland,2003). Gender is only one construction of identity; others include ethnicity, sexuality, disability, educational achievement and social class. Power differences exist between women in relation to these identities. In addition, men in society can be subordinated by women due to the social construction of their identities. This is demonstrated in chapter one (see 1.7) when discussing the negative public discourse around the male asylum seeker (Ward,2008). Therefore, contemporary gender research should focus more on the oppression of men and women due to the social construction of their identities rather than just focusing on women (Lena and Hammarstrom,2008). Although I adopted a feminist stance in relation to this study, the term feminist was considered in the wider sense. The term was used to consider the subordination and oppression of both men and women in relation to asylum seeking. However, as this study focused on female midwifery students and pregnant asylum seekers, the position of men was not central to the aim of the research.

Multiple accounts of reality are a key assumption underpinning social constructionism. Knowledge can be considered as perspectival and contextual and as a consequence, there is no one universal truth, there are multiple truths which are context dependent (Burr,2003). This relativist perspective, Rolfe (2000) describes as little narratives; interpretations that describe the world from

a particular perspective. This he compares with the realist notion of one universal truth or grand narrative. Relativist theory supports the notion that equally valid versions of social reality can be put together to create a body of knowledge. This suggests that midwifery students' constructions of the pregnant asylum seeker could be added to accounts originating from other contexts to build up a body of knowledge about the topic. However, it could be argued that this would become problematic if the little narratives contained conflicting versions of reality. This idea is illustrated in chapter one (see 1.7) in Pearce and Stockdale's (2008) study. People in different contexts; lay public and staff working with asylum seekers had constructed conflicting versions of realities about asylum seekers. Adopting this relativist perspective, viewing these constructions as equally valid, would not be helpful in trying to instigate change as a consequence of these findings.

Ramazanoglu and Holland (2003) argue that there is a mismatch between feminist research approaches and relativist theory. It is necessary to judge between competing knowledge claims to tackle issues of oppression. This argument is supported by other writers. Rolfe (2000) asserts that there needs to be some authority to make judgments about the value of different versions of reality. Taylor and White (2000) argue that professionals can make decisions about truth claims, based on multiple versions of events, by judging the believability of one account compared to another. In relation to my third research question, to make changes to midwifery education, judgments had to be made about the students' constructions of knowledge.

Stevenson (2004, p. 19) describes a relativist perspective as "nothing beyond the text, no fixed external reality to represent in words". This implies that everything is socially constructed and nothing else exists beyond this. This belief is not congruent with Lupton's (1992, p. 145) definition of discourse and the impact of "wider social structures", Jager and Maier's (2009) discussion of sources of power in society or feminist perspectives around subordination. According to relativists, there are no social structures, there is no power; these do not exist. However, Lupton (1999) argues that there is something real outside of socially constructed knowledge but that this "thing" is conceptualised and dealt with differently depending on cultural, social and historical context. Applying this to the pregnant asylum seeker, she is a physical person who has applied for asylum in the UK. How this is socially constructed will depend on the context of the group of people discussing the issue and by what discourses they are influenced. To generate knowledge of midwifery students' social reality about the pregnant asylum seeker, their accounts were deconstructed, underpinning discourses examined and power sources within them identified (Jager and Maier,2009; Rolfe,2000).

3.2.2 Power

So far, the concept of power as having an influence on the way in which people socially construct knowledge has been alluded to in two ways; the existence of dominant discourses influencing thinking (Jager and Maier,2009) and professionals/ people in authority making judgments on different truth claims (Rolfe,2000; Taylor and White,2000). This suggests that some people and some discourses are more powerful than others and can influence social reality.

Indeed, Burr (2003) argues that there are dominant and marginalised discourses, originating from powerful and oppressed groups in society and the dominant discourse will have more influence on a person's construction of social reality. These dominant discourses will lead to the construction of gender identity as well as other identities such as ethnicity and social class. In relation to the discussion around the asylum seeker in chapter one, (see 1.6), it could be argued that the dominant discourse influenced the asylum seeker being constructed by the public as a serious social problem in the UK. Both government policy and the media were powerful influencers on the way this reality was constructed.

However, this is a simplistic way of considering power and there is much debate around the power of individuals and as Burr (2003) points out, whether discourse uses people or whether people use discourse. It could be argued that this depends on who the person is, what the discourses are and where they originate from. From a Foucauldian perspective, power is complex, it is exercised through discourses but diffused throughout society (Fawcett and Featherstone,2000) Here, discourses are (re)produced and people construct contextual knowledge. In this case the knowledge was around the concept of the pregnant asylum seeker. However, discourses are complex and entangled masses of knowledge, (re)produced from a number of different social locations and are negotiated and ever evolving over time (Jager and Maier,2009). Furthermore, power is located in multiple social locations and is exercised through the interplay of these different discourses (Fawcett and Featherstone,2000). Therefore perceptions of reality are complex, influenced by

multiple competing discourses originating from different social locations exercising power struggles.

Jager and Maier (2009, p. 37) describe the “power of discourse” and the “power over discourse”. The former relates to the way in which discourses influence how people construct social reality. The latter is about how people will influence the evolving of discourses through time. Jager and Maier (2009, p. 39) assert that certain individuals and groups have different chances at influencing discourses, such as “powerful politicians, those with privileged access to the media or greater financial resources”. Within the context of this study, from a feminist perspective, it can be argued that asylum seekers are not in a position of power and therefore have little opportunity to influence the dominant discourse as discussed in chapter one, (see 1.6). Consequently they are a subordinated group of people in the context of UK contemporary society. However Van Dijk (2009) argues that with power goes resistance and dominant discourses are always under threat from others which can undermine their position of truth. By deconstructing discourses to understand their origins and the way in which they work, then the socially constructed truth claims can be questioned. In relation to my research questions, it is important to identify power sources within discourses which will influence the students’ constructions of the pregnant asylum seeker. This can be undertaken by examining the language found in accounts produced by the students which will reflect the language implicit within dominant discourses.

3.2.3 Language

Burr (2003) considers language to be fundamental to the process of social construction. It is not a means to transparently reflect reality. In itself it, is a construction and the way it is used legitimises how social reality is experienced and reproduced (Fairclough,2009). Power itself is invisible and language is a means by which power can be expressed (Wodak and Meyer,2009). When a child learns to talk, she/he has to learn to use the words already embedded in her/his particular culture. These words give meaning to that child's interpretation of reality. Therefore language is not used to describe the world, it actually constructs it and the words used will impact on the way that reality is perceived (Burr,2003). Knowledge can be constructed around social reality by examining both the meaning of words used and the power sources implicit within the words used, which can then be related back to the dominant discourses influencing social reality.

3.3 Critical discourse analysis embracing a feminist epistemology

Returning to Mason's (2005, p. 17) five important questions which can be addressed to ensure that the research strategy is philosophically consistent (see 3.1), question three relates to the topic with which the research is concerned. This must follow on from the ontological and epistemological perspectives held by the researcher and be something that can become "knowable" through research. In this case, the broad research area was around the concept of the pregnant asylum seeker. There are different discourses pertaining to this concept, some of which are dominant and some marginalized. Dominant discourses will influence the social construction of the pregnant asylum seeker within the context of

midwifery education. Therefore, research that focuses on discourses would generate knowledge that is consistent with this study's philosophical position.

In approaching the research area from a feminist epistemology, it could be argued that critical discourse analysis (CDA) as a research paradigm, with its focus on discourses, both respects the philosophical position and reflects the principles behind a feminist epistemology. CDA could be considered an umbrella term, with many different approaches depending on the philosophical perspective of the researcher (Wodak and Meyer, 2009).

My interpretation of CDA is that it focuses on examining language use in written texts, looking for examples of words and statements which reflect power and ideology implicit in underpinning discourses. It then critically analyses these discourses in order to develop an understanding of the way in which power has influenced the social construction of knowledge in certain contexts. Dominant discourses influence the way knowledge is socially constructed and CDA examines these to identify power sources and the consequent subordination and oppression of groups of people in society. Therefore, in the context of asylum seekers, CDA would facilitate the understanding of power sources leading to dominant discourses influencing the negative public perceptions about asylum seekers.

3.4 Intellectual puzzle

Mason's (2005, pp 17) next question relates to the term "intellectual puzzle". She describes this as a puzzle related to the researcher's ontological and epistemological positions and the research problem. It should also relate to theoretical contributions, current research and other literature which may shape the project. To formulate this puzzle, the what, why and how questions can be used which can then be developed into the research questions. The phrasing of research questions in this way is well documented and will be explored further (Yin,2003).

As identified in chapter two (see 2.6.), current research found that many asylum seeking women have poor experiences of maternity services and studies recommended further education for health professionals caring for these women so they can be well prepared to meet their health and social needs. I began to question why pregnant asylum seekers had such poor experiences of maternity care. Relating this back to the study's ontological position; it could be questioned as to how the concept of the pregnant asylum seekers had been socially constructed by health professionals, what had influenced this construction and how had this impacted on the care they provided. It can then be questioned as to how midwives could be educated to improve asylum seekers' experiences. More specifically, the focus moved onto midwifery students as the next generation of care providers for these women. Several questions emerged from this focus which later developed into the research questions.

Mason (2005, p. 19) discusses the importance of developing appropriate research questions as they form the “backbone” of the research project and formally address the intellectual puzzle. Again, these need to link back to the ontological and epistemological positions of the researcher and need to be researchable. Mason (2005, p. 20) also describes how theoretical contributions; current research and other literature act as the “springboard” for launching research questions and the topic area must be critically analysed (see chapter two) to identify the direction the research questions should take. The research questions introduced in chapter two are as follows:

- 1) What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?
- 2) How do midwifery students construct the pregnant asylum seekers health and social needs?
- 3) What are the implications of students' constructions for midwifery education?

When formulating research questions, Yin (2003) explores three types of questions and how they influence the focus of the research. The use of what questions suggests an exploratory approach to the topic. In relation to this study, it could be argued that it is important to explore what discourses influence midwifery students' constructions of the pregnant asylum seeker, in order to then explore how midwifery education can focus on addressing understanding from these discourses. The how and why questions suggest an explanatory approach to a phenomenon (Yin,2003). By explaining how students have

constructed pregnant asylum seekers' health and social needs, how they have approached the topic, organised their thoughts and presented this constructed knowledge will again be useful for informing midwifery education.

3.5 Aims and purpose

Mason's (2005) final question relates to what the researcher hopes to achieve from undertaking this study. The overall aim of this study is to contribute to the improvement of maternity service provision for pregnant asylum seekers by identifying how midwifery students can be best prepared in the educational setting to meet the individual asylum seeker's health and social needs in practice. In addition, from a feminist perspective, an objective was for midwifery students to understand the concepts of power and discourse and how they can influence social reality and lead to inequalities and oppression of asylum seekers in the UK.

3.6 Conclusions

Mason (2005) developed five key questions, which have been considered in this chapter to address my philosophical perspective and ensure that this remains consistent through the research process, up to the point of devising research questions. To address Mason's key questions, this chapter has explored my ontological and epistemological position and how this links to the topic area, the intellectual puzzle and the aims and purposes of the research. This chapter has explained how the study approached the topic of asylum seeking from a social constructivist, feminist perspective, embracing the concepts of multiple truths and discourses influencing these truths. However, it

has also argued that the concept of multiple truths does not necessarily lead to a relativist approach to knowledge construction in that all truth claims are of equal value and that there are no external social structures influencing social reality. It has been argued that competing versions of reality need to be judged in order that changes can be made to midwifery education and improve the maternity experiences of pregnant asylum seekers.

This chapter has also introduced critical discourse analysis as a research paradigm and discussed how power, knowledge and ideology are implicitly linked and articulated through language. By examining the language used by midwifery students, then it was argued that underpinning dominant discourses can be identified. These discourses can then be critically analysed, examining structures within society which (re)produce these discourses and lead to the oppression of asylum seeking women in the UK. Chapter four will now discuss how a research strategy was designed and will consider how it maintained philosophical consistency, when exploring the research approach and specific methods to address the research questions.

Chapter 4: Research Strategy

4.1 Introduction

A research strategy can be described as a plan of how a study will be undertaken and Mason (2005) suggests it should be an active process of thinking through key issues around how the research questions will be answered. She stresses the importance of adopting a flexible and data driven approach, but also the need to design the research strategy at the outset of the study, to ensure consistency with the philosophical underpinnings. After reading widely around the subject, the decision was made to adopt the principles behind a case study approach to design the research strategy. This chapter will discuss how these principles informed the planning process and how the resulting strategy is consistent with the ontological and epistemological perspectives for this study. Chapter five will then focus on demonstrating how the case study principles informed the methods used to undertake the research.

Literature around research methodologies appears to focus predominantly on a number of established approaches. Typically phenomenology, grounded theory and ethnography appear to be the most traditional qualitative methodologies (Smith, 1997). More recently new ideas and variations are appearing including ethnomethodology and narrative approaches (Rapport, 2004). It is beyond the scope of this chapter to describe each of these methods in detail and justify why they weren't used for this particular study. Instead the discussion will concentrate on discussing why the principles behind a case study approach were adopted to inform the research strategy.

It has been suggested that the reputation of case studies has been damaged by researchers applying the case study label to any research approach that does not fit neatly into traditional methods such as experiments, surveys, observation and ethnography (Burns,2000). In addition, traditional methodologies have well documented research procedures described in texts, which, if followed, are believed to enhance the rigour of a study. Case study procedures have not been addressed in the same way and for this reason have been criticised as lacking rigour (Yin,2003). Consequently, the case study approach has been interpreted in different ways and there is confusion about what a case study actually is. It is vital that researchers clearly justify their interpretation of a case study and how it is being used in any research context (Bergen and While,2000).

4.2 The case study

Robson (2002) describes a case study research approach as a way of developing a specific and thorough knowledge about a case or cases within a particular social and cultural context. Yin (2003) suggests that it is well suited to exploring contemporary phenomena when context is considered vital and the researcher wants to retain a holistic approach to data construction. The case study can offer insights into a phenomenon, that may not be achieved by other research methods, by encouraging a deeper more detailed investigation (Rowley,2002). The researcher has no control over events within the research process and consequently naturally occurring data is constructed in order to understand the phenomenon (Gomm, Hammersley et al.,2000; Yin,2003). It could be argued that these principles applied well to this study, by considering the case to be explored as volunteers from a cohort of midwifery students, the

phenomenon; caring for pregnant asylum seekers and the context of a midwifery course in a university setting in the 21st century. It is argued that following these principles encouraged the construction of in depth, holistic and detailed data, specific to the pregnant asylum seeker and the context, which in turn assisted a more thorough process of critical discourse analysis. This chapter will now move on to discuss these principles in more depth and in relation to specific research strategies, unique to the case study approach.

4.3 Sampling in case study approaches

Case studies use only one, or a small number of cases to construct data, concentrating on depth and detail rather than larger samples yielding superficial data, which other research approaches adopt (Gomm, Hammersley et al.,2000; Yin,2003). In addition, a case is not equivalent to a research participant, but is considered on par with an entire sample in another research context (Yin,2003). The aim of the case study approach is to select the most appropriate case to provide an understanding of the phenomenon being investigated. For this reason, purposive sampling is most commonly used for case studies (Burns,2000).

The case is selected as it is believed to contain the characteristics that will provide an insight and understanding of the phenomenon to effectively answer the research questions (Burns,2000; McDonnell, Lloyd Jones et al.,2000). Consequently, it is essential to clearly define what the case is and in this context, distinguish between those people who fit into the case and those who don't (Gillham,2000; Yin,2003). In addition, if a case is made up of people, then

the individuals must have a common identity and shared expectation related to the focus of the topic (Patton,2002). The process of selecting the most appropriate case should be demonstrated by developing clearly defined selection criteria. This is undertaken in chapter five (see 5.4).

Although Yin (2003) discusses the idea of single and multiple case study approaches and decisions around how many cases to study, in relation to the research question(s) being posed, he argues from a positivist perspective. This is one that represents the traditional scientific view of research, viewing the world objectively and searching for the one, ultimate truth (Ellis and Crookes,1998). Yin (2003) suggests that studying multiple cases, rather than just one, improves the validity of the study by increasing the chance of the case representing the characteristics of the population. This does not appear to fit with the social constructivist interpretation of case studies adopted for this study. It could be argued that each case is unique and will construct a version of reality that reflects the characteristics of the case and its social, historical and cultural background. Consequently, for this study, the principles of constructing an in depth, detailed and specific reality from one case was considered more appropriate than trying to improve the validity of the study by using multiple cases.

There are two different case study designs described in the literature (Scholz and Tietje,2002). The holistic design examines the case as a whole in a qualitative and descriptive way and the embedded design analyses the case as a whole, but also identifies subunits. These are smaller groups within the case

with particular characteristics which fit with the needs of the research questions (Scholz and Tietje,2002). The principles behind an embedded design fitted well in the context of this study. By examining the cohort as whole then selecting sub units of the cohort, further clarification of the issues raised or a greater depth to the data could be sought, thus enhancing triangulation (see 4.4) and leading to a more detailed construction of the pregnant asylum seeker. How the embedded design was used is described in chapter five (see 5.4).

Returning to the epistemological perspective of this study, knowledge is constructed by critically analysing discourses underpinning language found in texts. Wodak and Meyer (2009) suggest that sampling isn't always considered appropriate when undertaking some CDA studies. If the study involves examining existing texts, there is no selection process for research participants. However, it could be argued that there are sampling issues that need addressing. Firstly, like people, texts need to be purposefully selected in order that they are the most appropriate to address the research questions. This would involve some type of sampling procedure. Secondly, as is the situation in the context of this study, CDA can be used as a way of analysing transcripts developed from interview situations or analysing documents developed by a particular person for the purpose of the study (Crowe,2005). Consequently the people involved in the interviews or who constructed the documents need to have been subjected to a systematic selection process to ensure that they were the most appropriate sample for this. Again, this would involve purposive sampling. How this process was undertaken for this study is explained in chapter five (see 5.4).

4.4 Approach to data construction

The term data construction has been adopted for use in this study rather than other terms such as data collection or data generation. This is because it appears to fit well with the social constructivist perspective. If knowledge is constructed through social interaction, within a specific context, then arguably, in this context, data is constructed through the same process. Therefore, throughout this thesis, the term data construction is used as an alternative term.

It is generally agreed that a major strength of the case study approach is that data is constructed from multiple sources which increases the breadth and depth of the data but also increases the credibility of the findings (McDonnell, Lloyd Jones et al.,2000; Scholz and Tietje,2002; Yin,2003). Methodological triangulation is a widely discussed concept in relation to multiple methods of data construction but is theorized in different ways (Bergen and While,2000).

From a social constructivist perspective, the term is used with caution as it implies constructing and examining data from different sources to corroborate and validate the findings. It is believed that if several pieces of data offer the same information on an issue then a more convincing argument results.

However, when considering this from the perspective of multiple versions of reality, the validation of findings is not an issue; a construction is a construction and is unique to a case within a context.

Mason (2005) interprets methodological triangulation in a different way, which it could be argued respects the social constructivist perspective. Multiple methods of data construction can be used to increase the quality of the data by providing

the opportunity to focus on a research question in a different way. In addition, alternative methods can be used to probe further an issue, increasing the depth of data constructed. This interpretation was felt to be highly relevant and adopted for this study. How it was used is discussed further in chapter five in relation to data construction methods (see 5.5).

When undertaking case studies, there are data construction methods recommended within the literature including observation, interviews and documentary analysis (Burns,2000; Robson,2002; Yin,2003). However, methods should be guided by the individual needs of the case being studied. Clear explanations should be provided as to how different methods were selected (McDonnell, Lloyd Jones et al.,2000). As advised by Mason (2005) each research question was examined to decide on possible methods of data construction. Also, it is important to ensure that the way different methods are used is consistent with the underpinning ontological and epistemological perspectives of the researcher (Mason,2005). Mason devised a chart which can be used to make strategic decisions about data construction. She believes that it helps to identify inconsistencies between methods of data construction and the philosophical position adopted. This was adapted for this study to map how the data construction methods would fit together and link with the research questions but also maintain consistency with the ontological and epistemological positions of the study (See appendix one). The issues identified in the chart were used as the basis for the discussion about how data was constructed for this study in chapter five (see 5.5).

4.5 Principles of data analysis

As discussed previously (see 4.1), there are no specific methodological procedures documented for undertaking case studies. This is also an issue for analysing case study data with no clearly defined techniques for how this should be done. However, Yin (2003) suggests there are certain principles that need to be considered to increase the rigour of the process. These principles reflect ideas about how to undertake CDA, which also does not have clearly defined methods, but is interpreted in different ways depending on the philosophical perspective of the researcher (Wodak and Meyer,2009). Jager and Maier (2009, p. 46) suggest that the CDA researcher has a “toolbox”. Depending on the research question and subject matter, appropriate tools, i.e. analytical techniques are selected from the toolbox.

When analysing case study data, Yin (2003) stresses that the researcher needs to return to the research questions to organise and analyse the data. This involves looking for patterns in the data which address the research questions and identifying data that offers alternative explanations. Similarly, with CDA, the data is examined to look for patterns, but in this context, in the language used, which reflects underpinning discourses (Wodak and Meyer,2009). In addition, it is important to identify possible counter discourses to challenge the researcher’s assumptions in relation to the data (Wetherell, Taylor et al.,2001).

When reading around the topic of qualitative data analysis in more general terms, it appears that rather than different research approaches having specific steps to follow to analyse data, it is what is considered to be data that appears

to differentiate the process. This depends on the underpinning philosophical perspectives of the researcher which will influence what is perceived to be patterns in the data (Mason,2005). In this context, it is the use of language reflecting underpinning discourses that is considered data whereas in other contexts, such as phenomenology, it would be patterns of lived experience that would be searched for (Smith,1997). Chapter five (see 5.6) discusses how these principles were used to analyse the data constructed by this study and what “tools” were used from the “toolbox” to assist this process.

4.6 Generalisation

Case studies have been criticised as lacking the ability to generalise findings beyond the case being studied (Rowley,2002; Yin,2003). However, Bergen and While (2000) argue that these criticisms are based on traditional positivist sampling theory and the representativeness of the sample selected to the population. This is known as empirical or scientific generalisation (Yin,2003). Social constructionism, with its focus on individual, specific and contextual knowledge, makes no attempt to undertake this type of generalisation but the findings need to be used in some way (Burr,2003). However, some researchers suggest that case study data should not be generalised at all (Burns,2000; Gomm, Hammersley et al.,2000). Instead, the findings should provide an insight or illustrate a phenomenon for the reader to judge. If this idea was implemented, one could question the value of undertaking the research in the first place. If the findings from this study cannot be generalised outside of the case then the third research question cannot be addressed. There would be no implications of the

findings for midwifery education and therefore the quality of care provided for pregnant asylum seekers could not be improved.

The terms theoretical and analytical generalisation are used interchangeably by different researchers in relation to case study approaches. They suggest that generalisable arguments can be developed from case study findings by using underpinning theory to support the findings. However, if this is to occur, the starting point for the case study has to be existing theory on which it can build. The underpinning theory is then used in conjunction with the findings to develop a convincing argument to instigate change (Rowley,2002). This could refer to change in relation to midwifery curricula to address pregnant asylum seekers needs. Consequently, a case study is considered an extension of an existing theory rather than developing a new theory (Sharp,1998; Yin,2003).

In order that theoretical generalisation can occur, prior to the data construction process, the researcher must have undertaken a literature review to identify the underpinning theory to which the case study may potentially add. However, the extent of the literature review is an area of debate amongst different researchers. General research textbooks usually advocate the literature review being detailed enough to develop a theoretical framework to guide research design and data construction (Burns,2000; Holloway and Wheeler,2002). However, Gillham (2000) suggests that with a case study approach, you do not need start out with an extensive literature review in order to develop a theoretical framework. This is because until you get into the field, you do not know what theory is going to be relevant. However, it could be argued that if the

theory in the literature is not relevant to the case being studied, then theoretical generalisation cannot occur as there would be no theory to support the findings to develop a convincing argument.

As identified in chapter three (see 3.4), Mason (2005) discusses the importance of identifying research questions following a preliminary literature review, to ensure that the questions are informed by theory and that the research topic is justified in the first place. This supports Yin's (2003) assertions that the case study should build on existing theory. For this study, these were the principles adopted. An initial literature review was undertaken to develop an understanding of the topic area, then the research questions were written to fill a perceived gap in the literature around midwifery students and pregnant asylum seekers. The findings from the study could then be related back to the underpinning theory to develop an argument about how midwifery education should change. In this way, this study could be theoretically generalised, which fits with the principles behind the case study approach.

4.7 Conclusions

This chapter has clearly justified why the principles behind a case study approach were adopted when designing the research strategy for this study. It has explored the different stages of the research process to demonstrate the congruence between the case study approach, social constructionism and CDA. In relation to sampling, it has identified the "case" as volunteers from a cohort of midwifery students, using an embedded design to identify subgroups to further investigate the research questions. However, it has highlighted the need to

clearly describe the sampling strategy to justify the case selected and how it is best positioned to construct appropriate data, an issue which is followed through in chapter five (see 5.4).

This chapter has also justified how the case study approach supports the idea of using multiple data construction methods within this study to construct context specific, perspectival knowledge that is holistic and detailed. In addition, the case study approach has been argued as supporting the concept of methodological triangulation, which has been interpreted to reflect the underpinning social constructivist perspective, rather than focusing on the verification of data from different data sources. The case study also supports the principles behind a critical discourse analysis and in this context, looking for patterns in language use to identify underpinning discourses.

Finally, this chapter has explored the concept of generalisation and justified how theoretical generalisation is congruent with the principles behind a case study approach and social constructionism. It has identified how this study has lent itself to theoretical generalisation through the way that existing literature was used throughout the research process.

Chapter five moves on to provide an exploration of the specific methods used for this study. This includes how sampling, data construction and data analysis were undertaken and also discusses issues around quality, reflexivity and research ethics. Within this discussion, it explains how the case study principles

were utilised in the practice of undertaking the research, but also how the study remained consistent with its philosophical underpinnings.

Chapter 5: Research Methods

5.1 Introduction

This chapter provides a comprehensive exploration of how within the context of this study, the research was conducted. It discusses the methods used for sampling, data construction and data analysis. It also explores issues around quality, reflexivity and research ethics and how they were addressed for this study. It builds on the previous chapter by demonstrating how the principles associated with a case study strategy were integrated into the research methods. It also discusses how the methods used maintain congruence with the ontological and epistemological perspectives underpinning the study.

5.2 Quality

It can be argued that any research project that is undertaken, irrespective of philosophical underpinnings, should demonstrate rigour in the methods used in order that the findings can be trusted and implemented in real life. Traditional positivist measures of validity and reliability used to assess the quality of a study have been rejected by many qualitative researchers (Robson,2002). However, Mason (2005) stresses that this should not result in a qualitative study that does not consider it important to assess quality in its research process.

Nixon and Power (2007) suggest that there are two ways of undertaking this assessment. The terms validity and reliability can be used but redefined in a qualitative context. Alternatively, there are other criteria that have been proposed to assess quality. It could be argued that the underpinning

philosophical perspective of the researcher will ultimately influence which alternative is believed to be most appropriate. When considering the social constructivist position, assessing truth is not relevant. There is no right and wrong, only constructed versions of reality. Consequently, it can be argued that there should be no attempt to assess this. What needs to be assessed is whether the researcher accurately represents the data when constructing a particular version of reality.

Rolfe (2006) argues that there is no general consensus on how to assess quality in qualitative research as there is a vast range of philosophical positions underpinning the term qualitative. Indeed Nixon and Power (2007) provide a list of twenty four different terms that they found in the literature that can be used in this particular assessment. In addition, Rolfe (2006) argues that it is difficult for a reader to make an epistemological judgement on the quality of a research project, as the written report is not a transparent reflection of the process, it is a version constructed by the researcher. Consequently, it could be argued that it is important that adequate detail is included when the researcher describes specific methods to facilitate some form of judgement.

For the purpose of this study, I have selected the term credibility as a way of judging quality, a term coined by Lincoln and Guba (1985) twenty six years ago, but still used today. In this context, credibility is being interpreted as assessing whether the researcher can be believed and trusted in the way that the research process was conducted. This includes the sampling process, data construction and data analysis. Throughout this chapter credibility is a concept that will be

considered when discussing issues around each method. A detailed description of specific techniques is included to demonstrate the rigour of the study.

5.3 Reflexivity

Mason (2005) considers that personal reflexivity is an important component of the research process, with the researcher's beliefs and values being implicit in the way that research is conducted (Parahoo,2006). It can be argued that the socially constructed background of the researcher including political and philosophical position, will influence the stages of the research process (Robson,2002). Also, discourses will impact on the way the researcher thinks about issues (Jager and Maier,2009). Reflexivity involves looking inwards to consider how personal experiences may have influenced the researcher's thinking throughout the research process (Taylor and White,2000). It involves honesty and openness and an acknowledgement of actions and decisions regarding methodology that may have impacted upon the resulting data (Lambert, Jomeen et al.,2010).

Reflexivity is considered an essential component of the case study research approach (Yin,2003) and when using a critical discourse analysis methodology (Jager and Maier,2009). It is also perceived to be an important consideration for feminist research, where part of the research process involves making explicit power relations and how the researcher is socially situated in relation to these (Ramazanoglu and Holland,2003). From a social constructivist perspective, it is important to acknowledge that the researcher is part of the process of constructing contextual knowledge. However, from a position of multiple

versions of reality, it can be argued that reflexivity is not about understanding how the researcher may have distorted the truth; it involves the researcher being honest about how personal constructions may have influenced the research process. This will help facilitate the reader to assess whether the researcher can be believed and trusted in the way that the research was conducted.

5.3.1 Personal construct of the pregnant asylum seekers

In order to demonstrate how personal experiences could have affected data construction, I believe it is important to provide a brief analysis of my perspectives on asylum seeking. This will allow the reader to consider how my beliefs as the researcher may have influenced the research process. Reflecting back on my childhood and adolescent years, I believe that aspects of my philosophy of life have influenced the way I think today. A fundamental belief I held was around treating people fairly and equally, whoever they were. I believe that I have always constructed my own impressions of people based on the way they treated me and I have tended to avoid gossip and rumour. My granddad always told me to treat others as I would like to be treated and I have always tried to treat people with respect. In addition, as a young person, I was developing a belief that people should be able to live wherever they wanted, as long as they lived in peace and were financially self sufficient. The Earth does not belong to anyone and no one should be told where they are and aren't allowed to go. Although this was probably a simplistic way of viewing the world, it has fundamentally influenced my development into adulthood and my philosophy today.

On reflection, in my adult years my response to the evolving discourse around asylum seeking would appear a natural progression from these simplistic beliefs about life. I found myself feeling angry about the way that asylum seekers were talked about and portrayed in the newspapers. To me, it appeared unfair that they couldn't choose where they wanted to live and were forced to leave the UK if they were deemed "bogus". My experience of meeting pregnant asylum seekers in clinical practice was that they appeared unhealthy, often underweight, extremely unhappy and frightened. The government and media agenda of scapegoating and criminalizing these vulnerable people made me angry. Having read the McLeish (2002) study and the negative experiences some pregnant asylum seekers have when accessing maternity services, this PhD appeared the natural way that I could make a difference and prepare future midwives in a way that ensures that pregnant asylum seekers have positive experiences of maternity care.

Whilst undertaking research, Parahoo (2006) recommends the use of a reflexive journal to increase self awareness of how the researcher's background may have influenced different aspects of the research process. This I did and throughout this methods chapter, aspects of my reflexive journal are integrated into the discussion, to demonstrate my awareness of how I may have influenced the research process and how I addressed these issues.

5.4 Sampling

Mason (2005) believes that the sampling process is a vitally important stage of qualitative research, as it will have direct implication on the value of the findings

and ability to generalise these. It is therefore important to develop rigour in the selection criteria to demonstrate what would be the most appropriate case to address the research questions.

The case was identified in chapter four (see 4.2) as a cohort of midwifery students. Consequently the first criterion was that the case should be registered on a three year undergraduate midwifery diploma/ degree programme in a higher education institution in the UK. The institution must have an intake of around 20-30 students per annum to provide an adequate pool from which students could volunteer for the study. Ideally, between eight and twelve students would volunteer to make up the case, as this is the desirable number of participants for both a problem based learning (PBL) tutorial (Haith-Cooper, Macvane-Phipps et al., 1999) and a focus group interview (Fern, 2001) (see 5.5.1 for more exploration of this). Year two students would be approached as usually, by this point, they have had some clinical placements, where they may already have had experience of caring for pregnant asylum seekers. In addition, the students would have had time to get to know their peers and be working together towards achieving their common goal of becoming a midwife. For these reasons, year one students were excluded from the process. The intention was for the case to be studied for the duration of a full year, therefore year three students were excluded as they would no longer be students at the end of the study.

One of the methods of data construction for this study was through the use of a PBL scenario within a focus group interview (see 5.5.1). For this reason it was

considered important to target a case that was familiar with using PBL as a teaching and learning strategy, within the curriculum. It takes time for PBL novices to learn how to engage with this approach and the researcher would have had to spend time familiarising the students with it, if this was not the case. The second criterion therefore was selecting a case that uses PBL as a teaching strategy in the course, so they would be familiar with its use once participating in the research.

As I wanted to access a case with some individuals who had experience of caring for pregnant asylum seekers, it was important to target an institution with clinical areas covering a dispersal area for asylum seekers. All major towns and cities are dispersal areas (Home Office,2008) so the next criterion was ensuring that the institution provided placements in large urban areas.

The final selection criterion was the geographical location of the case which needed to be easily accessed by train. Therefore an element of convenience sampling was introduced into the selection criteria. This will be discussed further below.

Using the selection criteria to explore potential cases, a list of lead midwifery educators (LME) was downloaded from the Nursing and Midwifery Council Website. The LME tends to be the Head of Midwifery education within each institution. Using the National Rail Enquiries website to identify rail links, eight LMEs who worked at institutions that were accessible by train, were written to, providing a brief explanation and enquiring as to whether their midwifery

students were taught using PBL. Of these, one didn't reply and two institutions didn't use any PBL. The five remaining institutions were telephoned to clarify the size of their intake for the 2007-8 student group (year two at the time of the study). Only two institutions had a cohort of 20-30 students. Their LME was contacted by letter, providing a more detailed explanation of the study and seeking permission to access their institution. Only one LME replied and this University was selected for the study. However, this LME subsequently withdrew access to the cohort due to concerns raised about the amount of activities required of the students and the time this would take. The non-response from the other institution was interpreted as non-consent to participate.

Consequently, the only institution that fitted the selection criteria was the university that I currently worked at. Although I decided to proceed with undertaking the study, this was an issue that I included in my reflexive journal. Within this context, I was the lecturer and the participants were students enrolled on a course on which I taught and assessed academic and clinical progress. In addition to the perceived ethical issues around this relationship, I was also concerned about the potential impact of this on the quality of the data constructed. This is an issue that is referred to throughout this chapter. In addition the ethical issues around undertaking research within one's own area of work are explored further in the ethics section (see 5.7.2).

In 2008, the cohort of year two students was approached to request that they take part in this study. However, only one student from the cohort volunteered to participate in the study as it stood. Two more students agreed to take part

providing they were only involved in a PBL focus group and not any other methods of data construction (see 5.5). However, as there were not enough students to create a focus group, the data construction process was postponed for a year and the following year two cohort was approached. This year, prior to recruitment, the study was advertised in advance, with a poster which was circulated to all the year two students (see appendix two). Eleven students volunteered to take part and formed the case. The recruitment process is described in relation to ethical issues later on in this chapter (see 5.7.1).

After the initial round of data construction, a preliminary analysis was undertaken of the data and the research questions revisited. Following the principles of an embedded case study design (see 4.3), subunits of the case were selected to undertake individual interviews. The rationale for these decisions is discussed further in the section on individual interviews (see 5.5.3).

A purposive approach to sampling with some elements of convenience was used to select the case for this study. As identified in the inclusion criteria, year two students were believed to have the characteristics to address the research questions. Mason (2005) suggests that there needs to be clear rationale for selecting a sample and this must fit with the underpinning ontological and epistemological positions of the study as well as addressing the research questions. Although a convenience sample is considered the weakest type of sampling strategy, as the characteristics of the sample may not be representative of a population (Polit and Beck,2004), representation is not an issue for a study with the ontological position of constructing a version of reality

within a particular context. It was believed that year two midwifery students, with some clinical experiences would be able to construct a specific version of reality about the asylum seeker. These would be influenced by dominant discourses that they have been exposed to through their midwifery programme and life experiences. By focusing on the language that they use to construct their version of reality, then the underpinning discourses can be examined through CDA.

Rather than representation, Mason (2005) suggests that the researcher needs to consider how this case will illustrate the issue for the wider population; in this case, the wider population of midwifery students. As discussed in chapter two (see 2.8), midwifery education in the UK is governed by both the Nursing and Midwifery Council (NMC) and Quality Assurance Agency (QAA). Although midwifery courses may be designed very differently in individual institutions, all midwifery students are being educated, so at the point of registration, they are able to achieve specific outcomes prescribed by the NMC and QAA. Therefore there is an element of homogeneity in the student population. However, the case selected may differ from midwifery students in other educational institutions. In addition, it must be considered that each student will be individual in how she constructs social reality, based on her life experiences. Returning to the social constructivist perspective, this study is aiming to illuminate a version of reality around asylum seeking pregnant women, constructed by a small group of students in one institution. It is not aiming to statistically generalise the findings (as discussed in chapter four, see 4.6).

5.5 Data construction

As identified in chapter four (see 4.4), multiple methods of data construction are considered a strength of case study approaches. This facilitates methodological triangulation; allowing the researcher to address the research questions from a different angle but also increasing the depth of the data constructed (Mason,2005). For this study, PBL focus group interviews, individual interviews and documentary sources were utilised to construct data. However, consideration must be given to the credibility issues around the different methods. The data constructed from the first PBL focus group, SMART notebook and individual interviews was naturally occurring and spontaneous. This was in contrast to the second focus group interview, intranet discussion area and written reflections, which the participants had time to carefully construct. This may have influenced the content of the constructions.

It is recommended that data construction, sampling and data analysis in both CDA and case study approaches is undertaken simultaneously as the findings emerge (Wodak and Meyer,2009; Yin,2003). Consequently, the detail in designing the research methods was decided pragmatically in response to the themes that were developing. To ensure that the research questions were addressed sufficiently, whilst maintaining congruence with the ontological and epistemological perspectives of the study, Mason's chart (2005) was used as a basis for making decisions about methods for this study (see appendix one). The issues highlighted in the chart are explored below.

5.5.1 Focus group interviews using problem based learning (PBL)

The first data construction technique selected for this study was the use of PBL in a focus group interview. The case; a group of eleven year two midwifery students were presented with the PBL scenario; "Martha, a heavily pregnant young woman arrives in Hull from the Sudan with a toddler. She speaks only a few words of English", (see appendix three). One student chaired the focus group and another acted as the scribe, documenting the students brainstorm activity and learning objectives onto a smart notebook file. I acted as facilitator and operated the video camera which was used to record the focus group interview. The participants worked through a series of steps; the first four stages of the PBL process (see appendix four). They explored their own existing knowledge of a pregnant asylum seeker and related this to Martha to construct shared learning objectives.

Two weeks later, to allow the participants time to research and address their learning objectives; all but one focus group member reconvened to feedback their findings and complete the PBL process. The one member who did not return could not attend the focus group, but had not withdrawn her consent to participate. Again the focus group was video recorded. The participants had uploaded their findings onto the intranet discussion area. This was printed off, together with the content of the smart notebook file, to analyse as documentary data. The video data was sent to a professional organisation for transcribing verbatim. It was then replayed to check for accuracy and to insert non-verbal and other cues that were considered appropriate.

It was difficult focusing on the equipment being used whilst listening to the content of the interaction, consequently the video recording was invaluable to revisit the PBL focus group interviews and pick out issues that were missed at the time. An example which I found surprising when watching the recording back, was that one participant appeared tearful and struggled to speak at one point in the second PBL focus group interview. I was surprised that I did not notice this at the time. This is discussed further in relation to ethical issues (see 5.7.2).

Although no published literature could be found relating to the use of PBL as a means of data construction in the research process, it may have been used in other research contexts. An example was found where PBL was used in a similar way in another doctorate. PBL scenarios were used with a group of medical students, to collect data around how they construct their knowledge, during their six week rotation in obstetrics (Macvane,2010).

The use of vignettes in research has been explored elsewhere and has similarities to using PBL in this context (Rapport,2004). Vignettes are short written stories about hypothetical characters that are presented to a group of participants. The aim of the vignette is for individuals to relate to this story and explore their own experiences in this context. It is seen as a way of simulating the individual's world and allowing the participant to explore this world from their own experiences (Rapport,2004). In a similar way, PBL involves providing a group of students with a learning issue, in this case a hypothetical asylum seeker, that requires exploration and working through the PBL process

(Davies,2004b) . Through this process, students add to their previous experiences to construct new and relevant knowledge (Haith-Cooper, Macvane-Phipps et al.,1999). In this case, the outcome of the exploration and the new knowledge were used as data.

Mason (2005) discusses how bringing a context into focus in an interview situation will produce data local to that context. In this case, a scenario was used to bring the context of pregnant asylum seekers into the focus group interview. However, Mason (2005) disputes the use of hypothetical scenarios and asserts that the participant should be encouraged to explore lived experiences. However, in the context of this study, within the process of gaining ethical approval, there were potential issues identified around encouraging students to explore their experiences of caring for pregnant asylum seekers and the possible conflict of interest that I may have, if substandard care was reported (see ethics 5.7.1 for further discussion around this issue). Therefore, it can be argued that the use of a PBL scenario to encourage participants to apply existing knowledge to a context, encouraged them to think about their clinical experiences but not specifically focus on discussing these experiences.

PBL can be viewed as more than a teaching strategy, it is in itself an educational philosophy (Savin-Baden and Howell Major,2004). It can be argued that this philosophy mirrors the social constructivist and feminist underpinnings of this study for a number of reasons. Social constructionism supports the idea that knowledge is both situated and contextual (Rolfe,2000). Similarly, PBL encourages students to discuss their knowledge within a particular context. This

knowledge will have been constructed from different life experiences which will have been influenced by dominant discourses.

Feminist research aims to increase knowledge about oppressed groups by listening to each other's stories and sharing knowledge (Holloway and Wheeler,2002). Critical thinking skills are used to understand how these groups' previous thinking may have been distorted by the dominant discourse around a phenomenon. This knowledge can then be used to make changes to empower groups in society (Holloway and Wheeler,2002). Similarly, in the PBL process, the students are encouraged to share knowledge and examine information critically to develop a new understanding of a phenomenon (Savin-Baden and Howell Major,2004). Like feminist research, valuing each others' forms and sources of knowledge is a fundamental principle of PBL. This is encouraged by participants inviting one another to contribute to the group discussion, therefore sharing their knowledge (Davies,2004b)

Like vignettes, using PBL as a data construction strategy bears similarities to using focus group interviews and much of the limitations, advantages and suggestions for using focus groups can be applied to PBL in this context. Smith (1972) defines a focus group as the interviewing of a group of people at the same time. Mason (2005) regards them as a means to guiding a group through a set of topics to examine how an issue, in this case, the pregnant asylum seeker, is conceptualised and negotiated. The focus group bears many resemblances to a PBL tutorial. The usual size of the focus group is 8-12 participants. In this case there were eleven students. As in PBL, it is run by a

facilitator who aims to generate discussion about a particular issue (Robson,2002). Like PBL, group dynamics in focus groups are a powerful influencing factor and dominating participants can distort these dynamics (Gillham,2000). This will be explored further below.

Fern (2001) identifies that there are often two stages to a focus group interview, which can be equated to the PBL tutorial. Firstly the group is encouraged to identify ideas similar to identifying the learning issues in PBL, which can then be brainstormed and discussed in depth to construct new information, in keeping with the brainstorming activity in PBL. Although the PBL tutorial process continues, this is where similarities with the focus group ends. In the context of this study, like the focus group, the first three stages were undertaken but in addition the participants developed their learning objectives.

Fern (2001) wrote a thought provoking book specifically related to focus group interviews. He reviewed research undertaken, through the use of focus groups and raised a number of issues concerning the group and facilitator's role within the group. Having previously undertaken research related to the PBL group and the role of the facilitator I can see striking similarities between focus groups and PBL tutorials which will be discussed further (Haith-Cooper,2000; Haith-Cooper,2001a; Haith-Cooper,2001b).

Like PBL (Haith-Cooper, Macvane-Phipps et al.,1999), group dynamics are an important feature of focus group interviews and much is written about how dynamics can positively and negatively influence the quality of the data being

constructed (Fern,2001; Robson,2002). The aim of the group approach to interviewing is for participants to stimulate ideas from each other's contributions and probe each other to develop a greater depth of data. Alternative views can be weeded out and discussed by the group. However, like PBL (Haith-Cooper,2001b), quiet or more vocal participants can affect the balance of the discussion in focus groups (Robson,2002). Fern (2001) discusses this issue further. He identifies how individuals can vary in relation to age, race/ ethnicity, social status and gender. He considers it important to explore how these may influence the group dynamics, for example, an all women group may be more likely to disclose more personal information. Younger members may be individualists and older members' collectivists (Fern,2001). Individualists tend to be independent with the agenda of meeting their own needs, where as collectivists work on being a group and wanting to meet the needs of the group. Fern (2001) believes this can negatively affect the dynamics in the group. However, I consider that this could also positively impact on the quality of the discussion emanating from the group with more varied life experiences to draw from.

PBL involves creating a conducive environment for learning (Haith-Cooper,2001b). This is also vital for the success of the focus group interview (Fern,2001). It is important to consider the impact of both the ambience and the physical environment. For this study, the tables were removed and chairs arranged in a circle. The temperature, humidity, level of noise, size and shape of the room can all affect the quality of the group discussion and were considered when the room was selected. In addition, if personal space isn't ideal then the

participant may try to adjust her position by either creating more space if she feels crowded or engaging more in the group if she feels isolated. If this is impossible then the behaviour of the individual may change such as loss of eye contact, closed body posture, loss of attention and motivation for the task. Fern (2001) discusses how the perception of personal space is affected by an individual's characteristics such as gender (women tend to sit closer) race (Northern Europeans may need more space) dominant personalities (sit closer) friends (sit closer). If the group is seated side by side, this is perceived as close to the next person and as a result individuals may not talk to their neighbours.

There is much written about the disadvantages of using focus groups as opposed to individual interviews (Fern,2001). One issue is that it is difficult to think and listen at the same time. This can affect both the quality of the discussion and also lead to fragmentation of contributions. Individuals may feel the need to mentally rehearse their contributions before vocalizing them. If this is the case, they may not be listening to the discussion and could contribute at a time when the focus of the conversation has changed. They may also forget what they wanted to say if they have to wait for a gap in the discussion. Another issue is that in a focus group, some experiences are shared and discussed but some remain unshared within the group. Participants tend to share information that is familiar to more of the group members. Unusual or less obvious ideas are more likely to remain unshared. However, this was identified by the researcher and drawn out in an individual interview (see 5.5.3 for more exploration of this).

Like PBL, Fern (2001) discusses how effective facilitation skills are important in overcoming some of the issues around using focus groups. For example the facilitator can create an appropriate environment, encourage equal contribution by all group members, can respect thinking time for individuals to prepare their responses and encourage the exploration of unusual ideas as they surface. Like PBL, the facilitator needs essential skills such as active listening, non-verbal communication, questioning skills and a good memory (Haith-Cooper,2001b). Although I am an experienced PBL tutorial facilitator and have also previously used focus group interviews in the research context, I contributed as little as possible to the discussion. I remained aware of how my role in this context could have influenced the quality of information obtained in the focus group setting. In addition, this was a group of participants experienced in using PBL and I didn't perceive much intervention was required as the discussion flowed spontaneously; the PBL process was followed and accurately documented on the SMART notebook.

Although my presence in the focus group interview may have impacted on the contributions participants made, I would argue that my role in the PBL focus group would have had a minimal impact on the focus of the discussion. I purposefully restricted my role to operating the video camera. I spoke very little but did demonstrate active listening skills with nodding and smiling at the appropriate junctures. The participants were familiar with using PBL as a teaching method and engaged quickly with the process in the research setting. Taylor and White (2000) described a number of different persuasion strategies that people may use to verify their version of reality. This could be exacerbated

in a context of insider research where participants may want to appear in a certain way towards their lecturer and construct reality to reflect this. This is explored further in relation to individual interviews (see 5.5.3) and research ethics (see 5.7.1). However, it can be argued that the use of PBL scenario was a distraction from this occurring. Students appeared to settle into their role, working through the PBL process and appeared to forget that they were actually in a research context.

5.5.2 Written documents

The use of documentary evidence as a means of constructing data is a well established method and popular with case study approaches (McDonnell, Lloyd Jones et al., 2000; Scholz and Tietje, 2002; Yin, 2003). There are two types of documentary evidence; examining pre-existing documents and also data construction techniques which involve creating new documents. In the context of this study, the students constructed written documents as part of the research process in two ways. Firstly, written documents were constructed in a smart notebook file and intranet discussion area, containing notes which reflected the different stages of the PBL process. Within these constructions, they identified learning issues, illustrated their brainstorm, wrote their learning objectives and included their research to meet those learning objectives. Secondly, reflective accounts were constructed, which the students were requested to write over the period of the following year, whenever they came into contact with a pregnant asylum seeker in clinical practice. They were provided with written guidance on how to undertake this (see appendix five). However, a total of only two written

reflections were received. Nevertheless, they were analysed alongside the other sources and were useful in informing the findings.

When considering using documentary sources of evidence, Mason (2005) suggests that the researcher needs to question whether they fit with the philosophical perspective of the study and are appropriate for representing what they are intended for, in relation to the research questions. In the context of this study, the smart notebook file and intranet discussion areas contained written details of the discussion that occurred in both focus groups. It was useful to analyse the transcripts from the interviews alongside the documentary sources to identify which issues related to the health and social needs of the pregnant asylum seeker that were discussed, were considered important enough to be documented. In addition, the literature sources that the students used to construct their feedback in relation to the learning outcomes, added another dimension to the research question focusing on the implications of students' constructions for midwifery education. This will be explored further in the findings chapter (see 6.4).

By asking the participants to individually reflect upon their personal experiences of caring for pregnant asylum seekers in the clinical areas, their personal constructions could be analysed, in addition to how they were influenced by discourses in the clinical context. Participants raised issues within their reflections that hadn't been discussed in the PBL focus groups. All this added to the depth and breadth of data constructed by the participants and allowed the

research questions to be examined from a different perspective; thus supporting methodological triangulation as interpreted by Mason (2005).

Polit and Beck (2004) discuss two issues that the researcher should consider, when assessing the credibility of documents, as a method of data construction. The first is the authenticity of the documents. This relates to potential problems such as honesty, time delays and mood which can influence the way the participant writes the reflections. These issues are discussed in more depth in relation to the individual interview (see 5.5.3) but can be related to written data in exactly the same way. However, as the researcher is not involved in the process of data construction, then she has no way of observing for non verbal cues, which can be used as a way of confirming the honesty of responses. The second issue relates to how accurate and detailed the written data is. When considering the issue of insider research, the participant may have constructed the written reflection in a particular way, for the sake of the lecturer. This is explored further in relation to ethics (see 5.7.1). However, coming from a social constructivist perspective, one could question whether this is a real issue, as it is the participant's construction of reality that is required and not how factually accurate the construction is. It is important to consider the meaning of the data in the context that it was written and therefore view it as situated and specific.

5.5.3 Individual interviews

Following an initial critical discourse analysis of the PBL focus group data, four participants were invited back for an individual interview. The purpose of these interviews was to explore issues that these participants had raised during the

PBL focus group interview, which could have been explored further by the group, but were not pursued at the time. In addition, it was felt that more depth to the data addressing the third research question and how midwifery education could address the findings could be facilitated by exploring the participants' perceptions of "how they know what they know". Each participant was asked questions, related to the issues that they had raised at the PBL focus group interview, which weren't followed through. These questions were different for each participant, but the main thrust was around the concept of the genuine asylum seeker and prejudice towards asylum seekers in the NHS. Probes were used to encourage them to explore their sources of information in relation to these issues. Three of the four participants attended for their interview, one being unavailable. The interviews were audio recorded and sent to a professional organisation for transcribing verbatim (see appendix six for the transcripts from one of the individual interviews). They were then replayed to check for accuracy.

Data construction via individual interviews is a popular technique with case study researchers (Burns,2000; Robson,2002; Yin,2003). In particular, there is a wealth of literature around conducting interviews to construct qualitative data. The interview provides the opportunity for the participant to explore an issue from her own perspective by conveying experiences, using her own words to do this (Kvale,2004). The qualitative interview is usually semi-structured using an interview guide and themes and suggested questions. In this case, questions were generated for each participant, which linked back to her contribution in the PBL focus group.

As discussed above in relation to focus groups, the skills of the interviewer can impact on the quality of the information gained from the participant. This can be exacerbated in the individual interview where there are not other participants present to stimulate the discussion. In addition, the researcher is not neutral in the interview process. She may ask leading or closed questions by making judgments about information, based on her own theoretical perspective (Taylor and White,2000). In addition, the relationship between the researcher and participant may be different in the individual situation. The participant will not have the support of her peers, which will increase the need for a mutually supportive relationship with the researcher. This could be exacerbated when the researcher is undertaking the study in her own institution and is also the students' lecturer. These issues are addressed in the ethics section (see 5.7.1).

It is possible that my background and beliefs about asylum influenced the way that I selected the participants to interview. In addition, the questions that I asked and the probes that I used may have been developed in a way as to lead the participants. However, the participants were selected purely on the observation that a contribution that they made to the PBL focus group interview was not followed through and the questions developed from this contribution. In addition, my principle supervisor was asked to check the process used to identify the selection of participants and the direction of the questioning. This is explored further in data analysis (see 5.6).

The topic of asylum seekers could be considered emotive and the participant may respond to the researcher's questions in a way that she thinks the

researcher wants her to. Hollway and Jefferson (2000) discuss the notion of the defended subject in which the participant may respond to a question in a particular way to try to protect a vulnerable aspect of herself. Parahoo (2006) discusses the fact that people do not always mean what they say, or say what they mean during an interview situation. They may miss out aspects of a story in order to convince the researcher that their version is genuine (Taylor and White,2000). In addition to this, other difficulties may include poor recall and articulation (Yin,2003), poor motivation and mood (Hollway and Jefferson,2000) and hidden agendas (Silverman,2004). These issues may be heightened by the researcher being an insider. The participant having an existing relationship with the researcher, as lecturer may increase the fear of revealing too much. Conversely, this relationship may assist the process, the participant feeling comfortable talking to someone known to her, rather than a stranger.

From a social constructivist perspective, it is the participant's version of reality that is important in this context and not the notion of whether she is being truthful. However, the researcher could be misled should the student present a completely artifact version of events. Methodological triangulation and its focus on examining different perspectives of the research question, helped to address this issue. In the process of data analysis, each individual participant's contributions were examined separately to search for any contradictions in what she said or wrote.

5.6 Data analysis

When considering specific techniques for data analysis, the starting point is to revisit the epistemological position of the researcher and what constitutes data within the context of the study (Mason,2005). For this study, the data was the language used by students in their written and verbal constructions around the pregnant asylum seeker. CDA was interpreted as the search for underlying dominant discourses which influence language use, by examining words and phrases for implicit reference to discourses. As discussed in chapter four (see 4.5) both case study approaches to research and CDA do not have clearly defined procedures for undertaking data analysis, however, there are principles that should be followed, but the specific techniques are defined by the researcher depending on the research questions and selected from the "toolbox" (Jager and Maier,2009, p. 46).

In general, the analysis of qualitative data involves different stages which appear congruent with the principles described in relation to case studies and CDA approaches (Wodak and Meyer,2009; Yin,2003). These stages relate to reading and re-reading the texts, categorising the data, searching for themes, coding and then putting the data back together in order to address the research questions (Mason,2005). Although computer aided qualitative data analysis (CAQDAS) can be used in this process (Mason,2005), the individual software packages were focused on content rather than discourse analysis and didn't have the flexibility required to consider the data sets in different ways. For this reason, I decided to adopt Mason's (2005) approach to data analysis. How I

undertook this, using specific techniques to take from my toolbox, are described in detail below.

5.6.1 Reading and re-reading and re-reading.....

All the texts were repeatedly read to familiarise myself with the data and to begin to identify patterns in the words and phrases used. This reading occurred on different levels; one word at a time, one line, one paragraph, reading key phrases, reading different participants' contributions and different data sets and then how they related to each other. The texts were also read alongside the tape and video recordings to increase this familiarity. The video recordings were watched carefully and any non-verbal cues from the individual participants added onto the transcripts, such as nodding, long pauses, times when individuals appeared to disengage from the discussion and times when interruptions occurred. This was useful when identifying the context of the case and some of the issues around micro analysis, discussed below. In addition, Mason (2005) discusses how the text can be read reflexively, literally and interpretatively to gain different perspectives of the data.

5.6.1.1 Reflexive reading

Reflexive reading involved the researcher locating herself within the research process and examining how this presence may have influenced the reading of the data (Mason,2005). I explored two issue related to this within my reflexive journal. Firstly, as a researcher undertaking the study in my own institution, my ability to read the data may have been distorted by the familiarity of the context. There may have been local politics or power issues in the organisation which

could have affected the way data was constructed. This may have been missed because it was perceived as normal. In addition, I may have imposed my own beliefs and norms on the interactions and missed relevant patterns in the data (Morton-Cooper,2000; Roper and Shapira,2000). However, there are advantages to being an insider when reading the data, in understanding the subculture (Roper and Shapira,2000). Undertaking the research at another site can lead to problems such as culture shock, disorientation and not understanding rules and norms in the area.

Secondly, my beliefs about asylum seeking could have also influenced the way that I read the data. As identified in relation to individual interviews (see 5.5.3), I focused in on data around prejudice and stereotypes within the NHS. Although I believe that this addressed the first research question around dominant discourses underpinning constructions of the pregnant asylum seeker, it could have been that I focused in on the negative aspects of the data rather than the positive examples around the asylum seeker. However, I attempted to read the data in a balanced way and used examples of data where possible, which I believed demonstrated counter discourses around the pregnant asylum seeker. In addition, my research supervisors were helpful in checking the findings that I was constructing (see 5.6.3 for more discussion on this).

5.6.1.2 Literal reading

Literal reading involved examining the words and language used, group interactions and content of the data (Mason,2005). Examining the linguistics behind talk and text is a technique used in discourse analysis, which Van Dijk

(2009) refers to as micro analysis. It could be argued that this does not fit with the philosophy behind critical discourse analysis, as it assumes that reality is constructed locally by group members rather than being regulated by underpinning discourses. Despite this, literal reading was undertaken in this context to identify issues that could inform data analysis. The data was examined for any colloquial terms that needed defining and also for any contradictions made by individual participants and between different data sets. This assisted methodological triangulation by offering different perspectives on the issues discussed.

As discussed previously, (see 5.5.1), group dynamics can have an impact on the quality of the information constructed in the PBL focus group (Haith-Cooper, Macvane-Phipps et al., 1999). Consequently, data was examined to develop an understanding of how the group interacted; the influence of the chair and scribe to the group dynamics, the presence of quiet and dominant students, what argumentation and politeness strategies were used. Group dynamics can influence what isn't followed through in the focus group discussion as well as what is (Fern, 2001). As discussed previously (see 5.5.3), the lack of discussion around the genuine asylum seeker and prejudice in the NHS, influenced subsequent data construction in designing the individual interviews; who to interview and what to ask. In addition, the data sets for the first PBL focus group interview and the smart notebook were compared to examine which, if any issues, identified in the interview were excluded from the smart notebook.

5.6.1.3 Interpretative reading

Interpretative reading involves the researcher reading beyond the data, constructing her own version of what she thinks the data means and what can be inferred from this. In this case what discourses had influenced what was said or written. This Van Dijk (2009) refers to as macro analysis, looking at the wider context of where the data was constructed, from a societal, organisational and group perspective. Key words and phrases were identified and examined for implicit power sources that could link to underpinning discourses. Patterns in these key words and phrases were noted for future reference. Stevenson (2004) identifies potential problems when undertaking this stage of discourse analysis. He argues that there is the potential to focus on summarising the data rather than actually analysing it. Consequently the detail of the original text is lost. In addition, the researcher may miss important patterns in the data, especially when undertaking insider research, as discussed in relation to reflexive reading (see 5.6.1.1). Both adequate time and attention to detail is vital to ensure that this stage of the research process is rigouress.

5.6.2 Developing Categories

The next stage in the analysis process was to categorise the data. For the purpose of this study, data was categorised in two ways, around the research questions and around the individual participants. The first technique was to find patterns in the data that addressed the research questions and then to categorise these patterns. The research questions were used as category headings and the appropriate data from all the data sets were cut, paste and located into the categories. Care should be taken when undertaking this task as

statements can be taken out of context or grouped with others statements that don't relate (Burnard,1991). From a social constructivist perspective, as knowledge is constructed within a particular social, cultural and historical context, it is important to examine the data holistically to ensure the context of the case is not lost. By removing the context, the meaning of the data will also be lost (Burr,2003). Consequently, the whole of the contribution was included in a category rather than cutting and pasting only the keywords. Next, the data within the categories were labelled in different ways. Data that demonstrated different perspectives by students were included and highlighted. All the data were numbered 1-12 to identify which participant made which contribution and which data set it originated from, was also noted.

In addition, each participant was used as a category heading and their contributions for all the data sets were cut and paste in chronological order, including what literature was used to source their PBL feedback. These categories were also examined for any change in the way each student discussed the pregnant asylum seeker, or contradictions in what she said. As discussed earlier, four participants were identified as having made particular contributions which were not followed up within the focus group. These contributions were formulated into questions and used in the individual interviews. This data was then added to the existing data analysis process.

5.6.3 Searching for themes

To identify any themes that were emerging from the data analysis process, I returned to the philosophical perspectives underpinning the study

(Mason,2005). Boyatzis (1998) describes a theme as a pattern found in the data which may interpret aspects of the phenomenon. In this case, the theme was the patterns found in the language use, which reflected underpinning discourses around the pregnant asylum seeker. These patterns, Jager and Maier (2009, p. 46) refer to as discourse strands; common topics represented by a number of utterances found within the text. A discourse is the end product of a “great milling mass” of discourse strands. CDA aims to “disentangle” this “great milling mass” (Jager and Maier,2009, p. 36). However, this process wasn't straightforward. In this context, there was apparent overlap and contradictions between discourses strands which are discussed further in the findings chapters (see chapter six).

Mason (2005) stresses that to develop themes, it is important to interpret the meaning of the data in relation to the intellectual puzzle, to ensure consistency in the process. In this case the intellectual puzzle related to why pregnant asylum seekers had poor experiences of maternity care. Discourse strands were identified which influenced how the midwifery students constructed the pregnant asylum seeker.

Developing themes, is a vital part of the data analysis process but one that can be easily distorted by the researcher making assumptions about the data, based on her own personal, social and political values (Mason,2005). Stevenson (2004) argues that these assumptions can lead to an under analysis of the data. If the researcher adopts a particular perspective, then the other side of an argument is unlikely to be fairly portrayed. To avoid this, counter arguments; in

this case counter discourse strands should be included to balance the themes. Reflexivity is essential to make explicit personal beliefs which may influence the development of themes (Wodak and Meyer,2009).

There are a number of techniques suggested in the literature, which are believed to increase credibility in the development of themes. Member checking involves returning to the participants to ask them to comment on theme development (Burnard,1991; Lincoln and Guba,1985). However, from a social constructivist perspective, it could be argued as inappropriate to try to gain consensus in relation to the discourse strands developed. They are constructed and are a particular version of reality, not a reflection of reality. Therefore participants would have to be asked to comment on a construction not a transparent record (Wetherell, Taylor et al.,2001). This argument could also be applied to colleagues checking theme development, which is another credibility check suggested in the literature (Burnard,1991). However, in this context, it was useful to have a critical friend (Bassegy,1999) to examine the discourse strands for consistency in the way that the data was analysed, rather than searching for truth in relation to the discourse strands developed. Therefore, in this context, the research supervisors examined the data to ensure that the discourse strands were reflective of the data.

5.6.4 Coding

The next stage of qualitative data analysis is coding. A code is a label assigning meaning to a description. A label should be applied to a chunk of words in order to understand the meaning that has been applied to these words in the data

analysis process (Miles and Huberman,1994). In the context of this study, this was a simple process applying numbers to chunks of words which reflected the discourse strands identified. This was undertaken for all the data sets and the categories developed. In addition, to cross reference the codes, I returned to another paper copy of the data sets and cut and paste the chunks of words which I felt included words or statements that reflected the discourse strands as outlined above. These were included in a new category under the appropriate discourse heading. Following this, I could cross reference the data and ensure consistency in my interpretations.

5.6.5 Putting it all back together

The final stage of data analysis involves developing an argument or theory. This Dey (1998), describes as putting the pieces back together in a jigsaw puzzle but as a different whole. The whole would relate to addressing the intellectual puzzle and research questions. It is important to present enough evidence, both verbatim or documentary to demonstrate the links between the developing argument and the data clearly (Crowe,2005; Dey,1998). However, the overuse of quotations can distract from working out what the quotes actually mean in relation to the themes (Stevenson,2004). In addition, it is important to use counter arguments; in this case counter discourses to challenge the researcher's assumptions in relation to the data (Mason,2005; Wetherell, Taylor et al.,2001). This will assist in the process of theoretical generalisation; previously discussed in chapter four (see 4.6). The underpinning theory retrieved within the literature review is used to support the findings from the study and develop arguments which can then be considered in other contexts

outside of the case. It is essential not to try to impose a framework on the data, trying to fit it into the underpinning theory but to fit the theory with the data as it emerges (Stevenson,2004). How this stage of data analysis was undertaken is demonstrated within the discussion chapters (see chapters seven and eight).

5.7 Ethics

Ensuring that a study is ethically acceptable, should be a fundamental part of the research methods and consideration should be given to the ethical implications at every stage of the research process (Mason,2005). It could be argued that ethics, credibility and reflexivity are interrelated. A researcher that can be believed and trusted is an ethical researcher. Therefore, it is essential that the researcher treats the theoretical aspects of the study with respect, being open and fair in the way the literature is reviewed, research questions developed, data collected, analysed and discussed. In addition, it is important that the researcher treats the participants in an ethical way.

In the 1970's, Beauchamp and Childress (2002) developed an approach useful for exploring ethical issues in health care. The approach is based on four prima facie moral commitments; respect for autonomy, beneficence, non-maleficence and justice and considers each principle morally binding unless it conflicts with another principle; in which case a choice has to be made between the conflicting principles. I believe that these principles are helpful for guiding research ethics as my moral commitments as a researcher are no different to my commitments as a health professional. This chapter will now explore the four ethical principles within the context of this study, to consider any ethical

issues that arose throughout the research process and how they were addressed to ensure that this study was ethically as well as epistemologically justified.

5.7.1 Autonomy

When undertaking research, autonomy needs to be respected on two different levels. The researcher should obtain permission to proceed from the organisation involved in the research and also from the individual participants. From an organisational perspective, permission to undertake the study was obtained from both the Dean of the School and the School of Health Ethics Panel (SHEP). However, an issue arose which needed addressing before the study could proceed. It was identified that potentially the researcher could be exposed to participants' revealing ethically questionable situations, during the data construction process. In particular this could be stories of substandard care of asylum seekers in clinical practice. In this case, the researcher would find herself with a conflict of interest between being her role as a health professional or that of a researcher. There could be a dilemma as to whether the research process should continue or be terminated and confidentiality breached to report such practice (Holloway and Wheeler,2002).

Morton-Cooper (2000) discussed the need to consider professional and employers' codes of conduct when undertaking research in one's own area of work. The researcher must consider that any questionable practice that is reported could be damaging to an individual or institution. However, I would have a professional obligation to follow the Nursing and Midwifery Council's

(NMC) guidance (Nursing and Midwifery Council,2008) if a participant described such an event. For this reason, when acquiring informed consent, the participants were advised not to talk about specific care that they may have come across in clinical practice which could have been considered as substandard.

This issue became an entry in my reflexive journal, as I was concerned that the potential role conflict due to my professional background as a midwife, may have had a detrimental effect on the quality of the data constructed. Participants may have avoided sharing clinical experiences that they had, for fear of retribution. Without the contribution of clinical experiences to the data, I feared that the research questions would not be fully addressed and the purpose of the research would be lost. If participants avoided discussing clinical practice whilst constructing their perceptions of the pregnant asylum seeker's health and social needs, then the data would be incomplete and it would be difficult to examine how midwifery education could be moved forward to address pregnant asylum seekers needs.

As discussed previously (see 5.5.1), it could be argued that using a PBL scenario of a fictitious asylum seeker may have guarded against this to some extent, by the participants applying knowledge and understanding to the scenario, rather than directly discussing their clinical experiences of care. In addition, the participants were encouraged to limit their discussion about the clinical area to the informal talk that they had witnessed away from the women being cared for and not to attempt to discuss the care provided in the clinical

area. Valuable data was constructed from these discussions and was useful in informing the findings of this study in relation to how prejudice and stereotyping occurs in the maternity services and how this could be addressed in relation to midwifery education (see chapter seven; 7.5) for further exploration of this.

To respect the individual participant's autonomy, informed consent was obtained from the potential participants by arranging to meet the cohort a month before the intended date for the first PBL focus group interview. A poster had been displayed advertising the research and inviting the cohort to a meeting to discuss it further (see appendix two). At the meeting, the purpose of the study was explained and questions answered. Following this, a written handout was provided to re-enforce the issues discussed. This also consisted of a consent form (see appendix seven). The participants were instructed to complete and return this at the beginning of the first PBL focus group interview. In the meantime, those students who were intending to participate were asked to e mail me before the first interview in order that I could assess whether there would be enough participants for the PBL focus group interview to be viable. Before the interview began, the purpose of the research was re-iterated and further questions answered.

It has been argued that due to the flexible nature of qualitative studies, it is difficult for consent to be fully informed at the beginning of the study, as the methodology is often undecided or may change in response to the emerging data (Holloway and Wheeler,2002). For this reason, the concept of process consent has been developed. This involves providing information at every stage

of the research process, to allow the participants to withdraw from the study if they request to (Polit and Beck,2004). In this context, process consent was explained to the participants, stressing that they could withdraw from the study up to the point where data construction ended. This was due to the difficulties of withdrawing individual data during the writing up stage, where data integration occurs to develop arguments. However, all participants appeared happy with the study and no requests were made to withdraw. In addition, no major changes were made to the study methods which required new information to be provided to the participants.

There is a debate around how much information to provide research participants when obtaining consent. It could be argued that too much information may contaminate the data received, but too little could be considered as deception. Kvale (2004) suggests that it may be justified to initially withhold the specific purpose of the research, to avoid leading the participants to respond in a certain way. However, Gillham (2000) argues that you need to be honest, by informing the participants about the topic of the study at the outset. He suggests a potential bias is only introduced when you reveal to the sample what you expect to find. Hollway and Jefferson (2000) assert that there should be a clear distinction between the research questions and the information given to the participants. In this case, informing students that they will be asked about their knowledge and understanding of pregnant asylum seekers health and social needs, may have led them to feel that they were being tested. This may be exacerbated by the researcher being an insider (Roper and Shapira,2000). For that reason, in this context, the study was framed in a positive way, as a means

of assessing students' educational needs to improve care for pregnant asylum seekers.

Participants feeling obliged or being coerced to take part in a research study, has been highlighted as a major ethical issue impacting on autonomy (Hollway and Jefferson,2000). In addition, in this particular context, this could be exacerbated by undertaking research in one's own area of work. Roper and Shapira (2000) suggest that this depends on the position of the researcher in the organisation. A lecturer may be perceived by students as an authority figure, which could influence their progress on the course. They may then feel obliged to take part in the study, for a fear of retribution affecting marks, reports or references (Burns,2000). To try to overcome this potential situation occurring, clear boundaries were developed between my role as researcher and lecturer. Students who chose not to participate were assured that their educational experiences in relation to the curriculum would not be affected. Obviously though, these students would not have received the targeted education about asylum seekers facilitated through this study. Consequently, they were provided with a reading list should they wish to pursue studying this topic area.

In qualitative research, the relationship between the researcher and participant is often close (Polit and Beck,2004). It is important to prevent role confusion by being open and non-judgmental during the research process. In addition, it could be perceived that the insider is spying on the participants (Roper and Shapira,2000). Therefore it was important to explain how the information collected through the study would be used and to keep to this agreement.

5.7.2 Non-maleficence and beneficence

The ethical principles of non-maleficence and beneficence should be applied to research studies and a study cannot be ethically justified if the potential harm to the participants, outweighs the intended benefits of the study (Burns,2000; Holloway and Wheeler,2002). In this case, the perceived benefits of the study were to improve maternity care for pregnant asylum seekers. For the individual students, the benefits related to receiving more focused midwifery education regarding asylum seekers. Although there is no obvious physical harm that could result from this study, there is a potential to cause psychological harm to the participants.

Potential harm resulting from research participation can be subtle and therefore not always obvious to the researcher (Polit and Beck,2004). In addition, due to the flexibility of qualitative research methods, it is difficult to anticipate harm that may occur as a consequence of the study (Ford and Reutter,1990). However, it is well documented that some data construction methods, such as individuals interviews, could create more potential for psychological harm, due to the intimate relationship between researcher and participant leading to over anxiety and fearfulness (Burns,2000; Holloway and Wheeler,2002). Conversely, it is suggested that the interview process can be a positive experience for participants. They can find it useful to be listened to over a period of time (Kvale,2004).

In the context of this study, there was the possibility that a participant could have been a refugee, could have suffered from mental health issues or could

had been the target of racism at some point in her life, all of which would not be known to me as the researcher. If any of these situations, or other situations leading to psychological distress, had come to light during the research process, this would have been addressed at the time. Debriefing would have been offered to the participant. Also, if considered necessary the participant could be referred to the university support services such as the counselling services.

Whilst watching the video recording of the second PBL focus group interview, as highlighted earlier (see 5.5.1), it came to my attention after the data construction process that a participant had looked tearful at a particular point in the interview, but appeared to recover quickly and join in the discussion with the other participants. Due to her contributions, this participant had previously been selected for the individual interview, which had been conducted by the time I had noticed her non-verbal cues on the video recording. On reflection, this participant didn't appear upset during this individual interview and therefore I decided that it wouldn't be appropriate to recall her, to discuss the observation further.

Respecting confidentiality is considered essential to prevent psychological harm when undertaking research. This was maintained in a number of ways. Within the PBL focus group interviews, participants were requested to maintain confidentiality within the room. Hard copies of data including transcripts and students' reflections were kept in a locked filing cabinet. The smart notebook and intranet discussion area could only be accessed by the participants and the researcher. Video and audio files were stored on a password protected laptop

which was transported between work and home. Only my research supervisors, the computer technician and the professional transcription service had access to this information. The data will be stored until completion of my PhD then it will all be destroyed or deleted.

Like confidentiality, it is important to maintain anonymity during the research process. However, this is difficult to achieve in qualitative studies because it involves not even the researcher being able to link a participant with her responses (Polit and Beck,2004). Qualitative studies with smaller samples and a closer relationship between the researcher and participants creates difficulties (Ford and Reutter,1990; Polit and Beck,2004). However, providing participants are made aware of these difficulties, they have the choice to opt out of the study. In the writing up process, the use of quotes to illuminate discussion could lead to potential recognition of participants (Parahoo,2006). However, it is acceptable to explain this to the participants during the consent process and reassure them that through the procedures described above, every measure would be taken to prevent any breach of confidentiality.

5.7.3 Justice

The final ethical principle is justice. This relates to the obligation of fairness; treating people fairly and equally (Beauchamp and Childress,2002). In research ethics, it applies to the treatment of research participants and those who decide not to take part. As identified above (see 5.7.2), it was felt important that students who opted out of the study did not feel discriminated against in relation to the midwifery programme. In addition, it is important that those students, who

did participate, did not feel unfairly disadvantaged. The potential workload created by this study may have caused concerns around disadvantage therefore, the data construction activities were timetabled so that the students who volunteered were not undertaking a large amount of work in their own time. In addition, it was felt to be important that the researcher treated the research participants fairly and equally not showing any preferential treatment to one participant over another.

5.8 The spirit of action research

As the research process progressed, it became apparent that it was actually being undertaken in the tradition of an action research approach. Morton-Cooper (2000) describes this as a cyclical process involving the identification of a problem within a particular workplace, in this case how to effectively prepare midwifery students in meeting the health and social needs of the pregnant asylum seeker. A group, in this case, of midwifery students, actively works together to identify a way of addressing the problem and improving practice. Arguably, this was undertaken through using the PBL focus group interviews as a research tool, with the second PBL focus group interview being an intervention to address the problem. Subsequently, a further intervention, a new model for midwifery education was designed (see chapter 9 for discussion of the model). To follow the cycle through, the effectiveness of this model in addressing the problem would be evaluated. How this may occur is discussed in relation to future research projects (see 10.7.4 for further exploration of this).

5.9 Conclusions

It can be argued that it is important that the research methods used to undertake a study are described in sufficient detail, to facilitate their assessment, by the reader, in relation to issues around credibility and reflexivity. This chapter has provided an indepth discussion of the methods used to undertake this study and potential biases that could influence the credibility of the findings. It has discussed issues around quality and the numerous criteria that can be used to assess qualitative research. In this context, credibility was interpreted as the researcher being trustworthy and believable in the way that the research process was undertaken. It can be argued that this chapter has provided sufficient detail in the discussion, for the reader to assess credibility in relation to the different methods used in this study.

This chapter has explained the sampling procedures that were used to recruit a case for this study, including inclusion and exclusion criteria. However, it identified difficulties encountered in successfully securing a sample and how these difficulties were addressed by turning to my own institution to access midwifery students. The epistemological and ethical impact of potential biases that could have occurred as a result of this and how these issues were addressed has been explained through the course of the chapter.

The different methods of data construction used to undertake this study, have been explored in relation to credibility and also how they maintained congruence with the social constructivist and feminist principles adopted. The use of PBL focus group interviews was compared with general research focus groups and

issues around the influence of group dynamics and the characteristics of the sample, the skills of the facilitator and the setting for the research were explored and how they were addressed in practice. Similarly, individual interviews and documentary sources, as data construction techniques were explored and potential credibility issues identified with these. The potential researcher and participant biases, due to undertaking the study within my own institution were related to these methods of data construction.

A detailed account of the critical discourse analysis of data was presented, including the stages of data analysis, which resembled general qualitative data analysis processes. However, the patterns in the data and the themes that emerged related to underpinning discourses, rather than the content of the data. This chapter explained how the data analysis process was conducted, with a focus on credibility and ensuring that the researcher was true to the data. This was enhanced through the use of a critical friend and also through searching for counter discourses to balance the developing argument.

Finally, this chapter explored the ethical implications of this study and how the four ethical principles were respected when dealing with research participants in the context of this study. Issues around autonomy through implementing process consent, beneficence, non-maleficence; in particular potential psychological harm and justice were related to the treatment of participants and students who opted out of the study. The ethical issues around insider research were explored and the potential for obligation and coercion, due to the perceived relationship between researcher and participant, was addressed.

Also, the issues of confidentiality and the difficulties around anonymity with qualitative studies were addressed. This chapter discussed the difficulties that were encountered when achieving ethical approval for undertaking this study and the possible ethical dilemma occurring for the researcher should sub-standard care of pregnant asylum seekers be highlighted by a participant. How this issue was addressed was explored within this chapter.

Chapter 6: Findings

6.1 Introduction

This chapter will provide a presentation of the study's findings. Firstly, it will outline the context of the case and some of the more general findings related to the use of critical discourse analysis (CDA). It will then return to the three research questions and present the specific findings that address each question, using examples of quotes to illustrate the discourse strands identified. These quotes are labelled according to the data set from which they originated; PBL focus group (Fg 1 or 2), individual interview (Ii), reflection (r) or SMART notebook (Sn). Quotes are also labelled with the participant number (p). Following the presentation of the findings, chapters seven and eight will discuss key issues that arose relating to the wider context and possible dominant discourses that have influenced the construction of the pregnant asylum seeker's health and social needs.

6.1.1 The context of the case

The case comprised of eleven midwifery students all part of a cohort enrolled on the second year of a three year graduate midwifery programme. They came from different ethnic backgrounds and were of varying ages (see appendix eight). The participants are numbered one to twelve. Although I was labelled by the transcriber as participant one, as I spoke first during the first PBL focus group interview, I was not a group participant and said very little throughout both focus groups. Participants that were perceived to be particularly quiet or dominant were identified.

The participant, who was the chair of the first focus group, undertook her role by interjecting to keep the discussion focused on relevant issues. However at times some group members appeared to become frustrated due to the focus of the discussion, folding their arms, sitting back in their chairs and withdrawing from the conversation. Despite this, when analysing non-verbal communication, focus group one appeared more lighthearted, than PBL focus group two, with more smiling, open body language and the use of humour. The second PBL focus group appeared more serious. The participants had closed body language, folded arms and legs and there was very little smiling. As identified in chapter five (see 5.7.1), one participant appeared tearful, had to wipe her eyes and found it difficult to talk at one point. In addition, there were prolonged periods of silence in this focus group interview.

Some participants contributed little to the focus group discussion. Intermittently, other participants noted they were quiet and encouraged them to talk but they didn't elaborate on any contributions, although they did engage in the group non-verbally, through nodding in response to others contributions and participated when humour was used in the group. However, the findings presented in this chapter predominantly represent the discussion from the more vocal students. At times, the quieter students' contributions were rejected by the more vocal students. This is highlighted throughout this chapter and alternative perspectives included where they are perceived to be relevant.

There were different perspectives offered on the pregnant asylum seeker, some positive and others negative. These negative perceptions were often portrayed

as the perception of the general public. However, some participants presented positive perceptions at some points in the discussion followed by negative perceptions. There were more positive perceptions during the second PBL focus group interview, which are discussed later in relation to the research question focusing on the implications for midwifery education (see 6.4).

6.1.2 Sources of literature

In endeavouring to meet the learning objectives and feedback their information during the second PBL focus group interview, participants had to identify what literature they had used. The main sources of literature are presented in relation to research question three (see 6.4) and the implications of the participants choice of reading material for midwifery education.

6.1.3 The research questions

The findings from the first PBL focus group interview and the contents of the SMART notebook mainly addressed research questions one and two. The participants followed the PBL process to develop their constructions of the pregnant asylum seeker's health and social needs. Arguably, the formulation of these needs was influenced by underpinning discourses. In contrast, the findings from the second PBL focus group interview and intranet discussion area, mainly related to research question three. The participants presented the information that they had found through researching their learning objectives. This information formed the focus of the group discussion. Generally, the findings from the individual interviews and the reflections, addressed all three research questions by providing more depth and a different perspective to the

data. This chapter will now present the findings related to each research question. The spidergrams illustrate the way that the data was organised in relation to each question.

6.2.1 The asylum seeker as a foreigner

“Welcome to my country”

- Language use
- Separate entitlements
- Abnormal pregnancy
- Must conform
- Volume of people

6.2.2 The asylum seeker needs to be controlled

“Going through the proper channels”

- Classification
- Follow correct procedures
- Financial control
- Control over health

Research question 1

6.2 What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?

6.2.4 Pregnant and an asylum seeker

“They are vulnerable”

- Deserving
- May have been raped
- Expected behaviour

6.2.3 The asylum seeker as a criminal

“They're not all genuine though, are they?”

- Same story
- Wanting UK benefits
- Claim needs to be serious
- Language use in asylum process

6.2 What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?

6.2.1 The asylum seeker as different or a foreigner-*"Welcome to my country"*

Throughout all the data sets language was used, which suggested an underpinning discourse around the asylum seeker as a foreigner, or being different to UK citizens. The words my, our, their and different were all used interchangeably when discussing countries of origin. This conjured up an image of boundaries and the land beyond boundaries belonging to a particular group of people. An asylum seeker crossing that boundary was considered a foreigner. Although the term "welcome to my country" was used in a humorous way, at a time when the group was laughing, the word "my" was still used. The asylum seeker as foreign and coming to the UK appeared to have negative connotations as a participant described:

li, p8 *"...there's just a general prejudice about asylum seekers. 'Oh, they're coming into our country. What are they doing here? Why are they coming here?' We give, it's like we welcome everyone here and you hear it everywhere"*

One participant used language suggesting the asylum seeker as even more foreign than immigrants coming into the UK, although the word "other" was used to describe immigrants, suggesting them as foreign and different as well.

Fg1, p7 *"(once asylum claim accepted)... then they'll be entitled to the same rights as other immigrants"*

In addition to the average asylum seeker, the language use around the pregnant asylum seeker reflected her as being different to the pregnant woman who is a UK citizen. This related to welfare benefits that she may be able to claim:

Fg1, p10 *"is there anything separate for asylum seekers, like not necessarily health and pregnancy grant or anything, but there might be something separate, you know, for asylum seekers and pregnancy."*

And also in relation to planning midwifery care:

Fg1, p2 *"I suppose like sort of in extreme circumstances, still sort of making space for what's going on, which is she's having a baby. The normal in the abnormal. What is normal for her."*

This quote can be examined in relation to two overlapping discourse strands. Not only does it suggest the pregnant asylum seeker as foreign, the words "normal in the abnormal" suggest a discourse strand around pregnancy being considered a normal event but being pregnant and an asylum seeker as abnormal or "extreme". This issue is explored further in chapter seven in relation to underpinning dominant discourses (see 7.2)

Another strand to this discourse was around expectations of the asylum seeker on arrival to the UK and focused specifically on language barriers.

Fg1, p7 *"if I was going to another country and I couldn't communicate in their language and they didn't understand me, I'd, yes, it might be slightly frustrating, but then I'd respect the fact that I'm in a different country And there's a language*

barrier I've lived in a foreign country before and you do your best until you've learned the language to communicate"

This quote is using a comparison of choosing to travel abroad with the enforced displacement of an asylum seeker, two situations which could be argued as incomparable. The words "respect" and "do your best" could suggest that the asylum seeker should conform and learn the language of the host country. Another strand to this discourse was around the volume of foreign asylum seekers coming to the UK and the fear of the impact on the population as a result:

li4 "...we're only a small island, so there's got to be rules and there's got to be cut-offs as to who can come. Otherwise things like the NHS, services that, that are provided for people, they wouldn't be able to carry on being provided because there'd be so many people. And housing, I mean asylum seekers are given housing, aren't they? And how could, you know, there, there isn't a, an infinite amount of housing for everybody to go round. So there have, there has to be rules and regulations as to who can stay and who needs to go home, harsh as that is."

li8 "how many do we allow, allow in because there's crimes being committed all over the world? Genocides in Africa, Palestine, Iraq. Every, everything, you know. What do we say? Where do we stop?"

Using the term "small island" reinforces the image of boundaries and land to cross for foreign asylum seekers. This needs to be controlled with "rules" to

protect UK citizens, their housing and other services. This reinforces the idea of foreign or difference which is explored further in chapter seven (see 7.2).

6.2.2 The asylum seeker needs to be controlled-“Going through the proper channels”

The language used by the participants suggested an underpinning discourse around controlling the life of the asylum seeker whilst in the UK. One strand of this discourse was revealed when participants were trying to work out the definition of an asylum seeker:

Fg1, p12 *“Would she be classed as an asylum seeker if she had family here?”*

Fg1, p7 *“And how long, how long does this state of asylum seeker, how long can that last? Because at some point, they’re either going to have to say, ‘You can stay in this country.’”*

Fg1, p3 *“to be an asylum seeker, you have to be coming from certain countries, and there’s a list of...Well, they can’t be an asylum seeker or a refugee because they’ve come from that country. They’re just an immigrant.”*

The words “class” and “state” suggest asylum as a category into which people fit. Immigrant could be perceived as another category, though the use of the word “just” in relation to immigrant suggested that they are considered as classified lower in relation to desirability than the asylum seeker.

Another strand to this discourse was that to earn the status of an asylum seeker, an individual had to conform and behave properly, according to UK legislation:

Fg1, p4 *"But they've gone through the proper channels, like they've gone through the authorities and not, they haven't just arrived in our country and started living in our country. Like hiding, you know."*

The word hiding suggests criminality and not following the correct procedures once arriving in the UK could be considered to be linked with criminality. This is connected with the discourse discussed below around criminality. Once they have followed the correct procedures when they enter the UK, the language suggested a discourse strand around asylum seekers being controlled in different of ways. This included asylum seekers being financially controlled through the welfare benefit system:

Fg1, p7 *"Now, I don't know if that's changed, but the voucher system is very, very difficult for them to use and it means that they can only spend certain money in certain places and there's only a small amount of money. So I know that there are a lot of issues around the benefits they get and they're not ideally suited to asylum seekers necessarily. They don't fit into their way of living and their culture and it causes problems."*

Fg1, p8 *"And then it'll be someone else making up, obviously deciding what she's entitled to and what she's not, and making assumptions if, you know, if she can't get her point across"*

These responses suggested the participants were critical of the benefits system for asylum seekers, with another party taking control over what they are entitled to. The discourse around control appeared to be entangled with the discourse around the asylum seeker as a foreigner, when it came to claiming benefits

Fg2, p3 *"I think the HC1's available for anybody on a low income. So that's, that's just use it for anybody. It's not, it's not just for asylum seekers."*

p5 *"Even we can claim."*

The words "even we" suggests surprise that the participant has something in common with the foreign asylum seeker, arguably reflecting the difference between them and us. Health care was another issue discussed by the participants and the language used was not only around asylum seekers health needs being controlled, but also the need to justify this control:

Fg2, p4 *"It (information website) said things like if they needed specialist treatment from a consultant, they can get it and it explained that like they'd probably have to wait, but everybody has to wait, you know. It's not just them because they're an asylum seeker."*

Another issue around control related to the power to expel the asylum seeker from the UK.

FG2, p8 *"But in this case, for this asylum seeker and she doesn't know where she's going to go, what's going to happen or anything. But she still doesn't know what's hanging over her head. She doesn't know if this country will allow her to become an immigrant or if she will be forced to go back to her country or."*

The use of the term "hanging over her head" suggests the ever presence of some superior power which has the capacity to decide her fate. In this case it can "force" her to do something and therefore has control over her life.

6.2.3 The asylum seeker as a criminal *“They’re not all genuine though, are they”*

The language use by participants suggested an underpinning discourse around criminality. There were several strands to this discourse, one being reflected above, the language use suggesting that asylum seekers are not who they say they are, therefore they could be illegal immigrants and thus criminals. The words “are they” in the phrase above could be seen as a leading, closed question to dissuade any counter argument from other participants. The participant who used this term in the first PBL focus group interview was invited back for an individual interview in which she was asked to explore this statement further:

Fg1,p4 “There’s a lot of people who have the same story, though. They’ve been told what to say. That they’ve, well, there’s all different kinds. They’re, they’re a Born Again Christian, so they definitely can’t go back to their country because they’d have to preach to everybody about it, or they’re gay. And that’s not allowed in their country”

In addition to this, perceived reasons were given as to why criminals chose the UK as their target. Participant eight had highlighted this in the first PBL focus group interview. In her individual interview she explained that the general public believed:

li8 “Oh, they’re here for the, the benefits we give out... We have a free NHS. We have benefits. We give, it’s like we welcome everyone here and you hear it everywhere. Everyone’s like, ‘Oh, we pay tax and people stay on their, you

know, backsides and don't do anything.' And you know, people will moan about it..."

The perceived financial benefit of coming to the UK was reflected by participant four:

li4 "... made up a reason so that they can stay in this country because there are, you know, more employment prospects, although at the moment, probably not. Probably aren't as many asylum seekers at the moment..."

The quote above suggests a direct link between the variation in number of asylum claims and employment prospects in the UK. This is explored further in chapter seven in relation to underpinning dominant discourses (see 7.3). This participant also gave a specific example of when an asylum claim wasn't serious enough to warrant it being accepted:

li4 "If there's not something major going on in, in their country that they're fleeing from. You know, so some people will say that they're homosexual and if they go home, they'll have to proclaim to everybody that they are homosexual. And then there will be, you know, whatever is going to happen to them. But that might not be the truth. They might, you know, they don't have to go home and tell everybody that, 'Oh, I'm gay now.' Like you know, why can't they just sort of be quiet about it?..."

In contrast, the language use by some students reflected a counter discourse to the asylum seeker as a criminal. There were suggestions that they may have genuine reasons for seeking asylum in the UK:

Fg1, p8 "(Africa) country and it has got quite a few genocides and stuff going on. I'm not sure if that's one of the areas where that's occurring, but."

li8" if I was to get kicked out of the UK and we were told, 'Go back home' I'd be like, 'I don't want to go to Pakistan.' It's horrible. I mean the things that are going on there. I, I could, if, I'm not, but if I was living there at the time, I'd want to be getting out of Pakistan now. If I was living there now, I wouldn't want to live there. I'd fear for my life and my family's life and I would want to get out of there. So in that sense, I can see the asylum seeker perspective."

One discourse thread around criminality related to the language used when describing the asylum process in the UK:

Fg1, p3 "When I was on placement, I met a couple of women who were having to travel to (big city) once a week to sign in, like, you know like when people are on parole and they have to sign in at the police station? It's a similar kind of thing. They have to go sign in (big city) once a week to prove that they're still where they say they are."

The words "parole" "police" and "prove" all reflect the discourse around the asylum seeker as a criminal. This was re-enforced when one participant described the role of the presenting officer during the hearing in which the asylum decision is made.

Fg1, p4 "go to court ...question illegal immigrants and asylum seekers. And there's a judge there and they have a barrister... put the case against them...."

The words here reflect the language used in a criminal court case. In addition, the asylum seeker is categorised with the illegal immigrant, an individual breaking the UK law. "Putting the case against" suggests trying to prove the asylum seeker is a criminal to facilitate expulsion from the UK. This reinforces the idea that the asylum seeker is of a criminal persuasion which will be explored further in chapter seven (see 7.3).

6.2.4 Pregnant and an asylum seeker- "They are vulnerable"

As identified so far, the findings from this study reflect discourses and some counter discourses around asylum seekers, associating them with being foreign and different, of a criminal persuasion and in need of being controlled. As this study is around the pregnant asylum seeker, a key issue was around whether language changed when the word "pregnant" was put in front of the term asylum seeker.

li 4 "I think my opinions would probably change if it was a pregnant woman that, that had come over and you know, I'd, I'd just feel like I'd want to do everything I could to help her, I think. Whether that's right or wrong, I don't know, but that's just what is instilled in you all the time when you're doing your training. And you know, it's the woman that you put first and you've got to care for her and give her the choices that she needs...they are vulnerable. Yeah, and definitely deserving of care."

This vulnerability was reflected by other students and linked with the pregnant asylum seeker's emotional health

Fg1, p8 "Quite often, we find that people that are seeking asylum or refugee, if they're pregnant, it's usually a case of rape."

Fg1, p12 "She's going to be scared."

Fg1, p9 "Perhaps lonely and isolated"

Fg1, p3 "What about adjusting? Like because it's going to be a big shock, isn't it?"

However, this discourse around the vulnerable asylum seeker, led to expectations of how this woman should behave and surprise was expressed when a student met a pregnant asylum seeker and she didn't meet these expectations:

li 8 "when I actually met the lady, she, I was, then I had the opposite prejudice. I was thinking, 'She's going to be grief stricken. You know, God knows what's happened to her. Oh my God, what, what am I going to do? What am I going to say? Is she going to be upset?' But she was laughing all the way through it. I mean she seemed happy. She seemed fineIf, if I hadn't known she was an asylum seeker, as it'd been termed before, then I would have just thought, It's just someone with a language barrier."

This can be linked back to the discourse strand around the genuine asylum seeker and this woman didn't conform in her behaviour patterns, "in seeming fine". However, the term genuine appeared to be judged differently with the pregnant asylum seeker, the need for care being more important than the authenticity of the woman:

li 4 r "I think once the baby's born, then it's, well, it's up to the authorities, isn't it, as to what the situation is back home, whether they should go home. She's still in a vulnerable position. She's got a new baby to care for. You don't want to be sending her travelling back to wherever she's come from straight away, just because, you know, she maybe wasn't genuine in the first place."

There was very little consideration given to how the needs of a pregnant woman seeking asylum may be different to those of a male asylum seeker, such as gender specific crime, which was discussed in chapter one (see 1.9). This is an issue explored further in chapter seven (see 7.2).

6.3.1 Physical needs

"Your normal role of the midwife, you do all your checks"

- Late booking
- Prioritise and speed
- Physical stress

6.3.2 Language needs

"We know enough".

- Respect foreign country
- Care without an interpreter

Research question 2

6.3 How do midwifery students' construct the pregnant asylum seekers' health and social needs?

6.3.4 Emotional issues

"The best way is to do minimal"

- Look for guidelines
- Professional boundaries
- Midwife's role limited

6.3.3 Social support

"It's not up to a midwife to sort it out, is it?"

- Liaising
- Limited role
- Offering advice

6.3 How do midwifery students' construct the pregnant asylum seeker's health and social needs?

When analysing the data to address this research question, four key issues were identified, relating to how the participants constructed the asylum seekers health and social needs. However, it was noted that differing amounts of time were spent discussing each of these areas. Consequently, the transcript constructed from the first PBL focus group interview was revisited and an estimation of how long participants discussed each area was undertaken. Around 26 minutes of the first PBL focus group was dedicated to discussing the physical aspects around pregnancy and the role of the midwife in meeting these physical needs. The concept of the asylum seeker, the confusion around this and the perceived difference between the asylum seeker, refugee, immigrant and illegal immigrant and benefit entitlements were discussed for around 21 minutes. The social and emotional needs of the pregnant asylum seeker took 18 minutes and language barriers and the use of interpreters, had only 7 minutes dedicated to this issue. The four areas which the participants used as the basis of their discussion around this research question were adopted to present the findings.

6.3.1 Physical needs “your normal role of the midwife, you do all your checks”

The priority when constructing the asylum seeker's needs appeared to be the physical aspects associated with the pregnancy. The largest proportion of time was spent discussing the midwife's role in relation to meeting these physical

needs. This was considered to be the "normal" role of the midwife, suggesting all other non physical care as extra, or an unusual aspect of the role.

Fg1, p8 " And obviously, your normal role of the midwife, you do all your checks, making sure everything's fine. Mum's, baby's fine. Making sure, you know, that you're not letting asylum seeker take over your perspective."

The use of the word "obviously" suggests that the normal role being the physical aspects is common knowledge and not something that was perceived to need learning. "Not letting asylum seeker take over your perspective" suggests that the woman being an asylum seeker should be put aside and not considered whilst doing these physical checks. This could be argued as reflecting the discourse around the asylum seeker as different (see 6.2.1) and the need to forget this difference when undertaking physical care. The word "check" suggests quick tasks that need to be completed and "your checks" suggests these are led by the midwife's needs rather than the woman's perception of her needs.

In addition, discussion centred around the fact that this woman was presenting late in her pregnancy and wasn't "booked"

Fg1, p8. "Well, she'll be a late booking, so everything should be checked out."

Describing her as a late booking suggests labelling her within a category. This category is outside the normal system of maternity care where the booking occurs early on in pregnancy. Participants discussed a number of medical issues that the woman should be "checked" for, including family history,

obstetric history, polyhydramnios and multiple pregnancy. It could be argued that these issues, together with the midwife's role to check for them, reflects a dominant underpinning discourse around the medical model of childbirth. This is explored further in chapter eight (see 8.2). In addition, being a late booking means the woman will have missed a lot of these checks.

Fg1, p11. "but like she won't have had any antenatal screening, so if she's coming from possibly a high-risk area...."

The term "high risk" suggests the need to categorise the pregnant asylum seeker according to medically defined criteria and change the care provided according to these. Gestation was a major concern in the discussion. One of the participants identified that this woman being a "late booking" had missed her dating scan and there was a possibility she could be post dates.

Fg1, p4. "We need gestation on there as well. She might know"

The term "she might know" suggests a lack of trust in the woman's ability to know her body and the need for an ultrasound scan to medically diagnose when the baby is due.

In addition, when discussing the pregnancy in the PBL scenario, Martha was described as being at a "critical stage". The participants discussed how you would prioritise what is most important if you have a woman at this stage arrive unbooked:

Fg1, p7 "It's whether we feel comfortable that we know what like what the most, to prioritise what needs to happen first if somebody's booking really late."

Fg1, p8 "The key thing you want to be doing is making sure you can send off her bloods, that you know, you're sending off stuff that you still can do and you're doing them as quick as possible."

Again, the physical care was considered the priority and speed appeared to be important. When prioritising care, it was the physical aspects that the participants considered most important, rather than the emotional, social or language issues which they discussed later. Again this reflects a dominant discourse around the medical model of childbirth.

Having completed a thorough brainstorm, the participants decided that they didn't need to generate a question in relation to the midwife's physical checks as they knew enough about this.

Fg1, p12. "Okay, so based on role of the midwife, I mean I think we've, we, we know what the role of the midwife is, thankfully, because we're going to be midwives."

Again, this suggests that the role of the midwife is to meet the physical needs of the woman, which the participants perceived they understood at this point in time, being in the second year of a midwifery programme. The other aspects of care; language, social and emotional, which have not yet been discussed, were not perceived to be the normal role of the midwife. In addition, when the issue around cultural needs was identified by a participant, this was classified within the physical checks undertaken by the midwife.

Fg1, p12. "Does that (culture) come under the heavily pregnant?"

When discussing emotional needs, this was also referred to in relation to the physical pregnancy. Medical research related to the physiological effects of stress was the focus of this discussion.

Fg1, p5. "You know the stress of all this moving countries and everything, would that have an effect on her, well, it will have an effect on her pregnancy"

Fg1, p2. "Yeah, there's definitely research being done in that."

Fg1, p10 "I found some research about stress and linking it to fetal development. And how stress, the woman's cortisol levels are very high. Apparently some research says that that can pass through the placenta and affect the baby's development once it's born. Usually in the toddler years."

Following this detailed physiological response to stress, the following learning objective was identified:

"How does stress affect pregnancy with reference to asylum seekers?"

However, in the second PBL focus group, the participants' response to this question, moved beyond the physical focus and incorporated the emotional aspects, focusing on issues such as post traumatic stress disorder:

Fg2, p9 "I just found that some asylum seekers, they get a lot of anxiety and stress with being sort of having all the social situations because they don't get a lot of money, so they're probably in poor housing. They get poor food, things like that. I found that a percentage of asylum seekers are actually already suffering from post traumatic stress disorder. And some of them are already suffering from what they've come from or they've just come here and then they start, like the signs and symptoms only start setting in once they're safe."

Some participants offered counter discourses to the medical model of childbirth.

They suggested there were other aspects to care beyond this medical focus:

Fg1, p3 "I were thinking something along the lines of what, what issues are there? Just in general, like cultural issues. Not just like the stress issues, but what general issues are there with having a heavily pregnant asylum seeker sort of land on your doorstep?"

This was clearly demonstrated in the discussion about female genital mutilation below:

Fg1, p 6 "What about, you know, like because she's coming from a different country, you know, there is like you know, the female genital mutilation as well, isn't there? I don't know if that country's..."

Fg1, p12. "Would that come under her health issues on the other enigma? On the other brainstorm, we put about her obstetric history and her, her health history"

Fg1, p6 "Yeah, but that's going to have an emotional impact on her as well, isn't it?"

In her written reflection, one participant discussed her experiences in practice in relation to caring for an asylum seeker:

R 8 "In this situation I felt like it was a normal partial booking interview whereby me and my mentor filled in the blanks that needed filling and we attended to the routine antenatal checks. There was only the initial mention of her refugee status when the interpreter mentioned why she and the other employee from the

gateway protection program was attending and after that it was not mentioned again,”

This quote suggests that in this clinical situation, the asylum seeker was assessed and fitted into the category of a “normal” booking. This is in contrast to the “abnormal” pregnant asylum seeker described earlier (see 6.2.1). In addition, the fact that she was an asylum seeker was set aside and the physical needs of her as a pregnant woman were met. This reflects the quote earlier, related to not letting the asylum seeker take over your perspective. The quote above is an example of this occurring in the practice situation. Again, this approach to midwifery care reflects a dominant discourse around the medical model and the role of the midwife in meeting the physical needs related to pregnancy.

6.3.2 Language needs “We know enough”.

Although in the first PBL focus group interview, the second issue to be identified related to language barriers, it was discussed for the shortest period of time; seven minutes and no learning outcomes were generated from the discussion. Most of the participants believed that they knew enough about the issue.

Fg1, p12. “I can’t think of a question to generate from there, other than we know there are language barriers. We know the importance of inter-professional communication. But do we want to generate a question from that?”

Fg1, p2. (interpreters) “Or, or maybe we feel like we know, we know enough so that we would be all right in the situation, so we don’t want to look into it.”

This suggests that language barriers were considered a low priority when constructing the pregnant asylum seekers needs. However, there were counter arguments to this perspective, participants who didn't agree with this:

Fg1, p8. (language barriers) "I'm not thinking from our point of view, thinking from their point of view, how does it affect them? If she can't, I, the, the question that I would have preferred if we can, if we can't, it doesn't really matter, I can look it up myself, but how does language barriers affect women in that situation?"

However, participants decided that this issue could be worked out with thinking it through logically:

Fg1, p10. "When you think about it this way, if it was you that went to a foreign country and you were heavily pregnant, you didn't understand what they were saying, maybe you, how would, how would it affect you?"

This quote appeared to be making a comparison between the language barriers that a pregnant asylum seeker may have to face with those of a tourist when travelling abroad. A discussion ensued around the possible language that Martha might speak. However, researching this was dismissed as a learning objective.

Fg1, p12. "I don't think there is anything on that one, is there? The language. Again, I mean we could, could do a question 'What languages are spoken in Sudan?' But there could be essentially - dozens. I don't think we'd get anything out of that"

The use of interpreters was the main issue discussed in relation to language needs and a debate followed around how the midwife could communicate with a woman if there was no interpreter available:

Fg1,p 12. "I don't think you could"

p2. Well, you're going to have to. Somehow you're going to have to communicate, aren't you? If you can't get an interpreter – So you're just going to say sorry I can't care for you?

p12 "Well no, you're not going to say that, but you'd have to, you'd have to get an interpreter. I can't see how you'd....."

Some participants provided examples of when they had to provide care without an interpreter present:

Fg1, p10. "We were all just miming like crazy - She did understand, yeah. She was like right, she did understand because some of the concepts are quite general, really. Like pain and things like that."

The example of miming used above related to pain. Again this reflects the underpinning discourse around the medical model and appeared to narrow down the midwife's role to just ensuring physical needs are met. However, it was argued that even if there wasn't understanding, providing care without an interpreter can be justified:

Fg1, p12 but if you're doing it for her benefit and you're caring for her in her best interests, that's as good as you can do, really, isn't it?"

Fg1, p5 "Like I guess some care is better than no care."

The term “in her best interests” suggests that the midwife has the power to decide what these are. Providing some care suggests that the care is physical rather than holistic. It could be argued that you cannot care for the whole person without communication as the emotional and social care needs could not be provided without an interpreter. The participants discussed whether there should be a learning objective in relation to this issue:

Fg1, p4. “I think you deal with it. If you have a woman who you really, you can’t get a translator for her, you’d mime it. You’d just do it there and then.”

6.3.3 Social support “it’s not a midwife to sort it out, is it”

The need for social support was the third issue to arise in the 1st PBL focus group interview and the discussion around this was interlinked with the emotional needs and discussed for around eighteen minutes. A learning objective was developed as a consequence of this discussion:

Sn “ How much social/ financial support is available for asylum seekers?”

The way the question was worded suggested that the participants were aware that there was some support, but it was the specific details that needed researching. The discourse strand around social support appeared to reflect the underpinning medical discourse and the midwife’s role being predominantly to meet the physical needs of the woman. Social support was perceived by some participants as something the midwife needed to be aware of, but it was not specifically the role of the midwife to “sort it out”. However, the midwife needed to be aware of social support and who provides this:

Fg1, p2. Would like the people that we would work with or liaise with, would that come under, or is it that role of the midwife? Because I'm thinking who would we need to know exists in order to...."

Fg1, p2 "how much do we as midwives want to know about what is available for her, like counselling or help with the benefits or help with making her asylum case?"

Fg1, p7. I'd want to know that if I was sat there with a lady that was in that situation, I would say, "Well, there's this really good support group down the road that's near where you live and there's this and I can find out for you.' I'd want to be able to offer her – not just the medical care"

The quote above appears to question the domination of physical care needs that was occurring. This counter discourse was reflected by other participants: *Fg1, p12. So would you say sort of role of a midwife, you'd be, got to be in the know how the system works? - points of contact, so it could be the midwife's offering the advice as well as to what she can, what she's eligible to claim for"*

The word "system" reflects the discourse discussed above (see 6.2.2) around the asylum seeker needing to be controlled, the system being the controller. In this context, the midwife could be considered an ally to the pregnant asylum seeker, understanding how the system works to help the woman out. However, "help" suggests that the power is with the midwife in the relationship with the pregnant asylum seeker. This relationship was considered a positive relationship, compared to that between the asylum seeker and immigration services:

Fg1, p3 "It's like the midwife is seen as a trusted person, so the, the, this woman in particular coming back and saying, 'Oh, can you help me do this? Can you help me with these benefits? Can you?' Because the immigration people were seen as the bad people."

6.3.4 Emotional issues "the best way is to do minimal"

This was discussed with social support, within the first PBL focus group interview. However, like language and social support, this issue was considered a low priority when compared with the physical needs of the pregnant asylum seeker. Indeed the learning outcome that resulted from the discussion around emotional needs was framed in a way that reflected the discourse around the medicalisation of pregnancy. As discussed above (see 6.3.1), the question referred to the physical effects of stress rather than the emotional wellbeing of the pregnant asylum seeker. In addition to this, when discussing emotional needs, medically constructed policies and guidelines were discussed:

Fg1, p2. "... it makes me interested in whether or not there are guidelines and policies that address the emotional needs."

As well as medicalising emotional needs, there was a discourse strand around professional boundaries and the importance of maintaining these:

Fg1, p8. "I'd probably be crying if I actually heard about such a woman before I went in to meet her"

p12. "You're meant to be there as an emotional support, not somebody who falls to pieces"

p2. She might be glad to see someone –

p12. *(Interrupts) You can do that when she's left the room.*

Participant two appeared to be about to comment in a positive way about the midwife showing emotion. However, participant twelve identified that the midwife shouldn't show emotion, alluding to professional boundaries. This was discussed further:

Fg1, p7 "...it worries me as well in that situation that you could, if you get caught up in the emotional side of things, you can start promising things that you can't necessarily –deliver. So I think it's about sort of do no harm in that side of things. You've got to be very careful how you remain, keep reasonably detached to a certain extent, otherwise you could end up, as you said, this, this particular case, can obviously get very attached to her."

There was a counter discourse to this, one of the participants wanting to follow through the midwife's role in relation to the emotional issues and leading to the acknowledgement that the midwife does have a role to play:

Fg1, 2. "Could we have, don't want too many questions, but just like a really basic question is like 'How best can a midwife counsel a, an asylum seeker?'

p7. "But this is not one of our jobs"

p12." And I think the best way is to do minimal"

p4. "If they come in and they're crying their eyes out, then you're going to help them, aren't you?"

p12. "Yeah, you're going to comfort them and reassure them"

These statements suggest emotional needs as a low priority in the role of the midwife. Not wanting too many questions, not one of our jobs and the words "comfort" and "reassure" suggest a very basic role in emotional support.

However, another participant adopted an alternative perspective, to argue her point about the emotional needs of the pregnant asylum seeker:

Fg1. p11. "I thought I read somewhere about asylum seekers being at greater risk from postnatal depression."

This contribution wasn't followed through and the participant sat back in her chair, crossed her arms and did not contribute any more to this subject.

Participant two had offered a counter discourse (see above) when suggesting a question around how the midwife can counsel a woman. As this was not followed up during the PBL focus group interview, this participant was asked a direct question in her individual interview, related to what she would see as the main priority of the midwife caring for a pregnant asylum seeker:

li 2 "To support that woman to have as much of a positive experience of having children as, as possible. Yeah. Support. Supporting her as opposed to having specific goals of my own as a professional. That's what I see as, that's what I would feel is my key role, so the, sort of I would be, probably half my work, at least half my work would be trying to glean from her what, what the, what her priority needs were that I could try and support her with. The rest of it, well, I mean I guess just assuming that there might be language issues. Trying to take a really good history. An obstetric history and I guess just her general well-being history, you know. As much of her story that she wants to share. To try and,

yeah, just more about finding out what she needs rather than assuming what she needs. I guess it starts with people"

Support in this context suggests emotional support and this participant offered an alternative perspective of prioritising the woman's perceptions of her needs rather than the midwife's perceptions. "Starting with people" could be argued as a counter discourse to the discussion so far, around prioritizing the physical checks undertaken by the midwife, which has been referred to so far in the students' constructions. Obviously, to identify the woman's perceptions of her needs, the midwife needs to be able to communicate with the woman. Therefore, coming from this perspective would suggest language needs as paramount.

An issue referred to very little in the discussion about the pregnant asylum seeker's health and social needs but forming a learning outcome for the study was around cultural issues. The learning outcome from this was:

Sn *"What is Martha's social and cultural background?"*

As discussed earlier (see 6.3.1), culture was classified as being related to heavily pregnant but wasn't brainstormed separately in the SMART notebook. However, it did form part of the brainstorm around the midwife's role and the emotional issues, where the issue of culture shock was discussed:

Fg1, p3 *"Coming to a different country, where different things are happening in different ways."*

As well as showing sensitivity to cultural needs, this contribution reflected the underpinning discourse around the asylum seeker as different or a foreigner (see 6.2.1). The midwife was perceived to have a role in meeting cultural needs: *Fg1, p12 "I suppose role of the midwife, understanding cultural differences."*

A discussion followed about understanding cultural differences of women from so many different cultural backgrounds. However, this is discussed under the next research question under contextual learning (see 6.4.3).

6.4.1 Questioning dominant discourses through reading
"It's not so surprising then that people have these stories"

- Sources of material
- Dispersal
- Detention
- Refusals

6.4.2 Questioning prejudice in maternity services

"I didn't challenge anybody"

- Labelling
- Handovers
- Time and social pressure

Research question 3

6.4 What are the implications of students' constructions for midwifery education?

6.4.3 Rethinking approaches to midwifery care

"It's like going back centuries and centuries you know compared to how we live isn't it"

- Compared to teenagers
- Individual v Context
- Reliance on guidelines
- Country of origin

6.4 What are the implications of students' constructions for midwifery education?

6.4.1 Questioning dominant discourses through reading "*It's not so surprising then that people have these stories*"

During the course of the second PBL focus group interview, as the participants discussed their findings to address the learning objectives, it became apparent that they had learned more about asylum seeking from their reading. The language that some of the participants used suggested that they were beginning to construct alternative versions of reality around the dominant discourses discussed earlier (see 6.2). Negative adjectives including "horrible, awful and ridiculous" were used to describe their reaction to the new information that they had found through their reading. This section will explore these findings and the implications of these for midwifery education.

During the first focus group interview, the participants expressed the public perception that asylum seekers come to the UK due to the generous benefits. However, after participants had read around this issue, the following perspective was contributed:

Fg2, p3 "the amount of money that asylum seekers are getting. I, I was quite horrified at how little it is. How are they supposed to support them, family and a child with that amount of money?...It's like the passport-sized photos. It says you've got to take four passport photos of each person you're claiming asylum for. Have you seen that? Have you seen how expensive passports photos are?"

However, not all the participants agreed with this perspective around financial support; one participant compared the benefits for an asylum seeker to those that UK residents who are unemployed can claim:

p5 "Yeah, and people on income support, they have to pay their bills, electric bills and the rest of it, so in a sense, they're (asylum seeker) actually better off if you think about it. And also our woman, she's pregnant, isn't she? She could actual claim for the £300 maternity committee payment."

Although the asylum seeker can claim additional financial support, whether this occurs in reality was questioned by one participant:

Fg2, 8 "Well, just socially, a lot of asylum seekers aren't getting the support that they could, you know, that anyone generally would be able to get support because they're not being informed about it or they don't know where to go or they can't travel that far out, you know, depending on where they're living. So I mean the Refugee Council were criticising the government quite a bit."

This participant had constructed this perspective through reading literature from the Refugee Council, the largest non government organisation working with refugees and asylum seekers. This compared to the other participants, eight of whom accessed the UK government websites to learn about social support. It could be argued that midwifery educators encouraging the exploration of alternative sources of information could facilitate the opportunity to explore counter discourses around asylum seeking.

In the first PBL focus group interview, there was the perception that asylum seekers are provided with housing. This was discussed again in the light of new knowledge constructed by one participant:

Fg2, p2 "It says here that they're given housing, but not, but people, I know for a fact people who they're not because Short Stop which is run by an asylum seeker support group in Leeds, where people privately just let an asylum seeker come and stay for a night or two."

Again, this questioning of the discourse strand around the generous welfare system was as a consequence of a participant accessing a local charity website. In the first PBL focus group interview, the dispersal of asylum seekers around the UK was not discussed by the participants, which suggested that they were unaware of the policy. Through their reading, they had learnt that this happened and the fact that asylum seekers could be sent anywhere in the UK:

Fg2, p10 "They're shipped out to anywhere, aren't they; horrific"

Participants learned that through the dispersal policy, pregnant asylum seekers that they may care for, could be living in a place that they have not chosen to live in and one which they are not familiar with and may not know anyone else living there. Living in detention centres was another issue that the participants had only briefly highlighted in the first PBL focus group interview, suggesting a lack of knowledge about this. However, during the course of their reading, they learnt a lot about detention and detention centres and a detailed discussion followed around the impact of detention on asylum seekers:

Fg2, p8 "I found how asylum seekers are put in detention centres and if, if there's not space in detention centres, they're put into prisons...that's awful and then that can lead to asylum seekers because their initial step when they come to this country is freedom, but then they feel imprisoned."

Fg2, 2 "People just not, not decent access to healthcare and the stress of being a child in detention or your partner being in detention if you're pregnant."

In addition to being held in detention centres, students discussed how asylum seekers were expected to comply when told that they were being moved somewhere else at short notice:

Fg2, p3 "when they seek asylum, they might be put in temporary accommodation or a, a detention centre. And she were talking about women being told, Right, you need to be ready at eight o'clock tomorrow morning. We're taking you somewhere else and not being given very much notice. It's like, well, pack up anything you can carry. Leave everything else behind and be on this bus in the morning. And they don't know where they're going until they're on the bus."

Fg2, p3 "...two pregnant women being placed in the same place. And they were comforting each other and they were really supporting each other. And then before one of the babies was due, they got split up with only couple of days notice and sent to different places. And it really thought, you know, finally these women have got some support and then when they make a friend and they've got somebody who knows what they've been through. And they get separated. I think that's awful."

Fg2. P3 “.. a woman that, women being moved at various stages of pregnancy and after birth, but one woman was even moved while she was in labour. She was moved from one detention centre to another.”

P6 Oh my God.

The reaction from the participant above suggests that she wasn't previously aware that pregnant women could be forced to move at short notice. This construction of reality around the use of detention was as a result of one participant reading work by Sheila Kitzinger, a midwife and social anthropologist campaigning to give a voice to pregnant women in custody (Kitzinger,2006).

In the 1st PBL focus group, there was a discourse strand around concerns at the volume of asylum seekers coming into the UK. After reading around the issue, a counter discourse strand was presented:

Fg2, p3 “I was quite surprised at how many people, when you, when you sort of hear politicians and people in the news going on about, ‘Oh, let everybody in, we’ll let anybody in. We’re open to all.’ And I found a chart in one of the books, which told you how many people actually were gaining asylum and I was quite shocked at how many people were refused.”

However, there was still an underpinning belief that the numbers of asylum seekers needed to be restricted, even if this was based on geographical inaccuracies:

li 8 I don't know. It's, it's, but what can we do? Can, it's the space, isn't it? In the UK, we're the smallest island in the world and everyone's wanting to come

here, and how many do we let in? It's like who do you vote for? Gordon Brown, who wants to let a certain amount of people in and, you know, just make sure that there'll be enough space. Clegg, who wants to make sure they're living where they can get jobs and everyone else has got a job. They're not preventing them. Or then we've got Cameron, who's now saying, 'We're going to put a cap on them. We're going to let a certain amount in.' So after that certain amount, what do you do to those people that, you know, that are having severe, you know, severe crimes committed against them? Do we say, 'That's it, go back home and live the rest of your life being beat up or killed'?

In addition, participants read around issues specifically relating to being refused asylum:

Fg2, p3 "another one really upset me, where she talked about a 52-year-old woman who'd been refused asylum because she couldn't possibly be at risk of rape because she was too old. But while I was reading that, it was on the news about that pensioner being raped in (large city) and the guy being put in prison, and she was 82 year old. And I thought, 'How can they say that she's too old?'

p11 "Shocking"

p2 "That, that makes me so angry."

Fg2, p10 "I did look at a few stories where there were women who didn't have proper legal representation because they couldn't afford it, and their case was just like thrown out and it was made a, just like made a mess out of it and things, so it can be quite hard for them. And it's all waiting, waiting, six whole months, it's a long time."

The language used above could be interpreted as a strong negative reaction to what they were reading through words including “shocking”, “upset me” and “angry”. In addition was the realisation that failed pregnant asylum seekers were expected to pay for maternity care that they received:

Fg2, p4. 'Maternity services should always be classed as immediate necessary treatment and provided even if the pregnant woman is unable to pay in advance. As with other immediately necessary treatment, however, the patient remains chargeable if they are not eligible for free hospital treatment and reasonable steps should be taken to recover the debt.'

P5 "I wonder what that means"

P4 "I know, that's what I thought. I dread to think"

P7 "Send around the heavies"

The asylum interview was discussed in relation to the new material that the participants had researched which appeared to question the underpinning discourse around the asylum seeker as a criminal:

Fg2, p8 "It's quite, yeah, very strict. And unless they've got, you know, a lawyer or someone to tell them that all beforehand, and that's their only chance of..."

Fg2, p2 "It's not so surprising then that people have these stories because the only way to find out what you need, what you're supposed to do when you get somewhere is by asking everybody else who might have heard that- from somebody else, it's happened, you know, so you're relying on..."

P3 "It's like what you were saying that some people all have same story. That's probably why because it gets passed on this worked. This worked for me. Tell them that. But if you don't tell the right story when you get to the port, the port

authority, the authorities then make the decision whether or not –What, however many months it's taken you to get to that point. You just don't want to risk it, do you? If you can"

However, a counter argument was offered in relation to this process, suggesting an element of choice for the asylum seeker:

Fg2, p7 "I think the other side of that, though, you have to bear in mind that they're fleeing apparently a, a life-threatening or oppressive situation, so to be stuck in limbo in this country for a few months, they've chosen to do that. And that's obviously a better option than being in their war-torn country or being raped or oppressed because they've got different beliefs or whatever And so on that side of things, I think, well, this is a choice that you've made. That's been forced upon you, yes, but you're here and we're giving the opportunity for you to have refugee status, yeah. And I think six months, I thought that was, if they get it done within six months, but I think that's probably quite reasonable."

This section has argued that by midwifery educators encouraging students to read alternative sources when learning around an issue that could be perceived as controversial, then alternative constructions of reality can be presented which could challenge underpinning dominant discourses. This will be discussed further in chapter nine in relation to the development of a new model for midwifery education (see 9.3.2).

6.4.2 Questioning prejudice in maternity services “ I didn’t challenge anybody”

As discussed in chapter five (see 5.7.1), to avoid possible ethical dilemmas arising in relation to substandard care being discussed, this study was limited to the informal “talk” that occurs in the NHS away from the woman being cared for. It was beyond the ethical boundaries of this study to examine any impact of “talk” on clinical practice.

During the 1st PBL focus group interview, the words “prejudice, stereotypes and racism” were used by two participants when discussing maternity care provided in the NHS. However, these issues were not followed through within either PBL focus group. Consequently, during their individual interviews, the two participants were questioned further about these issues. They were asked to explore why they raised these issues in the PBL focus group in relation to “talk” in the clinical area:

lib “A lot of people are prejudiced, but they don't realise they are. And when you say that to them, they're like, 'Oh no, oh.' And then when you tell them, they're like, 'Oh really? I don't, I didn't realise that.' Sometimes they don't realise they're coming across a certain way, or you know...everyone has their own personal prejudice, but then you have this like a group prejudice as well, which when you discuss it with someone else, they're like, 'Oh yeah.' And it happens in every, I mean it's not just the NHS. It happens in every institute.”

Both participants were asked how they thought that they knew that there was prejudice within the NHS:

li 2 "I suppose I know that because I feel like I've witnessed people saying things that I think are prejudiced...in group situations, in NHS staffrooms, and it hasn't gone challenged by anybody, travellers; making assumptions about why they'd come into this particular hospital and why they might have, because they'd been to another hospital previously, and so it was just making assumptions and, and generally joking about their situation. And a time I can remember was midwives talking about, about how all Asian men bugger their children. And it was half-joking, but yeah, there's just a couple of examples."

li 8 "By a certain midwife that's really busy, that's so frustrated, so overworked. We're short-staffed today. We've got to do so many discharges. Delivery suite's ringing up, wanting to book so, so and so. We've only got so many beds. We want to get them, you know, we've got to get people out and then someone buzzes. Can you help me to...? Some buzzes. Can you change a baby's nappy? Someone buzzes, same person buzzes and then you're doing that as long as, with everything else. And they get frustrated. Oh, she wants it all. She wants me to do everything. She's a princess and then that woman's looked at as princess by the whole unit for the rest of her stay there, even though she might not be"

Handover appeared to be the time when these opinions were revealed:

li2 "Yeah, so you do handover and talking about different people's foibles and having a bit of a laugh and getting through it Because we're all under so much pressure. Yeah, to lighten it a bit and to also I think there's a kind of a jokey, sometimes a jokey style of handover, where you're kind of pinpointing either the troublemakers or the people you need to get out of the ward as fast as possible

or the people who you think are really sweet and actually aren't any bother. And the way that this woman was handed over was kind of part of that style."

li8 "... in handover, it's heard, when they're in handover, 'Okay, room three, yeah, we've got a princess in there who wants you to do everything.'

These opinions appeared to be aimed at any woman and not particularly asylum seekers. The participants were asked specifically about this:

li8, "Anybody. Any behaviour. You know; if it's just something we're frustrated with at that time, just say something. And to make yourself feel better, to make yourself calm down, but in a way, you're doing that, but you're labelling another person. And then making everyone else perceive that person in that way."

li8, "Ethnic minorities, like South Asian families. And like in postnatal care, if, if they're being a princess or if they're being, you know, if they're not, if they're wanting you to give the baby a bath and feed the baby because they can't get up, then people call them princesses or precious or you know, drama queen."

Participant two went on to describe a situation that she had come across when a pregnant asylum seeker was talked about:

li 2 "I felt under time pressure and social pressure. I didn't challenge anybody about people seemed to be talking about her in a fairly uncaring way And I was assuming that she will have experienced some sort of trauma. I didn't ask her about that or talk to her about it. I wasn't working with her for very long. So I suppose it was partly the time pressure and the social pressure....And like there was, there wasn't much trust in the air. There was, it's like, 'Well, why didn't she

tell me her real birth date? And why, why has she got so many names? And why does she laugh hysterically when, when we talk about these issues?’

These findings have obvious implications for midwifery education. They are explored further in chapter seven in relation to underpinning dominant discourses (see 7.5). Educators need to ensure that students are equipped with the skills and knowledge to tackle these issues in clinical practice. This will be discussed further in chapter nine in relation to a new model for midwifery education (see 9.3.2).

Participant two offered ideas on how the clinical area can be tackled to change this culture of prejudice:

li2 “Have more midwives. To take that pressure off. Wouldn’t on its own change culture but but without that, it’s quite hard to make changes, but I don’t think we can wait for that either Okay, so that would be helpful, but we can’t wait for it.”

li2 “Supervision. I think people who notice this happening being supported to change their own practice and maybe change the culture a bit that way. I mean I guess the things that I can imagine making a difference take time and that’s why I feel like we need more midwives so that you can have that time to do it,”

li2 “more reflection, more sort of reflective practice and everybody being encouraged to do that from like at all levels in the ward.”

The ideas will be discussed in the conclusions chapter (see 10.7.3) in relation to recommendations for change to clinical practice.

6.4.3 Rethinking approaches to midwifery care “It’s like going back centuries and centuries, you know, compared to how we live, isn’t it”

This chapter so far has presented findings which have discussed midwifery students’ social constructions of the pregnant asylum seekers. The emphasis of these constructions appeared to be on the physical needs of the woman and the tasks that the midwife has to complete to meet these needs. Social, cultural, emotional and language needs appeared neglected at the expense of the physical needs. In addition to this, when exploring the needs of the pregnant asylum seeker, meeting these needs was compared to those of a pregnant teenager:

Fg1, p12 “Because we do advise teenagers on what is, what extra things are available to them and - so it’s only fair that we know about for asylum seekers. We can’t assume they have been told about everything.”

This suggests that this participant perceived that there was a comparison between different groups of women who are categorised as having extra care needs. To follow this comparison through, the data from the first PBL focus group was revisited and the term “pregnant teenager” was inserted into the original transcripts at every point where the term “pregnant asylum seeker” had originally been written. This was to consider whether the transcript still made sense when talking about a woman with different but specific health and social needs. The learning issues around asylum and language and cultural needs did not relate to the pregnant teenager, but the other learning issues could still be applied.

The discussion around "Heavily pregnant" was still relevant, as it discussed the physical needs of a woman who booked late and the tasks the midwife needed to complete, to meet these needs. In relation to social support, all the issues discussed still applied; assessing family support, eligibility for benefits, liaising with outside agencies and the need for housing. This was the case for emotional issues where "prejudice, stress, lonely and isolated and professional boundaries" could all be applied to the pregnant teenager. This apparent focus on a generic assessment of women, rather than examining the specific needs of the individual women will be explored further in chapter eight (see 8.3).

Another detailed discussion that took place related to the way that a midwife should approach the care of the pregnant asylum seeker in a different way. This was started by a participant questioning how your approach to care would be different to other pregnant women:

Fg1, p3 "what issues are we going to have to deal with? Like, like you've got the language barriers. You've got the cultural differences. She might be traumatised. You've got, there's quite a lot of issues there, which I know come under stress, but they have effects, not just stress-related, they have effects sort of with all your logistics and things, if you like. Do you know what I mean? How you care for her, would you care for her differently?"

p12. "Think it'd be on an individual basis. Wouldn't it? I don't think you can generalise how you would care for asylum because they're, they're all going to be, they're all going to have their own different experiences. Some less traumatised than others. We can't assume they are traumatised by, you know..."

p3. "There must be something out there that says they might have this need that need".

p8 "But then you've putting them all in a box. and we need to be staying open-minded...provide appropriate care according to the woman"

Participant three saying "there must be something out there" suggests that she was searching for something concrete to help her understand the care needs of the pregnant asylum seeker. The other participants talked about a woman centred, individualistic approach. The discussion moved onto discussing the specific example of culture, to illustrate their perceptions of how they should approach care:

p12 "I suppose role of the midwife, understanding cultural differences

p4 "You can try and do that to a certain extent, but you can't know the cultures of everybody. She's arrived from Sudan, could be somebody from somewhere completely different. You learn as you go along, I think."

p8. "Even each culture has different cultures"

p2. "I think you do, you tend as a midwife to work in an area, don't you? And then they tend to get certain groups of people. So you can educate yourself, can't you?"

However, participant two offered a counter perspective questioning this individualised approach:

p2. "Sometimes we can, we can kind of push away the work by going, I just deal with somebody as a person, you know. With, and that means I don't have to learn about cultures and I don't have to learn about general counselling skills

and I don't have to learn about, about ways and skills for, for dealing with people from different cultures because you know, I just work on a one-to-one basis. And I think that means, I don't know, for me, that means that sometimes I can just, just, yeah, just kind of think, 'Oh, I'm being nice to somebody.' But maybe actually from their perspective – I'm getting it all wrong"

Participant ten offered a solution to these different perspectives. She suggested to participant three:

Fg1, p10. "You could say are there any maternity guidelines in relation to asylum seekers"

Participant three accepted this solution although she identified in the second PBL focus group that she:

Fg2, 3 "Couldn't find any specific guidelines. Found articles about sort of maternity care for asylum seekers, but more about what, what tends to happen, rather than what's, you know, this is how it's supposed to be done."

It appeared from the solution reached in relation to this issue, that when the students were presented with an issue which had no clear guidance, then they defaulted back to something concrete and familiar, guidelines which instruct the midwife what tasks to complete when a woman presents with a specific issue; usually a physical issue. This is explored further in chapter eight (see 8.3).

As this issue had been worked through and resolved during the PBL focus group interviews, participant two, who presented an alternative construction to

approaching care did not discuss her perspective any further. Consequently, she was asked to explore this issue further within her individual interview:

li2. "I suppose how I feel is that all individuals exist within a context. So, and in, I suppose in Western culture, we're quite interested in the individual as a consumer But I don't really see people, it's not as simple as that. I think that's why I'm torn is because it is a constant balancing act and taking into account someone's context and the fact that you can't make any assumptions"
"And I don't think there's any easy getting round that, but that you have to be aware, I suppose. And, and that it doesn't, I don't think it does any harm to try and educate yourself about, about cultures that you don't have any experience of if you're coming into contact with people from those cultures. It doesn't mean that you're going to be, that you have to be, that you have to make more assumptions about a person just because you understand a culture that they come from a bit better Yeah, I think it might even mean that you make less assumptions Because yeah, because you understand the background a bit more."

This suggests that it is important to learn about a person's context in order to understand the care needs of the individual woman. This is what the students appeared to do when identifying learning objectives in relation to the PBL scenario; Martha's health and social needs. One of the objectives was:

Sn "What is Martha's social and cultural background (Sudan)?"

From the language used when feeding back this learning objective, it could be argued that students came to a realisation of the experiences that the asylum seeker may have endured:

Fg2, p5 "Well, looking at the map and Sudan to England, oh my God. Have you seen, you know, how far it is? The trauma it is, and it's like how on earth did they arrange the transport?"

Just "looking at a map" seemed to provide this participant of some understanding of what Martha may have experienced to get to Hull. In addition, participants had researched Sudan as a country, its history and why someone may be seeking asylum from there. They examined the poor economic situation within the country, the low life expectancy of 45 years, the ongoing civil war and the starvation faced by the population due to economics and drought. One participant highlighted that colonialism by the UK may have started these problems:

Fg2, p2 "So having, having sort of used that country for our interest, it does seem a bit like maybe we should take some responsibility in looking after....."

One participant brought an article into the group which she used extracts from to describe the experiences of a woman asylum seeker and her need to flee from the Sudan:

Fg2, p3 "She talks about people being raped, houses being set on fire. She had to flee her, the, the, she calls them the devil riders who came on horseback with machine guns into the village, and they literally just shot everyone. They set the houses on fire and the women and children ran. And there were children being

given babies and things and said, 'Take your brother, take your sister. Just run.' And the men stayed behind with daggers to try and defend the village. And then they came, they went and hid in the woods and then they came back and all the men were dead. And she ended up having to run because she was seen as, can't remember what word she uses, but she was seen as, because she was educated, she was a doctor and she was trying to help people and she was trying to tell like the UN what was going on and things, she was seen as a rebel, if you like. So they came after her. So that's why she ended up in the UK."

The topics of human trafficking, slavery and forced prostitution were discussed and one participant linked this back to asylum seekers:

Fg2, p2 "Oh, that's disgusting. Those are refugees and asylum seekers"

The words "those are" suggests that this participant realised what asylum seekers from the Sudan may have been through before arriving in the UK. However, they also reinforce the discourse around asylum seekers as foreign or different (see 6.2.1). In addition, discussing asylum seekers and refugees in the plural suggests categorising them as one group of people rather than considering them on an individual basis.

The implication of the asylum seeker's life in the Sudan was discussed in the context of the pregnant asylum seeker:

Fg2, p3 "particularly talking about Sudan quite a lot in that, weren't it? It were talking about torture rooms as well being given medical names so women will be

terrified to go into hospital because if they've been tortured, they may have been tortured in a room that's called the operating theatre".

In addition, asylum seekers who are pregnant as a consequence of rape were discussed and how accessing maternity services in the UK can retrigger these memories:

Fg2, p8 "Retriggers of everything, especially if that woman had been raped and the child is, you know, a, a product of that rape, yeah. That chapter, I've read it and oh my God, some of the women, they, they keep on talking about, they refuse the baby and they'll give it away or something. The baby's evil. Take away some, this bad thing inside me. Take it away and you know. They believe that if, there was something about once they'd been raped, they believe that any baby they conceive after they've been raped would be born evil, even if it's conceived out of love because their insides have been contaminated."

Again, the response suggested the participants' realisation of the experiences that the asylum seeker may have endured:

Fg2, p2. "Oh, that's awful".

Fg2, p3 "It's just horrific".

One of the participants attached photographs of the Sudan in the intranet discussion area.

Fg2, p5 "God, it's like going back centuries and centuries, you know, compared to how we live, isn't it?"

*Fg2 p5 "It must be quite shocking then coming over here. To see the traffic
Buildings, tall buildings, cars"*

The participants discussed the psychological impact of being an asylum seeker in the UK:

Fg2, p8 "There's a scale of judging who's got stress and there's like, I think there's loads, there's loads of factors taken into account. And the major ones are like life-changing events, moving house, never mind moving country, if you've got dependents, if you've, if, if you're alone, if, you know, if you're independent, if, if you've got a job, if you're bereaved I'm just thinking for an asylum seeker, majority of those would definitely be ticked. And then we've got at the bottom of that list natural disasters and war"

Learning about the context of the asylum seeker, where the pregnant asylum seeker had come from and what she may have experienced, appeared to reveal to the participants the reality of her situation. This is something that was highlighted by the participants during the course of the 2nd PBL focus group interview:

Fg2, p3 "I think it kind of gives you an understanding of what these women might be coming from as well because you, you kind of make assumptions about, and what, what I'd read is far worse than what I thought and it just shocked me, really."

li 8 "I'd heard of them and that's about it. It, it was just a general someone's come here from a poverty stricken area and they need help. I wasn't aware of

what kind of problems they come across until, you know, until come here and we had a discussion and stuff."

li 4 "if I did come across asylum seekers, I feel, I'd feel like I knew a bit more about them. Because you do hear a lot of bad press, you know, people sort of, 'Oh, they're coming over here, you know.' All that kind of stuff and obviously, I don't like that anyway, but hearing a bit more about background would make me more understanding in the future as well."

Fg2 p7 "It's a warped view. A lot of the papers and stuff very unfavourably report and I think it's been dumbed down a lot, what they're escaping from. It's only when there's situations like Rwanda and you're sort of more involved or you can see what's going on. But the Sudan's been going on for years and -- and it's just not, and everyone's like, 'Sudan what? I know it's somewhere in Africa.' I was sort of a bit desensitised. So yeah, it was good."

This participant continued by describing a clinical experience of caring for an asylum seeking family and how learning about the Sudan had led to her interest in knowing more:

li 7 "The father was still in wherever country they'd come from. Didn't ask. And it was interesting. He had loads of scars all over his face and I was really itching to say, 'Want to know your story. Talk to me. Tell me what happened here.'

Learning about the context appeared to impact on the care one participant provided in the clinical area, when faced with a woman who had previously been labelled as a "princess":

li 8 " it's not been, 'Okay, she's a princess.' It's been, 'Okay, what's going on? What's the story behind her because there's a story behind it?' So it's finding out that story. In that sense, it's made me more, well, less judgmental, I hope."
Yeah, it has.

However, this participant was concerned that learning more about asylum seeking had led to her making too many assumptions about what a woman may have been through:

"...but then I think has it made me overly prepared in the case of where I'm thinking, 'Oh, you know.' I'm thinking the opposite now, rather than treating as a, as a woman. I'm treating her as a, oh, she's been potentially, you know, God knows what's happened to her. Am I, am I treating her too fragile, you know?"

This links back to the comments made by participant two earlier in relation to learning about the context of the individual. She discussed the:

li 2 "constant balancing act and taking into account someone's context and the fact that you can't make any assumptions"

This has implications for midwifery education. The discussion above around participants learning about the Sudan and realising the difficult experiences that Martha may have had, suggests the need to address context within midwifery education. However, the comments above, about needing to balance the context with the assumptions that could be made, suggests the importance of rethinking approaches to midwifery care and how education can help to facilitate

this balance. This is explored further in chapter eight in relation to “midwifery” discourse (see 8.4)

6.5 Conclusions

This chapter has presented the findings from this study and discussed them in relation to the three research questions. It has included quotes from all the data sets and demonstrated a social constructivist interpretation of methodological triangulation and how different perspectives and depths of data can be examined from this strategy. It has also considered group dynamics and included specific examples of when these may have influenced the findings. Throughout the chapter, quotes have been included which can be argued as containing language, which reflects the influence of underpinning discourses. These discourses will be explored further in chapter seven and eight.

The key findings which have arisen from this study relate to the way that the pregnant asylum seeker has been constructed. Although there appeared to be counter discourses, the findings revealed underpinning dominant discourses around the asylum seeker being foreign or different and of a criminal persuasion. Being pregnant did not appear to influence the presence of these discourses, however, the pregnancy was considered the fundamental concern and the woman was perceived to be deserving of midwifery care. There was little discussion of alternative constructions of the pregnant woman and how her reasons for seeking asylum and her needs may differ to those of a male asylum seeker. These issues will be discussed further in chapter seven, with an

exploration of the sources of these dominant discourses and structural issues influencing their (re)production (see 7.4).

When approaching midwifery care, the participants' priority appeared to be the physical needs of the pregnant asylum seeker, reflecting an underpinning dominant discourse around the medical model of care. The findings suggested that the midwife must undertake checks to ensure the physical wellbeing of the woman. Language, social, cultural and emotional needs appeared neglected as a consequence of addressing the physical needs. The medical domination of midwifery care will be explored further in chapter eight with a focus on how medical discourses may be (re)produced within contemporary midwifery practice (see 8.5).

The findings revealed participants apparent confusion in how midwifery care should be approached and whether it is important to consider the woman on an individual basis, or whether to consider her context in the way that care is approached. This will be addressed in chapter eight (see 8.4).

When comparing the findings from the first and second PBL focus groups interviews, some participants had selected and read literature, which appeared to influence their perspectives on asylum seeking. This has implications for midwifery education in encouraging the questioning of discourses by reading alternative sources of material. This will be explored further in chapter seven, when discussing the way forward (see 7.7).

The findings revealed a perception of prejudice in the NHS, in the way that some women were talked about in the clinical area. Some participants highlighted situations where they had overheard talk that revealed underpinning prejudices in the staff in the clinical areas. This is explored further in chapter seven in relation to dominant discourses around asylum seeking (see 7.5) and chapter in nine with a focus on how to tackle this issue through the development of a new model for midwifery education.

The following chapters will now move on to discuss these findings in more depth and use supporting literature to develop an argument as to how midwifery education can address the issues raised. Mason (2005) suggests that in order to construct analytical arguments, you should return to the intellectual puzzle, not to try to simply answer the question but to use it to focus the arguments. For this study, the intellectual puzzle related to why pregnant asylum seekers had poor experiences of maternity care. Chapters seven and eight will explore the discourses perceived to be dominant and how they may influence the care provided to pregnant asylum seekers.

Chapter 7: Discussion

Dominant Discourses and the Midwife

7.1 Introduction

To construct a discussion from the research findings, Mason (2005) suggests returning to the intellectual puzzle developed for the study (see chapter three; 3.4 for more detail of this). This is to ensure that the discussion remains focused on the questions originally posed in the preliminary stages of the research process. To address the intellectual puzzle related to this study; why some pregnant asylum seekers may have poor experiences of maternity care, the discussion is divided into two chapters. Chapter seven will focus on a discussion around the perspective that these poor experiences may be due to the way that the pregnant asylum seeker is socially constructed by midwives. Chapter eight will concentrate on the way that midwives approach their care provision and how this may have influenced pregnant asylum seekers' experiences. Both chapters will present examples of findings from this study, which will be supported by other literature to develop an understanding of why some pregnant asylum seekers may have poor experiences of maternity care.

Discourses exercise power in society because they institutionalise and influence ways of talking, thinking and acting (Jager and Maier, 2009, p. 35). It can be argued that a combination of entangled influential media and political discourse strands, create a powerful dominant discourse which influences the way people talk and think about the asylum seeker. These discourses are (re)produced through social interaction and construct a particular version of asylum seeking.

Pearce and Stockdale (2008) assert that the mass media plays a powerful role in (re)producing dominant ideology and its discourses around asylum seekers through the use of negative stories in the popular press, which then influence the public and arguably midwives perceptions. Indeed, McLeish (2002) found that the midwives in her study appeared to reflect the negative opinions of the general public about asylum seeking. In addition, Gaudion and Allotey (2008) found that the only information many midwives had gleaned about asylum seekers had originated from the media.

Chapter six identified four discourses that were perceived to influence the midwifery students' constructions of the pregnant asylum seeker. However, these discourses were entangled and overlapped. Therefore, this chapter will focus on two of the discourses identified in chapter six, but which arguably contain discourse strands from all four discourses; the asylum seeker as different and being of a criminal persuasion. This chapter will argue that they are (re)produced from powerful sources, the media and political locations through social interaction and that midwives' constructions of the pregnant asylum seeker reflect these underpinning dominant discourses. The consequences of these constructions can then be considered in relation to clinical practice and the way that midwives may talk about pregnant asylum seekers, which in turn could influence their experiences of maternity care and students' learning. However, when discussing power sources within society, this will be argued from a Foucauldian perspective in which power is exercised in multiple social locations (Fawcett and Featherstone,2000). This chapter intends to explore only

some locations to provide an insight into how power may be exercised to influence dominant discourses around asylum seeking.

7.2 Discourse around difference

The findings from this study revealed an underpinning dominant discourse around the asylum seeker being foreign or different; see chapter six (6.2.1). This difference was expressed in a negative way, through the language used by the participants such as “*our country*”; “*What are they doing here?*” and “*separate*” (in relation to welfare benefits). There was no evidence of an alternative discourse existing when considering the pregnant asylum seeker. Although she was considered “*vulnerable*” and “*deserving of care*”, the language use still mirrored this perceived difference.

This perception of the pregnant asylum seeker as different was reflected in other studies. Gaudion and Allotey (2008, p. 23) undertook a study examining the perceptions of midwives, working in Hillingdon, near Heathrow airport, about pregnant asylum seekers. The language that these midwives used to describe the women suggested this idea of difference. Quotes included “*those people from Heathrow*” as opposed to the “*white British population*”. Similarly, McLeish (2002, p. 38) found in her study that terms reinforced differentness such as “*these Africans*” were used when discussing pregnant asylum seekers.

The findings related to midwives perceptions of pregnant asylum seekers are comparable to studies examining the perceptions of the general public about asylum seekers. Lewis (2005, p. 33), undertook the largest study that could be

found around this topic, undertaking thirty two focus group interviews across five areas of the country. This study found that asylum seekers were perceived as different, some participants describing them as those "*people with a different skin colour*". Those people had "*destroyed our communities*" and were undermining British culture. Ward's (2008) study, which interviewed some of the local population of Coventry, also included direct quotes reflecting the asylum seeker as different; quotes including "*get 'em out and lets have our country back*" (p. 24). The language use here suggests that not only were asylum seekers considered different but they were also considered a threat to British social life.

The perception that asylum seekers are a threat was a discourse strand identified in this study around the fear of the volume of asylum seekers coming into the UK. This was reflected in the participants' language used such as the UK being a "*small Island*" and "*how many do we allow in?*" This threat is reflected in both Gaudion and Allotey's (2008) study of midwives, who discussed large numbers of pregnant asylum seekers and Lewis's (2005, p. 38) study of the general public; one participant quoting that the "*indigenous population will be squeezed out*" and the "*UK is not physically big enough to cope*". Similarly, Ward (2008, p. 27) found reference to the numbers arriving in the UK; this participant referring to specific countries of origin: "*all these Bosnians, Kosovans and Iraqis*". The perception that there are a large number of asylum seekers in the UK does not reflect the actual numbers of registered asylum seekers. One of the areas where Lewis's (2005) study was undertaken was Norwich, which the participants believed was overrun with asylum seekers. In reality, there were just

eighty five registered asylum seekers living in Norwich in September 2009 (Aspinall and Watters,2010).

Political discourses around asylum seekers, reflected in social policy, can be argued as (re)producing the discourse underpinning the public (and midwives) perceptions of the asylum seeker as different and a threat. Sales (2002) asserts that the emphasis of government policy is around control of the asylum process, with little focus on integrating existing asylum seekers into the local community. It can be argued that this relays a message to the public around the need to control numbers as well as reinforcing the perception that the asylum seeker is different. This threat is reproduced through negative media coverage which describes the asylum system in the UK as being out of control, due to the large numbers arriving (Greenslade,2005; Lewis,2005). Mulvey (2010) argues that, as a knee jerk reaction to negative media coverage, the government legislated six asylum acts over a thirteen year period which have been focused on developing targets to cut numbers and thus control the volume of asylum seekers entering into the UK.

Current policies around the detention, deportation and housing of asylum seekers in accommodation centres, separate from the local community, could be considered to compound the sense of difference described above. This may be exacerbated by excluding asylum seekers from the job market and education (Gedalof,2007; Sales,2002). Asylum seekers who have a successful claim, have to pass citizenship and language tests before becoming UK citizens, suggesting that they have to try to reduce this differentness before they can live here on a

permanent basis (Gedalof,2007). Arguably, all these policy measures contribute to the dominant discourse around the asylum seeker as different and as a threat to Britain due to the large numbers arriving. This discourse is then (re)produced through everyday social interactions by the general public, including midwives.

7.3 Discourse around criminality

The perceived threat from asylum seekers is not limited to the numbers arriving in the UK. The findings from this study suggested an underpinning discourse around the asylum seeker being of a criminal persuasion and a threat to the UK, for this reason (see chapter six; 6.2.3). This threat was mainly around bogus asylum seekers coming to the UK for economic rather than genuine reasons; for example to abuse the welfare system and access the NHS. Participants used language which reflected this perceived threat, including some asylum seekers not being considered “*genuine*” having “*made up a reason so that they can stay*”. One participant linked the number of asylum seekers with the employment prospects in the UK at any given time, rather than linking numbers with conflicts around the world. In this context, the fact that the asylum seeker was pregnant appeared not to influence this discourse; one participant suggesting that “*once the baby’s born, then it’s, well, it’s up to the authorities*”. Like other asylum seekers, there was the perception that she may not be genuine; “*she maybe wasn’t genuine in the first place*”

This discourse around criminality is reflected in the language used in other studies examining midwives perceptions of pregnant asylum seekers. The midwives in Gaudion and Alloteys’ (2008) study used the word “genuine” in

relation to questioning authenticity, stating how they believed that “*you can pick up the genuine cases*” (p. 24). Other pregnant asylum seekers were described as not truthful about their age and what had happened to them. Midwives believed Hillingdon hospital was a “*soft touch*” for pregnant asylum seekers, who weren’t genuine due to the close proximity to Heathrow airport. They described the pregnant women from Heathrow airport as “*health tourists*” arriving at the hospital to benefit from the NHS and then leave again (pp. 23-24).

Studies focusing on the general public’s perception of asylum seekers had similar findings to the midwifery studies. The participants tended to use similar language when describing the asylum seeker, which reflected the discourse around criminality. The word “genuine” has been found in a number of studies including a MORI poll of young people using the term “genuine” in the construction of its questions (Amnesty International UK, 2003). Participants in both Ward’s (2008) and Lewis’s (2005) studies believed that asylum seekers come to the UK solely to claim welfare benefits.

Finney (2004) undertook a study exploring the public perception of asylum seekers in five areas of the UK. She had similar findings, with the public questioning whether asylum seekers are genuine or bogus and the belief that some come to the UK to claim benefits and take jobs from the British people. In addition, the participants in Finney’s (2004) study perceived that asylum seekers were a threat to UK security, due to a fear of terrorism. Although this was an issue raised in chapter one (see 1.6), it wasn’t discussed by the participants in this study. However, it does relate to the discourse around criminality which

arguably became more powerful following the terrorist attacks in America in 2001 and the UK in 2005 (Aspinall and Watters,2010; Sales,2002). Arguably, these historical events (re)produced a powerful discourse around the asylum seeker as a terrorist and a more serious threat, than one who is accused of abusing the UK benefit system.

It could be argued that the discourse around criminality is (re)produced due to a lack of clarity and a simplification of who is actually an asylum seeker. In this study, as identified in chapter six (see 6.3), the participants spent a large proportion of time discussing the concept of the asylum seeker and trying to distinguish the difference between this, a refugee, an immigrant and an illegal immigrant. This confusion about categories of immigration was reflected in the Gaudion and Allotey (2008) study, where the midwives talked about all the illegals arriving from Heathrow airport. They weren't able to distinguish between illegals, health tourists and pregnant asylum seekers. In addition, it was perceived that women were using admission to hospital with a fake condition, such as abdominal pain, as a way of evading immigration services, especially deportation from the UK.

There was similar confusion in both Ward's and Lewis's studies. Ward (2008) found that the majority of participants believed asylum seeking was a means to economic migration and didn't understand the difference between asylum seekers and other migrants. The participants in Lewis's (2005) study were confused about the term "genuine". This was thought to refer to the way that an asylum seeker entered the UK; for example, arriving smuggled in the back of a

lorry was perceived to be illegal and therefore this person was not a genuine asylum seeker. Other participants believed that any non-white person was an asylum seeker. This misinformation could be linked to the perception of the large numbers of asylum seekers coming to the UK. It would appear that there are more asylum seekers, if any non-white person was considered to actually be one.

As argued above in relation to difference (see 7.2), the ideology underpinning the discourse around the asylum seeker being of a criminal persuasion may be (re)produced from both powerful media and political locations. Pearce and Stockdale (2008) assert that the words that the public used when referring to the asylum seeker reflected the language used in the popular press. Similarly, The Equality and Human Rights Commission (2010) found that negative attitudes of the public in Wales towards asylum seekers was reflected from media coverage. Aspinall and Watters (2010, p. 9) support this, blaming the popular press for the portrayal of the asylum seeker as a "*scrounger*". In addition, they argue that the popular press is responsible for the public confusion about the term used to describe asylum seekers by merging the categories of migrant, refugee and asylum seeker in press coverage (Aspinall and Watters, 2010). Provocative terminology, such as the illegal refugee, asylum cheat, fraud and parasite are reproduced, reinforcing the discourse around the asylum seeker as a criminal (Bloch and Schuster, 2002; Lewis, 2005). The participants in the Lewis (2005) study discussed how they did not believe the media coverage of the asylum seeker. Despite this, they used similar terminology in their descriptions. When considering the origin of the terms "genuine" and "soft touch", it can be argued

that this is also the case with both participants in this study and midwives in Gaudion and Allotey's (2008) study, using language that originates from press articles.

It can be argued that the discourse around the asylum seeker as a criminal is (re) produced through government publications. An example was a speech made by, Damian Green, Minister for Immigration this year. He stated that "*Britain is no longer a soft touch*" for "*criminals*" entering the UK (United Kingdom Border Agency,2011b). Current policy re-enforces this, suggesting that most asylum seekers are considered bogus and there are too many of them (Mulvey,2010). Aspinall and Watters (2010) describe how asylum seekers experience the criminal justice system as soon as they enter the UK. They have checks such as biometric information age assessment procedures, including x-ray and other medical measures. This continues throughout the asylum process as identified in the findings from this study with "courts", "judges" and "lawyers" being discussed in relation to asylum hearings. The UK Government Border Agency Website (United Kingdom Border Agency,2011a) uses language which reflects this discourse around criminality with its discussion around bogus applicants: "*We are determined to refuse protection to those who do not need it, and will take steps to remove those who are found to have made false claims*" And failed asylum seekers; "*...If you do not leave the country, we will remove you. We may detain you until you are removed.*"

Aspinall and Watters (2010) assert that government policy purposefully reinforces the confusion around asylum seekers by categorising them with

migrants in broader policy issues. Indeed, the UK Border Agency Website groups asylum seekers with immigrants in general, when clearly they are not the same (United Kingdom Border Agency, 2011a). Misconceptions are spread through inaccurate discussion of the asylum seeker. An example is Stephen Byers, the former cabinet minister, who in 2003 suggested that "all asylum seekers who fail to register should be deprived of access to British schools and hospitals" (Gedalof, 2007, p. 83). Clearly, someone would not become an asylum seeker unless they registered their asylum claim with the UK government. This misreporting leads to public confusion about who is an asylum seeker. In addition, one participant in Lewis's (2005) study blamed the government for not providing information to the public to help this distinction. It can be argued that policy measures have purposefully reinforced this confusion. Consequently, the discourses around the asylum seeker become entangled with those around general immigration (Ward, 2008). There is little differentiation between the case of the asylum seeker, who is forced to migrate due to conflict and persecution and the situation for the immigrant who chooses to come to the UK.

7.4 Power and social structures

This chapter, so far has identified how the midwife's construction of the pregnant asylum seeker appears to be influenced by powerful dominant discourses around difference and criminality, which are (re)produced through power exercised from both media and political locations. So far, this chapter has alluded to the concept of power and how it is linked with dominant discourses, to influence the way people view the pregnant asylum seeker. However, when

interpreting Foucault's theory around power, it is more complex than merely (re)producing discourses.

As discussed in chapter three (see 3.2.1), discourses are "located in wider social structures" (Lupton,1992, p. 145). These structures, Jager and Maier (2009, p. 48), refer to as social locations from which the "speaking takes place". Discourse strands operate from these different social locations which can include the media, politics and everyday life (Jager and Maier,2009). Social locations are described as the social structures which exercise power and (re)produce dominant discourses (Jager and Maier,2009). However, from a Foucauldian perspective, power is not absolute; it is more complex than this. Although "social locations" exercise some power, it is diffused through society in the form of discourses (Fawcett and Featherstone,2000).This exercise of power throughout society, through the (re)production of discourses, constructs contextual knowledge.

In this context the knowledge is around the concept of the pregnant asylum seeker. However, discourses are complex and entangled masses of knowledge, (re)produced from a number of different social locations and are negotiated and ever evolving over time (Jager and Maier,2009). Furthermore, power is located in multiple social locations and is exercised through the interplay of these different discourses (Fawcett and Featherstone,2000). Therefore perceptions of reality are complex, influenced by multiple competing discourses, originating from different social locations, exercising power struggles.

Although this chapter is not attempting to simplify the complex and entangled nature of discourses and power struggles, so far it has argued that the findings from this study present language which reflects dominant discourses (re)produced within different social locations. This chapter will explore three such social locations; political, media and social locations, which can be argued as contributing to the dominant discourses around difference and criminality. However, other social locations exist and are likely to have had an influence on dominant discourses. It can be argued that the complex and ever evolving nature of discourses would make it impossible to offer more than an insight into the social locations influencing discourses.

7.4.1 Political location

It can be argued that the political location is a powerful social location from which dominant discourses around asylum seeking are (re)produced. As discussed earlier, government policy reinforces the construction that the asylum seeker is different and of a criminal persuasion, through explicit measures such as controlling bogus asylum seekers and cutting numbers. These policies do not discriminate between men and women and therefore do not consider the different circumstances in which the female asylum seeker may find herself (Aspinall and Watters, 2010). In addition, the power of government can be argued as reproducing dominant discourses which inflame public hostility and contribute to the concept of "moral panic". This was reflected in Lewis's (2005, p. 42) study in which a participant stated that "*Enoch Powell had the right idea, they should have put a stop to it then and there*". This participant was probably referring to Enoch Powell's 1968 "Rivers of Blood" speech in which he arguably

attempted to induce a moral panic, warning that mass immigration into the UK would result in disaster; racial conflict and violence which would lead to the "*River Tiber foaming with much blood*". He used language such as "*we must be mad, literally mad*" and "*it will be of American proportions long before the end of the century*" (Haralambos and Holborn,2004, p160).

Gilroy (2008) reflected on this speech forty years later. He argued that the attempt to inflame public hostility did not succeed. Although there had been racial conflict in some areas of the UK, they were not on the scale that Powell predicted and it was in fact a politically motivated tactic. Gilroy (2008) asserts that the number of immigrants arriving in the UK still provokes anxieties but the focus is more around national security, social cohesion and the fear of home grown terrorism. This chapter has argued that these anxieties continue to be inflamed by dominant discourses (re)produced through government policy designed to control immigration. Asylum seekers are considered a key threat, related to the fear of immigration and are therefore controlled by government policy (Ward,2008).

The concept of moral panic has been considered useful when reflecting on current debates about asylum seekers (Cohen,2002; Finney,2004). It can be defined as "an exaggerated outburst of public concern over the morality and behaviour of a group in society"(Haralambos and Holborn,2004, p374). The term was coined by Cohen in relation to public concern around mods and rockers in the 1960s; groups of people who were considered deviant at the time. Cohen argued that the deviance was manipulated by the popular press, which

led to an eruption of moral panic. This panic is used as a method of expressing anxiety about social change and results in scapegoating and hostility towards a perceived deviant group (Cohen,2002).

As argued so far in this chapter, in contemporary society, asylum seekers are considered a deviant group of people, who provoke public anxiety partly due to their perceived impact on crime and on the economy. Like Powell's "rivers of blood" speech, it can be argued that the government has inflamed this anxiety, reflecting concerns about general immigration through asylum seekers and revealing this through speeches ministers have made and through policy documents, (re)producing the discourse around false claims and criminality. This has led to hostility and moral outrage and over reporting of the issue by the popular press (Greenslade,2005). However, it can be argued that moral panics tends to escalate rapidly (Cohen,2002) and in this case, asylum seekers have been the subject of constant hostility over a prolonged period of time (Sales,2002), although historical events such as 9/11 have periodically inflamed this hostility (Aspinall and Watters,2010). This hostility has therefore continued beyond a number of changes in government, but successive governments still address the issue of immigration and exercise power which (re)produces the dominant discourses, prolonging the hostility towards asylum seekers (Cohen,2002).

7.4.2 The media

The media, particularly the popular press, is a powerful location from which dominant discourses around asylum are (re)produced. As discussed earlier,

media discourse strands combined with government strands produce powerful dominant discourses around asylum. However, in addition to this, it has also been discussed that the media can (re)produce powerful discourses to which the government has reacted by introducing new policies. This suggests that the power of the media works in two ways; with government power to create a more dominant discourse (Greenslade,2005; Lewis,2005), but also as a way of influencing government by causing knee jerk reactions to media discourses (Mulvey,2010). This symbiotic relationship between the media and government could further legitimise dominant perceptions of the asylum seeker as a threat to British society.

The popular press has scapegoated asylum seekers in the UK by blaming them for social issues such as levels of crime and housing shortages. Constant negative reporting has reinforced the hostility that the public feel towards asylum seekers (Greenslade,2005). It could be argued that this is fundamental to the concept of moral panic discussed above (see 7.4.2). The machinery of government may influence the manner in which the popular press develops an agenda around asylum seekers and vice versa. In turn political and media agendas reinforce the sense of panic through reporting issues, which inflame the perceived difference and criminality of the asylum seeker (Cohen,2002).

7.4.3 Everyday social practices.

From a Foucauldian perspective, within society, power is exercised at the micro level through everyday social interactions which (re)produce dominant discourses (Fawcett and Featherstone,2000). This social location, Jager and

Maier (2009, p. 48) refer to as “everyday life”, which they suggest is influenced by people’s activities and experiences. It can be argued that, within these everyday interactions, the dominant discourses around the asylum seeker as different and of a criminal persuasion, are (re)produced. In addition, in contemporary society, the advent of the internet and social network sites can be argued as increasing the ability of different groups of people to converse and debate ideas about current issues in society. Through this medium, power is exercised and dominant discourses can be negotiated and (re)produced.

Arguably, this theory can be illustrated by examining an aspect of everyday life; British identity, which can be linked with the dominant discourse around the asylum seeker as different. Undermining the British culture was a perceived threat caused by asylum seeking raised in Lewis’s study (2005) (see 7.2). This will be explored further and how this perception may have been influenced by power exercised from within a social location, through interactions occurring between groups of people in society, over a period of time.

It can be argued that British National identity is a social construction and one which is fundamentally context dependent, changing over time as historical events unfold. Cohen (2002) argues that colonialism and more recently, globalisation have changed the boundaries of what it means to be British. Recent historical events, such as increased Jewish immigration in World War two and the migration of South East Asian people in the 1950s to meet industrial employment needs, should have impacted on the social construction of the British National identity. This trend has continued with globalisation resulting

from improved technology, communications and travel, contributing to increased migration patterns and therefore increasing ethnic and cultural diversity in the UK (Cohen,2002). The British National identity needs to be reconstructed to encompass this increasing diversity. However, within this context, this did not appear to be the case. The participants in Lewis's (2005) study, who suggested that asylum seekers were undermining the British culture, expressed a belief that the British culture is in fact homogenous and this is threatened by "the other", the immigrant, or in this case the asylum seeker.

"The other" appears to be a key concept described in the literature and one which is arguably influenced by the social location of the UK population.

Goffman (1968) cited in Haralambos and Holborn (2004) undertook an observational study of asylums which has become a seminal piece and one which arguably has elements of its findings relevant to this context. Amongst other issues, Goffman found that people, who are considered to have unwanted "differentness", in his case people with mental illness, become stigmatised by society. This differentness is perceived to include personal characteristics or reputations that are against cultural norms. In this context, when examining the language used, it could be argued that asylum seekers are stigmatised, being treated unfairly and inferiorly by people within a British context. "Them and us" and the assumptions made about their reasons for coming to the UK, could be argued as exacerbating this unwanted differentness.

Gedalof (2007) argues that there is perceived to be a limit to the amount of "differentness" that can be absorbed into society before the sense of national

identity is impacted upon. In this context, the perceived numbers of asylum seekers coming into the UK was impacting on British society and therefore stigmatisation is likely to occur. As well as this, as identified in chapter one (see 1.8) the UK is currently in the middle of an economic crisis, with government spending cuts impacting on the general population. Cohen (2002) argues that, historically, in times of social instability, the identification of difference is further compounded to help create a sense of social cohesion and community stability. Arguably, this theory could be applied to the current economic recession and the likelihood that the stigmatisation of asylum seekers will be exacerbated as a consequence of this need to create this image of social cohesion, to see the community through difficult economic times.

Finney (2004) asserts that asylum seekers who are perceived to be even more different, due to having unwanted characteristics, may face increasing stigmatisation. Examples of such characteristics could include sexual orientation, ethnicity, gender or religion. An example could be men perceived to be Muslim, who are labelled as terrorists in response to the 9/11 and 7/7 bombings in America and the UK (Aspinall and Watters, 2010). In addition, as identified in chapter one (see 1.7), the general public perceived the typical asylum seeker as young, male and hanging around in gangs (Ward, 2008). However, Bruna (2003) undertook a study which interviewed members of the public. They perceived the female asylum seeker as more threatening than the male. The women were perceived to use young babies as a way of appealing to the public conscience when begging in the streets. They were described as "professional beggars and scroungers" (p.158) who were more threatening

because they approached women asking for money whereas the men did not. This increased the sense of hostility towards these asylum seeking women. Consequently, rather than attempting to consider how the female asylum seekers' circumstances may differ to men's (see chapter one; 1.9), these asylum seekers may actually experience an increase in stigmatisation due to the fact that they are female.

7.5 Discourses and the midwife

So far, this chapter has argued that dominant discourses around the asylum seeker as different and of a criminal persuasion are (re)produced through different social locations, including the media, politics and social practice. Arguably, midwives are a product of these discourses and construct the pregnant asylum seeker in a way which reflects underpinning dominant discourses. These constructions may be influenced by the perceptions described above; "professional beggars and scroungers" (Bruna,2003, p. 158).

7.5.1 Feminist perspective

Returning to the feminist philosophical underpinnings of this study (see 3.2 and 3.3), it can be argued that there was little attempt by the students to engage with the pregnant asylum seeker as a woman. The fact that she was an asylum seeker appeared to override any other identities, with no evidence of an underpinning feminist discourse. Arguably, this was evident when discussing the asylum seeker as a criminal (see 7.3 above) and the perception that "*once the baby's born, then it's, well, it's up to the authorities*". The pregnant asylum

seeker appeared to be perceived in the same way as other asylum seekers, with the pregnancy secondary to her identity as an asylum seeker.

In addition, in this study, there was very little discussion around alternative social constructions offered on behalf of her identity as a woman, despite the fact that women often have different reasons to men for claiming asylum. As discussed in chapter one (see 1.9), women may have experienced gender specific violence, possibly resulting in pregnancy, which are not included in asylum policies and therefore do not influence asylum decisions (Reed,2003; Ukoko,2007). It could be argued that this lack of acknowledgement of female asylum seekers specific needs in government policy, has led to a lack of awareness in the media, the population in general and amongst midwives.

Consequently, these women can be argued as being even more powerless than other asylum seekers. There was a lack of acknowledgement of this by the participants in this study and the oppression that they may be experiencing. Arguably, the fact that her identity as a woman was neglected re-enforces the subordinate position that she may hold in society. From a feminist perspective, research aims at addressing women's inequality and oppression in society (Holloway and Wheeler,2002) and this key issue is re-addressed in chapter nine, in relation to the development of a new model for midwifery education (see 9.2 and 9.3.2).

This chapter will now explore how the influence of dominant discourses on midwives constructions of the pregnant asylum seeker were demonstrated in

this study in the context of the NHS environment and could impact on the way these women are perceived in clinical practice. As identified in chapter five (see 5.7.1), to avoid possible ethical dilemmas arising in relation to substandard care being discussed, this study is limited to the informal “talk” that occurs in the NHS away from the person being cared for. It was beyond the ethical boundaries of this study to examine any impact of “talk” on clinical practice.

Chapter six (see 6.4.2) presented findings that were considered to reflect the dominant discourses discussed throughout this chapter around the asylum seeker as different and of a criminal persuasion. This chapter included examples of quotes made by the participants and relating to their experiences of talk about asylum seekers in the clinical area. Below are two examples which discuss the talk that had occurred in the staff handover when an asylum seeker was admitted to the maternity unit. The language in the first quote appears to reflect the discourse around difference and the second quote around criminality: *“where you’re kind of pinpointing either the troublemakers or the people you need to get out of the ward as fast as possible or the people who you think are really sweet and actually aren’t any bother. And the way that this woman was handed over was kind of part of that style.”*

“And like there was, there wasn’t much trust in the air. There was, it’s like, ‘Well, why didn’t she tell me her real birth date? And why, why has she got so many names? And why does she laugh hysterically when, when we talk about these issues?’

The term “pinpoint” suggests trying to identify those women who are perceived as different or the other, in this case the “troublemaker”. This reflects Goffman’s theory (1968) cited in Haralambos and Holborn (2004) about difference and the stigmatisation of people because they do not conform to the expected cultural norms. This woman did not fit with the expected norm of being identifiable by her names and date of birth. Consequently, there appeared to be an underpinning fear that she was not who she said she was and was in fact of criminal persuasion, not being truthful about her identity. The midwives did not appear to consider the fact that some cultures do not celebrate birthdays and do not use the date of birth as a way of identifying an individual (Burnett and Fassil,2004).

Returning to the issue around pinpointing or identifying women perceived to be different; this activity appeared to underpin a number of quotes made in this study. However, these were in a wider context, related to other women perceived as different rather than just focussing on pregnant asylum seekers. These women were perceived to have undesirable characteristics which led to them being stigmatised by the midwives:

“if they’re being a princess or if they’re being, you know, if they’re not, if they’re wanting you to give the baby a bath and feed the baby because they can’t get up, then people call them princesses or precious or you know, drama queen.”

Although this participant was referring more generally to South Asian women when discussing the concept of the princess, it reflects the idea of difference in relation to women who do not conform to midwifery constructions of postnatal care. In some cultures, including South Asian and Chinese, after childbirth

women are expected to rest and receive care for a prolonged period of time which can lead to women being stereotyped as lazy (Somerville and Sumption,2009). This appears to be the case in this situation. Another perception of difference related to travellers and midwives who were *“making assumptions about why they’d come into this particular hospital”*. It could be argued that, in this context, the traveller was perceived as different, due to their lifestyle.

Taylor and White (2000) discuss the concept of membership categorization and how, during social interaction, people may be assigned to a particular moral category. These categories are socially constructed and define expectations for proper behaviour, with non-compliance being considered deviant behaviour. It can be argued that the talk undertaken by midwives during handover reflected this moral categorization, with the “princess” being considered deviant.

Arguably, this categorization is embedded within the culture of the NHS with everyday talk implicitly reflecting moral categories and little questioning of this “common sense” talk. Consequently, as a midwife undertaking research within this context, when reading the transcripts, I would argue that it was difficult to identify such moral categories as they were embedded within my cultural norms of working within the NHS.

Despite the fact that two participants had raised the issue of stereotyping being a problem in the maternity services, when asked to explore the issue further they did not use the word stereotype again. However, one participant talked about the resulting prejudice and discussed this as a problem. She stated that

individuals have their own personal prejudices about some women and that they don't always realise this but through informal talk, these prejudices are relayed to other people and become a "*group prejudice*". Examples were given of informal talk that could be interpreted as prejudiced, the 2nd example relating specifically to an asylum seeker:

"all Asian men bugger their children"

"people seemed to be talking about her in a fairly uncaring way"

Cross-Sudworth (2007) describes stereotyping as making broad assumptions about a woman due to her characteristics, such as her gender or ethnic background. There are a number of published studies that have examined stereotyping of women as they access maternity services. Perhaps the most well documented was Bowler's (1993) seminal study which found that midwives stereotyped Asian women in a number of ways. One stereotype was that these women make a fuss about nothing in relation to pain experienced in labour. Indeed other studies found that assumptions were made about pain in childbirth. Richens (2003) had similar experiences, but in relation to Asian women and pain that they experienced in the postnatal period. Harper Bulman and McCourt's (2002) study of Somalian refugees found that some of the women they interviewed perceived that they were stereotyped because they were Somalian, as being more tolerant of pain in labour and were consequently offered less pain relief compared to other women.

In addition, the published studies which have been referred to throughout this chapter, contain quotes that provide examples of where women have arguably

been stereotyped by the midwives caring for them. McLeish (2002, p. 50) included a quote made by an asylum seeker. *"A lady looks Asian, a foreigner, wears a hijab, so maybe she thinks I don't understand anything of English"*. Gaudion and Allotey (2008, p. 23) referred to the midwives caring for asylum seekers. *"We have particular problems with women from Nigeria and Rwanda...they just come to have their babies"*

Although stereotyping can occur towards any woman who is perceived as different when accessing maternity services "on the basis of circumstances" (Kirkham,1999, p. 119), women from minority ethnic groups, in particular asylum seekers are more likely to be stereotyped by midwives (Sookhoo,2009). It can be argued that, in addition to ethnic background leading to assumptions being made about women, the findings from this study suggest that the stereotypes around being an asylum seeker can compound the problem. Arguably, this is due to the underpinning dominant discourses around the asylum seeker as different and being of a criminal persuasion seeping through into the NHS and being reproduced by the midwives talking to each other in clinical practice.

Lewis (2005) argues that there is no legislation designed to protect asylum seekers from discrimination that they may experience. This is because asylum seekers are constructed as a social group of people rather than being people from a particular ethnic background. Therefore, the legislation protecting people against racism is not considered relevant to asylum seekers. In addition, it is argued that the new equality act does not provide any added protection to the

pregnant woman because she is an asylum seekers, as it does not include asylum as a characteristic needing protection within it (Griffith,2010). However, it does include people with protected characteristics including pregnancy, race, religion/belief and sex (Government Equalities Office,2010). This suggests that the pregnant asylum seeker cannot be discriminated against, in relation to her characteristic either directly or indirectly, but the fact that she is an asylum seeker is not considered within the act. The issue of stereotyping therefore needs addressing in other ways to protect pregnant asylum seeking women from possible assumptions, such as those described above, whilst accessing maternity care. One way of addressing this is to focus on negative dominant discourses and how they can be challenged.

7.6 Power of discourse or power over discourse?

Foucault describes power as having the potential to be productive instead of just repressive. Where there is power, there is also resistance and it is this resistance that can be targeted in order to construct alternative explanations of social reality. This positive exercising of power can lead to the production of alternative discourses (Fawcett and Featherstone,2000) and in this case, as a means of challenging negative dominant discourses around the pregnant asylum seeker.

Although Foucault considers power to be a complex multifaceted concept (Fawcett and Featherstone,2000), in the context of this study, it has been interpreted as originating from powerful social locations and then being diffused throughout society. Politics and the media have been explored as examples of

potential social locations which (re)produce dominant discourses around asylum seeking. These discourses are then (re)produced in different societal contexts to socially construct contextual knowledge about the asylum seeker. This suggests that people in society can exercise power to construct alternative discourses around the pregnant asylum seeker. However, Jager and Maier (2009, p. 37) debate the "power of discourse" and the "power over discourse" and argue as to whether people can influence powerful discourses, or indeed as to whether some discourses are too powerful to be influenced.

Jager and Maier (2009) suggest that some people have the ability to exercise more power than other people, to influence social locations and therefore discourses (re)produced in these locations. This power can be exercised through different means including economic, political or educational means (Jager and Maier,2009). In addition, resistance to dominant discourses evolves over time as historical events unfold (Van Dijk,2009). Therefore, changing perceptions about pregnant asylum seekers needs to be addressed by focusing on people as power sources and how power can be exercised to change perceptions in society over a period of time. Midwifery education could be considered as a way of empowering midwives to challenge the negative dominant discourses around pregnant asylum seekers and produce alternative discourses. This is explored further below.

7.7 The way forward

There is a general consensus in the literature reviewed for this study that education is essential to help overcome the hostility and stigmatisation of

asylum seekers by people living in the UK. This includes both education of the general public (Pearce and Stockdale,2008; The Equality and Human Rights Commission,2010; Ward,2008) and the midwives providing maternity care (Gaudion and Allotey,2008; McLeish,2002) Over half the participants in Ward's study of the local population of Coventry felt that they would benefit from education around asylum seekers' issues, including accurate statistics and different categories of migrants and where they come from. In addition, Pearce and Stockdale (2008) identified that the public need more education around understanding the asylum process and relevant legislation.

It can be argued that this is also the case for midwives working in clinical practice. Reynolds and White (2010) recommend more education for midwives on immigration issues, the asylum process, the experiences of asylum seekers but also more general equality and diversity training. This is supported by Gaudion and Allotey (2008) and McLeish (2002). However, it can be argued that in addition to the need to educate midwives about general asylum issues, there is also the need to increase their understanding about discourses and how these work to (re)produce dominant ideology about pregnant asylum seekers.

Lido, Brown et al (2006) undertook a study which demonstrated that people's assumptions about asylum seekers are often unconscious or automatic. When participants were provided with newspaper articles that presented asylum seekers in a positive way, these articles did not necessarily have a positive effect on the participants' negative assumptions about asylum seeking. The researchers argue that this may be due to a lack of strong positive associations

with asylum seekers in British culture. The asylum seekers living in Wales, who took part in The Equality and Human Rights Commission (2010) study, suggested that there is a need for more positive images around asylum seekers in the media but also through other means, for example using storylines in popular soap operas and through public awareness campaigns. In addition, Tribe (2002) highlights that there are influential people in the UK who arrived here as asylum seekers and became refugees who settled here. These people, including the inventor of the oral contraceptive pill and the first Governor of the bank of England, have made a positive contribution to society. Tribe (2002) believes that these people and others, should be highly publicised to improve public awareness of the positive impact of immigration.

Lewis (2005) argues that more positive public perceptions of asylum seekers can be developed by facilitating meaningful contact between the public and asylum seekers. In her study she found that there were more negative opinions by members of the public who had little or no contact with asylum seekers, than those who had experience of engaging with them. This is supported by the Pearce and Stockdale (2008) study which was referred to in chapter one (see 1.7). They compared the perceptions of members of the public who had little contact with asylum seekers, with people who were in employment and working with them regularly. They found that those people who had no contact with asylum seekers were more negative about them, whereas people who worked with them regularly were more positive, considering them mainly to be genuine, fleeing from persecution or life threatening poverty. This suggests that there needs to be the opportunity provided for the general public and arguably

midwives, to have meaningful and prolonged contact with asylum seekers in the local community, in order to facilitate the development of a positive relationship and therefore more positive opinions about asylum seeking. This issue will be re-addressed in chapter ten (see 10.7.5) when making recommendations from this study.

Chapter six of this study (see 6.4.1) presented findings which suggested that some participants, through the course of their reading, were developing alternative constructions of the pregnant asylum seeker, which were questioning the dominant underpinning discourses around difference and criminality. These were related to specific issues around asylum policy including welfare benefits; being "*horrified*" at how little asylum seekers received, the fact that they are not always informed about the benefits they can claim and were not always provided with somewhere to live. They learnt about the policy for dispersal and how women can be "*shipped out to anywhere,*" and the policy for detention where people can "*feel imprisoned*" and may "*not have decent access to healthcare*". They relayed stories of pregnant women being moved at short notice and separated from other pregnant women when they "*were really supporting each other*". They also expressed shock at a woman being moved from one detention centre to another whilst in labour.

Through their reading, participants also learnt about the very small numbers of asylum seekers who had their asylum claim accepted and were allowed to remain in the UK "*I was quite shocked at how many people were refused.*" They researched some specific reasons why people were refused asylum including a

"52-year-old woman who'd been refused asylum because she couldn't possibly be at risk of rape" and expressed negative reactions to this; *"Shocking"* and *"that makes me so angry"*. They found that some women were refused asylum because they *"didn't have proper legal representation because they couldn't afford it"*. They learnt about pregnant failed asylum seekers and how they would be charged for their care and steps taken to recover the debt; *"Send around the heavies"*. They also learnt about how the asylum interview was conducted and suggested that *"It's not so surprising then that people have these stories"*. *"..however many months it's taken you to get to that point. You just don't want to risk it, do you?"*

Despite this, there were also issues around asylum that were still questioned by some participants, such as the fact that the asylum seeker would receive more welfare benefits than the UK citizen on income support; *"people on income support, they have to pay their bills, electric bills and the rest of it, so in a sense, they're (asylum seeker) actually better off"*. In addition, there was still an underlying fear of the number of asylum seekers coming to the UK and the need to control these. *"We're the smallest island in the world and everyone's wanting to come here"*. One participant continued to express the belief that asylum seekers chose to come to the UK, they had escaped the oppression that they were experiencing and the length of the asylum process was *"probably quite reasonable"*. Despite this, these findings suggest through reading selected literature, then reflecting on this in clinical practice, dominant discourses around the pregnant asylum seeker could be questioned.

It can be argued that the selection of literature will have an important influence on how pregnant asylum seekers are perceived. This chapter has highlighted how politics is a powerful social location in which dominant discourses are (re)produced and how the language used in government publications (re)produces the negative dominant discourses around the asylum seeker as different and of a criminal persuasion. By students merely reading government produced publications, these negative discourses could actually be reinforced rather than being challenged. Chapter six (see 6.4.1) identified alternative sources of literature that the participants used and reflected on, when they began to construct alternative versions of reality around the pregnant asylum seeker. These included local and national charities and work by Sheila Kitzinger. Within midwifery education, it would appear to be important that students are guided to these alternative sources of literature to facilitate their constructions of the pregnant asylum seeker and to help them to challenge dominant discourses reproduced in other literature sources, such as government documents. By reading and reflecting on these counter discourses, when in clinical practice, it could be argued that assumptions and stereotypes around pregnant asylum seekers could be questioned. This issue will be discussed further in chapter eight (see 8.6) where the focus will be on exploring the way forward in midwifery education to address the challenging of dominant discourses around the pregnant asylum seeker.

7.8 Conclusions

This chapter has returned to the intellectual puzzle developed for this study and developed an argument as to why some pregnant asylum seekers may have

poor experiences of maternity care. This argument has focussed on the negative dominant discourses around the pregnant asylum, as different and of a criminal persuasion. These discourses were revealed through the language used by participants in this study. This chapter has explored these dominant discourses and how they reflect the findings from other studies, related to both midwives and the general public. They also reflect the language used in newspaper articles and government publications and policies around asylum.

The concept of power has been explored from a Foucauldian perspective and how power is exercised from social locations and also diffused and exercised throughout society. This chapter identified social locations which it has argued may (re)produce the negative dominant discourses around asylum seeking. The complex relationship between political and media locations has been explored and how they work together to (re)produce these dominant discourses, through complex entangled discourses strands, which are diffused and (re)produced through social interaction in different societal contexts. Examples of specific influences have been described including the construction of the concept of British Nationality and the similarities between the concept of moral panic and the situation of the pregnant asylum seeker.

The findings from this study have provided little discussion of how the pregnant asylum's situation may differ to that of the male asylum seeker, consequently there was no alternative discourse offered around the pregnant asylum seeker here or in this study or other midwifery literature. However, one study (Bruna,2003) found that perceptions of female asylum seekers with babies were

even more negative than those of the typical image of the young male asylum seeker. These women were perceived as even more different and threatening.

This chapter demonstrated how the negative dominant discourses around the pregnant asylum seeker as being different and of a criminal persuasion may be (re)produced in the NHS maternity unit . The language used by the midwives in practice when talking about asylum seekers and indeed other women from minority ethnic groups, reflected the language used in other midwifery studies, as well as those studies exploring the public perception of the asylum seeker. The language used reflected assumptions and stereotypes about these women's behaviour whilst accessing maternity care.

Finally, this chapter focussed on the way forward; how negative dominant discourses around pregnant asylum seekers can be challenged. Literature related to public perceptions of asylum suggests a number of strategies that could facilitate this change; developing positive images about asylum seekers and their achievements in the public arena, through campaigns and popular television storylines and increasing meaningful contact between the asylum seeker and the general public, arguably including midwives. In addition, this chapter presented findings which suggested that, through accessing alternative sources of literature, midwives can be facilitated to question these dominant discourses and through reading and reflection, develop alternative constructions around the pregnant asylum seeker.

Chapter eight will now return to this study's intellectual puzzle and relate it to approaches to midwifery care. It will explore the argument that pregnant asylum seekers may have poor experiences of maternity care, partly due to the way that this care is approached by midwives. It will present findings from this study, which will be supported by other literature, to address how midwives approach care provision. The educational needs that develop from chapter eight can then be considered with the needs developed from this chapter and explored in chapter nine to move forward midwifery education.

Chapter 8: Discussion

Dominant Discourses and Approaches to Midwifery Care

8.1 Introduction

Returning to the intellectual puzzle developed for this study, see chapter three (3.4), this chapter will argue that some pregnant asylum seeking women may have poor experiences of maternity care, partly due to the way that midwives approach their care provision. This chapter will refer back to the students' social constructions of the pregnant asylum seekers' health and social needs and discuss these needs and the influence of dominant discourses on how these needs could best be met. It will use examples of the findings, supported by other literature, to develop an argument around how the provision of midwifery care may influence asylum seeking women's experiences.

In contemporary midwifery practice it can be argued that the dominant medical discourse, entangled with other competing discourses, is (re)produced in the social location of the NHS (National Health Service) maternity services. There is a power struggle between these competing discourses which impacts on the way that midwives practice and midwifery students' learn to practice. This chapter will explore this argument, examining the power struggles that operate between discourses and how they influence the way that midwives approach care provision in maternity services. It will discuss how this could influence pregnant asylum seekers experiences of maternity care. It will explore the "wider social structures" (Lupton, 1992, pp 145) from a historical perspective, to

demonstrate how these discourses have become entangled and (re)produced and how this may have influenced midwifery care provision in this context.

8.2 Medical discourse

As demonstrated in chapter six (see 6.3), the findings from this study appeared to reveal an underpinning dominant discourse around the medical model of childbirth which impacted on the midwife's role in practice. The participants predominantly focussed on meeting the physical needs of the pregnant asylum seeker at the expense of other holistic aspects to care, including social, emotional, language and cultural issues. This prioritisation was reflected through the language used by the participants.

The largest proportion of time was spent discussing the midwife's role in relation to meeting these physical needs, which consisted of a series of "*checks*" which were perceived to be "*your normal role*". These checks related to the medical aspects of pregnancy and detecting physical deviations from the norm. The reliance on technology was implicit in this role, with the need for a dating scan to diagnose the woman's due date. This was perceived to be more reliable than the woman who "*might know*" when her baby is due. Speed appeared to be important; "*prioritise what needs to happen first*" and also "*making sure you can send off her bloods..... as quick as possible*". Some participants believed that they didn't need to learn any more to understand the role of the midwife; "*we know what the role of the midwife is, thankfully, because we're going to be midwives.*"

The other constructed health and social needs of the pregnant asylum seeker were believed by some participants not to be the “*normal role of the midwife*” and consequently were not discussed as widely as the physical needs. When debating these issues, some participants tended to frame them within a medical context: “*Does that (culture) come under the heavily pregnant?*” and in relation to emotional needs: “*How does stress affect pregnancy with reference to asylum seekers?*” In relation to social needs, some participants believed that it was not the role of the midwife to “*sort it out*”. When discussing language needs, if there was no interpreter available, some participants focussed on the ability to still provide midwifery care by communicating physical needs through miming; “*because some of the concepts are quite general, really. Like pain and things like that.*” Again, this reflects the dominant medical discourse as it can be argued other aspects of care, especially emotional issues, could not be addressed without being able to communicate with a woman.

Other published studies, which examined the experiences of pregnant asylum seekers when accessing maternity services, had similar findings to this study. Kennedy and Murphy-Lawless’s (2003) study of women in Southern Ireland found that midwives provided good standards of physical care, but emotional and support needs were neglected. This was blamed on a lack of time to address these issues, especially if a woman was booking late in her pregnancy. Women in general, often relied on family members to meet their emotional and support needs, but an asylum seeker may be alone and therefore not have any means of meeting these needs. Similarly, Harper Bulman and McCourt’s (2002) study of Somalian refugees found that professionals were impersonal when

providing midwifery care, discouraging communication and focused on completing physical tasks. Briscoe and Lavender (2009) also found that when caring for pregnant asylum seekers, there was a perception amongst health professionals that physical tasks needed completing as quickly as possible due to the fact that they were “late bookers”.

These findings were reflected in other studies which examined approaches to midwifery care in more general terms. Reynolds and Shams (2005) undertook a study which focused on midwives’ perceptions of cultural barriers and how these influenced the care provided for South Asian women. They found that some midwives believed that their role in caring for women was to address the physical health needs only, when other aspects of care not being perceived to be in the midwife’s remit. Kirkham (1999) undertook a study which examined the organisational culture within maternity services. She found that midwives concentrated on routine tasks at the expense of wider care issues. This task orientated approach to care appears to be a wider issue, being reflected in the Downe, Finlayson et al (2009) metasynthesis of studies examining antenatal care for marginalised women in the UK, USA and Canada.

It can be argued that this emphasis on providing midwifery care to address the pregnant woman’s physical care needs, through completing checks and tasks, reflects the powerful dominant discourse around the medical model of care. This Hunter (2006) describes as the model which controls childbirth in the Western world. It emphasizes the body as a machine, separate from the mind, which can become broken or pathological. This pathology is diagnosed and treated

through medical intervention including technology. This pathology can be related to the pregnant body and the medical model emphasizes the need for physical checks to be undertaken on the pregnant woman in order to detect deviations from the norm. Consequently, childbirth is considered a potentially pathological process which can only be considered normal in retrospect. Gould (2002) suggests that the medical model of childbirth has become so engrained in midwifery care that it can be difficult to recognise it in the way care is approached. Indeed, Davies (2004a) argues that many midwives define their role in relation to this medical model of care. They embrace the technical skills that accompany the use of technology and consider social, psychological and emotional aspects of care as separate from this. This mirrors the findings from this study in which the participants focused on the physical needs of the pregnant asylum seeker as the normal role of the midwife and the other aspects of care as being outside of this role.

8.3 Managerialist discourse

Returning to the findings from this study, there appeared to be an influence of another discourse entangled with that around the medical discourse to influence the way in which the midwife approaches the care of the pregnant asylum seeker. As described in chapter six (see 6.3), the language used by the participants suggested that the pregnant asylum seeker was perceived as a deviation from the normal pattern of antenatal care, as she was *"a late booking"*. This pattern of care is defined within the NICE guidelines for antenatal care which, in addition to any locally written policies, underpin midwifery practice (National Institute for Health and Clinical Excellence, 2010). These guidelines

state that routine care of the healthy woman should include the booking appointment taking place at around ten weeks gestation (p. 37) and the woman should have seven or ten antenatal appointments in her pregnancy depending on her parity (p. 72). A major focus of these appointments is around the medical needs of the mother and fetus through screening and clinical assessment. As a consequence of being a "*late booking*", this asylum seeker needed "*everything checked out*"; all the physical screening and monitoring that she had missed which occurs in the "*normal*" pregnant woman earlier in her pregnancy.

The perception that the asylum seeker's care has deviated from the normal pattern of antenatal care, by booking late in her pregnancy, has been identified in other midwifery studies. Nabb (2006) examined health professionals' perceptions of the care needs of pregnant asylum seekers whilst they were being housed in emergency accommodation centres. There appeared to be an overwhelming concern amongst the professionals about the physical risks associated with being a late booker and not having received any antenatal care or an ultrasound scan. Consequently, the health professionals perceived a problem with not knowing the placental location and the implications of this for delivery and also not knowing if she had any pathological blood conditions which could impact on her care needs. Similarly Reynolds and White's (2010) study found that the asylum seeker was considered high risk due to being a late booker who has had no previous antenatal care.

The concern with pregnant women booking late in their pregnancy is reflected in other, more general midwifery studies. Smith, Cantab et al (2009) undertook a

study of 591 health professionals, examining their perceptions about safety in the maternity services. Respondents believed that women, who book late in their pregnancy, including asylum seekers, put extra pressure on maternity services, impacting on safety. The perception was that these women may have underlying physical, potentially life threatening problems that have not been identified in the course of their antenatal care, which need urgently addressing to ensure their safety and are both time and resource intensive. Safety appears to have become a fundamental concern in relation to how midwives approach providing care. This issue is implicitly addressed within guidelines and policies, which identify "safe" procedures which should be followed at various stages of the childbirth experience in order to assess the physical health of the woman and identify any deviations from the normal. However, Wickham (2004) argues that this is at the expense of other aspects of the woman's care including emotional, social and cultural needs.

As discussed in chapter six (see 6.3.1), the use of the term "high risk" suggests the need to categorise the pregnant asylum seeker according to medically defined criteria and adapt the care provided according to these. These criteria are contained within policies and guidelines and will define how care should proceed. The concept of risk is an integral part of assessing pregnant women at booking, with them being labelled as low or high risk, depending on their physical health (Fleming,2006). This standardized risk assessment was recommended in the maternity matters publication (Department of Health,2007) as it was believed to increase safety by ensuring women's physical needs are considered in the context of clinical guidelines, including NICE and other

relevant guidelines and policies. This will impact on the level of care that women receive through their maternity experience. The influence of medical discourse appears clearly visible in relation to the concept of risk. However, Tew (1990) argues that risk assessment does not predict perinatal and neonatal morbidity and mortality, with low risk babies unexpectedly dying and high risk, vulnerable babies surviving. Consequently, it is argued that there is a need to reconsider the concept of risk assessment and its value in predicting potential problems arising in the childbearing process (Fleming,2006). This would appear to be particularly relevant for the pregnant asylum seeker who may be labelled as high risk, purely due to her immigration status.

It can be argued that the influence of the medical discourse entangled with the managerialist discourse, has led to the construction of a pregnant woman who has become a passive recipient of, rather than a partner in her care decisions. If the “*checks*” she requires are clearly prescribed within policies and guidelines, then one can question how she has any choices in the management of her care. This is reflected in the language used in the findings (see 6.3). Quotes made by participants included; “*You do all your checks*” and “*everything should be checked out*”, suggesting following the midwife’s rather than the woman’s agenda, which has become a regimented compliance with policies and guidelines (Battersby and Deery,2004). The use of the quote; “*she might know*” in relation to her due date, suggests a lack of confidence in the woman’s ability to make decisions, reinforcing the need for the midwife to control the care provided. In addition, the discussion that occurred in relation to being able to provide care without an interpreter present, suggests a lack of importance in

interacting with the woman to develop a partnership in care decisions. In this situation, participants justified this language barrier in relation to *“caring for her in her best interests, that’s as good as you can do, really, isn’t it?”*, suggesting that the midwife holds the power and she decides what she thinks is in the woman’s “best interests”.

The asylum seeker as a passive recipient of midwifery care is an issue highlighted in other midwifery studies. Nabb (2006) found that in the emergency accommodation centre, midwifery care for asylum seekers was provided according to the perspective of the health professional rather than that of the woman. Similarly, in the McLeish (2002) study, many of the asylum seeking women recalled experiences where they had not been consulted about the care they required. This was particularly noticeable for women who developed pregnancy induced hypertension, who became the passive recipients of medical intervention to treat this condition. In addition to this, Lankshear, Ettore et al (2005) undertook a study examining how midwives and doctors approached their decision making in the delivery suite setting. They found that decisions were often made about a woman’s care needs by midwives and doctors outside of the room. This suggests a lack of acknowledgement that the woman has any autonomy in her care decisions.

Some studies have explored the issues around language barriers between the health professionals and women and the impact of these on women’s abilities to be involved in decisions about their care. Harper, Bulman and McCourt (2002) found that midwives did not attach a great deal of importance to using an

interpreter when caring for Somali refugees. This suggests that care was undertaken without communication and therefore these women would have been unable to make choices about their care management. Similarly, Robinson and Phillips (2003) undertook a study in the primary care setting examining communication between clients who spoke little or no English and practice nurses and doctors. The practitioners did not perceive the use of interpreters as an efficient use of time and therefore used other methods such as miming and pictures to communicate. Again, how much information clients were provided to make care decisions is questionable and arguably, in this context, these clients were passive recipients of care.

Both Hunter (2006) and Battersby and Deery (2004) focused on the interactions between midwives and pregnant women, but in the absence of a language barrier. They identified that even when the woman spoke English, the midwife's choice of terminology used during interactions actually increases the woman's compliance in the midwife's decisions about care. Hunter discussed the use of the word "check" as demonstrating the midwife's agenda. Battersby and Deery argued that medical terminology used by the midwife creates a power difference between herself and the woman, leading to compliance due to a lack of understanding. This could be further exacerbated with an asylum seeker who may speak little or no English.

It appears that this physical approach to midwifery care, influenced by medical discourse is compounded by the lack of attention to social, psychological and cultural needs within policies and guidelines. In addition, these are neglected

within the risk assessment carried out on the woman (Battersby and Deery,2004; Stephens,2004). A more holistic assessment may identify other issues such as poverty and deprivation, which may influence a woman's wellbeing as well as having a potential impact on her physical health. Seemingly to address this issue, NICE (2010) introduced new guidelines aimed at women perceived as being vulnerable and having complex social needs, including asylum seekers. These contain guidance on specific needs that these women may have, in addition to the normal antenatal needs of the pregnant women. However, these new guidelines do not discuss how these issues can be incorporated into the physical assessment of risk. They merely make suggestions on the organisation of maternity services and training needs for staff. Arguably, they pay lip service to addressing the holistic needs of the pregnant asylum seeker.

It can be argued that the dominant medical discourse, together with the managerialist discourse, have decontextualised the pregnant asylum seeker. Within the NICE guidelines there is little consideration given to the social, psychological cultural or other dimensions of her life which may impact on her midwifery needs (National Institute for Health and Clinical Excellence,2010). This decontextualisation appears to be reflected in the language used within this study, including the quote, "*not letting asylum seeker take over your perspective.*" This was also the case in clinical practice when a participant was involved in a booking interview; "*there was only the initial mention of her refugee status*". One participant discussed the need to focus on "*the normal in the abnormal*" suggesting that the physical checks are the normal and the woman's

refugee status the abnormal. The focus needed to be on the physical routine checks undertaken on all pregnant women and therefore decontextualising the asylum seekers and treating all women the same.

In addition to this, chapter six (see 6.4.3) presented findings which related to taking out the context of the asylum seeker and inserting the pregnant teenager into the transcripts to consider if the discussion around the heavily pregnant woman was still relevant if the context was changed. The issues that had been discussed around social and emotional needs were still relevant to the pregnant teenager, which suggests, even when considering the wider context of care, this is a generic approach rather than examining the specific needs of the individual women. Participants appeared to be searching for this generic focus when discussing other aspects of care and whether there were policies and guidelines that should be followed; *"it makes me interested in whether or not there are guidelines and policies that address the emotional needs."* And in relation to planning care for asylum seekers; *"You could say are there any maternity guidelines in relation to asylum seekers"*. There appeared to be such a concern with following policies and guidelines that they became central to the participants' learning around the pregnant asylum seeker, which arguably resulted in her wider contextual needs being neglected.

Other studies which have examined approaches to midwifery care identified similar issues. They found that midwives rigidly followed policies and guidelines (Kirkham and Stapleton,2004) and standardised care pathways (Hunter and Segrott,2009) which they believed were mandatory. This has obviously

impacted on the participants in this study, who in the learning environment appeared to believe that policies and guidelines were central to identifying and meeting their learning needs.

8.4 “Midwifery” discourse

This chapter so far, has argued that the entangled dominant medical and managerial discourses have impacted on the way that midwives approach caring for the pregnant asylum seeker in the clinical setting. However, as presented in chapter six (see 6.3), within this study, some participants’ discussions reflected a counter discourse. Examples were presented in which participants argued against the focus of discussion being around the physical needs of the pregnant asylum seeker. However, in most cases, the issues were dismissed by other group members in favour of addressing the physical needs.

The examples presented in chapter six included the questioning of female genital mutilation as just a physical care issue, when it was argued that there could be a big emotional impact on the woman of having been subjected to the procedure. Another example related to the discussion around one participant wanting to address the emotional needs of the pregnant asylum seeker in more depth; *“How best can a midwife counsel a, an asylum seeker?”* However, this wasn’t perceived to be *“one of our jobs”* and *“the best way is to do minimal”* and therefore this was rejected as a learning issue.

One participant offered an alternative perspective to approaching midwifery care. She discussed *“Starting with people”* and prioritising the woman’s

perceptions of her needs rather than the midwives perceptions. The aim of her approach to care was providing *"as much of a positive experience of having children ...as possible"* and *"Supporting her as opposed to having specific goals of my own as a professional"*. The approach to care offered by this participant could be argued as woman centred, which starts with addressing the woman's individual needs and builds on this (Wickham,2004). This woman centred approach was reflected by another participant in this study, when she described how the midwife should; *"provide appropriate care according to the woman"*.

Walsh (2004) suggests that a woman centred approach to care should be based on the principles behind feminist values and beliefs. Leap (2009) asserts that the focus should be on the woman's perspectives of her needs and choices, rather than the institutional approach which was described earlier and reflects the dominant medical and managerial discourses. The focus therefore is on the relationship between the woman and midwife and not the potential pathology related to childbirth (Hunter,2006). A woman centred approach to care should value all aspects of care equally; including the physical, social, psychological and cultural aspects (Stephens,2004). However, Jentsch, Durham et al (2007) argue that there is no consensus on how to provide woman centred care, with different interpretations of what it actually means.

Hart, Hall et al (2003) argue that central to different approaches to woman centred care is whether it is perceived that the midwife or the woman should make decisions on the woman's care needs. Bates (2004) interprets the approach as the woman making the decisions herself, by the focus being on

encouraging the development of her self confidence and an internal locus of control. The Royal College of Midwives (RCM) offers an alternative perspective in its position statement on woman centred care. The RCM discusses the need to take into account a woman's beliefs and judgments in an equal partnership in approaching care and considering emotional psychological, social and physical needs of the woman (Royal College of Midwives,2008). This suggests that the midwife has some autonomy in care decisions but works with the woman to address her needs. The Nursing and Midwifery Council (Nursing and Midwifery Council,2009, p. 4) has a similar standpoint, describing women centred care as being "responsive to the needs of women and their families in a variety of care settings", but that the midwife assesses woman's needs and determines the care programme for her.

All the NICE guidelines around maternity care contain a preamble discussing the need to undertake woman centred care in that a woman's views and informed choices should be respected (National Institute for Health and Clinical Excellence,2010). This is despite the fact that the mainly physical needs of pregnant women are clearly prescribed throughout each document. It can be argued that the possible informed choices offered to women would be constrained to those care issues prescribed within NICE guidelines. Therefore this interpretation of woman centred care appears narrow and arguably reflects medical and managerial dominant discourses. Similarly, the National Service Framework (Department of Health and Department for Education and Skills,2004) discuss the concept of woman centred care, however this in relation to following defined care pathways. Arguably, this does not suggest an

individualised approach to care provision or facilitating a woman to make choices around her care needs.

The findings from this study identified another apparent area of conflict around the concept of woman centred care. This conflict concerned the issue of whether the central focus in assessing needs should purely be on the woman as an individual, or whether it is important to consider her wider context and how this might impact on this assessment (see 6.4). There were two perspectives expressed within the findings chapter around this issue.

One perspective was that the central focus should be on the woman as an individual to avoid generalising; *“they’re all going to have their own different experiences.”* Generalising was described as *“putting them all in a box”* and participants discussed the need to avoid this. A specific example of cultural issues was shared and the fact that *“you can’t know the cultures of everybody”*; *“Even each culture has different cultures”*. This suggests that some participants did not believe that you need to try to learn about a woman’s cultural context. However, one participant believed that not considering a woman’s cultural context could lead to difficulties in meeting her individual needs; *“deal with somebody as a person.... and that means I don’t have to learn about cultures and I don’t have to learn about general counselling skills and I don’t have to learn about, about ways and skills for, for dealing with people from different cultures because you know, I just work on a one-to-one basis. Oh, I’m being nice to somebody.’ But maybe actually from their perspective – I’m getting it all wrong”*.

The dichotomy about whether to focus on the woman as an individual, or whether to focus on learning about her context, is reflected in the literature around nursing and midwifery. Nairn, Hardy et al (2004), in their discussion about the importance of teaching about culture in nurse education, argued that it is important to place everyone in a cultural context when providing nursing care. Squire and James (2009) support this, arguing that care of pregnant asylum seekers could be enhanced by learning about the wider context of their cultural background, but also about the countries from which they come. The Nursing and Midwifery council document, "Standards for pre-registration midwifery education" states that the midwife should "ensure that the care is sensitive to individual women's cultures and preferences" (Nursing and Midwifery Council, 2009, p. 23). This suggests that to be "sensitive to", then the midwife must learn about the woman's cultural context.

Contrary to this perspective, Cowan and Norman (2006), suggest that cultures are constantly changing and contain different subcultures and therefore it would be impossible to fully understand different cultural contexts. In addition, Schott and Henley (1996b) stress that it is important not to treat everyone within a particular group, such as cultural group all the same, as this encourages labelling and ignores individuality. Squire and James (2009) suggest that the generalisations that result from learning about context should act as a paradigm from which the individual pregnant asylum seekers needs can be explored. This suggests the need to develop knowledge about contextual factors that may

impact on the pregnant asylum seekers needs, but also be aware of individuality and the need not to generalise. This will be explored further below (see 8.6).

Returning to this study, one participant reflected this perspective when attempting to articulate her approach to midwifery care:

"I suppose how I feel is that all individuals exist within a context... it is a constant balancing act and taking into account someone's context and the fact that you can't make any assumptions...I don't think it does any harm to try and educate yourself...about cultures that you don't have any experience of if you're coming into contact with people from those cultures. It doesn't mean that...you have to make more assumptions about a person just because you understand a culture that they come from a bit better Yeah, I think it might even mean that you make less assumptions Because yeah, because you understand the background a bit more."

This chapter so far, has argued that the way that midwives approach caring for the pregnant asylum seeker is influenced by the powerful medical dominant discourse, entangled with the managerialist discourse. These discourses are (re)produced in the NHS clinical environment and manifest as meeting women's physical needs at the expense of her other holistic care needs. In addition, this chapter has also revealed a counter discourse reflected in the concept of a woman centred approach to care. This will be referred to as a "midwifery" discourse due to the original meaning of the word midwife, "with woman". Arguably, to provide woman centred care, being "with woman" is important, whereas following policies and guidelines and undertaking physical

assessments does not appear to need that same relationship. However, the way that woman centred care is understood is variable and this appears to have led to difficulties in participants grasping how to adopt this concept in practice. This chapter will now examine approaches to care from a structural perspective, by exploring the power struggle that exists between these different discourses.

8.5 Power struggles and social locations

It can be argued that the findings from this study have revealed a dichotomy which midwives face in clinical practice when making decisions about approaching midwifery care. On the one hand, the medical discourse (re)produces the focus on physical assessment of women and on the other, managerial discourse reflected in policies and guidelines focuses on the need to identify potential pathologies and reduce risk. Midwifery discourse reflects the concept of woman centred care and approaches care in relation to educating women to enable them to make an informed choice in their maternity care. To complicate matters, midwives have to consider their employer, who sends out a clear message about safety, risk and adherence to policies and guidelines. Carolan and Hodnett (2007, p. 144) argue that midwives have a daily struggle to maintain normality and reduce medical intervention in their approach to care; "midwives as guardians of vulnerable childbearing women versus physicians wanting to take over and medicalise pregnancy."

As identified in chapter seven (see 7.4), discourses are complex and entangled masses of knowledge (re)produced from a number of different social locations and are negotiated and ever evolving over time (Jager and Maier,2009).

Discourses are a manifestation of power which is located within different social locations in which dominant discourses are (re)produced. This chapter will now explore the social structures, in which, arguably the dominant discourses influencing midwives' approaches to care are (re)produced. However, other social structures exist and are likely to have had an influence on dominant discourses. As discussed in chapter seven (see 7.4), it can be argued that the complex and ever evolving nature of discourses would make it impossible to offer more than an insight into how they influence everyday phenomena.

It can be argued that the historical events discussed in chapter two (see 2.2) have been central in shaping the way that midwives practice today. Most midwives work within the hierarchical culture of the NIIS, where wider decisions about care are taken by medical staff and managers, through policies and guidelines, away from where the caring takes place (Davies,2004a). Midwives have to fulfill their contract of employment which includes the adherence to these policies and guidelines (Porter, Crozier et al.,2007).

Walsh and Newburn (2002) assert that midwives often work in an environment which is understaffed and is driven by technology and the medical model of care. Frequently, new Department of Health initiatives are introduced which further control the way that midwives practice (Walsh and Newburn,2002). In addition, midwives practice is regulated by the NMC, which has a number of roles, but predominantly functions to protect the public from potential harm caused through substandard midwifery care (Nursing and Midwifery Council,2004). This regulation occurs through professional guidelines published

by the NMC. However, Pollard (2010) undertook a discourse analysis examining midwives practices in contemporary maternity care and argues that professional guidelines are framed within a medicalised approach to care. Consequently, it can be argued that midwives are practising in an environment influenced by competing medico-scientific, managerial and midwifery discourses which will impact on the way that midwives approach their care provision. Walsh (2004) questions how midwives can have any power in the way that they practice when considering the rules originating from different sources that govern their practice.

Kirkham and Stapleton (2004) argue that power exercised through medical discourse is still an issue today, with doctors still being considered in authority over midwives when making decisions about care. In addition, the Lankshear, Ettore et al (2005) study found that obstetricians consider themselves as more senior than midwives in clinical decision making. However, it can be argued that midwives themselves have (re)produced their position in maternity services. Lankshear, Ettore et al (2005) observed that midwives do hold some power in the delivery suite setting, with doctors only entering the room when invited by the midwife. However, doctors were often called for reassurance about decisions made by midwives, which were within their scope of practice, suggesting a lack of confidence in the midwife's ability to fulfill her normal role without medical support.

The managerialist discourse is still evident in the plethora of policies and guidelines which midwives are expected to follow when approaching care

provision. Kirkham and Stapleton (2004) argue that the fear of litigation is the key force which continues to control contemporary maternity care. However, the Lankshear, Ettore et al (2005) study found that it is not just midwives decision making around care that is controlled, obstetricians are also constrained by rigid policies and guidelines when making clinical decisions about pathological situations. This suggests that over a period of time, the balance of power has changed within maternity care, from medical discourse ultimately controlling practice in the NHS to the managerial discourse exercising power and controlling practice through policies and guidelines, with an agenda of reducing the likelihood of litigation.

Kirkham and Stapleton (2004) argue that the hierarchical structure in the NHS in which midwives work has led to them undertaking menial roles, such as acting as a waitress and secretary. In addition, they found that bullying and horizontal violence is a problem in maternity units, where frustrations about approaches to care are taken out on colleagues. Hunter (2005) argues that senior and junior midwives may approach care in different ways and that to maintain their status as senior midwives, there may be unwritten rules and sanctions enforced on junior midwives. This may be difficult to challenge and consequently the junior midwife may conform to the medical approach to care. In addition, Kirkham and Stapleton (2004, p. 124) discuss the concept of “doing good by stealth”, in that midwives are so concerned with the consequences if they do not conform to policies and guidelines, that they may approach care in a covert way, in order to do their best for the women that they are caring for.

It can be argued that the dominant discourses, which govern the way that midwives practice, impact on both the autonomy of the midwife in making care decisions and the woman in exercising informed choice. This will have a negative impact on the morale of midwives (Ellis,2004; Stephens,2004). Smith, Cantab et al (2009) undertook a study examining perceptions of safety in maternity services. They found that many midwives were unhappy with the dominant medical model of childbirth, believing that ever increasing medicalisation was actually a **threat to safety**. They also believed that women and their partners were often frightened about childbirth because of the possible medical intervention.

Lavender and Chapple (2004) undertook a study which explored midwives perceptions of current maternity care. They found that some midwives tried to follow a philosophy of normal midwifery, but that the medical model ultimately controlled care provision. In addition, senior midwives sustained this medical model through the way that they practiced. The senior midwives were described as being demotivated by the constant battles to maintain normality and consequently, they had conformed to the medical model of care. This had a knock on effect on other midwives, who in turn felt pressured to conform. This could also have an impact on midwifery students working in the clinical areas. Although they may be learning about woman centred approaches to care in the university setting, in reality they may find this difficult to follow, due to the dominance of the medical model. This was an issue identified in Lavender and Chapple's (2004) study, where midwifery students felt under pressure to conform from qualified midwives and therefore felt unable to achieve the

standard of care that they wanted to. This issue will be explored further below (see 8.6).

The medical model of childbirth is argued as being ethnocentric and based on the needs of the dominant majority population (Raynor and Morgan,2000; Sookhoo,2009). Kitzinger (2000) argue that new immigrants in the UK, including pregnant women, are expected to comply and fit into the medically dominated health care system. This may be totally alien to the health care experiences that they have had in their country of origin. They may have arrived from a country, such as Afghanistan, where natural remedies, including herbs and flowers are the main focus in curing illnesses (Feldmann,2006). In addition, pregnant asylum seekers may have experienced torture in their home countries, undertaken in rooms resembling hospital wards and by people in white coats resembling health professionals (Squire and James,2009). Arguably, this alien environment will negatively impact on their maternity experiences in the UK and could stir up distressing memories of the experiences that they have encountered.

In addition, this chapter has argued that the way that midwives approach midwifery care and neglected the emotional and social needs of the pregnant woman, could exacerbate the pregnant asylum seeker's poor experiences of maternity care. When considering the potential emotional vulnerability of these women, perhaps it is these needs, which should be the main focus of midwifery care, with her physical needs coming secondary to this.

8.6 The way forward

This chapter so far has identified dominant discourses which can be argued as having a negative impact on the way that midwives approach care provision. These medico-scientific and managerial discourses exercise power, which appear to influence the way that midwives practice at the expense of a woman centred approach to care. This power struggle needs addressing to improve both midwives working lives and pregnant women, including asylum seekers' experiences of maternity care. It is beyond the scope of this study to adopt a structuralist approach and address all the factors highlighted in this chapter. However, it will make recommendations for changes to improve practice (see chapter ten; 10.7.3). The focus of the remainder of this chapter is on midwifery education and how this can be addressed in relation to some of the issues identified in this chapter.

The first issue which can be addressed, within the context of midwifery education, relates to the confusion around the concept of woman centred care and how it should be approached (see 8.4). In this study, the participants appeared to have difficulty in identifying what woman centred care actually means and the balance between treating the woman as an individual but also considering how her wider context may impact on her care needs. There was a fear that it would be easy to make assumptions about what her context may be and make generalisations about her care needs. However, the need to learn about context was an issue identified in the first PBL focus group interview which was discussed in the findings chapter (see 6.4.3). One of the questions

participants decided to address was *“What is Martha’s social and cultural background (Sudan)?*

Participants’ presentation of their findings from this question appeared to demonstrate a wider understanding of the asylum seeker’s background. This included knowledge of geography; the distance some displaced people had to travel before they actually claim asylum. It also included the history around the Sudan and its poor economic situation and history of colonialism and civil war. With that knowledge, one participant expressed that the UK should *“take some responsibility”* having contributed to the current position of the country.

Participants also developed an understanding about some of the reasons why women may flee the Sudan; human trafficking, slavery, forced prostitution, rape and torture and the implications for midwifery care of bad memories being re-triggered; *“It were talking about torture rooms as well being given medical names so women will be terrified to go into hospital because if they’ve been tortured, they may have been tortured in a room that’s called the operating theatre”*. There was also a discussion about how the pregnant woman may feel on arriving in the UK; *“It must be quite shocking then coming over here. To see the traffic buildings, tall buildings, cars”*. The students revealed that this contextual learning had a positive effect on their understanding. As one participant pointed out; *“I think it kind of gives you an understanding of what these women might be coming from as well because you, you kind of make assumptions about, and what, what I’d read is far worse than what I thought and it just shocked me, really.”* This suggests, rather than learning about a woman’s

wider context increasing assumptions, the knowledge about context actually reduced the assumptions made about a woman.

These findings suggest that the way forward in midwifery education is by encouraging midwifery students to learn about a pregnant asylum seeking woman's context and the impact that this will have on her maternity experience. This will be followed through in chapter nine, by developing a new model for midwifery education which will facilitate students to consider contextual factors when approaching midwifery care. This should also help to facilitate a consistent approach to undertaking a woman centred approach to care.

Another issue related to midwifery education, which was identified in this chapter, was the difficulties midwifery students may face in the clinical area. It was identified that they may be unable to adopt a woman centred approach to care because they became influenced by the dominant medico-scientific and managerial discourses once in the hospital setting (see 8.5). There are two issues to consider here; whether current midwifery education is effectively facilitating students to adopt a woman centred approach to care and also, how educational programmes can organise clinical practice in order to optimize the opportunities for midwifery students to adopt a woman centred approach to care.

The first issue relates to the organisation of midwifery education and Davies (2004b) argues that it continues to be approached from a medico-scientific paradigm; students acquiring facts and compartmentalized knowledge about

different midwifery subjects. She argues that subjects need to be integrated to encourage synthesis of knowledge, rather than adopting a reductionist approach in practice. However, it can be argued that contemporary approaches to midwifery education, including problem based learning (PBL) do adopt a more holistic and integrated, woman centred approach to education (Haith-Cooper,2001b). The educational philosophy behind PBL is that knowledge is constructed and synthesized around a woman's perceived needs. These needs are identified through the use of scenarios developed from clinical practice, including fictitious women such as Martha, in the context of this study (see appendix three), or through using mediums such as photographs of a mother or baby (Rowan, McCourt et al.,2007).

Although it is beyond the scope of this study to explore the use of PBL in midwifery education, it is important not to become complacent about its merits as a woman centred approach. Rowan, McCourt et al (2008) undertook a study which examined midwifery students' perceptions of their experiences of PBL in their curriculum. Although there was positive feedback, some students expressed concern about the mismatch between problem based learning and practice. They found that clinical mentors were often too tired or busy to embrace the PBL philosophy and students felt that they were not supported to learn in this way. It is important to consider clinical colleagues when introducing new, woman centred approaches to education and ensure that there is a consistency between the way students learn in the university setting and what they experience in clinical practice.

The second issue identified above, related to how educational programmes can organise clinical practice in order to optimize the opportunities for midwifery students to adopt a holistic, woman centred approach to care. It can be argued that the traditional approach of allocating students to different clinical settings for a period of time to develop knowledge and skills relevant to that area, is incongruent with the concept of providing a holistic, woman centred approach to care, where continuity of care would appear important to meet the woman's individual needs.

The Nursing and Midwifery Council (2009, p. 16) in the standards for pre-registration midwifery education document, identified that "student midwives must be involved in the care of a small group of women throughout their childbirth experience". This requirement has been interpreted as introducing caseloading into the midwifery curriculum. This appears to encourage students to adopt a holistic, woman centred approach to care provision (Lewis, Fry et al.,2008).

It will be argued in chapter nine that a new model for midwifery education will be particularly useful for midwifery students whilst caseloading. It will enhance their experience by encouraging them to consider contextual factors, which will impact on the care needs of women in their caseload, especially asylum seeking women. Although it is beyond the scope of this study to explore the caseloading initiative in any depth, as highlighted above in relation to using PBL as a teaching methodology, it is important to be supported by clinical colleagues

when introducing a new initiative into midwifery education and consider the impact of the initiative on the clinical environment (Lewis, Fry et al.,2008).

This chapter has identified how dominant medico-scientific and managerial discourses have impacted on what is perceived as authoritative knowledge in clinical practice, which in turn influences the way in which midwives approach care provision. Knowledge developed through randomised controlled trials and written into policies and guidelines appears to be the main driver when planning midwifery care. Hunter (2006) argues that this reliance on medico-scientific knowledge has undermined other forms and sources of knowledge which traditionally were considered relevant to midwifery practice.

The findings from this study identified that there was a lack of feminist theory considered in the discussions around the pregnant asylum seeker's needs. In particular, there was no discussion of women's gendered experiences, or gendered power imbalances and how the woman could be empowered in her midwifery care. It is argued that the midwifery profession has not yet embraced feminist principles with little being included in midwifery texts (Bates,2004; Walsh,2004). In addition, Wickham (2004) argues that traditionally midwives learned their caring skills in many ways; through the use of stories shared between women, midwives sharing experiences and testing these out in new contexts and through tacit knowledge. It can be argued that these other ways of learning have been lost in contemporary midwifery practice, with the emphasis being on the application of medical knowledge, in making care decisions. Consequently, it can be argued that contemporary midwifery education needs to

address these issues. It should consider the multiple sources of knowledge, which can be tapped into, to build and test theories which are relevant to women as practitioners and receivers of care.

Belenky, McVicker Clinchy et al.(1997) wrote a book entitled “Women’s Ways of Knowing”, which has arguably become a seminal text. They originally undertook a study of 135 women from different socioeconomic and ethnic backgrounds to examine these women’s experiences of learning throughout their life. They described women’s cognitive development as passing through five different stages, from silence, where women perceived themselves as silent and dependent on external authority, to the constructed knower (see appendix nine). As the women passed through these stages, they became increasingly trusting that knowledge is constructed from within rather than from an external force telling you what you need to know. Initially, women did not have the confidence to express this internally constructed knowledge. However, as they moved through the five stages, they began to believe that internally constructed knowledge could be shared as a subjective interpretation of the world.

Although this study could be criticised as being simplistic and also applicable to men as well as women, I found it useful when considering midwifery knowledge and the consistent power struggle between authoritative medico-scientific knowledge imposed on midwives from external authorities, telling them what they need to know and other forms of midwifery knowledge, such as experiential knowledge, which could be argued as an internally constructed sources of knowledge. Arguably, to reach the desirable stage of constructed knower, the

midwife should view the different forms of knowledge as contextual, such as medico-scientific, experiential and feminist in order to develop a personal construction of knowledge in a particular context.

It can be argued that the philosophy underpinning the use of PBL as a research methodology, is striving to achieve the constructed knower described by Belenky, McVicker Clinchy et al (1997). PBL encourages students to explore and share their previous experiences and contextual knowledge to construct new knowledge relevant to the current context (Haith-Cooper, Macvane-Phipps et al.,1999). However, as discussed above, the situation in practice does not mirror this philosophy. This study will now move on to develop a new model for midwifery education which will strive to develop constructed knowers in the midwifery student population. The intention will be that the student can use this model to help her to maintain focus on providing a woman centred approach to care, using different forms and sources of knowledge to achieve this.

8.7 Conclusions

This chapter has returned to the intellectual puzzle developed for this study and constructed an argument around why some pregnant asylum seekers may have poor experiences of maternity care. This argument has focussed on the way that midwives approach their care provision. This chapter has argued that a power struggle exists between traditional midwifery discourse, from which woman centred approaches to care evolved and medico-scientific and managerial discourses from which policies and guidelines, underpinned by the medical model and scientific research have controlled practice. These discourses are

reflected in the findings from this study, which demonstrated participants' apparent confusion around the inconsistent messages as to how midwifery care should be approached.

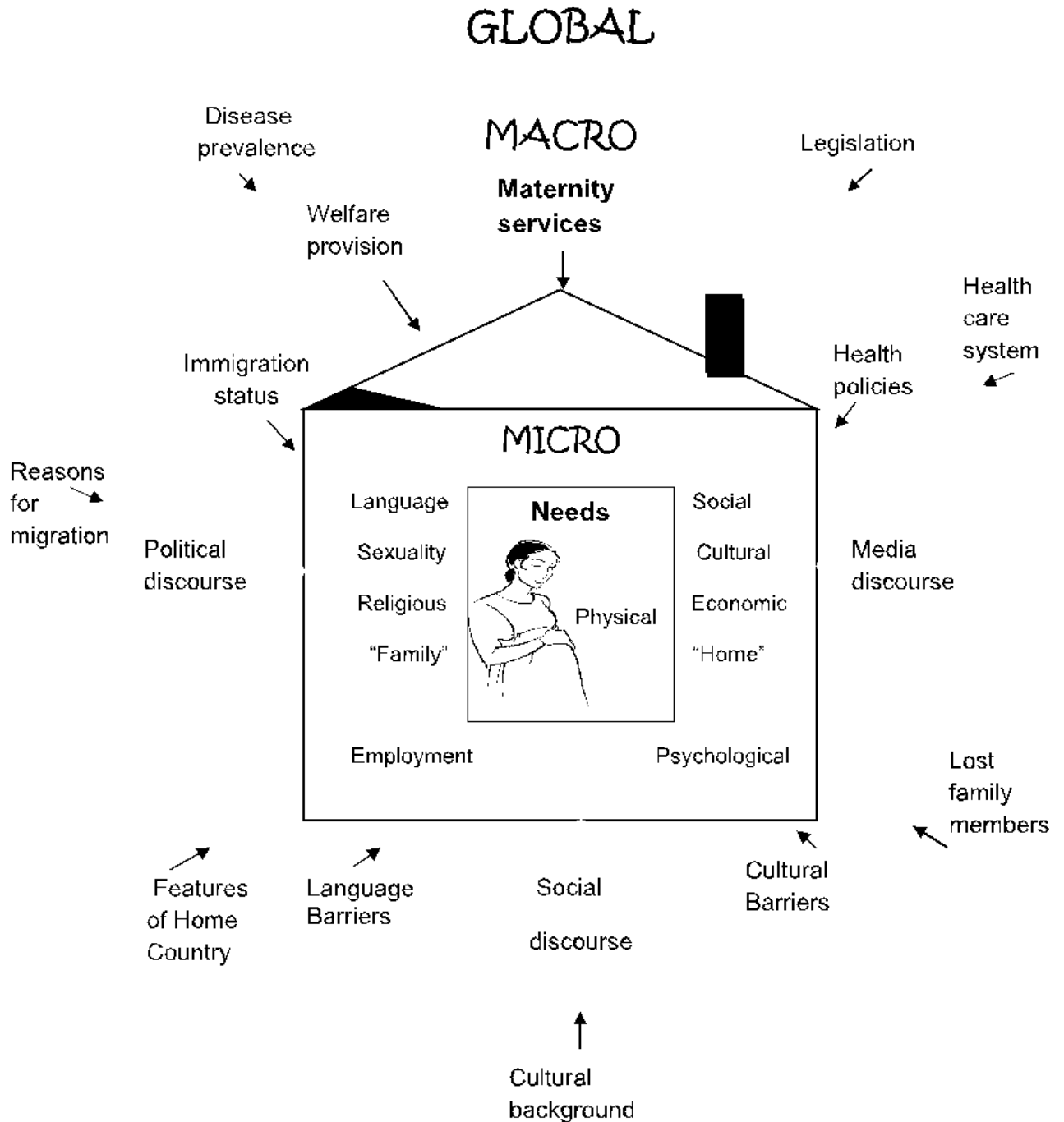
The concept of power has been revisited from a Foucauldian perspective and applied to the power struggle within maternity units. This was examined from a historical perspective to plot changes within maternity care over the last three hundred years. This historical perspective explored how different discourses evolved over this period to influence maternity care provision and how the midwife became marginalised with the progression of time. It also explored the changing relationship between medico-scientific and managerial discourses and how this has impacted on midwives approaches to providing care.

This chapter then moved on to discuss the way forward in addressing these power imbalances. It discussed how PBL as a teaching methodology and the integration of case loading into the curriculum, could help to address the apparent dichotomy between what students learn in theory and then experience in the clinical environment. It also focussed on issues around knowledge and power. It explored the work by Belenky, McVicker Clinchy et al(1997) and compared the five stages of women's cognitive development to the current context of maternity services. It discussed how the influence of different types of knowledge may lead to midwives being situated in different stages of the five categories of learner. Midwifery education strives to develop constructed knowers and currently, the influence of knowledge underpinned by the medical model and reflected in policies and guidelines, is not conducive to the individual

being able to interpret different forms and sources of knowledge as contextual and create her own constructed knowledge from this.

Chapter nine will now focus on the development of a new model for midwifery education. It will draw on relevant theoretical concepts to explore how the new model could be useful for midwifery students when learning to care for pregnant asylum seekers. The model aims to work with both caseloading and PBL to facilitate students to explore contextual learning and how this may improve the care that pregnant asylum seekers experience when accessing maternity services.

“The Pregnant Woman within the Global Context”



Chapter 9: “The Pregnant Woman within the Global Context.”

A New Model for Midwifery Education

9.1 Introduction

The central focus of this chapter is on exploring the development of a new model for midwifery education. It can be argued that this new model, “the pregnant woman within the global context”, represents a culmination of all the key theories, developed from undertaking this study. The model is designed to encompass these theories, but also to respect the philosophical position underpinning the study and the context of contemporary midwifery education.

The aim of this model is to provide a structure to facilitate midwifery students' learning by considering the issues that this study has argued are important, when caring for a pregnant asylum seeker. However, this model is not designed to constrain the way that a midwife works in clinical practice, neither is it designed to prescribe what a student needs to learn. It is intended to act as a guide to facilitate learning around some of the issues that may be important in a particular context.

The model is constructed in such a way as to facilitate a holistic assessment of need, rather than the apparent focus on physical assessment at the expense of other aspects of care (see chapter eight; 8.2 for more discussion around this). In addition, it addresses the apparent confusion around the term woman centred care, by providing a consistent approach to the assessment of individual needs (see 8.4). It is designed to facilitate the balance between taking into account the

woman's context, but also treating her as an individual, as discussed in chapter eight (see 8.4). Finally, it incorporates the wider contextual factors, on a global level, which could impact on the pregnant asylum seeker's health and social needs (see 8.4).

As the title of this model suggests through the use of the word "context", it respects the social constructivist philosophical position, the starting point from which this study was designed (see 3.2.1 for a discussion of this). In addition, it also respects the belief that socially constructed knowledge is influenced by discourses within the context of an individual's situation in the world, by incorporating the discourses, identified within this study, which may influence the way that the pregnant asylum seeker is perceived (this is explored further below, see 9.3.2).

The use of the term "the pregnant woman within" in the title suggests that the, woman as an individual, is central to this model, reflecting the feminist, woman centred principles underpinning this study and what the student needs to learn to care for this woman, will be from the woman's perspective (see 3.3 for further exploration of this). In addition the word "global" is used to represent the issue of globalisation as an aspect of contemporary society (see 7.4.3 for more exploration of this), to highlight to the student, that the woman is from another country and the importance of considering this, when assessing a pregnant asylum seeker's health and social needs (see 8.6 for more detail of this). In addition, the word global arguably respects the principles for education for

sustainable development, implicit within this model (see 9.3.3 for further discussion of this).

It will be argued in this chapter, that this approach to the assessment of the pregnant asylum seeker is consistent with other aspects of the local midwifery programme; using PBL as a teaching methodology and also introducing caseloading into the curriculum. With guidance, the model aims to enhance midwifery students' learning experiences, by providing a learning tool which complements the use of PBL, but also encourages students to consider contextual factors, which will impact on the care needs of women in their caseload. Although the focus of the use of the model in this thesis is the asylum seeker, it could be broadened to include any immigrant woman, especially if she has recently arrived in the UK. Many of the issues identified within the model could be applied to immigration in a more general context.

9.2 The influence of contemporary midwifery education

The starting point when designing “the pregnant woman within the global context” model was examining current issues in pre-registration midwifery education. Consideration needed to be given as to how to ensure congruence between this model and contemporary issues influencing midwifery curricula. For this reason, current governance of midwifery education was revisited. The standards set by both the Nursing and Midwifery Council (NMC) and the Quality Assurance Agency (QAA), which regulate and review pre-registration midwifery education in the UK, were reviewed. The NMC standards are written into educational curricula (Nursing and Midwifery Council,2009) and the QAA subject

benchmark statements and code of practice frameworks, are used to assess the quality of the institutions delivering the midwifery curricula (Quality Assurance Agency,2001; Quality Assurance Agency,2011). For this reason, it was perceived important that the standards and benchmarks were implicit within the new model.

In addition to this, the initiative around education for sustainable development was considered to be important. The United Nations Educational, Scientific and Cultural Organisation programme (UNESCO) developed principles which have been adopted within local institutions to guide curriculum development (University of Bradford,2011). Some of these principles were considered relevant in the development of this model and were respected when the model was designed. Relevant governance issues and UNESCO principles are referred to throughout the course of this chapter.

Hart, Lockey et al (2001) undertook a study on behalf of the English National Board (ENB), one of the organisations preceding the NMC. Although this study is now dated, it can be argued that the findings are still relevant to contemporary midwifery education. Hart, Lockey et al (2001) identified that midwifery curricula tended to focus on preparing midwives to approach care of pregnant women in an anti-discriminatory, individualised way and that midwives lacked knowledge of wider structural issues, which can lead to inequalities and oppression in some women in society. They recommended that midwifery education should learn from the social work approach and progress from this micro approach to care, to an anti-oppressive model of practice, examining wider structural issues to

identify and address inequality and oppression in women. This is supported by one of the QAA benchmark statements, which discusses how midwives should practice in an anti-oppressive way, promoting social inclusion (Quality Assurance Agency, 2001). The Hart, Lockey et al (2001) study also reflects one of the key issues to arise from this study in that when assessing health and social needs, consideration should be given to the wider context, rather than just the woman as an individual, and how this might impact on this assessment (see 8.4 for further exploration of this).

As a result of the findings from this study, I undertook a search for midwifery models of care, which could facilitate this anti-oppressive approach to practice, whilst also encouraging an individualised holistic assessment of needs.

Although literature could be found recommending that midwives and other health professionals consider wider structural issues when approaching care; for example Chevannes (2002), no specific midwifery models were found in the literature which could facilitate students in approaching care in this way.

However, Midwifery 2020, the most recent national programme, commissioned to review and provide a vision for contemporary midwifery, identified that holistic models of care should be used by midwives, when caring for women (Midwifery 2020, 2010).

A model which had been adapted for use in social work education, was considered useful in this context (Bronfenbrenner, 1994). Elements of Bronfenbrenner's Ecological Systems were adapted to help provide a structure to this model. In addition, elements of other midwifery models and theoretical

concepts were implemented for specific purposes, the details of which are explored throughout the course of this chapter.

9.3 Structure of the model

Bronfenbrenner (1994) developed a theory which focuses on child development and how it is influenced by relationships within her/his environment. This environment is divided into layers, which all have an impact on the child's development, but in different ways. Although the concept of these layers has been adapted for this global context model of midwifery, this is within the context of how three layers of the environment will impact on the pregnant asylum seeker's health and social needs. Bronfenbrenner (1994) describes how change or conflict in any one layer of the environment will ripple through the other layers and in this context, this will impact on the pregnant asylum seeker's needs. This chapter will now explore the three layers adapted from Bronfenbrenner's (1994) model and how they were interpreted within the context of this study.

9.3.1 The micro layer

Bronfenbrenner (1994) describes the micro layer as the level of the environment closest to the child (or in this case the pregnant asylum seeker) and contains the structures with which the individual has direct contact. These structures will be influenced by ripples emanating from the other layers of the environment, which will be explored further below. The micro layer encompasses the relationship between the individual and the immediate environment, including people, which in this case would include the midwife and other members of the household within which the woman lives. These people may not necessarily be family

members if the asylum seeker is unaccompanied in her asylum application. In addition, the environment may not necessarily be considered a home, due to the transient nature of asylum seeking (Mulvey,2010) and the fact that she may be living in an accommodation centre. For this reason, within the model, both family and home are emphasised to highlight the possible different interpretations of the terms.

From a midwifery perspective, the micro layer represents the relationship between the woman and the midwife and within this layer the midwife should assess the woman's individual health and social needs. Consideration should be given to the aspects in the micro layer which could influence these needs, but also the factors in the other layers which may send ripples through to this layer. These factors are discussed further below in relation to the other two layers. However, it is important to undertake this individualised assessment with the woman, to avoid stereotypes about the woman based on the midwives interpretation of factors in the other layers which may impact on her care needs. As part of this assessment, the woman's physical needs would be considered, but the way the model is designed, the physical assessment would not dominate this holistic approach, as appeared to be an issue in the findings from this study in relation to the way midwives approach care provision (see chapter eight; 8.2 for more exploration of this).

Within the micro layer of the model, language is identified as an aspect of care which needs consideration within the individualised, holistic assessment of the woman. The midwife should assess the woman's language needs and

overcome language barriers where necessary, in order to work with the woman and plan her care with her (Nursing and Midwifery Council,2009). Language barriers were an issue identified in this study and participants gave examples of where care was provided with a language barrier but without an interpreter present (see 8.2). Nicholls and Webb (2006) undertook a systematic review of the literature which concluded that the fundamental attribute of a midwife is good communication skills. Indeed, the NMC (2009) considers the need for effective communication skills as central to a midwife's role. However, language barriers are a problem in maternity services (Cross-Sudworth,2007) and providing care without an interpreter could be argued as indirect discrimination (Schott and Henley,1996a). Therefore it is vital that midwives address language barriers before attempting to undertake an individualised holistic assessment of a woman, as it could be considered impossible to undertake this in the presence of a language barrier without an interpreter.

As identified in chapter eight (see 8.4), the focus of a midwifery approach to care should be woman centred, individualised and holistic. It should also respect feminist ethical principles based on a woman's perceptions of her own needs and aspirations (Leap,2009; Stephens,2004). The philosophy of woman centred care is encompassed in both the NMC and QAA standards which govern midwifery education. They identify that woman centred care should encompass the cultural, social and psychological factors which influence childbirth (Nursing and Midwifery Council,2009; Quality Assurance Agency,2001). In addition, government reports such as Maternity Matters (Department of Health,2007, p. 8) discuss women focused approaches to maternity services and state that care

should “take full account of their individual needs including different language, cultural, religious and social needs.” The terms used by the NMC, QAA and in Maternity Matters have been encompassed within the micro layer of the global context model to reflect the aspects that should be considered within a holistic assessment of the woman. In addition, the dimension of sexuality has been added, which could be argued as being an important aspect of the pregnant asylum seeker’s identity. An example of a consideration in relation to sexuality around the pregnant asylum seeker could be whether she is pregnant as a consequence of rape, or whether she has been subjected to female genital mutilation. Both these issues may impact on her needs, including psychological needs, which should be considered within this holistic assessment.

When reviewing the literature around midwifery approaches to care, it became apparent that the social model of midwifery is an approach which some authors believe midwives should be striving to achieve and has been adopted by many maternity units (Briscoe and Lavender,2009; Walsh and Newburn,2002). This is also a recommendation from the Midwifery 2020 programme (Midwifery 2020,2010). However, it can be argued that some aspects of this model do not fit with the circumstances in which a pregnant asylum seeker may find herself.

The emphasis of the social model is around striving for home birth, with close friends and family being central to supporting the woman, rather than the emphasis being on the health professional (Walsh and Newburn,2002). As identified above, the asylum seeker may not consider that she has a home and

may be unaccompanied in her asylum claim and therefore be socially isolated. For this reason, it would appear that these aspects of the social approach are not appropriate in the context of this model. However, the social approach also identifies that the woman/ midwife relationship is central and it can be argued that it should also be an important component of the global context model.

The social model of midwifery considers the relationship between the midwife and woman as paramount and more of an equal partnership, rather than the midwife taking control over care decisions. Walsh and Newburn (2002) describe the midwife in the social model as a professional friend rather than an advisor. Indeed, the importance of a good mutually trusting relationship is a crucial component of providing a wider woman centred approach to care (Bates,2004; Carolan and Hodnett,2007). The unsupported asylum seeker may benefit from this relationship and the need to find someone in whom she can trust. However, Carolan and Hodnett (2007) argue that not all women want a close relationship with the midwife and may request that the midwife makes the key decisions about her care needs. In addition, Kent (2000) argues that the midwife has the expertise to make these key decisions, which the woman may not, especially if she has migrated from a country with a different health care system. Consequently, the midwife working with the woman should consider in her assessment how the woman wants to approach her care decisions and adjust her assessment to respect this.

Returning to the idea that ripples from the other layers of this model can impact on the micro layer and the experiences of pregnant asylum seekers, an example could be around domestic abuse. Asylum seeking women are perceived to be at an increased risk of domestic abuse due to the stress caused by the asylum process and the poverty in which asylum seekers live (Cross-Sudworth,2009; Sales,2002).

Burnett and Fassil (2004) assert that poverty and social isolation can have a negative impact on psychological health. Welfare provision and immigration status are two factors contained within the macro layer of the model, which arguably could have had a ripple effect through to the micro layer and should be considered within the holistic assessment of the woman.

The Nursing and Midwifery Council (2009, p. 4) states that midwives should “use a range of assessment techniques appropriate to the situation and make provisional identification of relevant determinants of health and physical, psychological, social and cultural needs/problems”. Arguably, this requirement is reflected within the micro layer of this model, where the student undertakes an individualised assessment of the pregnant asylum seeker’s holistic needs, with consideration to factors rippling through the other layers of the model, arguably determinants of health. Other factors within this macro layer are discussed further below.

9.3.2 The macro layer

Although the macro layer is described as the outermost layer of the child's environment (Bronfenbrenner,1994), in the context of the pregnant asylum seeker, it has been interpreted as encompassing the UK society in which she is living. Bronfenbrenner (1994, p. 40) describes this layer as the "societal blueprint", the structural layer comprising of belief systems, material resources and laws amongst other societal factors, which ripple through to the micro layer and influence the individual's experiences of life. Although there is no reference made to the concept of power within Bronfenbrenner's (1994) model, it could be argued that the structures contained within the macro layer exercise power, through the (re)production of discourses; the ripples; which influence the individual in the micro layer.

As identified in chapter three (see 3.2.2), power is a central concept in a critical discourse analysis approach to research. Multiple social structures, in this case contained within the macro layer of the global context model, exercise power and (re)produce dominant discourses (Jager and Maier,2009) which are diffused through society (Fawcett and Featherstone,2000), where contextual knowledge is constructed (within the micro layer of this model). In this study, it was argued that the findings demonstrated three possible social structures which (re)produce the dominant negative discourses around the asylum seeker; the media, government and social practice (see chapter seven; 7.4). However, power is more complex than merely (re)producing discourses and this interpretation provides only an insight into a complicated phenomenon.

To represent power (or ripples) within the macro layer, arrows have been added which indicate the perceived direction of power flow. In addition, the block arrows were added to represent the social structures, which the findings from this study suggest (re)produce the negative dominant discourses around the pregnant asylum seeker. However, when considering the Foucaudian interpretation of power, it is also exercised at the micro level through everyday social interactions which (re)produce dominant discourses (Fawcett and Featherstone,2000). This suggests that there should be arrows within the micro layer, pointing out towards the macro layer. However, as discussed in chapter seven (see 7.6), Jager and Maier (2009) assert that in society some people hold more power than others which can be exercised through economic, political or educational means. Within this model, the pregnant asylum seeker is the individual being considered within the micro layer and as argued in chapter one (see 1.9), this group of women are amongst one of the most marginalised groups of people in society (Squire and James,2009). For this reason, it was considered more appropriate to illustrate this powerlessness by excluding arrows from this layer.

The focus of the macro layer is for the student, when undertaking her holistic assessment, to consider the factors within this layer and the direction of the power emanating from these factors and how this may influence the pregnant asylum seeker's health and social needs. An example could be the immigration status of the woman. The pregnant asylum seeker may feel particularly anxious, due to the uncertainty of whether she will be allowed to stay in the UK. This uncertainty could be impacting on her psychological and physical health.

Therefore, the asylum process is exercising power which is impacting on the woman's wellbeing. As well as considering this, it would be expected that the student would read around the asylum process to increase her knowledge of the subject. This is an area that has been highlighted in previous research, of which midwives lack knowledge (Reynolds and White,2010). It would be expected that the student would consider the other factors in the macro layer in a similar way and how they may influence the pregnant asylum seeker's health and social needs.

The macro layer is also designed to facilitate students to focus on the block arrows and what they mean. In particular, the student should focus on the word discourse and how this may impact upon their understanding of pregnant asylum seekers. It is expected that the student would learn about social structures and how they (re)produce discourses and in turn, how this may lead to inequality and oppression in the pregnant asylum seeker. This could address the Hart, Lockey et al.(2001) argument, identified above (see 9.2), in that midwives lack knowledge of wider structural issues influencing pregnant women.

An example could be to examine political discourses around asylum seeking and how government policy may impact on the asylum seeker's health and social needs. It is well documented that midwives and other health professionals lack knowledge of wider political issues which influence pregnant women (Chevannes,2002; Hart and Lockey,2002; Leap,2009; Narayanasamy and White,2005), despite it being a requirement of the NMC (Nursing and Midwifery Council,2009). The macro layer of this model provides the midwifery student the

opportunity to explore this, in relation to a specific woman for whom she is providing care and to use her political understanding, in the assessment of the pregnant asylum seeker's health and social needs.

As discussed earlier (see 9.2), midwives should be approaching care provision in an anti-oppressive, rather than anti-discriminatory way, in which they challenge the social structures which exercise power, leading to inequality and oppression for some women in society (Hart, Hall et al.,2003). The global context model for midwifery education is designed to facilitate students to identify these social structures, by focussing on the block arrows within the macro layer. In conjunction with reading relevant literature, this model could be a catalyst to facilitating midwives to challenge negative dominant discourses around pregnant asylum seekers and begin to construct alternative discourses. The findings from this study suggested that, over the course of the second PBL focus group interview, participants were beginning to challenge these dominant discourses, through reading alternative sources of literature (see 7.7). This reading, in conjunction with focussing on the model, could be the beginning of this anti-oppressive approach to midwifery practice. Indeed addressing oppression, facilitating social inclusion and overcoming prejudice and discrimination, are benchmark statements identified by the QAA (Quality Assurance Agency,2001). It also encompasses the principle of achieving social and economic justice, within the programme for education for sustainable development (University of Bradford,2011).

This approach to midwifery practice appears to mirror the public health model of midwifery, which Ukoko (2005) argues should be an integral part of the role of the midwife and Midwifery 2020 recommends should become a wider focus of the midwife's role (Midwifery 2020,2010). The public health model focuses on approaching care from a woman centred perspective, but looking beyond the clinical encounter to examine the background factors which will influence the pregnant woman's life. This can be applied to the global context model, in which the macro layer contains the background factors and the micro layer the woman centred perspective.

Edwards and Byrom (2007) argue that in the public health role, it is important to achieve a balance between the individual woman's needs, whilst taking into account the context in which she lives. This reflects the findings from this study, in which there was a dichotomy between whether to focus on the woman as an individual or whether to focus on learning about her context (see chapter eight, 8.4 for more discussion of this). However, in addition to this, Ukoko (2007) asserts that to address the public health role, midwives have the ability to speak powerfully about vulnerable pregnant women and convince politicians, on behalf of the profession, to target policy to address structural issues impacting on these women's lives. This suggests that the midwife could be a useful advocate for the pregnant asylum seeker and through her public health role, work towards challenging policy that leads to oppression, in asylum seeking women.

One of the factors identified with a larger arrow within the macro layer of the global context model, is the maternity services and the key focus of this study

has been around pregnant asylum seeker's experiences of maternity care. As identified in chapter seven (see 7.5), midwives appear to be influenced by the negative dominant public discourses around pregnant asylum seekers, which may present as stereotyping and prejudice in maternity services. In addition, midwives appear to approach care provision influenced by dominant medico-scientific and managerial discourses, consequently addressing pregnant asylum seeker's physical needs at the expense of her other holistic needs (see chapter eight; 8.2). The large arrow within the macro layer is designed to facilitate the student to consider how discourses may be (re)produced within maternity services and how in turn this may ripple through to the micro layer and impact upon the pregnant asylums seeker's potential experiences whilst accessing maternity care. This may facilitate the student to consider her role in the woman's maternity experiences and how any negative issues can be addressed.

9.3.3 The global layer

One of the principles for education for sustainable development is to respect all people throughout the world (University of Bradford,2011). It can be argued that the title of the model containing the word "global" reflects this but also that the global layer of the model, addresses this principle by considering the wider context of the pregnant asylum seeker's world and the impact of factors in her world on her experiences whilst in exile in the UK. Although the global layer of the environment is included in Bronfenbrenner's (1994) model, there is little explanation of this in his book chapter. Consequently, the global layer has been interpreted to fit with the context of this model.

It can be argued that this layer is the outermost layer of the pregnant asylum seeker's environment and considers the global factors which will send ripples through the other layers and impact on her health and social needs whilst living in the UK. The main focus of the global layer is for the student to consider the pregnant asylum seeker's home country, how it may differ to the UK and how this may influence the assessment of the woman's health and social needs. Within this layer, there are specific factors which the student could consider and how they may ripple through the model to reach the micro layer and the pregnant woman.

Suurmond, Seeleman et al (2010) undertook a study of nurse practitioners who were involved in caring for asylum seekers. They were questioned about what they perceived was important, for practitioners to understand about asylum seeking, to help them in their role. They highlighted an important issue was being aware of the political situation in the asylum seeker's home country. It can be argued that this is an important consideration for this model, together with other features of the pregnant woman's home country, such as economic context, war and conflict and how these may impact on the woman's wellbeing. In addition, exploring possible reasons for the forced migration may help to understand her perspective, especially her psychological wellbeing. As identified in chapter one (see 1.9), asylum seeking women may have experienced gender specific crime such as rape, domestic violence and female genital mutilation, which may have contributed to the decision to flee her home country (Reed,2003; Ukoko,2007). This may have an impact on the woman's health and

wellbeing and as identified earlier, her perception of her sexuality as she may be pregnant as a consequence of rape.

Chapter eight (see 8.6) discussed how participants in this study, after reading around the features of the Sudan as a country, appreciated their increased understanding of what the pregnant asylum seeker may have experienced before leaving her country. Through their reading they perceived that her experiences were worse than they had imagined. They discussed the impact of this forced migration on the woman and the culture shock she may have felt, due to the different environment in which she found herself. Having this understanding of the home country may help assessment of needs and care planning on an individual basis. In particular, in this study, participants considered the fears that the pregnant asylum seeker may have, being admitted to hospital in the UK, due to the associated similarities with the torture room in her home country.

In addition to considering the reasons for forced migration, one of the factors identified in the global layer is lost family members. The pregnant asylum seeker may have family, including children, who she left behind, or who have been killed or gone missing (Dumper,2002). Obviously, this could have a massive impact on the woman's psychological wellbeing and Burnett and Fassil (2004) identify that post traumatic stress disorder is common following witnessing of atrocities such as the torture or murder of family members.

Legislation is an important issue highlighted in the global layer of this model and focuses specifically on legal measures designed to protect people, from an international perspective, such as human rights legislation. Specifically, for asylum seekers, this would include the 1951 Geneva Convention and the obligation of the UK to protect those seeking asylum (United Kingdom Border Agency,2011a). In addition, some UK legislation is relevant from a global perspective. The NMC (2009) requires that midwives have knowledge of legislation which addresses the issue of equality and diversity. This would include the Race Relations and the 2010 Equality Acts (see 2.3). The student would be expected to understand how measures such as these are designed to protect the pregnant asylum seeker and the implications of this legislation for midwifery care.

Another factor identified in the Suurmond, Seeleman et al (2010) study, was that practitioners should have an understanding of diseases prevalent in the asylum seeker's home country, in order that assessment of her physical needs is focused on potential infections. In this context, it can be argued that it is important to understand disease prevalence, but also wider issues around physical health which may influence the assessment of the pregnant asylum seeker's physical needs. Extreme poverty and prolonged conflict in the women's home country, as well as the journey to the UK, may have led to a deterioration in her physical health. As identified in chapter one (see 1.10) asylum seeking women may be malnourished, have anaemia, malaria, tuberculosis, HIV/AIDS and/or other sexually transmitted infections (Carolan,2010). It is important for the student to identify this, within her assessment of the woman's physical

needs and how they could impact on maternal and fetal health and then plan care to include appropriate medical intervention.

It could be considered important to consider the health care system in the pregnant asylum seeker's home country and how this may differ to the maternity services that she accesses in the UK (Somerville and Sumption,2009). In particular, some women may have not had access to any health care in their home country, due to poverty and conflict (Burnett and Fassil,2004). In addition, a country in extreme poverty is unlikely to have the technological advances which are available in the UK maternity services. Briscoe and Lavender (2009) found that a procedure, which is routine in the UK, may be viewed from a very different standpoint by a woman from a developing country. A surgical procedure of any description could be linked with the knowledge that women die during childbirth. This may increase an asylum seeker's anxiety whilst experiencing procedures in maternity services and the student should be aware of the need to consider this whilst acquiring informed consent for care. In addition to this, Feldmann (2006) interviewed Afghan refugees in the Netherlands about their understanding of health and how they approached health care in their country of origin. They tended to use drugs and herbs to treat minor illness, which could be purchased without a prescription. Also, Bhatia and Wallace (2007) undertook a study of asylum seekers and identified that some came from countries which did not consider the concept of psychological wellbeing, health was believed to be purely a physical phenomenon. This could have implications for a midwife assessing a woman's psychological needs; in particular, wanting to refer her if she suspects that she has mental health needs.

There may be a difference in the relationship between health care provider and client in the woman's home country. Feldmann's (2006) study found that, in Afghanistan, the doctor was perceived to be an authority figure telling people what to do in relation to illness. There was no understanding of the concept of autonomy and informed consent. This was also an issue identified in Egyptian society where paternalism was the accepted norm in health care practice and health professionals make decisions for their client (Rashad, Macvane-Phipps et al., 2004). This could lead to difficulties in maternity care if the health professional is attempting to gain informed consent for a procedure, from a pregnant asylum seeker who does not understand this concept. This could be exacerbated by language barriers. In her assessment of the pregnant asylum seeker's health and social needs, this is an issue that the student may want to consider when discussing the idea of informed choice.

This section so far, has identified how the factors included in the global layer of this model may ripple through to the micro layer and impact on the pregnant asylum seeker's health and social needs. The model encourages the student to consider how she can address these factors when planning midwifery care, in conjunction with the woman. She may be able to implement simple strategies to improve the woman's experiences of maternity services. Carolan and Cassar (2007) undertook a study examining the life experiences of African refugees living in Australia. As a result of this study, a number of simple initiatives were introduced into maternity care in one area, to improve their experiences; such as photographing pictures of the bus stop and antenatal clinic, to help women find

their way there. Also, considering issues such as how they tell the time when planning antenatal appointments. They found that women appreciated these simple initiatives which helped them to orientate to a country that was perceived as foreign. By examining the difference between health care in the UK and a pregnant asylum seeker's home country, there may be simple measures which can be implemented, to improve their experiences of maternity services in the UK.

Part of the process of planning care to meet the health and social needs of the pregnant asylum seeker could involve multi agency working and referring the woman to another service, to address her specific needs. One aspect of the student's learning from this model could be researching how to access appropriate services, to meet specific needs and how the student would work with other professionals and care providers to facilitate these needs. An example could be where the student and woman together identify the need to address her social isolation. Working with a charity, established to help asylum seekers, may be a way of the woman being introduced to other women who either speak the same language, who are from the same home country, or from a similar cultural context. In addition, when planning care, the student should identify when the woman needs referring to other professionals within the maternity services, such as the consultant obstetrician, should a medical issue be identified.

9.4 Incorporating cultural competence

As identified in chapter seven (see 7.5), one of the key issues which arose from the findings in this study, related to midwives in clinical practice and the apparent stereotyping and prejudice directed towards some women accessing maternity services. This was aimed particularly at women from a minority ethnic group, which included asylum seekers. This was also an issue identified in published research around women from different minority ethnic groups. Women were stereotyped by midwives because of their ethnic background and the cultural expectations of how they would behave due to their ethnicity. This was mainly related to women's pain threshold and how pain is perceived to be interpreted differently in women from particular ethnic backgrounds (Bowler,1993; Harper Bulman and McCourt,2002; Richens,2003).

The importance of respecting a woman's cultural background is identified by the NMC (Nursing and Midwifery Council,2009, p. 23), which states that the midwife should "ensure that the care is sensitive to individual women's culture and preferences" Similarly the QAA (Quality Assurance Agency,2001) discusses the need for midwives to consider cultural sensitivity when maintaining relationships with clients from different ethnic backgrounds. In addition, one of the principles for education for sustainable development refers to respecting cultural diversity and a commitment to building locally and globally a culture of tolerance, non-violence and peace (University of Bradford,2011). Consequently, identifying issues around cultural difference is argued as being an important aspect of the midwife's role and one that requires further exploration within the global context model for midwifery education.

Due to the perceived importance of the concept of culture, it is included in all three layers of the global context model. The global layer refers to the cultural background, customs and values present within the pregnant asylum seeker's home country. The macro layer refers to cultural barriers which may exist for the pregnant asylum seeker, due to incongruence between her cultural values and beliefs and the majority cultural beliefs implicit within the UK. In the micro layer, assessing cultural needs is a component of the individualised, holistic approach to assessment and within this; the student should consider the woman's perceptions of cultural barriers. By working with the woman to try to establish her cultural needs, it can be argued that possible stereotyping and prejudice, due to a lack of understanding of cultural background, can be overcome.

Assessing cultural needs is an area of practice which is widely referred to within contemporary health care literature and the term cultural competence has emerged, as a means of preparing practitioners for this role. Generally, cultural competence refers to developing a cultural awareness, cultural knowledge and skills to deal with ethnic diversity in practice (Suurmond, Seeleman et al., 2010). Probably the most cited model found in a literature review, was Campinah-Bacote's (1999) interpretation of cultural competence. She states that in order to meet the needs of different ethnic groups, achieving cultural competence can be broken down into five elements. The professional must have a desire to learn about culture and the opportunity to practice this in the clinical environment. She must develop cultural specific knowledge and be able to use this to develop skills in the cultural assessment of individual clients. Acquiring cultural competence is an ongoing process requiring constant reflection on practice, in

order to further develop this competence. Although this approach can be facilitated in the midwifery student to develop her cultural competence on a micro level, it has been criticised for a number of reasons.

Suurmond, Seeleman et al (2010) argue that cultural competence, as interpreted by Campinah-Bacote (1999), re-enforces the idea that the midwife's cultural background, (if she believes she has one), is the norm and that women from other cultural backgrounds are perceived as different. Therefore, standards for cultural assessment are based on the midwives own perceived norms and values. Difference, as a theoretical concept, was explored in chapter seven (see 7.4.3) in relation to Goffman's (1968) theory of difference cited in Haralambos and Holborn (2004). This difference includes personal characteristics or reputations which are perceived to be against cultural norms, with "them and us" developing from this. In this case, the argument appears to be that ethnocentricity is the norm from which the midwife starts in her assessment of cultural needs. The woman from a minority ethnic background is different and her beliefs are seen as a deviation from the norm. It can be argued that this approach to cultural competence would not help the development of a trusting relationship between midwife and woman, which has already been identified as essential for the possibly socially isolated pregnant asylum seeker. In addition, the midwifery student, who herself may belong to a minority ethnic group, may have difficulties in assessing the cultural needs of a pregnant woman from yet another minority ethnic group, if she has to start with beliefs of the perceived UK majority culture, which is different to her own cultural background.

Another criticism of the micro approach to cultural competence is the simplistic interpretation of ethnicity and culture and the interchangeable use of the terms in practice. Nairn, Hardy et al (2004) argue that culture needs to be applied in a broader ethnic context, rather than merely focusing on minority cultures, customs and traditions which are considered different. Suurmond, Seeleman et al (2010) argue that culture is a complex phenomenon influenced by other factors, which construct an individual's identity and consideration must be given to these other factors, which are not addressed by Campinah-Bacote (1999). Factors such as poverty, language barriers, class, age and gender are all issues which will influence cultural needs and should be considered when addressing cultural competence (Anderson, Browne et al.,2003; Garity,2000; Raynor and Morgan,2000).

In addition to this, Hart, Hall et al (2003) describe the Campinah-Bacote (1999) model as an anti-discriminatory approach to cultural competence, rather than an anti-oppressive approach, which was argued earlier as the approach midwives should take to examine inequality in practice (see 9.3.2). Rather than just focusing on the micro layer, this involves examining the power structures; in this context in the macro layer of the model; and questioning how cultural barriers are reinforced and inequality is perpetuated in practice (Hart, Hall et al.,2003). This argument is supported in other literature, where it is believed that culture needs to encompass wider issues around ethnic background, such as inequality, oppression and power relations (Nairn, Hardy et al.,2004).

To address this issue, Hart, Hall et al (2003) developed the inequalities imagination model which broadens the focus of culture to consider more general issues around disadvantage and inequalities. Within this model, they replaced the word "culture" with "inequality" and discuss how the midwife can develop competence in addressing wider issues around inequality in practice. Like Campinah-Bacote (1999), they discussed the elements of the model as motivation to learn, awareness of personal biases and prejudices, developing knowledge and skills, but in relation to addressing wider inequalities rather than specifically focusing on culture. They also considered this inequality in the wider context of care including gender, culture and economic disadvantage.

Suurmond, Seeleman et al.(2010) support this in their study of nurse practitioners' educational needs in working with asylum seekers. They argue that an individualised approach to cultural difference is inadequate and culture needs considering within the wider socio-political complexities around asylum. In addition, they argue that asylum seekers may present care providers with different challenges around cultural competence, which may force the questioning of one's own personal prejudice and stereotypes around asylum seekers. This can be linked back to the dominant public discourses around asylum discussed earlier, in relation to the macro layer of this model (see 9.3.2) and how the holistic individualised assessment of the pregnant asylum seeker should lead to the questioning of these dominant discourses.

As the focus of the global context model is on the holistic assessment of a pregnant asylum seeker's individual needs, but within a national and

international context, then it can be argued that cultural needs should be embedded into this model and examined along with the other care needs which make up the self. However, it should also be addressed at a macro and global level, teasing out these cultural issues and encouraging the student to examine the differences between the woman's customs, laws and cultural norms within her home country and the UK and how the woman needs to negotiate this within her micro environment. There may be cultural barriers which impact on her care needs and these need addressing, but within the context of other barriers which may be in existence. Arguably, the student's focus needs to be on the wider socioeconomic and political factors in which this woman is living and how this will impact on her cultural needs. Through examining this, the student may be facilitated to develop skills in challenging prejudice, discrimination and inequalities between women (Narayanasamy and White,2005).

9.5 Respecting the educational philosophy

When designing the global context model for midwifery education, it was felt to be important to ensure the philosophy, underpinning the way that the local midwifery curriculum is delivered, is respected and how this could be incorporated into the model. As identified earlier, although, in this context, the model is focussing on the pregnant asylum seeker, it could be used in other contexts, where assessment of the woman's health and social needs could incorporate the global layer, such as a woman who is a recent migrant or refugee. The intention is that the global context model would be useful for students, who identify such women to include in their caseload in year three of the programme.

PBL is used within the local midwifery curriculum to respect a woman centred, social constructivist philosophy of education (Haith-Cooper, Macvane-Phipps et al.,1999). Through PBL, knowledge is constructed around a scenario and is both situated and contextual (Rolfe,2000). Similarly, this model is encouraging the student to consider the woman as central and to construct knowledge relevant to her, within her context.

PBL encourages students, as a group of women, to work together, share knowledge and value each others' forms and sources of knowledge (Haith-Cooper, Macvane-Phipps et al.,1999). It can be argued that this model encourages the student to work with the pregnant woman to value her knowledge and understanding and learn from her about her background, as well as teaching her about the context of the UK.

PBL encourages students to examine information critically and develop a new understanding around an issue based on critical thinking (Savin-Baden and Howell Major,2004). This model is encouraging the student to examine the factors in each layer of the model critically, with consideration as to how power can lead to inequality and oppression in the woman they are assessing.

PBL is used to impart a feminist philosophy, by placing the woman at the centre of her care and treating her as an individual with unique needs (Haith-Cooper, Macvane-Phipps et al.,1999). This model aims to put the asylum seeker at the centre of the model and undertake a holistic assessment of her unique needs, but within the context of her individual background.

The concept of forms and sources of knowledge, as constructed through the use of PBL also respects the concept of the constructed knower as the desirable learner, described in the continuum of cognitive development (see appendix nine) (Belenky, McVicker Clinchy et al., 1997). As identified in chapter eight (see 8.6), the influence of knowledge underpinned by the medical model and reflected in policies and guidelines, is not conducive to the individual being able to interpret different forms and sources of knowledge as contextual knowledge and for her to construct her own version of reality from this. This model is designed to address this issue and to facilitate the student to move along the continuum, striving for the constructed knower in her midwifery practice.

9.6 Conclusions

The ultimate outcome of this study has been the development of “the pregnant woman within the global context” model for midwifery education. This model has been developed with consideration to a number of findings and theoretical concepts constructed through the course of this study. It has been designed as a tool to assist midwifery students in assessing the health and social needs of pregnant asylum seekers and other women, where it can be argued as important to consider the global context influencing their experiences of maternity services.

To approach the key issues developed from this study, the model was designed with three layers each addressing different issues. The micro layer focuses on

assessing the pregnant asylum seeker's individual holistic needs. The macro layer concentrates on the concept of power and the dominant negative discourses around asylum situated within this layer. The global layer focuses on examining global factors which could impact on the pregnant asylum seeker's experiences whilst living in the UK.

This chapter has argued that it is important to consider both macro and global factors in the pregnant asylum seeking woman's life, which can impact on her midwifery care needs. It has adopted the social work approach, striving towards anti-oppressive practice, to address how these macro and global factors can lead to inequalities and oppression in the pregnant asylum seekers and how the midwife should expand the public health aspect of her role to encompass political awareness and action, in an attempt to strive for equality for the pregnant asylum seeker.

This chapter has explored how the global context model has respected the wider issues influencing midwifery education. It has incorporated significant principles behind the regulation of midwifery education by the NMC and QAA and the relevant principles behind education for sustainable development. It has also attempted to maintain congruence with a woman centred, social constructivist philosophy for education delivered through the use of PBL. Ultimately, the model is striving to achieve the constructed knower, by critically examining information gleaned through different sources of literature, together with the pregnant woman, in order to develop a critical thinking practitioner with

the ability to question negative public dominant discourses around the pregnant asylum seeker.

Chapter 10: Conclusions

10.1 Introduction

This chapter will provide an overall impression of what this study has achieved. It will revisit the research questions and discuss how the findings have contributed to addressing them. As Mason (2005) asserts, research questions cannot be fully answered, the findings will only provide an illumination of some of the issues of relevance to them. In addition, socially constructed knowledge is perspectival and contextual (Burr,2003) and therefore this study has not revealed the universal truth about midwifery students' understanding of pregnant asylum seekers. It does however offer a standpoint which could be useful in informing midwifery education.

This chapter will discuss how this new knowledge can be shared within the midwifery profession. It will also discuss the limitations of this study and make recommendations for changes to midwifery education, midwifery practice and suggest potential future research projects.

The concept of theoretical generalisation was considered relevant and the principles were adopted for use in the context of this research (see chapter four; 4.6 for an explanation of this). The findings from this study, together with relevant supporting theory, were considered together to extend knowledge of discourses around asylum and their influence on midwifery students' perceptions of pregnant asylum seekers health and social needs. This new

knowledge was then used to develop “the pregnant woman within the global context” model for midwifery education (see chapter nine).

The overall aim of this study was to contribute to the improvement of maternity service provision for pregnant asylum seekers. To address this aim, “the pregnant woman in the global context” model for midwifery education was developed, as a tool to prepare midwifery students in the educational setting, to meet the pregnant asylum seeker’s health and social needs, in the clinical area. In addition, this model is designed to increase the student’s awareness of discourses and how they may lead to inequality and oppression in pregnant asylum seekers. Ultimately, this model could be introduced into the educational setting, as a way of preparing students for caseloading asylum seekers and other recently arrived migrants, in clinical practice. It could also be useful as a tool for reflecting on practice and facilitating students to address the wider political role of the midwife, in challenging inequality in society, health policy and service configuration.

Critical discourse analysis (CDA) was used during the research process to examine the language used by midwifery students (see chapter five, 5.6 for an exploration of this).

Arguably, this strategy worked by illuminating words and statements, which reflected power and ideology within dominant discourses, around asylum seeking and also around how midwifery care is approached (see chapter six for more detail of the findings).

These discourses were then critically analysed to examine social structures exercising power to (re)produce these discourses (see chapters seven and eight). This chapter will

now revisit the research questions and the main findings which emerged from this CDA approach.

10.2 What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?

A detailed presentation of the study's findings can be found in chapter six, including the discourses which were identified within the data from this study, which addressed this research question (see 6.2). These discourses appeared complex and overlapped, with entangled discourse strands. Consequently two discourses were explored in more depth, which encompassed all of the identified discourse strands (see chapter seven for this exploration). It can be argued that these discourses; the asylum seeker as different and of a criminal persuasion influenced some midwifery student's constructions of the pregnant asylum seeker. They were revealed through the language used in discussing asylum seekers, particularly in relation to individuals crossing borders to come into the UK and some "criminal" asylum seekers coming for economic gain, rather than for genuine reasons. The words used suggested that they were perceived as a threat, due the large numbers arriving and the impact of this on public services. The perception of asylum seeking appeared no different for pregnant women, although they were considered to be deserving of maternity care.

Chapter seven (see 7.2 and 7.3) demonstrated that other studies had similar findings, with the language used by midwives reflecting these discourses, including midwives in Hillingdon (Gaudion and Allotey,2008) and also in the

maternity alliance study (McLeish,2002) . In addition, it was argued that studies examining the general public perceptions of asylum seeking, also reflected the discourses around difference and criminality, including the largest study by Lewis (2005) and the study undertaken in Coventry (Ward,2008). Referring back to the discussion above (see 10.1), the principles behind theoretical generalisation were adopted, by considering the findings from this study, together with those from other studies and underpinning theory around moral panic, “difference” and power. An argument was constructed around the (re)production of discourses and how midwifery education could address this (see chapter seven).

Chapter seven argued that the negative dominant discourses around the asylum seeker as different and of a criminal persuasion are (re)produced within social structures. For this reason, the macro layer of “the pregnant woman within the global context” model identified these perceived social structures, to facilitate the student to consider how these work in (re)producing discourse, when exploring the idea of inequality and oppression in pregnant asylum seekers. The macro layer also contains factors which will impact on the pregnant asylum seeker’s needs, including immigration status, to facilitate an accurate exploration of the asylum process and welfare provision to which asylum seekers are entitled. In addition, the global layer contains features of the asylum seekers’ home country and reasons for migration, to encourage these to be explored in relation to the reasons, rather than just for economic gain, which may lead to the pregnant asylum seeker fleeing her home country. These issues

could be considered when addressing the micro layer and the individual needs of the pregnant asylum seeker.

10.3 How do midwifery students construct the pregnant asylum seeker's health and social needs?

Chapter six provided a detailed discussion of the findings from this study which related to this research question (see 6.3). Overall, the participants highlighted four key aspects of care which they perceived needed considering; the physical, social, emotional and language needs of the pregnant asylum seeker. However, they predominantly focused on the physical needs of the woman at the expense of the other needs and showed a reliance on policies and guidelines to help them to plan the physical aspects of midwifery care. When the other perceived needs were discussed, they were often framed within a medicalised context or with reference to policies and guidelines to inform practice.

Chapter eight argued that this emphasis on a physical approach to midwifery care reflected underpinning dominant medico-scientific and managerial discourses which influence the way that midwives practice (see 8.5). A "midwifery" counter discourse was presented, reflected in a discussion around a woman centred approach to care. However, there appeared to be confusion about how to provide this woman centred care. As well as this, there were concerns about the balance between how to treat the woman as an individual but also consider how her wider context may impact on her care needs (see 6.4.3).

Chapter eight described other studies, which emphasized the physical aspects of midwifery care provision for asylum seekers and refugees, including Kennedy and Murphy-Lawless's (2003) study in Southern Ireland and Harper Bulman and McCourt's (2002) study of Somalian refugees. Also, other studies examining midwifery care of women more generally and not necessarily asylum seeking women, had similar findings, including Downe, Finlayson et al (2009) metasynthesis of studies and Kirkham's (1999) study focusing on organisational culture in the NHS maternity services. In addition, like the participants in this study, literature suggests that midwives tend to follow policies and guidelines and standardised care pathways in their approach to care provision (Hunter and Segrott,2009; Kirkham and Stapleton,2004) (see chapter eight; 8.2 and 8.3 for more detail around this).

The confusion around the concept of woman centred care was reflected in the wider literature (Hart, Hall et al.,2003) (see 8.4), as was the dichotomy around individual or contextual needs. Some writers believe that it is important to consider cultural context when providing midwifery care (Nairn, Hardy et al.,2004; Squire and James,2009) and others express concerns about the potential to label and generalise women from the same cultural background (Schott and Henley,1996b). However, the findings from this study appeared to partially address this issue, with students expressing that they believed that learning about context, had a positive effect on their understanding of the asylum seeker's potential needs (see 8.6).

The findings from this study, together with the underpinning supporting theory, led to the construction of an argument that midwifery education needs to address the emphasis on the physical aspects of care, the confusion around a woman centred approach and the need to find a balance between considering individual and contextual factors, when assessing needs. Midwifery education also needs to consider that, although students may be learning how to approach care in a holistic woman centred way, within the university setting, once in the hospital environment, they may encounter the dominant medico-scientific and managerial discourses (see 8.6 for more detail around this).

It can be argued that “the pregnant woman within the global context” model for midwifery education addresses all these issues. Within the micro layer, the physical needs are presented as only one aspect of the assessment of the pregnant asylum seeker’s holistic needs. This takes the emphasis away from the physical aspects of care towards a holistic assessment. In addition, it provides a consistent woman centred approach to the assessment of individual needs. The model also incorporates the wider macro and global layers, which contain factors which could facilitate the students to consider the woman’s wider context within her assessment of needs.

10.4 What are the implications of students’ constructions for midwifery education?

It can be argued that this chapter has already partly re-addressed this research question within the context of the findings from the other questions. It has already been identified that there are implications for midwifery education

relating to challenging the dominant discourses underpinning the construction of the pregnant asylum seeker and also relating to the construction of the pregnant asylum seeker's health and social needs. In addition, chapter six presented findings specific to this research question which have not yet been reviewed in this chapter. These findings related to two issues; participants questioning dominant discourses around asylum seekers through reading and also questioning practice in relation to perceived prejudice in the clinical environment (see 6.4.1 and 6.4.2).

Although "the woman within the global context" model for midwifery education has been designed to facilitate students to consider the influence of dominant discourses, in relation to inequalities and oppression in pregnant asylum seekers, it was identified in chapter six (see 6.4.1) that the literature students read can also lead to the beginning of the construction of alternative discourses. This suggests that educators need to direct students towards other sources of literature, which question the dominant discourses around asylum seeking. In the context of this study, participants referred to publications by local and national charities and work by Sheila Kitzinger to support their reading.

In addition, midwifery education needs to provide the opportunity for students to develop skills in challenging clinical practice, which they feel is questionable. By using the global context model to identify possible inequalities and oppression in the pregnant asylum seeker, together with the opportunity in the university setting to read alternative literature and reflect on practice and how the model

was utilised, then arguably critical thinking skills could be facilitated in relation to both reading literature and also issues around oppression in clinical practice.

10.5 Limitations of this study

As identified earlier (see 10.1), the main limitation of this study relates to the epistemological assumption that knowledge is constructed within a social, cultural and historical context and therefore new knowledge is only one interpretation of social reality (Burr,2003). In addition, groups of people are influenced by different discourses depending on their social, cultural and historical position in the world (Jager and Maier,2009). A case of midwifery students in another geographical location, at a different time, may have addressed these research questions in a contrasting way. Also, the case used in this study may have presented different data at another point of their programme.

Another limitation of this study relates to the issue around conducting research in the institution in which I work and have an underpinning lecturer/ student relationship with the study participants. As identified in chapter five (see 5.5.3), it can be argued that this existing relationship may have affected the quality of the discussion, especially in the context of the individual individuals, where the participant did not have the support of her peers. She may have responded to the questions asked, in a way that she perceived the lecturer would expect her to, or due to a fear of revealing too much about an issue that can be argued as emotive. This may have been exacerbated by the difficulties encountered gaining ethical approval for the study (see 5.7.1) and the need to ensure that

participants did not discuss examples of sub-standard care of asylum seekers in the clinical area. This may have led to the participant being guarded in what she revealed about clinical practice and consequently, influenced the quality and depth of data constructed around experiences, with pregnant asylum seekers in clinical practice.

It can be argued that undertaking educational research, within the context of a group of midwifery students, engaged in a midwifery programme, with a heavy workload, limited the amount of time that they could dedicate to data construction. In this context, only two written reflections were received from students, which explored the application of theoretical knowledge to the clinical experiences of caring for pregnant asylum seekers (see 5.5.2). This could have been due to the existing workload pressures of the midwifery programme. However, it may have also been due to the fear of discussing clinical practice, as discussed above or due to a lack of contact with asylum seekers, which will be discussed below. Ultimately, the lack of reflective accounts may have limited the quality of the data in relation to applying knowledge about asylum seeking, constructed within the PBL focus group interviews, to clinical practice.

Another factor which is perceived to be a limitation of this study relates to the legislative changes made to the asylum process over the last six years, since the idea for this PhD project was conceived. As identified in chapter one (see 1.8), since the introduction of the new asylum model in 2005, the government agenda has been focussed on reducing the number of asylum seekers both arriving and staying in the UK. The processing of asylum claims has speeded

up, with those asylum seekers who are considered less credible, being fast tracked through the system and rapidly deported. Those who are considered more credible should now have an asylum decision within six months of making their claim (Hynes and Sales,2010). In addition, the juxtaposed border controls in France and Belgium are preventing possible asylum seekers even reaching the UK (Aspinall and Watters,2010). As a consequence of these policy changes, there could be less pregnant asylum seekers requiring maternity services for the duration of their pregnancy and therefore fewer opportunities for students to build a relationship, with an asylum seeker over a period of time.

In addition, it has been identified that pregnant asylum seekers often book late for their maternity care (Briscoe and Lavender,2009; Nabb,2006), reducing their contact with maternity services even further. Those who do require maternity care, but subsequently fail in their asylum claim, are likely to have a shorter stay in the UK, or become failed asylum seekers, who are driven underground, possibly due to a fear of returning to their home country (Ukoko,2007). All these issues may provide less opportunity for the midwifery student to implement “the pregnant woman in the global context” model. However, as highlighted in chapter one, it is argued that the current global economic crisis may actually instead, increase the number of people seeking asylum in the UK (Somerville and Sumption,2009). Whichever scenario occurs, it can be argued that there is still a need for midwifery students to be well prepared to meet pregnant asylum seekers’ health and social needs, should they need to care for them in the clinical environment.

As discussed in chapter nine (see 9.1), “the pregnant woman within the global context” model for midwifery education could be considered useful for exploring the health and social needs of any woman who has recently migrated to the UK, including asylum seekers, refugees and other migrants. The layers of the model contain factors which could be considered relevant to any pregnant migrant’s health and social needs. In addition, it is argued that immigration is perceived to be a major issue in this country, with public hostility towards migrants in general, increasing in times of economic crises (Somerville and Sumption,2009). Therefore, any pregnant migrant may have similar experiences to asylum seekers when accessing maternity services, relating to negative public discourses influencing midwifery care. The global context model may be useful for addressing migration and pregnancy in more general terms, as well as addressing the specific needs of pregnant asylum seekers.

10 6 Communicating the findings

There are four key topics arising from this research which arguably demonstrate originality and could be a worthwhile contribution to the knowledge base of midwifery. It is the intention that these areas will be followed through and communicated to the wider profession, through publications and conference presentations:

This study has provided an insight into the way in which negative public discourses around asylum seeking may influence how pregnant asylum seekers are perceived in midwifery practice. Although there are published studies relating to the prejudice towards pregnant women from British Minority Ethnic

(BME) groups, no other studies could be found which used CDA to undertake an in depth examination of how public discourses are perceived by midwifery students, to influence some midwives in clinical practice.

This study has provided an understanding of the way in which some midwifery students approach the assessment of pregnant asylum seekers' health and social needs. No other studies could be found relating to this and the difficulties which they may encounter due to competing medico-scientific, managerial and "midwifery" discourses in the clinical area.

Arguably, this study has effectively used PBL as a research methodology.

Although it has found to be used in a similar way in another research context (Macvane,2010), no published studies could be found relating to the use of PBL as a means of data construction in the research process.

"The pregnant woman within the global context" model for midwifery education has been constructed from the issues arising in this study. No other midwifery or other health care models could be found which resembled this model. The use of this model appears to support the vision of Midwifery 2020 which has recommendations, including that the midwife should use holistic models of care, manage a woman's health and social needs and also challenge inequalities in health (Midwifery 2020,2010). These are all issues integral to the global context model for midwifery education.

10.7 Recommendations

In addition to communicating this new perspectival knowledge in the wider arena, there are specific recommendations arising from this study, relating to midwifery which are explored below:

10.7.1 Pre-registration midwifery education

There are a number of recommendations relevant to pre-registration midwifery education programmes. Firstly, “the pregnant woman within the global context” model for midwifery education could be utilised as a way of educating midwifery students around the assessment of health and social needs of pregnant asylum seekers, but also more generally for refugees and recently arrived migrants in the UK. To accompany the use of this model, it is recommended that midwifery students be guided towards literature which questions the dominant discourses around asylum. These may include publications by asylum seeking charities and writers such as Sheila Kitzinger.

In addition, this study recommends that midwife educators should consider how the curriculum is delivered and whether a holistic and integrated, woman centred approach is encouraged, for example through the use of PBL (Haith-Cooper,2001b), rather than students learning through acquiring facts in a compartmentalized, subject based approach to midwifery education (Davies,2004b). This integrated curriculum, together with the global context model and the alternative sources of literature could be a useful tool with which to prepare students for the midwifery care of pregnant asylum seekers, but also

to challenge dominant discourses leading to inequality and oppression in these women.

Another recommendation for pre-registration midwifery education relates to the organisation of clinical placements. This study has highlighted the difficulties which students may face in clinical practice when they find that they are exposed to the dominant medico-scientific and managerial discourses. This may lead to confusion around how to implement women centred approaches to care, about which they may have learned in the educational setting (see chapter 8; 8.5). Although a debate on how to address these conflicting discourses in the clinical area may be useful, this thesis is limited to considering this from an educational perspective.

It can be argued that student's clinical placements need organising in such a way that they are exposed to a holistic woman centred philosophy of care. The use of caseloading to address this issue is explored further in chapter eight (see 8.6). Caseloading has recently been introduced as a requirement of the NMC, into midwifery curricula. This study recommends that "the pregnant woman within the global" context model be implemented alongside the caseloading activity and the effectiveness of this approach to learning be evaluated, once students have engaged with the caseloading activity.

10.7.2 Post-registration education

It is recommended that the issue of continuing professional development (CPD) for qualified midwives, working in clinical practice, is addressed in relation to

asylum seeking. This study presented findings which described how qualified midwives may stereotype and make assumptions about women whom they perceive to be different to themselves, including pregnant asylum seekers (see chapter seven; 7.5 for more discussion around this). In addition, chapter seven (see 7.7), discussed how qualified midwives require more education about general immigration issues, specifically the asylum process, asylum seekers' experiences, but also general equality and diversity training (Gaudion and Allotey,2008; McLeish,2002; Reynolds and White,2010).

"The pregnant woman within the global context model" for midwifery education could be a useful tool in facilitating qualified midwives in addressing these issues. As identified in chapter nine (see 9.3.3), the model could be useful in increasing midwifery students awareness of interagency working and specific agencies involved in the care of pregnant asylum seekers. It can be argued that this is applicable to qualified midwives, who through learning about issues such as the asylum process could have a greater understanding of the role of the immigration service. In addition, the role of social services, asylum charities and other agencies and the midwife's role in liaising with these agencies could be facilitated through the use of the global context model

Another use of the global context model could be around increasing qualified midwives awareness of the concept of discourses and how both the dominant discourses around asylum seeking and the competing discourses in midwifery practice, can influence the way in which they approach their care of the pregnant asylum seeker. In addition, this study recommends that the global

context model is utilised with qualified midwives to facilitate them to consider the wider role of the midwife and how they could address inequality and oppression in practice and in wider society. Chapter six (see 6.4.2) presented findings from one participant who recommended that to reduce stereotyping and assumptions being made about women, midwives should be encouraged to undertake more structured reflection on practice. This could be facilitated using the global context model as a tool to linking theory to practice. In addition, this participant suggested that midwifery supervision could be used as a means of support for midwives to change practice. This could be another focus for the global context model, equipping supervisors of midwives with a tool to encourage reflection and practice development.

There are other health professionals and staff involved in the delivery of maternity services to asylum seeking women and this study recommends that doctors, health care assistants and other relevant personnel concerned with maternity services, are also targeted in relation to their educational development. "The pregnant woman within the global context" model for midwifery education could be adapted and used to facilitate other health professionals and staff in identifying the wider factors which may influence asylum seeking and other recently arrived migrant women's' experiences of maternity care in the UK. This could include considering assumptions and stereotypes around women, due to the perception that they are different. It can be argued that developing an understanding of the context of these women's lives may help staff working in maternity services to provide care which is appropriate to the pregnant asylum seeker's or recently arrived migrant's needs.

The NHS plan, (Department of Health,2000) identified that service users should be involved in the planning and delivery of health services, including maternity services. The patient and public involvement (PPI) agenda has developed since the NHS plan was published, with service users being consulted in different areas of health services, including midwifery education. Here, service users are involved with the recruitment, assessment and teaching of students. However, Lockey and Hart (2004, p. 784) argue that the more “pro-active, articulate and empowered service users” tend to be involved in this initiative and identify that it is hard to involve disadvantaged service users, who may be homeless, speak poor English and who may be perceived as unpopular.

A further recommendation from this study would be to try to engage asylum seekers and refugees in pre and post-registration midwifery education, possibly through refugee charities, with the specific agenda of them talking to students and relating their stories, about their experiences of asylum, but also of maternity services. This would provide a useful insight for students, but could also be argued as contributing towards questioning the dominant negative public discourses around asylum.

10.7.3 Midwifery practice

It is beyond the scope of this study to explore the organisation of maternity services in any depth, however the findings from this study highlighted issues that are relevant to midwifery practice and arguably worthy of addressing in relation to recommendations. As identified in chapter eight (see 8.6), the dominant medico-scientific and managerial discourses may influence the way in

which midwives approach care provision. The development of new systems of care, such as midwifery led units, may facilitate midwives to adopt a woman centred, holistic approach to care, away from the domination of the medical profession. However, these units tend to be designed to care for perceived low risk women with high risk cases remaining in consultant led units (Magill-Cuerden,2005). As identified in chapter eight (see 8.3), asylum seeking women are considered high risk according to national policies and guidelines (National Institute for Health and Clinical Excellence,2010) and therefore are unlikely to receive their care in midwifery led units. Consequently, this study recommends that other options are considered as to how asylum seeking women could be facilitated to receive a holistic, woman centred approach to care away from medical domination.

Continuity of care schemes could be one such option, which Bentham (2003) asserts would benefit the pregnant asylum seeker. Such a scheme could also be argued as supporting the global context model by providing the option for the named midwife to adopt a holistic woman centred approach to care, over a period of time. Schemes such as team or caseload midwifery would appear ideal to achieve this. However, in reality, team midwifery has been associated with high levels of burnout for midwives (Sandall,1999) and caseload midwifery has become increasingly common as a replacement in the UK, with the benefits of continuity of care and a woman centred approach to care amongst others (Lester,2005). However, caseload midwifery is not practiced in the clinical areas where participants in this study have accessed their placements. Perhaps this is

an option which is worthy of further exploration, within the organisation of the maternity services, in the locality.

Another way of addressing the issue around facilitating a woman centred, holistic approach to care of the pregnant asylum seeker, could be the development of a local initiative which could be integrated into the existing services. There are examples of good practice around the UK in relation to meeting the needs of pregnant asylum seekers. One example of a successful local initiative is located in East Kent and involves asylum seeker lead midwives providing antenatal and postnatal care to a caseload of asylum seekers, but also providing education to other midwives (Harris, Humphreys et al.,2006). Obviously, other areas of the country have different needs and maternity services are organised in varying ways. However, initiatives such as this have the potential to provide appropriate care. Therefore, it may be helpful to consider how such an initiative may be useful in different locations, where asylum seekers are dispersed.

10.7.4 Research

As identified earlier (see 10.1), this study has constructed contextual and perspectival knowledge within a specific social, cultural and historical context and is therefore only one interpretation of social reality (Burr,2003). For this reason, further research is recommended, examining the perceptions of pregnant asylum seekers' health and social needs, with midwifery students in other locations and at different points in their programme. Also, it would be valuable to undertake a longitudinal study, examining midwifery students'

perceptions both before and after receiving focused education, using “the pregnant woman within the global context” model for midwifery education. The effectiveness of the global context model could then be evaluated.

In addition, a study examining the perceptions of qualified midwives and other professionals involved in the care of pregnant asylum seekers, could assist in the planning of CPD for these personnel. It would be particularly useful to undertake research examining perceptions of managers and other agenda setters, in relation to their perceptions of pregnant asylum seekers. These, are arguably people in power who have the agency to influence dominant discourses. As identified in chapter seven (see 7.6), some people have the ability to exercise more power than others to influence social structures and therefore discourses (re)produced in these locations. This power can be exercised through different means, including economic, political or educational means (Jager and Maier,2009). Targeting the people with more perceived power could be a means of addressing the power structures identified within the macro layer of “the pregnant woman within the global context” model for midwifery education.

The use of PBL as a research methodology and the use of CDA in midwifery research are two areas where there appears to be a dearth of published literature. It is recommended that these two methods are explored further in relation to midwifery research. It can be argued that the use of PBL as a tool for data construction may increase the quality of data, as it is a way of distracting students from the focus of the research, by encouraging them to undertake their

usual role in the PBL process in the classroom setting. Further research could help in confirming this assertion. In addition, the use of CDA in midwifery research may be a means of highlighting and addressing the underpinning power and ideology which impact upon midwifery education and practice in different ways. It can be argued that these methods are both worthy of further exploration, through research and an area which I intend to explore in other research contexts.

10.7.5 General recommendations

As identified in chapter seven (see 7.7), there is a general consensus in the literature reviewed for this study, that education of the public is essential to help overcome the hostility and stigmatisation of asylum seekers by people living in the UK (Pearce and Stockdale,2008; The Equality and Human Rights Commission,2010; Ward,2008). Like these preceding studies, this study recommends increasing public awareness of asylum seekers' experiences, including relevant legislation, accurate statistics and different categories of migrants and their home countries.

As identified earlier (see 7.7), this education may be approached through implementing positive perceptions around asylum, including their achievements in society, public awareness campaigns, storylines in popular soap operas and increasing meaningful contact between the general public and asylum seekers in the local community. This study re-enforces these recommendations as these measures may help to question the negative dominant discourses around

asylum seeking, which appeared to influence the way in which midwives approached their care of the pregnant asylum seeker.

10.8 The final word

Over the last five years, a number of people have asked me about the topic of my PhD and it has been interesting to observe the different responses. Some individuals have not responded at all to my topic, others have laughed. Some people have believed that this is a good choice of topic, because asylum seekers are badly treated. Others offered me advice suggesting that some asylum seekers are bogus and that there is abuse of the asylum system. My final word on this is that I believe that it is not for the general public, including midwives, to judge the authenticity of people who are registered with the UK government as asylum seekers.

Through the course of this PhD, I have learnt that asylum is a complex, multifaceted issue and that people are individuals who should be treated with respect, whoever they are. As Squire and James (2009) state, the term asylum seeker should be considered within the context of a situation and not the identity of a person. In the context of the scenario for this study, Martha was a heavily pregnant woman from the Sudan who just happened to have claimed asylum in the UK and this should be respected when she accesses maternity services.

Appendices

Appendix 1: Methodology chart (Mason,2005)

	PBL focus group interview	Written record of intranet discussion area and smart notebook	Individual interviews	Written reflections
What discourses have influenced midwifery students' constructions of the pregnant asylum seeker?	Power implicit in language used reflecting underpinning discourses.	Sources of information used for personal research reflecting underpinning discourses Power implicit in language used reflecting underpinning discourses.	Personal contributions not explored in focus group Probes related to language use reflecting underpinning discourses	Discourse embedded in clinical context rather than in group
How do midwifery students construct the pregnant asylum seekers health and social needs?	Use of PBL scenario and PBL process Pedagogy mirrors research philosophy	Perceptions of verbal constructions considered important enough to document.	Personal contributions not explored in focus group	Similarities and differences to social constructions in PBL context.
What are the implications of students' constructions for midwifery education?	Addressing discourses underpinning constructions Addressing knowledge deficits	Addressing sources of information used for personal research	Addressing discourses underpinning constructions	Addressing discourses underpinning constructions



**“Exploring the health
and social needs of
asylum seekers;
midwifery students’
perspectives”**

**Volunteer to take part in
this study and:**

- Take the opportunity to be actively involved in a research project (something to add to your CV)
- Learn about many issues in relation to caring for asylum seekers

I am looking forward to giving you more information about this opportunity. See you on December 9th 2009.

Appendix 3: PBL scenario

An asylum seeker

Martha, a heavily pregnant young woman arrives in Hull from the Sudan with a toddler. She speaks only a few words of English.

Appendix 4: PBL process

1. Clarify terms and concepts not readily comprehensible
2. Identify learning issues
3. Analyse problem, brainstorming prior knowledge
4. Formulate learning objectives
5. Collect information
6. Synthesise and check new information

Adapted from Schmit (1983) the seven "jumps" of problem-based learning.

Appendix 5: Guidelines for reflections

- Please undertake a reflection approximately every three months or when you have cared for an asylum seeker
- Please write it in word format, approximately 500 words and send it to me attached to an e mail. I will then ensure that your name is not attached to it.
- If I don't receive a reflection from you at 3, 6, 9 and 12 months I will send you an e mail reminder. If you have not cared for an asylum seeker you don't need to write a reflection.
- These reflections are not an assessment of your academic ability; they are to provide me with more data for the study. I will therefore not be marking/ assessing or providing feedback on them. They will not be used in any way towards your midwifery education, purely for the research process.
- It is not necessary to include references in your work.
- When writing your reflections, think about what you already knew and learned in the PBL about pregnant asylum seekers and how you used this in practice.

Thank you very much for supporting this study and undertaking written reflections.

Appendix 6: Redacted transcript from individual interview

Individual interview, participant 4

Interviewer

Okay, so have you actually come across any asylum seekers since the focus group?

Participant

No.

Interviewer

No?

Participant

Haven't come across any. I know, I was kind of looking forward to meeting some.

Interviewer

Yeah.

Participant

You know, using the kind of bit of knowledge that I learned to sort of interact with them, but no, I haven't seen any.

Interviewer

Have you used the knowledge in any other way, from, from there? Has it been helpful in any other context?

Participant

Not that I can think of. I just found it really interesting and just something different to look at and something that, as I say, if I, if I did come across asylum seekers, I feel, I'd feel like I knew a bit more about them. Because you do hear a lot of bad press, you know, people sort of, 'Oh, they're coming over here, you know.' All that kind of stuff and obviously, I don't like that anyway, but hearing a bit more about background would make me more understanding in the future as well.

Interviewer

So where, you say you hear about bad, bad press. Where, where does, do you think that comes from? What, where does, what's the source of that?

Participant

Probably some from the media, but, and things like the BNP and -

Interviewer

Yeah.

Participant laughing

But yeah, I think, I think a lot of people think like that. They might not say it out loud, but, but as I said in, in the, in the session, [REDACTED]

[REDACTED]

[REDACTED] But they think, 'Oh, keep them all out.' It's just ignorance, I think.

Interviewer

So have you ever met an asylum seeker anywhere at all in any other context?

Participant

Don't think so.

Interviewer

No?

Participant

Not that I know of.

Interviewer

So when do you think you first learned about what an asylum seeker was? Do, do you think it's something you know since you were very young, or is it something that -

Participant laughing

No, I don't think so [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Interviewer

And you said something in the interview. You said something about, you know, some asylum seekers aren't genuine. Do you know what you were meaning by that because that wasn't followed up?

Participant

Because people are so desperate to come to this country, a lot of them have the same story that they've been given by a contact when they come to this country. And they're told to say, 'This is what's happened and this is why I can't go home.' So it might not necessarily be the truth for them, but because they're so desperate to stay here, they'll say anything, which I can understand. So yeah, it's not necessarily always their story that, that is told when, when they come over and they have to go to court and fight for their right to stay here, basically.

Interviewer

So if you, if you were thinking about reasons people come here, what, when would you think perhaps they shouldn't stay? What, what would be the reasons when you think perhaps they shouldn't stay?

Participant

If there's not something major going on in, in their country that they're fleeing from. You know, so some people will say that they're homosexual and if they go home, they'll have to proclaim to everybody that they are homosexual. And then there will be, you know, whatever is going to happen to them. But that might not be the truth. They might, you know, they don't have to go home and tell everybody that, 'Oh, I'm gay now.' Like you know, why can't they just sort of be quiet about it? I don't know. I don't know what the situation is like in their country.

Yeah, so if, if, if there's no real reason why they want to, why they can't go home, but they've, they've made up a reason so that they can stay in this country because there are, you know, more employment prospects, although at the moment, probably not. Probably aren't as many asylum seekers at the moment. Or you know, because of the NHS or something like that, they, they see it as a better life here. They shouldn't be claiming asylum here if there's no, nothing to claim asylum from. I think that's what I meant.

Interviewer

Yeah. So if you're thinking about that, could you relate that to pregnant asylum seekers? And would you be a situation when you think, 'Oh, that's not really genuine' or maybe they shouldn't be allowed to stay either?

Participant

I think my opinions would probably change if it was a pregnant woman that, that had come over and you know, I'd, I'd just feel like I'd want to do everything I could to help her, I think.

Interviewer

Because she was pregnant?

Participant

Yeah. Whether that's right or wrong, I don't know, but that's just what is instilled in you all the time when you're doing your training. And you know, it's the woman that you put first and you've got to care for her and give her the choices that she needs. And it's never a question that you wouldn't do that for somebody. I think that'd be very, very difficult.

Interviewer

So if you put the, put the word 'pregnant' in front of the word 'asylum seeker' does it mean a different thing to you?

Participant

Yeah, I think so.

Interviewer

Yeah?

Participant

Yeah.

Interviewer

Yeah, deserving of care and...?

Participant

Yeah. Yeah, because they're, they are vulnerable. Yeah, and definitely deserving of care. It would be very difficult. I know there's the issue we talked about, about charging for services if they haven't been accepted into this country and I think that'd be so difficult if somebody just turned up and you had to discuss the issue of money with them because obviously, we work for the NHS and everything's, everything's free, really. Be uncomfortable and I wouldn't really want to do it.

Interviewer

And what about after the baby was born?

Participant

What? The issue about money or...?

Interviewer

The, the issue about they were genuine.

Participant

I think once the baby's born, then it's, well, it's up to the authorities, isn't it, as to what the situation is back home, whether they should go home. She's still in a vulnerable position. She's got a new baby to care for. You don't want to be sending her travelling back to wherever she's come from straight away, just because, you know, she maybe wasn't genuine in the first place. She's still got to be in a fit state to go home if she does have to go home. I'd still feel that they needed to be cared for for a certain period of time.

Interviewer

Okay, okay. Something else that you said. Trying to think what the wording was. Something like, 'They can't all stay.' I think that was the words you used as well when you were talking. I think we were talking about genuine asylum seekers and you said, 'They can't all stay in this country.' Why? Why couldn't they stay if they're, if people come over and want to live here, why, why can't they stay?

Participant

Because if, if, if the country accepted everybody, then people from any country that see that there's a better life in England or, or the UK would want to come here, if they could. If they could travel here, they would want to come here and we're only a small island, so there's got to be rules and there's got to be cut-offs as to who can come. Otherwise things like the NHS, services that, that are provided for people, they wouldn't be able to carry on being provided because there'd be so many people. And housing, I mean asylum seekers are given housing, aren't they? And how could, you know, there, there isn't a, an infinite amount of housing for everybody to go round. So there have, there has to be rules and regulations as to who can stay and who needs to go home, harsh as that is.

Interviewer

Okay. So just give me a little summary of where, where you are now. You, we, you did the focus group. It's quite a few months ago. You've not come across an asylum seeker, but when you think now back to this time a year ago, have you had any change in your feelings towards or your knowledge base or anything towards asylum seekers that would help you when you're out in practice?

Participant

Well, we learned about things like the services that are provided for them, which I didn't know about. So maybe I can't remember everything off the top of my head, but I can go back and look at the PBL session and find out what services would be provided if I came across somebody. Or what, there are like websites that they can look at and things like that, you know, obviously if they've got access to computers, but I could print some information off for them. Numbers that they can contact, places that they need to go to if, if they arrive and haven't gone through the, these channels first.

I would feel more confident about sending them to the right place, rather than just, 'Oh, I've got a, you know, this pregnant asylum seeker's turned up and I have no idea what to do with her;' which is what I would have felt before. I just think I've, I've got the information there that, as I say, might not be able to remember it all, but I can go back and, and look at it, whereas before, I wouldn't even know where to start, really. So it was a definitely a valid session.

Interviewer

Okay, okay. Right, well, that was it for me, really.

Participant

Oh right, okay.

Interviewer

Is there anything else that you want to add to this while we've got the tape recorder on that you feel might be helpful to me?

Participant

No, I don't think so. Just that I think it should be on the curriculum.

Interviewer

Thank you very much.

Participant

No problem.

Interviewer

That's great. I'll just switch it off.

Appendix 7: Information Sheet and Consent Form

You are invited to take part in a research study:

Title Exploring the health and social needs of asylum seekers; midwifery students' perspectives

Researcher Melanie Cooper, Research Student and Lecturer in Midwifery, University of Bradford

This study forms part of my PhD studies and has been through robust ethical processes. It has been approved by the School of Health Ethics Panel.

Research supervisors Professor Brigid Featherstone, Professor Gwendolen Bradshaw, University of Bradford

What is the purpose of the study?

Pregnant asylum seekers are a group of women who originate from all over the world and all backgrounds. They are unique individuals with their own health and welfare needs, but they also need appropriate and good quality maternity care. As the next generation of midwives, it is important that students feel well prepared in meeting the needs of asylum seekers. The purpose of this study is to understand what students need to learn in order that midwifery education can prepare them for this role.

Why am I eligible to take part?

You are eligible to take part in this study as you are a year 2 midwifery student at the University of Bradford. I have chosen this University as you are familiar with using Problem Based Learning (PBL), you belong to a large cohort of students and you have clinical placements in an area where asylum seekers live. I would like to work with you to establish what you already know and need to know about pregnant asylum seekers in order that I can help you to feel prepared for this role.

What commitment would be expected of me if I take part?

The main commitment expected from you would be time. This study is not part of your midwifery curriculum so you would be attending University in addition to your normal hours. However, this attendance has been scheduled to co-inside with block weeks. In addition you would need to spend time in completing your reflections, though the amount of time would depend on the frequency of your clinical experiences caring for asylum seekers. However, the reflections are

relatively short (500 words each) and are not an assessment of your writing skills; they are a source of data to inform the study. The reflections do not need to include references and therefore you would not need to undertake further reading before completing them.

Do I have to take part?

You are under no obligation to take part in the study and your midwifery education will not be affected if you decide that you would like to opt out. However, if you decide to take part, you will learn about many issues in relation to caring for asylum seekers and will also have the opportunity to be actively involved in a research project. If you do opt out, I will provide you with a reading list with key text relevant to the health and social needs of pregnant asylum seekers should you wish to study this further. If you participate then later on you change your mind about taking part in the study, then you are able to withdraw right up until the point when I complete the data collection.

What will I be expected to do if I take part?

This study has several parts to it. These are described below. For each part confidentiality will be maintained (see overleaf).

- 20th January 2010: You would be involved in a PBL tutorial which I will facilitate over a morning session. This would involve providing you with an enigma (as you normally would be) and watching you and your group working through the PBL process then feeding back your learning outcomes on Thursday 4th February 2010, 10-12.30. The aim of this PBL would be for you to identify your learning needs in relation to the scenario and set some learning objectives for the feedback PBL session. I would like to video record this process.
- I may contact you by e mail at some point to ask you to be involved in an individual discussion. This would be to explore some of the issues raised in the PBL tutorial. I would like to tape record this.
- Over the following year I would ask you to undertake short written reflections (approx 500 words each) every 3 months or when you have been involved in the care of an asylum seeker and feel able to link the theory that was covered in the PBL to practice. I would ask you to submit these online I will be providing written guidance on how to undertake the reflections.

What about confidentiality and anonymity?

I will maintain confidentiality in relation to the PBL videos, discussions and the reflections and participants will be asked to maintain confidentiality in relation to the group work and reflections that are undertaken. It is harder to maintain anonymity due to the fact that this is a small sample of students in one University setting. I cannot guarantee that you won't be recognisable from something you say but I will do my best to maintain anonymity by removing

names. If you say or write something very unusual that you believe could lead to your recognition then I will endeavour to check with you that you are happy for it to be included in the research report.

Please note that during any stage of the research, should you disclose any information regarding clinical practice that the NMC could consider as unprofessional behaviour towards asylum seekers, then I may have a professional responsibility to follow this up. In this case confidentiality would have to be breached. Should this situation arise, I will remind you of this responsibility at the time.

The data from this study will be shared only with my research supervisors and the secretary undertaking the transcriptions. They will also maintain confidentiality. All data relating to this study will be stored in locked filing cabinets or password protected computer areas and will be destroyed/ deleted once I have completed the study.

What will happen to the findings of the study?

Research is an important contributor to the quality of midwifery education and this study could have a positive impact on midwifery students' understanding and ultimately asylum seekers experiences of midwifery care.

The findings will be written up as a research thesis and submitted to the University of Bradford where it will be held and stored in the library. It is expected that a number of articles will be written from the thesis and published in midwifery related journals and presented at conferences.

Thank you for reading this information sheet. Please consider whether you would like to take part in the study for at least 24 hours. If you would like to take part, please E mail me as soon as possible (after 24 hours) and complete and return the consent form to me at the beginning of the 1st PBL tutorial on 20th January 2010. If you would like more information at any stage of the process, please don't hesitate to contact me

Consent Form

Issued 9th December 2009

Project title Exploring the health and social needs of asylum seekers; midwifery students' perspectives.

Name of Researcher: Melanie Cooper

Please initial next to statements below:

1. I confirm that I have read and understood the information sheet dated 9th December 2009, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
2. I understand that my participation is voluntary and am free to withdraw at any time (until the final stages of data collection) without having to give a reason
3. I agree to maintain confidentiality in the PBL sessions and when writing my reflections.
4. I understand that should I disclose any information regarding clinical practice that the NMC could consider as unprofessional behaviour towards asylum seekers, then confidentiality may be breached and the issue followed up.
5. I agree to take part in the above study

Name of participant:

Date:

Signature:

Appendix 8: The Characteristics of the Case

Participant	Ethnic background	Age approx	Individual interview	reflection	Noted as quiet or dominant
2	White British	30s	yes	no	no
3	White British	30s	Yes but (couldn't attend)	no	no
4	White British	30s	yes	no	no
5	South Asian British	20s	no	no	no
6	South Asian British	30s	no	no	quiet
7	White British	40s	no	no	no
8	South Asian British	20s	yes	yes	no
9	White British	20s	no	no	quiet
10	South Asian British	20s	no	yes	no
11	White British	20s	no	no	quiet
12	White British	40s	no	no	Dominant

Appendix 9: Women's Ways of Knowing

- 1) **Silence**; women consider themselves as mindless and voiceless and dependent on external authority
- 2) **Received knowledge**; women consider themselves as able to receive knowledge from external authority
- 3) **Subjective knowledge**; women consider that they have small inner voice which facilitates them to construct some knowledge but this is personal and not shared
- 4) **Procedural knowledge**; women actively begin to apply objective procedures to obtain knowledge
- 5) **Constructed knowledge**; women view knowledge as contextual and individuals construct their own knowledge

From Belenky, McVicker Clinchy et al (1997)

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