

Experiences of Maternity Services:
Muslim Women's Perspectives

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The Maternity Alliance

The Maternity Alliance is a national charity which works *to* improve support for, and end inequality amongst, pregnant women, new parents and babies under one.

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SUMMARY

Ethnic minority women are twice as likely to die during pregnancy or immediately after the birth of a child as white women. Over one fifth of mothers who die during this period receive poor quality maternity care, and women from ethnic communities are more likely to receive sub-standard care than women in other groups.

The UK's Muslim population is 1.6 million and growing. Yet few studies have explored Muslims' needs and experiences of, health services including for maternity care.

In 2003 the Maternity Alliance conducted a small-scale qualitative research study into Muslim parents' experiences of maternity services in England. The study found that whilst some Muslim women receive good quality maternity care, many do not. Basic facilities and services in the NHS are often insensitive to their and their partners' needs.

Problems include:

- low awareness and use of antenatal classes
- acute discomfort and embarrassment amongst Muslim parents due to the lack of privacy in hospitals and too few female staff
- a lack of appropriate, easily understandable information during pregnancy, childbirth and the postnatal period, particularly for Muslim women whose first language is not English and for those with low literacy skills
- poor communication between health professionals and Muslim parents
- a severe shortage of interpreters who are available when Muslim women and NHS staff most need their support
- on over-reliance on English speaking family members and friends to act as translators, which can affect the quality of maternity care being provided to Muslim women
- insufficient involvement of Muslim parents in maternity services, and little choice for Muslim women about the treatment and care they receive

These difficulties are partly due to a lack of understanding amongst NHS staff about how Islamic beliefs and practices can affect Muslim women's experiences

of maternity care. This is exacerbated by insufficient resources within hospitals and too few staff, particularly midwives.

However, the poor quality and insensitive care received by many Muslim parents also appears to be a result of discriminatory attitudes held by some NHS staff. Many women we interviewed had experienced stereotypical and racist comments during the course of their maternity care.

Maternity services must be informed and shaped by the diverse needs of the communities they serve. Increasing the accessibility and quality of maternity care will play an important role in improving the health outcomes of the UK's black and minority ethnic population, including Muslim communities.

Key recommendations include:

- Ensuring effective pre- and post-qualification education and training for all health professionals on religious, cultural and ethnic issues that can influence users' needs for and experiences of health services, including maternity care.
- Having a designated midwife for every woman to ensure continuity of care throughout pregnancy, childbirth and the postnatal period, and to increase health professionals' understanding of the needs of parents from different ethnic backgrounds.
- Increasing the availability of community-based services that provide new mothers and fathers with a range of medical and other support services throughout the antenatal and postnatal period, to meet parents' medical, social and psychological needs and to increase take-up of services.
- Improving the content and accessibility of information for pregnant women and new parents and increasing the number of interpreters, to help improve Muslim women's involvement in, and choices about, the care they receive.
- Employing more female and Muslim health professionals to improve the sensitivity of maternity services and to ensure NHS staff reflect the communities they serve

INTRODUCTION

Confidential Enquiry into Why Mothers Die

In 2001, the National Institute for Clinical Excellence published *Why Mothers Die*, the fifth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom.¹ The report, which looked at maternal deaths between 1997 and 1999, found that women from ethnic minority groups were twice as likely to die during pregnancy or just after birth than white women.

Over one fifth of the women who died had not received optimum antenatal care, for example they were late bookers at antenatal clinics and/or were poor clinic attenders. Women from ethnic minority groups were twice as likely to book later than 20 weeks into their pregnancy than white women. Nearly half of all women who missed four or more antenatal care appointments came from an ethnic minority group, and half of these women did not speak English. The use of family members as interpreters by these women was highlighted as a particular cause for concern, as the practice can lead to incorrect information being conveyed by and to the woman about her medical needs and treatment.

The report made a series of recommendations on how to improve maternity services in the UK. These include ensuring that healthcare professionals understand women's different social and cultural backgrounds, providing interpreters for women who do not speak English, and encouraging health professionals to consider whether there are unrecognised but inherent racial prejudices within their organisations that affect their ability to provide an equal service to all users.

Why Mothers Die did not indicate how many of the women who died during pregnancy or just after childbirth, or who had received sub-standard antenatal care, were Muslim. However, many of the women had ethnic origins in countries with predominantly Muslim populations such as Bangladesh and Pakistan.

The UK's Muslim Population

1.6 million people in the UK (approximately 3% of the population) describe their religious affiliation as Muslim. Muslims are the second largest religious group in the UK after Christians.² Areas with the largest Muslim populations include London local authorities like Tower Hamlets (71,000) and Newham (59,000), which represent 36% and 24% of the total population respectively, and cities in the North and Midlands, such as Bradford (75,000 - 16 per cent of the population) Blackburn (27,000 - 19 per cent of the population) and Birmingham (140,000 - 14 per cent of the population).³

The UK's Muslim population is diverse. 41% of UK Muslims describe themselves as of Pakistani origin, 13% as Bangladeshi, 11% as Indian, 23% Middle Eastern or African, and 12% as 'Other' (which includes countries like Malaysia).⁴ Many South Asian Muslims arrived in the immediate post-war period and are therefore among the most established Muslim communities in the UK. Muslims that arrived during the 1980s and 1990s have tended to come from areas such as the Horn of Africa, Kurdistan, Bosnia, Algeria and Iraq. In total, 50% of the UK's Muslims were born in the UK.

¹ National Institute for Clinical Excellence, the Scottish Executive Health Department, The Department of Health, Social Services and Public Safety: Northern Ireland (2001) *Why Mothers Die 1997-1999: The Confidential Enquiries into Maternal Deaths in the United Kingdom* RCOG Press, London.

² Office of National Statistics, census 2001, <http://www.statistics.gov.uk>

³ Office of National Statistics, census 2001, <http://www.statistics.gov.uk/census2001/profiles/rank/ewmuslim.asp>

⁴ The Runnymede Trust (1997) *Islamophobia – a challenge for us all*, cited by Muslim Council of Great Britain <http://www.mcb.org.uk/mcbdirect/statistics.php>

As well as being diverse, the UK's Muslim population is young. 33.8% of Muslims are under 16 years old compared to a national average of 20.2%, and 18.2% are aged 16-24 compared to a national average of 10.9%. Some ethnic groups have particularly young populations. For example, 31% of the Pakistani population and 30% of the Bangladeshi population are aged 15-29.⁵ This is an important issue in relation to maternity services since younger populations are more likely to need antenatal and postnatal care.

Influence of Islam on experiences of maternity care

There is a substantial body of evidence on the health needs of Britain's ethnic minority communities.⁶ This includes studies on ethnic minority women's use of, and views about, healthcare including maternity services.⁷ However, few studies have looked at the health needs of Britain's Muslims⁸, and none have focused specifically on Muslim women's experiences, including of maternity services. Yet Islamic beliefs and practices can have an important affect on the need for health services and support, including antenatal and postnatal care.

However, the diverse nature of the UK's Muslim population means it cannot be considered a homogenous group with a uniform set of beliefs, practices, customs and needs. Islamic beliefs may find different expressions in practice within different cultures and ethnic groups. It is therefore important to distinguish between the aspects of patient care which may be influenced by the commonality of Islam and those which may be influenced by ethnic and cultural diversity.

All Muslims believe in the five pillars (or duties) of Islam: faith or belief in the Oneness of God (*Kalima*) and the finality of the prophet Muhammad, prayer five times a day (*salat*) giving alms (*zakaat*) fasting during the month of Ramadan for self-purification (*sawm*) and making a pilgrimage to Mecca (*hajj*). The concepts of *hiyo* (modesty) and *purda* (seclusion) are central tenets of Islam. The most visible external sign of this is the wearing of the *hijab* (a) by some Muslim women. Muslim women often interpret *hijab* according to their ethnic origin. For example, Muslim women from Bosnia might wear head scarves and knee-length skirts, Muslim women from South Asia might wear the *shalwarkameez* and a *duputa* (scarf) to cover their heads, and women from Afghanistan may wear the *burqa* (covering the entire body). *Hiya* also extends to the conduct of Muslim men. For example, it may mean respecting separate male and female spheres and not intruding upon spaces that are considered to be dominated by women.

Islamic beliefs and practices raise important issues in relation to the provision of health services, including maternity care. Many Muslim parents want to be able to continue observing and practicing their religion when they are in hospital, for example, by having a quiet place to pray and by eating *halal* food⁸. As this report will show, retaining privacy is a particularly important concern for Muslim parents when they are in hospital, during childbirth and in the immediate postnatal period. The absence of privacy can compromise *hiya* and *purda* and cause considerable embarrassment and discomfort for both mothers and fathers alike.

5 Office of National Statistics, 2001, *Online Census*, <http://www.statistics.gov.uk>

6 The Runnymede Trust (1997) *Islamophobia – a challenge for us all*, cited by Muslim Council of Great Britain <http://www.mcb.org.uk/mbcdirect/statistics.php>

7 Office of National Statistics, 2001, *Online Census*, <http://www.statistics.gov.uk>

8 See for example Balarajan, R, Raleigh, VS., 1995, *Ethnicity and Health*, Department of Health, HMSO, London, Samaje, C., 1995, *Health, 'race', and Ethnicity, Making sense of the Evidence*, Kings Fund, London; Nazaroo, J., 1997, *The Health of Britain's Ethnic Minorities*, Policy Studies Institute, London; Ahmad, W.I.U (ed.) 1993, *Race and Health in Contemporary Britain*, Open University Press, Buckinghamshire; Hopkins, A, Bahl, V (eds.), 1993, *Access to Health Care for people from Black and ethnic Minorities*, Royal College of Physicians, London, McIver S (1994), *Obtaining the views of Black Users of Health Services*, The King's Fund, London

NHS professionals and managers need to understand the influence Islam can have on shaping new parents' needs for antenatal and postnatal services. Insensitivity to these issues can adversely affect Muslim women's use of maternity care. At best, this can make childbirth an unpleasant experience, leaving both mothers and fathers embarrassed and disappointed at what should be a joyous and important time. At worst, it may deter Muslim women from accessing maternity care, which may in turn lead to poorer health outcomes for them and their children.

AIMS OF THIS REPORT

In 2003 the Maternity Alliance conducted a small-scale qualitative research study into Muslim parents' experiences of maternity services in England (see *Appendix 1 for further details*). The study involved three main stages:

1. **Focus groups with Muslim mothers** to explore their experiences of, and views about, maternity services. The women we spoke to were from a range of different ethnic backgrounds including Pakistan, Bangladesh, Somalia and Iraq.
2. **Questionnaires with Muslim fathers** to assess their and their partners' experiences of antenatal and postnatal care.
3. **Interviews with health professionals** to identify barriers to providing good quality maternity care for Muslim parents and models of good practice. We spoke to a range of professionals including midwives, health visitors and obstetricians.

This report outlines the findings from our research. The report aims to raise awareness amongst health professionals who work with pregnant Muslim women about models of good practice in maternity care. It also seeks to challenge some of the racial and religious stereotypes that have adversely affected Muslim women's experiences of maternity services in the UK to date. The report concludes with a series of recommendations on how the NHS can deliver more accessible and better quality maternity services that meet the diverse needs of a multi-ethnic and multi-faith society.

A *Hijab* is the traditional head covering for Muslim women and may be worn in various forms, from a head scarf to complete covering.

B *Halal* food is defined as food permitted under the Islamic law and covers types of foods that can be eaten as well as methods of preparation

KEY FINDINGS

SERVICES, FACILITIES AND STAFF

Some of the parents in our study felt they had received good quality health services during pregnancy, childbirth and the postnatal period.

However, most said that maternity services, facilities and staff had been insensitive to their needs and preferences. The difficulties faced by Muslim parents, particularly women, in protecting their privacy was a major cause for concern. Muslim parents felt this issue was given scant attention or priority at every stage of their maternity experience, from the structure and content of antenatal classes and choice of doctor, through to their experiences of childbirth and maternity wards.

Antenatal classes

Why Mothers Die found that 60% of the cases of direct maternal death and 17% of the cases of indirect maternal deaths had substandard antenatal care.^C 20% of the women who die had booked for maternity care after 24 weeks of gestation or had missed over four routine antenatal visits. Black and minority ethnic women were significantly over-represented amongst this group.

Awareness of antenatal classes amongst the Muslim women in our study was low. One non-English speaking participant did not know what an antenatal class was. Other women said they had not been told about the availability or content of antenatal classes, and had not been invited to attend:

"No one offered me any antenatal classes...nobody mentioned it to me. They don't tell you. They don't mention anything. They just do the routine stuff and then that's it."

"No one offered me any antenatal classes...nobody mentioned it to me..."

"I really wanted to go but they [health professionals] don't mention it to you, that's the thing...[they think] Asian people don't want to come to these antenatal classes."

Several women who did manage to attend antenatal classes said the classes made them feel uncomfortable because men were often present:

"The class about giving birth and going through labour men were present and I felt that some of the Muslim women were inhibited. I did not feel comfortable with two or three men there and it was not Muslim men, none of the Muslim men turned up."

Many of the Muslim men in our study felt that participating in antenatal classes alongside Muslim and non-Muslim women was inappropriate and therefore did not attend. Some of the women agree that it was inappropriate for men to be present at antenatal classes and during labour. They felt that childbirth should be an entirely female sphere and that partnering a woman during labour should be the role of female relatives:

"They [health professionals] should not make the assumption that they [Muslim men] are going to be present at the birth. My husband was not there, I didn't want him there. My mother was there."

However, other women felt that their husbands should attend antenatal classes in order to provide them with effective support throughout pregnancy and labour.

"If they are going to be there at the birth then they need to know"

"I just felt that my husband could have been better prepared if he knew, you know, what area to support me in."

^C Direct deaths are defined as those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium) from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these. Indirect deaths are defined as those resulting from previous existing disease, or disease that developed during pregnancy, and which was not due to direct obstetric causes but which was aggravated by the physiologic effects of pregnancy.

“After my baby was born we organized a group on baby care management...I think that was really helpful...”

“You know, like you have to tell him everything. It is better that someone tells him before you have the baby that this is the kind of support she will need, because then you feel like a nag.”

Some women suggested that male-only antenatal classes might encourage Muslim husbands to take on more of a role:

“If it was just men doing something they would probably come to that...They do try but if they can be more prepared they can really help us a lot more.”

Some women felt they would have benefited from antenatal classes provided by Muslims, for Muslims. Such classes could help tackle the lack of information about the religious issues surrounding pregnancy and childbirth. This was an important omission for some women, who felt they could not ask particular questions relating to Islam and childbirth. Such women had to rely instead on getting this information from family or friends.

“They [women in Muslim only antenatal classes] would be able to ask and people would understand about religion, like needing a female doctor...”

“There are women-only antenatal classes in Luton but they are in Urdu or Bengali and I wanted English, there was nothing.”

Some examples of good practice in providing antenatal care for Muslim women were identified by the healthcare professionals in our study. Community based services that covered antenatal and postnatal care, as well as general health and wellbeing issues, were highlighted as being particularly effective in providing appropriate care for Muslim women. Such services involve not only health professionals like midwives and health visitors but also local voluntary and community groups. They also specifically acknowledge and incorporate religious and cultural issues in all aspects of care.

For example, one midwife had been involved in a community based maternity service that included aqua classes for pregnant Asian women, ensuring female pool attendants were present in order to preserve the women's privacy and modesty.

One of the women in our study said she had been involved in setting up a parent support group herself. This was held in the local community and was organised by a group of Asian women, which helped increase attendance rates:

“After my baby was born we organised a group on baby care management...I think that was really helpful, there was so much I learnt in terms of dealing with children and different stages and behaviour ... If it was held at some clinic we probably would not have gone ... It was held here for Asian women and a lot of mums with difficulties still came and there was targeted advertising to get us here, you know? If it was a general course at a clinic I probably would not have gone because I don't know what you would have gained from it.”

Female doctors

Research shows that many women, regardless of their ethnicity or religious beliefs, prefer to be seen by a female doctor, especially for gynaecological treatment.⁹ However, Muslim women may be particularly keen to be seen by female doctors for physical medical examinations and discussions about female health issues, for reasons concerned with *purda* and *hiya*.

Islam permits women to be seen by a male doctor when no female doctor is available. As one woman in our study observed:

“Sometimes if it is very necessary to be seen by a male doctor and it is very dangerous for your life, so you have to see the male doctor. If you have to see the male, you have to see them.”

⁹ See for example Wright C.M. 'Language and Communication Problems in an Asian Community.' *Journal of the Royal College of General Practitioners* 1989; 33:101-104.

"It is quite uncomfortable because it is not like a lady, it is a man and you are wearing the hijab and then you have to get your tummy out..."

A few of the women in our study had discussed choosing a male consultant even when a female consultant was available:

"When I was referred I was given the choice of a woman consultant but the woman consultant is a nightmare, she's really, really insensitive so I chose to be referred to the man because of the insensitivity of the female. "

However, most Muslim women felt that being treated by male health professionals was profoundly upsetting and contradicted *hiya* and *purda*. Some of the women in our study successfully observed the rules of *purda* throughout their pregnancy, but felt disempowered when their request for female doctors and other staff during labour and birth was ignored, giving them no choice but to accept a male doctor:

"I don't even allow my husband to be in the labour room at that time because I feel uncomfortable with men ... Even he [my husband] refused to come in at that time because it should be for just women ... If I don't want my husband in the labour ward then why should I let any other men, you know, come in even if he has to just give me an injection, right? They said that there was no one else to give it to you."

"I know that they are doctors at the end of the day, it depends on the individuals. I feel comfortable talking to them but I wouldn't want to have an internal examination by them."

One woman described how she felt when she was examined by a male doctor (even though a female nurse was present):

"It is quite uncomfortable because it is not like a lady, it is a man and you are wearing the hijab and then you have to get your tummy out for a man... It is uncomfortable... It is just the feeling of it. "

Some women said they would be embarrassed even if the male doctor they were treated by was Muslim. The lack of female health professionals, particularly doctors, was also an issue raised by Muslim men. This issue was regarded as the most negative aspect of their experience during their wives' pregnancies and births.

The health professionals in our study said that the attendance of a female doctor was one of the most frequent requests made by Muslim parents. However, some felt that Muslim men were more opposed to having a male doctor than Muslim women - a suggestion that was supported by some of the women themselves. For example, one woman said:

"I was in hospital and there was a woman next to me and her husband was with her and when the [male] doctor came to check her ... She asked her husband ... He said that the doctor has come to check you but I don't want him, even if he is white, to check you ... He started fighting with the doctor. The woman said that he is a doctor and he has checked the whole ward, what will he think? She didn't mind, but the husband did. "

Some of the health professionals and women in our study felt that having a female doctor was a religious issue, whereas others believed it to be more related to culture. As one woman said:

"It is not about religion ... All women are embarrassed being seen by men..."

However, it is clear that in many cases women felt their choices and preferences to be seen by female staff were often ignored or dismissed. As one Muslim man commented:

"The good performance of all the staff gets overlooked because of this extremely sensitive issue [having a female doctor]. The issue is generally not noticed and we are generally made to feel guilty for having asked for such a need"

"They won't allow, unless you're breastfeeding or being examined, they won't let you have the curtains pulled and they don't care if you say to them, 'I wear hijab and I don't want men.' They say, 'We can't trust what you are going to do with the baby.'"

Separate rooms

The discomfort caused by being in the presence of men (other pregnant women's partners and male health professionals) during childbirth and whilst on the wards was a major issue for the women in our study. Many said they would have liked to have had a separate room in hospital in order to protect their modesty. However, few had been able to secure one. As one woman explained:

"I wanted the privacy. The dads are there 12 hours, 9 till 9, and I just wanted to be able to have privacy to breastfeed without people walking around, because I wear hijab as well. The English women, or the non-Muslim women, are happy to breastfeed openly and you know, I didn't want that because, you know, they do pull the curtains back. "

One woman said that being on the hospital ward meant she felt forced to keep her curtains shut most of the time. However she, like many of the other women interviewed for our study, said this was insufficient to protect her privacy.

Another woman said that hospital staff had not allowed her to keep the curtains closed:

"They won't allow, unless you're breastfeeding or being examined, they won't let you have the curtains pulled and they don't care if you say to them, 'I wear hijab and I don't want men.' They say, 'We can't trust what you are going to do with the baby.' That's what they said to me."

Some women said they had requested a separate room as part of their birth plan but that the request had been ignored. Others reported feeling uneasy about making a request for a separate room, for fear of a hostile response:

"I find that even if you ask for a separate [room], they say, 'What is wrong with this? You are here' I find that there is still 'ifs' and 'buts' about it."

Even those women who had managed to secure a separate room said that staff remained insensitive to their need for privacy:

"The doctors that came to examine me would just knock and just come in, right? So you've got twenty seconds to do whatever you have to do, whether you wear the hijab or not. I was in a side room but they just stroll in."

Muslim women adopted a variety of mechanisms for tackling the lack of privacy they experienced during pregnancy, childbirth and the postnatal period. Some chose to wear the hijab throughout their labour and delivery to allow them to maintain purda. Others chose to have home births specifically to avoid these difficulties:

"There are some women that have babies at home just to make sure that there are no men."

Having sufficient facilities and resources is likely to be a key factor in the NHS's ability to provide pregnant women with separate rooms. However, many of the women in our study felt the problem was often down to a lack of understanding amongst hospital staff. Muslim women felt staff showed little sensitivity about the reasons why they wanted a separate room during and after the birth of their child. As one woman commented:

"They are still not aware of what religion means, Islam ... or if they are, they don't care."

**"Why do they assume that all Muslims want to eat curry?
You ask for a halal meal they will send you a curry. Maybe not everybody likes
curry..."**

Prayer facilities

Another reason why privacy is an important issue for Muslim parents in hospital is to enable them to pray. Many of the women in our study said they felt uneasy asking for a quiet room to pray in, either for themselves, their husbands or for other family members (hospital visiting times often clashed with prayer times):

"I asked her [a nurse] if we could use this room please, you know I didn't know how to ask her that I want to pray. It is six o'clock and I don't want to miss the Magrib prayer. There was nothing, so my husband prayed on a chair. She [the nurse] said 'Is he okay?' You know, she didn't know that he is praying. I think she got frightened or something that he is a terrorist or something."

"There is no separate area, you have to do it in the area, you know, beside your beds and obviously if there isn't a lot [of room]...if someone walks in they will probably walk into you ... If the visiting times clash with prayer times, then that is really difficult. "

"Once my husband asked about praying. Again it is a matter of ignorance, you know, they don't know I asked and they said, 'Yes, down the stairs in the chapel. 'It is just a matter of introducing it because now in the university they have praying rooms. "

The women in our study recognised the fact that scarce hospital resources mean it is difficult to cater for everyone's needs, such as providing a quiet place for Muslims to pray in. However, many of the women felt staff should at least understand that this is an issue, rather than simply ignoring the problem.

Hospital food

Halal food was available in all the hospitals used by the women in our study. One woman was positive about the halal food she had had:

"It was very nice, I was eating and putting weight on, I couldn't move."

However, most thought the halal food they were given was extremely poor quality and that Muslim women were given little choice:

"The halal food is not really edible. I found there is more choice in a school dinner. "

The main issue highlighted by the women was the fact that many hospitals seem to believe halal food is synonymous with rice and curry. The women felt this was largely due to ignorance and the tendency of hospital staff to see all Muslim women as the same, despite the ethnic diversity of the UK's Muslim population:

"Why do they assume that all Muslims want to eat curry? You ask for a halal meal they will send you a curry. Maybe not everybody likes a curry. There are Chinese Muslims, there are Caucasian Muslims, you know? Muslims from all over"

Inappropriate assumptions about the diets of Muslim women meant that many of the women were not given a choice about what food they ate during their time in hospital. The 'default' position seemed to be to provide Muslim women with curry. Several women said the food they were given was too spicy, leaving them with only the vegetarian option:

"Halal food.. I didn't like it, I preferred to have the baked potatoes and things and they presumed that I wanted the halal curries and stuff. When I wasn't there to sign it they just gave it to me ... they just presumed that because you are Asian or whatever. "

E Magrib is the prayer at sunset

"The nurse was just saying 'If you want to bottle feed, it is up to you', but not like, 'Don't worry, it will get better' ... I didn't know it was going to be that sore. Nobody told me and it was the cleaning women who told me, 'Just keep it up, after one or two weeks you will be fine.'"

INFORMATION, INVOLVEMENT AND CHOICE

All of the women in our study highlighted the lack of appropriate and accessible information during pregnancy, childbirth and the postnatal period. This was a particular problem for women with little or no written or spoken English and those with low literacy levels. The lack of information made effective communication between health professionals and Muslim women extremely difficult. It was also a major barrier to effectively involving women in decisions about their treatment and care, especially during childbirth. Too many women were forced to rely on relatives or friends to act as interpreters, which created problems for both the women and health professionals alike.

Information

Many of the women in our study raised important concerns about the accessibility and content of the information they received before, during and after childbirth. The lack of high quality, accessible information meant many felt insufficiently prepared for giving birth. Unsurprisingly, the women who understood spoken and written English and attended antenatal classes were the most well informed, whereas those who spoke some English but could not read English and those with no spoken or written English and low literacy skills were less well informed. This affected women's understanding of maternity services, which treatments they could receive, as well as their knowledge about wider rights and entitlements, for example to financial support.

The health professionals we interviewed said that information on a range of different issues during pregnancy and childbirth, and in the postnatal period, was available. They said this information came in different formats, such as videos, and different languages, and was supplemented with extra support wherever possible.

However, most of the women in our study felt their information needs had not been appropriately met. Most said they had received standard information such as one of the different Bounty Packs. But many found this information difficult to understand and said that health professionals had neither the time nor the inclination to provide the additional support necessary to help them do so:

"They [health professionals] don't give you any time to sit and talk through anything, like any symptoms ... I had to phone friends [to ask] 'Is this normal?'"

Other women felt that their spoken English was insufficient either to understand the verbal information that was provided by health professionals, or to effectively communicate their needs. Even those women who spoke and read some English felt they did not fully understand some of the information they were given, particularly if it contained medical or technical terms.

A lack of information and support on breastfeeding was raised by several of the women as a particular cause for concern. Requests for information and support on breastfeeding were often ignored, leaving women to 'fend for themselves'. Women were particularly disheartened if they had committed to breastfeeding but experienced initial difficulties. One woman said:

"Even with breastfeeding, the nurses were so unhelpful with my first. They never told me it was just incredibly painful. The nurse was just saying 'if you want to bottle feed, it is up to you, ' but not like, 'Don't worry, it will get better'... I didn't know it was going to be that sore. Nobody told me and it was the cleaning women who told me, just keep it up, after one or two weeks you will be fine. '"

"I feel if there were more Asian midwives, services would be improved and mums would be free to ask whatever their concerns, which they might not through an interpreter."

Women also wanted more and better information about their rights to financial support. Several said they had not been told they were entitled to vouchers to buy fruit and vegetables and milk^F, or that if they had been given information, it was difficult to understand:

"The midwives should tell you about the vouchers, and cash, they don't give it to you if you don't come... Midwives or people at hospital should tell you."

"All the information is there in the leaflets but you really have to read them, particularly about vouchers and financial implications. You have to take the initiative, they do not mention it. The information is there but it is knowing where to look. "

Both the women and men in our study highlighted the need for information on religious aspects relating to pregnancy, birth and the postnatal period. Specific topics that Muslim women wanted information on included how long to wait after the birth before shaving the baby's head, when to perform male circumcision, when to recite the azan (prayers) in the baby's ear, and how long women should wait after giving birth before resuming regular daily prayers.

Very few of the parents in our study received such information from health professionals. Women generally turned to female friends and relatives, or to their husbands, who in turn consulted with relatives or Islamic scholars.

For example one woman, whose sister in law was a doctor, explained:

"I had issues regarding bleeding and when I was meant to be praying ... Is this postnatal bleeding or menstrual bleeding? From what she [her sister-in-law] told me I was able to decide to pray or not. If I had asked someone who was not Muslim, a doctor who was not Muslim, they would be wondering why I am asking these questions"

because bleeding is bleeding. They wouldn't understand"

One woman said she had been able to find out information relating to religious issues from a Muslim midwife:

"She [the midwife] has gone out and bought books on childbirth from the Muslim perspective, about the embryo...when the life is put into the baby. That really helps if you've got a midwife that is a Muslim."

Both the women and men in our study suggested that increasing the number of health professionals who are Muslim or from the same cultural background could help provide Muslim parents with more appropriate information. For example, one Muslim man commented:

"I feel if there were more Asian midwives, services would be improved and mums would be free to ask whatever their concerns, which they might not through an interpreter"

Communication and interpreters

Health professionals identified communication as the most important barrier to providing effective maternity services to Muslim women and said that inadequate communication was a particularly serious problem for women who spoke little or no English.

These concerns were echoed by many of the women in our study. Women felt that non-English speaking women were treated differently to English speaking women. For example, one woman said:

'They [health professionals] treat them [Muslim women] differently. The people who speak English and the people who don't speak English. I had two children and they talk about me but I understand them, and you won't believe what they say Afterwards when I speak English they try to be nice."

^F The Welfare and Food Scheme, which is available to low income pregnant women and new parents, provides tokens to buy infant formula and milk. A new scheme, Healthy Start, will replace this in late 2005. Healthy Start will provide low income women with vouchers to purchase fruit and vegetables, as well as an infant formula and milk.

"Maybe they [non-English speaking Muslim women] just accept that this is how I am going to be treated."

Poor communication undermined the ability of Muslim Women to make proper choices and decisions about their treatment and care. Some English speaking Muslims thought non-English speaking Muslims were particularly vulnerable:

"Maybe they [non-English speaking Muslim women] just accept that this is how I am going to be treated."

A lack of independent interpreters was identified as a critical factor influencing the quality of maternity care. Even those health professionals who had managed to identify a link worker or an interpreter said they experienced difficulties in ensuring continuity of language support. Both the women and professionals in our study said that it was difficult to access language support 24 hours a day, seven days a week, since interpreters often had to be booked two or three days in advance. The quality of maternity services provided was significantly affected by the time of day a non-English speaking Woman needed care. One health professional said:

"There are some [interpreters] but they are not always available ... You have to book them; how, if you don't know who to ask? You are delivering the baby and at night time there is no one there. "

As a result many women tried to deal with communication problems by asking English speaking relatives or friends to act as interpreters. However, this practice may be inappropriate for a number of reasons. These include the fact that women may be too shy to seek help for intimate concerns, that it is inappropriate for children to translate intimate details about their mother, that it is not clear how much correct information is being conveyed to the woman and that, if the translator is a perpetrator of domestic violence, the woman may not be able to ask for advice or help. ¹⁰

In addition, not all Muslim women have English speaking family members or friends to whom they can turn. One woman in our study pointed out that women who have recently arrived in the country as refugees or asylum seekers may not have a readily available support system to call upon when language and communication become a problem. These women are most vulnerable, particularly as they are less likely to know and understand the systems and procedures they encounter during pregnancy, childbirth and the postnatal period. ¹¹

Some women do not want to use family or friends as interpreters because they fear they will focus on their own issues or concerns, rather than those of the pregnant woman:

"I find that in extended families, in my experience they don't help you, they don't. The mothers-in-law say, 'As long as I get my grandson, everything's fine,' you know? I had children and no one told me and I was going on my antenatal and I wasn't given enough information. "

"Sometimes when there is an interpreter there the husband doesn't want to use the interpreter. They try and explain themselves, but it is not the patient's own choice. "

"How are they asking people if they don't even understand, you know? It is the matter of understanding...Most of them don't even understand the questions they are asking, so how do they expect them to, you know, give their consent for whatever is being done to them?"

¹⁰ National Institute for Clinical Excellence, the Scottish Executive Health Department, The Department of Health, social Services and Public Safety: Northern Ireland (2001) *Why Mothers Die 1997-1999: The Confidential Enquiries into Maternal Deaths in the United Kingdom* RCOG Press, London.
¹¹ McLeish. J. 2002. *Mothers in Exile: Maternity Experiences of Asylum Seekers in England*, Maternity Alliance, London.

"They [Muslim women] might not have heard of epidurals and they are not aware that these options are available because they can't understand English."

Involvement and choice

Most of the women in our study said they were given insufficient involvement in, and choice about, the treatment and care they received. A third of the men in our survey also said that staff did not include them in decisions that were made. Whilst many non-Muslim parents say their preferences before and after the birth of a child are ignored, a lack of involvement and choice may be a particular problem for Muslim parents because of the difficulties of effective information and communication, as outlined above.

Many women said the lack of involvement and choice they experienced was particularly problematic during labour. The women felt that whilst the birth plans they had agreed with their midwives were supposed to empower them to make birth choices, these were not put into practice, particularly in the event of an emergency.

"I wanted an epidural, it was on my birthing plan but the doctor wasn't available, so I just had to stick to the gas and air. So it is whatever is available."

"It's my body so I would want a choice but sometimes they just don't give you a choice. Everything happens so fast. What happened was that my placenta got stuck, it wouldn't come out. They took me to theatre and they gave me epidural 'cos she had to actually take it, the placenta, out by hand. They gave me epidural but that didn't work, it happened so fast they didn't actually give me a choice. He goes, 'Oh sorry, we have to put you to sleep, ' I didn't even have chance to read the kalmia ... I couldn't believe it, they didn't even give me a choice...I didn't sign anything They didn't ask me for my consent that they are going to put me to sleep or anything."

The health professionals in our study acknowledged that a lack of information and interpreters creates particular problems in ensuring Muslim women are effectively involved in the treatment options that are available to them during childbirth.

"They [Muslim women] might not have heard of epidurals and they are not aware that these options are available because they can't understand English."

"I think when they get to 36 weeks they should get an interpreter in and explain everything, all the options to them, what they want at the time of the labour because that's really an important time. "

Some women who had been cared for by Muslim health professionals felt this helped improve their ability to make genuine choices. One woman said:

"The midwife who delivered me was Muslim ... I was in a fortunate position so my choices therefore were Islamic because I had a midwife who understood me, knew me and said, 'Do you want a Muslim doctor? Do you mind if a male doctor comes in?' It does make a real difference."

"...I asked two or three times...I wanted to breastfeed and they didn't come to me, yet they...helped all the white women."

DISCRIMINATION

Most of the parents in our study talked about experiencing some form of discrimination during antenatal and postnatal care. This discrimination was often subtle and difficult to specify, such as staff responding to women's questions or requests in a rigid and inappropriate manner. However, other women experienced more direct forms of discrimination, such as staff making unfair, stereotyping and racist comments. In general, there was a perception amongst both the women and men in our study that a lack of understanding about Islam means maternity services are insensitive and sometimes even racist in their policies, practices and procedures.

Lack of knowledge and understanding

As this report has already outlined a lack of understanding about the basic needs of Muslim women, such as wanting to be seen by a female doctor or to have a separate room in order to preserve *hiya* and *purda*, meant that women often felt extremely uncomfortable and embarrassed.

The most negative perceptions parents held were of health care assistants and nurses on postnatal wards, who were frequently criticised for being unsympathetic and for treating Muslim women 'differently'.

One woman described her experience of seeking help with breastfeeding:

"I asked for help with breastfeeding and I asked continuously. They gave me the bottle. In the morning I got up and said, 'You are going to discharge me today and look, I really want to breastfeed her,'

'And I asked one of the healthcare assistants who had four times gone to the women next to me. I was on a ward of four white women and I asked her, 'You were really good with the person next door, could you help me. I asked two or three times I wanted to breastfeed and they didn't come to me, yet they helped all the white women. "

The woman put in a formal complaint against the healthcare assistant. However, others were not confident enough to complain or felt doing so would make little difference. As one woman commented:

"You complain, but they don't care."

An issue raised by some women in our study, and about which there was a particular lack of understanding, was female genital mutilation (FGM). FGM is a cultural issue, not a religious one, since it is not sanctioned by Islam. However, FGM is practiced in some countries which are predominantly Muslim. For the women in our study, a lack of understanding about FGM by health professionals compounded any discrimination they had already experienced whilst using maternity services.

Women understood the need for health staff to be trained on the issue. However, they also felt that a lack of knowledge about FGM led to insensitive and prejudicial attitudes and practices. For example, women often felt they were put 'on show' at an acutely sensitive and private time, that their consent for other staff to be present was not always sought, and that they were given insufficient information or choice about their treatment.

"I had my first baby and there were lots of students in the delivery unit, there were lots of women nurses and they were eager to see, they were training and they were all surprised and they were saying, 'How, how can you conceive?' I had a full circumcision but basically there was no one who had the experience to deliver the baby, so they had to call someone from another hospital. He was a Sudanese man so I had to have a male doctor to deliver the baby because there was no one else."

One woman felt that assumptions had wrongly been made about how women with FGM could give birth and that she had not been asked for her views about childbirth, or given information about the choices that might be available to her, including for pain relief:

"...They did the epidural, then I see my legs paralysed and I was scared what has happened to my legs, I wasn't in pain. I was saying, 'What has happened to my legs?' They say, 'Because you are circumcised maybe you will have long labour.' I could feel nothing."

"I am circumcised and they could not believe that I was having a baby. I was pregnant three months and the GP said, 'You are not pregnant'. They did the epidural, then I see my legs paralysed and I was scared what has happened to my legs, I wasn't in pain. I was saying, 'What has happened to my legs?' They say, 'Because you are circumcised, maybe you will have long labour. 'I could feel nothing."

An additional issue for the Somali women in our study was the fact that many health professionals believe FGM means women should avoid having children. Ignorance about this issue led to some health staff inappropriately pressuring women into using contraception.

All of the healthcare professionals we interviewed said there was a need to improve understanding about the cultural and religious needs of Muslim women. Having a designated midwife to provide continuity of care was thought to be critical to achieving this goal. Midwives who look after the same woman throughout her pregnancy, childbirth and the postnatal period can build relationships with the woman and her family and have time to identify and understand their specific individual, religious and cultural needs.

One midwife described how she had been able to do this:

"last week I booked a woman for care. She's not actually been in this country very long, she's moved from Pakistan. Her baby is due in May, a Muslim couple. I was able to say to them, 'You know, if there are particular things that you want to happen at the time of the birth which is important to you because of religion or culture, then you know this is the time for us to be talking about it, in the next six to eight weeks.' I feel that I am much less likely to put my foot in it. I think it is very positive for the women and for myself that I feel comfortable and confident we know what is wished for at the time of birth."

The health professionals in our study felt strongly that having a designated midwife to provide continuity of care would help increase understanding of Muslim women's needs, and in turn improve the quality of maternity services provided. However, a lack of resources, particularly in terms of staff numbers, means that such continuity of care is often impossible to provide.

Stereotyping and prejudice

Some of the women in our study said that health professionals held stereotypical and racist views about Muslim women. Several women talked about staff belittling their worries and concerns, implying they were exaggerating symptoms, wasting time or complaining about 'minor' problems in order to get help. The women said staff often referred to this as 'Asian woman syndrome':

"They are using this term the 'Asian woman syndrome', the doctors are using this term...people coming in with silly excuses and waste time and resources...so doctors target Asian women."

Some women said they felt health staff also believed Asian women 'over-use' maternity services:

"I just feel that they just treat you differently because there are a lot of Asian women there and its like, 'You lot come in everyday, you women are here all the time.' Asian women tend to have more children ... I felt I was treated very differently ... The way they spoke to me, the way they treated me."

Others said professionals had accused them of becoming pregnant simply to get more money from the state:

"I have had doctors who tell me to have a coil put in after I have had the baby ... and when I say I want to carry on having babies he said, 'You want to receive more benefits, that's why you having more babies. ' "

"They don't do that [tell you the baby's sex] in Luton and I have heard that it is because the Asian, if they find out it is a girl, they tend to go for terminations, but that is not always the case ... [I want to know my baby's sex] to know if I should paint the room pink or not."

A number of the women perceived that the NHS as a whole had racist policies and practices. For example, one woman believed that some hospitals refuse to tell Muslims about their baby's sex for fear that the baby will be aborted if it is a girl:

"They don't do that [tell you the baby's sex] in Luton and I have heard that it is because the Asian, if they find out it is a girl, they tend to go for terminations, but that is not always the case ... [I want to know my baby's sex] to know if I should paint the room pink or not. "

Another said: *"They don't like telling us. Sometimes if it is a baby girl they say we are not sure, if it is a boy they tell you."*

Several women in our study thought that discrimination had got worse in recent years because of fears about Islamic fundamentalist terrorism. This meant people in general, including health staff, saw Muslims as 'different' and 'dangerous':

"Before (September 11th) people used to think you are different, now they think you are different but you could be dangerous as well."

"With the hijab they know immediately you are a Muslim, whereas if I am not wearing a hijab you don't know if I am Hindu, Sikh or Muslim and you wouldn't be seen as a threat. "

Not all non-Muslim staff were found to be insensitive or prejudiced by the parents in our study. Several women described very positive experiences with non-Muslim staff. For example, one said that when she asked to sweeten her new baby's mouth with a date or honey (an Islamic custom):

"The midwives were happy to do that, she said, 'Whatever you have to do,' so they were quite sensitive, they know what we had to do."

However, parents who had been cared for by Muslim health professionals felt they had received a better quality service, primarily because the staff offered more sensitive care and support.

"There were two Muslim healthcare assistants and you know the service they provided me was excellent. They kept on coming up to me, they showed me how to change her nappy, they tried to help me breastfeed, a real difference between when I had Muslim healthcare assistants on during the day and white healthcare assistants on during the night."

CONCLUSION

The small-scale study that the Maternity Alliance conducted in 2003 sought to provide a qualitative account of Muslim parents' experiences of maternity care in some parts of England. It reveals that whilst some Muslim women receive good quality maternity care, many do not. Basic facilities and services in the NHS were often insensitive to Muslim parents' needs. Most of the parents involved in our study described a lack of appropriate, easily understandable information on health needs and health care during pregnancy, childbirth and the postnatal period. Women with little or no spoken and written English were particularly likely to feel ill informed. Many women relied on English speaking family members and friends to help them access information and care, despite the problems this can cause.

Both the women and health professionals identified the lack of available interpreters, and the barriers to effective communication this resulted in, as a major cause for concern. This was an important factor contributing to the lack of involvement and choice many Muslim parents were given about the services and care they received.

These problems are in part due to a lack of understanding amongst NHS staff about how the beliefs and practices of Islam can affect Muslim women's experiences of maternity care. Such problems can be exacerbated by a lack of hospital resources and staff capacity, particularly amongst midwives. However, the poor quality and insensitive care received by many of the women in our study also appear to be as a result of some NHS staff holding stereotypical and racist views. Our research indicates a lack of consistency in professional practice and behaviour towards Muslim parents, even within the same hospitals. This suggests anti-discrimination policies are not being effectively implemented throughout the NHS, as current legislation requires.

Health professionals and parents suggest a number of changes that would help improve the quality of maternity services for Muslim families. Improving the content and accessibility of information will be vital to increasing Muslim women's involvement in, and choices about, the maternity care they receive. Having a designated midwife to provide continuity of care throughout pregnancy, childbirth and the postnatal period could play an important role in increasing health professionals' awareness of, and sensitivity towards, the needs of Muslim families. Ensuring the NHS employs more Muslim health professionals in the maternity services would also contribute to this goal. Increasing the availability of community based services that provide women and men with a range of medical and other services and support throughout the antenatal and postnatal period would also play an important role in improving the quality and accessibility of maternity services in the UK.

Improving choice for patients is a key plank of the Government's programme to reform the NHS¹² The Government has also pledged to give all children the best start in life by investing in early years services, including in the NHS through the National Service Framework for Children, Young People and Maternity services, and Sure Start and local Children's Centres¹³. The Government must ensure the needs of all of the UK's population are met as these initiatives are taken forward, including Britain's Muslims.

In particular, maternity services must be informed and shaped by the diverse needs of the communities they serve. Otherwise the poor quality maternity care and worse health outcomes that are experienced by black and minority ethnic communities, including the UK's Muslims, will continue to exist.

12 Department of Health (2004) Building on the best: Choice, Responsiveness and equity in the NHS. The Stationary Office, London.

13 The National Service framework for Children, Young People and Maternity Services published its standard on Maternity Services in November 2004 [www.dh.gov.uk] It addresses the requirements of women and their babies during pregnancy, birth and after birth and puts a strong emphasis on individualised services designed to fit around a woman's needs particularly those of women from disadvantaged groups. Sure Start is the Government's programme to provide the best start in life for every child by bringing together early education, childcare, health and family support. Children's Centres will provide a range of services for parents with young families, including antenatal and postnatal care, parenting support groups, and health clinics for new parents and their babies. 2,500 Children's Centres will be available in the 30% most deprived areas in the country by March 2008

RECOMMENDATIONS

Better training and more staff

- Ensure effective education for all health professionals on religious, cultural and ethnic issues that can influence users' needs for, and experiences, of health services including maternity care. To be implemented in both pre-qualification training and continuing professional education.
- Provide additional training and support on specific religious and cultural issues for health professionals that work in areas with large Muslim populations.
- Increase the number of staff working in maternity services including those from ethnic communities to improve the continuity and quality of maternity care. In particular, institute a concerted recruitment and retention drive to increase the numbers of midwives and health visitors.
- Ensure every woman has a designated midwife to ensure continuity of care and to improve health professionals' understanding of individual women's cultural and religious needs during the antenatal and postnatal period.
- Ensure NHS staff are more reflective of the communities they serve. In particular, the NHS should seek to recruit from diverse racial and religious groups.

Improving facilities and services

- Increase the availability of community based maternity services, which provide a range of medical and other support to pregnant women and new fathers. In particular, ensure antenatal and postnatal care is fully integrated in the 2,500 new Children's Centres that will be available in the 30% most deprived communities in England and Wales by March 2008.
- Provide a choice of gender and language-specific, community-based antenatal classes with crèche facilities. In particular, provide more information about religious aspects of pregnancy and patients' rights for Muslim parents, including through trained facilitators.

- Provide separate rooms before and after birth and segregated delivery suites for women who request them wherever possible.
- Provide prayer areas in hospitals for Muslim families, particularly in places with large Muslim populations.

Improving information, communication and choice

- Provide more written information in different languages on the health needs, medical treatment and different stages of pregnancy, childbirth and the postnatal period for women whose first language is not English.
- Provide more information in community languages and in non-written formats (such as audio tapes or videos) for pregnant women and new parents whose first language is not English or who have with low literacy skills. In particular, additional support and assistance should be made available for non-English speaking refugee and asylum seeking women.
- Provide more information on the rights and benefits pregnant women and new parents are entitled to, including financial support.
- Increase the numbers of interpreters that are available in the NHS, including those available at all times and at short notice
- Increase efforts to provide information and opportunities for informed consent to pregnant women during childbirth, including in emergency situations.

Effective anti-discriminatory policies and practices

- Clarify policies on providing information about the sex of babies antenatally to remove discriminatory practices.
- Ensure the NHS complaints procedure is clear and accessible to parents whose first language is not English.
- Ensure the effective implementation of anti-discriminatory policies in all NHS organisations

APPENDIX 1

STUDY METHODS

The study comprised three parts:

- 1 Focus groups with Muslim women
- 2 Questionnaires with Muslim men
- 3 Telephone interviews with health professionals

Focus Groups

Focus groups were carried out to explore Muslim women's experiences of maternity services and how culture and religion influenced their service use.

Muslim women who had recently had children (within the last 3 years) were recruited through contacts made via the project's advisory group (see *Appendix 2*) The focus groups were held in various locations around the UK and included women from a range of ethnic backgrounds (see table 1).

Table 1: Focus Group Participants

Location	No of participants	Ethnic group
Leeds	10	Iraqi
Glasgow	8	Iraqi, Pakistani, Bangladeshi, Indian, African, European
Keighley	11	Pakistani
Luton	5	Pakistani, Indian, Bangladeshi
Manchester	9	Somali

The focus group composition reflected as far as possible the variety of Muslim women in Britain. Participants included women:

- raised within Islam and women who converted later in life.
- who wore the *hijab* and those who did not from rural and urban areas
- born and raised in Britain and those born/raised overseas
- on a low income and more affluent women
- who were fluent in English and women who spoke/ read little or no English

- Crèche facilities and refreshments were provided and women were given £10 for participating. Consent was taken before discussions started and anonymity was assured.

The focus group sessions took place at a convenient location for the women and were carried out in participants' chosen language. The Leeds, Glasgow and Luton focus groups were carried out in English, although some women taking part in the Leeds focus group were briefed in Arabic by the local contact who was available throughout the discussion. The Keighley focus group was carried out in Punjabi, with occasional translation into Pahari (a dialed of Punjabi) by a participant (who is also a registered NHS interpreter). The administrator (who also acts as an interpreter) at the Somali Women's Group translated into Somali at the Manchester focus group.

The discussions lasted between 1-1½ hours and were tape recorded (with permission). A topic guide was used to facilitate the focus groups. This explored participants' experiences of maternity services, both good and bad, and how services could be improved for Muslim women. In particular, participants were asked about:

- their hospital experience, such as cultural and religious sensitivity around food, prayer facilities, scans, check ups etc
- their experiences of staff, including attitudes, involvement in decision making and sensitivity to religious and cultural needs
- their experiences of information, including its provision, accessibility and acceptability, during pregnancy, labour and delivery and in the postnatal period

Questionnaire

A questionnaire was distributed to research the views of recent (within the last three years) Muslim fathers regarding the maternity services used by their wives and partners. The questionnaire asked men about their satisfaction with their partner's care, the information they were provided with and their involvement in decision making processes.

Focus group participants were asked to give a two sided questionnaire to their husbands or partners to complete and return in a stamped addressed envelope. A further 40 questionnaires were sent to key contacts for distribution, including to the congregation at the Wolverhampton Mosque and at the Bobbers Mill Community Centre in Nottingham.

A total of twenty two responses were received. Half [11] were from Wolverhampton, the rest were from men living in Glasgow, Leeds, Keighley and Nottingham. Fourteen respondents were Pakistani; others were Arab, Indian, Kurdish, Indian/African, Kashmiri and English.

Telephone interviews

Telephone interviews were carried out with health professionals in Blackburn to gain an understanding of their experiences of caring for pregnant Muslim women and new families. Blackburn has one of the highest South Asian Muslim populations in the UK and consequently the health professionals interviewed had an established record of working with Pakistani, Bangladeshi and Indian Muslim women and were familiar with the cultural and religious requirements of their clients.

Health professionals were recruited through a key contact in Blackburn, following approval by the local Research Ethics Committee. Individuals' consent was received and anonymity was assured. The interviews were semi-structured, with questions about their perceptions of Muslim women's needs and how services meet these needs, barriers and problems experienced, information provision, information and

support for health professionals and possible ways to improve services.

A total of eight health professionals were interviewed: six midwives, two of whom worked for Sure Start programmes, a health visitor and a consultant obstetrician.

The open-ended questions in the men's questionnaire and the telephone interviews with the health professionals were examined using content analysis.

Analysis

The focus group sessions and the interviews with the health professionals were analysed using the framework method suggested by Jones and Pope and May.

APPENDIX 2

ADVISORY GROUP FOR PROJECT

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