UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Title

Does the provision of a native language maternity information DVD for non-English-speaking Somali women improve their knowledge of maternity care in a manner that they find acceptable and useful?

By

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Doctorate in Clinical Practice

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ABSTRACT

FACULTY OF HEALTH SCIENCES
DOCTOR in CLINICAL PRACTICE

DOES THE PROVISION OF A NATIVE LANGUAGE MATERNITY INFORMATION DVD FOR NON-ENGLISH-SPEAKING SOMALI WOMEN IMPROVE THEIR KNOWLEDGE OF MATERNITY CARE IN A MANNER THAT THEY FIND ACCEPTABLE AND USEFUL?

Gloria Rowland

Introduction
It is well documented in the literature that many Somali women living in the UK do not speak English and have poor access to maternity services because of communication and language barriers. This project was designed to determine knowledge change and women's acceptance of a maternity information Digital Video Disk (DVD), developed for non-English-speaking Somali women using a social marketing approach.

Objectives of the Study
1. To identify and recruit Somali women who do not speak English.
2. To test the participants' knowledge of maternity services before and after watching the Somali maternity information DVD.
3. To assess whether the DVD was a useful and acceptable information format for Somali women by interviewing the participants during the postnatal period.
4. To note any change of behaviour linked to maternity care as a result of this study.

Method
The theoretical framework for this project is based on the principles of social marketing. The knowledge change, acceptability and usefulness of a maternity information DVD, specifically developed for Somali women, were explored using a mixed data collection method (pre- and post-DVD viewing knowledge tests and post-natal semi-structured interviews). Fourteen Somali women completed every aspect of this study.

Findings and Discussion
It was evident that most Somali women who took part in this study lacked knowledge of maternity information. This was demonstrated by the variance (6.7) between the pre- and post-DVD knowledge tests' scores of the participants in this study. The participants explained that the information and knowledge they received from the DVD raised their awareness and empowered them to make informed choices and decisions. As a result of the findings from this study, a new application of the concept of cultural safety in maternity care was developed, illustrating how use of a relevant DVD may enhance maternity cultural safety.

Conclusion
In conclusion, the study has shown that the provision of a native language maternity information DVD to non-English-speaking Somali women improved their knowledge of maternity care in a manner that they found acceptable and useful.

Recommendations
The DVD should be rolled out to a wider community and evaluated. YouTube or other similar media could be used to disseminate this further. Cultural safety should become part of education and training of health professionals and included in local and national policies. Furthermore, as this study was a pre-test of the DVD, there is a need for further research using a comparison group, preferably controlled.

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Author's Declaration

I, Gloria Olubusola Rowland declare that this thesis and the work presented in it are my own and have been generated by me as the result of my own original research.

Study Title: Does the provision of a native language maternity information DVD for non-English-speaking Somali women improve their knowledge of maternity care in a manner that they find acceptable and useful?

 I confirm that:

1. This work was done wholly, or mainly, while in candidature for a research degree at this university;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this university or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. Either none of this work has been published before submission, or parts of this work have been published.

8. I changed my name from Gloria Urhoma to Gloria Rowland during the period of this study.

9. The DVD has been removed to prevent breach of confidentiality.

Signed: Gloria Rowland

Date: 6th August 2014

Final Submission: 15th January 2016

Acknowledgements

List of Abbreviations

AWWC - African Well Women Clinic

CEMACH - Confidential Enquiry into Maternal and Child Health

CMACE - Centre for Maternal and Child Enquiries

CS – Caesarean Section

DClinP – Doctorate in Clinical Practice

DH - Department of Health

DVD - Digital Video Disk

ECV – External Cephalic Version

EmCS – Emergency Caesarean Section

FGM - Female Genital Mutilation

GCP - Good Clinical Practice

GP - General Practitioner

HM – Her Majesty

IMR – Infant Mortality Rate

IOL – Induction of Labour

IRAS - Integrated Research Application System

IUCD – Intrauterine Contraceptive Device

IUS – Intrauterine System

LARC – Long Acting Reversible Contraceptives

LSA – Local Supervising Authority

NHS- National Health Service

NICE – National Institute of Clinical Excellence

NMC – Nursing and Midwifery Council

ONS – Office of National Statistics

PhD – Post Higher Diploma

PSA - Public Service Agreement

REC - Research Ethics Committee

SMART – Social Marketing Assessment and Response Tool

STI – Sexually Transmitted Infections

TRAIL – Taking Responsible Actions in Life

UK - United Kingdom

UNESCO – United Nations Education Scientific and Cultural Organisation

UNICEF – United Nations International Children's Education Fund

UNDP – United Nations Development Programme

USA - United States of America

WHO - World Health Organisation

Chapter 1

Introduction

1.1 Introduction

This chapter introduces the study described in this thesis by firstly providing some background information about an earlier project which motivated me to undertake the present study. An overview of the entire project is presented in Table 1.1 below. The chapter then continues by presenting the Doctorate in Clinical Practice study's aims and objectives, explores the policy context within which the present study was completed, and highlights some important underlying concepts that guided the development of this work. The chapter concludes with details of the remaining chapters in this thesis.

Table 1.1 Summary of Timelines of the Entire DVD Project from 2009 to 2014

Timeline	Activities	Project
January 2009	Local maternity profile (see details in Chapter 3) (Urhoma et al. 2009)	
October 2009-June 2010	Mary Seacole Project: Informing the Development of a Maternity Information DVD for Pakistani Women: a social marketing approach. Mary Seacole Award Project (Urhoma 2009).	Mary Seacole Project
December 2010	Maternity Service User's Language Need Audit (Urhoma 2011a). The outcome of the audit Identified most spoken languages amongst the maternity service user's and also Identifies the community with the most language need -Somali Women (see Chapter 3 for more details)	Trust Project as part of my role as the Consultant Midwife for Public Health
January 2011- August 2011	Write DVD Script and Design DVD in collaboration with project stakeholders (Services users, Local Authority, Primary care and Hospital Communications Department)	Trust Project as part of my role as the Consultant Midwife for Public Health
September 2011- December 2014	Doctorate in Clinical Practice (DClinP) project commenced- DClinP Project: Can the provision of a native language maternity information DVD for non-English-speaking Somali women improve their knowledge of maternity care, and do women find the DVD acceptable/useful? (DClinP study was funded by Florence Nightingale Foundation Research Scholarship Award 2011).	Doctorate in Clinical Practice's Project (DClinP)

1.2 Background

This study evolved from the recommendations of a project I undertook in 2008. This project, entitled "Informing the Development of a Maternity Information DVD for Pakistani Women: a social marketing approach" was funded by the Department of Health of the United Kingdom (UK) and completed as a Mary Seacole scholarship project while I was working as a practice development midwife (Urhoma 2009). It became evident during the project that non-English-speaking ethnic minority women lacked appropriate childbirth information, and this affected their engagement with healthcare services and their choices and options for care. The project concluded that there was a need to develop and evaluate a multilingual maternity information DVD for non-English-speaking ethnic minority women (Urhoma 2009). Subsequently I took these ideas forward in the Doctorate in Clinical Practice (DClinP) project reported in this thesis.

After completing the Mary Seacole project in 2009, I moved to another hospital where I was appointed as a Consultant Midwife in Public Health. One of my key roles was to ensure equality of care for all women who were using the maternity services at the hospital. I was also responsible for providing care to women, and their families, for whom the traditional UK maternity model of care is unfamiliar, and I led and mentored others in this context of care.

In practice, most women, irrespective of their language competence, literacy and ethnic background, are provided with the Department of Health "The Pregnancy Book" (DH 2007c, 2009c), which is written in English. This has implications for midwifery practice, because the lack of appropriately translated maternity information for non-English-speaking ethnic minority women may prevent some women from engaging with maternity services. Hence, this may put both the women and their fetus, or neonates, at risk of poor pregnancy and health outcomes as a result of inappropriate or inadequate care (Lewis 2007, 2011).

The importance of this issue in clinical practice, in terms of non-engagement with maternity services and poor health suffered by this disadvantaged group of women, triggered my interest in developing a maternity information DVD that could contribute towards addressing their information needs (Lewis 2007, 2011). It was envisaged that the DVD would serve as an intervention (Decision aid) designed to support Somali women to make informed choice and decisions about pregnancy and childbirth care (Dugas 2012; Shorten 2005b).

Having developed the DVD, it was essential to ensure that it was in a format that is useful to the women. It was envisaged that this project would help to improve Somali women's

knowledge of the available maternity services in a way that was acceptable and useful to them. This would be a positive response to recommendations in various government policy documents such as Changing Childbirth (DH 1993), the National Service Framework for Maternity (DH 2004a), Maternity Matters (DH 2007a). In turn, it was hoped this would help to improve patient safety, equality and the quality of care provided to this group of women in maternity units.

The specific health needs of ethnic minority groups have previously been identified as: access to health services (Burnett & Fassill 2002); mental health service provision (Aldous et al. 1999; Watters 2001); and language/communication, advocacy and translation (Davies & Bath 2001; Harper-Bulman & McCourt 2002; Bischoff et al. 2003; Binder et al. 2012). These needs can become more serious for Somali women during pregnancy and childbirth, as they find it difficult to engage with services (McLeish 2002). Despite the identification of these needs, no research studies have thus far been carried out to suggest recommendations for action to resolve these problems. In my current place of work, 90% of the maternity service users are members of ethnic minority groups; the Somali group were reported to have language, communication and Information challenges (Urhoma 2011, 2012).

Therefore, this project was designed to pilot and evaluate knowledge change and women's acceptance of a newly developed maternity information Digital Video Disk (DVD) for non-English-speaking Somali women. In summary, my interest in improving services for this group of women stems from my role as a Consultant Midwife for Public Health, my position as a Mary Seacole and Florence Nightingale scholar, and also from my reading of the literature. The whole thesis, as a public health project, is centred on using a social marketing approach to improve communication, information provision (the DVD), health literacy among non-English-speaking maternity users, with specific reference to Somali women, as well as maintaining their cultural safety.

1.3 The study question and objectives of the study

Set against this background, the following research question was devised to guide the project:

Does the provision of a native language maternity information DVD for non-English-speaking Somali women improve their knowledge of maternity care in a manner that they find acceptable and useful?

The study objectives were:

- To identify and recruit Somali women who do not speak English
- To test the participants' knowledge of maternity services before and after watching the Somali maternity information DVD
- To assess whether the DVD was a useful and acceptable information format for Somali women by interviewing the participants during the postnatal period
- To note any changes in behaviour linked to maternity care as a result of this study

The next section will explore some of the local and national drivers for this study.

1.4 Local and national practice context

Millennium Development Goal 5 focuses on improving maternal health with the aim to achieve universal access to reproductive health by 2015 (McNeil et al. 2012, United Nations 2008). Access to, and use of, public services by ethnic minority groups is an increasingly important consideration for UK service providers and policy makers. The Department of Health's (DH) document "Maternity Matters: choice, access and continuity of care in a safe service" identified access to maternity services as a particular problem for minority ethnic groups (DH 2007a), which is more prominent among the UK based Somali population. The Centre for Maternal and Child Enquiries (CMACE) found that in comparison with White women, women from minority ethnic communities were twice as likely to contact maternity services late in pregnancy, and to miss routine antenatal appointments (DH 2007a; Lewis 2007, 2011).

The local maternity profile of the hospital used for this project revealed that 90% of the women who gave birth in the maternity unit in the year 2010 were non-British (Urhoma 2012). Somali women formed the second largest group of ethnic minority service users in the maternity unit (9%), after those women who identified themselves as Indian (24.6%), the denominator was all service users. However, most of the Indian women were educated and able to read and write in English. It was concluded that their language needs were less of a priority in comparison with the Somali women.

The above assumption was validated by the maternity profile and language need audit, which revealed that the Somali service users were three times more likely to need an interpreter to communicate with health staff, as compared with maternity service users of Asian origin (Urhoma 2012). It was also reported in the profile that 53% of the Somali service users were late in booking antenatal care (Urhoma 2012). One of the implications of late

antenatal booking is the missed opportunity to offer antenatal screening tests, which are crucial in detecting fetal abnormalities (Maddocks et al. 2009). Furthermore, women who book late may miss out on health promotion advice relating to such issues as nutrition and strategies for coping with pregnancy.

Providing maternity services to Somali women presents challenges to healthcare professionals who are unfamiliar with Somali cultural beliefs and practices (Davies & Baths 2001). Obstetricians, midwives and other health professionals in London noted that many Somali women began antenatal care in the second trimester or presented at maternity units in late-stage labour with no record of antenatal care, despite the easy availability of maternity care services (Davies & Baths 2001). Antenatal educators have noted that Somali women do not attend antenatal education classes, regardless of their English language competence or interpreter availability (Johnson et al. 2005).

Healthcare providers' concerns have heightened as studies have reported higher rates of oligohydramnios, gestational diabetes, post-term Caesarean delivery and new-born complications in Somalis, compared with women born in the UK (Lewis 2011; Johnson et al. 2005; Marlin & Gissler 2009). Explanations given in the literature for why Somali women seek late, or have no, antenatal care include: cultural preferences, maternity practitioners' lack of familiarity with the prevalent Somali custom of female genital mutilation (FGM), and hesitation among Somali women to accept indicated obstetric interventions (Vangen et al. 2004; Johnson et al. 2005; Dundek 2006). Many maternity services are now encouraging self-referral to maternity services as soon as a woman is pregnant to mitigate issues around late booking. But in practice, this is not well utilised by the Somali women as many are still booking antenatal care late and mainly through their General Practitioners (GP).

Studies reveal that Somali women, who are now living in developed countries such as the UK, the USA and Canada, show an increase in adverse obstetric outcomes, including perinatal mortality, compared to their host country's population (Vangen et al. 2002; Malin & Gissler 2009). Somali women are also represented in reports of high maternal mortality among Black African women in Europe. For example, in the UK over the period between 2003 and 2005, Black African women were identified in the national Confidential Enquiry into Maternal and Child Health (CEMACH) Report as having a maternal mortality rate nearly six times higher than their White counterparts (Lewis 2007).

It is important to note that there has been reduction in maternal deaths amongst the Black African women (Lewis 2011). The CMACE study (Lewis 2011) reported a decrease in the

mortality rate among Black African women. This reduced mortality rate could be attributed to initiatives such as Sure Start, which included maternity care provision in its Children's Centres. This made access to maternity care possible for disadvantaged women (Kurtz et al. 2005). Nevertheless, it was stated in the CMACE report that women from Black and other minority ethnic groups still have a significantly higher maternal mortality rate: 3.8 times higher than White women (Lewis 2011).

It was also reported in the CMACE report that 43% of the seventy-five ethnic minority women who died in childbirth (the denominator was deaths per 100,000 maternities), spoke no English. Many of these women did not access maternity services due to communication barriers and lack of information. These reports recommended the development and provision of a sustainable information system to encourage, support and enable non-English-speaking ethnic minority women to access care early and engage with maternity services throughout pregnancy, labour and the postnatal period (Lewis 2007, 2011).

In addition, interventions to increase antenatal care adherence and reduction of high complication rates among child-bearing Somali women were suggested, including the provision of early, culturally sensitive antenatal information, education and care (Vangen et al. 2004: Johnson et al. 2005; Dundek 2006). Maternity services have a duty of care to ensure that all women have the information they need in an appropriate format so that ethnic minority women in general, and Somali women in particular, can fully engage with those maternity services.

It was thought that a Somali maternity information DVD may be a useful tool for providing basic maternity information, since the content of the DVD encompasses information on preconception care and antenatal, labour and postnatal care, as well as general information including useful contacts such as health visitors, social services and other support networks. However, no research has been conducted that has evaluated the use of such a DVD for providing maternity information to Somali women in the UK. Thus, there was a need to pilot and evaluate the newly-developed Somali maternity information DVD, for which purpose this study was initiated (see Appendix 14 for the DVD scripts and contents of the DVD). Hence, the goal of this project was to evaluate the appropriateness, usefulness and acceptability of a maternity information DVD developed specifically for Somali women. It was also envisaged that the DVD may contribute further to the mission of reducing maternal/infant morbidity/mortality rates in the UK.

1.5 Policies on health inequalities

Tackling health inequalities is a priority according to the UK Government's health policy agenda, and is a stated priority for all four UK home nations. The focus is on reducing the health gap between disadvantaged groups, disadvantaged communities and the rest of the country, with an overall aim of improving health (Darzi 2007; House of Common Health Committee 2009; Marmot 2009; National Equality Panel 2010). In contrast, a recent report by Maynard (2014) argues that there has been little recent policy development to specifically address ethnic inequalities in health at a national level. This dearth has been compounded by only occasional and fragmented implementation of policy at a local level. There is no real evaluation of the impact of targeted or general policies on ethnic inequalities in health (Maynard 2014).

Where policy has been developed and implemented, it has largely been concerned with addressing questions of accessibility to, and delivery of, services. There has typically been a focus on language and communication in the health services through the provision of interpreters and translated material, rather than addressing the social and economic inequalities highlighted above. As a result, there is a shortage of useful recent evidence arising from the development and evaluation of policy (Maynard 2014). This goes some way towards explaining why few recent references on health inequalities were available for use in this report.

Other government policies, such as Maternity Matters (DH 2007a), the National Service Framework for Maternity (DH 2004a) and the Maternal and Child Nutrition Guidance (National Institute of Clinical Excellence [NICE] 2007), advocate the pursuit of equity in care and equal access to health services. Many strategies have been advanced for the reduction of health inequalities (Scrambler 2002; DH 2004a; RCM 2014). However, linguistic barriers continue to make ethnic minority groups vulnerable (DH 2004a; DH 2007a; Lewis 2007, 2011; Maynard 2014).

The Acheson Report provided clear evidence for the existence of health inequalities among the populace, and this report has remained the cornerstone for action on health inequalities (Acheson 1998). Building on Acheson's work is the recently published Marmot Review entitled 'Tackling Health Inequalities: 10 Years On' (Marmot 2009). This report reviews the policies designed to tackle health inequalities, as well as inequalities in the social determinants of health. It takes into account the best global evidence appropriate to England from the World Health Organisation (WHO), the Commission on the Social Determinants of Health, and other work carried out over the past ten years. It was identified that health

outcomes are variable across the social gradient, but the review did not explore which of the determinants of the social gradient were the most critical in determining poor health (Marmot 2009; Maynard 2014).

One of the main areas examined by the Marmot team (Marmot 2009) was the change that had occurred in infant mortality rates, because infant mortality is considered to be a good indicator of the overall health of a society. Reducing the gap in infant mortality rates between the routine and manual socio-economic groups, and the average rate in England, is one of the key measures of the national health inequalities target. The vision of reducing health inequalities will also contribute to reaching the life expectancy target. An important national achievement, recognised in Marmot's report, was the fall in the national infant mortality rate (IMR) to 4.7 infant deaths per thousand live births between 2005 and 2007, compared with 5.6 per thousand between 1995 and 1997 (Marmot 2009). While the IMR is at an historic low and is still falling, the Public Service Agreement (PSA) report revealed that the infant mortality rate among Black African women is 2.3 times higher than for mothers of a white ethnic origin (DH 2007b; CMACE 2011).

Globally, the importance of the Millennium Development Goals (MDGs) that originated from the 2000 United Nation's (UN) Millennium Declaration adopted by 189 UN member states during the Millennium Summit (United Nations 2000), cannot be underestimated. Of particular importance to the present study is the Health MDG 4, which seeks to reduce Under 5 Mortality Rates (U5MR) (U5MR, the number of deaths of children under 5 per 1,000 live births) by two thirds. Despite reports of positive progress from some African countries, Somalia is recorded as the worst performing country in achieving the MDG4 (World Bank 2013) - only a 1.4% reduction of the MDG 4 was recorded for Somalia compared to other African countries such as Zimbabwe which has achieved about 50% reduction (World Bank 2013). However, this figure should be treated with caution as data quality in developing countries is often very poor (WHO 2013). The world trajectory for MDG 4 for 2035 is 25 U5MR per 1000 births; it would be very difficult for Somalia to achieve this considering their progress in the past unless a high volume of resources is diverted to the country to enable a rapid change of priorities towards improving health-care services. Undoubtedly services are better in the UK.

In the UK, The Public Service Agreement (PSA) target (DH 2007b) was to reduce the UK's inequalities in infant mortality rates by 10% by 2010. However, the PSA has not been able to actualise this aim to date, and the national focus on reducing inequalities in infant mortality is still in effect (DH 2011). In order to achieve this target, strategies need to be put in place to

reduce the IMR among ethnic minority groups, with special reference to Somali women. Essén et al. (2000) reported that even after migration to Sweden, Somali immigrants seem to maintain their cultural attitudes, strategies and habits during pregnancy and childbirth. This may contribute to the higher incidence of perinatal mortality and morbidity being reported among this group of women. In order to break these cultural/communication barriers and bridge the maternity inequalities' gap experienced by Somali women, adequate information which is tailored to their pregnancy and childbirth needs should to be given to them.

Wanless (2004) has asserted that the former approach to health behaviour change was having a minimal impact, due to what he termed "information failure". This was attributed to the failure to craft messages carefully according to target audiences and desired outcomes. The Wanless Report recommended market research within target populations, using the results to design interventions that would fully engage the population. The choice of social marketing as the preferred model to achieve this was first articulated and published in the 2004 Public Health White Paper (Department of Health 2004b). The publication highlighted the potential of social marketing in building public awareness and facilitating health behaviour change (DH 2007b).

Therefore, Wanless (2004) proposed a model, as highlighted above, which provided a mechanism for engaging and improving health promotion through social marketing. That model has been adopted as a fundamental principle guiding this study. In effect, the model has helped to evaluate the knowledge change, acceptability and usefulness of a maternity information DVD developed in a native language within and for an identified ethnic minority group; namely Somali women. NICE also reinforces the statement that it is the responsibility of the organisation providing local antenatal services to offer information about pregnancy and antenatal services, including how to find and use such services, in a variety of formats such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs. This suggests that the concept of the Somali information DVD is in line with national recommendations (NICE 2010).

Hence, the maternity information DVD for Somali women, used in this study, is intended to serve as a catalyst for behavioural change, as well as a valuable health promotion communication tool that will contribute to bridging the health inequalities' gap. The DVD adopts a non-didactic approach and provides Somali women with knowledge that should assist them to make informed choices, act as a decision aid, improve their access to

maternity services, particularly antenatal care, and signpost them to other services which may be of benefit for improving their overall health via social marketing.

1.6 Culturally sensitive communication

Communication is one of the most important and complex aspects of human social life (Littlejohn 2002). Language provides the tool, the content and the medium for expressing human thoughts and knowledge (Johnson 2009). Johnson drew on the work of Herder (1986) and concluded that language and thought are inseparable. Johnson (2009) further explained that the thoughts and culture of an ethnic group can only be influenced in and through their native language. This notion directly influences the concept behind the development of the Somali maternity information DVD. The philosophy behind the production of a maternity information DVD for non-English-speaking Somali women was an attempt to bridge communication and information gaps in the context of maternity care.

Culture is a complicated social phenomenon with broad and narrow definitions, depending on the context of discussion. Culture is defined as a depository of knowledge, experience, beliefs, values, actions, attitudes, meanings, religious, notions of time, spatial relations and concepts of the universal group of people (Samovar et al. 2000). Indeed, communication between individuals from different ethnic and cultural backgrounds is a symbolic exchange process (intercultural communication) whereby those individuals negotiate shared meanings in an interactive situation (Ting-Toomey & Chung 2005). In the intercultural communication process, people from different cultural backgrounds may have preconceived stereotypes about each other, which may affect the group's interaction dynamics (Ulrey 2001; Hughes & Baldwin 2002; Brown 2006) and communication.

Individualised female-centred communication is critically important in promoting interpersonal, intercultural interaction between health professionals and women. It involves two parties that have divergent forms of communication which may not normally mesh well in maternity care settings (Ulrey & Amason 2001). Ulrey and Amason (2001) further suggest that health care providers must first overcome their cultural differences and beliefs in order to communicate with patients about their health-related concerns. Effective intercultural communication and cultural sensitivities are found to be inter-related (Ulrey & Amason 2001). Communication difficulties, due to language and cultural differences between health care professionals and patients, are widely recognised as a major barrier in providing health care services.

Miscommunication has the potential for serious consequences at all levels of health care. Effective communication between the health care provider and the patient is a critical element for improving patient satisfaction, treatment compliance and health outcomes. Patients who understand the nature of their illness and its treatment, and who feel that the health care provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimens (Lowell 1998). Similarly, non-English-speaking women will better engage with services if they understand the rationale underlying their care (Urhoma 2009).

Women and maternity care providers may also face other problems, such as a lack of privacy during communication, time constraints due to heavy workloads, or fear of a lack of cultural knowledge or confidentiality. Since the early 1990s, after the introduction of Changing Childbirth, attention to improving the quality of maternity services has highlighted the need for women-centred care. This includes respect for women's privacy and dignity and a greater emphasis on the need for women's involvement in birth plans (DH 1993). A previous study has also shown that effective communication is associated with positive health outcomes (Ong et al. 1995). Anecdotal experience from midwifery practice indicates that expectations about encounters between maternity care providers and women differ from case to case, since each woman is an individual with her own cultural expectations and traditional childbirth concepts.

Anthropological theories argue that patterns of behaviour, attitudes, beliefs and the ways in which people communicate are culturally significant (Harris 1971; Shedlin 1979). In the social roles of women and maternity care providers, the role of the healthcare professional is viewed as complementary to the role of the woman (Scrambler 2003). Just as the woman is expected to cooperate fully with the midwife or obstetrician, the midwife or obstetrician is expected to apply his or her specialist knowledge and skills for the benefit of the woman. This argument identifies the general expectations that guide the behaviour of maternity care providers and women, and shows how these roles facilitate interaction during care consultations, because both parties are aware of how the other is expected to behave (Scrambler 2003). However, this role interaction may be unbalanced when one of the parties lacks understanding of their role. For instance, a newly arrived Somali woman will hold a different view of her role and have different expectations of maternity care from a second generation Somali woman born in the UK, since women's roles in childbirth differ greatly between the UK and Somalia.

The most common complaints made by women about midwives relate to the quality of communication; particularly that midwives are perceived not to provide enough information, as well as showing a lack of concern or lack of respect for women (Davies & Bath 2001). As a result, many women leave antenatal clinics without asking questions about their health concerns, or else they do not receive what they regard as satisfactory responses to their queries (Barry et al. 2000). At times maternity care provision can be complex, and health care professionals are often too busy to understand a non-English-speaking woman's need. Healthcare professionals require time and an understanding of culture and cultural concepts to enhance and facilitate maternity care (Barry et al. 2000).

Previous studies have shown that the use of cultural knowledge in community-based health care practice begins with the provider's careful assessment of patients and families in their own environments (Degni 2004). This notion is equally applicable to maternity care, since the purpose of attendance at antenatal clinics is to continually assess and discuss care pathways with the woman and her family, in order to develop mutually shared goals (Andrew & Boyles 2003). Religious and other cultural factors may play a crucial role not only in childbirth decision making, but also in the way in which individuals experience and perceive their bodies. It has been reported that religious beliefs and traditional perceptions are culturally patterned, since the structure and functioning of the body are a reflection of culturally-determined cognitive categories (Andrew & Boyles 2003).

Taking into account religious influence and culture on body knowledge, an examination of compliance to routine antenatal care among Somali women must consider the cultural acceptability of some childbirth procedures. Acceptability is not acceptance, but rather the compatibility of childbirth intervention with the values, norms and beliefs of those Somali women. Evidence seems to indicate that any assessment of compliance with care must begin with the woman's understanding of the provider's recommendations. However, understanding and acceptability, while crucial to correct use and continuation, are not sufficient, because culturally-determined perceptions can also influence compliance (Benagiano & Shedlin 1992).

Language itself, as a means of communication, was the main barrier identified among ethnic groups in some of the literature (Johnsdotter et al. 2000; Essén et al. 2002; Small et al. 2008; Binder et al. 2012). Somalis experienced the most significant language difficulties relative to other ethnic minority women. A concern expressed among Somali women was the perception of being a "problem patient," and the notion that their language difficulties led to providers feeling "fed up." This is evident in the findings of a study conducted by Davies and

Bath on the concerns of Somali women in maternity care, with particular regard to their language abilities (Davies & Bath 2001).

The potential disparity caused by this perception therefore seems to remain an immediate source of vulnerability for some women (Duggan 2006), both at the onset of pregnancy and in labour care. Limited language proficiency over the course of a pregnancy might serve to reinforce any misconceptions between care providers and women about certain antenatal or labour interventions (Essén et al. 2011), and may also pose an eventual risk for negative obstetric outcomes (Johnsdotter et al. 2000; Essén et al. 2002; Small et al. 2008).

Kreps and Sparks (2008) noted that immigrants in general are more often cited as having significant language and health literacy difficulties. Such inequality also tends to coincide with higher levels of health disparity and worse health outcomes than among other social groups. One review mentions that patients with language barriers have lower satisfaction with care, even in cases when women are compared with other patients of the same ethnicity who have good language skills (Brach et al. 2005). The possibility that having an adequate capability in English conforms to a better perception of the overall health experience did not directly present itself in this study's findings (see below). However, unlike the non-English-speaking informants, those originating from Anglophone Africa did not report that perceived restrictions in their overall care were based on language difficulties.

In a study conducted by Binder et al. (2012), language compatibility was stressed as essential by women more often than was a desire to meet a provider of the same ethnic profile. Care providers may hold a misconception about women's desires on this issue, but they did share the recognition of the significance of a common language. Therefore, the findings in Binder et al.'s study lend weight to the need to create a balanced linguistic communication between health providers and women as one key to the provision of optimal care (Kim et al. 2003; Binder et al. 2012). Language becomes the root, rather than simply a component, of a culturally-sensitive approach. Moreover, teaching effective care-seeking communication skills to women, and simultaneously preparing providers to sensitively embrace the women's enhanced participation, is only likely to become possible once the needs of language concordance are met. The importance of language guided the development of a DVD presented in a native language.

1.7 Health literacy

Language and communication barriers remain an especially challenging issue in maternity care provision for Somali women due to their difficulty in engaging with services, but

problems may also be compounded by their lack of health literacy. Thus, an additional purpose of developing the DVD is to help non-English-speaking Somali women who may have challenges with health literacy in terms of understanding the UK's maternity care system. Nutbeam (2008) argues that health literacy should be perceived as an asset that can be built up through education and support.

'Literacy' is generally taken to mean the ability to read and write, and a 'literate person' is someone 'who can with understanding both read and write a short simple statement on his [or her] everyday life' (United Nations Educational, Scientific and Cultural Organization 2005, p. 15). However, 'literacy' may also be given a broader meaning, in terms of the ability to grasp meaning and develop critical judgement (United Nations Educational, Scientific and Cultural Organization 2005). A comprehensive, multi-faceted definition is provided in the American 1991 National Literacy Act, which refers to the ability to read, write and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and to develop one's knowledge and potential (National Institute for Literacy 2008).

There are indications that governments and international organisations are increasingly regarding literacy as an 'access and equity issue' and as a 'right of citizenship' (Green et al. 2007). This trend was demonstrated in the UK in 2011 when new legislation was introduced, specifying that new immigrants applying for British citizenship need a certain number of points in order to be considered by the Home Office; English literacy is one of the criteria for consideration (Travis 2009). Literacy is now used not only to refer to reading, writing and comprehension ability, but also to describe a person's knowledge of a particular subject or field, such as nutritional literacy (Diamond 2007), financial literacy (Vitt et al. 2000; Financial Literacy Foundation 2007; Fear 2008) and 'computer literacy, cultural literacy, media literacy, scientific literacy, and health literacy' (Keleher & Hagger 2007, p. 25).

The term 'health literacy' has been used for thirty years to reflect the intersection of the fields of literacy and health (Green et al. 2007). However, some confusion arises because most of the published literature focuses not on concepts such as Nutbeam's health literacy model (World Health Organization 1998), but on more limited (and easily measurable) constructs involving people's ability to read and act on oral and written information in health care settings (Ishikawa & Yano 2008). A number of definitions refer to an individual's ability to locate, understand and use information for health-related decisions and to make 'appropriate health decisions' (Ratzan 2001; Green et al. 2007). It is anticipated that the DVD piloted in

my study might, if implemented widely, help ethnic minority healthcare service users in making informed appropriate health decisions in relation to maternity care.

Health literacy is regarded as a key determinant for health (Kichbusch 2008), a crucial factor for empowerment (Kichbusch 2008) and a question of social justice (Hill 2007). There are 2 types of health literacy: a) Functional health literacy and b) Comprehensive health literacy. Most health literacy research sets out from a medical-model approach, mainly focusing on an individual's ability to read information and instructions about health (Nutbeam 2008), which is functional health literacy (FHL) (Rowlands 2013). Less research originates from the health promotion approach where health literacy is regarded as more complex than mere information giving, this is called comprehensive health literacy (Sorensen et al. 2013). Sorensen et al. (2013) explain that comprehensive health literacy is people's ability to access, understand, appraise, and apply health information in order to make judgments and decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life.

Health literacy of a refugee according to their country of origin is determined by their level of education and health outcome (Geltman et al. 2013). Existing knowledge about health literacy levels among ethnic minority groups is scarce; however, Somalia education and literacy statistics indicate that adult literacy is about 24% and out of which, male children (43%) have more access to education than female children (14%) (Lahmeyer 2004). One study focusing on the impact of functional health literacy of Somali refugees in the USA reported that about 326 (74%) of the study population (439) had low functional health literacy (Geltman et al. 2013).

It is well documented that refugees such as the Somali women share many characteristics associated with low health literacy (Kreps & Sparks 2008; Gerritsen at al. 2008; Bevelander 2009): poor health and having a low level of education are associated with low functional health literacy whereas low social status, low socio-economy and being an immigrant are associated with low comprehensive health literacy (Easton et al. 2010). Low FHL is associated moreover with greater use of emergency care (Berkman et al. 2011; Morrison et al. 2013; Herndon et al. 2011), poorer ability to interpret health messages (Berkman et al. 2011) and lower participation in preventive services (Berkman et al. 2011; Sanders 2011). Those phenomena are seen among refugees (Eckstein 2011; Ingleby 2012; Young & Mortensen 2003), which strengthens the hypothesis that low health literacy is common among refugees and contributes to their poor health.

Despite the importance attributed to the role of health literacy and communication during childbirth, it is evident that information inequalities persist in some of the UK's maternity units, and non-English-speaking women are the worst affected (DH 2007a, 2004a; Lewis 2007, 2011). This assertion supports the significance of developing a maternity information DVD for non-English-speaking Somali women, and the associated need to evaluate its effectiveness.

1.8 The structure of the remaining thesis

The remaining thesis has been organised into six chapters. Chapter two presents a review of evidence related to social marketing, a technique used in this study. Chapter three reviews literature (see Appendices 1 & 2 for details of the Literature Search Strategy) related to the history of Somalia, Somali women and the cultural/maternity services' issues addressed in the DVD. This chapter includes a discussion on cross-cultural medical ethics and culturally responsive health care. Chapter four details the Phase 5b of Neiger & Thackeray's (2002) Social marketing SMART Model-Pre-testing, the process of obtaining ethical approval and the recruitment of participants to the study, and justifies the approach and the method adopted to collect data. This chapter concludes with a discussion of the strategies used to maintain the quality and credibility of the study. Chapter five presents the results relating to the demographic questionnaires, the quantitative data (knowledge tests, scoring technique and results) and the qualitative data. This chapter highlights the knowledge change before and after watching the maternity information DVD and presents the Somali women's views about the acceptability and usefulness of the maternity information DVD. Chapter six presents an analysis and discussion of these findings, drawing on the literature discussed in the first three chapters of the thesis. It also introduces a newly developed model for cultural safety in maternity care. Chapter seven discusses the implications of the findings of this study for practice and future research. The strengths and limitations of the study are examined. Finally, this chapter draws some conclusions related to the study.

Chapter 2

Social Marketing

2.1 Introduction

As explained in Chapter 1 the project described in this thesis forms part of a larger piece of work rooted in the principles of social marketing. In this Chapter I will firstly explain what social marketing is and provide a brief history of its origins and adoption in public health; also I will review the available evidence on the application of social marketing principles to issues relating to health. At the close of the chapter, I will provide an overview of the whole project, from the Mary Seacole Award project to the Doctorate in Clinical Practice (DClinP) study, pinpointing which part of the process of social marketing each belongs to.

2.2. What is social marketing?

The original idea of social marketing is attributed to Wiebe, who demonstrated in an article entitled "Merchandising Commodities and Citizenship on Television" how mass media campaigns can motivate people to take action (Weibe 1952). This was the precursor to more serious thinking about taking marketing methods that were being used successfully to influence behaviour in the commercial sector and transferring them to non-profit areas (Gordon et al. 2006). The unique aspect of social marketing is the application of marketing tools that have been proven to work in commercial settings, to the resolution of social and health problems (Ling et al. 1992; French et al. 2010). However, the adoption of social marketing principles to social causes initially met resistance from traditional marketers. For example, Luck (1974) objected to the concept of replacing the marketing of tangible products with the marketing of ideas/values, believing that this threatened the economic exchange concept. Others feared it would lead to social control and propaganda (Laczniak et al. 1979). However, this opposition appears to have helped the proponents of social marketing to refine their ideas and address the ethical concerns that have been raised (McFadyen et al. 2002).

Social marketing was described by Kotler and Zaltman (1971, p.5) as: "the application of principles and tools of marketing to achieve socially desirable goals, with benefits for society as a whole, rather than for profit or other organizational goals and includes the design, implementation and control of programs calculated to influence the acceptability of social ideas and involves considerations of product planning, pricing, communications and market research." In other words, social marketing is defined as a process that applies marketing principles and techniques to create, communicate and deliver interventions that will influence a target audience's behaviour and benefit society in general (public health, safety, the

environment and communities) as well as the target audience (Kotler & Lee, 2008; Andreasen 1995).

Although other social marketing definitions have emerged since 1971 (Andreasen 2002; Kotler et al. 2002; Maibach 2002) they appear similar, all emphasising the use of marketing principles for social good. The most widely used definition in the UK public health sector is from the National Social Marketing Centre, which states: "Social marketing is the systematic application of marketing concepts and techniques, to achieve specific behavioural goals to improve health and reduce health inequalities" (French & Blair Stevens 2006, p.33).

2.3 Features of social marketing

Social marketing, it is argued, is not a theory but rather a discipline that draws from other bodies of knowledge such as sociology, anthropology and communication to understand how to influence people's behaviour (Kotler & Zaltman 1971). Social marketing has four main features that distinguish it from other health improvement approaches:

- Behavioural change is voluntary, i.e. not by coercion or enforcement
- It operates on the principle of exchange, i.e. there has to be a clear benefit for the customer (target group or individual) if change is to occur
- It uses marketing techniques such as consumer-oriented market research, segmentation and targeting, and marketing mix
- The ultimate goal is to improve individual and societal welfare and not make a profit for the organisation carrying out the intervention, as is the case with commercial marketing (Houston & Gassenheimer 1987; MacFadyen et al. 2002)

Andreasen (2002) further clarifies how the social marketing approach relates to health improvement and behavioural change. He refers to what he defines as the essential benchmarks of a genuine social marketing approach, namely: *specific behaviour change goal, consumer research/orientation, segmentation and targeting, marketing mix, exchange*, and *competition.* These are summarised in Table 2.1 and discussed in more detail below.

Table 2.1: Andreasen's (2002) benchmark criteria for social marketing interventions

Benchmark	Explanation
Behaviour change	Intervention seeks to change behaviour and has specific measurable behavioural objectives.
Consumer research	Intervention is based on an understanding of consumer experiences, values and needs. Formative research is conducted to identify these. Intervention elements are pre-tested with the target group.
Segmentation and targeting	Different segmentation variables are considered when selecting the intervention target group. Intervention strategy is tailored for the selected segment/s.
Marketing mix	Intervention considers the best strategic application of the "marketing mix". This consists of the four Ps: "product", "price", "place" and "promotion". Other Ps might include "policy change" or "people" (e.g. training is provided to intervention delivery agents). Interventions which only use promotions are social advertising, not social marketing.
Exchange	Intervention considers what will motivate people to engage voluntarily with the intervention and offers them something beneficial in return. The offered benefit may be intangible (e.g. personal satisfaction) or tangible (e.g. rewards for participating in the programme and making behavioural changes).
Competition	Competing forces to the behaviour change are analysed. Intervention considers the appeal of competing behaviours (including current behaviour) and uses strategies that seek to remove or minimise this competition.
Source: Andreasen 2002	

2.3.1 Behaviour change

Behaviour change by clients, leading to the adoption of suggested health behaviours, is the ultimate goal in health-oriented social marketing. Such change could relate to the use of a particular health product, such as contraception, or a particular service, such as promoting screening programmes like antenatal screening or sexually transmitted infections (STI) tests. However, other desired process-related outcomes may include raised awareness of the health service, or increasing knowledge about how to access appropriate healthcare, such as the Somali maternity information DVD. In social marketing it is recommended that the desired behaviour change is clearly defined and supported by specific, measurable, realistic and time-bound (SMART) objectives to guide the implementation and evaluation process (National Social Marketing Centre 2007; French et al. 2010).

2.3.2 Consumer research/orientation

In commercial marketing, a commitment to understanding the consumers of a product or service is emphasised. This is based on the fact that the consumers' needs and wants determine whether a product or service will be bought or not. In social marketing the same principle applies, as there is a need to understand the people whose behaviour and intervention is intended to change (Andreasen 1995). Formative research with the target population is therefore important in understanding what motivates or deters people from adopting recommended behaviours, such as using a condom for protection against sexually transmitted infections (STI), taking a chlamydia test, or compliance with antenatal

appointments/classes. Consumer research also provides vital information on population subgroups and their socio- cultural environments, data which is important in making decisions about what segments of the population to target, and how (Grier & Bryant 2005). Consumer research also includes other stakeholders who are not necessarily beneficiaries, such as community leaders, health workers and other professionals who may have a significant impact on programme implementation (National Social Marketing Centre 2007). Therefore, consumer research can be described as the main foundation for social marketing interventions.

2.3.3 Audience segmentation and targeting

This component is derived from the consumer research, using its results to differentiate populations into subgroups or segments of people who share needs, wants, lifestyles, behaviours or values that make them more likely to respond to public health interventions. These include gender, age, ethnicity and socio-economic status, but may also include distinct current behaviours, such as some Somali women's refusal to engage with a male practitioner during antenatal care or a refusal of medical intervention during labour (e.g. Caesarean sections). The identification of target segments is crucial in the design of the marketing mix component (Grier & Bryant 2005; French et al. 2010).

2.3.4 Marketing mix

In commercial marketing, the main goal is about getting the right "product" at the right "price," in the right "place," presented in such way as to satisfy the consumer ("promotion"). These conditions are termed the four Ps of marketing, and they make up what is also called the marketing mix, which has been adopted by social marketing as a key component of its approach (Stead & Hastings 1997; Kotler 1999).

Product

In social marketing a product may be tangible (for example contraceptives, a chlamydia test kit or medication) or intangible (for example health education or a counselling service) (National Social Marketing Centre 2007).

Price

Unlike commercial marketing, where price refers to the monetary cost of buying a product, in social marketing this represents something that consumers must give up if they are to adopt a certain health behaviour, a sacrifice that often involves emotional and psychological factors. This might involve looking different in one's community group – for example, a girl who is uncircumcised, that is, who has not undergone female genital mutilation (FGM) would

be stigmatised in Somali culture. However, in the UK the message is clear that FGM is illegal and immigrant Somali women must not perform FGM on their female children (HM Government 2006; National Social Marketing Centre 2007). Therefore, an immigrant family who want to live and settle in the UK would have to abide by the law of not performing FGM on their female children (giving up FGM).

Place

Place refers to channels by which a particular product is made available to consumers in commercial marketing. In social marketing this refers to places in which consumers can obtain certain products, such as contraceptives, or services, such as screening or counselling. Place includes settings such as workplaces, homes, schools, colleges and health institutions (National Social Marketing Centre 2007).

Promotion

As in commercial marketing, promotion refers to the means and messages by which the benefits of a particular product or behaviour change are communicated. The most common means of promotion include advertisements (radio, televisions and bill-boards), leaflets, posters, DVDs, dedicated websites and community outreach activities. However, social marketers have since recognised the limitations of applying the four Ps to public health, and therefore also recommend that building "partnerships" with other stakeholders and influencing "policy" and "politics" for the benefit of public health are included as well (Kotler 1999; National Social Marketing Centre 2007).

2.3.5 Branding

Branding is considered a vital aspect of a marketing mix strategy. A brand is defined as a name, term, sign, logo, symbol or design, or a combination of some or all of these, which is intended to identify the goods or services of one seller or a group of sellers and to differentiate them from those of other competing sellers (Hastings 2007; French et al. 2010). The importance of branding has been proven in commercial marketing and is now increasingly used in social marketing interventions. The creation of a powerful brand that will engage with the target audience and influence that brand's position in the market, in relation to similar or opposing products or services, involves understanding the needs and wants of customers. This is achieved by conducting robust consumer research (French et al. 2010). A successful brand reinforces the functional and emotional benefits of a product, service or behaviour, thereby encouraging consumption, behaviour change and loyalty (Hastings 2007). Examples of social marketing interventions, where branding has been successfully employed, include the Florida Anti-smoking Truth campaign (Social Marketing Institute

2011), the VERB Summer Score Card physical activity promotion programme (Wong et al. 2004) and the Heart Truth (Long et al. 2008).

2.3.6 Exchange

Contrary to commercial exchanges, where a consumer receives a product for cash, in public health situations there is rarely an immediate, explicit payback to target audiences in return for their adoption of specified health behaviours. In the past this delay has been considered a significant barrier to health behaviour change and the uptake of certain services, such as screening, which have no immediate rewards. Social marketing therefore emphasises the need to consider using either tangible or intangible incentives, as well as outlining their importance clearly to the consumer/client, who must feel that he or she is receiving valued benefits in return for their efforts (Grier & Bryant 2005; National Social Marketing Centre 2007).

2.3.7 Competition

Whereas competition in commercial marketing refers to products and companies that try to satisfy similar needs and wants as the product being promoted, in social marketing 'competition' refers to behavioural options that compete with public health recommendations, such as traditional misconceptions about childbirth among the Somali cultural group. An example of one such misconception is the need to conceal pregnancy; a behaviour which may be consistent with the incidence of high numbers of late antenatal care bookings that is a persistent problem with this group of women (Chesney 2005; Meddings & Porter 2007: Cross-Sudworth 2009). In designing an intervention, a social marketer would therefore consider how to counter the existing competition and develop a sustainable competitive advantage (Hastings 2007).

More recently, the National Social Marketing Centre, England, reviewed these six benchmark criteria (Table 2.1) and included two more, namely *insight driven* and *theory-based and informed*. These two additional components emphasise the need for a deep understanding (insight) of what moves and motivates consumers, and for interventions to be guided by behavioural theory. The eight components make up the National Benchmark Criteria for England, which guide policy and strategy development, as well as the implementation and delivery of social marketing interventions (National Social Marketing Centre 2007).

2.4 Critique of social marketing

Literature dealing with critiques of social marketing is limited in quantity and scope. A few scholars (e.g. Buchanan et al. 1994) have questioned the validity of the two main components of social marketing, namely consumer research/orientation and marketing mix, especially the aspects of the integrated approach and profitability. They have also challenged social marketing by questioning whether it offers anything new or is just a repackaging of familiar ideas overlaid with marketing jargon, and also whether social marketing is more effective than current health promotion practices (Buchanan et al. 1994; National Social Marketing Centre 2006a, 2007).

2.4.1 Consumer research/orientation

Critics of social marketing have acknowledged that the social marketing emphasis on consumer orientation has provided a refreshing alternative to the provider approach, otherwise known as the "top down" approach, to health interventions (Buchanan et al. 1994). However, they have also pointed out that this insight has existed in health promotion since as early as 1945, when Derryberry recognised that people had to be involved from the outset of any programme for it to be successful (Derryberry 1945).

Such critics further argue that health promotion documents, such as the Planned Approach to Community Health (National Centre for Chronic Disease Prevention and Health Promotion 1991), Community Participation in Local Health and Sustainable Development: Approaches and Techniques (World Health Organization 2002) and Community Participation in Public Health: World Health Report (World Health Organization 2004) emphasise the importance of involving consumers in the initiatives, which they consider to be synonymous with *consumer research*. They also point out that the first step in public health campaigns is widely accepted as a needs assessment, which is directly comparable to *consumer research/orientation*, as it is referred to in social marketing (Buchanan et al. 1994). However, in response to Buchanan's assertion above, Hastings (2007) argued that, in social marketing, *consumer orientation* goes beyond needs assessment and people's involvement. It is more about gaining competitive advantage in a market place that is characterised by contradictory messages.

2.4.2 Integrated approach

The integrated approach to social marketing, otherwise termed the *marketing mix* or the four Ps (promotion, product, price and place), has also been under scrutiny from health promotion specialists. According to Hill (2001) and Buchanan et al. (1994) these ideas are not new to public health, and they represent a comprehensive approach which forms the

bedrock of public health theories founded on the familiar triad: agent, host and environment. They further point out that the need for a multi-sectoral approach was emphasised as early as 1978, during the Declaration of Alma-Ata (World Health Organisation 1978). It is argued that the four Ps are not easily manipulated in the health field. For example, the target to "stop smoking" (product) is difficult (price) and involves a degree of suffering by the targeted individual, such as withdrawal symptoms and loss of social capital (Buchanan et al. 1994). In recognition of the difficulty in applying the four Ps marketing mix, social marketers advocate a thorough consumer orientation through research and the use of data systems. It is recommended that this is followed by a broad and robust analysis of behavioural patterns and trends in order to determine the problem and the desired behaviour. The understanding of the key influences of behaviour, and what moves and motivates consumers, is also emphasised (National Social Marketing Centre 2007).

2.4.3 Voluntary behaviour change

The social marketing principle about the understanding of what moves or motivates people towards a particular behaviour (*consumer research/orientation*), and utilising that knowledge in designing effective interventions that result in voluntary behaviour change, has been challenged. In their book entitled "Nudge: Improving Decisions about Health, Wealth and Happiness," Thaler and Sustein (2008) describe the concept of "nudging", which is based on the idea of behavioural economics. They argue that most health behaviour challenges observed among populations result from personal choice, environment, culture and economic factors, and that people don't always act in a logical manner or make decisions that are advantageous to them. They further explain that most people do not dispassionately analyse their behavioural decisions and that decisions are mostly based on automatic mental systems, otherwise termed as 'mindless choosing'. If this is the case, health organisations or governments have to act as choice architects, crafting successful nudges to overcome mindless choosing and help people to make alternative, good choices (Thaler & Sunstein 2008; French 2011). Examples of nudges include actions such as increasing the prominence of healthy food in canteens, requiring people to opt out of, rather than into, organ donor schemes, or providing small incentives for people to act more healthily, without such actions being perceived by 'consumers' as coercive (Bonell et al. 2011).

Bonell et al. (2011) argue that the nudge theory doesn't offer anything new because existing public health is not generally coercive (and where it is, as with the smoking ban, this is usually to prevent harm to third parties), and it goes beyond merely communicating health messages to influencing how choices are presented (for example, using techniques like social marketing). They further point out that many of the examples in Thaler and Sunstein's

book don't fit with their own definition. Bonell et al. (2011) describe an example of a nudge programme in the USA, which pays a dollar a day to teenage mothers contingent on their having no further pregnancies. They consider this approach to be coercive and a major pressure on young women in poverty, thus contradicting the authors' definition of nudges as not exerting such pressures (Bonell et al. 2011). French (2011) gives a more balanced view. He argues that, rather than adopting a position where positive rewards and mindless choosing are the default intervention mode, robust and proactive citizen engagement (starting with *consumer/target population research and orientation*) should always provide the evidence base for deciding on the intervention approach in all initiatives.

2.4.4 Marketing failure

There has also been scepticism about whether the basic principle guiding commercial marketing – supply and demand – can flourish in a health promotion context. Foxall (1989) suggests that social marketing renders the concept of a "marketing place" redundant, and that it has no place in consumer choice or for the function of the market mechanism (supply and demand). Buchanan et al. (1994) further clarified this by explaining that in true functional markets, entrepreneurs produce products to satisfy unmet needs. However, in social markets producers are not responding to consumer demand (market failure), and in fact social marketers largely try to persuade people to give up things such as cigarettes and alcohol, which the commercial market has delivered too successfully.

Other debates about the concept of social marketing in health are often perceived as contradictory, because marketing itself is usually interpreted as the business of selling goods and services (Ling et al. 1992; French et al. 2010) rather than impacting on society in a positive way, in terms of the concepts of health/illness. Since marketing is essentially the process of buying and selling (exchanging values) in a competitive market, where the seller has to be highly motivated and aggressive to succeed, the question has been whether the incentives for a health promoter can be equivalent or even comparable to those of a commercial sales executive with high performance related bonus payments (Ling et al. 1992; French et al. 2010).

In contrast, social marketing theorists (e.g. Andreasen 1995; Kotler & Lee 2008) have argued that the primary intent of social marketing in public health is to identify and understand consumer preferences and barriers related to an intended service or programme before its development and implementation. What distinguishes the social marketing process from other traditional approaches is the consumer orientation at all levels of the planning, development, implementation and evaluation process (Andreasen 1995; McDermott 2003;

Evan 2005; French et al. 2010). This is in contrast to programmes that are more paternalistic and driven by a top-down approach. Hastings and Haywood (1991) suggest that the incentive for a health promoter is not profit or bonus payments, but rather a better quality of life and improved public health for the targeted population. Furthermore, they argue that in both commercial and social markets, success results mainly from a thorough understanding of consumers, followed by a well thought out strategy to influence their behaviour. Social marketers generally argue that we should criticise commercial marketing when it does harm, such as the tobacco industry, but also learn from it when the opportunity exists to do good (Stead et al. 2007).

2.4.5 The social marketing ethics debate

Although social marketing's key aim is to contribute towards social good, the issue of ethics in social marketing practice has been debated for decades. In particular, social marketing has been criticised as having sinister motives of social control, and being part of governments' agendas for population behaviour re-modification (French et al. 2010). However, social marketers have argued that the need to collaborate with governments is fundamental and that governments have democratic mandates to modify and control behaviour through legislation to ensure the smooth running of society. This may be necessary in public health, especially where voluntary approaches have failed, as in the case of smoking in public places. Social marketers further argue that in most cases voluntary approaches work, especially where robust consumer/client research is carried out before the design and implementation of programmes (Hastings 2007; French et al. 2010).

Partnerships in health interventions between social marketers and some institutions have also been questioned. Whereas partnering with big business institutions often brings in the much needed finances that may enhance the quantity, and probably the quality, of programmes the risk of being part of unethical practices has been of major concern (Hastings 2007; Eagle 2009). To this end social marketers argue that this is not a risk that is unique to social marketing, and recommend that a thorough partnership analysis should always be carried out, and an agreed ethical code signed, before collaborative interventions are undertaken, in order to avoid getting trapped into unethical practices (French et al. 2010).

2.5 Social marketing and public health

The adoption of social marketing by public health authorities is thought to have been formalised when Weibe (1952) evaluated four different social change campaigns in the United States of America and concluded that the more similarity they had with commercial

marketing, the more successful they were. Public health experts developed and refined this thinking by examining international development efforts, where social marketing was being used mainly in family planning and disease control, and made a similar observation (Manoff 1985; Gordon et al. 2006). Although initially social marketing was mainly practised in developing countries, the approach has spread rapidly to most developed countries in the past two decades (Centres for Disease Control and Prevention 2005). In the USA social marketing is increasingly being advocated as the core public health strategy for influencing voluntary behaviours such as smoking, drinking, drug use and diet (Centres for Disease Control and Prevention 2005).

In the UK the potential for social marketing was recognised in the 2004 Public Health White Paper (Department of Health 2004b) which highlighted the power of social marketing and marketing tools in building public awareness and behaviour change. This was followed by the creation of the National Social Marketing Centre in 2005, with a mission to help realise the full potential of effective social marketing in contributing to national and local efforts to improve health and reduce health inequality (Gordon et al. 2006). The National Social Marketing Centre, in collaboration with the Department of Health, released the first strategic framework for maximising the potential of social marketing and health-related behaviour in 2008 (Department of Health 2008a). In 2009 a specific social marketing and sexual health strategy document was published, which has since guided the implementation of government sexual health programmes (Department of Health 2009).

More recently the UK Department of Health published a new social marketing strategy for public health (Department of Health 2011). In this policy paper the government reiterates its commitment to using social marketing in improving public health, and highlights the achievements of social marketing interventions such as the Change4Life programme addressing obesity (Department of Health 2010), the Smoke-free England campaign (Department of Health 2008b) and the Act-FAST stroke awareness campaign (Department of Health 2009). There has been a notable change in this strategy with a shift away from addressing single issues, instead taking a lifestyle approach of delivering support on all topics that are relevant to a person at a given stage of life. Among young people this implies that the strategy will focus on influencing behaviours such as risky sexual activity, alongside other related issues such as binge drinking, experimenting with drugs and smoking (Department of Health 2011).

2.6 Effectiveness of social marketing

Social marketing projects have now been implemented in some developed countries, mostly in the USA. The pioneering applications of social marketing in health were first seen in the 1980s, mainly addressing cardiovascular disease morbidity and mortality (Ward 1984). Later, social marketing was adopted by other agencies working on public health issues, such as the Centre for Substance Abuse Prevention and the Office of Cancer Communications at the National Cancer Institute in the USA, the Victorian Health Promotion Foundation in Australia, the Health Sponsorship Council in New Zealand and the National Social Marketing Centre in the UK. The studies that have been carried out in developed countries have indicated that social marketing may be an effective approach to health behaviour change interventions (National Social Marketing Centre 2006a; National Social Marketing Centre 2006b; Stead et al. 2007).

Evidence on the application and effectiveness of social marketing in pregnancy and childbirth interventions is scarce, with few studies and those mainly emanating from the USA. A literature search showed that no studies have been conducted with Somali women using a social marketing approach. However, four social marketing studies on teenage pregnancy were identified, which are summarised in Table 2.2 and discussed below, in relation to contraception and unintended pregnancy.

2.6.1 Contraception and unintended pregnancy

Four studies; Bertrand et al. (1987); Tanfer et al. (2000); Tanner et al. (2009); Messer et al. (2011) evaluated social marketing interventions on contraception use and unintended pregnancy.

Bertrand et al. (1987) carried out some *consumer research* to ascertain family planning needs before the establishment of a family planning service. The study involved a thousand women aged between 15 and 35 years who were resident in New Orleans, USA. The majority were from a Black ethnic background. The study was designed to provide data on the four Ps in the *marketing mix* (*product*: the extent of need for the service; *place*: alternative current sources, satisfaction levels with the current service, preferred service delivery methods; *price*: amount believed reasonable for the service; *promotion*: recognition of the service provider's name and preferred channels of communication).

The study successfully demonstrated how *consumer research* can be carried out and the results used to design services that are accessible to a targeted population. However, by using telephone interviews to collect data, the study might have excluded some low earners

with no phones in their homes. Another limitation was the ethnicity of the target population which was mainly Black, which implies that the study findings may not be generalisable to other populations with a different ethnic mix. Also, the study did not undertake a multivariate analysis to determine the association between various socio-demographic characteristics and responses, which would have been vital in a targeted *marketing mix* strategy.

Table 2.2: Review of social marketing reproductive related studies

Authors	Study Title	Study/Intervention Description	Study Aim	Social Marketing Components
Bertrand et al. (1987) USA	Marketing Family Planning Services in New Orleans.	Telephone survey involving women aged 15 to 35 to inform the design of family planning services	To demonstrate the role of social marketing in the development of family planning programme strategies	Consumer research Segmentation & targeting Competition Marketing mix
Tanfer et al. (2000) USA	Why are U.S. women not using long acting contraceptives?	A secondary data analysis of the National Survey of Women (1993 & 1995)	To identify reasons why women have spurned LARC methods in order to inform the design and implementation of interventions and targeted social marketing to promote their use.	Consumer research Segmentation & targeting
Tanner et al. (2009) USA	Evaluating a community saturation model of abstinence education: an application of social marketing strategies	An evaluation of a social marketing strategy promoting abstinence education and its effects on adolescents' sexual attitudes and behaviour	To determine the effectiveness of a social marketing strategy in abstinence education and reduction of teenage pregnancy	Consumer research Segmentation & targeting Competition Marketing mix Behaviour change
Messer et al. (2011) USA	Reported adolescent sexual norms and the development of a social marketing campaign to correct youth misperceptions	A description of how data on local sexual norms were collected and analysed, and how the results were used in a social marketing campaign	To correct youth misperceptions about teen pregnancy	Consumer research Segmentation & targeting Competition Marketing mix Behaviour change

Tanfer et al. (2000) carried out an analysis of data from three US National Women's Surveys (1991, 1993 and 1995) in order to identify reasons why the uptake of LARC (Long Acting Reversible Contraceptives) methods (implants and injectables) among women aged 20 to 39 was low. The findings from the *consumer research* were to inform the design and implementation of interventions and targeted social marketing to promote LARC use. Tanfer et al. (2000) found three main reasons: lack of knowledge about the specified contraceptives; fear of side effects; and satisfaction with the current non-LARC methods. They also observed that older women (those over 30), those with a college education or higher, and single women with one or more children were less likely to cite side effects as a

reason for not using LARC methods, as compared to younger women (younger than 30), those with no college education and the married and childless.

Most women had a negative attitude towards the use of the two LARC methods, highlighting their cost, side effects and partner disapproval as the main reasons in all waves of interviews. The study successfully identified important factors associated with LARC use. However, the attrition rate was high, especially among Black and single women who are known to be at a higher risk of unintended pregnancy, making it difficult to draw conclusions on the applicability of the findings to the general female population. Although the study identified factors associated with low LARC uptake, due to the limitations of the study design it was not possible to identify the decision-making processes (and the role of partners and health professionals) among those using LARC methods. Nor was it clear if the non-use of LARC methods, and the reasons given, were based on experience or anecdotes. The study did not include teenage women who, evidence shows, are the group most affected by unintended pregnancy and are therefore an important target group. The study was limited to only two kinds of LARC methods; Intra-uterine Contraceptive Device (IUCD) and Intra-uterine System (IUS) were not included.

Tanner et al. (2009) evaluated an abstinence education programme branded *"Worth the Wait."* The programme was based on social marketing principles and was implemented in five counties in Texas, USA, involving 2007 students from years 7 to 12 (aged 11 to 16). The main intervention outcomes were a reduction in intentions to engage in sexual activity and a commitment to abstinence. The main measures were the likelihood of remaining abstinent, sexual activity or abstinence intentions, attitudes towards abstinence, and attitudes towards teenage sex. The intervention included a sexual health school curriculum, extra-curricular activities, parent and community involvement, advertisements and professional/staff development *(marketing mix)*. The programme was based on findings from baseline surveys carried out with the target group and other stakeholders *(consumer research).* Evaluations were carried out at varied times during the intervention over a five-year period. Results showed that years of participation were associated positively with knowledge, beliefs, attitudes and intentions. No relationship was found between intentions to engage in sexual activity and parental monitoring, talking to adults and media recall.

Although the study found that 'years of participation' was a significant factor in achieving positive results, but it could not be established if this was as a result of the social marketing intervention or a consequence of the traditional school curriculum. Improved outcomes could also have been due to a maturation effect among participants and not necessarily due to the

intervention. The participation rate was low (48%), meaning more than half of the parents withheld consent. Measuring intentions is also controversial because what people say is not always what they do. Considering that the school policy was restrictive and only allowed abstinence education, the responses could have been biased towards what was socially acceptable in the participants' settings. Although the study concluded that the social marketing programme was effective in reducing teenage pregnancy rates before and after the intervention. Also, no baseline survey findings for the outcomes were reported.

Messer et al. (2011) carried out a study to demonstrate the application of social marketing techniques in the development of an intervention aimed at correcting youth misperceptions about teenage pregnancy. The intervention was part of the project branded *"Taking Responsible Actions in Life"* (TRAIL). Four schools in North Carolina (USA) were involved. The programme targeted students from grades 7 to 9 (aged 11 to 13); a thousand students were involved in the study. The schools were chosen because they were experiencing a high incidence of teenage pregnancy. The majority of the participants were from low socio-economic backgrounds. The study used self-administered questionnaires to collect information on the following themes: parent child communication, attitudes towards teenage sex and marriage, sexual intentions, abstinence commitment, and prior sexual activity.

The findings from the baseline study *(consumer research)* were used to design and implement a social marketing campaign which included: adolescent pregnancy prevention education, youth development programming, parental involvement, and a norms marketing campaign which utilised various media such as video shows, billboards, radio and newsletters *(marketing mix).* However, the study did not report the post implementation results to demonstrate the effectiveness or otherwise of the intervention, and it relied on informal feedback from participants to conclude that the intervention supported appropriate behaviour and corrected the normative misperceptions. The generalisability of the study findings is also limited, due to the low socioeconomic status of the participant population and their high risk of teenage pregnancies.

The above four studies suggest that using social marketing principles in public health projects may help to achieve positive outcome in a target population. Therefore, the principles of social marketing were adapted in my study. This is deemed appropriate as the focus of the study was based on targeted population- Somali women, giving of information and change of knowledge/behaviour through the use of a DVD as an intervention tool.

The next section describes how social marketing principles were applied to my study.

2.7 Study mapped against the SMART social marketing model

There are many models that have been proposed in the literature for research using a social marketing approach. However, there are only two models that are applicable to this study: the Social Marketing Assessment and Response Tool (SMART) (Neiger & Thackeray 2002) and the Social Marketing Wheel (Evans et al. 2005). Out of these two social marketing models, the Social Marketing Assessment and Response Tool (SMART) was deemed the most appropriate. The main strength of this model is that it explicitly explains the process to follow at each phase, and therefore it was useful for a novice researcher/ social marketer. The key steps in the Social Marketing Assessment and Response Tool (SMART) model are illustrated in Table 2.3 below:

Table 2.3: Application of Neiger & Thackeray's (2002) Social Marketing SMART Model to the concept of the maternity information DVD

Phases	Application to Social Marketing	Application to my project
Phase 1	*Preliminary Planning* Identify a problem and name it in terms of behaviours. Develop general goals. Outline preliminary plans for evaluation. Project programme costs.	Local maternity profile (Urhoma et al. 2009)
Phase 2	*Audience Analysis* Segment and identify the target audience. Identify formative research methods. Identify consumer wants, needs and preferences. Develop preliminary ideas for preferred interventions and communication strategies.	Mary Seacole Project: Informing the Development of a Maternity Information DVD for Pakistani Women: a social marketing approach. Mary Seacole Award Project (Urhoma 2009).
Phase 3	*Channel Analysis* Identify appropriate communication channels. Determine how many channels should be used. Assess options for programme distribution. Identify communication roles for programme partners.	
Phase 4	*Market Analysis* Establish and define the market mix (4 Ps: product, price, place, and promotion). Assess the market to identify competitors, allies and partners.	

Phase 5	*Develop Interventions and Materials and Conduct Pretesting* Interpret and translate the marketing mix into a strategy that represents exchange and societal good (DVD).	
Phase 5a	Develop programme interventions and materials using information collected in audience, market and channel analyses.	Write DVD Script and Design DVD
Phase 5b	Pre-test and refine the programme.	DClinP Project: Can the provision of a native language maternity information DVD for non-English-speaking Somali women improve their knowledge of maternity care, and do women find the DVD acceptable/useful? (DClinP: Florence Nightingale Research Scholarship Award 2011)
Phase 6	*Implementation* Communicate with partners and clarify involvement. Activate communication and distribution strategies. Document procedures and compare progress to time lines Refine the programme.	Future work-based Service Development Project
Phase 7	*Evaluation* Assess the degree to which the target audience is receiving the programme. Assess short-term results and make refinements in interventions. Ensure that programme delivery is consistent with established protocol. Analyse changes in behaviour and health status in the target audience.	

Neiger & Thackeray (2002)

Each of these phases is briefly discussed below. Phases 1 – 4 formed the roots upon which the current study is based and are presented here to contextualise the development of Phase 5, my DClinP project. Phases 6 and 7 are planned future service developments and are discussed in more detail in the concluding chapter of the thesis.

Phase 1: Preliminary Planning

Preliminary planning in social marketing involves identifying a problem of interest. Therefore, the lack of appropriate maternity information for non-English-speaking ethnic minority women (including Somali women) was identified as a problem of interest in the geographical

area where I worked. This was identified through an integral part of my then job, a local audit. This audit ascertained that many non-English speaking ethnic minority women did not, or could not, read the maternity information booklet written in English that was given to every pregnant woman in the area, regardless of ethnicity. This issue, the lack of appropriate information, has been linked by research studies to a number of poor childbirth outcomes experienced by this group of women (Davies & Bath 2001; Harper-Bulman & McCourt 2002; Upvall et al. 2008; Binder et al. 2012).

The national goals for maternity services are to offer women a choice regarding the place where they give birth, a choice of where they receive antenatal care, easy access to maternity care, and continuity of midwifery care that is specifically designed to meet individual needs and those of local communities (DH 2007a). The Maternity Matters policy emphasised the obligations of both service providers and commissioners to commit to providing individualised women-focused care, with special reference to those who are disadvantaged or vulnerable (DH 2007a).

Hodnett's systematic review (2002) revealed that women have better physical and emotional labour outcomes if they understand the care they will receive and if they are involved in the decision-making process. A study by Green et al. (1990) found that good information was important to a woman's birth experience and her subsequent emotional recovery and well-being. It is noteworthy however, that in the context of the recommendations by the Department of Health and others (Green et al. 1990; Hodnett 2002; DH 2007a), some ethnic minority women continue to be at a disadvantage. This is primarily due to communication barriers arising from a lack of equity in the medium in which the maternity information is provided, which is not always in the women's own language or in a form in which it can be read by them (Harper-Bulman & McCourt 2002).

This phase constituted the start of the journey which led to the DClinP project reported in this thesis.

Phases 2 to 4: Formative work (the Mary Seacole project)
In developing health interventions, Tripp-Reimer et al. (2001) suggest that programme planners should perform a cultural assessment focused on an analysis of the beliefs, values and practices of the target audience. This assessment may be complemented and enhanced by the Social Marketing SMART model's phases 2 to 4: audience analysis, channel analysis and market analysis, which are collectively referred to as "formative research." Formative research is defined as the process of identifying the wants and needs of the target audience,

as well as factors that influence its behaviour, including benefits, barriers and readiness to change (van den Akker 1999; Kotler & Lee 2008; Luca & Nuggs 2010).

In this formative phase, the practitioner's goal is to describe the target audience: who they are, what is important to them, what influences their behaviour, and what would enable them to engage in the desired behaviour. This description then guides the development of a programme intervention strategy designed to make it easier for individuals in the target audience to engage in the desired behaviour (Kotler & Lee 2008; Luca & Nuggs 2010). The Mary Seacole Award project (Urhoma 2009) provided me with the opportunity to undertake this formative research and it was the successful completion of this that led me to progress my work to developing and testing the maternity information DVD for ethnic minority women with a group of Somali women (Phase 5).

The three formative research phases (audience analysis, channel analysis and market analysis) are summarised below.

Phase 2: Audience analysis/segmentation
The aim of audience analysis/segmentation is to identify the target audience's needs and the costs and benefits of addressing those needs (Lefebvre & Flora 1988). This includes understanding the consumer's point of view, desires, and values (Hastings & Haywood 1991; Siegel & Doner 1998). In addition, it provides for knowing the consumer's perspective before starting the intervention design (Lefebvre et al. 1995).

From the onset it was clear that the DVD could not be produced in all the ethnic minority languages spoken in the UK, as it is well documented that over three hundred languages are spoken in London alone (von Ahn et al. 2010). The assumption was that all non-English-speaking ethnic minority women would have similar maternity information needs, but some variations in their cultural needs. Pakistani women formed the largest group of ethnic minority service users in the particular maternity unit where I worked at the time of the Mary Seacole project. Therefore, in agreement with the local NHS Trust, they were the focus for the formative research (Urhoma 2009). The Mary Seacole project thus provided a platform to identify the maternity information needs of non-English-speaking ethnic minority women, as well as some specific cultural needs of the target group. When I moved jobs and started the Phase 5 work of this project, another group – Somali women – were focussed upon.

The main aim of the Mary Seacole project was to actively involve the target community (Pakistani women) in considering the potential usefulness of a maternity information DVD for

non-English speaking ethnic minority women. This was achieved by using a social marketing approach, with the objective of conveying key messages about the benefits of early and continuous antenatal care, as well as knowledge of the maternity care system. Similarly, the concept of this phase (2) was also used with the Somali women when developing the Somali Maternity Information DVD. My midwifery experience of working and leading maternity services with a high proportion of women from diverse ethnic backgrounds has indicated that the predominant common need is for maternity service information. This was the focus of the DVD. Culturally specific information is a very small component. When the participant group changed from Pakistani to Somali, I consulted with a Midwife from the Somali community and some Somali women service users. In addition, this was fully discussed at the DVD development stakeholder meeting before the development of the DVD, to ensure that the DVD concept was appropriate to the group (full details of the DVD design are discussed in phase 5a below).

Phase 3: Channel analysis

The channel analysis process helped to discover the best way to reach the target audience and identify their preferred sources of information. It included determining what communication channels audience members come into contact with on a regular basis, and which of those are the most influential and important (Grier & Brumbaugh 1999). Channels can be people, institutions, organisations and specific communication techniques, such as mass media, personal communications or public events (Grier & Brumbaugh 1999). The channel of communication used during the formative research (the Mary Seacole project) was via midwives, a voluntary organisation (a Pakistani Muslim Women's Association) and general practitioners.

Phase 4: Market analysis

The main aim of market analysis is to identify partners with a shared goal and to establish the marketing mix, also referred to as the 4 Ps: product, price, place, and promotion (see Table 2.4 below). Social marketing-based programmes aim to change behaviour by establishing an exchange between the consumers and the programme developer, based on the consumers' wants and needs (Smith 2000). In the exchange, consumers give up something of value and in return they receive something of equal or greater value (this will be discussed further in the evaluative phase). However, it is suggested that for behaviour change to occur (i.e. for the exchange to take place), the social marketer must understand the consumers' preferences regarding the 4 Ps (Hill 2001).

The market mix phase applies to both the Mary Seacole project (Pakistani Women participants) and the DClinP project (Somali women participants). The participants in the Mary Seacole project recommended the use of a DVD as a means of passing information to non-English speaking women. The DVD concept was then developed and piloted in this study (see chapter 4). The 4Ps in this study are summarised in Table 2.4 below, they are applicable to both the Mary Seacole project and the DClinP study.

In summary, the outcome of the formative research phase of my study (the Mary Seacole project) identified and recommended the use of a native language DVD as the preferred method of communicating effectively with, and exchanging information between, healthcare professionals and non-English-speaking ethnic minority women.

Table 2.4. The Marketing Mix (4 Ps) in the Maternity Information DVD Project		
P	Definition	Application to DVD Production
Product	An idea, behaviour, service or tangible item that the target audience adopts/recommends	DVD based on maternity information tailored to the needs of specific ethnic minority women
Price	What consumers have to give up to adopt the product; can be psychological or tangible	Traditional practices Time to enable: 1) change in knowledge of maternity care; and 2) change of misconceived traditional beliefs about pregnancy and childbirth
Place	Where consumers will receive the product, engage in the behaviour/communications	Available at access points to maternity services, e.g. antenatal clinics, GP surgeries, groups etc.
Promotion	The means of communicating the message to the target audience	At first through face-to-face interaction. Later potentially through networks, groups/families (word of mouth), posters in strategic places in different ethnic minority languages.

Phase 5: Develop interventions and materials and conduct pretesting

In this fifth phase, materials and interventions are developed in response to the findings of the formative research. The DClinP project forms part of this phase, which is described in detail in the remaining chapters of this thesis. I have presented a summary here by way of an introduction.

Before the full production of messages and materials and full-scale programme implementation, key elements including methods, communications and strategies are presented to members of the target audience to elicit feedback. Modifications are then made, based on that feedback. This involves pretesting to verify that the programme developer has created strategies/interventions that are reflective of, and in response to, audience needs, wants and expectations. Typical methods for pretesting include focus

groups, intercept interviews and surveys (Neiger & Thackeray 2002). Therefore this fifth phase is sub-divided into 2 parts (5a-design of the DVD and 5b- Pre-testing).

Phase 5a: Design of the DVD

In relation to the maternity information DVD, the material was developed based on the recommendations made by the participants during the formative phases described above. Funding for the production of the DVD was acquired from the local authority and the local NHS Trust to which I had moved.

One of the social marketing principles advocates developing interventions with the target population. Therefore, a stakeholder group (comprising healthcare professionals, service user representatives from ethnic minority communities, commissioners, local authority representatives and Trust communication representatives) was formed to help with the development of the DVD. I also conducted a language needs audit of the non-English speaking service users in this local maternity unit. A decision was made by the key stakeholders to develop the DVD in the seven most commonly spoken languages based on the language needs audit. These languages were: English, Somali, Gujarati, Arabic, Polish, Romanian and British Sign Language. The audit showed that Somali women had the most language need based on their high usage of interpreting service and so this group was chosen for the first non-English speaking DVD.

It has been previously mentioned in chapter 1 one that the DVD may serve as a decision aid for Somali women, therefore, the development of the DVD and the content complies with the guidelines of The IPDAS-International Patient Decision Aids Standards (IPDAS 2005). The International Patient Decision Aids Standards (IPDAS) Collaboration states that decision aids should provide evidence- based information about a health condition, the options, associated benefits, harms, probabilities, and scientific uncertainties (Elwyn 2011; IPDAS 2005; Stacey 2011). In general, decision aids lead to more informed values-based choices and appear to improve communication between consumers and health professionals (Stacey 2011). I wrote the English script (see Appendix 14) based on the pregnancy book (DH 2007c, 2009c) and NICE guidelines on care of healthy mother and their babies during childbirth (NICE 2007) in order to ensure standardisation of information and to comply with IPDAS' Standards (IPDAS 2005).

Therefore, the DVD was developed and the content of the DVD was designed to follow the women's childbirth journey from the prenatal to the postnatal period, including key public health and pregnancy related messages. However, some modifications were made to

accommodate a number of specific cultural and service issues relevant to certain ethnic minority groups (these are discussed in Chapter 3, section 3.7.).

Phase 5b: Pre-testing prior to the DClinP project

Before the full implementation phase of the project commenced, it was necessary to carry out a pre-test (a pilot implementation and evaluation) with one of the ethnic minority groups to verify that the DVD was effective. Somali women were chosen for this pre-test stage because they were identified as the ethnic minority group with the greatest language needs within the local community. Hence, the DClinP study, funded by a Florence Nightingale Research Scholarship award commenced. This phase consisted of the pilot implementation of the DVD and its evaluation; each is summarised below and detailed in Chapter 4.

Part 1: Pilot implementation

The pilot implementation phase in this project involved testing the knowledge change, usefulness and acceptability of the DVD with Somali women by asking pre-knowledge test questions, after which the DVD is given to the participants to watch. A post-knowledge test was then conducted after watching the DVD, and finally a postnatal interview was carried out.

Part 2: Pilot Evaluation

An evaluation to assess the quality of the intervention, whether it served the target population's need or not, whether it operated as expected, and whether there were areas in need of improvement (Neiger & Thackeray 2002) was undertaken.

Phases 6 and 7: Full implementation and evaluation

These implementation and evaluation phases are beyond the scope of the DClinP study. The feasibility of moving from this DVD to the generation and implementation of another five language/ethnic group-specific DVDs will be considered once Phase 5 is completed.

2.8 Summary

This chapter has described the principles of social marketing and its application to the journey of this study. My study is the first study to use social marketing to create and evaluate an intervention with Somali women. As explained above, this thesis presents the pre-testing stage, Phase 5b, in the Social Marketing Assessment and Response Tool (SMART) procedure. The remainder of this thesis will focus on the pilot implementation and pilot evaluation of a DVD designed to improve Somali women's knowledge of maternity care. The next chapter focuses on history of Somalia, culture and the Somali women.

Chapter 3

Culture and Somali Women

3.1 Introduction

This chapter provides information about the target audience of this intervention – Somali refugee women. The chapter begins with information about the conflict that led many Somalis to leave their native country and settle in the UK. Attention is then turned to Somalian refugee women and their perspectives on childbirth. A discussion of cross - cultural medical ethics and culturally responsive health care follows preceding sections on issues related specifically to the maternity care of Somali women, who are being targeted by this intervention.

The literature used in this chapter emerged from searches of various nursing, midwifery, medical and other health and social care journals and databases. Although, specific searches were undertaken using the strategy outlines in Appendix 1 additional literature from wider searches (Appendix 2) has been included in this chapter to provide context. Some literature retrieved from the searches has also been interwoven throughout the relevant sections of this thesis. A specific search relevant to the study question was undertaken of 8 databases from which 173 relevant citations were identified. Following screening and removal of duplicates, 11 studies were identified as eligible for inclusion. Critical appraisal was undertaken using the relevant CASP tool and a detailed table of evidence including limitations has been appended (Appendices 1 and 2).

Often the literature identifies Somali women as part of the Black African ethnic group, despite differences in culture, religious, beliefs and languages among the disparate African ethnic groups (Bhopal 2002; Jayaweera 2005). Due to this dearth of literature specifically addressing the maternity information needs of Somali women in the UK, the literature search was expanded to include research carried out in other developed countries such as the USA, Australia and Canada. Some clinical research studies were found, mainly focusing on improving information for other ethnic minority groups (Bell et al. 1999; Gerrish 2001) and other studies particularly focused on childbirth experience of Somali women (Ameresekere et al. 2011; Binder et al. 2011; Essén et al. 2011; Binder et al. 2012).

3.2 History of Somalia: a refugee-producing nation

The foundations of the Somali conflict were laid during the colonial era from the 1880s until 1960. Before colonisation, Somalia operated on a system of segmentary lineage (Lewis 1994), with agreements and affiliations being made between elders of clan groups (Lewis 1994). Under colonisation, Somalia was split into five regions: French Somaliland, now Djibouti; the Ogaden region (controlled by Ethiopia); an area now situated in northern Kenya; the British Somaliland protectorate in the north; and an Italian-administered area in the south. In 1960 Somalis gained independence from Britain and Italy, and the two 'halves' of Somalia were united to become present-day Somalia. The centralised systems of governance introduced by the British and Italians remained, promising stability (Andrzejewski 1964).

However, from 1969, under the leadership of Siad Barre, the centralised system was used against the Somali people, heralding a time of crisis for the Somali region. Barre took control in a coup in 1969, and the centralised system facilitated his manipulation of clan politics to retain power in the region. Placing members of his own clan family (Marehan/Darod) in key government positions was a calculated move that exploited the centralised government, while also invoking the traditional clan system to ensure allegiance from a large proportion of the population who were of Barre's and his wife's clan (Mahadalla 1998). Having combined both the clan system and the centralised system of governance to secure his power over the entire country, Barre made clan membership officially illegal, effectively disempowering other clan and sub-clan leaders. As a consequence, dissatisfaction and disputes grew among the Somali population.

After a failed attempt by Barre to take over the Ogaden region, the dissatisfied Somali people turned their attention away from Ogaden and toward internal politics, and civil war broke out. The first clashes occurred in 1982 as a backlash to Barre's continued nepotism (Menkhaus 2003). Throughout the decade, opposition to his regime grew. Open rebellion developed as Barre responded to unrest with oppression, corruption and manipulation of divisive clan politics. By 1990 opposing clans were uniting against Barre, and he was removed from power in 1991. In the period immediately following Barre's departure, tensions escalated as clans vied for control over areas and resources. Between August and November 1991, Mogadishu witnessed a massacre as members of the mainly Hawiye United Somali Congress 'clan-cleansed' the city of Barre's clan members (Menkhaus 2003). Clan fighting, opportunistic looting by youths, rebel activities, rape, murder and widespread

violence were all part of the descent into chaos that turned Somalia into a refugee-producing nation (Menkhaus 2003).

By 1992 Somalia was facing a severe humanitarian disaster. Fighting made relief work impossible and 70% to 80% of food aid failed to reach its destination (Refugee Council 1994); consequently, many rural Somalis were forced to move to relief camps to access food. It was estimated that between three hundred thousand and half a million people died in 1991–92, many of disease in relief camps. Out of a population of eight million, two million Somalis were displaced and 4.5 million were considered to be in need of emergency assistance.

Today, Somalia remains a refugee-producing nation with a population of 9.5 million (Central Intelligence Agency 2008; WHO 2013). Food security assessments carried out over the period from December 2008 to January 2009 confirmed that over three million people in Somalia were in need of humanitarian assistance. Security concerns continue to impede the delivery of assistance, with thirty-four aid workers being killed in Somalia in 2008 (United Nations Security Council 2009).

3.3 Gender and Somali refugee women

The Somalis are known to have a rich oral tradition and are oriented towards storytelling; this is a unique human skill shared between people. By telling stories, people of different backgrounds and cultures can build a sense of community (Ahmed 1996). Somalis are a culturally and linguistically homogenous people. Somalis are divided into clans; they are almost all Muslims (Sunni), and their traditional Muslim beliefs prescribe defined gender roles. Men are the heads of the households.

The competing influences of sending and receiving countries, the cultural and religious bases of those countries, and the degree to which transnational links and practices are maintained, may result in complex connotations of the words 'woman', 'man' or 'gender' (Hyndman & de Alwis 2003, 2004; Conway 2008). While there has been an increased focus on refugees, including women, in research and policy, the impact of gender on the issues faced by a refugee woman during and after flight, her responses to situations and strategies for resolution, the outcomes of flight and resettlement, and issues of data and data collection, all require investigation. Binder and Tošić (2005) assert that 'gender plays an essential role in the decision for or against a flight'; this is especially so for Somali refugee women. Many Somali women have been subject to, or have lived in fear of, violence and

serious sexual abuse prior to and during flight from Somalia and in refugee camps (Human Rights Watch 1993), and many families sent female family members out of the region for this reason. Almost all the respondents in this study reported some experience of the danger and fear of rape, whether this was experienced by themselves, by family members or close friends, in their homes, during flight or in camps.

Family roles are determined by gender and are disrupted in exile where hierarchical status and power relations may be challenged (Binder & Tošić 2005). In Somalia, a woman's relation to her own and her husband's family and her identity and capacity as woman, wife and mother are mediated by traditional rules of kinship, which set norms for appropriate gender-related and age-related behaviour (Kapteijns 1993). Such relations pose challenges even in Somalia, but if marital and family lives are to be harmonious in the country of resettlement, then norms of family relations, responsibilities and interactions need to be maintained. However, increased opportunities for women regarding education, employment, freedoms and rights, combined with decreased household and childcare support from the extended family. Increased unemployment amongst Somali men and an often worsening financial status, dictate inevitable changes in roles, responsibilities and self-images of husband and wife which often have negative effects on married and family life (Boyle & Halfacree 1999; Harris 2004; Crosby 2006).

In traditional pre-colonial Somali society, while men acknowledged the crucial contribution of women to pastoral life, women did not form households or hold positions of authority, for example in government (Ibrahim 2004). Many years have passed since then and the regime prior to the war, as well as the war itself, proved instrumental in bringing Somali women into political life and prominent positions. This has necessitated the formation of female-headed households, both within Somalia and in the diaspora. Ibrahim (2004) found some evidence of barriers to women in positions of authority and old habits of protectionism extending to the diaspora. For example, in London women were under-represented in management committees of Somali community organisations, although they were over-represented at the service delivery end as programme managers or facilitators. Exceptions to this trend existed in smaller organisations run by the women who founded them (Ibrahim 2004).

Female heads of households in Somalia have become more common as a result of the conflict claiming the lives of Somali men. In the diaspora, these instances have become even more frequent as Somali women exercise new-found rights in relation to marriage and divorce with support from foreign (often British and Canadian) welfare systems (Boyd 1999).

To ignore alterations to the gender dimensions of experience, and responses to experience, is to ignore the ways in which people's gender roles are altered by fight, migration, culture, resettlement and transnational connections (Boyd 1999). Such an act of ignoring also neglects valuable information upon which effective policy and practice could be based. It is important for midwives, and other service providers, to have an understanding of these different experiences in order to deliver sensitive care. The particular circumstances of Somali refugee women influence their resettlement experiences and how they relate to their receiving society and to the Somali community into which they enter. These circumstances shape their identity as Somali women in the face of desired or required links with Somalia and the Somali diaspora (Ibrahim 2004). Embodied in "roles, relationships, and hierarchies, gender is seen as a core organizing principle of social relationships and opportunities" (Boyd 1999, p. 8). From their research in Sri Lanka, Hyndman and Hyndman & de Alwis (2003, p. 5) note that the impact of war has been disabling for women, resulting in the redefinition of women's roles in society.

The same may be said of Somali refugee women in London, since the conflict in Somalia has presented them with challenges and opportunities to redefine what it means to be a Somali woman. This may explain why the Somali community is so unified which, in effect, may be a positive concept for this study, as the knowledge acquired via the maternity information DVD can easily be shared within the Somali community. Furthermore, producing the DVD in Somali, rather than in English, may be linked to social identity connections. Hence, the DVD may help in building better relationships between the Somali women and the healthcare professionals.

3.4 Somali in the diaspora

The challenges faced by Somali people in their diaspora and diasporic identities (Hall 1990; Young 1995; Cassanelli 2001; Kusow 2001) have proved useful in conceptualising differences between groups of people with a migrant history. The term 'diaspora' was used to conceptualise a common ground on which migrants with differing ethnic backgrounds could unite, later coming into wider use and becoming politicised in relation to the Muslim diaspora (Werbner 2000) and the Black diaspora (Gilroy 1993). However, the term has been criticised variously as 'an analytical abstraction that cannot capture the contradictory nature of social change' (Wahlbeck 2002, p. 332), as extending essentialised notions of ethnicity, ignoring divisions such as gender and class as well as privileging 'the point of "origin" in constructing identity and solidarity' (Anthias 1998, p. 565), and as being historically located and embedded in specific histories (Mitchell 1997). What these criticisms of the notion of a

diaspora as a useful analytic tool seek to highlight is the complex, contested, contextual, relational and changing character of migrants as individuals and groups (Anthias 1998). Such complexity is important to note with Somalis, in order to dispel notions of a homogeneous Somali diaspora or a unified Somali collective, or of notions of assumed belonging to a wider Black or Muslim diaspora (Cole & Robinson 2003).

There are differences in affiliation and relationships between the Somali population in diaspora and those living in Somalia. The Somali population in diaspora tend to click together as a unified group; whereas the assertions of Somali homogeneity based on common ethnicity and language are erroneous, and the multiple divisions and affiliations related to clan in Somalia are well documented (Lewis 1994; Cassanelli 2001; Griffiths 2002).

Further differences exist relating to urban and rural origins, levels of education, age, gender and class; there are just as many differences as similarities between long-established Somali seamen (in Britain), political exiles, temporary educational migrants, forced migrants, and second generation Somalis (Danso 2001; United Nations Development Programme 2009). With diverse and often divided groups such as Somalis, it is important not to assume that membership of a single community is possible, or even desirable. A Somali woman in Britain therefore has a complex array of images to contend with in considering her 'Somaliness'; recognising this diversity is important for how such a woman fits into the UK's maternity care culture. Thus, there is a need to understand Somali culture and its impact on childbirth.

3.5 Somali women's perspectives on childbirth

Somalia has one of the worst sets of health statistics in the world for instance; birth rate (the total number of births per 1,000 of a population in a year) in Somalia is 45-47 per 1000 births compared to the UK with 12-13 per 1000 births. Death rate (the number of deaths occurring during the year, per 1,000 population) in Somalia is 13-18 per 1000 deaths compared with UK with 4 per 1000 deaths in 2013. Life expectancy in Somalia is 47 years compared with UK's figure of 81 years (World Health Organization 2012). Access to safe drinking water in Somalia is 37% compared to the UK with 100% of people having access to safe water. The number of people to physician rate in Somalia is 1900 to 1 whereas in UK it is 2.8 to 1. This latter statistic also has an impact on reproductive and sexual health (Lahmeyer 2004, Vijayaraghavan et al. 2012; World Health Organization 2012).

The maternal mortality rate in Somalia is 1100 per 100,000 births which is among the highest in the world. This is largely due to two factors, the first being the sustained collapse of the Somalian health system following the collapse of the government in 1991 (Vijayaraghavan et al. 2012; World Health Organization 2012) and the second is that women and girls are disproportionately suffering the effects of instability and conflict. Somalian women have a one in ten risk of dying during their reproductive years (McGinn & Purdin 2004).

In Somali culture women tend to marry young, and the experience of pregnancy and childbirth in Somalia differs in many ways from that of women in the United Kingdom. In Somalia there is very limited prenatal health care and women often rely on other women within their community to act as midwives during childbirth (World Bank 2010). For example, it is estimated that in Somalia only 2% of all deliveries take place in a health facility and are attended by skilled personnel (WHO 2010, 2013). Female circumcision/female genital mutilation (FGM) is common throughout Somalia, and the type most commonly performed is Pharaonic or type 3 circumcision (FGM will be discussed in detail later in this chapter), during which the clitoris and labia minora are removed and the labia majora are sewn closed, leaving a small opening for urination and the release of menstrual blood (Niera 2003).

Children are highly valued in Somali society; therefore, giving birth to many children enhances a woman's status, and having many children is viewed as a gift from God (Niera 2003). The average (global) infant mortality rate is 46 deaths per thousand live births (World Bank 2010). At 120 per thousand live births, the Somali infant mortality rate is one of the highest globally; in the United Kingdom the rate is 4.7 deaths per thousand live births (World Bank 2010). According to statistics from the World Health Organization (2010), the maternal mortality ratio in Somalia is estimated to be 1,200 per hundred thousand live births, making Somali women one of the highest risk groups in the world (WHO 2013).

A number of interview studies have also investigated Somali women's experiences of maternity care after resettlement, identifying concerns about care and highlighting important challenges for achieving a satisfactory provision of sound, respectful and appropriate maternity care for resettled Somali women (Beine et al. 1995; Essén et al. 2000). The participants in these studies expressed appreciation for the care received, but issues raised included fears about seeking antenatal care in their new homeland, considerable anxiety and fear about interventions, particularly Caesarean section. The participants in the study

expressed their preference for female companion support in labour, difficulties in communication with caregivers because of language problems and lack of access to interpreters (Beine et al. 1995; Essén et al. 2000).

One Swiss and two Norwegian papers reported health providers' views and delivery practices for African women with infibulation (This is FGM type 3 which involves the partial or total excision of all of the external female genitalia, followed by stitching intended to narrow the vaginal opening). They noted that Caesarean section was sometimes resorted to with women with infibulation, rather than undertaking defibulation to enable women to give birth vaginally (Vangen et al. 2004; Thierfelder et al. 2005; Johansen 2006). One of the Norwegian reports also highlighted the tendency by care providers to over-interpret Somali culture in their care of women, rather than clarify the relevant cultural issues with individual women themselves. In some cases this tendency led to Caesarean section to 'protect' women's infibulation in the name of culturally sensitive care (Vagen et al. 2004).

Another study (Small et al. 2008) reports data from six countries – Australia, Belgium, Canada, Finland, Norway and Sweden – with the aim of investigating pregnancy outcomes for post-migration Somali women, compared with outcomes for women born in each of these receiving countries. Country inclusion was facilitated by access to relevant national or regional data sets and by the authors' participation in an international collaboration of perinatal researchers. A primary purpose of this collaborative study was to determine the feasibility of international comparisons of reproductive outcomes for groups of immigrant and refugee women (Somali women in particular) in resettlement countries and, where feasible, to undertake comparisons to contribute to understanding and improving the care that such immigrants receive (Small et al. 2008).

Following migration from a high-mortality, low-income country to a low-mortality, high-income country, immigrant women of reproductive age are likely to remain closely influenced by adverse maternal health experiences brought with them from their setting of origin. This assumption is supported by prior research (Essén et al. 2000; Essén et al. 2002) and is called the 'maternal migration' effect. A definition of migration that supports this assumption is relocation to a setting which is a stark contrast to the one of origin, involving exposure to unfamiliar social, cultural and economic conditions, where spontaneous assimilation is assumed to be less profound among those migrating as adults (Silverstein 2005; Lindström & Muñuz-Franco 2006).

The maternal migration effect can be exemplified by Somali women's responses to obstetric interventions such as Caesarean section (CS). The aversion of sub-Saharan African women to CS is due to delivery or facility-related fears and an increased risk of negative attitudes towards future pregnancies after having had a Caesarean experience (Collin et al. 2006; Mrisho et al. 2009; Sunday-Adeoye & Kalu 2011). Studies conducted in Western countries among women from comparable settings suggest that similar perceptions persist after migration. Therefore, some of the obstetric issues identified above were addressed in the DVD to reduce the misconception view held by some Somali women towards medical interventions.

3.6 Cross-cultural medical ethics and culturally responsive health care

The 2001 national census revealed that 4.6 million (7.9%) of the United Kingdom (UK) population described themselves as non-white (Office of National Statistics [ONS] 2001). However, a recent population estimate by the ONS shows an increase of 4.6%, bringing the total non-white population to 14% (ONS 2011; Chapman 2014). Somalis have been one of the largest groups of refugees to arrive in the UK over the last ten years (Refugee Council 2005; ONS 2011).

It was noticed that after the collapse of the Somali government in 1991, many Somali refugees relocated to the United Kingdom and other developed countries (Jefferys & Martin 2007). It is estimated that in 2001 there were 43,000 Somalis living in the UK, 79% (34,000) of whom resided in London (Office for National Statistics 2001; Home Office 2009). Women made up 54% of the 2001 Somali population within the UK, and 44% of them were under 39 years old (Office for National Statistics 2001; Home Office 2009). However, these statistics are likely to be underestimates, because asylum seekers are not included in census data. It has been noted that there are problems with collecting accurate information from ethnic minority groups (Elam et al. 2003). Somalis are usually categorised as Black African under the UK's ethnicity classification (Lewis 2011).

The recent influx of immigrants and refugees such as Somalis to the United Kingdom has led to changes in the practice and delivery of health care services communication (Davies & Bath 2001; Harper-Bulman & McCourt 2002; Bischoff et al. 2003). Providing health care to diverse populations with different cultural perspectives requires attention to both the routine ethical questions that UK practitioners deal with on a regular basis, as well as the unique ethical questions that arise in cross-cultural health care relationships (Culhane-Pera et al. 2003). Conflicting worldviews and ideas about health, illness and healing can influence

provider-patient relationships and health care outcomes. When caring for patients with different cultural perspectives and moral practices to those of the care provider "the nature and quality of cross-cultural health care depend on how professionals understand and prioritize their obligations to respect patients and families with culturally diverse health beliefs and to protect and secure patients' best interests" (Culhane-Pera et al. 2003, p. 317).

Previous studies have shown that the use of cultural knowledge in community-based health care practice begins with the provider's careful assessment of patients and families in their own environments (Degni 2004). This notion is equally applicable to maternity care, since the purpose of attendance at antenatal clinics is to continually assess and discuss care pathways with the woman and her family, in order to develop mutually shared goals (Andrew & Boyles 2003). Religious and other cultural factors may play a crucial role not only in childbirth decision making, but also in the way in which individuals experience and perceive their bodies. It has been reported that religious beliefs and traditional perceptions are culturally patterned, since the structure and functioning of the body are reflections of culturally-determined cognitive categories.

Taking into account religious influence and culture on body knowledge, an examination of compliance to routine antenatal care among Somali women must consider the cultural acceptability of some childbirth procedures. Acceptability is not acceptance, acceptability, within this context is the ability of the Somali women to comply with childbirth procedures but not necessarily accept the rationale behind them (Essén et al. 2011; Benagiano & Shedlin 1992). Rather, the compatibility of childbirth intervention with the values, norms, and beliefs of Somali women. Evidence seems to indicate that any assessment of compliance with care must begin with the woman's understanding of the provider's recommendations (Essén et al. 2011; Benagiano & Shedlin 1992). However, understanding and acceptability, while crucial to correct use and continuation, are not sufficient, because culturally-determined perceptions can also influence compliance (Benagiano & Shedlin 1992).

Beauchamp and Childress (2001) attempted to adapt the ethical principles proposed by Gillion (1994) 'culturally neutral' care model. These principles are autonomy, beneficence, non-maleficence and justice. Gillion considers his approach neutral in that health care workers can share a common moral commitment, despite originating from disparate moral cultures. This neutrality is therefore impartial to competing theories, including those of religious and culture. Cultural neutrality supposes that carers can ignore their own perspectives shaped by their particular living and working contexts and by any religious

beliefs they may hold. This enables the adoption of a 'neutral' outlook about clients. However, it is worth commenting that whether this is even possible is debateable. The contention is that, in this new state, carers will not use any of their previous feelings or awareness to inform their approach to providing care (maternity care in this instance).

Adopting a culturally neutral approach to care should also mean that carers do not take account of the culture of their clients. However, I would suggest that it is important to consider the background of the client and the health care worker. Using Gillon's (1994) model, I will now discuss the importance of health care workers' backgrounds when considering ethical issues in clinical practice (Gillon 1994). I will focus on the context of midwives providing care to pregnant women of Somali origin; carers who may not share the same ethnic, cultural or language backgrounds as their clients. Beneficence and non-maleficence will be considered together because these two concepts are acknowledged jointly by health care professionals.

3.6.1 Autonomy

Gillon (1994) defines autonomy as deliberated self-rule, and considers that to respect autonomy in health care ethics, informed consent should be acquired before undertaking procedures. He suggests that effective communication is essential for this. Indeed, the Department of Health (DH 2001) states that the fundamental principle for establishing the ability to consent to procedures is effective communication. A study of people from minority ethnic groups (Khan & Jones 2004) showed that most women of Somali origin living in the UK were not able to speak any English. Many of these were uneducated women who had recently immigrated to the UK (Wissink et al. 2005). They did not work outside the home and had limited contact with non-Somali British people (Khan & Jones 2004).

Ideally, midwives should be able to communicate effectively with these women. To give information and gain informed consent, midwives should assess whether a woman has a full understanding of the choices available. This could be impossible when the woman speaks little or no English. The ethical and legal ramifications of not obtaining informed consent from pregnant women are profound. If midwives continue with care, in addition to not respecting the woman's autonomy, they could be deemed to have undertaken a physical assault against the person, particularly when the imposed care may involve intimate examinations (Dimond 2002). It was apparent in my study that most of the women who had had previous engagement with maternity care in the UK did not understand basic maternity procedures or

the choices available to them. This perception was substantiated by the low scores attained by these participants during the pre-knowledge tests of my study, as explained in Chapter 5.

The cultural context of communication is a poorly researched area of health care (Ralstron 1998), yet midwives are instructed to consider this within their daily practice (NMC 2011a). Childbirth is a time when a number of cultural traditions come to the fore. Where dissonance exists between the woman's and the midwife's cultural beliefs about childbirth, one could argue that the foundations of the relationship could be distorted by a lack of common ground. In contrast, Gillon (1994) suggests that a health care worker's background does not influence the concept of cultural common ground because carers adopt, or try to adopt, a culturally neutral approach. A lack of commonality (due to cultural disparity) will, however, influence the type of information that the midwife presents, thus affecting the woman's ability to provide informed consent.

For example, in Somalia, during pregnancy and following childbirth, Somali women often rely on community support for cooking, childcare, advice and other forms of assistance. When a child is born the new mother and baby stay home for forty days, a period known as *afatanbah* (Kemp & Rasbridge 2004, p. 322). Female relatives, friends and neighbours visit the new mother, help to care for her and her baby, and prepare special foods such as porridge and tea. Extended family and friends, especially older Somali women, serve as teachers and providers of emotional and physical support for pregnant Somali women.

This support system (Pavlish et al. 2010) is a significant factor in pregnant Somali women's health and obstetric experiences, because "norms and beliefs concerning illness and therapy are profoundly coded into the lives and minds of sufferers and their kinsmen, friends, and neighbours" (Pavlish et al. 2010, p. 75). An understanding of Somali birth traditions may explain why Somali women book late for antenatal care and show patchy attendance at antenatal appointments. Therefore, a midwife must endeavour to develop an understanding of women's cultural perspectives of the world, because this may directly impact on the choices and decisions made by the women in the midwife's care. If the midwife has little comprehension of a woman's beliefs about childbirth then one could argue that she cannot provide appropriate information that respects the woman's existential autonomy.

When considering the broader context, a society's cultural beliefs will impact on an individual's interpretation of the world. In turn, how society views autonomy will become significant when an individual is faced with making personal decisions. As previously

explained, Somalia is a mainly Muslim society; paternalism is the accepted norm in health care practice (Johnson et al. 2005). Consequently, the importance of respecting a woman's autonomy (from a Western understanding of the term) is not considered relevant because health care practitioners take on the role of decision makers for their clients. Most Somali women would look up to maternity care providers as being superior, and would therefore not value their own ability to make decisions around their care, expecting midwives to take on this role. It is quite likely they do not realise that they can make decisions, as is clearly evident in my study. This demonstrates the different cultural interpretations of the concept of autonomy, and although Gillon (1994) acknowledges that people may want varying degrees of autonomy, this is not placed within a cultural context. Any cultural disparity will have an influence on midwives' ability to gain informed consent for procedures and therefore their acknowledgement of, and respect for, autonomy.

To be able to gain informed consent, midwives (and indeed any other health care professionals) need to engage women fully, understanding their "hopes, fears, physical condition and limits of intellectual understanding" (Gudorf 1994, p.174), employing a language in which the women can interact. Once this is achieved, information can then be tailored to match recipients' needs, thus providing ethically and culturally sensitive care. It can therefore be seen that true informed consent cannot be achieved in a culturally neutral way. If consent is gained in the absence of these conditions, it could be said to have disrespected the ethical principle of autonomy.

3.6.2 Beneficence and non-maleficence

It is generally agreed in health care that professionals should act in a way to do good and not to harm their clients. In relation to caring for pregnant women of Somali origin, it could be argued that if the midwife cannot communicate with a woman, then she cannot assess whether her care is indeed respecting these principles. It is alarming that the most recent Confidential Enquiries into Maternal Deaths (CMACE 2011) demonstrated that women from minority ethnic groups who spoke little or no English were twice as likely to die in childbirth as women whose first language was English. This was because these women could not communicate their needs and therefore the professionals concerned missed important symptoms of life-threatening conditions.

Studies have demonstrated more subtle examples of how communication difficulties can impact on the care women receive. Midwives may also stereotype and categorise women who speak little or no English (Bowler 1993; Davies & Bath 2001; Binder et al. 2012).

Women may be labelled as 'unresponsive, rude and unintelligent', which may lead midwives to hold preconceived expectations of women's behaviour and cultural values (Bowler 1993; Davies & Bath 2001; Binder et al. 2012). Ineffective communication, coupled with a lack of common ground and a poor understanding of cultural issues, will exacerbate this concern. Consequently, an inappropriate demeanour on the part of midwives may lead to women becoming uncooperative, thus consolidating the stereotype (Coker 2001).

For instance, it was normal for women of certain ethnic origins to express their pain in labour vocally. In reality this stereotype could distract midwives from exploring other potential reasons for this behaviour. For example, if a woman was in severe pain but could not communicate this, she would not receive appropriate care and could ultimately suffer in silence. In this situation, midwives' lack of knowledge of cultural issues therefore leads to a failure in respecting the principles of beneficence and non-maleficence. This suggests that it is important to consider the cultural context when applying these principles.

3.6.3 Justice

Although people appear to be treated equally, they can be treated unjustly. An example of this is in accessing health services which are free to everyone in the UK. However, in reality, being able to read and write in the majority language is an important facet in enabling users to learn about and then access health services (Free & McKee 1998). For example, in maternity services, telephone triage is commonly used to access care. Utilisation of such a service demands a reasonable command of the English language, including an understanding of, and ability to communicate with, descriptive words and some medical terminology. Without this, one could argue that these women's rights of access to this service are not being respected met.

Health services may not take into account the cultural needs of people from different ethnic groups (Ahmed 2000). Non-acknowledgement of cultural diversity within communities can exacerbate problems in accessing health services for women whose first language is not English. This is reflected in research that found that non-English-speaking women were deterred from attending cervical screening owing to a lack of understanding about the importance of the test, and not wanting to expose themselves to male doctors for the procedure to be undertaken (Naish et al. 1994). This example is similar to parent education classes provided to pregnant women. Somali females will not attend these classes for several reasons: they are facilitated in English, they may not know that such classes are available, as was evident in the findings of my study, and multiparous women may think that they are only for nulliparous women. Therefore, despite the service being available, women's

rights to access a culturally sensitive service may not be considered important in many instances of health care provision.

Another issue related to justice is the need to evaluate existing services to ensure equity in the quality of care provided to the target population. A legal requirement under the 2001 Race Relations Act Racial Equality Amendment (2000) (Commission for Racial Equality, 2002) is that the standard of care provided for people from minority ethnic groups is equal to that provided to the indigenous population. When establishing a service, it is also necessary to take cultural sensitivity into account.

In the absence of effective communication there is little hope of establishing whether the quality of care provided for pregnant Somali women is of the same standard as that provided to other maternity service users. However, establishing the quality of a service is often judged by the number and type of complaints received, and it is these that can influence enhancements or changes to services. Owing to language barriers, Somali women are unlikely to use the complaints procedure effectively (Neile 1997). It is therefore difficult to ascertain whether they are being treated equally and therefore justly. One of the ways to mitigate inequalities of maternity care is the concept of cultural safety (see Chapter 6 for more information on this concept).

A study by Wissink et al. (2005) found that health care providers' lack of knowledge and understanding of differences in practices, beliefs, preferences and expectations regarding pregnancy and childbirth were a barrier to improving refugee women's care in the United States. Herrel et al. (2004) described perceptions of diminished staff sensitivity to Somali women's individuality, and emphasised that inappropriate care may be the result of racial discrimination and stereotyping. To address the ethical and clinical challenges that arise in providing health care to diverse populations, health care professionals must be aware of, and responsive to, the cultural backgrounds of their patients. Studies in immigrant health, medical anthropology and other disciplines have acknowledged the need for health care providers to be conscious of the cultural diversity of clinical settings (Culhane-Pera et al. 2003; Hirsch 2003; Sobo 2009; Good et al. 2011).

Many phrases have been used to refer to this obligation of health care providers to respond effectively to the cultural perspectives of their patients, the most common being "culturally competent". However, this term has sparked debate among anthropologists who object to the idea that culture is a static entity in which one can be competent. Instead, the use of the

term 'culturally responsive' suggests that health care providers can "respond to pertinent aspects of patients' cultural practices, beliefs, and values in clinical settings and stresses the application of knowledge, skills, and attitudes without requiring that clinicians be 'competent' in other people's cultures" (Culhane-Pera et al. 2003, p.1). Cultural responsiveness thus requires that health care providers possess enough knowledge regarding the beliefs, practices, social organisations and experiences of their patients to be able to ask pertinent questions and interact in an appropriate manner. Anthropological concepts can help providers become 'culturally responsive'.

In terms of obstetric care, culturally responsive care depends on the ability of the maternity care provider to understand the significance of birth in the life experience of each woman, and to understand the cultural context that surrounds birth (Dundek 2006). Cultural competence is not just problematic due to the static, oversimplified concept of culture that the term suggests. Rather, the emphasis on cultural competence "reifies racial and ethnic differences as the key explanatory variable to which we must attend, and reduces the salience of social class factors" (Hirsch 2003, p. 242). Instead of focusing so heavily on culture as the primary challenge in providing appropriate health care to diverse communities, the social organisation of health care support and other factors – including health economy, immigration, demographics and institutional structures – should also be considered as significant determinants of immigrant health.

Anthropological theories argue that patterns of behaviour, attitudes, beliefs and the ways in which people communicate are culturally significant (Harris 1971; Shedlin 1979). In the social roles of women and maternity care providers, the role of the healthcare professional is viewed as complementary to the role of the woman (Scrambler 2003). Just as the woman is expected to cooperate fully with the midwife or obstetrician, the midwife or obstetrician is expected to apply his or her specialist knowledge and skills for the benefit of that woman. This argument identifies the general expectations that guide the behaviour of maternity care providers and women, and shows how these roles facilitate interaction during care consultations, because both parties are aware of how the other is expected to behave (Scrambler 2003). However, this role interaction may be unbalanced when one of the parties lacks understanding of their role. For instance, a newly arrived Somali woman will hold a different view of her role and have different expectations of maternity care, since these roles differ greatly between the UK and Somalia.

There were only a few research papers available that explored healthcare professional's perceptions of their clinical encounters with ethnic minority clients (Widmark et al. 2002; Kamath et al. 2003; Leval et al. 2004). There are no studies available in UK on the midwife's perception of providing maternity care to ethnic minority women. Kamath et al. (2003) argued that at times ethnic minority patients need to accept responsibility for their own care. They also need to take responsibility for failure to comply with advice regarding treatment and prevention (Kamath et al. 2003). My experience, as a midwife, supports this view.

In drawing the above debate to a conclusion, I would advocate strongly that health professionals, especially those with direct care involvement in childbirth, should work at all times to improve education in cross-cultural obstetric care to help prevent potential bias and stereotyping. Similarly, I support the view to give more education to ethnic minority women about maternity care, early health seeking behaviours and prevention of disease, as well as the skills needed to navigate today's complex health care system in the UK so that they may work better in partnership with service providers. However, this will only be achievable if services provide the information in a manner that women can access. Hence, this is one of the issues my study is aiming to address.

With an understanding of the history of Somali women and the ethical impact of maternity care, it is now important to discuss the childbirth issues addressed by the newly developed Somali maternity information DVD.

3.7 Somali cultural/maternity service issues addressed in the DVD

As explained in Chapter 2, the overall framework that underpins this research is rooted in the concept of social marketing. Tripp-Reimer et al. (2001) suggest that the purpose and function of a social marketing approach is to create culturally innovative interventions. The ethos of social marketing is embedded in the requirement to create interventions that are consistent with the shared language, beliefs, value systems and lifestyles of a target audience, while eliminating biases, prejudices and discriminatory practices (Tripp-Reimer et al. 2001). Therefore, conscious efforts were made when designing the DVD not to contravene any Somali cultural values, such as showing nudity. Furthermore, some culturally specific clinical challenges and issues associated with Somali women and childbirth were addressed in the DVD.

Based on evidence and experience from a local maternity unit four key cultural issues related to childbearing Somali women were recognised and these were all addressed in the Somali maternity information DVD. The issues were:

1. The use of interpreters
2. Presence of a male health care professional (doctor/midwife) at the point of care
3. Female genital mutilation (FGM) and the specific service that is available for women who have undergone FGM
4. The need for medical interventions during childbirth, such as induction of labour (IOL) or Caesarean section (C/S)

In addition, there were two other local service issues addressed in the DVD that are pertinent to this group of women: the importance of early booking of antenatal care and the importance of keeping antenatal appointments and general engagement with services

3.7.1 The use of interpreters

A variety of research studies have emphasised the importance of information provision as a useful tool for effective communication and the promotion of good health for women (Green et al. 1990; DH 1993; Davies & Bath 2002; DH 2004; Hodnett et al. 2004; DH 2007a). This is because respect for a woman's wishes, and her involvement in decision-making about matters affecting her pregnancy or health, are essential to her care during childbirth (DH 1993; DH 2007). However, the notion of informed choice and informed consent advocated in the changing childbirth document (DH 2003) may not be applicable to some women from ethnic minority backgrounds. It may be particularly difficult with Somali women where family knowledge is held by all and individual confidentiality is secondary to the family (Kemp & Rasbridge 2004). Furthermore, the permission to access healthcare services is held by the male or female head of the household. Therefore, ability to give or receive informed choice and consent does not solely rest on maternity services but it a collective responsibility on the part of individuals and service providers (Pavlish et al. 2010).

Healthcare organisations in the UK have employed various mechanisms for addressing communication barriers among non-English-speaking clients and patients. The most commonly used methods are professional interpreters, telephone interpreting services, bilingual health workers, friends, family members, untrained volunteers and advocates (Gerrish et al. 2004). However, there have been concerns regarding some of these methods. For instance, the services of a male interpreter, either on the phone or in person, may be

culturally unacceptable for some ethnic minority women; this would certainly be the case in the Somali context (Gerrish et al. 2004; Watt et al. 2004).

Research has also demonstrated that the use of family members can be counterproductive and is not a good measure of quality (Nuefeld et al. 2002; Crisps 2004; Gerrish et al. 2004; Rosenberg et al. 2004). These researchers argue that family members may not necessarily know how to interpret, and poor translation may lead to misunderstandings. Further, the presence of a family member breaches the patient's right to confidentiality and autonomy in decision making. Family interpreters may wittingly or unwittingly distort or misrepresent the information given by or to the patient (Nuefeld et al. 2002; Gerrish et al. 2004; Rosenberg et al. 2007; Lewis 2011).

It is well established in the literature that the use of professional interpreters is a useful tool in health communication for improving the quality of care and patient-provider satisfaction (Jacobs 2001; Green et al. 2005). However, the use of interpreter services has been found in other research to be suboptimal (Davies & Bath 2001; Herrel et al. 2004). Maternity care providers and women both had well-founded reservations about using this service (Davies & Bath 2001; Herrel et al. 2004). In practice, concerns have been raised about placing trust in the ability of the interpreters, in their skill-level as an objective conveyer of maternity information, and in the interpreter's ability to manage medical terms in both languages. Such a lack of trust might strongly suggest that standardised training for medical interpreters is an important and relatively neglected issue to facilitate effective communication with care providers.

Some studies have revealed distrust among Somali women towards the use of unskilled and/or unfamiliar interpreters (Davies & Bath 2001; Herrel et al. 2004). However, in practice the reality is that Somali women would not generally refuse an interpreter as long as that interpreter was a female (Carroll et al. 2007). Where sensitive dialogue is needed, creating the necessary sensitivity between the woman and provider also involves a need to ensure sensitivity by and through the interpreter.

In an emergency situation the availability of trained interpreters may be very limited, since most maternity units in the UK do not operate on-site interpreting services. In such situations, some providers have complained about the extra pressures added to acute situations where the need for an interpreter had not been previously identified. Such time delays have been documented in the literature, and many result in the use of any available

source such as a family member or a member of staff (Hampers & McNulty 2002). Use of health interpreters who are personally known to the patient is also discouraged in the most recent UK Confidential Enquiry into Maternal Deaths (Lewis 2011).

3.7.2. Presence of a male healthcare professional (doctor/midwife) at the point of care

Some Somali women feel that the sharing of gynaecological, pregnancy and birthing information is a highly sensitive matter. Some of these women may feel extremely stressed, emotionally traumatised and disempowered when sharing such information with men other than their partners (Burnett & Fassill 2002; Harper-Bulman & McCourt 2002).

Conceptual barriers that are based on sociocultural factors, such as the influence of gender on a woman's choice of provider, the role of a woman's religious beliefs in her obstetric care decision making and the woman's attitudes toward compliance, all appear to result from misunderstandings in communication (Beine et al. 1995; Carroll, et al. 2007). Across all provider groups, there was an expressed perception that immigrant women prefer female care staff for religious reasons. Their perception is supported, for example, by empirical findings examining prenatal care among Somali women living in the United States (Beine et al. 1995; Carroll, et al. 2007). A study conducted by Urhoma (2009) reiterates the importance of confidentiality, privacy and maintaining dignity while caring for non-English-speaking ethnic minority women. This is because there were certain issues that Somali women considered to be female matters, which they found culturally unacceptable to discuss with a male, even their husbands. This assertion concurs with other studies that encouraged the presence of more female professionals in obstetrics (Crisp 2004; Gerrish 2004; Carolan & Cassar 2007; Lewis 2007). Maternity care consultation by a male professional could prove detrimental because crucial medical information, which the woman may consider to be sensitive, might not be elicited even in the presence of a female interpreter.

In contrast to the above concerns over gender issues, the majority of Somali women who participated in the study carried out by Binder et al. (2011), showed no preference for a female health care professional, instead stating that this factor depended on personal choice. The women in this study explained that the belief that the provider was competent and respectful far outweighed any gender distinction. Some studies argue that the widespread assumption of women's gender preference among health care providers raises a question of whether Somali women's maternity choices are explored or conceptualised as a desire or expectation for quality care (Binder et al. 2011). Barriers relating to social

marginalisation, as presented through such provider perceptions, therefore require further analysis. It has been reported in a study carried out in Bolivia that many Somali women may experience social stereotyping, rather than cultural marginalisation, in the obstetric care setting (Rööst et al. 2009).

The availability of the DVD therefore may promote the willingness of the maternity unit to accommodate such cultural requests; stressing that only as a last resort, in an emergency, would a male doctor be used.

3.7.3. Female genital mutilation

A plethora of articles has been written about female genital mutilation (Perera et al. 2009). It has been reported that 99% of Somali women are Muslims. 98% of all Somali women have undergone female genital mutilation, suggesting that the large majority of Somalis believe that this practice is linked with Islam. The belief that every Muslim woman must be subjected to it is a strong Somali tradition (Sorbye & Leigh 2009). However, it has been argued by Islamic scholars that FGM practice has no religious bearing (Obermeyer 1999; Mackie 1996). FGM is also practiced by other religions and not just only practised by Muslims. Other reasons given for practising FGM are related to tradition and culture, hygienic and aesthetic purposes, the preservation of virginity and the need to control women's sexual desires (Momoh 2005, 2010).

FGM is also sometimes known as 'female genital cutting' or 'female circumcision' or by Somali communities as "sunna" (WHO 2008). Within this thesis I have adopted the term 'FGM' since this is the most commonly used term in the UK, where the practice is considered to constitute child abuse and a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child, it is a violation of the child's right to life and their right to their bodily integrity, as well as their right to health. The UK government has signed a number of international human rights laws against FGM, including the Convention on the Rights of the Child. FGM is practised mainly in twenty-eight African countries and in a few countries in the Middle East, including Yemen and Northern Iraq, Asia, and within certain ethnic groups in Central and South America. With increased immigration, FGM is now being seen in the UK, other EU countries, North America and Australia. This is not only because Somali women, who have undergone FGM, have migrated to these countries, but also because younger women are still undergoing FGM either within their migrant communities or when they return on trips back to their homeland.

This is difficult to justify or quantify as there are no evidence available to support the assertion of current continued FGM practice in the UK.

Between 100 and 140 million girls and women worldwide are estimated to have undergone FGM (WHO 2008). Three million girls in Africa are estimated to be at risk of FGM each year (WHO 2008). It has been estimated that up to 24,000 girls under the age of fifteen are at risk of FGM in the UK (Dorkenoo et al. 2007; Momoh 2005, 2010). Girls are at particular risk of FGM during the school summer holidays. This is the time when families may take their children abroad for the procedure. Many girls may not be aware that they could be at risk of undergoing FGM (Dorkenoo et al. 2007). UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians and Eritreans. In addition, women from non-African communities who are at risk of FGM include those of Yemeni, Kurdish, Indonesian and Pakistani origin (Dorkenoo et al. 2007).

Female genital mutilation has four definitions, depending on the type (UNICEF 2005). Type 1 involves the removal of the prepuce, or outer skin, of the clitoris. Type 2 involves the excision of the clitoris coupled with partial or total removal of the labia minor, the inner folds of the vulva. Type 3 involves the partial or total excision of all of the external female genitalia, followed by stitching intended to narrow the vaginal opening. This category, commonly known as infibulation, represents the most extreme and invasive form of female genital mutilation. Type 4 is labelled "unclassified" and encompasses a range of practices, including cutting, nicking, piercing or burning of the clitoris and surrounding tissue, the stretching of the clitoris and/or labia, and the cutting of or placement of caustic substances into the vagina. Most Somali women who have undergone FGM would have had a type 3 procedure. This category has major childbirth sequalae.

The original notion was that FGM is performed for cultural reasons. No analgesia is commonly given during procedures, and all the three common types of FGM involve the removal of certain parts of the genital organs. The procedure is often carried out with 'kitchen knives, old razor blades, broken glass, and sharp stones' (Denniston et al. 1999). Some of the resulting medical complications include difficulties with urination, incontinence, menstrual problems, sexual dysfunction, and complications with later childbirth, psychological trauma, and even death (Denniston et al. 1999; Momoh 2010). Many women who have undergone the procedure have noted a lack of sexual desire or sexual enjoyment. Dangerous health complications are most likely with infibulation.

Critics of female genital mutilation have initiated a global campaign to eradicate the practice as an abuse of fundamental human rights. These critics highlight the physical pain and damage that is caused to the girls and women who undergo the procedure, in order to make the case that it constitutes a human rights abuse (Denniston et al. 1999; Momoh 2010). A further complication of FGM is the associated high rates of infant and maternal mortality in the Sudan and Somalia, which are attributed to the prevalence of infibulation in these societies (Davis 2001; WHO 2008). These negative consequences of female circumcision, in both physical and emotional terms, impinge on a variety of basic human rights issues, including the right to life, the right to be free from torture, the right to liberty and security of a person, the right to privacy, and the right to enjoy the highest standards of physical and mental health (Davis 2001).

The pain of infibulation (FGM) has been described as a lived bodily experience, an intolerable pain that you never forget, and a heavy burden that you always carry with you (Johansen 2002). A Somali woman was asked why she was opposed to infibulation. She answered that it is pain three times: the pain when the infibulation (FGM) is done, the pain when it has to be opened again at marriage, and the pain when it has to be further opened when giving birth (Johansen 2002).

The revitalisation and association of the embodied pain from infibulation (FGM) during pregnancy and childbirth was also demonstrated in a different study carried out in Canada (Chalmers & Omer-Hashi 2000). This study postulates that healthcare professionals have a lack of awareness of the increased pain caused by the infibulation (FGM). This indicates that pain management is important. The positive effect of epidural analgesia in labour for infibulated women has been described in a study from the USA (Baker et al. 1993). On the other hand, half of the women interviewed in the Canadian study wanted a vaginal delivery without pain relief (Chalmers & Omer-Hashi 2000). However, empowering Somali women through education and information, as described in the Somali information DVD, will help to manage the psychosocial effect of FGM by equipping them with an understanding of the available childbirth pain relief methods. This will relieve their fear and anxiety and control flashback associations between the pain of FGM infibulation and childbirth.

Government policies have supported the prohibition of FGM practice in the UK, such as 'Working Together to Safeguard Children' (HM Government 2006), which sets out the core processes for safeguarding and promoting the welfare of children, and 'What to do if you're

worried a child is being abused' (HM Government 2006), which provides guidance to assist practitioners to work together to safeguard and promote children's welfare.

There is legislation in place to prosecute people involved in the practice of FGM in the UK. The law relating to FGM was amended by the introduction of the Female Genital Mutilation Act 2003, which came into effect in March 2004. This repealed and replaced the Prohibition of Female Circumcision Act 1985. The 2003 Act:

- makes it illegal to practice FGM in the UK
- makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM, whether or not it is lawful in that country
- makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad
- Enforces a penalty of up to fourteen years in prison and/or a fine.

Despite this law, to date no prosecution has been made in the UK, but a recent case is in court, which may lead to the first prosecution (Topping 2014).

With knowledge of FGM and its consequences for childbirth, along with an understanding that many women would have had the procedure before the Act of 2003, it is important that accessible facilities are available to perform a reversal (de-infibulation) during pregnancy or at the point of birth. De-infibulation services are available in the local maternity unit where the Somali maternity information DVD was produced, so FGM de-infibulation services were promoted in the DVD.

3.7.4. The need for medical interventions during childbirth, such as induction of labour (IOL) or Caesarean section (C/S).

Somali women's perspectives regarding waiting for labour to progress correspond to many scholars' critiques of biomedicine's medicalisation of childbirth, which is seen as indicative of increasing power and control of medicine over women's natural place in birth (Martin 1987; Davis-Floyd 1992). Further, because Somali women generally do not anticipate needing a Caesarean section, a provider's sudden recommendation that a woman have an induction of labour or a Caesarean section intensifies the feeling of rushing the birth process.

Many Somali women correctly assume that Caesarean sections eventually limit the number of children a woman can safely bear. Since Caesarean sections involve an incision in the woman's uterus, the risks of uterine rupture increases with each successive Caesarean

section. In Somalia, most women have large families, giving birth to an average of 6.26 children nationally (Central Intelligence Agency 2012). The belief of most Somali women is that "big families are important in Africa." Large families are important to Somali women for a number of reasons: 1) having large families is supported by culture and religious; 2) some Somali women believe that it is the role of Allah to determine the number of children a woman will give birth to; and 3) it was considered that a Caesarean section not only limited the number of future children a woman could bear, but was also seen as intervening in Allah's plan (Straus 2009).

Caesarean sections, just like any other surgical procedure, require a period of recovery time following the operation. However, a pregnant woman is not sick, and unless the Caesarean section is planned, she is neither mentally nor logistically prepared for the recovery period (Borkan 2010). During this time, the mother often experiences pain from the incision and her mobility is inhibited, requiring a cessation of her regular daily activities and responsibilities. Somali women often view their health in terms of their ability to care for their family and home (Carroll et al. 2007), and thus the effect of immobility after a Caesarean section can be especially alarming and make women experience a sense of powerlessness (Carroll et al. 2007).

Ameresekere et al. (2011) explored perceptions about Caesarean delivery and patient-provider communication surrounding female circumcision and childbirth through interviews with Somali women residing in the USA. Interview transcripts were coded and themes identified in an iterative process. The participants in this study were aged 25 to 52 years and had been living in the USA for an average of seven years. All the women had experienced female genital mutilation Five women had undergone a Caesarean delivery. Women feared having a Caesarean because of their perception that it could result in death or disability. Women also indicated that providers in the USA rarely discussed female genital mutilation or how it could affect childbirth experiences. The study concluded that previous experiences and cultural beliefs can affect how Somali immigrant women understand labour and delivery practices in the USA, and may explain why some women are wary of Caesarean delivery. Educating providers and encouraging patient-provider communication about Caesarean delivery and female genital mutilation can ease fears, increase trust, and improve birth experiences for Somali immigrant women in the USA.

The findings of Ameresekere et al. (2011) validated the result from the study by Brown et al. (2010) which found that twenty-five (75%) of the participants expressed an aversion to

Caesarean section, with twenty-two describing worry about, or fear of, Caesarean sections. Four women stated that they were personally afraid of having a Caesarean section and would only have one if it were an emergency. Fourteen of these women responded that women died from Caesarean sections. Three reported that death occurred in Africa, and one stated that death from Caesarean section occurred in both the United States and in Africa.

The influence of religious beliefs was expressed by care providers as a frustration, which was then generalised towards some of the women. For example, Somali women were considered to be difficult to deal with on the basis of perceptions about their adherence to religious tenets when crucial decisions needed to be made (Binder et al. 2012). This was especially the case when Somali women refused medical intervention. In contrast, the women used expressions that supported a fatalistic attitude, driven by submission to God's will, rather than a strict adherence to doctrine.

The reasons why some women may require an induction of labour or have to give birth by Caesarean section are discussed in the DVD. Some clips on what to expect during the procedure are also explained in the DVD. Experience from clinical practice suggests that Somali women usually refuse induction of labour or Caesarean section, sometimes at crucial points when the wellbeing of mother and baby may be compromised. This view was also found in the study conducted by Essén et al. (2011). This study highlights the idea that Somali women's refusal of obstetric interventions, in particular Caesarean section, was rooted in their negative beliefs that C/S is associated with death (Essén et al. 2011; Binder et al. 2012). However, it should be acknowledged that maternity services need to have an agreed approach to addressing these issues. A suggestion may be early discussion during the antenatal period, where professional versus client's childbirth expectations are discussed. This, in effect, will prevent unnecessary delay or stress on both parties when crucial decisions are to be made during labour.

In addition, there were other local and evidence-based service issues addressed in the DVD that are pertinent to this group of women, which may interact with the above highlighted cultural issues. These are discussed below.

3.7.5. The importance of early booking of antenatal care

The importance of early booking was discussed in the DVD, as it was evident from a local audit that 53% of Somali service users were late bookers (Urhoma 2012). It is well documented that one of the implications of late antenatal booking is missed opportunities to

take advantage of antenatal screening tests, which are crucial in detecting foetal abnormalities in the unborn child (Maddocks et al. 2009).

A model (the three delays framework) developed by Thaddeus and Maine (1994) explains women's pre-migration socio-cultural experience and how it can cause delays in health care engagement. The framework was initially developed in response to the low intrinsic value of women's wellbeing represented in contemporary maternal and child health initiatives. The authors aimed to better understand the challenges faced by maternal mortality intervention initiatives in low-income, high-mortality African settings. The social determinants identified in the framework, including both socioeconomic and socio-cultural factors, were supported by a literature review that encompassed a wider base of evidence than just isolated medical factors. The three phases are posited by the authors as viable across all income contexts.

The three delays framework assumes a lack of timely and adequate care to be the foundation of maternal death in developing countries such as Somalia, but it does not generalise the problem by blaming women for delays in seeking care. It focuses on three points (phases) of potential delay for the timeframe between a woman's first suspicion of an obstetric problem and its outcome. The chronological order is emphasised: the decision to seek care (Phase 1), where delays mainly result from either perceived or actual barriers that create disincentives to act; the infrastructure involved in reaching a medical facility (Phase 2), where delays can result from actual barriers of cost and transportation in the form of inadequate ambulance and road systems; and finally, the receipt of appropriate and adequate treatment (Phase 3), where delays result from actual barriers at the care facility, such as the lack of skilled birth attendants, technological equipment and medical supplies.

Avoiding delays relies on overcoming both perceived and actual barriers. Disincentives in Phase 1 might result from having to negotiate with a partner involved in decision-making, or from a woman's low social status. These issues may influence her ability to judge the severity of a complication in relation to whether an appropriate care facility is accessible. Perceived barriers from negative expectations rely on a woman's prior experience or those of others close to her. Actual barriers in the African setting are obvious for each phase: 1) the local economic environment can hinder a woman's ability to act; 2) long geographic distances and poor infrastructure make it difficult to reach a health facility; and 3) resources for optimal care may be limited or non-existent.

The need to gain timely access to facility-based care was made implicit in the first and second phases. Overcoming an adverse complication therefore presumes a facility-based solution, which appears to be the component referred to by Thaddeus and Maine (1994) as the most applicable across income settings. In the original, low-income scenario, access to a healthcare facility means overcoming delays to timely care for an obstetric emergency within a rural setting, where home birth is the norm. We conceptualise overcoming a complication in an urban scenario, where facility-based care and childbirth are universal norms, and where the type of facility sought depends on the type of maternal care required (emergency or non-emergency).

In applying Thaddeus and Maine's (1994) model to the UK maternity care scenario, one can assert that Phases 2 and 3, as illustrated above, may not be delay points for Somali women in the UK. However, the point raised by Thaddeus and Maine (1994) about Phase 1 may affect any Somali women, irrespective of where they live, since it involves knowledge, decision making and judgement. Where there is an error of judgement on the severity of clinical symptoms, or a lack of knowledge about the need to access care, this will eventually result in poor decision making about the need to seek early intervention. Furthermore, misconceptions at this phase have a role to play, since some cultures believe that pregnancy is not be announced until after twelve weeks of gestation, which therefore causes delays in the early booking of antenatal care. Consequently, women miss crucial antenatal screening tests. The importance of early booking is reinforced in the Somali maternity information DVD.

3.7.6. The importance of keeping antenatal appointments and general engagement with services

National and local evidence indicates that Somali women are habitual non-attenders of antenatal appointments (Betancourt et al. 2003; Lewis 2007, 2011; Urhoma 2012).

Straus (2009) reported that many Somali women commented that when they had been pregnant in Somalia they would have seen only one person for their maternity care throughout their whole pregnancy and birth. In rural areas and small towns this is likely to have been a traditional birth attendant. In some cases they may have attended an established government health centre, with a trained public midwife. However, even in larger towns or cities, where hospital maternity services are available, women often elect to have home births with a midwife or traditional birth attendant. This may explain the lack of engagement with health care services from Somali women, once they are in the UK.

Straus (2009) also highlighted non-compliance as a recurrent issue identified between Somali women and their providers. Somali women were particularly described across all providers as noncompliant, with the suggestion that these women lacked trust in the information conveyed to them. Given the basic language-based problems experienced by these women, further investigation about whether compliance behaviours are the outcome of language deficiencies could be interesting. This group of women are most likely to rely on using passive language and expressions and might also be most susceptible to pervasive cultural ideas about supernatural influences and docile behaviours in relation to childbirth (Kim et al. 2003). Therefore, there is a need for information to help these women to question preconceived culturally-influenced childbirth ideas.

Women from these groups are sometimes described as hard to reach because of their lack of adherence to regular contact with health professionals (Chesney 2005). However, it is evident from studies that a lack of knowledge and understanding of the need for continuous contact during antenatal care, as well as ignorance about the benefits for both mother and child, may be reasons for this high antenatal default rate. This finding strengthens the need for the production of the maternity information DVD in Somali. In effect, it is envisaged that the DVD will increase the non-English-speaking Somali women's knowledge of the importance of accessing maternity care early, in order to avail themselves of options for care. This is in line with recommendations made in the most recent *Saving Mothers' Lives* report (Lewis 2007, 2011).

Hence, the importance of engagement and attendance at routine antenatal appointments is strongly emphasised in the DVD. The usefulness and appropriateness of a DVD as a tool to deliver health information, impart knowledge and influence behavioural change (improving engagement) is discussed in detail in Chapters 5 and 6.

3.8 Summary

This chapter has provided background information to the development of the Somali maternity information DVD. The next chapter describes the pre-testing of a native language maternity information DVD for non-English-speaking Somali women.

Chapter 4

Method for Pre-testing the Somali Maternity Information DVD

4.1. Introduction

As discussed in Chapter 2, the theoretical framework for this project is based on the principles of social marketing.

Therefore, chapter describes the pre-testing of the DVD, which is in line with Phase 5b of Neiger & Thackeray's Social Marketing SMART model explained in Chapter 2 (Neiger & Thackeray 2002). Therefore, the knowledge change, acceptability and usefulness of a maternity information DVD specifically developed for Somali women were explored using a mixed data collection method.

The choice of this approach was supported by the need to capture the participants' feedback on the maternity information DVD and to evaluate their knowledge before and after viewing the DVD. This encompassed both qualitative and quantitative methods. Other research approaches were considered such as a mixed-methods study and a randomised controlled trial. It was decided that a social marketing approach would fit with the objectives of this study as it encourages active involvement of Somali women to articulate their views about the newly developed Somali Maternity Information DVD. As previously mentioned in chapter 2 this is a pre-test study and thus no comparison group was sought. Larger scale of research will be needed to substantiate the findings of this study – this may be achieved in the future through an RCT.

4.2 Setting

The setting for this study was an NHS maternity unit with two antenatal clinic sites (site A and site B), in an area in London with a large ethnic population.

4.3 Ethics consideration and approval

Ethical approval was obtained (as the study involved human subjects) from the relevant Research Ethics Committee (REC), and research and development approval was obtained from the NHS Trust's Research and Development Committee in the hospital where the study took place (as the research was done in the NHS). An Integrated Research Application System (IRAS) form was completed and submitted online with the consequent generation of a Research Ethics Committee (REC) reference number. This, together with the required documentation, was submitted to the relevant ethics committee. A favourable ethical opinion

and approval were received from the Proportionate Review Sub-committee of the NRES within five days of submission of the IRAS form, and approval was granted during the meeting (see Appendix 13).

One of the ethical principles of a research project that requires seeking information from patients is that those who voluntarily provide information should be afforded confidentiality and anonymity as appropriate. In addition, their participation should not harm them in any respect (Beauchamp & Childress 2001; Polit & Beck 2006). Good Clinical Practice (GCP) is an international ethical and scientific quality standard for designing, conducting, recording and reporting studies that involve the participation of human subjects. Therefore, this study was conducted in compliance with GCP and applicable United Kingdom regulations. I ensured that the rights, safety and wellbeing of the study participants were protected in a manner consistent with the ethical principles – respect for autonomy, beneficence and justice (Beauchamp et al. 2008) – which have their origin in the Declaration of Helsinki.

Thus, the privacy and confidentiality of the participants were respected. Informed written consent was obtained from the participants by the interpreter reading the consent form to the participants that could not read in Somali (see Appendices 9a & 9b) before the commencement of data collection. Participants were informed that their names and any other identifying information would be removed from the transcripts. Each participant was allocated a number. I maintained a log of all participants who signed the informed consent form. The original signed informed consent forms were retained in the study's documentation files. The interpreters used during the study were also required to sign a statement of agreement (see Appendix 12) to maintain the confidentiality of the information supplied by the participants and ensure their anonymity. Participants were also informed that transcripts would only be seen by me and my supervisors, if required. The participants were informed that they were free to withdraw from the study at any stage without prejudice to their subsequent maternity care. Kavanagh and Ayres (1998) stressed the importance of assessing the participants for signs of distress during an interview on sensitive topics, and identifying strategies for minimising discomfort. Thus, debriefing sessions were offered to women at the end of each interview to allow them to reflect and ask questions. Provision was made to refer any woman, should there be a need, to the maternity debriefing counsellor as recommended by Robinson (2000). However, none of the participants showed any need for referral.

4.4 Access

Access and permission to conduct research was requested from the Head of Midwifery after obtaining ethics approval for the study. Gatekeepers controlled the flow of interaction within the setting (Burgess 1997). Hence, I set up meetings with the midwife at the Africa Well Women Clinic (AWWC), who also speaks Somali, to formally brief her about the project. The AWWC midwife watched the Somali maternity information DVD for quality assurance purposes, and to prepare her for possible questions that the participants may ask about the DVD, before the commencement of the study. A critical reflection on the role of the study interpreter is presented in chapter 7.

4.5 Recruitment

The participants were recruited via a variety of strategies, from the antenatal clinics on both sites of the hospital, the antenatal ward, from triage, and the majority from the Africa Well Women Clinic located in the antenatal clinics of one Trust. The Africa Well Women Clinic (AWWC) was purposefully established for Somali women, in order to mitigate poor engagement with the maternity services.

A recruitment information sheet (see Appendix 3) was distributed to midwives on the two maternity sites to raise awareness of the project. The AWWC midwife, who acted as the main gatekeeper, issued the English or Somali written study information sheet (see Appendices 4a and 4b) to potential participants (the content of the information sheet was also available on a CD in an audio format for women who cannot read). The AWWC midwife subsequently collected the contact details of interested individuals.

I contacted those who agreed to participate, and who fulfilled the inclusion criteria, via the AWWC midwife, who also acted as an interpreter (bilingual) and mailed the study information leaflet (in both English and Somali) to all the women. This gave them a better understanding of the study before the initial meeting. Furthermore, the women would have the information to hand if family or other health professionals wished to see it or discuss the study with them. A date was negotiated with them during their routine antenatal care visits to discuss the study. The participants signed informed consent forms (Appendices 9a and 9b) to indicate their agreement to voluntary participation during the first meeting. In addition, following consent, each of the women was given an administered questionnaire to complete as a pre-DVD knowledge test. They were then given the DVD to watch. A second date was set for the post-DVD knowledge test.

The participants in the study received care similar to other maternity service users. This included routine antenatal care depending on their care pathway, labour management and routine postnatal care. The only difference between the participants in the study and other Somali women using the maternity services was that the participants had access to more childbirth related information via the DVD.

4.6 Sampling

Purposive sampling is a specialised form of non-probability sampling that is typically used for targeted qualitative research (Domholdt 2005). This method of sampling selects individuals for study participation based on their particular knowledge, or experience of a phenomenon, for the purpose of sharing that knowledge (Speziale & Carpenter 2007; Polit & Beck 2008). This type of sampling is applicable also to social marketing. Patton (1990, 2002) stated that: "the logic and power of purposive sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those cases from which one can learn a great deal about issues of central importance to the purpose of the research" (Patton 1990, cited in Speziale and Carpenter 2007, p. 94).

In purposive sampling, several strategies have been identified (Patton 2002). Patton's classification shows the kind of diverse strategies that qualitative researchers have adopted to meet the conceptual and substantive needs of their research: maximum variation sampling, homogeneous sampling, extreme case sampling, intensity sampling, typical case sampling, critical case sampling, criterion sampling, theory-based sampling, and sampling confirmation and disconfirmation (Patton 2002; Polit & Beck 2008, pp. 355–356). I decided to use criterion purposive sampling in this research project to recruit participants who met the inclusion criteria, since, as mentioned earlier, a targeted audience is important in social marketing.

4.7 Sample size

In addition to deciding how to select the sample for the qualitative and quantitative components of a study, it was important to determine the appropriate sample size. The choice of sample size is as important as the choice of sampling scheme, because it also determines the extent to which the researcher can make statistical and/or analytic generalisations (Onwuegbuzie & Collins 2007). Unfortunately, as has been the case with many sampling schemes, discussion of sample size considerations has tended to be dichotomised, with small samples being associated with qualitative research and large samples being linked to quantitative studies (Srinivasan 2004; Onwuegbuzie & Collins

2007). However, small samples can be used in quantitative research that represents exploratory research or basic research. In fact, single-subject designs, which routinely utilise quantitative approaches, are characterised by small samples. Conversely, qualitative research can utilise large samples, as in the case of programme evaluation research and the describing of a lived phenomenon (Onwuegbuzie & Collins 2007). Moreover, to associate qualitative data analyses with small samples is to ignore the growing body of literature in the area of text mining, the process of analysing naturally occurring text in order to discover and capture semantic information (Del Rio et al. 2002; Powis & Cairns 2003; Srinivasan 2004). All of these concerns are important when thinking about social marketing projects.

Therefore, some of my concerns during the course of this study in relation to the sample size were:

- Some participants may voluntarily withdraw from the study at any time
- Some of the participants may relocate without notice due to the high mobility status of the study population

As a result of the above potential concerns, and due to the fear of high attrition rates, I planned to recruit twenty Somali women. It should be noted that Davies and Bath (2001) used only thirteen Somali women in their study and were able to obtain useful data.

Furthermore, the size of the sample should be informed primarily by the research objective, the research question(s) and subsequently, the research design (Onwuegbuzie & Collins 2007). As Sandelowski (1995) stated, "a common misconception about sampling in qualitative research is that numbers are unimportant in ensuring the adequacy of a sampling strategy" (p. 179). In general, sample sizes in qualitative research should not be so small as to make it difficult to achieve data saturation, theoretical saturation, or informational redundancy (Sandelowski 2001). At the same time, the sample should not be so large that it is difficult to undertake a deep, case-oriented analysis (Sandelowski 2001). Hence, a sample of 15 was also deemed appropriate for the pre-testing of an intervention in this social marketing study. In addition, on a more practical note, Somali women are a relatively small group within the study location and they are hard to reach; therefore a conscious effort was made to be realistic with the sample size while considering the time frame of this study.

4.8 Inclusion criteria

The initial inclusion criteria were set as follows:

- The women must have no English speaking ability

- They must live within the borough of the project
- They must be pregnant (twenty-five to thirty-two weeks gestation). This group was selected because the women would have passed the viability point of twenty-four weeks
- However, due to women of a gestational age of more than thirty-two weeks requesting to participate in the study, the ethics committee was contacted and an amendment was made to the inclusion criteria. The gestational age was increased to all women who were at least twenty-five weeks pregnant.

4.9 Exclusion criteria

The exclusion criteria were set using guidance from NICE's (2010) pregnancy and complex social factors clinical guidelines. Therefore, women who were at less than twenty-five weeks gestation, experiencing additional vulnerability or who had complex health issues such as previous miscarriages, still births, neonatal deaths, mental health problems or severe maternal ill-health, were excluded from the study.

4.10 Data collection methods

Data was collected by the following processes:
- Knowledge tests (administered questionnaire)
- Semi-structured interviews.

4.10.1 Knowledge tests

Two sets of knowledge tests were planned. Administration of the first knowledge test questions was carried out during routine antenatal care, as agreed by the participants. Post DVD tests were carried out in person or by telephone based on participant's preference. The majority of the testing was done in person during routine antenatal visits. The knowledge test questions were developed using the *Pregnancy Book* (DH 2007c, 2009c) and NICE (2007) *Care of Healthy Women and their Babies during Childbirth* guidelines.

4.10.2 Pre-DVD knowledge test: this involved testing the participants' knowledge of some basic maternity care procedures that any pregnant women would be expected to know; procedures which are addressed in the DVD as well as in the national pregnancy booklet (DH 2007c) (see Appendix 6 for the pre-DVD knowledge test questions). The knowledge tests were carried out by the Somali-speaking midwife interpreter, who asked the women specific questions from the questionnaire at twenty-five weeks or more gestational age. The purpose of the pre-DVD knowledge test was to gather baseline data and to evaluate the

participants' level of understanding of maternity care. This process lasted ten to fifteen minutes each time. Thereafter, the maternity information DVD was given to the women to watch. In addition, socio-demographic data were also collected from the participants at this stage (see Chapter 5 for the participant's socio-demographic details).

4.10.3 Post-DVD knowledge test: The post-DVD knowledge test (see Appendix 7) was performed at the next antenatal visit (1-3 weeks) after watching the DVD, and constituted exactly the same questions as the pre-DVD knowledge test. This facilitated an evaluation of the degree of improvement in the women's knowledge of what to expect during childbirth. (See scoring technique in chapter 5 and appendices 6 & 7).

4.10.4 Interviews

In order to gain more detailed feedback from participants about the acceptability and usefulness of the DVD, and to complement the knowledge test questions, semi-structured interviews were conducted during the postnatal period within four to six weeks of birth. These interviews also helped to understand participants' perceptions of the impact of the maternity information on their childbirth experience, and to find out if they had any recommendations for changes to any aspect of the DVD.

This stage was crucial, as it suggested what impact the DVD had on the Somali women and provided the possibility of noting any immediate or future changes of behaviour, expressed by the participants, as a result of watching the DVD. Field and Morse (1985) recommend an hour for each interview, even though the length of the interview depends on the informant. In this study, the average interview time was thirty minutes. I ensured that I went through the interview guide and all questions in the interview schedule were explored (see appendix 8 for the interview schedule). Interviews were audio recorded with the permission of the participants, and in line with principles of respect for anonymity.

I conducted the interviews with a Somali interpreter translating the questions and immediately reporting back the response from the participant to me, in English. All the postnatal interviews took place at the participants' homes because the women were all within four to six weeks of having given birth. There were times during the interviews when the participant's baby would start crying or the interview situation would encounter interruptions by other siblings. On such occasions, the interviews were stopped until the participants were ready and able to carry on. A reflection of my contribution to the study is detailed in chapter 7.

4.11 Pilot work

The knowledge test and interview questions were reviewed with the AWWC midwife and then used with a Somali woman, prior to the commencement of the data collection process, as a pilot. This was necessary to maximise the appropriateness of the wording and the processes involved in carrying out the study with this group of women (Polit & Beck 2008). However, no changes were made to either the knowledge test or the interview questions.

4.12 Data analysis

4.12.1 Knowledge test

Quantitative data from the participants' knowledge test questionnaires were collated and entered into an Excel database. Results were presented as descriptive data. Statistical support was provided by the University of Southampton. It was agreed that statistical tests could not be used for this study as the sample size is relatively small. Twenty-six pre-DVD and fifteen post-DVD knowledge tests were done. Although, the findings in chapter 5 focus only on those women who completed both pre and post knowledge tests, it is worth mentioning that all 26 women had poor pre-knowledge test scores (Scores in appendix 5).

4.12.2 Interview data

Out of the fifteen participants who completed knowledge tests (pre- and post-DVD), fourteen postnatal interviews were conducted; one participant was excluded because of postnatal mental illness. All the English components of the interviews were transcribed verbatim by me soon after the interview to avoid gaps in recall. Holloway and Wheeler (2002) encourage transcription by the researcher themselves, as this helps to achieve immersion in the data. Personally transcribing the tapes also ensured the confidentiality agreed with the participants.

A thematic approach (Cormack 1997; Silverman 2005) was used to analyse the data after reading and rereading the transcripts. Audio records were transcribed verbatim onto a computer using Microsoft Word and later analysed manually and categorised. A file and block approach was used to analyse the data retrieved from the interviews. The process commenced with segmentation of key statements made by the participants, data which were later put into categories guided by the objectives of the study. Key words such as knowledge change, benefits, acceptability, cultural/behavioural change, appropriateness and usefulness were used to facilitate categorisation. This made comparison of trends and patterns, within and across categories, easier to navigate. Ultimately these categories were clustered into a number of themes.

4.13 Data management and storage

All knowledge tests, transcripts and analysis are void of any information that identifies participants. All the original data used for the study is kept in a safe that is inaccessible to unauthorised persons. The knowledge tests, digital tape recordings and transcripts will be kept for ten years and will be deleted, or destroyed afterwards, according to the University of Southampton Research Integrity and Academic Conduct Policy (University of Southampton 2011). All the data collection, utilisation and retention procedures adhere to the Data Protection Act, 1998.

4.14 Study Quality Assurance - Trustworthiness

The quality assurance process, in terms of the quantitative data, is transparent and robust as all the participants were scored based on the same questions and scoring technique. Steps to ensure the rigour of the whole process were taken, using the four criteria for establishing the trustworthiness of qualitative studies suggested by Lincoln and Guba (1985). The criteria are: credibility (confidence in the truth of the data), dependability (data stability over time and over conditions), conformability (objectivity or neutrality of data) and transferability (extent to which findings from the data can be transferred to other groups or settings).

Methods used to strengthen data credibility included audio recording of interviews, which were later transcribed verbatim. Field notes were also taken. Participants were adequately described. Patton (2002) suggested that in order to ensure research credibility, the researcher should report any personal and professional information that may have negatively or positively affected data collection, data analysis and/or interpretation – this is also important in social marketing projects. As an African interviewing black people, the researcher was aware that it would be possible for data collection to be influenced both by the issue of self-identity and by the participants' perceptions of her and their common identities; therefore I remained aware of this potential at all points throughout the process.

To ensure conformability, the transcripts have been kept to enable an independent auditor to be able to come to conclusions about the data. Transferability was assured by providing a detailed description of the processes encountered during the study. Rigour and validity were also ensured via the concept of external validity, by showing some of the transcripts to the interpreter to confirm the account of the interview.

On the issue of data stability, the data obtained from both the quantitative and qualitative methods can be replicated, as the information provided by the participants at the interviews

and during the knowledge tests was not unique to individuals because of similarities in the responses. Therefore they may be replicated by other groups of similar Somali women.

One way of enhancing the trustworthiness of the qualitative study was to invite another PhD researcher, a senior lecturer, together with my supervisor, to examine the audit trail pertaining to key decisions made during the research process, and to validate the accuracy of my research account. The decisions about data collection and data analysis were reviewed with the supervisor and also discussed with two other PhD colleagues during the course of this study. With suggestions put forward by supervisors and colleagues, identified points of difference were discussed, confirmed and resolved. Furthermore, the reliability of the categories developed during the data analysis was reviewed with the supervisors. Using this method, the results were found to be reliable by the independent readers.

My two supervisors, who have had significant experience with this type of research and are familiar with applying qualitative coding procedures, discussed the analysis with me during supervision: they both agreed with the coding and the categorisation used in the data analysis. Finally, the validity of the research findings was further enhanced by checking the accuracy of the interview transcripts with 2 of the interviewees via a telephone conversation with the AWWC Somali midwife, allowing them to offer their feedback on their transcript. I would have conducted more checks of the transcripts if discrepancies had been identified in these 2 cases. However, they both agreed that the transcription was a reflection of their discussion during the interview. In addition, the section on findings was given to the interpreter, who participated throughout the study and also validated the accuracy of the findings.

4.15 Summary

This chapter has explained the process used in collecting and analysing data for phase 5b - pre-testing, of the social marketing SMART model. The use of mixed data collection methods, as described above, generated numerical and qualitative data which are presented in Chapter 5.

Chapter 5
Findings

5.1 Introduction

This chapter presents the findings of the demographic questions, quantitative knowledge tests and the qualitative (postnatal) interviews. Recruitment of the participants commenced in May 2012 and the data collection was completed in January 2013. Thirty-eight Somali women, who fulfilled the inclusion criteria, were approached to take part in the study. In total, twenty-six (68%) of the women were recruited and did the pre-knowledge tests; however, only 15 completed the post-knowledge tests. Finally, fourteen participants took part in the pre and post knowledge tests and the postnatal interview, as one participant was later excluded from the project due to one of the exclusion criteria set out in chapter 4. The reasons given by the eleven (42%) women who did not complete the post-DVD knowledge test were: premature delivery (two women), lack of time (four women), fasting (three women- see more details on impact of fasting in chapter 7) and pregnancy complications (two women).

Figure 5.1 Recruitment process and outcome

Women meeting the criteria asked to participate in study (N=38)

Reasons given for not participating:
- **No reason**
- **Not Interested**

Women who agreed and completed pre DVD test (N=26)

Reasons for no post DVD test:
- **Premature delivery**
- **Lack of time**
- **Ramadan (fasting)**
- **Pregnancy complications**

Women who completed post DVD test (N=15)

Reason for no interview:
- **Maternal mental health issue**

Women who provide interview data (N=14)

5.2 Socio-demographic data of the participants

All the participants had little or no English-speaking abilities. The socio-demographic characteristics of the 26 women who completed the study are summarised in Table 5.1 below.

Table 5.1 Characteristics of women who participated in pre and post knowledge tests

Demographical Data							
Participant	Age	Occupation	Source of income	Marital status	Mode of delivery	Parity at the time of recruitment	Gestation at booking
1.	19	Student	Student loan	Married	Emcs	P0	10
2.	29	Student	Benefits	Married	SVD	P0	9
3.	39	Unemployed	Benefits	Married	Elcs	P4	10
4.	35	Student	Benefits	Separated	Emcs	P3	23
5.	26	Unemployed	Benefits	Separated	SVD	P2	10
6.	27	Domestic assistant	Self-funding	Married	Kiwi cup	P0	12
7.	30	Unemployed	Benefits	Single	SVD	P1	9
8.	31	Unemployed	Benefits	Married	SVD	P4	23
9.	42	Unemployed	Benefits	Married	Emcs	P5	11
10.	33	Unemployed	Benefits	Married	SVD	P5	21
11.	27	Unemployed	Benefits	Married	Emcs	P2	12
12.	30	Student	Benefits	Married	SVD	P1	9
13.	23	Unemployed	Benefit	Married	Emcs	P0	9
14.	37	Unemployed	Benefits	Single	Emcs	P0	17
15.	32	Unemployed	Benefit	Married	SVD	P2	36
16.	22	Unemployed	Benefits	Single	SVD	P1	10
17.	21	Student	Student loan	Married	Emcs	P0	10
18.	27	Unemployed	Husband	Married	Elcs	P1	12
19.	32	Unemployed	Husband	Married	SVD	P2	10
20.	34	Unemployed	Husband	Married	Emcs	P6	14
21.	29	Domestic assistant	Self-funding	Married	SVD	P0	16
22.	34	Unemployed	Husband	Married	SVD	P7	9
23.	41	Unemployed	Benefit	Married	Emcs	P10	19
24.	31	Carer	Self-funding	Single	Emcs	P0	12
25.	30	Unemployed	Benefit	Single	Elcs	P0	13
26.	41	Unemployed	Benefit	Married	SVD	P10	16

Key

SVD- Spontaneous Vaginal Delivery
Emcs- Emergency Caesarean Section
Elcs- Elective Caesarean Section

The age of the participants ranged between 19 years and 42 years. Four of the participants, identified themselves as students but spoke very little English, it is difficult to comment on their literacy level as this was not explored at the time of the study. Nine of the participants were first-time mothers, while others had had one or more babies at the point of recruitment to this study. The age range of the first time mothers ranged between 19 and 37 years which is comparable to child bearing age in England (Royal College of Obstetrics and Gynaecology 2013). Eighteen (69%) of the twenty six participants were unemployed and seventeen (65%) acknowledged that their main source of income was state benefits. The majority of the participants were married (nineteen, 73%), while others were either single or separated. The women's booking gestation ranged from nine to thirty-six weeks pregnant with ten (39%) of the women booked late. This confirms the assertion from other studies that Somali women tend to book antenatal care late. Thirteen (50%) of the participants gave birth to their babies through Caesarean section, which is very high compared to the UK national average of 25% (Royal College of Obstetrics and Gynaecology 2013). The sample is too small to draw any conclusions from stratifying the group by age or parity, as Table 5.1 shows variation within the group in terms of age and parity. Stratification may be considered in any larger subsequent study.

5.3 Findings from knowledge tests

5.3.1 Introduction
All the initial 26 participants completed the pre-DVD knowledge test; however, only fifteen (58%) completed both the pre- and post-DVD knowledge tests. The scoring technique and results of the 15 women who completed the pre and post knowledge tests are presented below for each question (see appendix 5 for pre-knowledge test results for the remaining 11 participants that did not complete the post-knowledge tests).

5.3.2 Knowledge tests scoring technique
The participants were asked ten questions focused as follows: antenatal care (six questions), intra-partum care (two questions) and postnatal care (two questions). The questions were asked by the AWWC midwife in Somali, and after translation the answers given by the participants were written in English by the AWWC midwife. The questions were the same before and after watching the maternity information DVD. Each question was allocated a score of one point (see appendices 6 and 7). A definitive answer sheet was used for all the participants. If all the items on each answer list were given correctly by the participant, she was given a full point for the question, but if she provided over half but not all

of the required answer, she was awarded half a point. For less than half the answer, the score given was zero (see results below).

Q1. At how many weeks of pregnancy do you need to register your antenatal care?

The participants were asked when they needed to book their antenatal care. Before watching the DVD, twelve (80%) of the fifteen women felt they should book their antenatal care immediately after missing their menstruation within the first ten weeks of pregnancy, as shown in Figure 5.2. below. The three participants who scored zero points said during the pre-DVD knowledge test that they should register for antenatal care after three months of pregnancy. However, the post-DVD knowledge test result showed that all the participants knew they should book their antenatal care as soon as they were aware of their pregnancy, and preferably within the first ten weeks of pregnancy. However, in reality only 7(47%) booked their antenatal care within 10 weeks of pregnancy, as highlighted in the booking gestation data in Table 5.1 above. This finding demonstrates that 5 of the participants despite having the knowledge of the need for early antenatal booking actually booked late. All the participants were recruited between 25-32 weeks gestation as stated in the inclusion criteria in chapter 4.

Figure 5.2: Results for Question 1
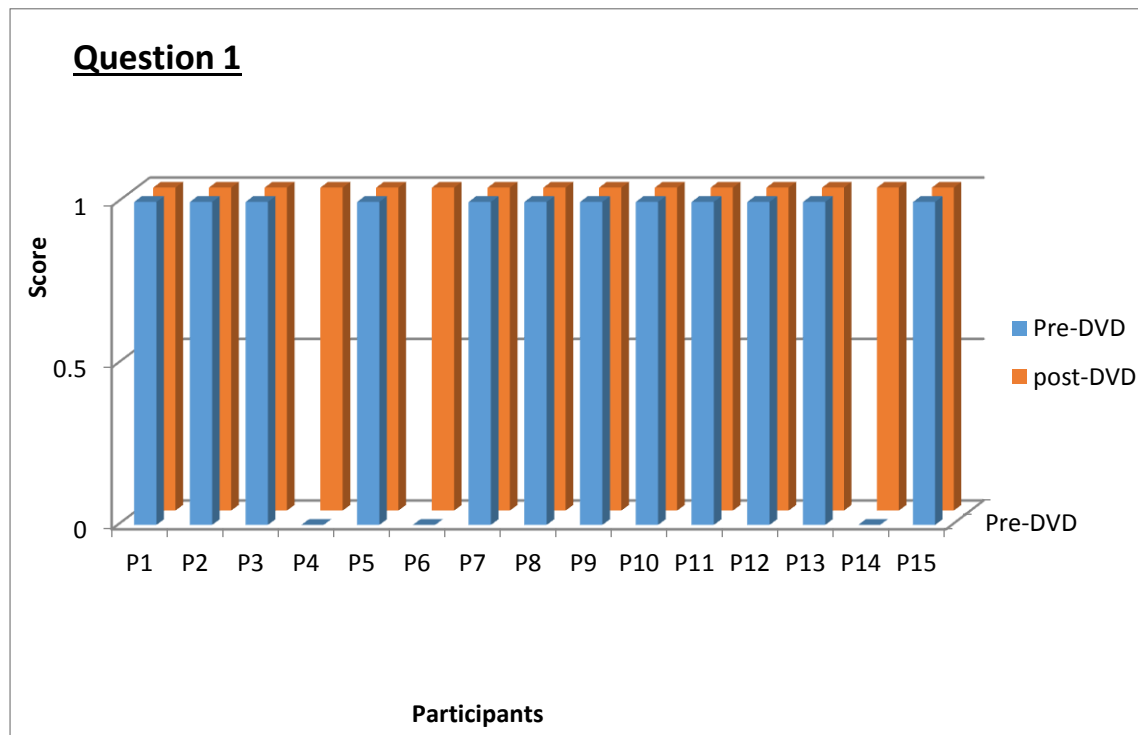
Q2. How will you contact your midwife directly to book your antenatal care when pregnant?

The participants were asked if they knew how to contact their midwife directly to book antenatal care. Figure 5.3 indicated that during the pre-DVD phase, none of the participants knew that they could self-refer to the midwife to book their antenatal care, without going through their GP. The participants' knowledge significantly improved after watching the Somali maternity information DVD, since all (100%) of the participants answered the question correctly during the post-DVD knowledge test.

Figure 5.3: Results for Question 2
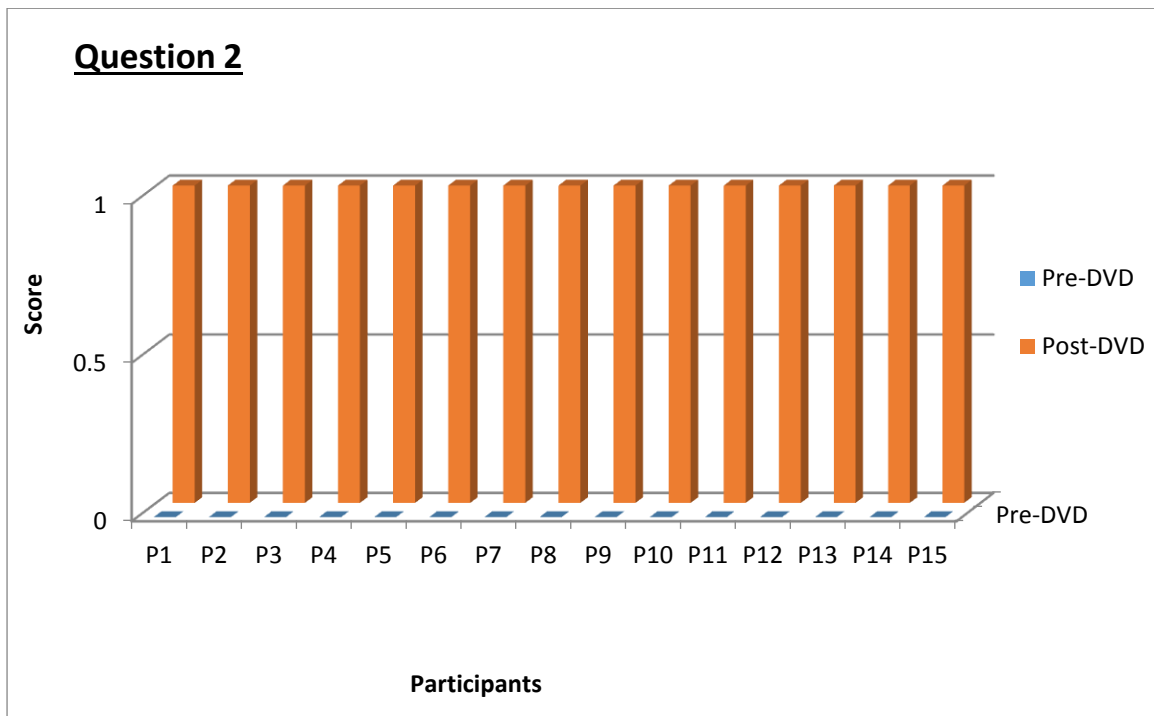
Q3. What educational sessions will you attend if you need more information about pain relief methods in labour?

As shown in Figure 5.4 below, only one of the participants knew about the existence of antenatal classes during the pre-DVD knowledge test. However, this changed significantly during the post-DVD knowledge test, when twelve (80%) of the participants answered the question correctly. However, three (20%) could not remember.

Figure 5.4: Results for Question 3
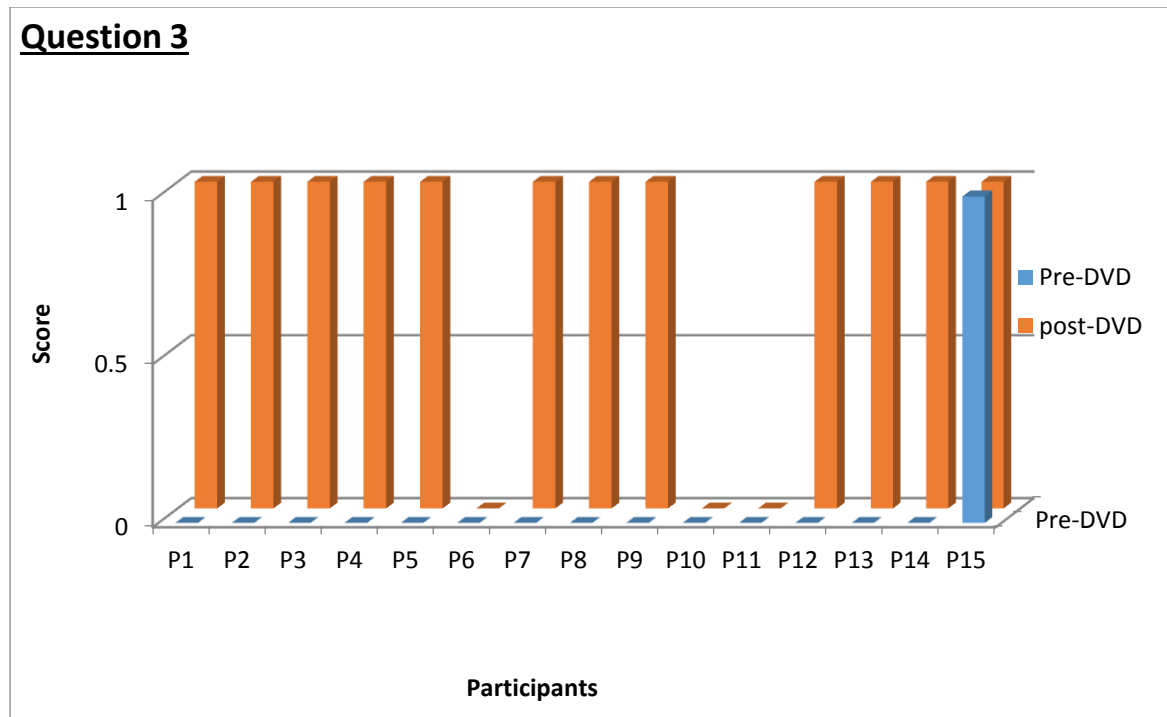
In addition, the review of the attendance records of the parent education classes of the maternity unit used for this study indicates that none of the women in my study attended antenatal classes. This is not unusual, but in defence of the Somali women, these classes are delivered in English, therefore, language may be one of the reasons for non-attendance.

Q4. What is the importance of vitamin D to your pregnancy?

Figure 5.5 shows that only one of the participants knew about the importance of vitamin D to her pregnancy during both the pre- and post-DVD knowledge tests. The number increased to a total of eleven (73%) during the post-DVD test, although four (27%) did not know the importance of vitamin D either before or after watching the DVD.

Figure 5.5: Results for Question 4
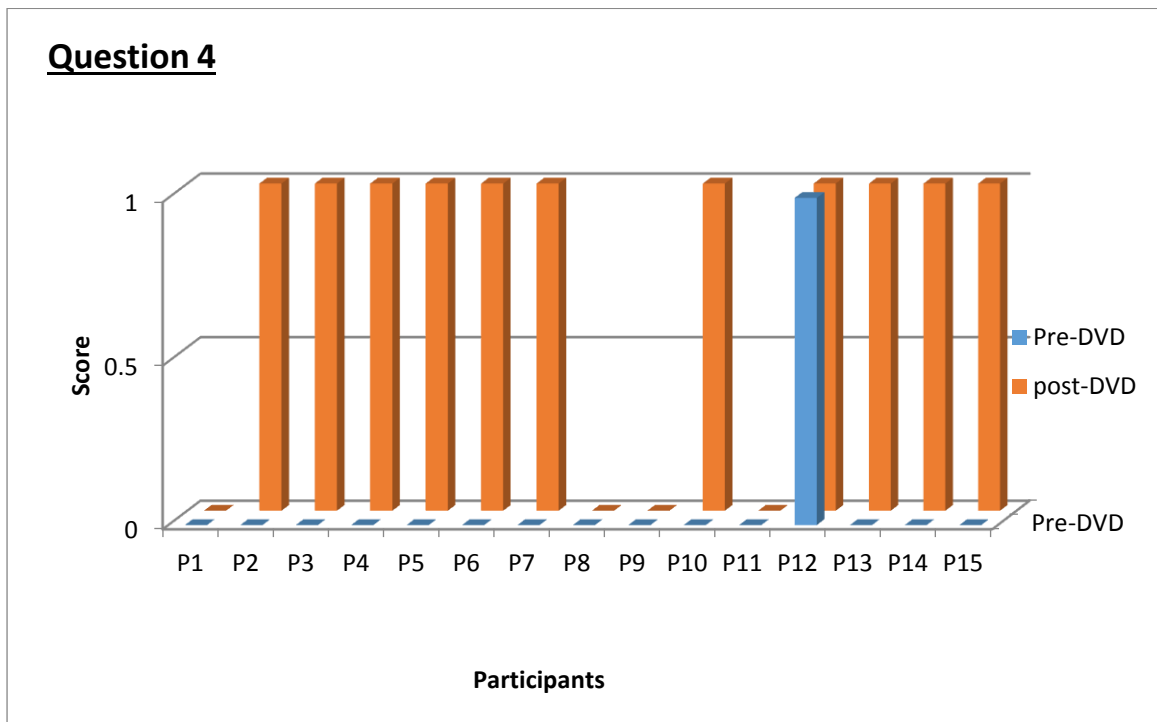
Q5. Tell me at least two blood tests that will be taken during your antenatal care.

Before watching the Somali maternity information DVD, none of the participants had knowledge of at least two blood tests that would be performed during their antenatal care; however, three (20%) mentioned one blood test. After watching the DVD this number changed: thirteen (87%) of the participants had knowledge of at least two blood tests, and two (13%) mentioned one blood test, as shown in Figure 5.6 below.

Figure 5.6: Results for Question 5
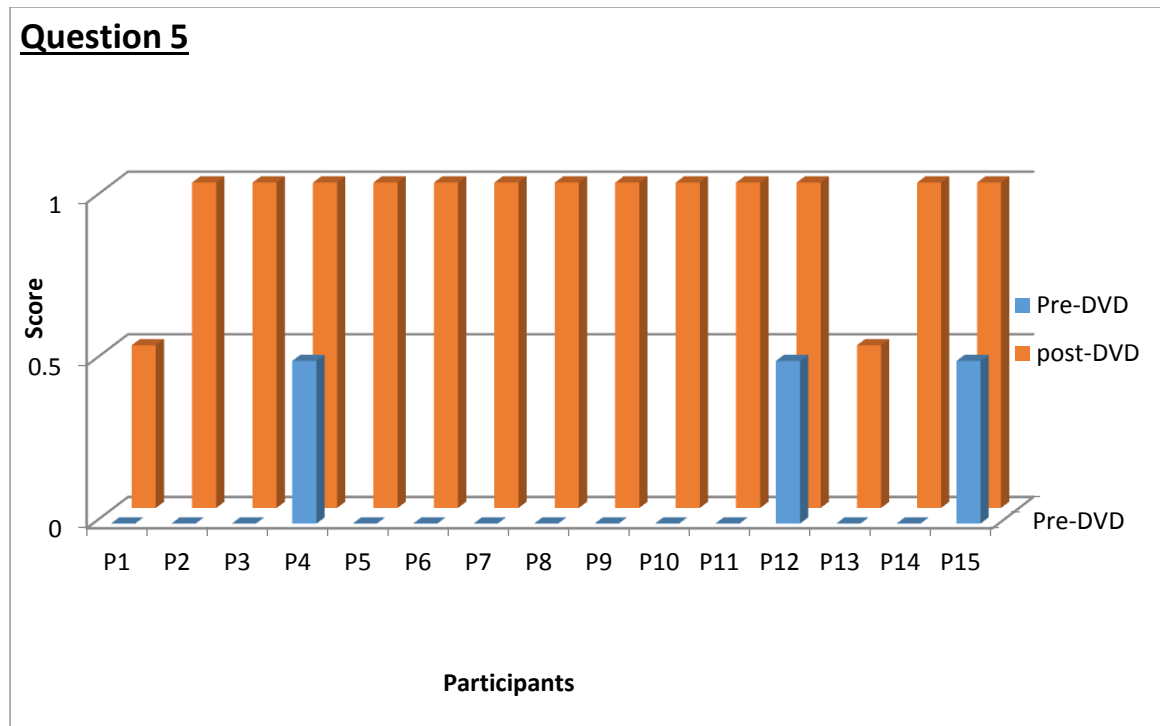
Q6. What will happen to you if you do not go into labour by forty-one weeks of pregnancy?

Figure 5.7 below indicates that only two out of the fifteen participants showed pre-DVD knowledge about induction of labour after forty-one weeks of pregnancy. This figure increased to eleven (73%) in the post-DVD knowledge test, but four (27%) of the participants showed no post-DVD knowledge increment.

Figure 5.7: Results for Question 6
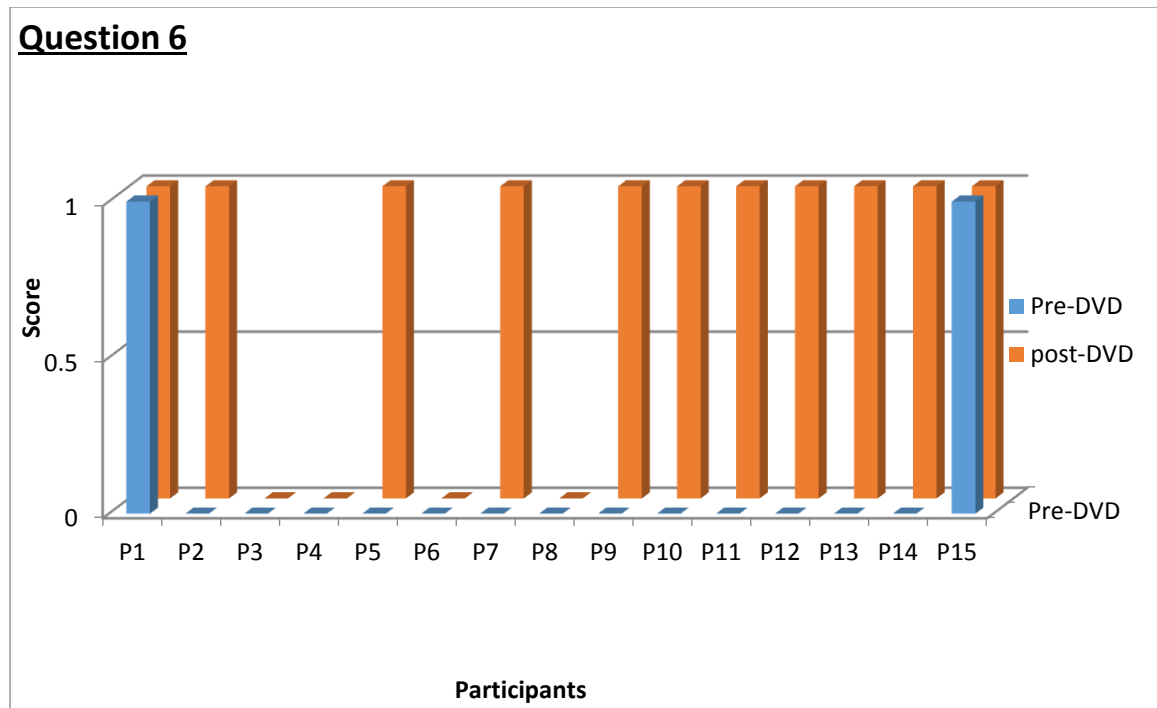
Q7. Tell me at least two types of pain relief method that are available for labour pain.

As shown in Figure 5.8 below, eight (53%) of the participants mentioned one pain relief method used in labour, while only one (7%) had full knowledge and six (40%) had no knowledge of labour pain relief methods. This changed in the post-DVD knowledge test, where thirteen (87%) of the participants were able to list at least two types of pain relief methods available for labour, and two participants could recall one type of pain relief method.

Figure 5.8: Results for Question 7
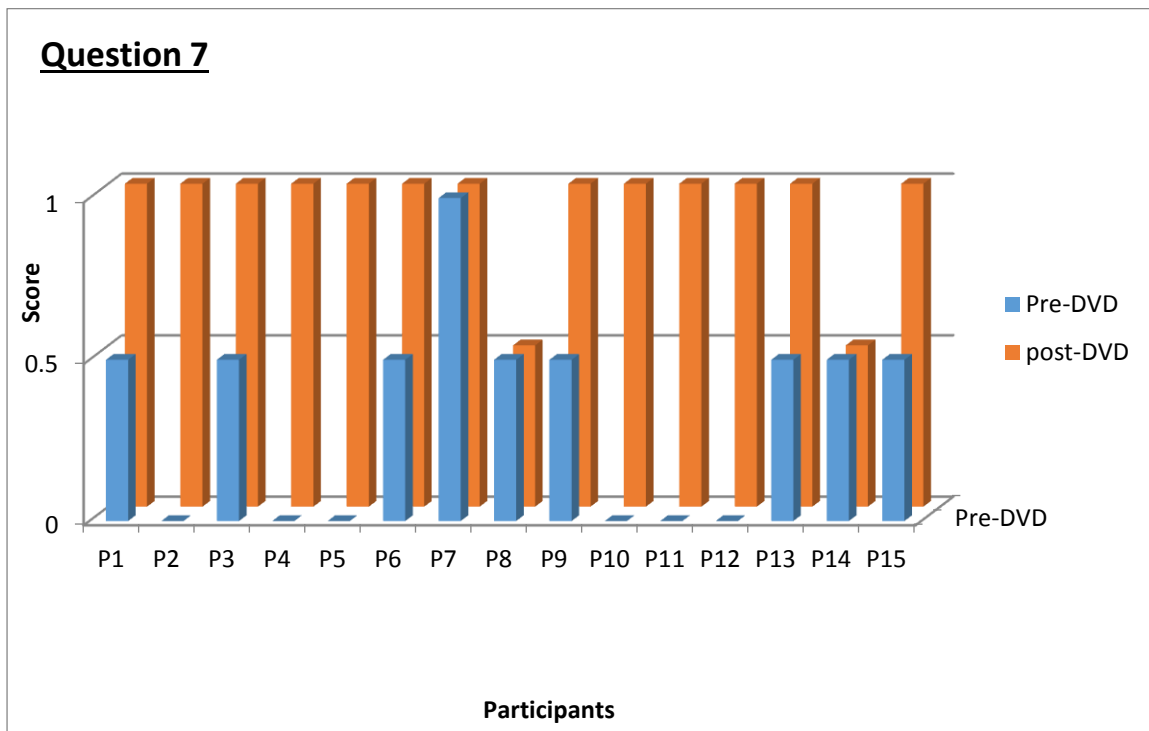
Q8. What injection may be given to you to help deliver your placenta?

In the UK, active management of 3rd stage of labour, which includes the administration of an oxytocin injection, is recommended to all women to prevent haemorrhage (NICE 2007). It is therefore an important part of the information given to women during pregnancy. Figure 5.9 below indicates that during the pre-DVD knowledge test, none of the participants knew that an oxytocin injection could be given to them after labour to help deliver the placenta. This significantly improved after watching the Somali maternity information DVD, since all (100%) of the participants answered the question correctly during the post-DVD knowledge test.

Figure 5.9: Results for Question 8
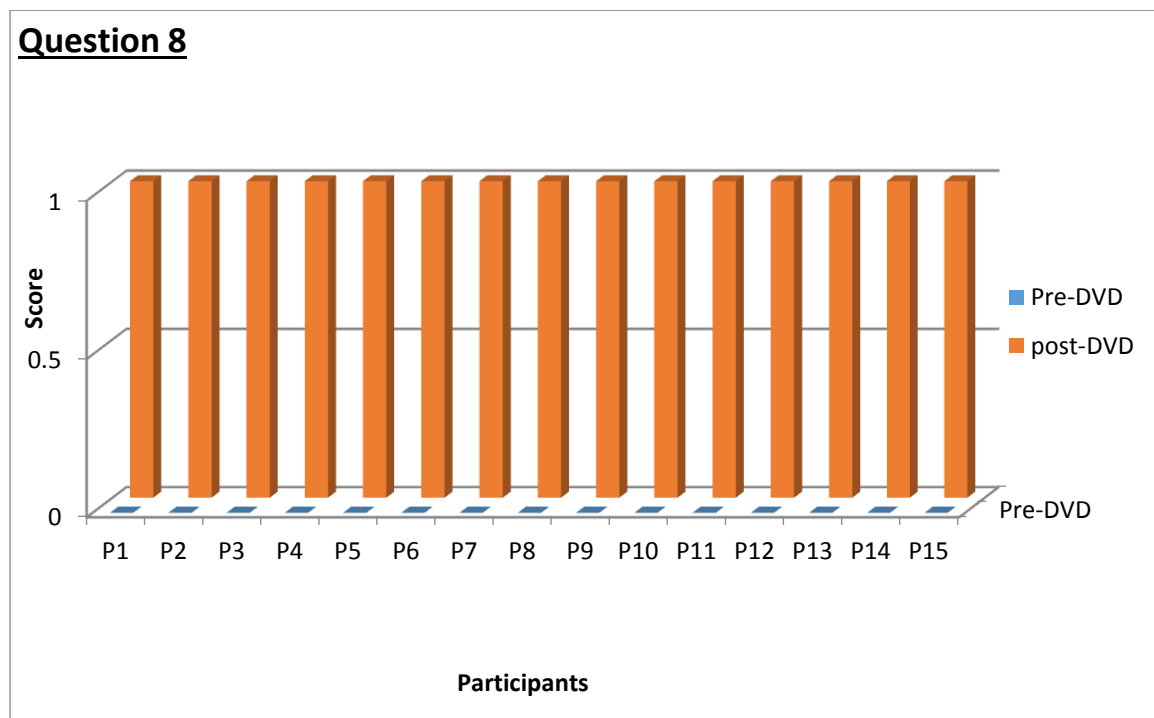
Q9. What injection will be given to your baby after birth, and why is it given?

Figure 5.10 below shows that only one of the participants knew that vitamin K injections are recommended to be given to all babies after birth and was able to explain the importance of vitamin K injection during both the pre- and post-DVD knowledge tests. However, two of the participants knew about vitamin K but did not understand why it is given to a baby. This figure increased to a total of eleven (73%) after watching the DVD, although two (13%) could not remember why vitamin K is given to babies.

Figure 5.10: Results for Question 9
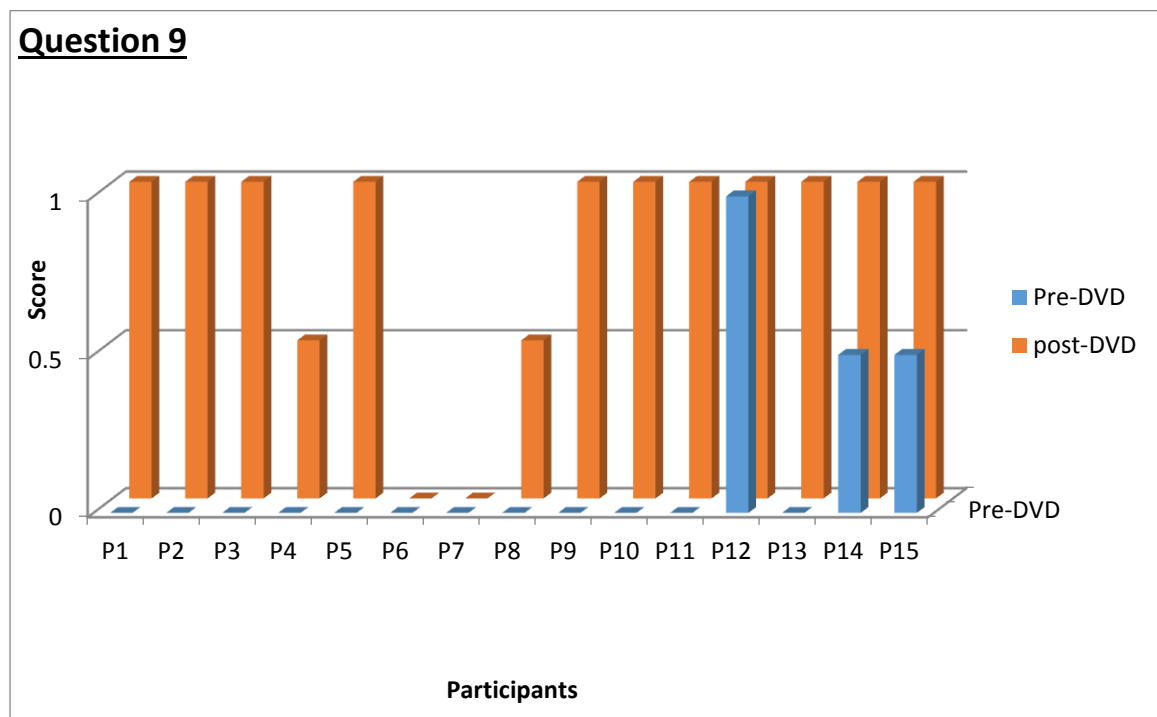
Q10. What is the choice of places to give birth that is available to you?

Figure 5.11 above shows that pre-DVD, all but two of the participants showed some knowledge of their choice of places to give birth. This changed during the post-DVD knowledge test; with thirteen (87%) showing full knowledge about the choices available to them, and only two (13%) participants failing to mention the birth centre.

Figure 5.11: Results for Question 10
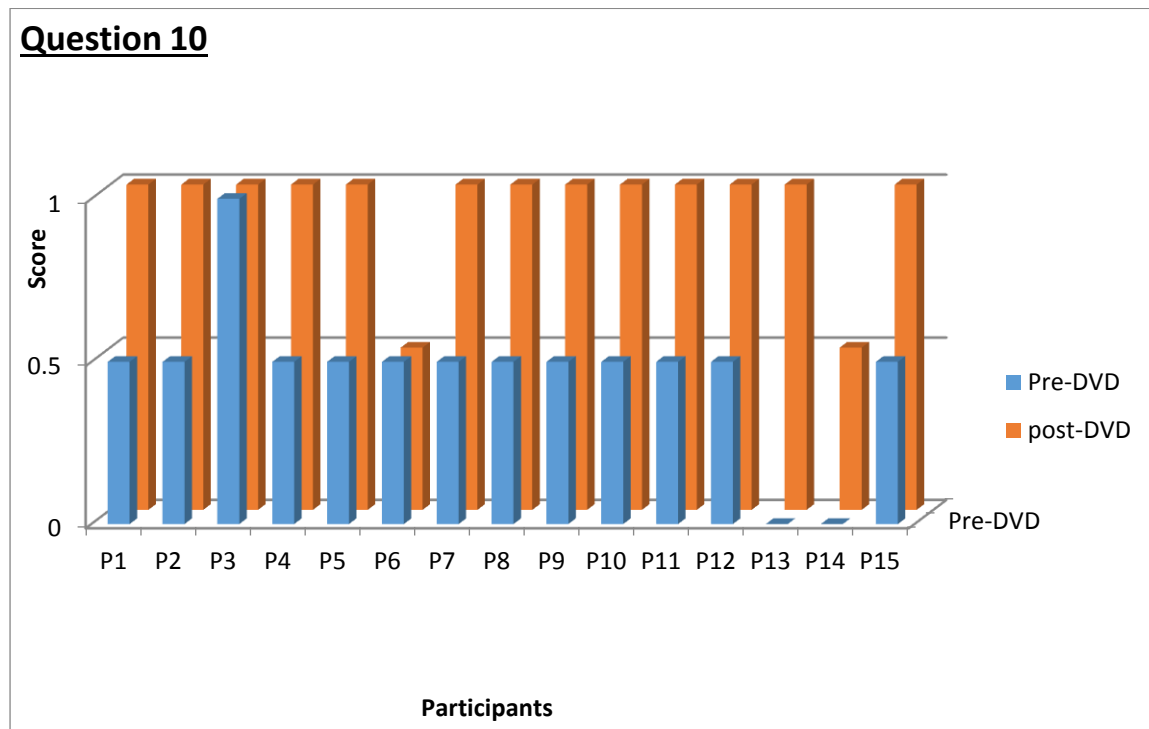
Participants' total scores on each question pre and post DVD

Figure 5.12 below shows that question 1 was the most accurately answered question in the pre-DVD knowledge test, while questions 2 and 8 scored zero. The post-DVD knowledge test showed that questions 1, 2 and 8 were the most accurately answered questions and 11 or more participants answered other questions correctly.

Figure 5.12: Participants' Total Scores on each question pre and post DVD

Participants' total score on each question pre- and post-DVD
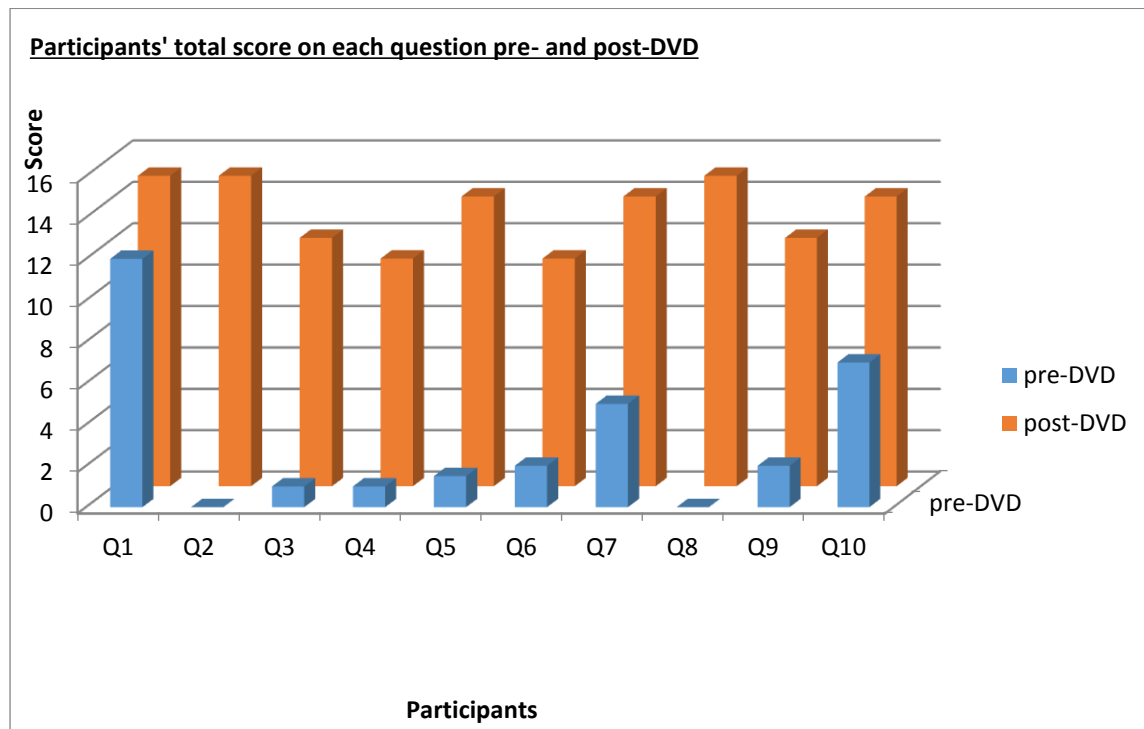
Participants' total scores pre and post DVD

Figure 5.13 shows that the total scores of the participants' pre-DVD knowledge tests range from 1 to 4, while the post-DVD total knowledge test scores range from 6.5 to 10. This indicates that all the participants answered more than six out of 10 questions correctly in the post-DVD knowledge tests.

Figure 5.13: Participants' total scores pre and post DVD
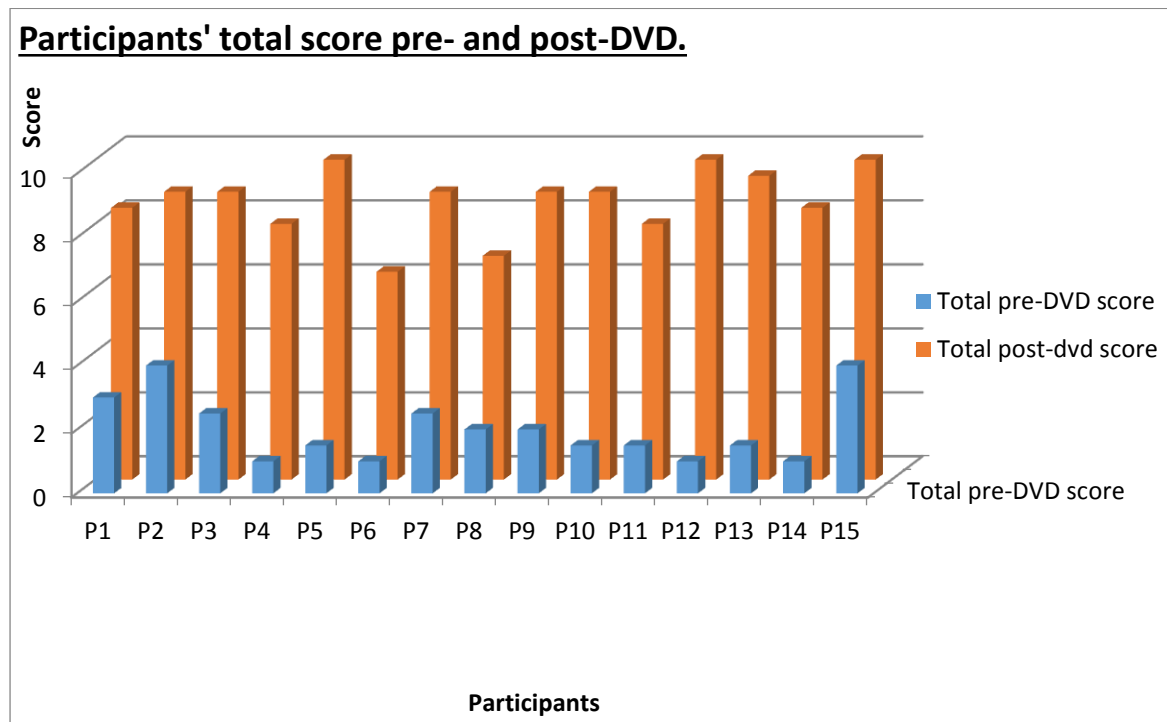
Mean total pre and post participants' scoring

The lowest score in the pre-knowledge tests was 1 and the highest 4 with a mean total of 2; this increased to a lowest score of 6.5 and the highest score of 10 with a mean total post-DVD knowledge test score of 8.7. Three participants got all the post knowledge test questions right. Participant 12 showed the most improvement in her knowledge change as she scored1 in the pre-knowledge tests but scored 10 in the post-knowledge tests. These results indicate improvement of knowledge by all the participants, from the pre- to the post-DVD knowledge tests, with a total score variance of 6.7, which is important as it suggests that the DVD did increase the maternity knowledge of this particular group of Somali women.

Figure 5.14: Mean total pre and post participants' scoring
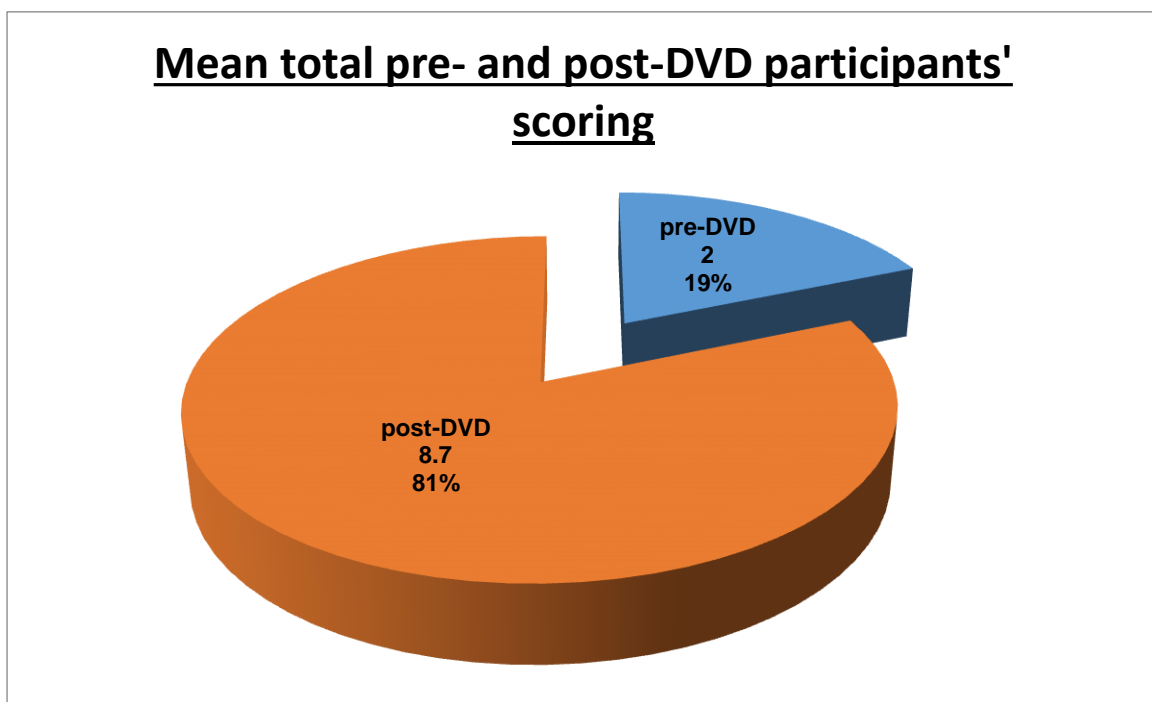
In conclusion, it was difficult to ascertain whether the participants chose to use other sources of maternity information between pre and post knowledge tests as this was not explore during the study. The participants in my study may have gained maternity care information via friends, family members and during antenatal clinics but this is difficult to proof. However, the results of this study have demonstrated a change in the knowledge of the participants after having watched the Somali maternity information DVD. This is evidence could suggest that most of the participants acquired more information about maternity care via the DVD which is one of the strengths of my study

The next section will present the qualitative findings.

5.4 Findings from postnatal interviews

5.4.1 Introduction

In this section, findings from the qualitative interviews of fourteen female Somali participants conducted during the postnatal period, using a semi-structured interviewing method (see appendix 8 for the interview schedule), are presented. The entire interview data were transcribed by the researcher, as explained earlier in this thesis. The information was approached initially by attempting to understand the overall meaning of the text; secondly by focusing on the discursive elements of the text and finally by bringing together developing codes into emergent patterns and themes (Graneheim and Lundman (2004) and Grbich (2007)). The identification of the themes was guided by the objective of this study.

5.4.2 Introducing the themes

This section serves the important role of introducing the participants' voices by taking extracts verbatim from the comments made by the interviewees to illustrate the common themes. As promised to the interviewees, their anonymity is retained by using the word "Participant" and a numeric identifier – for example: Participant 1. False names might have been used to describe the participants, as other researchers have done in the past and as suggested by Hardy and Bryman (2004). My opinion on the use of false names is that there may be loss of a sense of individual participant connection with the study. Even after concluding all the interviews, revisiting the comments of the interviewees brings a reminder of their faces.

The data collected during the interviews were categorised and clustered into patterns which then generated into the following themes:
1. Knowledge change
2. Behavioural changes: choice and empowerment
3. Usefulness and acceptability

1.   Knowledge change

The participants were asked if the DVD had increased their knowledge of maternity care and helped them make informed choices during pregnancy, birth and in the postnatal period. All the participants in this study indicated that the DVD had fulfilled its function as a teaching / learning tool. This theme was sub-divided into two further sub-themes:

a) Increased knowledge and awareness

b) Knowledge sharing

a) Increased knowledge and awareness

All the women in the study reported learning in relation to increased knowledge and awareness of maternity care, carers' roles and useful service contacts – for some this was related to their previous lack of knowledge. For example, **Participant 11** explained that:

"I would have preferred to have the DVD with my first baby, because I have learnt so much that I did not know before now, such as diet, fruits to eat, food to eat, folic acid you need to have before and during pregnancy, baby can have spina bifida and folic acid prevents that. All of what I watched in the DVD is like new information to me"

For others, the learning was articulated with clinical information about what they learnt concerning pain relief methods, as expressed by **Participant 5**:

"There were a lot of things I learnt, a lot surrounding labour, like pain relief methods. With my previous babies I only used the gas (entonox) but I found out that I can use other things, like this time I requested the injection (pethidine) which I was not aware that was available before. I was more aware this time"

Similarly, **Participant 13** explained:

"Yes the DVD has increased my knowledge. For example, the injection you get in the back (epidural) – I was not aware of it until I watched the DVD"

In addition, some of the participants showed that they had learned more about the role of the midwife, and more importantly about the services offered within maternity care. For example **Participant 1** expressed that:

"The DVD explained what I need to do during pregnancy and the birth of my baby. For example, when I need to have a scan, see my midwife and how to contact my midwife and the doctors"

Similarly, **Participant 2** gained a better understanding of the midwife's role and the rationale behind the care given:

"The DVD helped to understand the care the baby would be receiving after giving birth. I knew beforehand the injections the midwife is going to be giving to my baby. It helped to understand the care that was given and why midwives did things that they do"

Participant 9 also stated:

"The DVD has now helped me understand how to contact the midwife directly without going to the GP. I now understand the importance of contacting the midwife as soon as I am aware of being pregnant"

The above responses from the participants may explain why some Somali women do not engage with maternity services, as it was evident from the above comments that some of the participants lacked knowledge of basic maternity care and the role of the midwife.

b) Knowledge sharing

Some of the participants described how the information/knowledge gained from the DVD was transferred / shared with others, and stated that they would recommend the DVD to family and friends.

For some of the participants, they actually watched the DVD with someone else:

Participant 1: "*My mother and partner watched the DVD with me. They felt it was very good and it helped all of us to understand what was going to happen through my pregnancy and afterwards*"

Participant 11: "*I watched the DVD with my sister and I asked my sister to read the English subtitles to me*"

Participant 14: "*I will also be able to help and support others during pregnancy by passing on the knowledge and information I have gained from the DVD*"

Some participants expressed how they are currently supporting, or would in the future support, friends and families with the information and knowledge gained from the DVD:

Participant 5: "*For example, I recently met a friend of mine who is new in the country and cannot speak English, and who is very anxious about what was going to happen to her as she has been told by the doctor that she will be giving birth by Caesarean section. What to expect and the whole process of maternity care and labour. So I was able to explain to her through the DVD*"

Participant 2: "*The DVD is very good and insha'Allah[1], the DVD would help when my sisters are having babies in the future*"

Participant 6: "*It will help me and my sisters in the future. I will give it to my sisters when they become pregnant and are planning to have their babies*"

Participant 7: "*Yes, I would surely recommend the DVD to my friends and family. I have got a friend (a girl) that is living with me who had FGM done. I was going to show the DVD to her to think about reversal as she suffers a lot from this*"

Participant 14: "*I will also be able to help and support others during pregnancy by passing on the knowledge and information I have gained from the DVD*"

The above responses from the participants give some views on the future impact of the DVD because some of the Somali women in this study have already shared, or would in future

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[1] I*nsha'Allah* means by God's grace

share, the information received from the DVD with others. This may help to break cultural misconceptions around childbirth and improve access to care.

2. Behavioural changes: choice and empowerment

Choice and empowerment featured prominently under the general heading of behavioural changes. The phrase 'choice and empowerment' occurs throughout the responses obtained from the participants. The participants felt that the DVD had not only increased their knowledge of maternity care, it had also empowered them to make an informed choice about, and give informed consent for, the care they received. This was more pronounced during labour.

Participant 2 had her first baby during the time of this study; she explained her fear and anxiety during pregnancy about childbirth pain, especially with not having the information about pain relief methods. She expressed that the DVD had made her less anxious because the information received via the DVD made her more aware of the choices of pain relief methods that were available for use during labour:

Participant 2*: "In the beginning of my pregnancy I was afraid of the labour. But when I watched the DVD and understand the pain relief that I can get and saw the environment on the DVD, it made me feel less afraid during my labour and the delivery of my child. It also made me ask the midwife for my choice of pain relief knowing that it is ok to ask*"

Similarly, **Participant 5** said:
"I was aware of what to ask for during labour, I felt I had a choice and a voice in my care"

Other participants also articulated how the DVD had empowered them to make lifestyle behavioural changes, as shown in the following quote:

Participant 7*: "Yes, I have gained a lot of information. I have had a lot of babies before but I did not have much information about maternity care – for example, I used to eat liver, I was not aware that it is not advisable to eat liver in pregnancy. After watching the DVD, I stopped eating liver.*

Other participants found the information in the DVD reassuring:

Participant 5: "I was a bit afraid of having External Cephalic Version (ECV) done but the DVD made me less anxious and gave me the reassurance that I can have a normal birth, which I did"

Participant 14: "I did not understand much of the information given to me before the operation. But during the birth of my baby, I was aware of the different types of anaesthetic drugs that are available and I understood why I was awake during the operation but did not feel any pain. The DVD made me less anxious this time around"

Participant 9: *"I had an Emergency Caesarean Section (EmCS). I did not have time to prepare for it. I would have found it difficult to accept delivering my baby by EmCS as we Somali women do not like giving birth by this method. But during pregnancy, watching the part of the DVD that talked about EmCS helped relieve my anxiety because I was aware that it can happen"*

It is evident from the findings above that Somali women may not have a good understanding of the maternity childbirth choices that are available, and they certainly do not feel they can be involved in decision making in relation to their care. Furthermore, many of the Somali women expressed fear and anxiety in relation to medical intervention. Therefore, the simple use of a maternity information DVD has changed the perception of some of the women in this study towards birth interventions, such as ECV, pain relief methods and Caesarean section.

3. Usefulness and acceptability

Two sub-themes emerged from the main acceptability theme, which were:
    a) Usefulness
    b) Acceptability

a) Usefulness

The participants were asked what aspects of the DVD they liked the most. The aim of the question was to evaluate the usefulness of the DVD to the participants. The majority of participants expressed their preference, in term of usefulness, for the part of the DVD dealing with labour:

Participant 1: *"I love the part about the delivery, when they are talking about the pain relief that you use in labour, the different methods that are available"*

Participant 2: *"I like the labour aspects of the DVD. The DVD also showed me how labour was and what to expect, really"*

Participant 5: *"When I was in labour, if I was not aware of the pain relief options that were available for me the midwives would just choose for me. But because I was fully aware via the DVD, I was able to say which one I wanted"*

The majority of the women agreed that having the DVD in Somali would enable other Somali women to gain a better understanding of the maternity system, with special reference to new immigrants. Some of the participants felt that living and having previous babies in the UK did not guarantee knowledge of the maternity system. For example:

Participant 13: "When I watched the DVD, I thought it would help everyone, including people that already have little children"

Participant 4: "Even those who have been living in this country for a long time, the majority of them do not speak English very well"

Some of the participants felt that having the information in Somali will help differentiate between the UK and Somali maternity care system and will particularly help new immigrants. This will help to alleviate the misconceptions and assumptions they may hold about childbirth and maternity care, as suggested by the following participants:

Participant 6: "It will help women who are new in the country a lot, as they will not know the system in this country. It will help them a lot to understand maternity care"

Participant 3: "The system back home and the system in this country are completely different. In Somalia, for instance, we do not have midwives visiting you at home after giving birth, we don't have that"

In addition, **Participant 3** confirmed that care is not free in Somali; there is a cost attached with accessing antenatal care:

"Back home in Somali, there are no scans and no free care. If you want to attend antenatal clinics and have scans, you would have to pay"

This may explain the reluctance of new immigrant Somali women to use health care services, which may be attributed to the fear of costs.

In order to assess the quality of the DVD and to ascertain that the participants understood the information in the DVD, the participants were asked to comment on its clarity and their ability to understand the information given. All participants agreed that the content of the DVD was clear and easy to understand:

Participant 1: "The DVD was very easy; it was clear and clear to understand"

Participant 5: "I understand the language. The Somali used is very clear and easy to understand"

Participant 7: "It was clear. The voice was very clear and easy to understand. The person that was speaking on it was speaking slowly, so it was easy to understand"

Participant 14: "All the Somalis living here or in Somalia will understand the Somali that was spoken"

Some of the participants applauded the idea of including subtitles in English, because it gave them the opportunity to learn new words. The majority of the participants showed a willingness to learn the English terms:

Participant 1: "The DVD also has subtitles written in English for you to read as well. The English subtitles were very helpful. It helps you to try to learn"

Participant 2: "You also try to read the subtitles"

Participant 13: "I asked my sister to read the English subtitles"

Participant 14: "We got someone to translate what the subtitles said. It was very helpful to have the subtitles. Especially when people speak in English, it is very fast for someone learning English, but when you are reading the subtitles it is slow and you learn at your own pace"

This finding suggests the need to develop an English learning tool in a DVD format that will enable Somali women living in the UK to learn how to read, write and speak basic English, which will be beneficial to them in all areas of their lives.

b) Acceptability

Somali women, due to cultural and religious reasons, would not watch a film containing nudity. Therefore, care was taken when developing the DVD to prevent any scenes that might have been controversial; conscious efforts were made to focus the DVD on information giving, as discussed in Chapter 3. The value of this was also confirmed by the women who participated in the study.

None of the participants reported any cultural issues or concerns related to the DVD. They all reported that the DVD was culturally acceptable to them. See the comments below:

Participant 7: "There was no aspect of the DVD that was not culturally acceptable. It was all good"

Participant 14: "There wasn't any aspect of the DVD that was not culturally acceptable. There was not any nudity in it. I think you have taken a lot of care to make it culturally acceptable to us"

The participants showed a high level of appreciation that the DVD was produced in Somali, and the words 'mother tongue' were repeatedly used by some of the participants. Most of the participants felt that, because English was not their first language, having the DVD in Somali allowed them to receive the information in a language they understood, which meant they

could utilise the information easily and positively to improve their health and that of their unborn and born babies. The following comments from the participants show this:

Participant 1: "*Producing the DVD in Somali helps a lot, especially when you cannot speak in English*"

Participant 4: "*I do not understand English. Had the DVD been done in English, I would not have understood it, but because the DVD was in my mother tongue there was lots of information that I understood clearly*"

Participant 10: "*In Somali, it is our language and I understand it a lot better. If it was in English I would not understand anything and it would not be of any help to me. I would have asked someone else to come and translate the DVD for me*"

Participant 11: "*I understood everything in the DVD because it was spoken in my mother tongue, Somali*"

One participant felt that the DVD would help many Somali women, and she explained why Somali women that have been living in the UK for many years were unable to learn or speak English.

Participant 14: "*Many of us don't speak English; it would help us a lot. The majority of the Somali that have come here to the UK came as asylum seekers or are new in the country, and most of us have small children and never have the time to go and learn English*"

The above assertion may also contribute to the maternity information inequalities that exist among non-English-speaking clients across all health sectors, since the majority of the written information is in English. Lack of information in the native languages of non-English-speaking clients, as explained by **Participant 14**, may contribute to poor engagement with services. In effect, this may contribute to the high morbidity and mortality rates experienced by Somali women. Therefore, having the Somali maternity information DVD in their native language will have a positive impact on large numbers of Somali women using the services of the maternity unit involved in this study.

The majority of the participants liked the Somali maternity information DVD format. They believed that the DVD format gave them control over receiving and absorbing information at their own pace. For instance:

Participant 7: "*I can just listen and watch it at my own pace*"

Participant 10: "*With the DVD, I can do my housework, look after my children and at the same time gain a lot of information*"

Participant 11: " *You can see things on the DVD and the DVD also explains things clearly to me. It is of course better in a DVD format"*

In addition to the above, some of the participants felt that they preferred the DVD format in comparison to written Somali information leaflets and the use of an interpreter during antenatal clinics, as explained below:

Participant 7: "*More so, a lot of people will not read written information given to them. But watching the DVD and seeing pictures which will make you absorb the information better"*

Participant 10: *"A leaflet needs a lot of concentration and time to read. You probably read the first sentence and feel I understand this and put it away, but not read the whole information because it is time consuming"*

All the participants agreed that maternity information received in a DVD format is better than via written leaflets and the translation of antenatal information by an interpreter.

Acceptability of the DVD was assessed when the participants were asked to give their overall impression of the DVD. Thirteen (93%) out of the fourteen participants rated the DVD as excellent, and one (7%) rated the DVD as very good. All the participants made positive general comments on the DVD. Below are some of the comments made by the participants:

Participant 8: *"The DVD was excellent, and I do not know what I can really add more to the DVD. It says in a Somali adage that 'things that you have knowledge of and things you do not have knowledge of are not the same'"*

Participant 9: *"The DVD was excellent, because there will be a lot of people in need of this"*

Participant 10: " *Thank you very much for producing the DVD and giving it to me. I think you should give it to every mother. I think it was well thought out, and I do not think there is anything we can add to it at this present moment"*

Participant 11: " *Thank you for actually producing this, and I think it should done in other languages and be given to every pregnant woman"*

Participant 13:" *When I watched it I thought it would help everyone, including people that already have little children"*

5.5 Summary

In conclusion, the Somali women that participated in the study have shown, through their feedback, their acceptance and approval of the maternity information DVD. The pre and post DVD knowledge tests also showed an increased level of knowledge amongst the participants.

All the participants agreed with the appropriateness of the DVD and felt no section of the DVD needed any alteration. Therefore, no change was made to the final version of the DVD.

These findings suggest that the maternity DVD is an acceptable and useful information intervention that could be developed for full implementation and evaluation for Somali and other non-English speaking ethnic minority women using maternity services.

The next chapter will present a discussion of the findings.

Chapter 6

Discussion of Findings

6.1. Introduction

The findings presented in Chapter 5 showed that the participants involved in pre-testing the DVD thought it was acceptable and useful: their maternity related knowledge was also shown to increase. These findings are sufficient to suggest, within the social marketing model used, that implementing the DVD more widely would be an appropriate way forward. However, in order to create a firmer evidence base to support this study, I will now discuss my findings in relation to the wider context of the existing literature. Some of which has already been referred to in Chapter 3. Areas of discussion focus on the following:

1. Somali women have an information deficit
2. Somali women's acceptance of a DVD as an ideal format for information giving
3. DVDs help in overcoming cultural misconceptions and creating behavioural change

I close the chapter by considering the usefulness of evaluative models in assessments of this DVD and by introducing an outline of a model for cultural safety in maternity care, within which the DVD could fit.

6.2 Somali women have an information deficit

Information-communication is a process by which information is transmitted during human interaction (Littlejohn 2002). Every human deserves '*the right to information*', and this is more crucial than ever during childbirth.

It has been demonstrated by the findings of this study that this group of Somali women did have a maternity information deficit; this was evident in the difference between the mean total pre- and post-DVD knowledge tests: from 2 to 8.7. The findings of the pre-knowledge tests in this study showed that most of the participants lacked knowledge of basic maternity care. For example, 80% of the participants did not realise there were antenatal classes available to them and, before watching the DVD, none of the participants could name at least two blood tests performed during pregnancy. These findings have implications for practice, as it is apparent that procedures are carried out during childbirth with women who do not know the reasons for performing such procedures. This contradicts the message of government policy on the maternity choice agenda to facilitate informed choice (DH 1993; DH 2007a). It is clearly evident in my study that some Somali women are still experiencing

maternity care inequalities. This assertion was substantiated by the responses of the participants in theme 1 (knowledge change).

These findings correlate with a qualitative study conducted by Davies and Bath (2002) which examined the maternity information concerns of Somali women in the United Kingdom. Their findings revealed that the majority of Somali women were not provided with adequate information about maternity care. The strength of Davies and Bath's study was in the incorporation of both English-speakers and non-English-speakers in the Somali population sample, although the researchers did caution against generalising the findings, as there was a need for a larger quantitative research study to substantiate the evidence.

The issues surrounding information barriers are not peculiar to the Somali population; they also cut across other non-English-speaking ethnic minority groups. A study by Dormandy et al. (2005) reported that a lower uptake of antenatal screening for Down's syndrome in ethnic minority women did not reflect negative attitudes toward screening; rather it reflected a low rate of informed choice being offered to these women. A major flaw in this study is its selection bias; the researchers utilised only literate women from ethnic minority groups in their sample, and non-English-speaking women were excluded. This is in contrast to the recommendations of other reports that advocate the inclusion of non-English-speaking ethnic minority groups in research studies. This is because they are the most disadvantaged, as they find it most difficult to access health services due to communication and information barriers (Davies & Bath 2001; Craig & Pillai Ridell 2003; DH 2004a; Darwood 2008; Lewis 2007, 2011).

In an American study, Somali women (Johnson et al. 2005) also verbalised the lack of maternity information and wanted more information about events in the delivery room, pain medications, prenatal visits, interpreters, and the roles of hospital staff. In one Canadian study (Chalmer & Harshi 2000), pregnant Somali women felt that their needs were not always adequately met by care providers, with women reporting unhappiness with both clinical practice and the quality of the maternal care information they received. While the onus is on service providers to provide information in a format that is acceptable to the service users, it is equally important for the service user to make efforts in seeking such information. This notion is supported by some of the findings in my study which revealed that some of the participants are making conscious efforts to learn English in order to communicate. This in effect may improve their knowledge of available health care services. It can be deduced from the findings of my research and other previous studies that Somali

women lack sufficient knowledge of maternity care and need a tool to bridge that knowledge and information gap and the DVD can be one of the tools for achieving this.

6.3 Somali women's acceptance of a DVD as an ideal format for information giving

Health service decision makers are routinely looking for optimum strategies to give information that will promote and support individuals to modify their behaviour towards a healthy life style, with specific reference to non-English-speaking service users. A common approach to bridging the information barrier has been the translation of leaflets originally written in English into various ethnic minority languages. However, there are some doubts about the value and the appropriateness of this approach (Gerrish et al. 2004).

Printed materials in the form of leaflets, posters and booklets have been the most common methods of informing women about maternity care and clinical interventions. A study by O'Cathian et al. (2002a) examined the use of evidence-based leaflets to promote informed choices in maternity care. They suggested that the leaflets were not effective in promoting informed choice among women using maternity services. The women felt that too many leaflets were given during the antenatal period and they may not be able to prioritise the important ones to read. The randomisation technique was not explicit. Following the trial, O'Cathian et al. (2002b) substantiated their argument on the need for informed choice by conducting qualitative research on the same topic (O'Cathian et al. 2002a, 2002b). This, in effect, added more rigour to the studies, as the use of a mixed methodology can aid triangulation (Bryman 2008).

Some maternity service providers have translated most of their information materials into different languages in an attempt to meet the needs of various ethnic minority groups. However, simple reliance on leaflet translation is inadequate because, for example, some of the English words may not be available in some of the ethnic minority languages. In addition, the translation of written materials assumes that the recipients are literate, or that their information needs are all the same. In most cases, even where materials are translated, they may not contextualise cultural imperatives or convey the appropriate messages.

In practice, many ethnic minority women may not be able to read or write in their native languages, despite their fluency in speaking that language. This caution is supported by the work of Bell et al. (1999) who focused on interventions to improve the uptake of breast cancer screening within different ethnic minority groups. Their findings showed that uptake was highest amongst Urdu and Gujarati speaking groups and lowest for Bengali and Somali

speakers which are hardest to reach. Their findings also suggested that translated literature is beneficial. The low uptake noticed in the Somali women may be due to their inability to read the translated Somali leaflet used in this study. The written word for the Somali language was only developed thirty years ago, and many Somali women may not have had the opportunity to learn how to read (Bell et al. 1999). However, this also applies to a small minority of the indigenous British population, who can speak English but cannot read or write it (Bell et al. 1999).

The findings of my study support the work of Nutbeam (2008), who found that using a DVD can bridge information gaps and therefore can improve health literacy, at a knowledge functional level, as discussed in Chapter 1 of this thesis. Following the DVD, most of the participants in my study felt they had a voice and were able to contribute to decision making about their care. This finding strongly supports the use of a native language DVD to achieve various goals in national childbirth policies (e.g. 'Changing Childbirth' and 'Maternity Matters') which advocate the need to treat women as individuals, as well as bridging the gap in inequalities experienced by non-English-speaking women (DH 1993, 2007a; Homeyard and Gaudion 2008; Gaudion et al. 2009). Hence the DVD provided basic maternity care information that will empower Somali women to make informed choices concerning their maternal health and well-being. However, it is acknowledged that while the DVD gives Somali women information about what to expect from maternity services, they still can't speak English so the need for interpreters, and/or more resources to enable Somali women to communicate their care choice learnt from the DVD, remains.

A video programme has been suggested to be the most effective medium of passing on information (Bottorff et al. 1998; DeStephano et al. 2010; Williams et al. 1998). It is useful in overcoming literacy barriers, and represents a valuable way of reaching some ethnic minority groups who have no written form of their own languages. Hewison et al. (2001) conducted a randomised controlled trial on the use of DVDs and video tapes for viewing at home to inform choices in Down's syndrome screening. The researchers suggested that knowledge of perinatal testing could be increased through the use of DVDs. Despite the rigour of this study, the authors did not mention how the DVD was composed, or if the service users were involved in the production of the DVD. Nevertheless, they strongly advocated the use of audio-visual materials as a valuable means of passing information on to hard-to-reach client groups (Hewison et al. 2001).

Videos or computer programmes offer possibilities, but the efficacy of such interventions has yet to be demonstrated widely among immigrant groups in the pregnancy or labour setting, or in anticipation of an emergency situation (DeStephano et al. 2010). Even so, the well-established immigrant women living in the United States have welcomed the use of video and audio tapes, as well as the use of printed materials and clinical tours (Herrel et al. 2004). Among newly arrived immigrant women, or among those with refugee status, the use of language-concordant, group educational programmes has also been shown to elicit a positive response (Carroll et al. 2007).

However, at present interpreter use remains the key default option for facilitating adequate patient-provider interaction with language-discordant immigrant and newly arrived women. Further, because appropriate care relies on a collaborative relationship between care providers and clients who willingly and effectively communicate their health needs (Kim et al. 2003); some immigrant groups still remain highly vulnerable. Research into interactive technology and videotapes in cancer care concluded that these forms of patient education were as effective as the traditional methods of information provision, including consultations and booklets (Gysels & Higginson 2007).

Other studies also examined the effectiveness of a single administration of a videotape to improve compliance. Four trials (Mahler et al. 1999; Janda et al. 2002; Stromberg et al. 2003; Wiese 2005) evaluated the effectiveness of a single session of viewing a videotape on compliance and other quality of life or functional variables. Mahler et al. (1999) reported on two different approaches for providing videotape education. Patients assigned to the videotape groups reported a significant increase in moderate exercise at one month post-discharge and in more strenuous exercise three months post-discharge. Janda et al. (2002) and Wiese et al. (2005) also found positive results from a single videotape session, which improved the frequency of breast self-examination in participants and the rate of return for follow-up by patients requiring continuous positive airways pressure treatment, respectively.

Furthermore, Stromberg et al. (2003) found that the use of a multimedia computer-based education session for patients with chronic heart failure significantly increased their knowledge levels. The study also reported no difference in compliance with planned medical appointments and recommendations, when compared to traditional information provision. Roddey et al. (2002), So et al. (2003) and Brewer et al. (2004) analysed whether compliance with home exercise programmes, which included a videotape, had any effect on physical outcomes such as knee symptoms, shoulder pain and disability or burn scar appearance. All

studies highlighted positive physical outcomes in their respective clinical fields. Notably, Roddey et al. (2002) found that the videotape group had self-reported physical outcomes equal to those of patients who had received face to face instruction.

Other studies evaluated the impact of videotapes on quality of life, anxiety and self-efficacy. However, results were contradictory. Petty et al. (2006) reported that subjects who used videotape instruction demonstrated a significant improvement in quality of life and coping skills. Mahler et al. (1999) and Stromberg et al. (2003) reported no significant differences between videotape or control groups in terms of anxiety, self-efficacy or quality of life. One research study reviewed the effects of videotape on self-care behaviour and healthcare resource use. Albert et al. (2007) investigated whether providing education on heart failure, using a videotape, impacted upon self-care behaviour and subsequent healthcare resource use. Their study found that there was no difference between the videotape and non-videotape groups in terms of their attendance at emergency care or hospitalisation. However, the video education group did require less telephone advice and less extra-diuretic dosing. In addition, they were significantly more assertive in asking health care providers for written literature on heart failure. Albert et al. (2007) also reported that the video education group demonstrated an increased adherence to observing signs and symptoms for worsening heart failure.

Other research into the provision of a video or DVD, and the subsequent effect on compliance, has shown mainly positive results. In terms of the likely clinical applicability of video and DVD technology to rural and remote populations, one of the studies found that this form of instruction was as effective in enhancing compliance to exercise as delivering face to face sessions (Roodey 2002). This finding is important, given the distance barriers faced by rural and remote patients which can prevent them from regularly attending personal sessions (Veitch et al. 1999; Vietch 2009). In situations where face to face instruction sessions are difficult for patients to attend, the provision of brochures and/or audiotapes is 'standard' treatment. Given that Petty et al. (2006) and So et al. (2003) found that the use of video/DVD, alongside standard treatment, actually enhanced compliance (and no studies have indicated negative aspects relating to their use), it could be recommended that this additional technological medium may be utilised for rural and remote populations.

The characteristics of the sample described in the study by Veitch (2009) show similarity with the issues faced by Somali women, in terms of difficulties of access and engagement with the health care system. The participants in my study have reported the acceptability of

the Somali maternity information DVD. The amount of information, the clarity of messages and the helpfulness of the video were all evaluated highly. All participants perceived the DVD as appropriate for Somali women and indicated their willingness to recommend the DVD to other Somali clients. Some of the women in this study indicated that they had already shared the DVD with friends and families. This point verbalised by the participants gives the reassurance that the participants have not been propelled to engage with this study. It indicates that they genuinely value the DVD.

DeStephano et al. (2010) conducted a similar study with Somali refugee women in the USA and find that one of the usefulness of a DVD is that the different beliefs, attitudes and experiences of diverse clients can come forward in narratives and storylines (Wang et al. 2008), serving as discussion starters in clinical settings to explore educational needs and clinical care. A previous study reported that culturally specific educational materials, patient centred communication, feeling valued as a person, and having access to healthcare services with female interpreters and clinicians, are all important to Somali women's clinical care (Carroll et al. 2007; DeStephano et al. 2010).

The notion that only the first-time mothers will benefit significantly from the DVD, in comparison with multiparous women, was not supported in my study. It was obvious from the knowledge tests that some of the participants, who had had two or more babies in the UK, still scored low marks on the pre-DVD knowledge tests about basic antenatal information. Therefore, the DVD has not just improved the knowledge of the participants; in addition, participants with previous pregnancies were able to gain more understanding about the decisions and care they received in the past. Furthermore, some of the participants in my study were able to test some of the misconceptions they had, against the information they received from the DVD, and then discuss these misconceptions with the Africa Well Woman midwife during their antenatal clinics. This suggests that the DVD may prompt Somali women to ask for additional information, which in turn will improve client-provider interaction and engagement with services.

6.4 DVD's help in overcoming cultural misconceptions and creating behavioural change

My perception, based on the findings of my study, is that culturally appropriate care will be achieved if there is heightened acceptance by health professionals that culture has a major role to play in maternity care provision: this view is also held by Johnson et al., (2005). Equally, Somali women need to accept that negative misconceptions can hinder service

provider's efforts. It is well documented in many research studies that the poor birth outcomes experienced by Somali women are not only associated with communication problems but may also be dominated by child birth misconceptions (Johnson et al. 2005; Robertson et al. 2005; Vangen et al. 2002; Yoong et al. 2005; Vagen et al. 2007).

It was established in chapter 3 that Somali women have poor childbirth outcomes. Studies of Somali women's post-migration pregnancy outcomes have been undertaken in Western countries: one in the US (Johnson et al. 2005), one in Norway (Vangen et al. 2002) and one small study in the UK (Yoong et al. 2005). Two studies of women from the Horn of Africa (including Somalia) have also been reported from Sweden (Robertson et al. 2005) and Norway (Vagen et al. 2007). These studies have identified a number of disparities in comparison to outcomes in the receiving populations. Higher rates of anaemia (Johnson et al. 2005) and gestational diabetes (Johnson et al. 2005; Vagen et al. 2007) have been found in Somali women, but lower rates of hypertension and pre-eclampsia have also been reported within this group of women, when compared to Caucasian women (Vagen et al. 2007). More perineal trauma has also been reported for Somali women (Johnson et al. 2005; Vangen et al. 2002) and postpartum haemorrhages were more common in Somali women, as reported in the Norwegian study (Vangen et al. 2002), although not in the US study (Johnson et al. 2005).

Higher rates of stillbirth among Somali women are also apparent (Essén et al. 2000; Vangen et al. 2002; Johnson et al. 2005), it was also found that infants born to Somali women have five-minute Apgars of less than seven (Essén et al. 2000; Vangen et al. 2002; Johnson et al. 2005). There have been mixed findings with respect to rates of labour induction in Somali women, with one study reporting lower rates (Johnson et al. 2005), one higher (Vangen et al. 2002) and a third finding no differences (Yoong et al. 2005). Nevertheless, it is well documented that higher rates of Caesarean section are reported among Somali women when compared to Caucasian women (Vangen et al. 2002; Johnson et al. 2005; Robertson et al. 2005; Vagen et al. 2007).

Somalis often do not feel the need to visit the doctor unless they have signs or symptoms of illness, as hospitals tend to be associated with the care of the sick and medication (DeShaw 2006). Therefore, preventative care, such as antenatal care, is an unfamiliar concept to some Somali women, and medical care might only be accessed during pregnancy if a woman was feeling unwell (Pavlish et al. 2010). Some of the poor maternity outcomes experienced by Somali women, as reported in many studies, can be attributed to cultural

misconceptions which have been influenced by families, values, traditions and rituals (Essén et al. 2000; Carroll et al. 2007). In a study of Somali women's views of health promotion and prevention, health was often expressed in terms of the ability to function as the caregiver of the family (Carroll et al. 2007). Mobility is therefore highly valued among Somali women, and Somalis will typically describe the extent of their mobility to health care providers by referring to a daily task that they are no longer able to perform (Binder et al. 2012). Somalis also regard health as the responsibility of Allah and often consider living healthy lifestyles and praying to be ways of becoming closer to Allah and consequently avoiding illness (Carroll et al. 2007, p. 369).

One of the major misconceptions often expressed by Somali women is the need to have a natural birth. As opposed to Caesarean sections, vaginal births were described as "natural" and "normal." This sentiment was expressed by **Participant 9** in my study, who explained that Somali women's use of these terms to describe their desired birth experience reflects their overwhelming preference for vaginal births. Pavlish et al. (2010) suggest that some Somali women may feel debilitation and powerlessness following a Caesarean section, feelings which may be compounded by the lack of emotional, physical and material support for these women in the postnatal period. This may explain their resentful attitude towards medical interventions.

However, these misconceptions can be changed or reduced through education, by providing the correct information in a way that Somali women will understand and which is acceptable to them. Therefore, it was theorised from the outset of this study that a Somali maternity information DVD as a decision aid would contribute to a change in Somali women's knowledge, which in turn would positively affect their cultural misconceptions and experience of childbirth (Elwyn 2011; IPDAS 2005; Stacey 2011). Overall, Somalis view health holistically and in the context of greater personal, social and religious responsibilities (Carroll et al. 2007). This assertion was supported by **Participants 5** and **9** in my study, who confirmed changes in their misconceptions about Caesarean section as a result of the information received from the Somali maternity information DVD. This finding concurs with the study by Wang et al. (2008) which suggested that disseminating health information, through the use of DVDs, increased health knowledge and reduced cultural barriers to medical interventions among the participants in their study.

The DVD does not just lay emphasis on helping Somali women understand Caesarean section but also focuses on the importance of early care to normalise birth which can prevent

the need for Caesarean section (Ameresekere et al. 2011). Public health information was given a section on the DVD so as to promote healthy life style which may contribute to the reduction of obstetric adverse outcomes faced by Somali women, as already discussed in this thesis. There are other early natural interventions that can reduce the need for a Caesarean section or induction of labour. For example membrane sweep[2] is available from 41 weeks of pregnancy to avoid the need of medical induction of labour which may result in Caesarean section. However, anecdotal from practice indicates that this service has not been embraced by many Somali women (Urhoma 2012; DH 2009). Therefore, this study supports the use of a native language DVD in communicating public health information to women in order to promote early intervention and prevent resistance to medical interventions. This perspective resonated throughout the postnatal interviews conducted in my study; because the participants showed great appreciation that the DVD had enlightened them on various childbirth care options available in maternity care which may be culturally acceptable to Somali women.

The findings in this study are similar to other studies that have reported the acceptability of culturally tailored videos or DVDs for ethnic minority populations and have recommended a video or DVD as the way forward in mitigating information barriers within the health system (Clabots & Dolphin 1992; Mahloch et al. 1999; Taylor & Lurie 2004; Poureslami et al. 2007; Wang et al. 2008). The usefulness of videos or DVDs is that the different beliefs, attitudes and experiences of diverse clients come forward in narratives and storylines which may provoke debates and challenge tradition or cultural misconceptions (Wang et al. 2008). All the participants in this study mentioned one or more changes, or proposed changes, of behaviour they were willing to undertake, which validates the usefulness and acceptability of the DVD. Furthermore, the participants' behavioural changes verbalised during the interviews also validate the use of a social marketing approach for this study. This concurs with the assertion, mentioned earlier in Chapter 2, that one of the main goals of social marketing is to facilitate behavioural change/ modification.

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[2] Membrane (cervical) sweep is a vaginal examination during which the midwife will use her finger to sweep the neck of the womb to try to separate the membranes from the cervix. This can encourage the body to release hormones called prostaglandins that work to soften and thin the cervix, which might encourage labour to start naturally within the next 48 hours

6.5 Evaluating the success of the newly developed Somali maternity information DVD following full implementation to the wider Somali community

There are several models and theories that could be used when evaluating success or behavioural change in social marketing, such as the Health Belief Model (Glanz et al. 2002), the Theory of Reasoned Action (Miller 2005), Social Cognitive Theory (Bandura 2001), and the Trans-Theoretical Model (Prochaska & Velicer 1997). The latter model is one that I would suggest as applicable to evaluating this intervention following full implementation to the wider Somali community (Phase 6 and 7 of the SMART social marketing model). The Trans-Theoretical Model provides a good fit with the overarching principles of social marketing (impacting knowledge and changing behaviour). This model consists of five main stages that individuals go through when adopting or changing behaviour (Prochaska & Velicer, 1997). These are listed below and by way of showing how this model might work; I have referred to the findings of this pre-testing phase as an illustration.

Stage 1 – Pre-Contemplation: Prochaska and Velicer (1997) explained that this first stage is a stage of the unknown. The person is unaware, and is not currently considering or intending to adopt or change a particular behaviour. In relation to the Somali maternity information DVD, this is the state the participants in the study were in before they were given the DVD. This is confirmed by carrying out a pre-DVD knowledge test on the participants before they watched the DVD.

Stage 2 – Contemplation: the person has now become more aware after the intervention and is beginning to understand and consider adopting behaviours detailed in the intervention. This is assessed via the post-DVD knowledge test carried out after watching the DVD. This helped to assess if learning had taken place and to evaluate the change of knowledge from the pre-contemplation stage.

Stage 3 – Preparation: the person is actively considering and beginning to make commitments to adopting a given behaviour. This is evident in the comments made by the participants during the post-DVD knowledge tests. There was a change in the participants' willingness to engage with the maternity services after watching the DVD; some of the women verbalised their realisation of their knowledge gap, despite having previous engagement with the maternity services.

Stage 4 – Action: the person undertakes, or starts to undertake, a given behaviour. In relation to the DVD, some of the women interviewed for this study had verbalised their ability

to make an informed choice during labour, especially in terms of choosing pain relief methods.

Stage 5 – Maintenance: the person sustains and consolidates the behaviour. This was also evident during the postnatal interviews, as some of the participants were able to recall some of the knowledge from the DVD more than ten weeks after watching it. Furthermore, they were able to articulate some behavioural changes and modifications that they would adopt in a subsequent pregnancy.   In addition, some women had passed on information to other members of their family and community and this in future might help consolidate their own behaviours.

6.6 Cultural safety in maternity care

After reflecting on the results presented in chapter 5 and those of the Mary Seacole Award project, I arrived at a conclusion that one of the ways to mitigate inequalities of maternity care, and address the maternity information needs of non-English speaking ethnic minority women, is to consider the concept of cultural safety which has been discussed within some nursing settings. I discuss cultural safety below and conclude by proposing a tentative model focusing on achieving maternity cultural safety linked to the use of the DVD.

The notion of cultural safety originated in New Zealand and has been used in Australia and Canada. Cultural safety is defined as "The effective nursing of a person or family from another culture by a nurse who has undertaken a process of reflection on their own cultural identity and who recognizes the impact of the nurse's own culture on nursing practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual." (Nursing Council of New Zealand 2013, p. 4).

Although already considered in some developed countries (Australia, New Zealand) there has been little uptake of this theory in the United Kingdom. However, with an increasingly diverse population in the UK, it now seems appropriate to consider this approach. The implementation of cultural safety within maternity care settings in the UK would require maternity care providers to consider what is, and is not, culturally safe with / for the recipients of the services. Clearly, this would require institutional buy-in from stakeholders such as policy makers and commissioning groups, as well as considerable engagement with many ethnic communities.

Undoubtedly, what is defined as culturally safe will vary from woman to woman but the use of cultural safety, as a guide for practice, has the potential to enable maternity care providers to consider the cultural perspective of the individual being given the care, instead of ignoring them in favour of the uni-cultural approach which, in many instances, may also be rooted in a biomedical culture (Doutrich et al. 2012).   One way in which cultural safety could be instituted is by clinicians (midwives and obstetricians) adopting the premises of women-centred care (Stewart et al. 2000).

The foundations of women-centred care are dignity and respect, information sharing (for example, via a maternity information DVD), participation, and collaboration (Nguyen 2008; NMC 2011b; Berwick 2013; Francis 2013). The premises of cultural safety are participation, protection and partnership, suggesting a match is possible between these two approaches. The reason cultural safety is critical to women-centred care is that cultural safety requires the maternity care provider to be cognisant of power differentials and the imposition of personal values e.g. onto Somali women, thereby disadvantaging these women (Richardson & Williams 2007).

Traditional conceptualisations of culture tend to be vague, and may be criticised on the grounds that they offer only ambiguous definitions of cultural competency, they lack measurable outcomes, and they lack accountability. Interventions are sometimes aimed only at visible markers of difference, without attention to the effects of inter-sectionalities (conflict between healthcare professionals and clients' perception of care) (Drevdahl et al. 2008). Maternity care providers often overlook the culture of biomedicine and the effects of colonialism and historical trauma, as well as disregarding the dynamics of power as already discussed in chapter 3 (Drevdahl et al. 2008).

Cultural safety, by contrast, is a practice and philosophy that emphasises the relational aspect between the maternity care provider and individual clients, requiring the maternity care provider to be reflective about the ways in which their personal history and culture affect the encounter with the recipient of health care (Richardson 2010). The unique aspect of cultural safety is that it is sensitive to the individual, to institutional discrimination and to power imbalances. As such, it requires maternity care providers to be reflective about how the sociocultural dimensions of their practice affect clinical outcomes (Woods 2010).

Attending to power dynamics is difficult, because imbalances are often a covert and system-wide issue, making individual interventions to rectify imbalances ineffective. Cultural safety

addresses power differentials by clearly placing the power to define what is culturally safe with the recipient of health care (Richardson 2002). A dialogue that illuminates the disproportionality of power typically experienced by Somali women using maternity services may be undertaken in order to acknowledge (and resolve) inequitable power differentials (Scuzzarello 2009). Maternity care providers who understand the social, historical, political, institutional and economic contexts that healthcare recipients experience will be better able to understand and intervene in structural mechanisms, that exclude and un-privilege the perspectives of those recipients (Vandenberg 2010).

The use of a caring multiculturalism that is attentive to the power dynamics that privilege certain moral decisions over others, could be feasible in resolving this ethical dilemma (Scuzzarello 2009). The practice of cultural safety further illuminates the dynamics of power differentials in clinical settings by applying reflective practice (Richardson & MacGibbon 2010), and it may ultimately point the way to resolving power differentials and ethical conflicts.

The socio-ethical midwife and other maternity care providers who accept the premises of cultural safety may thereby improve the care of vulnerable populations and individuals (Wood 2003). The philosophical framework and practices of cultural safety are complementary and consistent with the ethics of care (McEldowney & Connor 2011). Practising with principle-based ethics in pluralistic settings is problematic, although sometimes maternity-care providers do ''attempt to match notions of desirable universal moral principles such as autonomy and justice with the largely relativistic cultural norms of different patients under the auspices of a dominant culture of medicine'' (Woods 2010, p. 719). This in turn contributes to ethical dilemmas. Maintaining individual and cultural notions of autonomy – as well as establishing trust – can be accomplished using relational ontologies. These are necessary components of being a socio-ethical, maternity-care provider (Woods 2010), as previously discussed in chapter 3.

Figure 6.1 (below), draws on the work of Narruhn and Schellenberg (2013) to summarise my study by developing a model called 'maternity cultural safety', within which I have integrated the use of a DVD as a mechanism for enhancing safety. The model demonstrates how maternity care professionals' influences (biomedical culture, authoritative knowledge and traditional ethics) may conflict with service users' (e.g. Somali women) influences (the Somali culture, traditional knowledge and relational ethics).

One of the arenas for these encounters is during pregnancy and childbirth within a maternity environment, where interaction between maternity care providers and women from different cultural backgrounds happens. Most times, the interactions between maternity care providers and the women are positive, leading to good clinical outcomes. However, there are a few occasions when such interactions do not generate expected outcomes, especially for non-English speaking ethnic minority women (Somali women), as previously described in chapters 1 and 3 of this thesis. Some of the possible negative outcomes for the non-English ethnic minority women, in terms of maternity care, may include: lack of cultural safety, reproductive disparities and access barriers.

Figure 6.1: **Diagram showing how a DVD may enhance maternity cultural safety**
(Adapted from Narruhn and Schellenberg 2013)
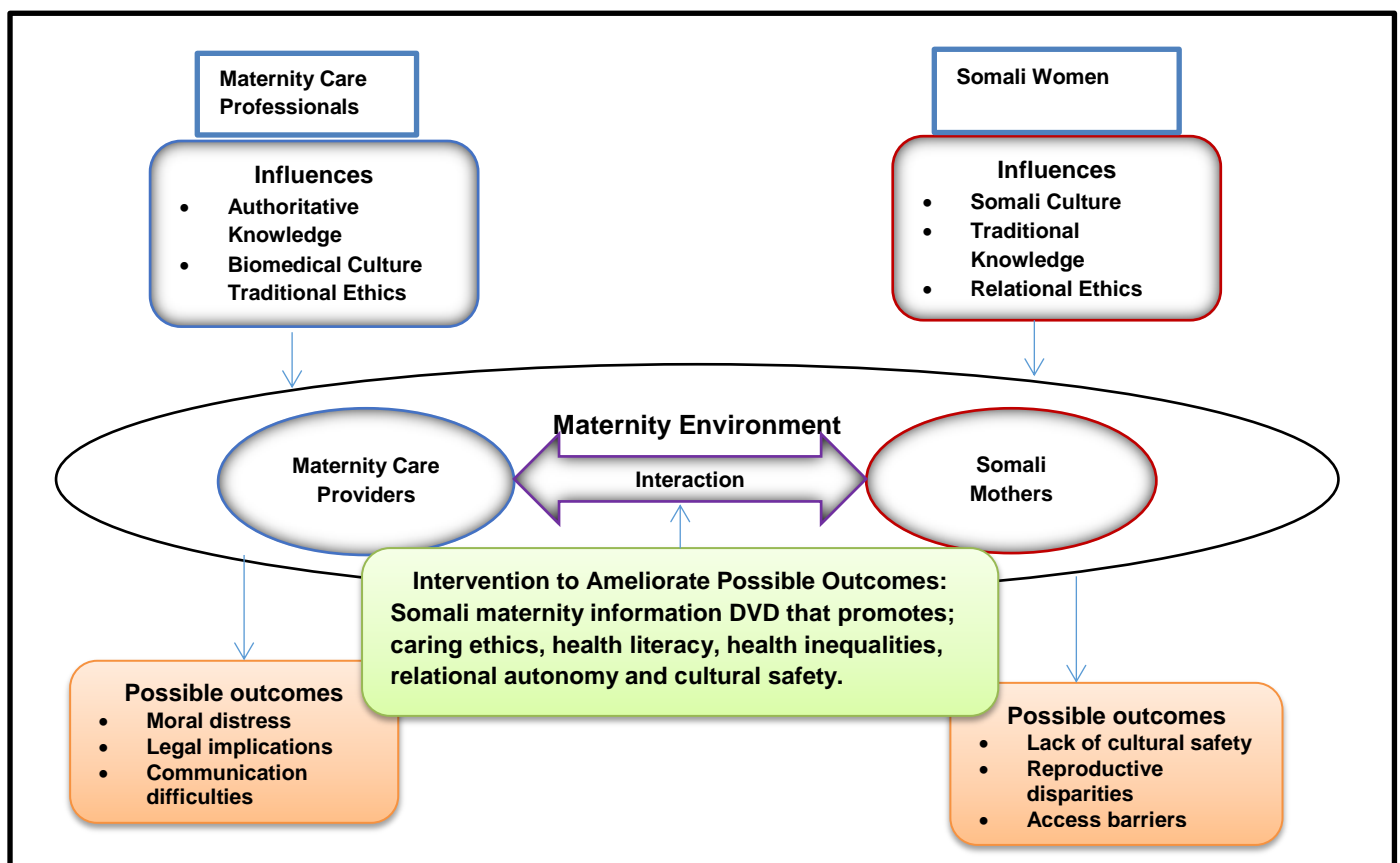
This breakdown in interaction not only affects the women but may also have a negative impact on the maternity care providers, potentially leading to moral distress, legal implications and communication difficulties. In Figure 6.1 above I suggest that the use of a DVD, generated through a social marketing approach, may be one means of enhancing maternity cultural safety.

6.7 Healthcare Professional's Perspective

I have argued in this thesis that healthcare professionals need to be culturally sensitive and embrace the concept of cultural safety. However, it is important to present a balanced view and acknowledge that many healthcare professionals are trying their best to give high quality, effective care to non-English speaking ethnic minority women. As previously described in chapter 3 8 million people - 14% of the UK's population are non-white (ONS 2011; Chapman 2014). This means, for instance, that over 130 languages are spoken in one of the boroughs used in my study. It is therefore, impractical for practitioners to learn or have knowledge of every ethnic minority group's cultural needs or understand all the traditional norms. For instance, Somali culture is such, that in public, the decision making is the remit of the man. While in private women are likely to be involved in the decision making process, this is not universally true and the final decision remains with the man (Straus 2009). Not all health professionals will understand this concept as the UK system does not support such gender differences.

Many accusations have been made by Somali women regarding health professional's attitude towards them some of which I have discussed in chapter 3 of this thesis. Some of the accusations are: deliberate subjection to Caesarean Section, stereotyping, lack of understanding regarding sensitivities around vaginal examination, being/ feeling patronised and judged: many health professionals, when hearing this, are disconcerted (Chalmers & Hashi 2000; Dundek 2006; Essén et al. 2000; Lundberg & Gertzingher 2008; Vangen et al. 2004). Health professionals felt that they were doing their best despite the constraints of constant increased pressure on healthcare services with finite resources (Chalmers & Hashi 2000; Dundek 2006; Essén et al. 2000; Lundberg & Gertzingher 2008; Vangen et al. 2004).

As previously alluded to in chapter 3, gender influences communication between health care providers and patients (Dearborn 2006) especially among Somali women. A study on Somali women reported that conceptual barriers based on socio-cultural factors, such as the provider's gender, has been influenced by the religious beliefs and attitudes of some of these women (Essén et al. 2011). This perception is also supported by empirical findings examining prenatal care among Somali women living in the USA and UK (Beine et al. 1995; Caroll et al. 2007; Davies & Baths 2001). Both research and anecdotal evidence shows the frustration and social marginalisation experienced by male healthcare practitioners/doctors when some Somali women tend to be difficult and refuse medical interventions for gender reasons (Essén et al. 2011; Rööst et al. 2009; Schenker 1993).

The situation becomes even more difficult, since some women refuse care despite the presence of a female professional interpreter. One way of reducing misperceptions might be to ensure that all new immigrants were educated about the healthcare system in the UK as most will have engagement with health services. Furthermore the issue of gender difference should form part of the booking information as obstetrics is still dominated by male doctors - 54% (RCOG 2009) although the picture is changing and more choices are available. The perception that care will be only provided by male doctors is no longer current. It is important for services to ensure that Somali women are aware of this to enable them to make the best choice possible.

In some studies of healthcare professional's experiences of caring for Somali women, many healthcare professionals admitted that in order to be culturally sensitive they consciously try to hide any disapproval they may have of certain aspects of patient's cultural and religious beliefs or misconceptions (Leval et al 2004; Widmark et al. 2002). The same studies also reveal that despite their efforts to convey cultural sensitivity, patients still pick up on unspoken sentiments through providers' body language and attitudes. Providers from multiple studies admit to being aware of their inadequate efforts at concealment (Leval et al 2004; Widmark et al. 2002).

This is ably described by a Swedish midwife in relation to FGM who said, "You're angry and your body shows it. And then you think 'no, I mustn't show anything', but your eyes and body language . . . that isn't anything we can decide to control" (Widmark et al. 2002, Pg.118). These Swedish midwives described feelings of being protective of the women, treating them with tenderness and displaying paternalistic identification with the women's "loss of sexuality" as a result of the circumcision (Leval et al. 2004). In addition, some studies on healthcare professionals' perspectives on care for Somali patients demonstrate that lack of knowledge and experience is one of the most dominant themes (Chalmers & Hashi 2000; Essén et al. 2000, Herrel et al. 2004; Tamaddon et al. 2005, Vangen et al. 2002; Vangen et al. 2004). In fact, in studies from the United Kingdom and Sweden, providers go further, admitting that some of the adverse outcomes and experiences of Somali vaginal births are exacerbated by the fact that providers are unprepared and inexperienced with care of circumcised women (Straus et al. 2009; Widmark et al. 2002).

A way forward to resolve the above challenges is by both parties (Somali women and healthcare professionals) embracing the concept of maternity cultural safety as suggested in diagram in 6.1 above. This concept mirrors partnership working.

Therefore, the DVD, may bridge some of the reasons for frustrations experienced by healthcare professionals and equally the marginalisation experienced by the Somali women. This in effect may improve caring ethics, health literacy, health inequalities, relational autonomy and cultural safety as highlighted in figure 6.1. above. However, the above proposed maternity culture safety model needs further thought and discussion before its usefulness can be fully determined.

6.8 Summary

It can be concluded from the findings of my study, combined with the studies reviewed above, that other Somali woman are likely to benefit from the Somali maternity information DVD. The ultimate goal in social marketing is behavioural change – the pre-test/post-test data showed that knowledge and behaviours changed in this small group of women. It is envisaged that once the DVD initiative is fully implemented and evaluated during the sixth and seventh phases of the SMART model, as explained in chapter 2, the DVD is a decision aid that could facilitate a change in Somali women's attitudes, beliefs and misconceptions in relation to pregnancy, childbirth and the UK's maternity model of care. It is suggested that the Trans-Theoretical Model (Prochaska & Velicer 1997) could be used to evaluate the roll-out of the Somali maternity information DVD.

Reflecting on this social marketing exercise made me consider the notion of cultural safety and I have built a model of maternity cultural safety, in which the DVD can be used to breakdown professional and service user's cultural barriers that mirrors partnership working. Hence, this may improve clinical outcomes for both the English and non-English speaking service users.

The final chapter will detail the study's limitations, implications for practice and future research, recommendations, the dissemination of findings and the project's conclusions.

Chapter 7

Strengths and limitations of the study, Implications for Practice/ Future Study, Recommendations and Conclusions

7.1 Introduction

This chapter details the study's limitations, implications for practice and future study, recommendations, the dissemination of findings and the project's conclusions.

7.2 Study Strengths

As far as I am aware, this study is the first to use a social marketing approach to evaluate the use of maternity information DVD to meet Somali women's information needs. The study has contributed to the existing body of knowledge that postulates that Somali women have maternity information needs. The study has also generated a new body of knowledge associated with Maternity Safety Culture.

A great strength of my study was that I got this very hard to reach group to participate in the study. 14 completed all aspects of the data collection process as this operationalised the social marketing approach adopted by this study. In addition, it also addresses significant practice and research issues of caring and conducting research with this hard to reach group.

This study has created a platform for other studies in this area which is highlighted in the implications for practice and future research section below.

7.3 Study limitations

Whilst considering the limitations of this study it is important to note that it was a pre-test to determine feasibility and to get more insight into the topic area rather than a full-scale evaluative intervention. With this in mind the main limitations cluster around the sample. The sample size was deliberately small but the failure of some participants to progress from pre- to post-DVD knowledge test was a disappointment. Exploring the participant's literacy levels may have helped explain some of the attrition experienced during the knowledge tests data collection process. Some other topical issues particular to Somali women, such as the importance of Vitamin D, were not explored during the knowledge tests/postnatal interviews and could be in further studies.

Another potential limitation to this study was recruiting Somali women during the Ramadan period. It has been previously discussed in chapter 5 that 3 potential participants refused to take part in the study due to the Ramadan fast. Somali women give high spiritual significance to the Ramadan fast and they believe that you have to maintain purity during this period and avoid any thing that can make you commit sin (Pathy et al. 2011). These 3 women may be sceptical of watching a DVD that they are unsure of the content.

The lack of a control group also limits the conclusions that can be made and the generalisation of the findings to the population. However, the aim and design of this pre-test did not facilitate a control group, and while it is reasonable to anticipate that the findings do reflect the DVD intervention, future evaluative work could consider using an experimental design.

Furthermore, this study focused mainly on non-English speaking Somali women, which also makes the findings less generalisable to subsequent generations whose command of the language and understanding of maternity care are likely to be improved. Nevertheless, it might be transferable to other 1st generation immigrants with limited English. In addition, since the postnatal interviews were undertaken in the Somali language, discrepancies in translation could have inadvertently changed the meanings of some comments made by participants. However, one of the ways through which this was minimised was by using mainly one interpreter for the postnatal interviews. This interpreter was not just a generic interpreter but a midwife with a good command of both English and Somali.

7.4 Implications for practice

It has been confirmed by the London Local Supervising Authority (LSA) (Read 2013) that 36.7% of London's population were born overseas, making London the city with the second largest immigrant population in the world, behind New York. Hence, a significant number of mothers using maternity services have not been born in the UK and are therefore of different ethnic, cultural and language backgrounds (ONS 2011; Read 2012).

There is growing evidence within the maternity services in the United Kingdom that health professionals and policy makers are constantly emphasising flexible services, with a focus on individualised women's care, especially for those who are more vulnerable (DH 2004a; 2007a). This approach is in alignment with social marketing principles. Maternity services have been required to adopt a woman-centred approach to care that is accessible, efficient and responsive to changing local needs (DH 1993, 2004a, 2007a). The DVD tested in this

study provided a woman-centred, flexible and acceptable way to deliver information about maternity care and experiences of pregnancy and childbirth to women who would otherwise be excluded from this sort of information because of language deficits and isolation from health services.

The Nursing and Midwifery Council (NMC 2004) asserts that a nurse (this also applicable to midwives) must develop awareness and understanding of ethnic, cultural and language differences between themselves, as carers, and those for whom they are caring. In practice this difference is easy to see but hard to put right – the maternity DVD may contribute to achieving this. It is documented that women born elsewhere experience greater difficulties when receiving maternity care than British-born minority ethnic clients, because of their backgrounds (Bulman & McCourt 2002). Other studies have argued that even British-born ethnic minority women, with good English-speaking ability, also experience poor communication from health care professionals during childbirth (Bulman & McCourt 2002; Lewis 2007, 2011). This assertion was substantiated by a study of the birth experiences of second generation South Asian Muslim women educated in the UK, which described the women as being 'muted' by midwives who neither listened to them actively nor gave them the opportunity to voice their needs (Bowes & Domokos 2003).

Other difficulties were reported in other studies of ethnic minority women; in particular, Somali women's experiences of maternity care included interpersonal issues with professionals arising from stereotypes held by staff (Bulman & McCourt 2002). Therefore, it can be deduced that the poor communication experienced by Somali women goes beyond language barriers and may also be attributed to cultural differences: promoting working within a framework of cultural safety may be one way to reduce these problems.

The Somali maternity information DVD is addressing a targeted need (information and communication barriers) among non-English-speaking Somali women accessing a local maternity unit in London. This study, although small in scale, highlights the significance of giving information in acceptable tailored formats and that this sort of information can also impact on other people not directly targeted (e.g. family and others in the community). This is consistent with the current UK Public Health strategy for addressing health behaviour change among people. The focus is currently moving away from short-term public information campaigns aimed at influencing behaviours directly, to focusing on long-term interventions that aim at tackling antecedents to observed problem behaviours and reaching out to a broader audience (Department of Health, 2011).

This study has shown that even if a Somali woman has five or six children in the UK she still may not have adequate knowledge or understanding of the maternity system. There were also key cultural childbirth misconceptions noticed among Somali women that participated in this study, such as those surrounding obstetric interventions in terms of induction of labour or Caesarean section. Most of these interventions are perceived as 'bad' among Somali women. However, it was evident in this study that a simple maternity information DVD, presented in a native language, can shift and change such misconceptions, which in practice can otherwise prove difficult when seeking consent to carry out obstetric interventions in an emergency situation. In addition, giving this DVD during the antenatal period will give Somali women opportunities to deliberate on the content of the DVD with friends and families, thereby spreading key childbirth messages to wider Somali groups including non-pregnant women.

NICE guidelines on pregnancy and complex social factors (NICE 2010) state that women should always be treated with kindness, respect and dignity. These prescriptions include promoting choice as well as respecting views and cultural beliefs; furthermore, the values of the woman in relation to her care and that of her baby should be sought and respected at all times. Good communication between healthcare professionals and clients, particularly women with limited English speaking abilities, is essential. It should be supported by evidence-based information tailored to the women's needs. Treatment and care, and the information women are given about such issues, should be culturally appropriate. They should also be accessible to women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English (NICE 2010).

This study recommends the use of a native language DVD as one of the decision aid tools for providing culturally safe care, as well as for communicating maternity information to non-English-speaking ethnic minority women. This study has also developed a model showing how a DVD may enhance maternity cultural safety. It is evident in this study, as well as in previous studies, that the use of a culturally tailored health education video or DVD for Somali women can change their knowledge and behaviours. The participants in this study recommended that this intervention (the DVD) should be extended to other non-English-speaking ethnic minority women, as they believed that other groups of women will have similar maternity information needs. Following this study, the DVD will be given to all Somali women at the point of registering their pregnancies with the midwife of the maternity unit in which this research was based. Furthermore, editions of the same DVD in other ethnic minority languages will be produced.

7.5 Implications for future research

This small study showed the value of the maternity DVD. A larger scale evaluative study, using social marketing as a theoretical framework, should be undertaken to investigate the use of a DVD for overcoming information barriers among different ethnic minority groups. This sort of study may be able to find out if women in different ethnic groups find different media or messages useful.

A future research should explore whether there is also maternity information deficit in other groups of Somali women who can speak English.

A future research study should explore how midwives /others can best work with women and DVD to provide appropriate maternity care.

In addition, future research may focus on developing online maternity video information in different ethnic minority languages, and also evaluate its acceptability and usage by non-English-speaking ethnic minority groups.

It may also be worth considering how to expose men in ethnic minority communities to similar sorts of information, so that they could be better informed about maternity care.

In relation to the model of cultural safety, further exploratory research could focus on relational care and its effects on feelings of safety and security.

Future research should explore the use of bilingual registered professionals (nurses or midwives) as an interpreter for ethnic minority research versus generic bilingual interpreter. In my opinion, the use of a bilingual midwife interpreter contributed to the success of this study.

Future researchers should be aware of the importance of the Ramadan fast to Somali women and that engaging them in research at that time may cause difficulties and attrition.

Further research should explore the United Kingdom's maternity care provider experience of caring for Somali women to balance some of the views in the available evidence on professional's poor attitudes towards Somali women.

Future evaluative studies should consider a randomised controlled trial of using a DVD as an intervention to promote knowledge change. This may affirm the findings of this study and confirm the value of using DVDs to meet language and maternity information needs.

7.6 Recommendations

The following recommendations were drawn from the analysis of the findings of this study:

- Maternity services should consider using social marketing approaches to reach the hard-to-reach group of women.
- Public Health policy makers should consider investing on national decision aid tools such as DVDs in major spoken ethnic minority languages. The DVD may be subtitled in English, which some of the women in this study found helpful.
- Policy makers should consider using social marketing approaches to engage Somali women in changing behaviours toward some of the national cultural topical issues particular to Somali women such as Female Genital Mutilation (FGM).
- As the use of social media/ technology is increasing maternity services in the UK should consider developing diverse sources of maternity information in easy to access and read formats such as YouTube/Facebook and the impact should be evaluated by research studies.
- Maternity services should move away from relying on translated information leaflets for ethnic minority languages as, identified in this study, there are low literacy levels among Somali women.
- There is a need for a larger comparative study to further evaluate the usefulness of the DVD.
- More research engagement with Somali women is required and language competence or communication difficulties should not be a barrier to conducting research among this group.
- Cultural safety should become part of the education of health professionals. In short, the incorporation of cultural competence training into pre-registration midwifery and medical education, including courses on continuing professional education to prevent stigmatisation, is desirable.
- The concept of maternity cultural safety needs further exploration and development.

7.7 Reporting and dissemination

The findings from this study will be used in the development, implementation and evaluation of more DVDs in other ethnic minority languages.

A detailed report has been submitted to the funding organisations (Florence Nightingale Foundation and the London Network for Nurses and Midwives). The DVD has been launched and is now in use. The DVD is also now available in English, Gujarati, Polish, Somali, Romanian and Arabic. These 6 DVDs were collaboratively funded by the local Hospital Trust and the Local Health Authority. The summary of my findings has been presented at conferences and has been published by Florence Nightingale Foundation.

I have also written an article that is waiting to be sent for publication in a relevant professional journal once my thesis is approved. I have, since completion of this study, used a social marketing approach to facilitate other public health related issues specific to Somali women (e.g. related to FGM) at local and national workshops, seminars and conferences. The DVD has also been used as a health promotion tool in antenatal parent education classes for Somali women. The DVD has been presented to the Maternity Services Liaison Committee (MSLC) of the Trust in which this study was conducted. The Young Somali mothers (third generation) in the MSLC are planning to further develop the DVD into 10 minutes sub-sections of key messages on YouTube.

Based on my interest in this project, I am now the London Clinic representative for FGM in the UK national FGM Committee.

7.8 Reflection on Role of the Interpreter

There have been debates on the role of using an interpreter for researching non-English speaking participants. Some authors have argued that using interpreters may undermine the richness of qualitative data unless great care is taken in preparation and training (Elam & Fenton 2003; Ruhs et al. 2006; Grewal & Ritchie 2006). Other argued that the interpreters may not use language in the way that the researcher intends and there is the potential to omit, add, condense or substitute information (Mir & Tovey 2003; Atkin et al. 2009). My experience of working with ethnic minority groups leads me to acknowledge that there will be language difficulties when conducting research with these groups. However, these difficulties can be lessened if particular attention is paid to the role of the interpreter in the study.

The interpreter I used in my study was a midwife and although a bilingual Somali/English speaker she had no formal training in interpreting skills. She was involved in the development of the DVD as she did the quality check on the voice-over done by another Somali midwife. She was also involved in recommending some of the modifications made to

the DVD. Her involvement with development also fulfils the concept of social marketing that advocated involving the target population in the development of the intervention.

It is important to mention that this study had some initial recruitment and attrition difficulties that are not uncommon in doing research with people from the ethnic minority groups. Recruitment to the study was slow due to participants not completing the knowledge test, especially the post knowledge test. This was alleviated by working closely with the interpreter/ AWWC midwife and sitting in on some of the recruitment session to offer further explanations if necessary. I met with the AWWC midwife weekly to review the recruitment process as she was the gatekeeper to potential participants.

I also reinforced the importance of the study. I allowed her to express any concerns and her own misconceptions. One of the issues that came up at our first weekly meeting was her reluctance to recruit multi-parous women into the study. She held the view that because they have had baby in the UK previously, they may not want to participate or may not benefit from the DVD. We had a long discussion about this concept and we both decided to try recruiting a multi-parous woman (who would not be in the study) and conducting a pre-knowledge test (I was present). The woman scored 2.5 in the pre-knowledge test. This showed the interpreter that the DVD was beneficial for all and this changed her views and increased her level of commitment to the study. On one occasion she said she felt proud to be part of the study as a Somali midwife giving back to the community. Again, this assertion affirms her sense of joint ownership of the study.

The approach above has been used by other researchers. For example, in a study with Eastern and Central European migrants, Ruhs et al. (2006) report their experiences of the importance of extensive discussion of translated research instruments between principal researchers and assistants which, in addition to enhancing comparability of results, also had the benefit of giving interviewers greater understanding of the intention behind questions and a sense of ownership of the research. In another study, testing of research instruments identified that, despite the development of a translated version of the survey, in practice interviewers generally preferred to use the original English version in interviews but to conduct discussions in Somali, and suggested that use of the written Somali version would lose the flexibility and nuances of a predominantly oral language (Johnson et al. 2009; Lloyd et al. 2008).

Despite the benefits of using an interpreter of similar ethnicity, there have been arguments made that, if care is not taken, there is a danger of an uncritical assumption that ethnic matching equals culturally competent research. This view may prevent researchers developing their skills, experience and understanding of conducting ethnicity research (Elam & Fenton 2003; Culley et al. 2007). Nevertheless, Edwards and Alexander (2010) in contrast argued that peer or professional interpreters from a similar ethnic background can address tensions between emancipation and democratisation of knowledge production. In addition, they can be instrumental in developing trust, networks and improve access to 'hard-to-reach' communities. This may have contributed to the retention of all the Somali women that completed the knowledge tests and subsequently, postnatal interviews.

7.9 Personal Reflection

Surprisingly, I was able to keep all the women that took part in the pre- and post-DVD knowledge tests throughout the interview stage, with the exception of one woman who was excluded from the postnatal interview, due to postpartum mental illness. This was in contrast to my pre-study assumption that this group of women may not fully commit to the study. The reason for this success may be attributed to the following: 1) Participants recognition of the DVD benefits, 2) personality, 3) similar ethnicity and 4) similar sex.

My study mainly responded to issues raised in previous studies and current practice on non-English speaking women maternity information concerns. From the outset of my study, the intention was not merely to convince participants that the study was worth contributing to, but to address how the study could be made of greater use to those it targets (Ruhs *et al.* 2006; Poudrier & Mac-Lean 2009). McLean and Campbell (2003) suggest that recruitment should be about more than simply increasing the total number of members of ethnic minority groups in the sample. They recommend making efforts to relate research to the values, interests and practices of potential participants in order to engage them in developing findings and searching for ways to apply them (Salway *et al.* 2011).

Horowitz *et al.* (2009) report recruitment of minority populations using diverse initial contact points as part of a process of community-based participatory research, in which community members and representatives identified research priorities in partnership with academics, and were engaged and supported in carrying out research. The authors identify 'commitment of both community and academic partners to each other and to the research' as key to a project's success.

Researching people with similar ethnicity and race to myself may have impacted on my research fieldwork experience. Ochieng's (2010) work with people of similar race highlighted difficulties in keeping professional and personal life experiences separate in such instances. Coffey (1999) noted that fieldwork is shaped by personal and professional identities, and these identities are shaped by individual experiences while in the field. Some participants asked to see me before deciding whether or not to be part of the study, and some demanded a detailed introduction to myself, including my ethnicity. This information had both negative and positive consequences. Bhopal (2009) recognised that the interrelationship of researcher attributes, such as gender and race, can influence the research process. While it may appear advantageous, it has some complex issues. Serrant-Green (2002) highlighted that members of the Black community feel at ease in research about race and racism conducted by someone of similar identity because they share common experiences, but they become suspicious of the researcher's motives if the research subject is a sensitive one.

My research cannot be classified as very sensitive, as it does not involve sharing lived experience but only requires comments on a DVD. I found that most of the participants were considering behavioural change after watching the DVD and they were more open and willing to engage with me, the researcher; thus good relationships developed between us. Many participants not only identified with me as a Black woman, but also in terms of ethnicity and origin. Most of them asked me what part of Africa I was from; once they knew that I was from Nigeria, they immediately offered us (myself and the interpreter) spicy tea which is customary to both Nigeria and Somalia. This was expected as part of the rapport-building process that was initiated during the recruitment of participants to the study. Also, having a Somali midwife acting as an interpreter helped to build and strengthen the relationship. This rapport was important in building a relationship which allowed me access into their personal stories (Grbich 2007).

I believe that the 14 women who completed my study willingly committed to the study. This statement is justified since all of the women participated in the postnatal interview four to six weeks after birth when they had no further involvement with the maternity service. Their commitment to the study shows the importance placed on the DVD. Some of the women also said that it would be good to give the DVD to all Somali women. Trust gained by the participants also contributed to retaining all the 14 participants that completed the study.

Trust is identified in the literature as important when it is reciprocated by the care provider and the pregnant woman. Similarly, reciprocity occurs when there are mutual agreements

between the women's own birth plans and the provider's care recommendations (Tanassi 2004). Lack of trust among immigrant Somali women in relation to acute and non-acute labour interventions has been described from other migration contexts in the US and UK (Carroll et al. 2007; Herrel et al. 2004; Straus et al. 2009). Low levels of mutually-held trust can also magnify divergent conceptualisations about emergency labour care, especially as they relate to emergency Caesarean Sections, and can heighten vulnerability for women if they refuse treatment and for providers if they are not properly supported by health system care guidelines (Essén et al., 2011) in such difficult situations. I might tentatively suggest, in my reflection, that the trust developed in this study could also help participants feel more confident in health care and enhance more participation in research in the future. In addition, maybe the participants in this study would become advocates, within their community, encouraging others to seek maternity care early, and /or to participate in research.

7.10 Study Conclusion

Social marketing has been used in this study to develop and evaluate the usefulness and acceptability of a Somali maternity information DVD. During a pre-testing of the DVD, mixed data collection methods (knowledge tests and semi-structured interviews) were utilised to determine the acceptability and usefulness of the DVD.

It was evident that most Somali women who took part lacked knowledge of maternity information. This was demonstrated by the significant variance (6.7) between the pre- and post-DVD knowledge tests scores of the participants in this study. This lack of knowledge, if mirrored in other Somali pregnant women, may contribute to the known high morbidity and mortality among this group, due to their cultural misconceptions and poor access to care.

All the women in this study found the DVD informative, relevant and useful. They said that what they saw on the DVD reflected the reality of the care they received in pregnancy, labour and during the postnatal period. They explained that the information and knowledge they received from the DVD had raised their awareness and empowered them to make informed choices, especially during labour.

Most of the women felt they had a voice and were able to contribute to decision making about their care. This finding strongly supports the use of a native language DVD as a decision aid tool to achieve various goals in national childbirth policies 'Changing Childbirth' and 'Maternity Matters' which advocate the need to treat women as individuals and bridge the gap in terms of the inequalities experienced by non-English-speaking women (DH 1993, 2007a; Homeyard & Gaudion 2008, Gaudion et al. 2009).

It has been demonstrated by the findings of this study that the information, clarity of message and usefulness of the Somali maternity information DVD were rated highly (excellent). All participants in the study viewed the DVD as appropriate and culturally acceptable to Somali women. All the women in the study who took the post-test demonstrated an increase in their knowledge, from before-to-after watching the maternity information DVD. It is also suggested that the message on a DVD may elicit specific questions, leading to increased interaction with health providers and thereby allowing providers to better address the needs of Somali women. The acceptability of health education messages may be increased by using the viewers' language, in this case Somali, which was preferred by all the study's participants.

Therefore, it is reasonable to conclude that the study has answered the research question about whether the provision of a native language maternity information DVD for non-English-speaking Somali women improves their knowledge of maternity care in a manner that they find acceptable and useful to them. The research has also achieved the aim and objectives of the study.

This project is unique because it draws out various clinical-cultural childbirth issues from both Somali women's and healthcare professionals' points of view. It also provides practical recommendations in addressing these clinical-cultural childbirth issues with the use of a simple tool such as the Somali maternity information DVD to promote maternity cultural safety.

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Appendices

Appendix 1: Strategy of Literature Search for Relevant Studies

A wide range of literature was used in my study and the majority of the articles were retrieved via databases such as CINAHL, Medline, Maternal and Infant Care, Cochrane

Systematic Review, Pubmed MIDIRS, EMBASE and Google Scholar. These were interrogated searching for articles relevant to the research topic. Manual searches of journals were also necessary to identify relevant journal literature. The journals that were manually searched were: the British Medical Journal, Nurse Researcher, the Journal of Advanced Nursing and the Journal of Social Marketing. Some text books on research and ethnicity were also accessed. Some government and voluntary organisation websites were visited, such as the Office of National Statistics, the Department of Health and the King's Fund library. From the articles extracted from the searches above, 11 key studies were particularly relevant to the topic of my studies - they are summarised in figure 18 below. I adopted and followed the reporting guidelines and criteria set by Moher et al. (2009) for selecting relevant studies.

Databases and Journals

All databases listed above were accessed. However, relevant studies retrieved came from CINAHL and Medline and are thus included in the flow chart below (figure A). Although, I also did some hand searching, and back tracking (looking at references from one paper to another to see if anything relevant was identified) no additional studies were identified through this process.

Inclusion criteria for considering studies Study design or types of studies

In selecting studies to be used in this study, I did a wide search of studies of:

- Any research method written in English from 1990-2014.
- Research studies using both qualitative and quantitative study designs.
- The studies focusing on ethnic minority groups, especially, Somali women.

Exclusion Criteria

- Research articles based on commentaries of the literature (opinion articles).
- Articles that do not focus on ethnic minority women or Somali women.

Key Terms

The main key term used was set as Somali women and the term was then combined with other key words such as: maternity services, childbirth, pregnancy, parent education, health information, health literacy, decision making, patient information materials, health information

leaflets, video tapes, culture, cultural safety, birth outcomes, interpreter, FGM, Caesarean section, pregnancy outcomes, Somali and stillbirth.

Data Extraction

The flow chart below summarises how the relevant studies were selected.

Figure A: Flow Chart for Selection of Relevant Studies

Titles and/or abstracts identified and reviewed with Main term as Pregnancy, Childbirth, Maternity care

(Smart Text Search)

CINAHL (n = 137,594)

Medline (n = 175,223)

Focusing Search to Somali women (Boolean Search) Search limit to year 1990-2014

CINAHL (n= 68)
Medline (n= 105)

Screening Search extraction for relevance to Study

CINAHL (n= 30)
Medline (n= 32)

Removal of Doubles

CINAHL (n= 23)
Medline (n= 14)

Assessment of Quality
(CASP)

CINAHL (n= 8)
Medline (n= 3)
Total = 11

Studies Quality Assessment

The quality of these studies was assessed using appropriate checklists devised by the Critical Appraisal Skills Programme (Public Health Resource Unit 2005) for different methods used in research studies.

Appendix 2

Summary of Relevant Research Studies

No.	Study	Objectives	Characteristics of Articles	Limitation	Conclusion

1.	Ameresekere et al. (2012) Somali immigrant women's perceptions of caesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA.	To explore perceptions of Caesarean delivery and patient–provider communication surrounding female circumcision and childbirth through interviews with Somali women residing in the USA.	Qualitative Research. No. of Participants= 23 Somali women Data collection was through individual interviews.	Small sample size, reliance on recruitment via a *single community agency,* lack of audio-recorded interviews	Previous experiences and cultural beliefs can affect how Somali immigrant women understand labour and delivery practices in the USA and can explain why some women are wary of Caesarean delivery. Educating providers and encouraging patient–provider communication about Caesarean delivery and female circumcision can ease fears, increase trust, and improve birth experiences for Somali immigrant women in the USA.
2.	Binder et al. (2012) Shared Language is Essential: Communication in a Multi-ethnic Obstetric Care Setting	To gain a deeper understanding of the Multi-ethnic care setting and the roles that ethnicity and language play during the sensitive care encounter between immigrant women and their western obstetric care providers. .	Qualitative Research. No. of Participants= 112 50= women 62= Health care providers Data collections were through focus groups and individual interviews.	Dependability on the community broker for recruitment. Lack of clarity on sampling technique.	The provision of culture-sensitive care is faced with foundational barriers eg. communication, which must be adequately addressed before disparities in health outcomes for Underserved populations can be overcome.
3	Binder et al. (2012) Conceptualising the prevention of adverse obstetric outcomes among immigrants using the 'three delays' framework in a high-income context	To identify delay-causing influences on the pathway to optimal facility treatment. And to compare factors influencing the expectations of women and maternal health providers during care encounters	Qualitative Research No. of Participants 54= Women 62= Health care provider Data collections were through focus groups and individual interviews	Lack of clarity on sampling technique Combination of different ethnic minority groups, where there are many cultural difference.	The maternal migration effect further provides the groundwork for conceptualising delay-causing socio-cultural influences that can have broad implications for global maternal health initiatives
4.	Brown et al. (2010) "They Get a C-Section . . . They Gonna Die": Somali Women's Fears of Obstetrical Interventions in the United States	The authors explore sources of resistance to common prenatal and obstetrical interventions among 34 Somali resettled adult women in Rochester, New York.	Qualitative Research No. of Participants 34= Somali women Data collections were through focus groups and individual interviews	Limitations of this study include possible reporting bias given that the four interviewers were health care professionals.	The study concludes that both non-Bantu Somali and Bantu Somali women expressed the fear of dying from caesarean section and the belief that doctors rush obstetrical interventions

5.	Davies and Bath (2001) The Maternity Information Concerns of Somali Women in the United Kingdom	To explore the maternity information concerns of a group of Somali.	Qualitative Research. No. of Participants= 13 women Data collections were through interviews and demographic data were collected via questionnaire.	The length of time that the participants had spent in the UK was not considered when selecting participants for the focus group.	Poor communication between the non-English Somali women and health workers was perceived as an underlying problem in seeking information.
6.	DeStephano et al. (2010) Somali prenatal education video use in a United States obstetric clinic: A formative evaluation of acceptability	Because of low health literacy and low priority in seeking prenatal information, health education videos were explored for acceptability by Somali refugee women in a clinical setting.	Qualitative Research. No. of Participants= 22 women Data collections were through focus groups and individual interviews.	Absence of a pre-test or control group limit conclusions of the study	Preliminary results from this study suggest that a video format for prenatal education is acceptable to Somali clients with most clients preferring video health education materials presented in the Somali language.
7.	Essén et al. (2011) An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on Caesarean birth	To explore the perceptions of 39 Somali women and 62 obstetric care providers in London in relation to Caesarean birth	Qualitative Research No. of Participants= 112 39= Somali women 62= Health care providers	The recruitment method was not explicit.	Somali women expressed fear and anxiety throughout the pregnancy and identified strategies to avoid Caesarean section (CS). There was widespread, yet anecdotal, awareness among obstetric care providers about negative Somali attitudes.
8.	Hill et al. (2012) Somali Immigrant Women's Health Care Experiences and Beliefs Regarding Pregnancy and Birth in the United States	To describe Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth.	Qualitative Research No. of Participants= 18 Somali women	The participants have lived in US for so long, no new immigrant used which may not be representative. There were difficulties in transcribing the interviews which may invalidate the findings of the study.	Somali immigrant women were comfortable with their prenatal, birth, and breastfeeding experiences. The discussions illuminated difficulties in understanding the purpose of prenatal care, because pregnancy was not seen as a reason to seek medical care and delivery was seen as a natural process that did not require a medical intervention.
9.	Small et al. (2008) Somali women and their pregnancy outcomes Post-migration: data from six receiving countries	To investigate pregnancy outcomes in Somali-born women compared with those women born in each of the six receiving countries: Australia, Belgium, Canada, Finland, Norway and Sweden.	Design: Meta-analyses of routinely collected data on confinements and births. Sample: A total of 10 431 Somali-born	Inconsistent data collection methods from the 6 countries used in the study	This study has identified a number of disparities in birth outcomes between Somali-born women and their receiving country counterparts.

				women and 2 168 891 receiving country-born women.		
10.	Straus et al. (2009) Somali women's experience of childbirth in the UK: Perspectives from Somali health workers	To conduct a qualitative study of perceptions of experiences of childbirth from Somali health workers in the UK	Qualitative Research No. of Participants= 8 Somali women	However, interviews were conducted in English, only Somali Health professionals that have high literacy levels. Therefore, the findings in this study are not representative.	The findings demonstrate that there are major concerns around: the mismanagement of care for women who have been circumcised, aspects of communication, continuity of care and attitudes of health professionals
11.	Vangen et al. (2002) Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway	To explore how perinatal care practice may influence labor outcomes among circumcised women	Qualitative research Sample: 23 Somali women and 36 Norwegian health care professionals .	Most of the participants used in the study have been educated in Norway therefore the findings of the study may be biased.	the findings show a lack of consciousness among health care professionals regarding circumcision as a medical problem.

Appendix 3

Recruitment Information Sheet for the Research Study

Dear Midwife

My name is Gloria Urhoma and I am a doctoral student at the University of Southampton and I am conducting this study as part of my doctoral programme. I have developed a Maternity Information DVD for non-English speaking Somali Women and I need to evaluate the impact of the DVD.

The need for this study was recognised when we realise that most of the maternity information resources are only available in English and the majority of the women who use our services may not be able to read in English. This is an indication that the majority of these women have been missing out on important childbirth information, hence not receiving quality maternity care.

We would like to work closely with Somali speaking women to evaluate this DVD.

We would need you to kindly give my contact details to Somali women who are 25-32 weeks pregnant during routine antenatal clinics. An interpreter will be available for the recruitment process.

Do not hesitate to contact me on (phone number provided) if you required further information regarding this study.

Thank you for your support as we improve care for these vulnerable women.

Gloria Urhoma
Researcher
Maternity Unit

Appendix 4a

PARTICIPANT INFORMATION SHEET

(English version; also translated into Somali: Appendix 4b)

Can the provision of a native language maternity information DVD for non-English speaking Somali women improve their knowledge of maternity care and do women find the DVD acceptable and useful?

You are invited to take part in a study to evaluate knowledge change, acceptability and usefulness of a maternity information DVD developed for non-English speaking Somali women. Please take time to read the following information carefully and discuss it with others if you wish. Before you decide whether to take part or not, it is important for you to understand why the study is being done and what it will involve. Ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

1) What is the purpose of the study?

The purpose of this study is to evaluate a maternity information DVD developed for Somali women. Also to study whether a maternity information DVD for Somali women improves their knowledge-base of maternity services in a way that is acceptable and useful to them.

2) Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason.

3) What will happen to me if I take part?

You will be asked for complete a pre-knowledge questionnaire which is to help us evaluate your knowledge of basic maternity care information. After which you will be given the maternity information DVD to watch. At least one week after watching the DVD, you will be asked to complete a post knowledge test questionnaire to evaluate change in your knowledge of basic maternity care information. The questionnaire will take 10-15 minutes to complete. At least 4-6 weeks after delivering your baby, we would interview you to evaluate if the content of the DVD is culturally acceptable and is useful to you. We would also want to know if there are comments you wish to make on the content and the presentation of the DVD.   A Somali interpreter will be available at every stage of the study. It is envisaged that

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the interviews will last 30-60 minutes and it is going to be tape-recorded for me to remember our conversation.

If, during the course of the study, we identify that you are feeling particularly anxious about your childbirth experience, and may benefit from talking to someone who can give you further support, we will ask if you would like us to refer you to our hospital birth debriefing team or your GP.

4) What are the possible benefits of taking part?

There is no intended direct clinical benefit from taking part in the study. However, the information in the DVD may help you know more about maternity care. In addition, information from the study will help us to improve on the quality of the maternity information DVD.

5) What if something goes wrong?

I do not believe that there are any possible risks or disadvantages in taking part and we do not anticipate anything going wrong.

6) Will my taking part in this study be kept confidential?

Results from the study will not contain any personal information. All information collected during the course of the study will be kept strictly confidential and will not be traced to you in any form. I will keep this data for 10 years according to my school study policy (University of Southampton).

Everybody participating in the study will be required to sign a confidentiality form.

7) What will happen to the results of the research study?

The result will be presented in conferences, published in relevant journals and the DVD used as workshop materials for midwives. Further production of similar DVDs will be extended to other main ethnic minority groups. The DVD will also be made available to the local general practitioners as they collaboratively work with midwives in caring for pregnant women. Furthermore, other health care providers can adopt this innovative information system, as a way forward for bridging communication gaps with the non-English speaking ethnic minority clients.

8) Who has reviewed the study?

This study has been peer reviewed in the Faculty of Health Sciences, University of Southampton.

9) Contact for Further Information

If you would like any further information please contact the lead study co-ordinator: ***Gloria Urhoma, Level 5 Maternity Unit.***

If you have any complaints about the conduct of this study and you wish to discuss them with someone other than the study lead, please contact:

Professor Andree Le May or Dr. Elizabeth Cluett, Academic Supervisors, University of Southampton. Telephone (provided).

Thank you for taking the time to read this information sheet.

Appendix 4b/Iifaaqa 4b- Participant Information Leaflet- Somali Version

WARQADDA MACLUUMAADKA LOOGU TALA GALAY
KA SOO QAQYBGALAYAASHA

10) Baaritaan iyo daraasaad macluumaad ku saasan hooyada uurka leh ilaa inta ay ka dhasho oo DVD cajal ah oo loogu tala galay haweenka soomaaliyedd oo aan af-ingiriiska ku hadlin.

Waxa laguuugu casumay in aad ka soo qaybgasho baaritaan iyo daraasaad ku saabsan maclumaadka guud ee hooyada xaammildaa ilaa inta ay ka dhasho oo lagu soo bandhigi doono cajal DVD ah looguna tala galay dumarka soomaaliyeed oo aan af-ingiriiska ku hadlin. Fadlan si taxadir u akhri maclumaadkan kalana munaaqashoo dadka kale haddii aad doonaysid. Inta aadan go'aan ka gaarin ka qaybgalka baaritaankaas iyo daraasaadka, waxa muhim ah marka hore in add fahamto sababta loo sameeynayo baaritankaasi cilmiyeed iyo waxtarka uu leeyahay. Weydii ama su'aal haddii ay jiraan waxyaabo mugdi kaaga jira ama haddii aad doonaysid macluumaad dheeraad ah. Waqti kugu filan qaaddo ama ka soo fikir haddii aad ka soo qaybgalayso iyo haddii kale.

11) Waa maxay ujeeddada daraasaadkan laga leeyahay?

Ujeeddada darasaadkan laga leeyahay waxa ay tahay in la qiimeeyo horena loo mariyo aqoonta guud ee ku saabsan hooyada soomaalyeed ee xaamilada ah ilaa inta ay ka ghalayso. Sidoo kale in la ogaado isla markaana la baaro horumarka iyo isbeddellada ay samaynayaan hooyooyonka soomaaliyeed ee xaamioooyinka iyo in loo fidiyo adeeg wanaagsanay ay ku faraxsanyihiin oo la aqbali karo.

12) Ma in aan ka qaybqaato baa?

Adiga aya kugu xirantahay inaad ka qayb qaadato iyo in kale. Haddii aad go'aan ku gaarto in aad ka qayb qaadato, waxa lagu siin doonaa warqaddan macluumaadka ku qoranyihiin waxaana lagu weydiin doonaa in aad saxiixdo warqad aqbalid ah. Haddii aad go'aan ku gaartid in aad ka qayb gasho xor baad u tahay in aad marka aad doonto isaga baxdo adigo ooo aan sheegin wax sabab ah.

13) Maxaa igu dhici doono haddii aan ka qaybqaato?

Waxa lagu weydiin doonaa in aad buuxiso form su'aalo ah oo kaa kaalmayn doono xagga aqoonta ee arrrimaha hooyada xaamilada ah iyo sida loo daryeelo. Waxa kale

oo lagu siin doonaa cajal DVD ah ee aad daawan doonto kuna saabsan maclumaadka hoooyada xaamilada ah. Todobaad ka dib marka aad soo daawato cajalkaasi DVDga , waxa lagu weydiin doonaa in aad buuxiso foorm su'aalo ah ee ku saabsan wixii aad soo daawatay ee ku saabsanaa maclumaadka hooyada xaamilada ah iyo waxyalaha aad ka soo kororsatay.   Marka ay ugu yartahay lix todobaad ka dib markii aad canugga dhasho, waxa aan jeclaan lahayn in ku waraysanno si aan u qaymaynayo maqsuudnimadaada iyo maclumaadka   aad heshay intii aad dawatay DVDga iyo afkaarta   aad ku soo kordhin kartid.   Tarjubaan soomaaali ah ayaa diyaar ku noqonaya goobta. Waraysiyada waxa ay socon doonaan ama qaadan doonaan ugu yaraan 30-60 daqiiqadood waana la duubi doonaa si aynu u xasuusanno wixii aynu duubnay.

Haddii, inta uu tababarku socdo aan ogaanno in fooli ay ku hayso waxa aan isku dayi doonnaa in aan ku taakulayno waxa aan ku weydiin doonna in aan kuu gdbinno isbitaalka ama takhtarkaada haddii aad doonaysid.

14) Maxaa faaido ah ayaan ka helayaa haddii aan ka qaybgalo?
Ma jiraan wax farsamo ah in aad ka helayso oo aad ku shaqayso kartid haddii aad ka qaybgashid tababarkan. Macluumaadka aad ka hesho DVDga waxa laga yaabaa inay ka kaaalmeeyaan xagga daryeelka hooyada xaamilada . Intaa waxa dheer in maclumaadka aad ka halayso DVDga ay kaa kaalmayn doonaaan xagga tayada iyo horumarinta daryeelka ee hooyada uurka leh ilaa inta ay ka dhasho.

15) Maxaa dhacaya haddii ay wax qaldamaan?
Ma filayo in wax qqatar ah ama halis ay dhaci doonaan marka laga qaybqaadanayo tababarka mana idin sheegi karo wax qalad ah ee dhaci doona.

16) Ma in aan xifdiyaa ama sir ii ahaataa ka qaybgalka daraasaadkan?
 Daraasaadka wixii ka soo baxa lagama heli doono macluumaad taabanaya ama ku saabsan shaqsi. Dhammaan macluumaadka la uruuriyo inta daraasaadka tababarka socdaan waxa ay noqon doonaan kuwo la xifdiyo mana laguu oggolaan doono in aad tixraacdo ama daba gasho. Qof kasto ee ka qaybgalayo tababarka waxa laga codsan doona in uu saxiixo foormka sir xifdinta.

17) **Sidee bay noqon doonaan ama halkay bay ku dambayn doonaan natiijooyinka daraasaadka ?**

Natiijooyinka waxa lagu soo bandhigi doonaa shirar (conferences), kuwaasi oo lagu daabici doono jaraaidyo DVDgana waxa lagu keydiin doonaa xafiiska shaqaalaha umulaya dumarka ee qaybta dhallanka. DVDdii kanoo kale ah waxa loo fidin doonaa jaaalliyada kale eek u deggan dalka. DVDga waxa kale oo loo gudbin doonaa Takhaatiirta xaafadaha(GPs) kuwaasoo la shaqeeya xiriirna la leh umulasooyinka daryeela dumarka uurka leh .Hayado kale ee daryeela caafimaadka waxa ay ka fideysan karaan macluumaadka si ay taakuleeyaan jaaalliyadaha aan af- ingiriiska ku hadlin ama uu afkooda ahayn.

18) **Yaa soo baaray daraasaadkan?**

Daraasaadkan waxa soo baartay kulliyadda caafimaadka , jaamacadda Southampton.

19) **Kala xiriir macluumaad dheeraad ah**

Haddii aad doonaysid macluumaad dheeraad ah fadlan kala xiriir iskudubbaridaha barnaamijka: *Gloria Urhoma, Level 5 Maternity Unit. Telephone number (provided).*

Haddii aad qabto wax dacwad ah ee ku saabsan xagga mashruucan isla maarkaana aad doonaysid in kala hadasho qof kale oo aan ka tirsanayn kuwa hawshan wada fadlan kala xiriir

Professor Andree Le May or Dr. Elizabeth Cluett, Aca kala hadsh demic Supervisors, University of Southampton. Telephone number (provided)

Waad mahadsantahay in aad waqti kaaga ku lumay akhrinta warqaddan.

Appendix 5

Results of the 11 remaining participants that only completed the pre-knowledge tests

	Results of 11 Particpants that only completed pre-Knowledge Tests										
Participant	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total Scores
16	0	0	0	0	0	0	0	0	0	0.5	0.5
17	1	0	0	0	1	0	1	0	0	1	4
18	1	0	0	1	0	0	0	0	0	0.5	2.5
19	1	0	0	0	0	0	1	0	0	0.5	2.5
20	0	0	0	0	0.5	0	0.5	0	0.5	0.5	2
21	0	0	1	0	1	0	0.5	0	0	1	3.5
22	1	0	0	0	0	0	0	0	0	0.5	1.5
23	1	0	0	0	0	0	0	0	0	0.5	1.5
24	1	0	0	0	1	0	1	0	0	0.5	3.5
25	1	0	0	0	0	0	0.5	0	0	0.5	2
26	0	0	0	0	0	1	0.5	0	0	0.5	2
Total											25.5
Mean											2.3
Range										0.5-4	

Appendix 6

Pre-knowledge test questions and schedule

Pre-Knowledge test to commence on March 2012

No	Questions	Answer
1.	At how many weeks of pregnancy do you need to register your antenatal care?	
2.	How will you contact your midwife directly to book your antenatal care when pregnant?	
3.	What educational session will you attend if you need more information about pain relief methods in labour?	
4.	What importance is Vitamin D to your pregnancy?	
5.	Tell me at least 2 blood tests that will be taken during your antenatal care?	
6.	What will happen to you if you do not go into labour by 41 weeks of pregnancy?	
7	Tell me at least 2 types of pain relief methods that are available for labour pain?	
8	What injection may be given to you to help deliver your placenta?	
9	What injection will be given to your baby after birth and why is it given?	
10	What are the choices of place of birth that are available to you?	

Scoring Method:

Correct answer = 1 and Wrong answer = 0

Scores:

Appendix 7

Post-knowledge test questions and schedule

Post-Knowledge test to commence on April 2012

No	Questions	Answer
1.	At how many weeks of pregnancy do you need to register your antenatal care?	
2.	How will you contact your midwife directly to book your antenatal care when pregnant?	
3.	What educational session will you attend if you need more information about pain relief methods in labour?	
4.	What importance is Vitamin D to your pregnancy?	
5.	Tell me at least 2 blood tests that will be taken during your antenatal care?	
6.	What will happen to you if you do not go into labour by 41 weeks of pregnancy?	
7	Tell me at least 2 types of pain relief methods that are available for labour pain?	
8	What injection may be given to you to help deliver your placenta?	
9	What injection will be given to your baby after birth and why is it given?	
10	What are the choices of place of birth that are available to you?	

Scoring Method:

Correct answer = 1 and Wrong answer = 0

Scores:

Appendix 8

Semi-Structured Interview Schedule (Postnatal interviews)

No	Questions
1.	Did the DVD increase your knowledge of maternity care? Further inquiry during the interview: • Do you feel you have better knowledge of the care you will receive during your pregnancy, birth and in the postnatal period after birth? • If the DVD has increased your knowledge of maternity care, how did the DVD help you make an informed choice during your pregnancy, birth and in the postnatal period?
2.	What are the benefits of producing this DVD in Somali rather than English? Further inquiry during the interview: • Can you explain your views about receiving information in a DVD format or would you have preferred a Somali written leaflets? • How will it benefit others, e.g. new immigrants? • Are there any behaviour changes you have made or you would make in the future as a result of watching this DVD?
3.	What aspect of the DVD do you like most? Further inquiry during the interview: • Can you explain further why you chose those parts of the DVD?
4.	What aspect of the DVD do you not like? Further inquiry during the interview: • Is there other information that you would like to be addressed or included in the DVD?
5.	Was the content of the DVD clear and easy to understand? Further inquiry during the interview: • Do you think all Somali women will understand the language used in the DVD?
6	Was there any aspect of the DVD that was not culturally acceptable to you? Further inquiry during the interview: • Was there any aspect of the DVD that you would like to be removed? Give me some examples.
7	How would you rate the DVD? a) Poor b) Average c) Good d) Excellent Further inquiry during the interview: • Can you give me the reason for your chosen answer? • Did you watch the DVD with anyone else? • Will you recommend the DVD to your family and friends?

Appendix 9a

CONSENT FORM

Can the provision of a native language maternity information DVD for non-English speaking Somali women improve their knowledge of maternity care and do women find the DVD acceptable and useful?

Name of Lead Researcher: Gloria Urhoma

In order to confirm your willingness to take part in this research, we would be grateful if you would read, complete, sign and return one copy of this form (the interpreter will read to the women)

This study has been explained to me by _____

Yes   No

I confirm that I have read and understood the information sheet for the above study, and have had the opportunity to ask questions

☐ ☐

I agree for the researcher to record the interviews

☐ ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, and without giving any reason.

☐ ☐

I agree to take part in this study.

☐ ☐

Name of Participant _____ Signature _____ Date _____

OR

Thumb Print of Participant _____ Date _____

Name of Interpreter _____ signature_____ Date _____

Name of Researcher _____ Signature _____ Date _____

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Appendix 9b/Lifaaqa 9b Consent Form-Somali version

FOORMKA AQBALIDDA

Baaritaan iyo daraasaad lagu qiimeynayo macluumaad ku saabsan hooyada uurka leh ilaa inta ay ka dhasho oo DVD ah looguna tala galay dumarka soomaaliyeed ee aan af-ingiriiska ku hadlin.

Magaca Hooggaamiyaha Tababarka: Gloria Urhoma

Si aan u hubinno ka soo qaybgalkaada baaritaankan ama tababarkan, waxaan jeclaan lahayn in aan marka hore akhriso, buuxiso, saxiixdo hal nuqul ama koobi ee foomka soona celiso(Tarjubaanka ayaa u akhrin doona dumarka)

Daraasaadkan   waxa   ii   macneeyay

_____

	Haa	Maya
Waxan caddayaynayaa in aan akhriyay isla markaana fahmay warqadda macluumaadka ee kor ku xusan waxaana ii suurto gashay in aan su'aalo weydiiyo	☐	☐
Waxa aan oggolahay in la duubo, lana diiiwaangeliyo waraysigan	☐	☐
Waxa aan fahamsanahay in ka qaybgalkaygu yaahay mid aan raalli ka ahay mutadawac isla markaana xor nu ahay in aan ka baxo aniga oon wax cudurdaar ah bixin.	☐	☐
Waxa aan aqbalayaa ama doonayaa in aan daraasaadkan ka qaybgalo	☐	☐

Magac ka Qaybgalaha _____ Saxiixa _____ Taariikh _____

AMA

Saxiixa Suulka ee ka qaybgalaha _____ Taariikh _____

Magaca Tarjubaanka _____ Saxiixa_____ Taariikh _____

Magaca   Hoggaamiyaha   tababarka   _____   Saxiixa_____   Taariikh _____

Appendix 10

Letter Confirming Permission to Approach

Private and Confidential

Head of Midwifery and Gynaecology

Dear ,

Letter Confirming Permission to Approach

I write to formally request your permission to approach 20 Somali women via the Africa Well Women Clinic to participate in a study to evaluate knowledge change, acceptability and usefulness of a maternity information DVD developed for Somali women. The structure of the research study will involve pre and post knowledge test questions to assess change of knowledge before and after watching the DVD. A further interview will be carried out to evaluate their acceptability and the usefulness of the information received through the DVD. The study is scheduled to be completed by September 2012.

Authorised By:

Print Name …………………………….   Signature ……………………..

Designation …………………………….   Date ………………….…………

Researcher

Print Name …………………………….   Signature ……………………..

Designation …………………………….   Date ………………….…………

Appendix 11

Estimated Timetable 2011-2013

NO.	Dates	Activities
1.	29 September 2011	Acceptance of proposal by academic supervisors
	05 October 2011	Send proposal for peer review
3.	20 December 2011	Commence completing IRAS form
4.	01 March 2012	Apply for ethics approval
5.	09 May 2012	Commence recruiting & pre-knowledge test
6.	09 June 2012	Commence post-knowledge test
7.	1 August 2012	Data analysis on knowledge test questions
9.	21 September 2012	Interviews
10.	22 September 2012	Interviews data transcription and analysis
11.	28 September 2012	Submission of interim report
12.	1 October 2012	Commence write up of research dissertation
13.	December 2012	1st Viva
14.	January 2013	Completion of postnatal interviews
15.	January 2013	Submission of Florence Nightingale report
16.	August 2014	Submission of final thesis
17.	August 2015	Resubmission

Appendix 12

Study Interpreter's Statement of Agreement

Name of Lead Researcher: Gloria Urhoma

I agreed that any information obtained during the course of this study will not be discussed anywhere else. The participant's confidentiality will be maintained at all times.

Interpreter

Name of Interpreter _____ Signature_____ Date _____

Researcher

Name of Researcher _____ Signature _____ Date _____

Appendix 13

NHS
Health Research Authority

NRES Committee North West - Preston
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7818
Facsimile: 0161 625 7299

20 February 2012

Ms Gloria Urhoma
Doctorate Student

Dear Ms Urhoma

Study title:	Can the provision of a Native Language maternity information DVD for non-English Speaking Somali Women improve their knowledge of and satisfaction with maternity information?
REC reference:	12/NW/0156

The Proportionate Review Sub-committee of the NRES Committee North West - Preston reviewed the above application by correspondence.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, **subject to the conditions specified below.**

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

A Research Ethics Committee established by the Health Research Authority

Appendix 14- DVD Script

		VISUALS	**SOUNDTRACK**
Shot	Location	Description	

		Title Card *MATERNITY SERVICES INFORMATION PROGRAMME*		

| | EXT: **Maternity** **Hospital** | Establish North West London NHS Maternity | **VOICE OVER** **Congratulations on your pregnancy and welcome to our Maternity Unit. We provide antenatal care in two sites. Northwick Park Hospital and at Central Middlesex.** | |

| | INT: Maternity Ward **Hospital** **Comments** • **Divide into section** • | Establish the Maternity Unit | **These are both exciting and worrying times and this programme has been made to give you all the basic maternity information you'll need over the next couple of months.** **We've aimed to make this programme as easy to understand as possible, but if at the end you have any questions or issues regarding anything you've seen or heard, please don't hesitate to speak to your midwife.** **Our overall aim is to make sure your stay with us, and those first few special weeks after the birth of your new baby, are as pleasant as possible.** | |

| | STUDIO | **Title Card** *THE GOOD NEWS* | | |

| | | | | |

| | INT: Home with a positive pregnancy Kit **Home** | An expectant mother talking to a midwife. | **You can take a pregnancy test from the first day that you miss your period by using a pregnancy test kit.** **Once you've found out that you're pregnant, you will need to inform your midwife either by self-referring yourself directly to the midwife by obtaining the self-referral form from children centres or on the maternity web site at www.nwlh.nhs.uk/maternity.** **or** **You can contact your GP at your local health centre.** | |

		You'll need to register early to ensure that you and your baby get all the care you need and you will be able to have certain screening tests that need to be carried out ideally, by the 10th week into your pregnancy.	
STUDIO	**Title Card** ***THE STAFF***		

Hospital	Montage of midwife, consultant, GP, anaesthetist, paediatrician and student midwife in action. **CAPTIONS** Midwife Consultant GP Health Visitor Anaesthetist Paediatrician Student Midwife Maternity Support Worker Specialist professional	**There will be a number of professional people involved in your pregnancy and the birth of your baby. All of whom will be wearing the appropriate name badge complete with photograph.** **These include a Midwife, a Consultant obstetrician, a GP, an Anaesthetist, a Paediatrician, Maternity support worker and a student Midwife. All here to help you.** **Many of our doctors are males and you may not see a female doctor when you attend the hospital.**	

STUDIO	**Title Card** ***ANTENATAL/Children Centre***		

EXT/ INT: Hospital Antenatal Clinic/ Children centres **Hospital/ Community**	An expectant mother booking into antenatal care. **CAPTIONS** Midwifery led care Shared Care Consultant-led Care	**All pregnant women are expected to book their antenatal care ideally, by ten weeks of their pregnancy.** **You have a choice of having your antenatal care with…** **A Midwife.** **Shared Care, which is a combination of Midwife and GP Care.** **Or, if you have a medical condition, Consultant-led care.** **It is important that you receive the right plan of care at the right stage of your pregnancy, especially if for example you have some medical condition such as diabetes, hypertension, female genital circumcision, sickle cell, twin pregnancy or vaginal birth after Caesarean section etc. If you have had previous caesarean section, then you will be offered an appointment to discuss trying a vaginal**	

		birth in this pregnancy.	
Antenatal Clinic **Hospital**	A midwife booking a woman in the presence of an interpreter.	**Northwest London Hospital NHS Trust is a great promoter of equal opportunities. We would like to inform you that interpreting services are available throughout your pregnancy if you cannot speak English.**	
INT: Children centre cedars **Community**	An expectant mother being shown around an antenatal unit.	**First time mothers are expected to attend at least ten antenatal care visits, while others can have up to seven visits. Women with medical conditions such as high BMI, which means those with obesity issues, may have to attend on a more regular basis, dependant on advice from their consultant.**	
INT: Antenatal Clinic **Hospital**	An expectant mother attending an antenatal booking appointment and handing her maternity notes to the midwife at the antenatal reception desk. Shot Mat B1 form	**Once you've been registered, you are expected to attend all your antenatal appointments and parent education classes.** **If you need to inform your employer of your pregnancy, you can request a special form Mat B1 form and a leaflet for financial planning from your midwife or GP after 20 weeks of you pregnancy .** **You must always bring your maternity notes given to you by your midwife.**	
Antenatal Clinic **Hospital**	**Antenatal Public Health and Health Promotion Message** Pregnant woman in the antenatal clinic.	**At your booking appointment you will also be given public health and health promotion information on how you and your baby can keep healthy. This information is an important component of your antenatal care.**	
	Diet	**A healthy diet is very important when you become pregnant. Eating healthy during pregnancy will help your baby to develop and grow and will help to keep you fit and well. You don't need to go on a special diet, make sure that you eat a variety of different foods every day in order to get the right balance of nutrients that you and your baby need. Eat at least five portion of fresh, frozen, canned, dried or juice fruit and vegetables each day. Always wash**	

	them carefully before eating. Food that contains meat, fish, eggs have high protein nutrients but these foods should be well cooked. Bread, rice, potatoes, pasta, cereals, oats, noodles, maize, millet, yams, corn meal and sweet potatoes are carbohydrates and should be the main part of every meal. Do not forget to take fluids regularly. But, there are some foods you are advised to avoid during pregnancy such as mould-ripened soft cheese, all types of pâtés, raw or partially cooked eggs, raw or uncooked meat, liver products, supplements containing vitamine A, unpasteurised milk, some types of fish; shark, marlin, sword fish, raw shellfish and limit the amount of tuna you eat. You can ask your GP or midwife for more information about diet.
Caption	
Vitamins and Minerals	Eating healthy, varied diet will help you to get all the vitamins and minerals you need while pregnant. There are some vitamins and minerals that are especially important:
Folic Acid	Folic Acid: Folic acid is important for pregnancy as it can reduce the risk of neural tube defects such as spina bifida. If you are thinking of getting pregnant, you should take 400 microgram folic acid tablets every day until 12 weeks pregnant. If you did not take folic acid before you conceived, you should start as soon as you find out that you are pregnant.
Vitamin D	Vitamin D Take 10 micrograms of vitamin D per day, which is in the healthy start vitamin supplements or other supplements recommended by your midwife or GP. You should continue to take vitamin D throughout your pregnancy and while you are breastfeeding.
Iron	Iron: If you are short of iron, you will probably get very tired and you can become anaemic. If the iron level in your blood becomes low, your GP or midwife will advise you to take iron supplements. These are available as tablets or liquids.
Vitamin C	Vitamin C: You need vitamin C as it may help you to absorb iron. If your iron levels are low, it may help to drink orange juice with an

	iron-rich meal.
Calcium	**Calcium:**
	Calcium is vital for making your baby's bones and teeth. Dairy products and fish are rich in calcium.
Vitamin Supplements	**Vitamin supplements:**
	It is best to get vitamins and minerals from the food you eat, but when you are pregnant you may need to take some supplements as well. You can get supplements from pharmacies and supermarkets or your GP may be able to prescribe them for you.
Dental Care	**Dental Care**
	It is important to keep your teeth and gums healthy during pregnancy.
	Clean your teeth and gums carefully and avoid having sugary drinks/food too often. Go to the dentist for a check-up. NHS dental treatment is free while you are pregnant and for a year after your baby is born.
Smoking	**Smoking:**
	Every cigarette you smoke harms your baby. Cigarettes restrict the essential oxygen supply to your baby. Every time you smoke, the baby's heart has to beat harder. Cigarettes contain over 4,000 chemicals. Protecting your baby from tobacco smoke is one of the best things you can do to give your child a healthy start in life. Stopping smoking will benefit both you and your baby immediately.
	It's never too late to stop.
	You are 4 times more likely to stop smoking with support from the Brent and Harrow Stop Smoking Service. For further details please contact us on: 0208 795 6669 or 020 8966 1008
Alcohol	**Alcohol:**
	When you drink, alcohol reaches your baby through the placenta. Too much exposure to alcohol can seriously affect your baby's development.
	Because of this risk, pregnant women or women trying to conceive should avoid drinking alcohol.
	Drinking is not just dangerous for the baby in the first three months but can affect your baby throughout pregnancy. If you drink heavily during pregnancy, a

		particular group of problems can develop that are known as foetal alcohol syndrome (FAS). Children with this syndrome have: Restricted growth, facial abnormalities, Learning and behavioural disorders.
	Medicine and Drugs	**Medicine and Drugs** **Pills, medicines and other drugs:** Some medicines, including some common painkillers, can harm your baby's health but some are safe, for example, medications to treat long-term condtions such as asthma, thyroid disease, diabetes and epilepsy. To be on the safe side, you should: Always check with your doctor, midwife or pharmacist before taking any medicine. Make sure that your doctor, dentist or other health professionals know that you are pregnant before they prescribe you anything or give you treatment. Talk to your doctor if you take regular medication – ideally before you start trying for a baby or as soon as you find out you are pregnant, Use as few over the counter medicines as possible. Medicines and treatments that are usually safe include paracetamol, most antibiotics, dental treatments (including local anaesthetics), some immunisations (including tetanus and flu injections) and nicotine replacement therapy. But you should always check with your GP, pharmacist or midwife first.
	Illegal/Recreational drugs	**Illegal /Recreational Drugs:** Illegal drugs like cannabis, ecstasy, cocaine and heroin can harm your baby. If you use any of these drugs, it is important to talk to your doctor or midwife so that they can provide you with advice and support to help you stop. They can also refer you for additional support. Some dependent drug users initially need drug treatment to stabilise or come off drugs to keep the baby safe. For more information, contact Narcotics Anonymous, the drugs information line, on 0800 77 66 00.
	Infections **Sore Throat**	**INFECTIONS:** Throat Infection: If you have a sore throat and feel generally unwell, it is important to be checked by your GP

Rubella

Rubella-
If you catch rubella (German measles) in the first four months of pregnancy it can seriously affect your baby's sight and hearing and cause brain and heart defects. All children are now offered a vaccine against rubella through the MMR immunisation at 13 months and a second immunisation before they start school.
If you are not immune and you do come into contact with rubella, tell your doctor at once. Blood tests will show whether you have been infected.

Chickenpox-
Around 95% of women are immune to chickenpox. If you have not had it and you come into contact with someone who has it, speak to your GP, midwife or obstetrician at once. A blood test will establish whether you are immune. Chickenpox infection in pregnancy can be dangerous for both mother and baby, so seek advice as soon as possible.

Toxoplasmosis-
This infection can damage your baby if you catch it during pregnancy, so take precautions. (An organism which causes toxoplasmosis is found in cats' faeces, lambs and sheep). Avoid emptying cat litter trays while you are pregnant or use disposable gloves. Avoid close contact with sick cats and wear gloves when gardening. Avoid lambing or milking ewes and all contact with newborn lambs. If you feel you may have been at risk, talk to your GP, midwife or obstetrician. If you do catch toxoplasmosis while you are pregnant, you can get treatment.

Group B Streptococcus-
Group B streptococcus (GBS) is a bacterium carried by up to 30% of people which causes no harm or symptoms. In women it is found in the intestine and vagina and causes no problem in most pregnancies. In a very small number it infects the baby, usually just before or during labour, leading to serious illness.
If you had group B streptococcal infection in previous pregnancy, you will be offered a test for GBS in your current pregnancy. Women that are GBS positive will be offered antibiotics during labour to reduce the chances of your new baby getting the

infection.

Sexually transmitted infections:
Sexually transmitted infections (STIs) are on the increase. The most common is Chlamydia. However, there are others, for example, HIV and AIDS, Hepatitis B, Hepatitis C and Herpes. Up to 70% of women and 50% of men who have an STI show no symptoms, so you may not have any symptoms, so you may not know if you have one. However, many STIs can affect your baby's health during pregnancy and after birth. If you have any reason to believe that you or your partner has an STI, you should go for a check-up as soon as you can. You can ask your GP or midwife, or go to a genitourinary medicine (GUM) or sexual health clinic.

Keeping Active:

Keeping Active:
The more active and fit you are during pregnancy, the easier it will be for you to adapt to your changing shape and weight gain. It will also help you to cope with labour and to get back into shape after the birth.
Keep up your normal daily physical activity or exercise (sport, dancing or just walking to the shops and back) for as long as you feel comfortable. Don't exhaust yourself, and remember that you may need to slow down as your pregnancy progresses or if your doctor advises you to. As a general rule, you should be able to hold a conversation as you exercise. If you become breathless as you talk, then you are probably exercising too strenuously.

Safety

Safety on the move:
Road accidents are among the most common causes of injury in pregnant women. To protect yourself and your baby, always wear your seatbelt with the diagonal strap across your body between your breasts and with the lap belt over your upper thighs. The straps should lie above and below your bump, not over it.
Long distance travel (longer than 5 hours) carries a small risk of thrombosis (blood clots) in pregnant women. You can buy a pair of support stockings in the pharmacy over the counter, which will reduce leg swelling. If you fly, drink plenty of water to stay hydrated and do the recommended calf exercises.

If you have had female circumcision, a

	Specialist Services on Female Circumcision	specialist service is available to have reversal done during pregnancy or when you are in labour. Speak to your midwife for further information about these services.	

INT: Antenatal Clinic (children Centre) **Hospital/ Community**	An expectant mother being weighed. **CAPTIONS** Urine Test Weight and height measurement Blood Pressure Basic Clinical Observations Abdominal Examinations Blood tests	**During your booking appointment also, your weight, and height and body mass index will be measured. You will be asked about your health and family history as well as about your baby's father's family history. This is to find out if you are at risk of certain inherited conditions.** **Your other routine antenatal care and screening tests will include: urine test, weight & height measurement, blood pressure and basic clinical observations, abdominal examination and blood tests; from the 2nd trimester of your pregnancy, we will listen to your baby's heartbeat. You may start to feel your baby move from 19 weeks.**	

INT: Antenatal Clinic NPH/ children centre Cedars **Hospital/ Community**	An expectant mother having a blood test. **CAPTIONS** **Full Blood Count:** This test will enable us to know your iron levels. A low iron level may cause anaemia. **Identification of Blood-Group and Rhesus factor: If you are rhesus negative your midwife may give you injection called anti-D.**	**It's recommended that all pregnant women have some essential blood tests at the beginning and during their pregnancy. These are normally taken, with your consent, during your routine appointment in the antenatal clinic or at your GP's surgery, at home or children centre.** **The tests would include a full blood count. This test will enable us to know your iron levels. A low iron level may cause anaemia. Anaemia makes you tired and less able to cope with any blood loss when you give birth. If the tests show that you are anaemic, you will be given iron tablets.** **Your blood will be tested to check your blood group and to see whether you are rhesus negative or positive. Some women are rhesus negative; this is not usually a problem in the first pregnancy but may affect future pregnancy. If you are rhesus negative, your midwife will give you an Anti D injection after 28 weeks of your pregnancy or Immediately**	

after the birth of your baby if necessary to prevent any future pregnancy problem related to rhesus factors. This is quite safe for both mother and baby

Immunity to Rubella (German Measles
If your blood test shows low or no rubella immunity, you will be offered rubella immunisation after your baby is born.

If you get rubella in early pregnancy, it can seriously damage your unborn baby. If your blood test shows low or no rubella immunity, you will be offered rubella immunisation after your baby is born.

Syphilis: Syphilis is a sexually transmitted infection that if left untreated may cause miscarriage or stillbirth.

You will be tested for syphilis which is a sexually transmitted infection because, if left untreated, it can cause miscarriage and stillbirth.

Hepatitis B
If you have the virus or are infected during pregnancy, it may infect your baby and cause serious liver disease later in life. Your baby will be offered immunisation to prevent this soon after birth.

You will also be tests for hepatitis B. This virus can cause serious liver disease.
If you have the virus or are infected during pregnancy, it may infect your baby and cause serious liver disease later in life. Your baby will be offered immunisation to prevent this soon after birth.

HIV
As part of your routine antenatal care, you will be offered a confidential test for HIV infection. If you are HIV positive, both you and your baby can have treatment and care that reduce the risk of your baby becoming infected with sickle cell and thalassaemia disorders.
Sickle cell and thalassaemia disorders are inherited blood conditions that mainly affect the way oxygen is carried around the body.

If you are infected with HIV virus, you can pass the infection to your baby during pregnancy, at delivery, or after birth by breastfeeding. As part of your routine antenatal care, you will be offered a confidential test for HIV infection. If you are HIV positive, both you and your baby can have treatment and care that reduce the risk of your baby becoming infected.
You will be offered a blood test for sickle cell and thalasaemia disorder. Sickle cell and thalassaemia disorders are inherited blood conditions that mainly affect the way oxygen is carried around the body. You will also be asked information about your baby's father's family origin to decide if any further tests are required.

		Tests to detect abnormalities	You will be offered screening tests that can detect structural abnormalities like spina bifida, which is a defect in the development of the spine. You will also be offered screening for down's syndrome, which is caused by an abnormal number of chromosomes. The tests will provide valuable information for your care during pregnancy. However, no test is 100% accurate as some abnormalities may remain undetected. Therefore the tests cannot guarantee that your baby will be born without abnormalities.	
	INT: Antenatal Clinic/ Children centre	An expectant mother and midwife in conversation.	All the results of these tests are strictly confidential and you would be informed of any positive results in private.	
	Hospital/ Community			
	INT: Ultrasound Dept.	An expectant mother having an ultrasound scan.	Antenatal care also offers ultrasound scans. In most cases you receive two scans. The vital first one by twelve weeks of your pregnancy. This will help to determine when the baby is due.	
	Hospital		The second scan usually takes place between 18 and 20 weeks. This will help to check any structural abnormalities. Both scans are needed to check on the development and health of your baby.	
	INT: Parent education classes NPH	Group of parents attending a parent education class at Hospital. An expectant mother discussing pain relief with relevant staff.	Parent education classes can help to prepare you for your baby's birth, care of the baby after birth and feeding your baby.	
			Our parent education classes are facilitated by experienced midwives. Parent education classes are also available in English and the majority of most spoken ethnic minority languages in Harrow and Brent such as Gujarati/Hindi, Urdu, Somali, Arabic, Tamil, Polish and Romanian.	
			The parent education class sessions take place within the maternity unit and at the children centres.	
	Pain Relief Methods	**CAPTIONS**	During your parent education classes you will be able to discuss the type of pain relief methods available during labour.	

Hospital	**Controlled breathing** **Water birth** **Gas & Air** **Tens** **Pethidine** **Epidural**	**Controlled breathing, a water birth, gas and air, tens, pethidine and epidural are all available. Once again, your midwife will be happy to advise you accordingly.**	
INT: Antenatal Ward **Hospital**	Establish the antenatal ward.	**Should you need to come into hospital for any reason during your pregnancy and you are over twenty weeks, you will be admitted into the antenatal ward.**	
INT: Day Ass'ment Unit **Hospital**	Establish the Day Assessment Unit.	**Our Day Assessment Unit is available for short stay care such as foetal monitoring.**	
INT: Day Ass'ment Unit **Hospital**	An expectant mother involved in Fetal Monitoring.	**Foetal monitoring is carried out during your antenatal care and during labour to monitor the well-being of your baby.**	
INT: Antenatal Clinic **Hospital**	Doll and Pelvis	**Other issues that may be discussed during the later stages of your antenatal care could involve External Cephalic Version.**	
STUDIO	Doll and Pelvis	**This is when your baby isn't correctly positioned in the womb. Most babies are positioned head down, but some may be positioned with their buttocks down.** **If your baby is still in this position at thirty-six weeks into your pregnancy, you will be offered a procedure where an experienced obstetrician will attempt to turn your baby's head down during weeks thirty-seven and thirty eight.**	

Hospital	Montage of shots from the antenatal section.	**Antenatal is a very important part of your pregnancy and you will be expected to keep all your antenatal appointments.**

STUDIO	**Title Card** *WHEN TO CONTACT THE HOSPITAL*	

EXT/INT: NPH Hospital & Maternity Ward **Hospital**	Resume exterior shots of Hospital and the Maternity Unit. **CAPTIONS** Bleeding Abdominal pain Head ache Swollen hand and feet Reduced foetal movement Abnormal vaginal discharge Waters have broken Regular contractions Excessive itching Generally unwell	 **It is important that you contact your midwife or GP during your pregnancy if you, have any bleeding, abdominal pain, headache, reduced foetal movements, you experience abnormal vaginal discharge, your 'waters have broken'; if you're having regular contractions; if you have excessive itching, or you're feeling generally unwell.**
	Foetal Movements	**You will usually start feeling some movements after 19 weeks. Later in your pregnancy, your baby will develop its own pattern of movements- which you will soon get to know.** **The movement will range from kicks and jerks to rolls and ripples and you should feel them every day.** **A change, especially a reduction in movement, may be a warning sign that your baby needs further tests. Try to be familiar with your baby's daily movement pattern and contact your midwife or doctor or maternity unit immediately if you feel that the movements have changed.**
STUDIO	**Title Card** *INDUCTION OF LABOUR*	

Antenatal Ward Hospital	Montage of new born babies and expectant mothers. Midwife speaking to a pregnant woman on the antenatal ward (bed-side)	**Most women give birth after 40 weeks of pregnancy. However it is normal to start your labour anytime between 37-42 weeks. If you have not gone into labour by your due date, you will be given an appointment at 41 weeks gestation, where your midwife or doctor will offer you a membrane sweep.** **If you go twelve days over then we would use medication such as gels, tablets or infusions. We may also assist in breaking your waters if your cervix is favourable. All these procedures will be fully discussed with you and your consent taken before the procedure.**	
STUDIO	**<u>Title Card</u>** ***THE BIRTH***		
STUDIO (change picture)	3 screens on one screen showing a home birth set up, a midwife-led unit and the labour ward.	**You have the choice of having your baby where you like, depending on the situation of your pregnancy.**	
INT: A Home **Home**	Establish a home set up for a home birth.	**If all is well, you can have your baby at home with two experienced midwives present at the birth.**	
INT: Midwife Led Unit (birth centre) **Hospital**	Establish a midwife-led unit.	**Our co-located birth centre is run by midwives and provides one to one care for mums who would like a natural birth in a home-from-home and tranquil environment. There two pool rooms available on the birth centre in case you want a water birth.**	
INT: Labour Ward **Hospital**	Establish the labour ward at NPH.	**Or in the labour ward of your local hospital.**	
INT: A Home **Home**	Resume shots of a home set up for a home birth.	**Not everyone can have a homebirth, so please speak to your midwife early on in your pregnancy to see if it's suitable.**	
INT: Midwife Led Unit	Resume shots of a midwife-led unit.	**Rather like homebirth, not all women can have their baby at a midwife-led unit. This**	

Hospital		unit will only look after low risk pregnancies and will not take any women with pre-existing medical conditions. Once again please speak to your midwife.

INT: Labour Ward **Triage** **Hospital**	Resume shots on the labour ward .	**All women can have their babies in a labour ward.** **Our triage unit is located on the labour ward where women are been initially assessed before transferring them to the appropriate maternity ward or discharged home.**
INT: Home	**Home (Getting ready for the birth of your baby)**	**Whether you are having your baby at home, in hospital or at the midwifery led unit, you should get a few things ready at least two week before your due date. These may include the following items:** **3 loose and comfortable clothes** **Front-opening nightdresses** **Dressing gowns and slippers** **5-6 pairs of pants** **2-3 supportive and nursing bras** **24 maternity sanitary towels** **Towels** **Your wash bag with toothbrush, tooth paste, hairbrush, flannel etc.** **Clothes, hats and nappy for baby** **A shawl or blanket to wrap the baby in.** **Car seat**
Home	The signs of Labour • **Frequent Regular Contractions** • **The 'show'** • **Your waters break**	**One, of the main signs of labour is regular contractions. During the contraction, your uterus gets tight and relaxes. You may have experience this towards the end of your pregnancy, these are called Braxton Hicks contractions. When the true labour commences, you will be having regular contractions that last more than 30 seconds and begin to feel stronger. The contractions will become longer, stronger and more frequent. At this stage you may be getting ready to have your baby. These contractions may be accompanied by back ache, you may have a thick vaginal discharge called" the show" which is a plug of thick mucus in the cervix, which has helped to seal the uterus during pregnancy. The bag of water surrounding your baby may also break. If your water breaks before labour starts, you will notice either a slow trickle from your vagina or a sudden gush of water that cannot be controlled. Phone your midwife or maternity unit when any of these happen.**
INT: Labour Ward	**Demonstration of various pain relief methods.**	**Contractions can be very painful. You can ask for pain relief at any stage of your labour. The choice of pain relief methods**

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Room	**Entonox (Gas&Air)**	**are: Entonox (Gas&Air)** **This is a mixture of oxygen and another gas called nitrous oxide. It will not remove all the pain, but it can reduce it and make it it easier to bear. It has no harmful side effects for you of your baby.**
	TENS	**TENS** **Stands for transcutaneous electrical nerve stimulation. It is more effective during the early stage of labour. It is believed that tens works by simulating your body to produce more endorphins, which are the natural body's painkillers. It also reduces the numbers of pain signals sent to the brain by the spinal cord. There are no known side effects for you or the baby. You can always hire or buy it.**
	Pain Relief Injection	**Pain Relief Injection** **One of the common pain relief injections that may be given during labour is pethidine. It takes 20 minutes to work and the effect can last for 2-4 hours. The injection can help you to relax and this can lessen the pain. It is advised not to give pethidine too close to the time of delivery; because it may make the baby sleepy. It may also make some women sleepy, woozy and sick.**
	Epidural	**Epidural** **An epidural is put in through your back into the spine to numb some of the nerves involved in childbirth. For most women, epidural gives complete pain relief. The anaesthetist will explain this to you in detail and the possible side effects before the procedure.** **Some women prefer to use alternative pain relief methods such as acupuncture, aromatherapy, homeopathy, hypnosis, massage and reflexology. Most of these techniques do not provide very effective pain relief. If you would like to use any of these techniques, you need to discuss with your midwives as the hospital do not offer them for pain relief during labour.**
Labour Ward	Use or sonicaid and CTG machine	**Your baby's heart beat will be monitored throughout the labour. Your midwife will check for any marked change in your baby's heart rate, which could be sign that the baby is distressed and that something needs to be done to speed up delivery.**
Labour ward	Coping with labour **(More clips on birth, baby and birth**	**You will need lots of support and encouragement from your birthing partner. Your birthing partner can rub**

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	centre)? **Pool**	your back to relief pain if that helps. It is important to take fluids to keep you hydrated and your change positions as you wishes.	
	Shot of 'Congratulations on your new baby' cards.	Most of you will have a normal birth, but some babies might just need that extra bit of help to come into the world.	
INT: Labour Ward **Hospital**	On the labour ward with the practice Development Midwife suturing the perineum	Sometimes women tear their perineum naturally during childbirth or we might need to perform, with your consent, an episiotomy on you. This is where we make a cut on the perineum during birth to create more room for your baby. Any form of cut or tear will be repaired by your midwife or obstetrician. If you have perineum stitches as a result of tear or cut, It is highly important to always keep the area clean and dry by keeping good personal hygiene to prevent infection. Do not apply ointment or any other cream on the perineum as this may delay healing or cause infection. Always wash your hands before and after going to the toilet.	
EXT: Operating Theatre **Hospital**	An expectant mother being wheeled into the operating theatre.	If there is an urgent need to deliver your baby, we may have to perform a Caesarean section. This will be carried out in the operating theatre. There are several reasons, either mother or baby, why some women need a Caesarean section. The decision to have this operation will be made by your consultant and, of course, with your consent.	
EXT: Operating Theatre **Hospital**	Operating theatre filmed	If this isn't your first child and you've given birth by caesarean Section before, it might be a good idea to let your midwife know early during your pregnancy so that you can discuss the possibilities of having a vaginal birth.	
INT: Labour Room	Pack shot of oxytocin in its injection form.	Once your baby is born, you may be given an oxytocin injection. This is to help deliver the placenta and control any bleeding.	
INT: Labour Theatre **Hospital**	Pack shot of vitamin K in both its injection and oral drops forms.	With your consent, a vitamin K injection or oral drops will be given to your baby. This is to stop any bleeding in your baby and is perfectly normal.	
INT: Labour Theatre	Close up on the Baby Resuscitation Machine.	A Baby Resuscitation Machine will be present during birth as some babies may need a little help with their breathing.	

Hospital		

INT: SCBU **Hospital**	Establish NNU.	**Should your baby be premature or have any serious complications, he or she will be taken immediately to the Special Care Baby Unit where they will be given the best possible care and attention.**
STUDIO	<u>**Title Card**</u> ***POSTNATAL CARE***	

INT: Maternity Ward **Hospital**	Mother in bed with her new baby.	**You can stay at the hospital for a minimum of six hours and a maximum of three days after the delivery of you baby, depending on your condition.**

INT: Maternity Ward/ **Hospital** Pinner centres (Thursday)	Skin-to-skin and a mother breast-feeding her baby	**We strongly recommend that you start bonding with your baby immediately your baby is born (Skin-to-skin contact) until the first breast feed. Your midwives will discuss the advantages of breastfeeding with you during pregnancy. You will also be invited to attend a breastfeeding workshop. You will be supported to exclusively breast feed for six months and after that continue with solid food.**
INT: Maternity Ward **Hospital**	Father changing a nappy in a ward	**Fathers are encouraged to be actively involved in the care of their baby as well.**

Postnatal Ward **Hospital**	Hospital hearing test	**The maternity unit work closely in line with national policies and screening programmes and one of the tests we carry out is the newborn hearing screening test. All babies will be given a hearing screening test before they leave hospital.**

INT: Maternity Ward **Hospital**	A paediatrician carrying out a general examination of a new baby	**The paediatrician or midwife will carry out a general examination of your baby before you and the newest member of your family return home.**

INT: Maternity Ward	Baby being prepared for the BCG vaccination.	**During this time in hospital your baby will be offered a BCG vaccination as protection against tuberculosis if considered necessary. Your baby's BCG**

Hospital		vaccination will be recorded in the RED book which you can show to other professionals that will be looking after your baby.	
INT: Maternity Ward **Hospital**	A midwife discharging a woman	**A midwife will advise you on the care of yourself and baby at home before discharging you from the hospital. Some of the advice will include postnatal exercises, care of the perineum, feeding baby and registering your baby with the local authority to get birth certificate.**	
Ext: Maternity Unit	Safety: Mother, father and baby going home with the baby in a car seat.	**It is important to always put your baby in the car seat when driving.**	
INT: A Home **Home**	New mum carrying her baby to answer the door to the community midwife. - High temperature - Shivering - Heavy vaginal bleeding or - Clot - Smelly vaginal discharge - Dizziness - Palpitation, chest or calf pain - Severe headache, - Vomiting or diarrhoea - Severe anxiety or depression - not feeding - frequent vomit - do not pass urine or open bowels for more than 24 hours - feels floppy, - jaundiced, - blisters on the skin - Continuous cry. **baby stopped breathing,** **goes blue, unresponsive,**	**Once home, community midwives will care for you for ten days or more after you've been discharged.** **However, please contact your midwife, GP or local maternity unit immediately if you experience the following symptoms e.g. high temperature, shivering, heavy vaginal bleeding or clots, smelly vaginal discharge, dizziness, fainting, breathlessness, palpitation, chest pain, calf pain, severe abdominal pain, severe headache, vomiting or diarrhoea, severe anxiety or depression.** **Also contact the hospital immediately if your baby experiences the following: not feeding, frequent vomiting, does not pass urine or open bowels for more than 24 hours, feels floppy, jaundiced, blisters on the skin and continuous crying.** **Please dial 999 and ask for ambulance if your baby stopped breathing, goes blue, unresponsive, cannot be woken or has a fit.** **The community midwife will do postnatal checks at each visit. These will involve checking your and your baby's well-being. They will check the baby's weight, support you with breastfeeding and do some blood tests on the baby.**	

	• **Cannot be woken or has a fit.**	

INT: A Home **Home**	Midwife carrying out a Newborn Blood Spot Screening.	**When your baby is between five to eight days old, the midwife will offer to carry out a Newborn Blood Spot Screening. This screening test will detect any of the following conditions:**
	CAPTIONS Phenylketonuria	**Phenylketonuria: this occurs when babies cannot break down the protein in their food. In such cases, the baby may be put on a special diet.**
	Congenital Hypyroidism	**Congenital hypothyroidism: this may show that the baby isn't producing enough thyroxin hormones that are import for their growth and development.**
	Sickle Cell and Thalassaemia	**Sickle cell & thalassaemia: this is an inherited disorder of the red blood cells and needs to be identified as soon as possible.**
	Cystic Fibrosis	**And finally cystic fibrosis: this is another inherited condition which affects babies' digestion and lungs. You will be informed of any abnormal result.**

INT: A Home **Home**	New mum carrying her baby to answer the door to the local health visitor.	**After ten days your local health visitor will take over your care from the community midwife. The health visitor will give you some information about the baby Immunisations.**

INT: GP surgery Community	GP carrying out a postnatal examination on a six-week-old baby.	**Finally, when your baby is six weeks old it is suggested that you book an appointment with your GP to carry out a full postnatal examination.**

Supervisor of Midwives **Hospital**	Group of supervisor of midwives	**Whilst the supervisor will support the midwife in the care she gives you, the supervisor can additionally help you by:** **• Listening and advocating on concerns about the care you have received from your midwife. Supervisors will talk to your midwife if you are concerned or unhappy.** **• Supporting and advising you and your midwife in your care choices,** **for example place of birth.** **• They'll also create an environment that facilitates effective communication between you and your midwife about your care.**

	Children Centre		You can continue to visit your local children centres for on-going programmes and support for you and your baby.	
	STUDIO	Montage of shots from the programme.	As mentioned at the beginning of this programme, having a baby is an exciting time. It's also a worrying, sometimes uncomfortable and exhausting time for you the mother, but remember, we are here to help you.	
	Hospital	10 seconds testimonials from a variety of mothers extolling the virtues of the maternity service.	**TESTIMONIALS**	
	Hospital	Montage of midwife, consultant, GP, anaesthetist, paediatrician and student midwife.	**Each of us has our role to play…**	
	INT: A Home **Home**	Shot of a sleeping baby.	**…and together, with you, we will bring your baby safely into the world.**	

Maternity Services Information Programme

	Closing Clips	We are very proud of our maternity services here at North West London Hospitals. We try very hard to provide a service that meets the need of the local population. We are always looking for ways to improve the service and we are always interested in your feedback and comments. If you would like to become more involved with the groups that we have, to monitor and improve patients care, please contact the antenatal clinic on 0208 8692870. We have the parent partnership that focus	

		on feedback of maternity services and we monthly. The labour ward forum meeting takes place every two months and the Maternity Services Liaison Committee meets 6 times a year.	

All the information on this DVD is also available at www.nhs.uk/mypregnancy.
Testimonials

Hospital	Breast feeding advisor	**I am a specialist health visitor and my role is to promote breastfeeding on the maternity wards and in the community.**
Hospital	Supervisor of midwives	**Supervisors of midwives develop and maintain safe practice to ensure protection of you, your baby and family. They meet regularly with midwives and ensure a high standard of care is provided.**
Hospital	Consultant obstetrician	
Hospital	Midwife	
Hospital	Neonatologist	
Hospital	Matron	
Hospital	Nurse	
Hospital	Anaesthetist	
Hospital	GP	
Hospital	Children's centre manager	

End	**End**	**End**