UNIVERSITY OF SOUTHAMPTON

Contextualising Syncrecy
Exploring Health Beliefs and Behaviours of British Asian Mothers

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Thesis Submitted for Doctor of Philosophy

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September 2000

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Abstract

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Doctor of Philosophy

Conceptualising Syncrecy: Exploring the Health Beliefs and Behaviours of British Asian Mothers

By Kate Reed

This thesis explores the health beliefs and behaviours of thirty women who identify themselves as British Asian mothers. The study is situated in the midlands town of Leicester and is based on semi-structured interviews with British Asian mothers, that is Asian women either born in or who have lived in Britain from the age of five who have at least one dependent child. The research engages with and develops theoretical frameworks used in research on ethnicity and identity to explore the idea that the beliefs and behaviours of British Asian mothers within the study are syncretic. A theoretical framework of syncrecy is used to investigate the way in which the women draw on different types of health discourses, both western and non-western. The research also explores the role of contextual and material circumstances on beliefs and behaviours.

The findings indicate that women's beliefs and behaviours are syncretic. There is a need however to ground syncretic beliefs and behaviours within the contextual circumstances of the women researched. In particular the thesis shows that syncrecy within the women's accounts is influenced by: particular illnesses; family and position in the life cycle; community, religion and identity; and space and globalization. Overall, the women researched identify their position as 'British Asian' women, as members of a particular ethnic and generational group that affords them access to a plurality of discourses. These discourses are then used syncretically and conditionally according to context. Within the study women identify changes in their beliefs and behaviours over time. Respondents predicted a continued syncrecy within their beliefs and behaviours but suggest a shift in content of that syncrecy, favouring different discourses at different times. Women within the study also suggested a decreased use of non-western health discourses among the beliefs and behaviours of their children's generation.

Overall, the research contributes to the development of research on ethnic minority health beliefs and behaviours, and to research on women's health more generally. There have been few systematic qualitative studies of the beliefs and behaviours of minorities. Studies on minority health have tended to be couched within culturalist explanations or epidemiological approaches. As a result, the impact of gender, generation and globalization on beliefs and behaviours has been neglected. The research explores these themes in an innovative manner. Utilising frameworks of syncrecy and context the research transcends the static nature of approaches which locate 'British' minorities between two cultures and those which locate health beliefs and behaviours solely in cultural or structural explanations. Such an empirical application of theories used in research on ethnicity and identity in a health context highlights the study's originality.

Contents

Acknowledgements

I would like to thank my supervisors, firstly Graham Crow for all his advice, patience and support which has been invaluable throughout, Graham you're a star! Also thanks to my other supervisor Mike Hardey for his help. I would like to thank Wendy Bottero for helping me take dialectics beyond synthesis, also for her clarity of vision and for generally being fab. I would also like to thank others who have been involved with the thesis in various ways and at differing stages, Waltraud Ernst for initially supervising the project and for giving me the opportunity to publish (chapter 6) and also board members Susan Halford and Bernard Harris for helpful comments.

Special thanks go to all the respondents taking part in the study and to the various centres which helped me get started, including: the Evington playgroup, the East/West centre, Bhagini centre, Sikh community centre, and Sharma women's centre.

I would like to thank friends, Clare Alexander, Simon Blyth, Rose Lindsey, and Jane Parry. In particular I would like to thank my wonderful buddy Mel Semple who has been my partner in crime throughout, and of course the marvellous Derek McGhee for all the inspiration and joy he has brought during the last 8 months of writing this thesis.

I would also like to thank Glyn Evans and Doreen Davies for all their help, support and friendship. I would like to thank many other students and staff in the Department of Sociology and Social Policy at Southampton for making my time there happy and productive. Thank you to the Faculty of Social Sciences, University of Southampton for funding the project.

Finally I would especially like to thank my family, mum, dad, Sarah, Nick, Dom and Freddie for such love and support. I couldn't have done any of it without you. Thanks also to David.

Publications arising from this thesis so far: A version of the theoretical framework has been published as Reed, K (1998) 'Contextualising comparative research: The health beliefs and behaviours of American and British Asian mothers' NYSSA (New York State Sociological Association) Current Research Proceedings Journal Fashion Institute of technology/SUNY New York.
The analytical framework and overall argument of the thesis has been published as Reed, K, (2000) 'Dealing with Difference: Researching Health Beliefs and Behaviours of British Asian Mothers' in Sociological Research Online Vol 4, No 4, <http://www.socresonline.org.uk/4/4/reed.html>. A version of Chapter six is due to be published as Reed, K, 'Local/global spaces of health: British South Asian mothers and Medical Pluralism' in Ernst, W (ed) Plural Medicine: Orthodox and Heterodox Medicine in Western and Colonial Countries During the Nineteenth and Twentieth centuries London: Routledge.

Chapter 1

Introduction: Tensions and Transgressions

1.1 Introduction

Systematic studies of migrant and minority health beliefs and behaviours which are both politically and culturally situated have been few and far between (Ahmad 1993, Bowes and Domokos 1993, Eade 1997). This is one significant factor which has led to the failure to provide culturally sensitive health services within the UK (Ahmad 1993). Previous research has been characterised by large scale epidemiological studies which tend to have a clinical focus. Such research has focused on establishing patterns and explanations for the high rates of disease such as diabetes, heart disease, hypertension etc. among minorities within the west (Ahmad 1996, Pitchumon and Saran 1976).

The full impact of gender on the health beliefs and behaviours of minorities has yet to be explored. Women of colour have remained peripheral within the literature on health and have remained here as elsewhere objects of the biomedical western gaze (Bayne-Smith 1996). There have only been a small number of studies which have focused specifically on the health beliefs and behaviours of women of colour (Bowes and Domokos 1993, Donovan 1986, McAllister and Farquhar 1992, Thorogood 1990). Similarly previous research can be criticised for taking an ethnically reductive approach where minorities have tended to be lumped together and treated as one category (Goldberg 1993). Even when various minority groups are recognised, research has failed to take into account generational and immigration status. First, second and third generations have been situated together. The emphasis tends to be on those who have migrated to the west. Research has failed to look at the unique position of those that have been born and raised within the west.

Finally, existing research has failed to explore the impact of globalization on minority health beliefs and behaviours and on issues of plural medicine in general. We now live in an era characterised by a powerful phase of globalization (Massey 1994). Such a time

includes an intensification of time/space compression, the opening up of possibilities on the global market through the global media scape and transcultural flows of goods and people. Boundaries in these circumstances dissolve and are crossed by everything from investment flow, to cultural influences, to satellite networks. Such an intense shift to the global is also at the same time held in tension with moves back to local place bound traditions. Globalization is characterised by the interplay between these local and global processes (Friedman 1994). While studies on identity have begun to explore the impact of these two-way processes on British born migrants, health research on minorities has yet to take this up (Annandale 1998).

This thesis explores the use of western and non-western medical discourses in the health beliefs and behaviours of British Asian mothers. The research is based on thirty in-depth interviews with British Asian mothers, Asian women who have either been born or lived in Britain from the age of five. Respondents are from economically and geographically distinct areas in Leicester. They are individually, Hindu, Sikh and Muslim and can be classified as being part of varying social classes. The research addresses issues of women's health, plural medicine and ethnicity and identity in light of globalization. The research explores firstly, the idea that health beliefs and behaviours of the women within the study are syncretic. Secondly, the research explores the role and importance of contextual circumstances on beliefs and behaviours and use of syncretic discourses.

The aim of this chapter is to provide a background to the project and outline the research aims and theoretical framework. Firstly I will contextualise the research project, exploring existing literature in order to provide a rationale for the research, outlining the research aims and theoretical framework. This involves an exploration of the existing studies on race, ethnicity and health moving on to explore the interplay between gender, ethnicity and health. Existing studies are set in contrast to this research which takes a more dynamic approach to ethnicity, gender and health. I will also explore here the need for more research on generation and health beliefs and behaviours, situating respondents' generational position as 'British Asian' as a dynamic position transcending 'between two cultures' type approaches. Concepts such as beliefs, behaviours and discourses which are

central to the research are then outlined in order provide a better understanding of the research framework. Health beliefs and behaviours, and use of western and non-western medical discourses in existing research are also explored. After setting out a background to the project I will outline the theoretical framework of syncrecy and context. Finally, the study is geographically contextualised and the succeeding substantive chapters and their links to the theoretical frameworks are outlined.

1.2 The Racialization of Health

Within Britain, Ahmad (1993) argues, there have been two main trends regarding existing research on the health of minorities and migrants. The first trend is a culturalist approach, the second is value-free epidemiology. The culturalist approach constructs and explains realities in terms of cultural differences, differences which are then usually equated with deviance and pathology. In this view any existing inequalities in health and access to healthcare are explained as resulting from cultural differences and deficits. Integration on the part of minority communities and cultural understanding and sensitivity on the part of health professionals then become the obvious solution, personal and institutional racism have no part in this equation.

An example of such can be seen during the influx of black and Asian immigrants to Britain during the 1950s/60s (Ahmad 1993). During that time there was an overall increase in the rates of TB among the general population. This increase was blamed on the new immigrants and TB became known as an immigrant disease. Immigrant groups became labelled as problematic and as breeders of ill health. These types of culturalist approaches to research have led to culturalist health policy. An example of this is with the stop rickets campaign (Rocheron 1988). Rickets, once a common problem among white children, was acknowledged as a disease of poverty which was controlled through fortifying margarine with vitamin D, improvements in standard of living and nutrition and universally available free milk to schools. With the knowledge of a higher prevalence among Asian children in the 1970s it now emerged as an Asian disease signified by a new name 'Asian Rickets'. Rather then seeing rickets as a product of poor conditions migrants faced on arrival in Britain, it was explained in terms of non-British eating and living habits

and perhaps a genetic deficiency in absorbing vitamins into the blood stream or in synthesising sunlight. The predicted long term answer to Asian rickets was seen to lie in education and in a change to western diet and lifestyle. This was reflected in the official response of the DHSS working party and the resulting stop rickets campaign.

Ahmad (1993) argues that the second trend within health research on migrants and minorities has been with a supposedly value-free epidemiology, using the notion of a disinterested value-free scientific observer who makes pronouncements on the basis of carefully collected evidence which uses a rigorous scientific method, usually clinical questionnaires. Such studies focus on establishing and explaining patterns for the high rates of disease among minorities (Pitchumon and Saran 1976). According to Lambert and Sevak (1996) these epidemiological studies have demonstrated an increased incidence of conditions such as diabetes and heart disease in the groups under study relative to the white population rather than for example as result of expressed concerns emanating from within these groups. As Eade (1997) argues, such studies focus on quantitative data and biomedical models of disease. Views are sought only from the professional structure of health provision. Beliefs and practices of ordinary people do not inform the debates, nor do non-western medical discourses. According to Ahmad (1993) these trends often involve a racialization of health research. They assume that populations can be divided only into ethnic or racial groups, taking these groups as primary categories and using these categories for explanatory purposes. Stratification by class, income, gender and so on are seen as relatively unimportant. Ill-health is depoliticised and individualised treating the afflicted in isolation from their social and economic and citizenship context. This in turn legitimates existing inequalities and maintains the status quo.

At a sociological level this research project follows calls by Ahmad (1993) and others for the sociology of health and illness to recognise ethnicity as an important (but not the only) sociological dimension and to incorporate it into explanations of health-based practices. The aim of the research is to take up Eade's (1997) call for more research into minority and migrant health beliefs and behaviours, research which provides searching examinations of non-western medical systems. Research is needed which dispenses with

clinical questionnaires and interpretations and relies on qualitative data collection with ordinary people and does not dismiss them as ignorant and superstitious. This is not to deny the value of epidemiological research but should be seen rather to complement it, to be used to help inform large scale research. As Ahmad (1993) argues, the scientific method can not simply be reduced to ideology or social relations. That scientific medicine is value-laden is not in doubt; that it is valueless or that its ideological biases can dissolve the phenomenon itself must be contested (Ford 1988).

Ahmad (1996) argues that the concept of culture is useful but has been stripped of its dynamic social, economic, gender and historical context. As such it becomes a rigid and constraining concept which is seen somehow to mechanically determine peoples behaviours and actions rather than providing a flexible resource for living. Racialization takes place in terms of notions of cultures being static and homogeneous and having a biological basis. This is then extended to notions of cultures having a direct relationship to attitudes, expectations and behaviour. Within this research I draw on Kelleher's approach to culture. Culture here is defined as a set of beliefs/ideas that a group draws on to identify and manage the problems of their everyday lives. It is a dynamic entity which changes to incorporate fresh ideas and perspectives as people develop new ways of responding to their environment. This moves away from approaches which see culture as predicting precisely in a positivist way what people believe and how they will behave (Kelleher 1996). The term ethnicity, a historically contested term, has been used to describe groups with shared language, religion or nationality, but the idea of shared culture has perhaps been the most crucial issue. The term is used here generally to refer to the sense of belonging to a community which may not necessarily be defined in racial terms (Bradley 1996). I have left the definition of ethnicity deliberately open, this is in order to move away from deterministic approaches which draw rigid lines around social groupings. Within the research, as will be shown within the theoretical framework, culture and ethnicity are not seen as the only influence on people's lives but rather are situated in respondents' contextual circumstances.

1.2.1 Invisible Women: Gender, Ethnicity and Health

Over recent years there has been a significant body of feminist writing surrounding the area of women's health. Within sociology, white feminists have provided valuable and challenging research literature on gender in relation to among other areas, caring for the sick, medicalisation of medicine, the feminization of nursing, the journey from being a woman to becoming a mother, the sexist nature of medical ideology and institutional structures and positivist methods. Research has highlighted the omission of women from large-scale epidemiological studies. Doyal (1995) has demonstrated that research on conditions such as heart disease and cancer traditionally uses only men as study participants. Bayne-Smith (1996) argues therefore that when women are prescribed highly toxic medications on the basis of research done solely on men, women are in essence placed in jeopardy by the medical establishment. Kirchstein (1991) argues that biomedical research continues to reflect the bias of white men. The focus regarding women's health tends to be on women's reproductive capacities, little research has focused on non-reproductive related conditions that affect women such as osteoporosis or incontinence. Doyal (1995) has also pointed out that while women are well-represented within the health care professions they are over represented within the low paid professions. A number of studies in the U K have found also that women's own assessment of their health continues to be consistently worse then that of men (Blaxter 1990).

Even though research on women's health in general has begun to move into the mainstream there continues to be grossly inadequate information about the health and mental health status of women of colour. White feminists within sociology, despite valuable research within all the above areas, are guilty of excluding women of colour (Ahmad 1993). Black women were nowhere to be found in the earlier work of leading British feminist writers like Oakley (1980). There are a small number of studies that look at the health beliefs and behaviours of women of colour (Bowes and Domokos 1993, Donovan 1986, McAllister and Farquhar 1992, Thorogood 1990); I will document their findings in more detail in 1.4.1. These studies have focused on minority women's beliefs and behaviours. They have explored conceptions of health among women and use of

services. However, little research has focused on and highlighted the importance of the role of mothers' health beliefs and behaviours.

A prominent area of research regarding white women's health has been on women's activities as caregivers, in families and in society at large and as primary consumers of healthcare for themselves and others (Graham, 1984, 1993, Miles 1991). Women urge their loved ones to seek medical care: they make the doctor's appointments for their family members: and they purchase and replenish over the counter medicines for the family's bathroom cabinet. Similarly, they are more likely than men to monitor the health status of the extended family members, to become caretakers to the elderly and the infirm and to be the one to leave work to look after a sick child (Graham 1993). While there have been a number of studies in Britain which have highlighted the role of working class mothers in mediating the health of other members of the family and the importance of their health beliefs in shaping family health behaviours (Blaxter 1990, Cornwell 1984), little research has focused on the health beliefs and behaviours of minority mothers. Research which has focused on minority mothers has tended to be culturalist (Rocheron 1988). Bowes and Domokos (1993) point out the importance of looking at mothers when looking at health. In their research on Punjabi Muslim women in Glasgow they found that women are largely still responsible for the health of their partners and children and other relations.

This thesis situates women's health in a wider social context. It turns the epidemiological approach on its head. It aims to understand relations along the lines of race and gender along with the social construction of health and illness, offering important examples of how such links are forged in concrete situations. This study contributes to the existing literature on minority women's health beliefs and behaviours. It takes up the focus on women's use of plural discourses raised by existing studies such as Donovan's (1986) research on South Asian and Afro-Caribbean women and Bowes and Domokos' (1992) research on South Asian women. In particular, the research aims to pick up on findings of previous studies which focus on the role of women as mediators of family health (Blaxter and Paterson 1982). The research aims to explore respondents' beliefs and behaviours

drawing on their position as mediator of family health. By focussing on mothers the aim is to gain information not just about respondents' beliefs and behaviours but also those of children and other family members. By doing this I hope to explore respondents' gendered and generational positions within the family.

1.3 Situating a generation: British Asian women within the study

This project focuses specifically on an exploration of the health beliefs and behaviours of British South Asian mothers who have either been born or who have lived in the U K since the age of five. It is concerned with looking at how the interplay of ethnicity, culture and material circumstance affect and influence the health beliefs and behaviours of this generational group. Little research has focused on this particular generation.

Most research has tended to group generations and minorities together in an ethnic reductive approach (Goldberg 1993). Research which has explored differences between generations has often focused on epidemiological differences. For instance Greenslade, Madden and Pearson (1997) in their research on Irish migrants to the UK show differences in patterns of health among first and second generation migrants and those between northern and southern Irish. Similarly, Marks and Hilders (1997) in their research on European Jewish immigrants and Bengali immigrants in East London show how patterns of health change over the period of settlement and so vary dramatically over generation. Little research has been carried out on the differences and similarities in health beliefs and behaviours between generations. Researchers have often alluded to the differences between generations in this context but fail to explore them. Kraut (1997) in his paper on Italian migrants looks at the differences in the use of western and non-western beliefs among Italian immigrants to the USA from the turn of the century onwards. He found that, although the use of non-western medical discourse such as the 'evil eye' was still prevalent at times among all generations of Italian migrants, there tended to be a greater use of western discourse among second and third generation migrants and a greater use of non-western discourse among older generations.

The aim of this research is to focus on the generation of South Asians born/ or living in

Britain from the age of five. It takes up some of the ideas put forward by writers on identity. These writers on identity (Hall 1992, Parker 1995) have focused on the unique identity of those diaspora members born to a western society. Earlier studies on children of post-war migrants during the 1970's identified this generation as caught 'between two cultures' (Kahn 1977, Watson 1977). The 'problem' was that they might not integrate smoothly into British society; the authoritarian and old-fashioned cultures of their parents were deemed to be holding them back (Parker 1995). In recent years studies on ethnicity and identity have moved away from such approaches to explore the syncretic, multiply-located and changing identity of this particular generation. As Annandale (1998) argues, writers on ethnicity and health have yet to take this up. Similarly to Britain there has been a proliferation of writing on issues of identity concerning second generation American Asians (Rocher 1994). American Asians have been compared with British Asians within this literature. For instance Sunita Sundra Mukhi (1996) makes comparisons between American and British Asians. She talks of a transnational community of what she terms "Hyphenated Indians". She argues that the hyphenated American Indian is heavily influenced by British South Asians as well as by India itself. She draws on the complexity of colonial and post-colonial landscapes to present her argument of the transnational hyphenated Indian in a similar way to Gilroy (1993).

Kelleher (1996) in his research on ethnicity and health recognises the difficulties faced by certain ethnic minority groups born in English society. He argues that, although the parents of these groups migrated to England they themselves have been born and educated in the UK. They have had close contact with "English" culture. He goes on to argue that there are grounds for including them as members of the parent group. However, it may be that this membership is less central to their identity because they have moved out of that association with the parental generation as a result of education and socio-economic change. This research has, however, failed to put this group at the centre of research on ethnicity and health and explore the ideas of syncrecy and hybridity, and to look at how important ethnicity is within their health beliefs and behaviours.

In focusing on this specific generational group I became aware that it was necessary to

develop a suitably abbreviated terminology to describe the research group. I was faced with the same dilemma as Parker (1995) in his study on the identity of young British Chinese. How do you indicate within a term that you are looking at a specific generation of South Asians? To use the term "born", as one of his respondents argued seems to suggest that you do not belong here, that you just happen to be here. He settled on the term British Chinese to signify that specific generation. He makes the distinction that to be Chinese in Britain is not the same as being British Chinese. I decided to use a similar terminology to describe Asians who had been born/ or who have lived in Britain from the age of five or under as British Asian. This term is particularly apt for the respondents in this study as not all the women within the study were British born. Parker (1995) also problematises the term 'Asian' and 'South Asian'. He argues that in the United States Chinese dominate the signifier Asian American, connections being drawn between Chinese, Japanese and other East Asians. By contrast in Britain 'Asian' refers usually to those who are South Asian (originating from India, Pakistan and Bangladesh); Chinese and other East Asians do not fall within that designation (Parker 1995). Similarly, census data use the term 'Asian' to refer to those migrants originating from Asia. At this level the data does not distinguish by region. The more regionally focused definition 'South Asian' refers to those from India, Pakistan and Bangladesh. This also includes those migrating to Britain from South Asian via East Africa. (Ballard 1994). The term 'British South Asian' or 'British Asian' is used within the context of this research to refer to those with South Asian parentage who have been born and/or been raised within Britain.

1.4. Beliefs, behaviours and discourse

There has been a recognised difference between health beliefs and health behaviours within health research. McAllister and Farquhar (1992) in their comparative research on women's beliefs among Asian and white communities in the context of preventative care, adequately define and distinguish the two. They define health beliefs as feelings about lifestyles in relation to health and views about causes and symptoms of disease. On the other hand they use Kasl and Cobb's (1966) definition of health behaviour: as an activity undertaken by a person believing themselves to be healthy for the purpose of preventing disease or detecting it at an asymptotic stage. This definition is situated by many

researchers in terms of medically approved practices and the use of health services designed to prevent disease. Some of the questions within this research project are based roughly on the distinction. However, rather than superimpose this distinction on to the respondents I wanted to leave it more open to see if women themselves made the distinction between beliefs and behaviours in their accounts. As McAllister and Farquhar (1992) point out, there has been contradictory evidence on the effects of health beliefs on health behaviours. As Calnan and Rutter (1986) argue many researchers have found either no or only weak evidence of relations between health beliefs and behaviours. McAllister and Farquhar (1992) argue that a number of factors induce people to seek medical assistance, these can include peer group or family pressure, other stimuli are also required such as the onset of symptoms, illness of a family member, opportunistic screening, health education or reminders. This research is not concerned with focusing on establishing a fixed link between the two. It is more concerned to explore the potential differences, reciprocity and synthesis of the two.

Within the research I do not take either health beliefs or behaviours as given, rather I follow Radley and Billig (1996) in arguing that beliefs and behaviours are looked at as the way people construct their health as part of their ongoing identity in relation to others. They are seen as more than views about what people in society should do to avoid disease. They are also seen to articulate a person's situation in the world and indeed articulate that world in individuals' accounts to others. Approaching beliefs and behaviours in such a way can be seen to reflect broader trends within health research towards narrative accounts on health and illness. Depicting illness in the form of narratives is a way of contextualising illness events and symptoms by bringing them together within a biographical context (Hyden 1997). Within this research, however, while there is an engagement with narrative approaches to health and illness, the aim of the research is to explore beliefs and behaviours about health and illness, not detailed accounts of illness experiences per se. While exploring beliefs and behaviours over time, the research stops short of full exploration of particular episodes of illness. By taking such an approach, beliefs and behaviours will not be seen to be detailed explorations of illness nor indeed will they be seen as fixed in time. It will be acknowledged that these do form part of a respondent's

identity, and that these are multiply located and change according to time, space and circumstance.

Through respondents' health beliefs and behaviours the aim of the research is to explore their use of western and non-western health discourses. The concept of discourse is a central concept in Foucault's work (Shilling 1993). It is primarily concerned with, although irreducible to, language (Foucault 1972; Poster, 1984). Discourses can be seen as sets of deep principles incorporating specific grids of meaning which underpin, generate and establish relations between all that can be seen, thought and said (Dreyfus and Rabinow, 1982; Foucault 1972). The conceptualisation and use of the concept has been heavily critiqued for its denial of the socially embedded and embodied subject (Mcnay 1994). I argue this leads to tensions between discourse and material phenomena both in the sense of material as corporeality, and the material as social. Also, as Radley and Billig (1996) argue, to focus on discourse alone is to miss out on the fact that it proceeds as part of a relationship that is situated in time and place. Discourse is used within this research to signify systems of knowledge, as with previous usage this is related to structures of language but not exclusive to language. Within this research there is a recognition that discourses themselves are embodied. Our embodied existence forms a vital part of the shared socio-cultural experience upon which our systems of language and meaning are based (Shotter 1990, Yardley 1997). An exploration of illness centring on bodily experience of illness is not a central aim of this research, however it is important to recognise that respondents draw on discourses from an embodied position which the above approach enables us to do. This perspective does not, however, relieve the tension between discourse and the material as social. These tensions as will be seen later on in this chapter are central to the theoretical framework of research and are explored dialectically throughout the thesis using the accounts of the respondents. The potential to resolve such tensions is explored more thoroughly within the conclusion of the thesis.

1.4.1 Beliefs and behaviours in previous research

Existing studies on the health beliefs and behaviours of minorities have tended to find mixed results regarding the use of western and non-western medical discourses. Donovan

(1986) carried out a study of the health beliefs of South Asian and Afro-Caribbean women of various age and generation. Within her study she found that the use of home remedies was confined almost exclusively to the informants of Afro-Caribbean descent. She found that the informants of Asian descent preferred to rely on western trained doctors and drugs and although some could remember using Hakims in childhood, none consulted Hakims in the UK. Studies on women of Afro-Caribbean descent have subsequently supported the argument (Thorogood 1990). Armstrong and Pierce (1997) on the other hand carried out research on diabetes among Afro-Caribbeans in London and found no mention of folk remedies which they argued was different to the Asian experience. They argue that it is possible too that these remedies are used often for specific diseases such as diabetes being more usually taken for symptoms. Bowes and Domokos (1993) also demonstrated in their research on Punjabi Muslim women in Glasgow that these women did not use any "traditional" South Asian medicines. They went on to argue that the women's focus was on "ordinary" health care and was comparable to the white population.

Eade (1997) moves beyond a focus on binary approaches to minority use of health discourses in his research on Bangladeshi communities in Tower Hamlets. He argues that minorities and migrants draw on a plurality of discourses combining both non-western and western. He argues this involves drawing on Western medicine as well as Unani, the official Islamic medical system, as well as folk systems. He argues along with Gardner (1995) that these systems are not tightly bounded. The boundaries between the different discourses are blurred. He suggests that this drawing on a number of discourses is a part of the dynamic and contested process of cultural construction as conditions are adapted to the conditions of urban life within the west. Hillier and Rahman (1996) in their research on use of psychiatric services by Bangladeshi children support this argument. They argue that although western medicine was the most favoured source of medicine, this was closely followed by the Mullah. Such approaches are more useful for this research than those previously explored. With an emphasis on dynamic and contested construction of beliefs and behaviours they enable us to move beyond temporally static approaches and approaches which locate beliefs and behaviours within one type of discourse.

The question over use of different types of discourses however becomes more complex when we consider whether western and non-western medical systems can be seen as completely distinct. Brady, Kuntiz and Nash (1997) argue that we should not look at these systems separately, setting western and non-western medicine up against one another as binary oppositions. In their research on aboriginal health they argue that non-western medicine is often set up as antithetical to the Cartesian dualist model of western biomedicine. They suggest that the western medical model of health is not quite as monolithic as it is portrayed. Brady, Kunitz and Nash (1997) suggest that there is, after all, a long history of acceptance in the west of the relationship between affective and physical states and the influence of the mind on illness being expressed in different ways in different countries. They argue that non-western medicine, which in their research takes the form of Aboriginal medicine, embraces concepts of health that are practical in ways that on occasions belie more romantic conceptualisations. There is therefore (they conclude) a false dichotomy in presenting western and non-western medical discourses as polar opposites. Leslie (1992) suggests that medical systems are in themselves syncretic incorporating into their centres a mix and match of different systems which makes them far from coherent and bounded. I would argue that one cannot look at systems in simple isolation from one another, since systems often share a common feature. However, I would argue that to see systems themselves as syncretic or blurred, as only ever a mix and match of difference, denies that systems have characteristics that are specific only to them. A denial of difference between systems also fails to take into account the long history of unequal relations between biomedicine and non-western systems. In the eyes of the state, biomedicine is still viewed as superior to any alternatives, which have to strive for official recognition (Cant and Sharma 1999). While it is important to recognise these issues within the context of this research it is more fruitful again to explore whether the respondents themselves distinguish between discrete and separate systems or see crossovers.

In exploring the relationships between systems themselves this also brings me round to the issue of what constitutes 'non-western' medicine within this research. In talking about different medical systems recognising them as distinct yet having shared points of reference, it is also important to say why I chose the term non-western to describe systems

other than biomedicine. Despite the highly contested nature of the debate it is worth distinguishing between discourses at some level because of the legitimisation given by the state to biomedicine which is not as yet bestowed on others medical discourses. Ideas about what constitutes alternative, indigenous, non-western, unorthodox, or non-conventional medicine remains a contested domain. All the terms suffer from the same problems. All set western medicine up as the 'normal' and anything else as abnormal or fringe, as 'other'. In light of this, I chose the term non-western medicine. I argue that in these circumstances it is not the signified but the signifier which is important, it is not the term itself but the way it is used. While the term 'non-western' is as problematic in some respects as any of the other terms, I use it with caution.

In using this term 'non-western' it is important to recognise that not all alternative medicine is non-western in origin. Cant and Sharma (1999) develop a typology of alternative medicine. These types can roughly be broken into five, and are partly sequential; the first are those developed prior to (or alongside) contemporary modern medicine, e.g. Homeopathy. The second are those that became visible during the early modern period of medical individualism e.g. osteopathy. The third arose in the late nineteenth/early twentieth century in central Europe e.g. naturopathy. The fourth are those that re-emerged in the west or were imported by westerners in various versions from Asia e.g. acupuncture etc. and finally the fifth are those that have entered western countries with immigrant groups such as Unani Tibb, Ayurveda and Chinese herbal medicine, as well as various forms of ritual or spiritual healing or divining. Cant and Sharma (1999) argue that some of these are little known outside the ethnic groups who brought them, others have gained a wider repute and usage. Within the context of this research I am mostly referring to medical systems associated with the fifth type identified by Cant and Sharma, that is those originating within non-western contexts. However, I do refer to other types of alternative discourses throughout the thesis. While I do use the term non-western in order to avoid conceptual complexity I do recognise the diversity within the category alternative.

Finally in exploring issues relating to ethnicity and plural medicine caution must be

applied. Bowes and Domokos (1993) and Ahmad (1993) are strongly critical of research which has focused on South Asian use of alternative practices, describing it as derogatory and patronising. While I feel that by looking at non-western medical discourse one is in danger of presenting minorities as exotic, I also think that the inability to engage with other forms of discourse leads one to create western medical discourse as somehow pure and as a yardstick to which others must match up.

Within current cultural anthropology research is directed toward emergent cultural flows (Appadurai 1990). Narayan (1996) argues that in this context a focus on older traditions might well be mistaken as a misguided quest for bounded cultural authenticity (Handler 1986) a regressive return to the 'savage paradigm' that casts anthropologists' subject matter as disappearing or, as Clifford (1997) argues, a form of imperialist nostalgia whereby anthropologists mourn the passing of that which the present destroys. Narayan (1996) argues, however, that it is still important to look at what are seen as 'old traditions'. She argues that such traditions must be reframed analytically among a widening field of available imaginative positions. She also argues that these traditions can, in their own right be seen as processual and mixed instead of seeing 'residual' traditions as irrelevant to contemporary times, we might also explore whether they have an alternative or even oppositional relationship to the dominant culture. In this sense I think that it is important to look at the use of non-western medical discourse. In any case, as Worsely (1997) argues, in every culture there is a persistence of folk medical beliefs and practices. This is vividly illustrated by Helman's (1978) classic study of the archetypal British complaint justly called the common cold which is the focus of a whole complex of beliefs and practices.

The project explores this plurality of discourse in women's health beliefs and behaviours. Following on from Brady, Kunitz and Nash (1997), I move away from the binary paradigm which sets western and non-western medical discourses in opposition. I look at the boundaries between these systems as blurred and through a utilisation of the concept of syncrecy and a dialectic approach. I will be working in a paradigm which transgresses this binary opposition, exploring both plurality and context.

1.5 Building a theoretical framework: syncrecy and fluidity

The idea that beliefs and behaviours are syncretic plays on the complex interweaving of ethnicity, culture and material circumstance for this generational group. The research draws on the concepts of syncrecy as used in the current theoretical debates on identity (Parker 1995). I will take Radley and Billig's (1996) argument and look at health beliefs and behaviours not merely as given but as part of the active construction of identity. The research explores the idea that women within the study draw their beliefs and behaviours from distinct and disparate sources, both western and non-western discourses. The research explores the argument that respondents are likely to draw their beliefs in particular, from a combination of both non-western and western medical systems.

Authors such as Clifford (1997) and Gilroy (1993) have begun to explore the tensions between continuity, fracturing, commonality and difference which are present in all forms of identity. Gilroy (1993) in talking about black diaspora in both America and Britain describes a cultural formation that has arisen from the diaspora which he names the 'black Atlantic' to convey the idea that it is a hybrid, a mix of elements from western culture (both British and American), from the Caribbean and from the homelands of African slaves. Just as capitalism was founded on trade between these locations so culture is shaped by journeys (actual and symbolic) between the areas. Gilroy uses the idea to attack the ideal of the recovery of a 'lost' or 'original' African culture. The notion of hybridity has been developed by Bhabha (1992) to describe contemporary ethnic identity. For example Indian people settled in Britain are affected by aspects of both, or all , the cultures to which they are exposed. They are not simply British or stuck 'between two cultures' as Watson (1977) would argue, drawing instead on what Mohhood (1992) calls a 'hyphenated identity' or what Parker calls (1995) 'syncretic identity', which is different from an Indian or Chinese person who has never left Asia. By using the term syncrecy I explore the idea of health beliefs and behaviours drawn from both western and non-western culture and as forming part of a hybrid identity.

The concepts of syncrecy and syncretism have also been used in some research on health. Fitzgerald (1984) uses the concept of syncrecy in terms of general lay views about health.

He argues that lay views are syncretic in origin in that they originate from distinct and disparate sources and are continually being reworked in the light of experience. As argued earlier, the term has also been used to explore medical systems themselves. Leslie (1992) suggests that medical systems are syncretic, incorporating into their centres a mix and match of different systems. However, as Annandale (1998) argues, while there has been an exploration of global diaspora and the emergence of syncretic cultures within identity studies, and separately the use of the concept of syncrecy in studies on health, to date there has been little attempt to draw on frameworks of syncrecy when exploring ethnicity and identity within the context of health. It is the aim of the study to develop those frameworks with a health context

In using current theoretical buzzwords such as syncrecy or hybridity, particularly in regard to race and ethnicity one must do so with caution. Narayan (1996) argues that anthropologists are well advised to discard an emphasis on pristine authenticity, taking heed of hybridity, innovation and global connections. However, as Parker (1995) argues, both syncrecy and hybridity are uneasy biologistic metaphors for combination, which can connote a state rather than a process. It could lead to a position that implies a pure origin and an alternative which when combined together produce a new term 'the hybrid'. He argues the emphasis should instead be on process. Both terms run the risk of glorifying disjuncture, producing a new rigidity and an academic alterity which merely values itself for its own state. Grewal (1994) also argues that by suggesting in any way that diaspora are syncretic or hybrid one is in danger of setting up the white subject as somehow pure. The self/other distinction, which ideas of third spacing are supposed to overcome, end up being reconstructed.

Bhabha (1992) suggests that in the global society within which we live all cultures and societies are hybrid. There is no such thing as a pure culture since we have all inevitably been influenced by the processes of migration, travel and tourism and cultural communication and exchange. He turns hybridity into something positive by developing the notion of the third space from which an oppositional/critical stance can develop. Trinh Minh Ha (1989) develops this notion of the third space which can be seen as a space for

critical assertion, a space in-between the self and the concrete other where one can maintain the identity of Not You/Like you. Such third space can be seen as an intersubjective realm, which holds a space for resistance.

In order to avoid using syncrecy to denote a 'state', some kind of purity or a reification of a 'between two cultures' type approach, I have developed a framework of syncrecy which highlights the processual and dialectic nature of the framework. The concept of syncrecy is used here to explore and denote crossovers and tensions between categories of difference. The term is taken to resist the complete collapse of categories of difference. Whilst recognising that at times there may be crossovers between categories, syncrecy also allows the potential for tensions between categories at particular times and contexts. In this sense, rather than being a fixed or static framework syncrecy is seen rather as fluid and polyvocal. To echo Gilroy's (1993) argument, syncretic forms are never repeated in quite the same way but are re-worked and re-inscribed differently in differing contexts. Syncrecy then is an analytical not a chronological framework which will change according to historical, local and personal context. Within this study the framework of syncrecy is used to look at the way in which west and non-west are seen as mixed, both locally and globally, in a reciprocal context. The aim is to use this to look at the tension for British Asian women between west and non-west. Such a framework of syncrecy enables me to develop a suitable paradigm within which to look at the health beliefs and behaviours of British Asian women.

Within this framework I move away from a view of beliefs and behaviours as fixed. Current writers on identity make explicit the argument that identities are fluid and complex. Indeed those writing from a post-modern perspective (Hall 1992) argue that the post-modern subject has no fixed identity, the unified, completed, secure and coherent identity is fantasy. Similarly, Radley and Billig (1996) argue that health beliefs should not been seen as static but as processual as people actively construct their identities. I want to argue that just as there is no pure and single narrative of the self then beliefs and behaviours cannot be constructed as single narratives. This is part of the reason as to why I use the term discourse when talking about women's use of health systems, using it in the

Foucauldian sense where discourses overlap and become displaced. Such multi-layering and rhizomic formation (Bogue 1989) takes into account fluidity. I acknowledge that the beliefs and behaviours held during the research will be those held only at a certain time and in a certain context and are open to being reworked and reframed.

1.5.1 Localising the global: beliefs, behaviours and the importance of context

In discussing utilising post-modern approaches from studies on identity and ethnicity within a health context Annandale (1998) urges caution. She argues, on the one hand we might see the more fluid approach to, identity as the ultimate 'way out' of the problems that have arisen when an individuals health status, health beliefs and health behaviours are rather uncritically read off their designated ethnic group status (in both qualitative and quantitative research). But on the other hand, she argues that concern has been expressed that euphemisms of diversity can act as a smokescreen for the entrenchment of inequality (Smith 1993). While some imply that more fluid identities are a product of global social change, particularly in the European context, others warn that such approaches are themselves Areocentric and deeply racialized as they generate a vision which renders the immiserated irrelevant and as ornaments without agency or resistance (Harris 1993). In order to avoid the relativism of such approaches and the reification of culturalist approaches to health outlined earlier within the introduction, the framework of syncrecy is also explored through the influence of respondents' contextual circumstances. By context I am referring to a broad range of circumstances within respondents' lives that are not just about their ethnic or generational position. The aim is to include circumstances which range from familial, through to material socio-economic to wider structural constraints.

Previous research on ethnicity and health beliefs and behaviours has tended to view ethnicity as the only, or at the very least, primary factor in determining those health beliefs and behaviours. As Bowes and Domokos (1993) argue much research has focused on culture as a causative factor. They argue that this leads investigators to ignore influences on health and health beliefs and behaviours such as socio economic group, housing conditions and access to health care. As argued earlier, this has filtered down to a culture blaming approach in health policy (Ahmad 1993). It is important to look at factors other

than culture. Nagel (1994) develops the term symbolic ethnicity to look at how factors other than ethnicity affect people's life choices. Symbolic ethnicity is characterised as a nostalgic allegiance to the culture of the immigrant generation. However, this allegiance is "symbolic" in the sense that other factors such as work and class heavily inform identity and daily practice.

This project takes up Ahmad's (1996) call for culturally situated research, research which acknowledges that culture is materially and locationally situated. As such the research focuses on the importance of other factors such as the significance of respondents access to health services, work, other material circumstances and location in time and space in influencing health beliefs and behaviours. In recognising how factors other than culture affect health behaviour Ahmad (1996) gives the example of different experiences of childbirth in Pakistan. One woman's experience of child birth involved the use of an obstetrician, a second involved the use of a Dai (traditional birth attendant without any biomedical training, adhering to a 40 day recuperation process of Chilla), the third woman who works in road construction works before and after birth. All three are Muslim women employed in present day Pakistan but their lives are differentiated by class, urban/rural split and access to health care. All three types of childbirth are part of Pakistani culture and tradition regarding pregnancy and childbirth.

Whilst acknowledging that health beliefs and practices are shaped by more than ethnic and cultural processes, however, one should be careful not to move to a position which is overly deterministic. To take the position that beliefs and behaviours are completely determined by external forces leads to an approach which denies agency. It also tends to ignore the influence of other factors on beliefs and behaviours, for example the influence of the family. This is why I draw such a broad definition of contextual circumstances, to incorporate personal, social and structural influences. This avoids a complete denial of agency, influences relating not just to external factors. It is important to recognise that groups may use non-western health care. For instance Kelleher and Islam (1996) carried out research on incidence of diabetes among Bangladeshis in the UK. However in looking at Bangladeshis they found that people mixed both western and non-western health

discourses when managing diabetes on a daily level. On the whole they saw their diabetes as a problem which had to be managed by western medicine, they did not appear to think folk remedies had much to offer them apart from widely used Karella, neither did they think the wearing of amulets had much power to control diabetes. However, Karella, (a bitter vegetable) was widely used. Some said that they had been told by the doctor to use Karella and one person claimed that it was on a hospital diet sheet, which is an interesting example of western doctors being prepared to work with lay ideas.

Kelleher and Islam's (1996) study demonstrates the complex nature of choices about health care and how a number of factors are taken into account when choosing healthcare. The problem these Bangladeshi people were facing was much more than simply making personal choices about what to eat. It was nevertheless important given food and its symbolic meanings in Bangladeshi culture. As well as being confronted by the dialectic of the local and the global (Giddens 1991a) in integrating their traditional foods and choosing new internationally available foods like rice crispies, fish fingers etc. their traditional ways of thinking about life and death were being challenged by a medical treatment which is predicated on a notion of risk reduction. All the respondents within the constraints of their situations were actively constructing their lives as people with diabetes and their cultural beliefs were one of the resources they used. The frameworks, the structures of relevance that they draw on are shared but individuals construct their own lives within them.

This exploration of both syncrecy and context within women's health beliefs and behaviours is held in tension throughout the thesis through a dialectical approach. Whilst not entirely polarized, nor are the syncretic, and the contextual wholly joined. A dialectical approach provides a wider framework within which to situate the two theories of syncrecy and context and provides a wider framework throughout the thesis particularly when focusing on the operationalisation of research categories. I am defining dialectic here as a reflexive approach which makes room for a plurality of views and multivocal discourse. In this approach knowledge is seen as an outcome of dialogues of inter and intra subjective communications and of the confrontations of differing images of reality. Knowledge in this way is see as a temporary construct determined historically, locally and

personally (Shrijvers 1993). In allowing for plurality and multivocal discourse encapsulated in tension, this approach moves us beyond a theoretical framework based on static hierarchical binaries. It enables an exploration of both global and local processes, and recognises the importance of history, context and experiential rooting.

1.6 Situating the project: Why Leicester?

The research has been conducted in Leicester for a number of reasons. First, Leicester has a significant South Asian population, of varying religions and socio economic class. Secondly, previous research on minority beliefs and behaviours has focused on carrying out research in areas such as London (Donovan 1986, Eade 1997) or Glasgow (Bowes and Domokos 1993), few studies on minority health have been carried out in the midlands which is surprising because of the area's significant Asian population. I chose Leicester partly to see what differences there might be from previous studies relating to geographical location. The final reason for choosing Leicester was personal. I had grown up in Leicester and have links there so it was ideal in terms of facilitating a sample.

Leicester is known historically as a booming industrial city, famous for its hosiery, knitwear and footwear manufacturing and more recently engineering, printing, adhesive manufacturing and food processing. By the mid 1960s, Leicester was at the height of the boom. During this time it became a magnet town for immigrants from the Indian sub-continent, the Caribbean and by the later 1960s East and central Africans. According to data from the 1991 census (Leicester City Council 1991) Leicester ranks fifth in terms of absolute numbers of all ethnic minorities; second for all Asian groups; first for its population of Indian origin but only thirty fifth for those who classify themselves as black. However, outside the London area it is the local authority with the highest percentage of all ethnic minorities. It has a white population of around 71.5%, black population of around 2.4%, Asian population of 23.7%, Chinese and 'other' ethnic groups form 2.4% of the population. While Leicester's Asian population includes Ugandan, Kenyan, Tanzanian, Punjabi, Pakistani/Bangladeshi, and those from the rest of the sub-continent (e.g Gujarat), the population is now heavily weighted towards East African Asians and Gujaratis, both Muslim and Hindu.

The single feature which makes Leicester different from other cities which experienced post-war migration is its East African connection. In the 1950s the immigrants came because of the push factor from those newly independent African countries intent on Africanising their economies, a process which prompted the imposition of much tighter entry controls by successive British governments (Marett 1989). Leicester attracted East Africans, largely because of its *laissez-faire* policy to immigration. This stance was based on cautious pragmatism rather than on deliberate policies in regard to its immigrants. Many Asians moved to Leicester initially because of the prosperity, low incidence of strikes and range of industries (including work for women). There were other reasons for migration to Leicester, ease of access to other cities being one of them. Situated in the middle of England Leicester is at the focus of its communications networks, a very significant factor for minority groups who wish to visit and be visited by relatives and friends, for personal, social, religious and commercial reasons. Finally there was also cheap housing available.

Leicester still has a growing South Asian population concentrated in Highfields, Melton Road, Belgrave Road and Narborough Road. (*See Appendix A).*These are all inner city areas: residential, business and industrial, some in the prosperous area of Oadby. There are over 40 clubs and societies, and organisations devoted in the main to the social and welfare needs of Asian groups: there are 3 Hindu temples, 3 Sikh Gurwaras, and 2 Moslem mosques and an Islamic foundation (Marett 1989). There was also the opening of a Bollywood cinema by 1974 on Belgrave Road, 'The Natraj'. Jeffers, Hoggett and Harrison (1996) argue that, Leicester is made up of white and ethnic minority communities far less defensive than those in other localities such as Tower Hamlets. Moreover, the East African community have by virtue of the particular colonial role it had played in East African history become partially anglicised and therefore found the transition to the U K easier than many other minorities elsewhere. These factors have made it an ideal location for gaining a sample. Also because of Leicester's central location it is an ideal place in which to explore local/global links and the diverse and multifaceted nature of the South Asian diaspora.

1.7 Outline and structure of the thesis

The project explores the influence of syncrecy and the importance of context both material and locational on women's health beliefs and behaviours. As argued through this thesis the research addresses questions on health and indigenous health, and on ethnicity and identity. The research explores, first, the idea that respondents 'health beliefs and behaviours are syncretic. Secondly, the research explores the role and importance of contextual circumstances on respondents' use of syncretic discourses. These issues and their relationship to respondents' position as 'British Asian' (that is women of a particular ethnic and generational group) with wider diasporic connections will be explored in detail throughout the following chapters.

Chapter two constitutes an outline of the research methodology and method upon which the project is based. This explores a dialectical methodological framework from a feminist position. It builds a methodology upon a recognition of difference and a politics of location. The chapter moves on to outline the research method used, including the pilot focus group, in-depth interviews, issues of sampling, approach to interviewing, interview schedule, analysis and ethical concerns. Chapter three explores how respondents' use of syncretic discourse is relational to particular illness. Within the research women's beliefs and behaviours are more syncretic regarding some illnesses and less so for others. For general health issues respondents beliefs and behaviours tended to be weighted towards a use of western discourses whereas the more serious conditions are, the more respondents are likely draw mostly on western discourses. Here syncrecy also intersects with use of health care within the home and within the public realm. Drawing on Cornwell's (1984) tripartite categorisation of illness into normal illness, health problems and real illness I will explore the relationship between syncrecy and illness within the respondents' accounts.

Chapter four moves on to explore the impact of family and relationships on respondents' health beliefs and behaviours. Within the study, women talked at length about the family, about the influence of marriage on their beliefs and behaviours, about their attitudes and practices regarding their children's health. On marriage respondents' use of syncretic discourses increased. The arrival of children however

meant a shift in respondents' use of syncretic discourses, a move from using discourses mostly within the public realm to using them mostly within the home. Within the study, women also discussed generational differences between them, their parents and their children and syncretic use of discourses. This chapter will explore these influences situating them within a life course framework.

Chapter five focuses on the influences of respondents' religion and community on their health beliefs and behaviours. Within the study religion influenced women's use of syncretic discourses and there were distinctions between respondents of differing religions. Women's accounts also highlighted the influence of multiple and intersecting layers of community on beliefs and behaviours. These issues are tied in with issues relating to health and identity. Through their accounts on health women within the study discussed their position as 'British Asian'. Respondents' beliefs and behaviours often reflected their syncretic identity . Different aspects relating to respondents' identity such as religion, community and family became more prevalent at particular times as does influence on beliefs and behaviours.

The final substantive chapter, chapter six explores issues of space, geographical location, and globalization relating to respondents' use of syncretic discourses. Within the study, women's accounts highlight the importance of their context in Leicester their position in Leicester, giving them access to a plurality of discourses. They also highlight the significance of their connections and resources within India. These positions and connections are strengthened by processes of globalization, fostering the transcultural flow of syncretic health goods and giving the respondents use of discourses within India. Syncrecy is then opened up in both local and global contexts. The final chapter will be the conclusion which will explore the wider significance of the research findings and uses of the theoretical framework. It will situate these findings within broader debates and make projections for future research.

Chapter 2
Becoming Methodology

2.1 Introduction

This research project asks two main research questions: first, do 'British Asian' mothers within this study have syncretic health beliefs and behaviours? Secondly, how do contextual and material circumstances affect the respondents' ability to hold such health beliefs and to behave correspondingly.? Through these questions the research aims to address fundamental questions on women's health, ethnicity and identity, globalization and plural medicine. In order to answer these questions one requires a methodology which enables the researcher to access the processes of globalization and at the same time be attentive to regional and contextual specificities, to gain in-depth information involving 'data generation'. This is not to suggest an approach which intends to look beyond discourse, for as Butler (1993) argues we do not ourselves exist outside of discourse. Rather the aim of the research is to look at women's beliefs and behaviours as active constructions of identity and as representative of the social world at a particular time and in a particular context.

The primary aim of this chapter is to lay out this methodological process, to outline a feminist methodology. The second aim is to look at the choice of method and the specificity of chosen method. It will also look at the implementation and practicalities of the research itself including analysis, reflecting on the methodological approach taken. Finally it will include a look at some of the ethical issues raised by the research.

2.2 A Feminist Methodology

As Harding (1987) argues, a methodology is a theory and an analysis of how research should and does proceed. It includes accounts of how the general structure of a theory finds its application in particular scientific disciplines. It follows from an epistemology, which is the theory of who can be the knower, or what can be known. The methodological

framework in this project is centred on capturing the dialectic between global and local processes, recognising the importance of the global whilst at the same time recognising the specific. At the centre of the methodology are issues concerning gender and race. The approach taken here is feminist, is sensitive to race, and draws on a number of theoretical perspectives, particularly post-modernism and post-structuralism. A qualitative approach is used to bridge these theoretical approaches (Glassner and Miller 1997).

Feminism is made up of a multiplicity of perspectives. There has been much debate within social science as to what constitutes a feminist methodology and method (Harding 1987, Reinharz 1992). As Harding (1987) argues, there is no such thing as a feminist method. As feminists we should concern ourselves with feminist epistemologies and methodologies. The approach taken within the research is a feminist one and it is important also to recognise difference and diversity within this approach and within the study in general. As Reinharz (1992) argues, we seek to understand the commonalities and differences in women's experiences. Sound feminist scholarship must entail an understanding of class, race and sexuality. We must reject crude universalism and recognise plural experience (Doyal 1995). However, this does not mean we should embrace crude difference instead. A focus just on differences between women denies the possibility of exploring beliefs, values and interests that women might have in common.

In dealing with this issue, I draw on the perspectives of partial identity (Haraway 1988, Harding 1991). The benefit of the partial perspective is that it recognises both differences and similarities in women's experience. While there are differences in experience, positioning and power relations between women there are also commonalities. We can 'partially identify' with other women through our various experiences. For example in the context of research, while we may be of a different race to respondents we may be in the same socio-economic group and share experience there. These tensions and commonalities can help to build rapport within a research situation while situating women's differing experiences. This approach enables the building of what Skeggs (1997) calls interpretative

frameworks to cross dialogic bridges of diversity in women's experience, avoiding what Haraway (1988) identifies as totalising and imperialist forms of naming.

Caution must be applied when using the framework of the partial perspective. The framework has been critiqued for its evasion of research responsibility. Haraway (1988) argues that researchers feign commonality when it suits and emphasise diversity if issues of responsibility come to the fore. It is important to keep this in my mind when recognising both commonalities and differences between researcher and researched. In taking this approach, I argue the project must also be based on a politics of location. Partial knowledge must be historically and experientially rooted. Here I draw on feminist conjuncturalism (Frankenburg and Mani 1996) based on a politics of location. This approach asserts that there is an effective but not determining, relationship between subjects and their histories, a relationship that is complex, shifting yet not free. The concept of articulation links subjects and structures dynamically, such that practices, meanings and identities are forged by people operating within the limits of their real conditions and the historically articulated 'tendential lines of force'. This framework intersects with feminist appropriations of Althusser (Butler 1997) and states succinctly the dialectic of agency and context, the local and the global at the centre of this project.

2.3 Methodology becoming method

The research required methods which generate 'open' data rather than impose a formalised set of questions (Oakley 1981). The need was to utilise a main method, which was non-directive, and open ended. As Mama (1995) argues, this is necessary in order to gain a slice of on-going social practice. This is particularly important in this research which focuses on process. In his research on identity among young British Chinese people Parker (1995) points to the difficulty of capturing syncretic cultural forms as they are not highly visible. Bearing this in mind, I felt qualitative methods enabling respondents to talk at length about their beliefs and behaviours would offer the best opportunity to access syncrecy. Also, from a health perspective, I wanted to understand health and illness in the context of people's lives (Donovan 1986). I argue that this demands therefore a method

that is not taken from a traditional positivist research perspective nor from the medical model. As Eade (1997) argues, few researchers on ethnicity and health have provided searching examinations of non-western medical discourses and practices that dispense with clinical questionnaires and interpreters and rely on qualitative data collected through participant observation and in-depth interviews with ordinary people, in their own terms.

In order to gain this type of data I decided to carry out a focus group as pilot research. The main body of the research involved in-depth interviews with thirty South Asian mothers. In addition further background information for the study was gained through observation of health classes in Asian women's centres, visits to alternative clinics and use of secondary data from a Leicester Health Authority research project. The fieldwork was conducted between May 1998 and February 1999, the most intense period of data collection being from June until October. The pilot took place in May, the main interviewing period began in June and continued until February. The supplementary methods such as visits to clinics and alternative chemists were conducted sporadically throughout the fieldwork process.

2.3.1 Who were the respondents?

Initially the aim was to gain respondents of only one religion, namely Hindu women. I felt that it would be better to concentrate on a population which were also more likely to use the same non-western Asian medical system, the Hindu medical system being 'Ayurveda'. However once I began to approach various community centres, women's centres and schools I became aware of Leicester's incredibly diverse Asian population and also of its particularly high Muslim population. It seemed unlikely that I would be able to gain an appropriate sample of Hindu women. I was also struck by the incredibly diverse nature of the Hindu population not just in terms of geographical origins (e.g. East African, Gujarati etc.) but also in terms of caste. This led me back to the main aim of the study, which was to look at what was specific about 'British Asian' women's health beliefs and behaviours not at specific medical systems associated with particular religions. This being the case I decided to draw respondents who were Muslim, Sikh or Hindu. I also had respondents who

had Goan origins and were Catholic. In total 7 of the women were Muslim, 15 were Hindu, 7 were Sikh, and one was Catholic (the religion, age, occupation and marital status of respondents within the study are outlined in the appendix B(pp215-219).The respondents were of various classes. Such a focus on diverse socio-economic groups is driven mostly by the practicalities of research. I gained a mixed sample because my respondents came from differing city central locations, industrial, residential and business. Also although I recognised the importance of class within the research, comparison by class did not form one of the main arguments. Within the process of analysis I was open to the possibility that class might form one type of influence on respondents beliefs and behaviours.

Within the research, because of the aims, it was most important to gain respondents who were mothers and who were British Asian women. As argued in the Introduction, I wanted to target mothers within this research for a number of reasons. In methodological terms the reasons were tied up with women's roles as carers within the family. Blaxter (1990) has demonstrated the important role of mothers in mediating family health. The findings of Bowes and Domokos[3](1993) research on Punjabi Muslim women found the same. They argued that women are primarily responsible for caring for children and often relatives, particularly extended family members. I chose to focus on mothers because I felt that I may get accounts not just of women's own health but also of the rest of the family. I wanted to get at the issue of whether the women's health beliefs and behaviours altered depending on which family member they were talking about. I also wanted to include only British born Asian women within the sample because the aim of the research was to look at what is specific about Asian women born and socialised within British culture. This actually created significant sampling problems and worked against the focus on mothers. If women were mothers then they tended not to be British born. If they were British born they tended not to be mothers. This was due to the typical migration patterns of Asians in Leicester and also related to the fact that more women now choose to have children later in life. This led me to rethink my focus and I decided to modify my sample requirements. My focus became British born mothers and also those who had moved to Britain at the age of five or under. I included women who had moved under the age of five because that means

all their schooling would take place within Britain. This led to an age range within the sample from 20-45. The sample became split into two roughly equal clusters, women in their 20's/early 30's and those in their 40's.

The respondents were drawn from a number of areas and centres spanning the city centre. Respondents came from two Asian women's centres, the Sharma Women's centre, and the Bhagini centre. Respondents were also drawn from the Sikh community centre and the East/West Project centre. The pilot respondents came from a community centre. The supplementary research involved respondents from clinics and health centres. There was concern that by gaining a sample solely from community centres I would be gaining particular types of respondents. In order to take this into account, I also snowballed respondents outside of community centres from contacts made within the various centres. These respondents had no connection to community centres themselves.

2.3.2 The Research: pilot

Initially I carried out a pilot focus group in order to refine my method for the main body of the research, to test out questions for the in-depth interview schedule. A focus group was chosen as the preferred pilot method. This was because, as has been well documented, these provide an excellent tool for exploratory research and are often the first step in a research study (Vaughn, Shay Schum and Sinagub 1996) . The term 'focus' refers to the role of a moderator in limiting the discussion to areas of interest. Verbal and non-verbal information can be gathered and responses may be elaborated, defended or criticised by other members. I will define focus group loosely as an informal assembly of target persons whose point of view are requested to address a selected topic. Groups normally contain 6-12 persons. Focus groups often have an observer present as well as the main group facilitator, although within this context there was just myself as facilitator present. They are often used in health research both in terms of opinions for service improvement (Beck, Trombetta and Share 1986) and in order to gain 'lay' beliefs about specific health issues and practices. Focus groups have been used previously in research projects related to

looking at the health beliefs and behaviours of migrants and minorities (Armstrong and Pierce 1996).

For this focus group a community centre in an area with a high Asian population was approached. Connections with the community playgroup leader enabled me to gain a number of respondents who were mothers with small children. The group involved a discussion group of four women. These women were not representative of the women in the main body of the research; they consisted of 2 Hindu women born in Gujarat, both of whom had spent a number of years in Britain. The other two women were British born Muslim women. The group was followed by 2 individual pilot interviews, both with British born East African Asian women. The session lasted roughly 3 hours and took place in a room at the back of the community centre. I developed a rough interview schedule, which consisted of general background questions, general questions on the women's state of health and use of services, more specific questions on health and illness and finally, questions of identity and health. The pilot provided me with the exciting experience of finally gaining some raw data for the research. It also enabled me to reflect on the interview schedule, on the chosen method and on the sample. The most useful purpose of the focus group was to refine the interview schedule. After transcription of the group there was an effort made to make the interview schedule for the main body of interviewing more open ended and less rigid. Certain questions were added to the schedule, questions about menstruation, pregnancy and childbirth. Also more questions about diet were added.

2.4 Main body, individual interviews

In-depth interviews were chosen as the main method as it was felt they would enable me to gather in-depth individual information. Once the method had been refined from the pilot the main interviews began. Thirty respondents took part; thirty was deemed enough to make certain comparisons but small enough to gain in-depth information. After the initial pilot in May the main body of interviewing began at the end of June 1998. This process was then staggered over a seven month time span. Several interviews were carried out each month and then immediately transcribed and analysed. After deciding from the pilot to

broaden the sample the various community groups were contacted. The interviews mostly took place in the women's homes, some within the women's centres. The interviews lasted between 45 minutes and two hours, the average being an hour. They were all tape recorded.

Miller and Glassner (1997) identify two approaches to interviewing. On the one hand they argue that there is the positivist aim of creating a pure interview situation enacted in a sterilised context. As close as possible interviews mirror reality (this approach has been criticised both for its feasibility and desirability). On the other hand they identify the radical social constructionist approach, that there is no knowledge 'out there' in the social world which can be obtained from the interview. This approach sees interviews as contextually specific, exclusively an interaction between interviewee and interviewer in which both participants create or construct narrative versions of the social world. As Miller and Glassner (1997) argue, the prospect of viewing interviews as meaningless beyond context is daunting if the researcher hopes that they will learn about the social world and contribute to knowledge that can, by being expanded on bring benefits.

While refuting the first approach the second approach is used with caution. In particular caution should be applied to post-modern approaches to interviewing, approaches which espouse polyvocality (Clifford and Marcus 1986) and free floatation of signifieds in relation to referents (Schenrich 1987). I recognise that interview interactions are neither unitary nor teleological and that they are ambiguous and complex. However, I think that the interview approach of duality of voice can only ever remain an ideal type because I feel there is always a power relation inherent in the interviewing process. Despite claims that one can go to the interview and let the interviewee speak for herself with no intervention from the interviewer, I feel that there will always be a more or less hidden agenda, a research schedule. For instance within this research, no matter how much I aspired to a duality of voice, it would be me asking the questions as it was my research.

Within the research I drew on aspects of post-modern approaches to interviewing, recognising the multiple interpretations of reality inherent within the interview situation and the desire to move away from fixed hierarchical relations between researcher and researched. I also found it helpful within the research to engage with subtle realist approaches (Parker [1995] also calls this constructive realism). This approach is not too far removed from the relativism of post-modernism. However, it does recognise an ordering to the interview situation which is helpful in this context. The key elements of such an approach are outlined by Hammersley (1992): that validity of beliefs cannot be assumed with certainty, that there are phenomena independent of our claims about them, and that the aim of social research is to attempt to represent reality but not to reproduce it. In this sense there are multiple interpretations of reality.

Translated to the interview process Parker (1995) argues that through a subtle realist approach interviews are viewed as a space where experiences are related and then immediately problematised by questioning. In a similar way to post-modern ethnography, the outcome is perceived as the production of only one of many possible accounts and interpretations of social phenomena. The closest example of this approach to interviewing within the area of ethnicity and health comes from Bowes and Domokos (1993). In their study the women were interviewed about their notions of good health, their use of health services, satisfaction with them and views on improvements with services. The interviews were guided by a schedule which listed topics that it was hoped would be covered, at the same time it was intended from the outset to allow the women to raise their own concerns and tell the researchers which to them were the most important issues. The interviewers aimed by responding to the respondents' own comments to cover issues of health maintenance, the life cycle, illness, children, the use of health services,alternatives, non-professional help and support and the environment.

My approach was similar. I developed a research schedule, which was divided into four areas (*see* full schedule in Appendix C pp220-222). Questions were answered through women's experience, which were then further problematised by me.

1. **Section 1: Background information:** This section was designed to elicit background information about respondents in order to build up a sample profile for later comparison. Questions were asked about women's age, occupation, marital status, husband's occupation, number and sex of children etc.
2. **Section 2: General questions about health:** The second section was designed to get some general information about women's and their families' health, and some general views on beliefs and practices. Questions were asked on how women perceived their health at present (and that of their families), how often they visited their GP, did they use a healer, if so how often did they visit, and were they satisfied with health care in their area, etc.
3. **Section 3: Specific questions on health:** This section focused on more specific questions about women's health. This was in order to gain information about women's beliefs and behaviours over various illnesses to see if these vary depending on types of illness. Questions were asked about general minor health for example, colds/minor illnesses etc., on pregnancy and child birth, on manageable illnesses such as asthma, eczema and diabetes etc. and on more serious illnesses such as cancer.
4. **Section 4: Questions on identity and health:** The final section was aimed at looking at health and identity, this was really in order to get at how women saw themselves as Asian (Muslim, Sikh and Hindu) in Britain, how integrated they perceived themselves within the wider Asian community. Questions were cross cut with questions on generation and identity and on how all of these things impacted on health beliefs and behaviours. Some questions on diet were also included in this section. The interviews were finished off by asking a question about how the women saw themselves as passing beliefs and behaviours on to their own children.

2.4.1 Becoming an interviewer

The process of becoming an interviewer was based on trial, error and adaptation. I followed the schedule above but adapted it according to women's religion, class and context. Entering the field as a realist I was aware of the potential construction of expert/lay knowledge within the interview situation and was readily aware of the power

dynamic inherent within the relationship. I went into the field with Schenrich's (1987) notions that interview interactions do not have some essential/teleological tendency toward an ideal of joint construction of meaning. Again these ideas were developed after my cautious response to post-modern approaches to interviewing which see the interviewer/interviewee relationship as equal. In becoming an interviewer I found it difficult to embrace wholeheartedly the post-modern ideal of polyvocality. This was particularly because of my position as a white researcher researching Asian respondents. [1]Gramscian notions of continued dominance and resistance within the interview situation between researcher and researched take on relevance here.

As a feminist researcher I was aware of the emphasis in research on rapport building and taking a reflexive approach. It has been argued that rapport building can overcome certain obstacles to research such as class and race. Reflexivity has also been seen as a very important aspect of feminist research (Harding 1987). Reflexivity is defined as the researcher him/herself being placed in the same critical location as the subject of research, recovering the entire research process for scrutiny in the research results. As Miller and Glassner (1997) argue, subjectivity that exists in all social research contexts should be a visible part of the project and available to the reader for examination.

Some authors suggest that reflexivity and rapport building can enable us to overcome the power relations of the research process. For example Donovan (1986) in her research on the health beliefs of Afro-Caribbean and Asian women in London used her identity as a Jewish woman to try and overcome problems associated with being a white researcher researching women of colour. However I agree with Stacey (1988) that self-conscious sharing and empathy can in the long run prove more insidious in reinforcing hierarchies of knowledge production. Haraway's (1991) caution that there is no immediate vision from the standpoint of the subjugated is taken to heart. It is unclear whether advocating self-

[1] The concept of resistance emphaises that individuals are not just acted on by abstract structures but negotiate, struggle and create meaning of their own *see* Schenrich (1987). Dominance can never totally be secured. It is open to erosion by embodied agency *see* Clegg (1989).

conscious partiality and recognising the complex dynamics of social research in themselves secure accountability. Social research should not necessitate engaging in confessions with respondents revealing excessive details about oneself. While it was necessary to give some details of myself I felt that if I tried too hard to relate the respondents' experiences to mine the project would end up as an exercise in narcissism. I felt a policed reflexivity was needed.

My position was influenced by Turner's (1989) notions of the 'connected critic'. This position is post-Foucauldian. The researcher unlearns the privilege of research as she/he takes on the position of the connected critic. This is a position whereby the researcher acknowledges their own values. They seek a common enterprise within the moral world which the researcher and respondent both inhabit. This creates an ideal type research situation but recognises the limitations and impossibility of alignment with the concrete other (Tong 1989).

2.4.2 Interviewing across race

Throughout the research I was faced with the issue of researching across difference. Could I a white middle-class researcher interview women of different race and class positions? Within the earlier section on feminist methodologies I suggested that while we must be sensitive to diversity, it is important to recognise women do also share commonalities. A methodological framework of 'partial identification' was then adopted. Here I deal with the practicalities of interviewing across difference, (particularly across race) and the implications for research findings and ethical issues. Rhodes (1994) and others have raised questions surrounding the issue of a white researcher undertaking research with a non-white respondent. As Back (1993) argues, in Britain the central issue within the debate on research practice in the sociology of race has been the ability of the white researcher to understand and empathise with black experiences of racism. Ram (1996) argues that to do such research is difficult and that to hold a similar structural position to respondents is particularly beneficial in gaining information. However, as Kelleher (1996) argues, although there are good reasons for black researchers researching black communities (one

reason being that they might be better able to gain both physical and psychological access to people) there are also a number of reasons why such matchings are not necessarily desirable. There might be an increased tendency for black researchers to research only black communities and thus become marginalised. Secondly, it is important to recognise that there are other markers of identity besides ethnicity, or being black or white, for example gender, disability and class. Finally he argues that the notion of matching appeals to a notion of essentialism, the idea that there are essential differences between people which always override other aspects of their being.

In dealing with some of these issues I drew on the work of both Anderson (1993) and Rhodes (1994). They emphasise caution in entering research situations involving interviewing across race. However within their studies among non-white groups they argue that were benefits of being a different race to their respondents. They felt that their informants were encouraged to confide in them due to their outsider status. Anderson (1993) argues that white scholars can develop and utilise tensions in their own identities to enable them to see different aspects of minority group experiences and beliefs. As I maintained in the section above I do not feel that 'overkill' on details about yourself overcomes power differentials or indeed overcomes the problems of a white researcher researching respondents of colour. Like Donovan (1986) I asked my respondents whether they felt that my race in the interview situation mattered. They did not seem to feel that it did. I took the position as outlined above of the connected critic acknowledging similarity and difference. I hoped that this would enable me to deal with, if not totally overcome, some of the issues concerning race.

2.4.3 Deconstructing the field: field as place and space

In situating the above picture in a wider context, I felt it important for me to outline how I view the research field. Clifford (1997) argues that it is useful to see the field as a 'habitus' rather than a place, a cluster of dispositions and practices. This is an important point. There are a number of issues operating within this research which force us to look critically at the home/field distinction and these relate to the local/global dialectic. The field for me was

located within women's homes and took place in my home town of Leicester. This localism was cross-cut with the global issue of 'home' for many women being related to India/Pakistan etc. The construction of this dichotomy and fieldwork injunction to go elsewhere constructs 'home' as a site of origin, of sameness. Feminist theory and lesbian and gay studies have perhaps most sharply shown home to be a site of unrestful differences. Moreover in the face of global forces that coerce displacement and travel, staying at (or making) home can be a political act of resistance. Visweswaran's (1994) work is useful here. She develops a concept of ethnographic work, not based on the home/field dichotomy. Homework is not defined as the opposition of exoticist fieldwork. It is not a matter of literally staying home/ or studying one's own community. Home for Visweswaran is a person's location in determining discourses and institutions cutting across locations of race/gender/class and sexuality and culture. Homework is a critical confrontation with the often invisible process of learning that shape us as subjects. Homework is a discipline of unlearning as much as of learning. Home is a locus of critical struggle that both empowers and limits the subject wherever he/she conducts formal research. By deconstructing the home/field opposition Visweswaran clears a space for unorthodox routings and rootings of ethnographic work.

2.5 Reflections on a method

Reflecting on the 'success' of the interviews I was struck by a number of issues. I had gone into the field greatly worrying about the issues of race and class and my position. I worried that not only would these factors, particularly race, be barriers to gaining data but also that the interview would in itself appear as some kind of colonisation process. On doing the interviews although I felt that there was a power dynamic (ultimately I was the one with a tape recorder asking the questions), I also found that women got really excited by the interviews.

Although I did not feel this overcame issues associated with researching across race, I feel comfortable with the interview dynamic along similar lines. I could definitely see the importance of resistance within the research using the term in a Gramscian sense. As

Schenrich (1987) would argue if the researcher is open to seeing resistance she/he will find that interviewees are not just the subjects of researcher dominance, they are also resisters of such dominance. The interviewees in my research did not just go along with my schedule, they created a space of their own, they pushed against or resisted my goals. I often felt that at times the power dynamic shifted, they were leading me to new spaces both metaphorically in the sense of giving me advice on alternative/non-western health practices and care and physically in terms of taking me to geographical places that I had never visited. This provided an unexpected challenge to the lay/expert dyad for me. Perhaps to say the interview situation consisted of resistance and dominance is too crude. One must see this as fluid and shifting, Schenrich (1987) sees this as the development of a third space, a space which he calls chaos, a space of freedom. I prefer to see it in Trinh Minh Ha's (1988/1989) words as a space in between, the self and the other as a space of resistance where one can see both positions but cannot situate the self in the other's shoes.

Reflecting further another thing that surprised me was that the women were pleased and seemed more comfortable when they realised I was from Leicester and we could share experiences and such. They also engaged with me about my own visit to India and experience of health care there. These commonalities served as a base from which to build rapport and reflects the benefits of the 'partial perspective approach' outlined earlier in the chapter. Another interesting off-shoot to interviewing was the fact that the younger women were very different to the older ones in the interview situation itself. The younger women in their twenties were less likely to offer me drinks etc. They seemed less interested in the research and saw me more as a friend. On the other hand the older women enjoyed talking about their lives more, they seemed more relaxed and continually wanted to mother me. Some even wanted to find me a husband. This age difference was far more striking in the interview situation than any difference based on religion, class or other factors.

I expected to find certain difficulties whilst interviewing concerned with the practicalities of research. For instance many women cancelled interviews, and respondents were initially hard to come by. Another issue was interruption during the interview process; this

occurred frequently whilst interviewing in women's homes and in the community/women's centres in the form of children and phones or colleagues. On the whole the interviews enabled me to gain what I set out to obtain, in-depth information about women's health beliefs and behaviours.

2.5.1 Analysing and Accounting

After the interviews took place I transcribed them and drew up a brief sheet of key themes. I took Mason's (1997) view about transcribing. She argues that transcribing is always partial partly because it is an inadequate record of non verbal aspects of the interaction process and also because judgements are made about which utterances to turn into text and which not to. Once transcription had been completed I began the analysis. A conventional approach to analysis, as Baker (1997) argues, moves from 'thought processes, through language to themes'. This approach takes the view that the contents of respondents' thoughts (beliefs) are expressed in the medium of language and that this context is then rheumatized by the analyst who typically 'chunks' the data, categorises them, moves them around and then rearranges them into a different formation. The words spoken by the respondents and the idea that they are heard to represent are the data. The aim of the analysis of this research was not to treat the interview scripts as 'interiors' of respondents' minds, or to look at 'exteriors' descriptions of social settings through a representative view of language. Interviews were treated as accounts. This included a view of talk as both verbal and bodily modes of social action

I took a multilayered approach to analysis. First and foremost after each transcription had been conducted, I went through each and wrote out a page of key themes which had arisen during the transcript. This was a continual process throughout the research. This first stage of analysis can be likened to the first few steps of grounded theory. The basic procedures of grounded theory are outlined by Payne and Bartlett (1996). It involves a move from data collection, transcription, development/saturation of categories, theoretical sampling and axial coding, to theoretical integration. This is a continuing process. My research does not follow this in its purest form. It follows it in the sense that the process involved data

collection, continual transcription and analysis as ongoing processes. However, it departs from grounded theory first because at this stage themes and not categories were sought and secondly, because in my research interview transcripts were treated as accounts and because it did not take the mode of purely theory building.

After themes were identified the next stage of analysis took the form of accounting and membership categorisation. Transcripts were not categorised in the sense of grounded theory but rather into membership categories. As I mentioned above the transcripts in this research were treated as 'accounts'. As Radley and Billig (1996) argue regarding health research, these interview accounts should be deemed to be more than just views about what people in society should do to avoid disease, they also articulate a person's situation in the world and indeed articulate that world in which the individual will be held accountable to actions. Subjectivities are produced through the accounting process (Hollway 1989). Talk is as social action, through talk we routinely and pre-reflectively use membership categories as devices to organise our characters of what we hear/see. It should also be remembered that communication is also bodily, it is about disposition and demeanour. This is a particularly important feature of health research where bodies inform the interview process. This mode of communication is not separate from talk, nor is it of mere metaphorical importance, body talk constitutes women's lived spatiality. Gesture and clothes are also important markers of identity and should also be included in the accounting/identity construction and processes (these were noted directly after interviewing took place). In using accounting work as a method of analysis the researcher looks for the use of membership categorisation devised by the interviewer and respondent and shows how both are involved in the generation of versions of social reality built around categories.

On developing membership categories during the accounting process a further categorisation and accounting process took place. Cornwell (1984) talks of public and private interview accounts in interviewing. She argues that people give public accounts initially. These are accounts which are acceptable to others and which fit with social

currency and produce legitimate assumptions that are shared in the social world in the sense that they make use of social representation. Private accounts on the other hand are where individuals tell stories about themselves, accounts which they give to people like themselves that are normally shared by their own group in particular. She argues that as contact within the research progresses there may be a shift from public to private accounts. Radley and Billig (1996) question such a distinction. They argue that there are no firm criteria offered to distinguish between different types of accounts although there is a claim that they emerge in different sorts of contexts. If accounts are complex and intertextual and if the context of accounts typically involves justification then matters may not be so simple, stories may be told when giving the formal accounts and justifications and legitimation are still in order during private accounts.

I think it is useful to distinguish between personal and social accounts within the accounting process. I do not think however that accounts can be crudely split into public and private. This is why I move on from membership categorisation to personal and social accounting. That some accounts would be based on individual biography and some on social comment. Both types of account the personal and the social conditions of identity formations interconnect continuously e.g. personal or family identity. Accounts in my view do not progress from one state to another but co-exist in all interviews, as ideal types not one supplanting another. It is also important to recognise that I am not arguing that in one setting/encounter people will give one kind of account and in another talk about something completely different. Instead, accounting for health is constitutive of the relations in which it takes place. This process of analysis is completed by a reflection on the initial theory and how the ideas of syncrecy and context relate to the theme and the varying accounts.

Supplementary methods

Analysis of the data from the in-depth interviews formed the main method and main body of the study. In a more minimal sense I also capitalised on other opportunities to gain extra background information. First I approached the Leicestershire Health Authority

information department and got current statistics on reported health and disease by ethnic minority data on Excel. I also approached Leicester city council for the most current data on the ethnic make composition of Leicester by geographical location. This was done at the beginning of the research in order firstly to find out the location of Asian women and specifically the clusters of religion for sampling reasons. Secondly, data were gained from the health authorities just to look at the patterns of health and disease among Asian communities in general. As a source of data for analysis, this has not been used in the main part of research. I also visited the Ayurvedic clinic (Hindu system) of life in order just to talk to them about women's use of Asian medical practices on an official level. I also tried to make an appointment to visit a Hakim (Muslim doctor), a contact given to me by a respondent, but he refused to see me. He would also not allow me to talk to his wife.

As part of the supplementary method I would have liked to have carried out some supplementary ethnographic work. Observing women's health practices, however, I felt that like Parker (1995) in his research on Chinese people in Britain, it was very difficult within the parameters of my research to find a place within which to observe women 'doing' health. As he argues there was no organised meeting place for Chinese youth, similar situation to my research. I also felt that because I was looking at health it was actually unethical to observe women in a health setting, because of the nature of the topic. Parker (1995) found his solution by observing young Chinese in takeaways; this enabled him to gain ethnographic information whilst stopping short of a full-blown ethnography. Within this study I did participate in some observation of night classes around general health issues and alternative health/aromatherapy to see who was doing it. Although these groups included women of a range of cultural and ethnic backgrounds, they enabled me to listen to women engaging with health discourses. Eight Asian women attended the classes on a regular basis. I sat in on some of the classes towards the end of the main body of interviews when fieldwork was almost completed.

I analysed the supplementary interviews and observations in a similar way to the main interviews whilst doing so in a less formalised manner. I used them not just as a way to

complement and support my data from the interviews but also to cast a critical eye on my main method and findings.

2.6 A question of text reading and representation

So far within the practice of interviewing and analysing I have maintained that there is a power relationship inherent in these situations. This power relationship is in some way like a relationship of dominance and resistance but in some way transcends this dichotomy. Both interviewer and interviewee can be seen to take both positions at different points in the process and as situating themselves in a position in between both. This in turn leads us to the question of writing up and representing respondents. Even those that maintain that there can be some sort of joint construction of knowledge within the interviewing process between interviewer and interviewee acknowledge that the power relationship shifts on writing up. As Parker (1995) argues, no matter how much shared experience there has been, the sharing stops when the academic writing begins.

There are people who think that sharing can be achieved. In 'Writing Culture' Clifford and Marcus (1986) apply their notions of polyvocality and duality of voice not only to 'doing' ethnography but also to the process of and mostly in fact to writing up. They suggest that the obliteration of the researcher/researched dynamic can be taken to the text through a post-modern approach. They move towards looking at what they argue is the speaking text. They argue dialogue goes far beyond the more or less artful presentation of actual encounters. This focus locates culture, interprets it in many sorts of reciprocal contexts and obliges writers to find diverse ways of rendering negotiated realities as multi-subjective, power laden and congruent. This dialogic model goes further than autobiography and reflexivity (Reed 1995). It is polyvocal, unlike previous research in which texts have contained only the authorial voice. With polyvocality voices that have previously clamoured for expression are able to speak. There are those that have taken this literally to heart. A number of feminist and non-feminist texts have attempted this for instance Dwyer's (1991) 'Moroccan Dialogues' and Shostak's (1990) 'Nisa' both of which are collaborative endeavours between the researcher and researched.

Again, however, I think that this approach should be used with caution because, no matter what, there is always a power dynamic involved in writing up. For this process I adopted a dialectical approach. A dialectic approach (as seen in chapter one) is a processual approach which acknowledges the potential hierarchical ordering of categories. It sees these categories as having both crossovers and being contingent. Through such crossovers and tensions, however, these relationships become transformed over time to create different relationships. This I feel succinctly captures the relationship between researcher/researched. It acknowledges dominance and resistance, whilst also recognising that the relationship between these two is also as shifting. As Shrijvers (1993) argues, the challenge of a dialectical conception of knowledge is to find ways of constructing the established dichotomy between the personal and the professional in the process of academic writing which is no easy task. The problem is how to integrate in the ethnographic account itself with the interaction between subject and object and between researcher and the wider situation within which research takes place, overturning the gaze. This dialectic was achieved in this research by the utilisation as much as possible of 'thick descriptions' (Geertz 1993), so that multiple and in-depth quotes were included. These were integrated into the text, which was only my interpretation/reading of the data. It was hoped that this came through in the research writing.

The other issue concerning textuality is the question of representation and being representative. First it must be made clear that throughout this research I was not trying to achieve representativeness, I am not trying to argue for an essentialist conception of "South Asian woman" which is why there is an attempt at all levels to recognise diversity and difference. Neither am I trying to suggest that the text will replicate reality. A representation should be understood not as a true and accurate reflection of some aspect of the social world, but as something to be explained and accounted for through discursive rules/themes that predominate in a particular socio-historical context. Hollway (1989) argues in her approach for a combination of personal experience and the idea from Foucault that 'truth' is a historical product and therefore no knowledge is absolute. This led her to begin to see participants' accounts in her own research as only one among an infinite set of possibilities.

This links back to my argument earlier about the interviewing process and the production of multiple interpretations of the truth. This thesis should be read through these multiple interpretations.

2.7 Ethical Concerns

I went into the research completely openly telling the respondents all about the research project, that I was a research student in the Department of Sociology and Social Policy at the University of Southampton. I told them about the nature of the research and briefly ran through the sorts of questions in the research schedule. I gave them the option of being able to stop the interview at any time. I told them who the thesis would be read by and left a supervisory name and contact number should they require any further information about the research. Within the research I was strongly aware of the issue of maintaining confidentiality. I tape-recorded interviews only with women's permission and told them that I would stop recording at any time should they feel uncomfortable at all about certain topics. I also reassured them that if they were divulging any personal information that it would not be used in the final thesis. All the names of respondents have been changed in the text to pseudonyms.

The second main ethical concern of the research was related to this issue of interviewing women, opening a can of worms and then leaving. As I said earlier many of the women felt the interviews to be cathartic but with some of the respondents there was a certain feeling of sadness when I left. I dealt with this by enabling the women to have a contact address for me and telling them that they could contact me if need be. I also made the transcripts available and the findings of the research, should the respondents want to look at them. One woman took up this opportunity after completion of the research. A third concern relates to the possibility of being presented with information which is difficult to deal with e.g domestic violence or illegal activities. Within the context of this research this only happened once when a respondent sought medical advice from me about weight loss. I dealt with this by referring her to the relevant expert.

Having explored the background, theoretical underpinnings and method of the research I want to move onto explore the findings. As argued, the aim of the study was to explore women's use of syncretic discourses and the influence of context on women's ability to draw on these discourses. The findings highlight women's syncretic use of discourses but this use is dependent on various contextual circumstances. One set of those circumstances relates to health and different types of illness. Respondents' use of syncretic discourses is relational to particular illnesses. It's to an exploration of this that I will turn to first.

Chapter 3
Health and Illness: Syncretic Intersections

3.1 Introduction

Within the Introduction of the thesis two research aims were stated. The first aim was to explore syncrecy within respondents' health beliefs and behaviours. Secondly, the research aimed to explore the influence of context, both material and geographical, on the respondents' ability to hold and carry out such syncretic health beliefs and to behave correspondingly. This chapter looks at how their use of syncretic discourses is relational to particular illnesses. This emphasises the importance not just of respondents' contextual circumstances on their beliefs and behaviours but also highlights the significance of the specificity of illness itself on beliefs and behaviours.

Cornwell (1984) in her study on working class accounts of health in East London showed how her respondents categorised illnesses into 'normal' illness, 'health problems' and 'real' illness. This categorisation can be applied to syncrecy. Within this study, women's beliefs and behaviours are more syncretic regarding some illnesses and less so for others. In taking a more micro view of health and illness, we can also see that syncrecy itself is multi-layered. From the women's accounts, it becomes apparent that syncrecy can be placed along a continuum of different types of illness. For general health problems, as defined by the women within the study, beliefs tended to be weighted towards a use of non-western discourses whereas the more serious conditions are, the more women are likely to use mostly western medicines. This intersects with notions of health care within private and public domains. The terms private and public here are used to correspond to health care provision within the home and provision taking place outside the home. This includes both state and private care. While the respondents' beliefs and behaviours may be syncretic according to specific illnesses this syncrecy will also be located in either private or public areas of health care depending on the illness. Using Cornwell's (1984) categorisation of illnesses this

chapter will explore the respondent s' use of syncretic discourses relating to particular illnesses.

In focusing on illnesses at a more micro level I will draw on general studies of lay people's health. Studies, which have explored lay conceptualisations of health and illness have focused on what these concepts mean to people. Researchers argue (Blaxter 1990, Miles 1991), that in looking at the concept of health, it appears to mean different things to different people; on being questioned, many are unable clearly to define health and illness although they can say readily enough whether they regard themselves as healthy or not. To feel healthy or sick is a personal experience but concepts of health and illness are learnt by drawing on the accumulated knowledge of the relevant culture. Herzlich (1973) interviewed 80 middle class men and women in France about their conceptualisations about health. Health concepts were divided into three groups; the first saw health as within a vacuum, i.e. absence of illness/ something quite independent of the person, something impersonal. The second saw it more in terms of a good constitution, a reserve of health innate or cultivated, which endures despite episodes of illness. The third group saw health as a condition of equilibrium, as a normally healthy, well-functioning individual at ease both bodily and emotionally.

The concern of this research was not so much with defining concepts of health but with a focus on what kinds of discourses respondents draw on during times of ill health. However, the debate over concepts of health is useful in the sense that it helps us to contextualise that which is not health, i.e. illness. Also initially, before exploring their conceptualisation of illness many of the women within the research talked about whether they felt healthy or not. When talking about health issues which fell into the category of health problems women within the study, as will be shown, also alluded to concepts of health. Women's accounts on health can roughly be seen to be clustered around Herzlich's (1973) second and third categories, seeing health as having a good constitution and as being in a state of equilibrium.

Whatever meaning is given to health by lay people, ill health represents a breakdown in the normal expected state of health and well being, a deviation from how things should

be when things go wrong. A transition from a normal phenomenological mode of [1]bodily silence (Leder 1990) to bodily alienation or betrayal (Williams 1996, 2000). Cornwell (1984) develops her tripartite system of categories of illness from information drawn from 20 respondents interviewed in a study in East London. She argues that her respondents' conceptualisations can be placed within three main categories of illness. 'Normal illness' was what most people were expected to get sometime, such as infectious diseases in childhood or colds and flu in winter. 'Real illness' meant major disabling and life threatening diseases. 'Health problems' was the third category, those things which are not illness, those associated with natural processes, such as ageing or the reproductive cycle and also mental health problems such as depression and anxiety. The category of health problems, which cause pain, distress and much suffering, is especially important for women because it includes problems inherent in menstruation, childbirth, pregnancy and menopause. It is also because they suffer far more (or at least are perceived to suffer more) than men do from such conditions as depression, anxiety and agoraphobia.

Through the accounts of the women researched here, there was a need to take a dynamic approach to the categorisation of health and illness. Women within the study appeared not only to categorise health and illness in similar ways to the respondents in Cornwell's (1984) study seeing particular illness to relate to particular categories, but also their use of syncretic health discourses related to particular categories of health and illness. This highlights the need for a multi-layered approach to the categorisation of health and illness, an approach which recognises the importance not only of illness status and categorisation but also relates this to plural medicine. Respondents' accounts also highlight the need to recognise fluidity within the categorisation process, particularly when dealing with the category of health problems. This chapter takes Cornwell's (1984) tripartite categorisation and develops it further in the context of my

[1]Bodily silence signifies a time when all feels well with the body, we do not think about it on a day to day basis. Bodily alienation or betrayal on the other hand signifies a bodily breakdown and shifts towards illness. We become aware of our bodies when something goes wrong and feel betrayed by the body. These shifts and bodily interuptions have been written about within much of the literature on chonic illness *see* Bury (1982), Leder (1990) and Williams (1996, 2000).

respondent s'syncretic use of private/public and western/and non-western health discourses.

While we can roughly categorise illness in the women's accounts in this way it is important to recognise, particularly regarding health behaviours, that these are specific to individual women's circumstances. The importance attached to possible courses of action differ from one individual to another according to her position in the social structure and to prevalent social norms (Miles 1991). In this way categories of health and illness are not fixed but can be seen as socially constructed notions, which mean different things to different people in different times and contexts. Disagreements as to what constitutes illness abound: there may be consensus as to the 'killer' diseases being 'real' illnesses but how to treat them is often a matter for dispute among both lay and professionally trained people. Moreover the assumption that there are 'real illnesses' and thus 'real needs' to which individuals then respond, rests on the notion that biophysical reality exists and has primacy over human interpretation. It is important to recognise in this sense that while the women's accounts about illnesses can be situated into illness categories, neither the categories nor the women's accounts should be completely fixed. Rather as will be argued within chapter four regarding family influence, this should be seen as temporally and contextually specific.

In what follows I will focus on an exploration of the respondents' use of syncretic discourses firstly with regard to general illness. Regarding general illness I will suggest that respondents draw on syncretic discourses with a preference to non-western discourses, and these mostly take place within the private realm. While women within the study may use western remedies at home they move to use public western discourses such as the GP only when private remedies prove ineffective over time. I will move on to explore the women's beliefs and behaviours regarding health problems. The women's accounts have highlighted the eclectic and interstitial nature of this category itself. I will argue that as such the category fluctuates between categories of health, normal and real illness. Those problems, which make up the category of health problems, can at differing times and contexts constitute both health and ill health. For instance, pregnancy can be a 'healthy' state, a state of 'discomfort', or when

things go wrong, 'real illness'. As a result respondents' beliefs and behaviours can straddle different forms of syncrecy, moving as an interstitial category in and out of other categories. Their beliefs and behaviours draw particularly on religion for this category. It can be seen to incorporate a syncrecy of the broadest type, both public and private, western and non-western including diet and spiritual health. Finally I will go on to explore respondents' use of syncretic discourses for 'real illness' suggesting these lay mostly within the realm of western and public health discourses. Within the women's accounts as they move from talking about normal to real illness they shift focus from mostly non-western to western, from mostly private to almost wholly public. While GPs are a last resort for respondents regarding 'normal illness' so too do non-western discourses become a last resort regarding 'real illness'.

It is worth noting here that in discussing respondents' beliefs and behaviours about particular illnesses I am not exploring their narrative experiences of these particular illnesses. Rather I am exploring the discourses women would and do use regarding particular illnesses.

3.2 Syncretising 'normal' illness

As previously argued in Cornwell's (1984) tripartite classification system, people talked about certain general conditions which fall under the guise of 'normal illness'. In her study normal illness ranged from the infectious diseases of childhood such as chickenpox and mumps to adulthood infections of the kidneys, tonsils, sinuses and stomach problems as well as fevers and some common respiratory diseases. Within my study women also grouped certain general illnesses together and had particular beliefs and about them and behaved accordingly. Illness, which fell under the guise of 'normal illness' for the women, were much the same as those described in Cornwell's (1984) study, including colds, fevers and flu.

Studies focusing on lay health beliefs and behaviours regarding general illness demonstrate how people's beliefs and behaviours tend to be mixed and tend to focus on remedies based within the private (home) sphere. For instance in Donovan's (1986) study on Afro-Caribbean and South Asian women in East London, women in the study

used remedies including herbal teas, herbs were boiled and taken for coughs and colds and asthma. This is also supported by Helman's (1978) classic study of the archetypal British complaint, the common cold which was focused on a whole complex of beliefs including ideas related to food, such as "feed a cold, starve a fever". Within the study, women's views about general illness tended to be by and large syncretic with a heavier weighting towards the use of non-western discourses. This can be seen to be 'private' syncrecy, that is syncrecy located mostly within the private realm drawing on remedies which are food related but also related to Asian medical systems.

Regarding normal illnesses such as colds, women within the study used home remedies, these remedies ranged from remedies which were not specifically from Asian medicine, and quite often related to various teas, garlic capsules, or herbs from the garden. As Charlotte points out:

> **Charlotte:** I make ginger tea. I swear by that, it's usually really good for treating colds and things.

While the remedies respondents used for colds were not always specifically associated with Asian medical systems, they were related by the women to their cultural and religious background, particularly to diet. As Sakeena's quote shows:

> **Sakeena:** If it's a cough, a little bit of Turmeric powder in milk before we're going to bed and drink that. I do that regularly. Honey is also very good and it's in our religious book (Quran) as well that there's a cure in honey, if we have bruises.

Respondents' beliefs and behaviours surrounding colds and coughs were particularly syncretic as they also used remedies for colds associated with western health care. There are also crossovers in remedies suggesting that western and non-western health care cannot be seen as completely separate. The account from Kishwar highlights this:

Kishwar: I mean, with coughs we'd use lemsip. That helps a lot and also for sore throats, honey and lemon and stuff which I make myself with herbs and remedies from the kitchen.

This syncretic use of different types of health discourses is again reflected in other studies on lay attitudes to health. In Helman's (1978) study, whilst using herbal and home remedies for fevers, people often used antibiotics at the same time. Similarly in Donovan's (1986) study, her respondents often mixed remedies, for example using a mix of almond powders and milk and apple jam, anadin for headaches, panadol and lemon tea for flu. As Helman (1978) argues, there is an interaction between biomedicine and folk ideas on general illness. From this it appears that most 'lay' populations draw on a plurality of discourses for general illnesses. Within this study, however, women's position as British 'Asian' gives them access to a particular set of non-western 'Asian' remedies, not open to the general population of Britain. As women socialised within British culture they also have greater knowledge and access to resources within western medicine which more recently migrated women (such as those in Donovan's study) are excluded from. It is this particular dynamic I think that emphasises the specificity of syncrecy and the uniqueness of the women's accounts.

Under the guise of general health, respondents also talked about illnesses such as stomach bugs, general nausea and diarrhoea. Women within the study used a whole plethora of herb and food related remedies for such illnesses. As Surinder, a Sikh woman argues:

Surinder: If it's just in terms of a mild tummy ache then it is fennel, you take water with it. If you've got an ear infection as well just put some garlic and some mustard oil, then just heat that up and put a drop of that in the ear and it clears it up.

What was interesting within the accounts of the women studied was their significant use of Asian balms for a whole number of general illnesses. Women used balms for a whole plethora of general health problems including coughs and colds but particularly

for rheumatic pains etc. Muslim women in particular used balms; Shahnaz and Samina point out their wide-ranging usage:

> **Shahnaz:** Tiger balm, you can use it for rheumatic pains or whatever you know, muscular pains, especially good for colds and flu's and you know, you get sweaty, sweat your germs out.

> **Samina:** I use that on my back a lot. It doesn't cure it really but it gives you that comfort at the time. It's really hot stuff, very strong'

Sharma (1992) identifies pain and in particular back pain (along with allergies) as the most frequent problems for which people seek alternative care. Within this study, regarding aches and pains associated with general illnesses, while favouring non-western discourses women's accounts emphasised a use of 'syncretic' discourses, both western and non-western within the private realm. Women within the study also used their non-western remedies with general remedies often bought from the pharmacist. For example, regarding their use of balms for rheumatism and muscle pain women often used these in conjunction with anti-inflammatory medicines from the chemist. As Rambha's husband did:

> **Rambha:** My husband he has back pain, a back tumour or abscess whatever it is. He finds Ibuprofen makes it feel better so I keep Ibuprofen, Co-Codamol and Paracetamol.

Women within the study also used a plurality of discourses for conditions which were recurring but did not necessarily require day to day management. This often took the women out of the private realm of syncrecy to seek out public, Asian medical practitioners. This emphasises a shift from private to public domain as illness becomes slightly more concerning. For instance Kishwar discussed her husband's use of Chinese medicine for hayfever:

Kishwar: I have taken my husband to a Chinese herbalist on Evington Road. That's to do with his hayfever. He suffers so badly with his hayfever, so we've tried that.

This however was used in conjunction with western remedies within the home, emphasising the women's use of syncretic discourses for general health issues. If we use the example of the same woman again:

Kishwar: His western medicine helps but he has to take so many tablets so he decided to go to a healer as well.

Within the study, women's move from use of western to non-western discourses can be seen for other general illnesses as well. For example if we look at Kishwar's account regarding migraines:

Kishwar: I've had them (migraines) since I was a teenager and I was on very strong tablets and after a while I just felt sick one day with it so I thought no more tablets and when I do have migraines it's basically having the imocin balm (green balm) from India, rubbing it into my head, and then going into a dark room to sleep.

Within the study the focus was mostly on beliefs and behaviours surrounding ill health and health problems. In the absence of illness women talked about remedies and things they used in order to maintain health. Healthy life styles are promulgated by the medical profession and health promoters (Blaxter 1990). The links made between life styles and health reflect broader social changes and are linked to the rise of consumer culture (Nettleton 1995). In this respect there is a commercialization of health in that people are constructed as health consumers who may consume healthy life styles. At the centre of this is [2]body maintenance (for example exercise and food) (Featherstone 1991,

[2]*See* Bordo (1990) and Davis (1997) for wider debates on women and 'the body'

Nettleton 1995).Within this study women mostly talked about maintaining good health through diet, as Shahnaz shows:

> **Shahnaz;** Yes, I do tend to control it (diet) because a lot of it (ill health) we believe is through your diet. You know, we do try because there are a lot of unhealthy foods as well that are available in Indian cooking, but as I say it's down to you basically.

Hindu women in the study were mostly vegetarian and associated such a diet with good health. This involved most of the women within the study having syncretic diets, eating a mix of both western and non-western foods. As Musarat points out:

> **Musarat:** Yes, I cook mostly Indian foods yes, once or twice I'll make lasagne or something like that. We're mixed, I make Indian foods but I also make pasta and things like that.

Women within the study also used home remedies on a daily basis in order to prevent ill health:

> **Sakeena:** yeah, and what I believe is each month, 3 days in a row every morning if you have honey you won't suffer from any serious illness.

On the whole, for general illness few women within the study consulted either their GP, or Hakims or Vaidas. As Miles (1991) argues, the common response to conditions which are familiar and seem minor, such as coughs, colds and headaches is to ignore the problem in the hope that it will go away, prove temporary and insignificant. Worsley (1997) points out that for minor illnesses even today, people consult their GPs only about 1 in 5 times they feel ill. For common symptoms, including high temperature, arthritis, anaemia, and sore throat people consult pharmacists, self-help groups and health cults. Advice-seeking goes beyond consulting any kind of professional. The women in this study were likely to consult a doctor about general

illness only if symptoms continued after women had attempted to treat themselves at home.

Overall respondents' beliefs and behaviours surrounding 'normal illness' were syncretic, and syncretic mostly within the private realm, this means that they draw on a whole plethora of remedies both non-western and western. Regarding normal illness women were most likely to use non-western remedies within the home as their first port of call seeking other solutions to illness when these did not work. While concurring with other general lay studies on the use of different discourses regarding normal illness, the respondents' position as Asian women in Britain gave them broader access to different discourses.

3.2.1 'Normal illness' and the temporality of syncrecy

Within the study, women's use of particular and syncretic discourses for different types of illness were also temporally located. This was most prominently so for 'normal illness'. The respondents' beliefs around say colds and flu were fluid and not fixed. Respondents' may act in a certain way regarding a certain illness but when it does not clear up they may resort to the doctor's. Rambha's quote demonstrates this:

> **Rambha:** What I do first couple of days is get something over the counter or mixtures or something like that before I go to the doctor's.

Sometimes women in the research might perceive illnesses to be a certain way and act accordingly and then it turns out to be something different and again women act in a different way. For general illness this often involved a shift from using discourses mostly within the private realm to using those within the public. It also involves a move from using mostly non-western discourses to using western ones. As Surinder points out:

> **Surinder:** We do use herbal things before we go to the doctors. Well I try to unless I think it's really serious and I can't do anything at home. I try; I try the paracetamol/calpol thing at home and then if it's not doing anything,

if I know that the chemist's stuff isn't going to do anything anyway, then its straight down to the doctor's.

Within the next chapter I will examine how women's beliefs and behaviours within the study shift over the life course within the family context. Respondents' beliefs change as they get married and become mothers themselves. Women also make forecasts for how their beliefs and behaviours might change as they get older. Just as 'family time' intersects with the life course to influence the women's beliefs and behaviours, so too does 'illness time'. As suggested women within the study hold particular beliefs, drawing on particular discourses for specific illnesses but these are not fixed. Initially respondents might hold certain beliefs and carry out certain practices for a particular illness but these may change on a day to day basis as time passes. As women become more familiar with particular types of illness, they may stop using western treatments and start using Asian home remedies or healers instead. Inder discusses this in relation to her children having colds:

Inder: Initially I took her (her daughter) straight around to the doctor's a lot, for colds and stuff. I just stop taking her and now I make them (her children) stuff at home hot lemon and honey, milk and things like that.

Respondents also talked about how behaviours regarding certain illnesses changed in the broader context of the life course. The quote from Shahnaz shows how her beliefs and behaviours have changed as she has grown up:

Shahnaz: Then growing up we never used to make many visits to the doctor, we used to you know, if we had a cold we had Tiger balm which is a certain kind of Vicks. I mean (now) people normally go to the doctor's when they get a cold or cough or something. You used to have a good rub, or inhale with balm and things like that. That can ease your problems, like nowadays we just go to the doctor's and get medicine, capsules, you know what it's like.

Again the women in the study suggested that this reflected a broader trend within society where people were ever increasingly looking for a quick fix solution to general illness. From the women's accounts it became important to recognise that while their beliefs and behaviours might be syncretic for particular illnesses this cannot be fixed in time as beliefs and behaviours change over 'illness time' and as women pass through the life course. This was in particular relating to normal illness, this seemed to be because women suffered general ills frequently so became more used to dealing with them. The women researched were less likely to talk about temporal shifts in beliefs and behaviours in the same way relating to real illness. Other research has shown that age and experience is a key factor in shifting responses to chronic illness over time (Bury and Holme 1991). By the time people have survived into their 70s and 80s, experience may have equipped them to deal with and adapt to new situations such as chronic illness (Pound, Gompertz and Ebrahim 1998, Williams 2000). This relates to position within the life course. For the women within this study real illnesses were things to be feared. While women's attitudes over more manageable types of real illness (e.g. diabetes) might change as the illnesses become part of life, for fatal illness beliefs and behaviours while not fixed in time, seemed to be far less open to change. This however reflected the respondents' position within the life course and may well change as women grow older.

3.3 Health problems, interstitial illness

Cornwell (1984) within her tripartite categorisation system talks about a section defined as health problems. Health problems are those which are not necessarily illnesses, they are problems associated with natural processes of ageing and the reproductive cycle and problems that are thought to stem from a person's nature or personality such as allergies, asthma and eczema. She argues that the common feature of this category of problems is that they are thought not to be amenable to medical treatment. Sometimes some forms of self-treatment may be advocated. There are those associated with growing old (e.g. varicose veins) and those associated with menstruation, pregnancy and menopause (e.g. abdominal pain, depression, and dizziness).

With a focus on reproductive health issues and depression, Cornwell (1984) argues that the category of health problems is particularly pertinent for women. One must apply caution here in locating these 'health problems' as women's problems. There has been long history linking madness with so called 'feminine traits', relating the condition to women's reproductive roles (Showalter 1987). This filters through in much contemporary health literature to equations of women's health with reproductive health (*see* chapter four), and to contestation surrounding [3]women's over- representation within statistics on mental health (Pilgrim and Rogers 1993). Within this study it is recognised that for the women interviewed as 'young mothers' reproduction is an important (although not the only) aspect of their health. Therefore health problems relating to such play an important role within the women's accounts. Some women within the study also discussed mental health issues and suffered from anxiety and depression. Again, these were important. However, as argued previously, the aim of the study was to explore respondents' use of discourses for illnesses not to explore experiences of these illnesses per se. Also, given the stigma related to mental illness it may have been difficult for women within the study to tell me about experiences of mental illness. In light of this, I would argue that it is impossible from the accounts to make any general claims relating respondents' experiences to broader debates on the feminisation of mental illness.

Within this study women seemed to talk about health issues such as pregnancy and depression and anxiety as transgressing the health/ illness binary, not quite being one thing or the other, as being somehow 'improper' illnesses. This applies to issues relating to mental illness in the sense that these belong within the psychological not the physical realm, physical illness constituting 'real' illness. It applies to the women's views on reproduction and gynaecological issues because these were seen in many senses as natural processes, part of women's lot. Respondents' beliefs and behaviours

[3] The over representation of women and certain ethnic minority groups i.e Afro-Caribbeans within statistics on mental health has been well documented (Pilgrim and Rogers 1993). Both groups are seen as being more likely to be diagnosed with problems associated with mental health. Debates around reasons behind this have been broad, explanations ranging from methodological inaccuracy to labelling theory. For a fuller discussion of these debates, for women and mental health *see* Busfield (1996), for race, ethnicity and mental health *see* Nazroo (1997), and also Rack (1982).

surrounding these interstitial health issues were complex and diverse depending on the particular type of health problem. Within the women's accounts it seemed that as an interstitial category, health issues felt to be health problems had the potential to fluctuate between the category health problems, to a state of natural health, through normal illness to real illness. For instance pregnancy can at times be seen as a natural health state, for some pregnancy can be or can lead to all kinds of complications associated with real illness (Graham and Oakley 1986). Because of such fluctuations the respondents' beliefs and behaviours ranged freely within this category. In most ways they were syncretic, both privately and publicly drawing on western and non-western discourses. This syncrecy was relational to time and context. Beliefs and behaviours surrounding pregnancy for many of the women studied were heavily influenced by religion and diet. Respondents would often try to take care of these health issues at home but unlike behaviours surrounding normal illness women would often have contact with public professional health discourses both western and non-western much sooner. Within this section I will explore respondents' use of syncretic discourses regarding anxiety and depression moving on to look at their use of different discourses regarding pregnancy and reproductive health.

3.3.1 Anxiety, depression and spirituality

It has been a consistent finding of researchers, confirmed by health practitioners that lay people have uncertain, often ambivalent and contradictory views about the meaning of mental disturbance, about whether to regard it as an illness or not (Miles 1991). When talking about illness, Cornwell's (1984) respondents meant physical illness. When they talked about anxiety and depression they meant this as states of mind consigned to the category of health problems that are not illnesses. Other studies have also demonstrated a split in ideas between mental and physical illness (Donovan 1986), and discussed varying definitions of what constitutes anxiety and depression cross-culturally (Fenton and Sadiq-Sangester 1996).

Within this study several women talked about feeling depressed, or anxious at particular points and sought out various non-western and western medical and religious discourses as a response. Within the study however women did not talk in terms of

'mental health' generally but instead spoke about mental health issues using terms such as depression and anxiety. They saw depression as fairly common and nothing to be ashamed or fearful of. Depression appeared to be defined by the women as a health problem. When talking about mental health issues women in the study seemed to make a mind/body split. Mental health was seen as something quite separate from physical health. Women seemed to make this split and then base their use of particular discourses accordingly. Physical illness is often related more closely to western medicine and mental health with non-western discourses and in particular spiritual health discourses. Shahnaz makes the distinction:

> **Shahnaz:** Some things aren't sorted by the GP. When you've got something straightforward, physical, you know, when you've got a broken arm or leg or something the doctor can help. But sometimes, with other mental problems they just try and keep you drowsy, you know, docile, they're not actually facing the problem.

Again the women's views were syncretic but tended to be biased towards non-western medicine. This use of different discourses was also related mostly to the public realm. In cases of mental health problems respondents' quite often went to non-western or religious healers. While they might also go to the doctors for anti-depressants, their faith lay mostly with religious healers, taking a [4]'prayer and Prozac' approach (Matthews and Larson 1997). This was particularly so for Muslim women. As Shahnaz shows in relation to her mother's depression:

> **Shahnaz:** My mother suffers from depression and she's seeing a religious person for that. But it's had some effects. She's on medication as well from the doctor but she's also seeing a religious person.

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[4]Matthews and Larson (1997) chart the links between religion and medicine. By 'prayer and prozac' they are referring to the combined use of religion and medicine for (mental) illness. They portray a future where any divides between religion and medicine will be deconstructed. For a more detailed discussion of the links between medicine and religion *see* Chapter five. *See* also Porter and Hinnells (1999).

Other research on mental health has shown that it is common for women to turn to religion and religious healers in times of emotional distress (Donovan 1986). Hillier and Rahman (1996) studied Bangladeshi perceptions of childhood behavioural and emotional problems in Tower Hamlets, London. They found within the study, that at times of mental illness while doctors were the most favoured ports of call in both the UK and Bangladesh, this was followed very closely by the Mullah (religious healer) and persons at the mosque. They concluded that while in general people are open minded about western medicine, they are not uncritical. They accept it works for some kinds of physical illness, for other common and serious conditions, e.g. arthritis, neuralgia it is less effective when dealing with psychosomatic problems ranging from heartbreak to witchcraft.

Within this study there appeared a multilayering of types of problems associated with anxiety and depression and other emotional problems. Many of these were often related to being possessed by the spirits, although possession by spirits could cause other 'physically' located health problems as well. When women suspected possession by spirits religious healers were often sought, as Samina, a Muslim woman, argues:

> **Samina:** Spiritual healers they usually deal with things that are spiritually wrong with you. You know if there is something like depression that's really common now and some people think, well she's probably possessed or something, or there's something wrong with her or the house she lives in whatever'

While women within the study often sought public figures in the form of religious healers in dealing with these types of mental health problems they also carry out particular religious practices at home in order to rid the afflicted person of their possession. These practices within the private realm were related to practices associated with the evil eye (see chapters 4 and 5). While many women draw on religious healers for mental health problems some women also preferred to steer clear of such spiritual health remedies seeing them as frightening, Gurinder points out:

Gurinder: I wouldn't try it because some of the remedies are really superstitious like the evil eye.

As suggested, the respondents' use of spiritual healers and religion for issues relating to depression is supported by a number of studies on migrant and minority health beliefs and behaviours (Donovan 1986, Hillier and Rahman 1996). Researchers have often linked such lay use of non-western (particularly spiritual) medicine for mental health problems with the inadequacies of biomedicine. Fernando (1991) ties this with the psychiatric professional having little or no interest in cultural issues. He attributes this to the mechanistic model, which dominates western psychiatry. Biomedicine is seen to have no place for illness brought on by supernatural forces (Worsley 1997). As Worsley (1997) argues this leads people to turn to other forms of hope and comfort: to diviners, shamans, religious specialists for disorders that are believed to arise when people's social relations are out of kilter. Non-western medical systems theorise about mental illness in a completely different manner to biomedicine. Ayurvedic medicines and Unani, distinguish between mental illness caused by sorcery, that caused by evil spirits or ghosts, and a disease described as 'malfunctioning of the head' often produced by shocks/setbacks in life (Bhattacharya 1986, Hillier and Rahman 1996). As already suggested women's accounts emphasise this multilayering of causes of problems such as depression. Treatment for such is not dogged with the system of introspection or static theory of mind, which characterises western models of diagnosis and treatment. Women within the study talked about the inadequacies of biomedicine in dealing with mental health problems but not quite as strictly as the above model suggests. It seemed in many women's cases it was more to do with following their faith and a drawing of beliefs and behaviours of previous generations.

Within this study an interesting split developed between women who used religion and religious healers for depression and those that did not. This split was made along religious lines. It was mostly Muslim women within the research who sought out spiritual healers for mental health, although Sikh women talked about them to some extent. The Hindu women within the sample seemed on the whole to talk about depression less. Also, while two Hindu women had either suffered mental health

problems themselves or had family members who had, they had sought out western health remedies and care and focused on keeping themselves busy. As Ramila, a Hindu respondent points out:

> **Ramila:** I never used to go before (to the doctors) but now I go all the time because I'm suffering from depression. I go every six weeks for a check up, talk about how I'm feeling, get checked out.

(Later in the interview I asked Ramila how she dealt with her depression)

> I just keep myself busy. If I stayed at home all the time, I'd keep going over things in my mind, keep on crying and things like that. I just stay busy and take him (her son) out.

Religious difference among respondents relating to their health beliefs and behaviours is something which will be explored further, in chapter five. Regarding depression and other related issues it was not just a case of respondents' drawing on either western biomedicine or non-western health discourses. While women within the study would use doctors and western medicines for depression, they seemed eager to find other ways of dealing with it. This also ties in with the amorphous nature of mental health problems such as anxiety and depression and their position as 'health problems' not a 'real illness'; similar comparisons can be made in this sense with pregnancy. Women within the research also drew on the lay referral network. The lay referral network is a network which provides health solutions, when and how to seek medical advice, and is made up of a number of people, husbands, relatives and friends.

Within the research, some women did display signs of depression relating to feelings of isolation brought about by being at home alone. This relates to the argument made earlier by Brown and Harris (1978) relating women's positions and roles within society to higher incidence of depression. In this sense, the lay referral network regarding depression was an invaluable tool for respondents, talking their problems out to those closest to them. Previous research has also suggested the importance of the lay referral

network in influencing women's treatment of mental health problems such as depression. Women suffering from depression frequently report having talked to other women about feeling low, not coping or sleeplessness before going to the doctor (Miles 1991).

Overall, the women's accounts on mental health issues such as depression can be seen to be syncretic. Women within the study did use both western and non-western discourses when dealing with issues such as depression. Women's use of these discourses was also not restricted specifically to either the private or public domain but incorporated both. While beliefs and behaviours were syncretic though, there was higher weighting towards their use of non-western discourses. Respondent s were much more likely to draw on non-western religious discourses and healers and on the lay referral network when dealing with mental health. This did not appear to relate to any sense of stigma felt by the women. Rather, the women within the study seemed to see western medicine as in many ways ineffective and was a much lower priority on their lists. As argued, though, syncrecy here was significantly influenced by the respondent's religion. Sikh and in particular Muslim women were much more likely to seek religious healers and remedies. Hindu women talked less about depression and seemed more likely to seek help from their lay referral network and western medicine. As suggested mental health issues have the potential to move in and out of categories of health and ill health depending on their type and status. Within the study women talked mostly about depression which they saw as part everyday life and as a 'health problem'. Women within the research seemed not to have experienced or were perhaps more afraid to talk about more serious types of mental health problems relating to more severe forms of depression or conditions relating to psychosis. Because of this it is difficult to gauge beliefs and behaviours around a more varied selection of mental health issues. If we move on to look at other types of health problems such as pregnancy and other gynaecological issues, women can also be seen to use syncretic discourses with a heavy weighting to non-western discourses. By looking at these other problems we can also highlight the complexity and fluidity of the category of health problems and also see the effects of this on beliefs and behaviours.

3.3. 2 Contradictions and conflicts: periods and pregnancy

Gynaecological and reproductive health issues also fall under the guise of 'health problems'. Concurring with Cornwell (1984), and other studies (Graham and Oakley 1986, Scambler and Scambler 1993), women in this study tended to identify period pains and pregnancy as somewhere in between health and ill health. Again these types of 'health problems' can be seen to occupy interstitial spaces. Pregnancy in particular can be seen to shift in and out of different categories of illness. In dealing with reproductive and gynaecological issues respondents' beliefs and behaviours vary according to the condition itself. Regarding menstruation, women in the study were extremely reluctant to define it in any way at all as an 'illness' despite the fact that many women felt significant pain during that time. Respondent s accepted the pain; they saw it as part of being a woman and were very reluctant to medicalise the condition preferring to use things like hot water bottles instead. For pregnancy the women's views fluctuated more and the condition seemed more monitored and medicalised, beliefs and behaviours were much more syncretic and women drew on a number of discourses. These discourses related in particular to issues of religion, diet and culture.

Menstruation, like pregnancy is surrounded by ambiguities and uncertainties. Although it is a normal healthy function of the female body it causes pain and discomfort. Menstruation is described as 'the blossoming of the red flower' in many vernacular traditions, referred to as 'period' or 'monthly' by doctors or health workers; by 'being down' by many adolescents. These differences are not merely of nomination but are indicative of the multiple discourses that speak to contemporary experiences of menstruation, this is a vital factor in determining the actual efficacy of health education and health care (Chhachhi 1998). When menstruating, women are often incapacitated for a few days each month by this natural function, both healthy and painful. Periods are both pathologised within medical literature and also conversely seen as part of normal life (Martin 1989). According to A and G Scambler (1985) in a British study, women's perceptions of menstruation have to be considered in the context of deeply rooted social and cultural beliefs and they note that perceptions surrounding menstruation differ widely in different societies. In the accounts of the women I

studied, there seemed to be certain coyness around the whole issue. Women seemed to feel that they really needed to just 'get on with it' rather than make a fuss about pain and tension associated with them. These notions of getting on with it fit in with the findings of other studies on women and menstruation (Blaxter 1983).Women within the study did not seem to use anything in particular either western or non western for period pains. If we look at Samina's account:

(On being asked if there were any particular Asian remedies for period pains)

> **Samina:** I don't think so, I haven't heard of anything up until now. I don't have period pains, I don't really know.

Respondent s felt that period pains should not be seen as a problem. It was just a case of keeping comfortable. As Surinder points out:

> **Surinder:** I mean for period pains, it's just a hot water bottle which is as much for comfort as it is for pain, so just that.

None of the women researched consulted the doctor about their periods and anything used to comfort women during this time was either bought from the pharmacist or taken from the kitchen cupboard.

Miles (1991) argues that women's views on pregnancy tend to be characterised by ambiguity. Is it health or illness? Pregnancy and childbirth are often presented as both (Woollett and Marshall 1997). Consequently, women struggle to find an answer to attach meanings to their experiences and to ascertain the socially approved and appropriate ways to behave. Ambiguity arises from the conflicting messages which reach women from doctors and other health professionals, from relations and friends and from their own bodies. One message often assimilated by girls in the early teen years is of pregnancy as a natural state, part of womanhood and femininity. This is often contradicted by the opposite message from health professionals, i.e. that pregnancy is a medical condition to be checked and monitored by doctors, obstetricians in hospital antenatal clinics all of whom treat pregnant women as if ill. Uncertainties

about the nature of pregnancy are also aroused by the bodily sensations of pain and discomfort which many women experience (Graham and Oakley 1986).

During pregnancy this interstitial positioning between health and ill health often leads women to draw on lay advice; advice from friends and relatives. Many changes in lifestyle are advocated and tried: taking more exercise, eating at different times, resting more or less. Such measures are attractive partly because they can all be tried without seeking expert advice (Miles 1991). Regarding pregnancy, studies have demonstrated a revival of interest in traditional remedies in the UK and USA especially among women (Chamberlain 1981). Minor illnesses and discomforts during the natural biological processes are treated by many women in this way. Homans (1985) found that in her sample, the majority of British Asian women (73%) (mostly Punjabi) used traditional remedies for the discomforts of pregnancy, which they usually learnt from older female relatives. White women in the same study were less likely to have the relevant information but even among them 35% knew and used folk remedies (milk, lemonade, polo, roughage in the diet, almond, ginger and many other remedies for stomach problems in pregnancy).

Within this study, women's views on pregnancy were very eclectic involving syncretic beliefs about and use of discourses. For pregnancy, though, it was not simply that women used both western and non-western health discourses. It also related to the status of pregnancy as both health and illness, as occupying an interstitial space moving in and out of categories. This led women in the study to draw on a whole plethora of discourses not just those related to health systems and remedies but also those, which are socially, and culturally embedded relating particularly to diet and located in religious beliefs. As with the findings in other studies (Homans 1985, Woollett and Dosanjh-Matwala 1990) food was particularly important within the research. Women within the study explained their food choices not just in terms of nausea and sickness, but also in terms of hot and cold in the Ayurvedic/Unani tibb systems of medicine and in their cultural context. As Shahnaz demonstrates:

Shahnaz: Hot and cold, but not actually physically hot and physically cold but the way it reacts to you like certain things like, like milk is supposed to help you cool down isn't it? Bananas are meant to help you cool down but there are other types of food that are supposed to make you sweat [aubergines], 'hot' but not hot in temperature, or in spiciness or anything like that.

Within the study, women ate different 'hot' and 'cold' foods at different stages of the pregnancy. Older women (mothers) encouraged women trying to conceive to eat cool foods:

Samina: When you are trying to conceive a baby, trying to get pregnant they tell us to stop eating warm things like carrots and aubergines, ginger etc. they tell us rather just to have lots of milkshakes. They say the womb needs to be at a cool temperature to conceive.

Respondents are actively encouraged not to eat hot foods at this time and early into pregnancy as this might lead to miscarriage.

Shahnaz: If you have food that is especially hot it will make you bleed more. That's why you're not supposed to have it at an early stage as you don't want to bleed, you might miscarry.

This stood in opposition to later stages of pregnancy where respondents were encouraged to eat hot foods to ease labour. This occurred from about six or seven months on as Sakeena's quote shows:

Sakeena: When you're nine months, you should start eating foods which are hot and slippery. Slippery means like if you put a little bit of ghee or butter in your meal, so it helps the baby come quickly.

Similarly, women within the research are encouraged to eat certain (hot) foods after the birth to encourage bleeding, which signifies a clearing out of the system. Samina discusses what foods you are supposed to eat post-natally:

> **Samina:** After we have given birth they (mother/elders) make us this drink which has fennel seeds in it and they put this special brown sugar stuff in it, you put it in water with a bit of ghee. They make us this to help us clear out our system because we want a period after we've had our babies so that makes it all come out. It tastes horrible but it really helps to clear out your system.

The influence of hot and cold foods was also applied by Muslim women within the study to other gynaecological problems. Samina discusses the use of 'hot' and 'cold' foods for cystitis:

> **Samina:** Yes, if a woman suffers from cystitis and that, that's when they tell you to have cold things like yoghurt and milk and milkshakes.

Within Donovan's (1986) study South Asian respondents talked about the relationship between hot and cold foods and certain illnesses, although not particularly pregnancy. This was more in terms of keeping a healthy balance. A normal temperature signals health. Any deviation from this is seen to indicate some sort of ill health. Some illnesses and diseases are defined by her informants to be hot and cold and balance is restored in the body by taking hot and cold foods to cancel out excess. For instance, if you have a high temperature use a cold compound to bring temperature down, measles is a hot disease so you cannot eat hot foods for example meat, eggs, chicken etc. Within this study women's discussions of hot and cold foods was more or less tied to issues of pregnancy and reproductive health and did not really feature in women's accounts regarding other health issues.

Within the research, while Hindu and Sikh women did not eat foods that had hot or cold properties during pregnancy, they did try to eat particular foods. Sita discusses the various foods you are supposed to eat when pregnant to keep healthy:

> **Sita:** When you're pregnant, you're supposed to have lots of milk, nuts and cheese. They're supposed to be really good for you.

All the women within the study, continued to use a variety of discourses such as those used for normal illness for the various associated symptoms of pregnancy, such as balms etc. All the women's accounts demonstrated the importance of the lay referral network on beliefs and behaviours. Other studies have also highlighted the significance of women's wider social relations during pregnancy, such as friends and work colleagues (Woollett and Marshall 1997).Women within the study, however, did not discuss the role of their husbands and partners in the context of pregnancy. This is at odds with other studies on women and pregnancy which have highlighted the significance of men's role (Woollett and Marshall 1997). Concurring with the findings from other studies on pregnancy (Woollett and Dosanjh-Matwala 1990), within this study, women's mothers and older female relations had a significant influence on women's use of discourses during pregnancy. As the account from Sakeena shows:

> **Sakeena:** But you know, if you are living with an older person they will stop you from doing this or that most of the ladies tend to listen because they have experience, your mum or whatever.

Rambha's account also demonstrates her mother's influence regarding advice for general symptoms. She talks about this in relation to indigestion during pregnancy:

> **Rambha:** I used to say to my mum, "should I take anything"?, and my mum used to say, "no don't take anything, just have a glass of juice and lie down that's it and have small not big meals".

All the women within the study had regular check-ups with the GP during pregnancy and had their children in hospital. The women's accounts suggested though that pregnancy was not something to keep bothering the doctor over, that it was part of women's lot. Homans (1985) noted that Asian women (from the Punjab, Gujarat) living in Britain are less likely than white women to go to the doctors with complaints during pregnancy but this may be changing as other sources of help decline (family ties are breaking down). The difficulties experienced by black women and Hispanic women seeking help from white doctor s in Britain and the USA have frequently demonstrated adverse experiences may well result in their becoming reluctant seekers of help (Miles 1991). Many studies have highlighted the various ways in which black women experience racism during ante-natal care (Bowler 1993, Bowes and Domokos 1996). For instance Bowler (1993) in her study highlights the stereotyping of South Asian women by hospital midwives. Bowes and Domokos (1996) research among Pakistani women in Glasgow, also highlight the wide ranging experiences of racism by individual women in their study. Women often felt they were being viewed in a stereotypical manner. One of their respondents who usually wore western clothes explained why she wore *Shalwar Chameez* (Punjabi dress) to the antenatal clinic:

> I will wear these clothes, and open my mouth later on to shock people you know, shock white people, because they think this is an idiot sitting there wearing these clothes (Quoted in Bowes and Domokos 1996: 58)

Women also had positive experiences:

> I used to write to my mum, 'they're angels over here, and they don't consider if you're a black or white person' (Quoted in Bowes and Domokos, 1996: 58).

From the accounts of the women researched here, it seems clear that cultural norms, past experiences with doctors, and the existence of alternative help sources are more influential factors on medical help seeking than the doctor's actual ability to deal with the symptoms. This could in some ways explain why the women's use of non-western

discourses during pregnancy is restricted to the private realm. However, women within this study were reluctant to talk about racism as an issue for not visiting the doctor. This may concur with Bowes and Domokos's (1996) study, where negative experiences by women were not always perceived as due to racism.

Within the study women seemed to suggest their use of non-western discourses within the private realm was different to anything suggested through the care they received within western medicine. As Shahnaz demonstrates in her account on the use of hot and cold foods:

> **Shahnaz:** Certain types of foods and drinks and things during pregnancy. There are certain types of foods and things that you are supposed to have after birth to help clear out the body. We believe, and I don't know if this is western thought as well but I've never heard a midwife tell you this, but the more you bleed, the better it is for you because you get rid of everything. All of that build up inside you.

Women within the research seemed to state these differences but did not seem to see them necessarily as an imposition of biomedical views onto the women during the antenatal phase as suggested by Karseras and Hopkins (1987). Respondents never presented these differences as outright conflict between discourses although there seemed to be potential for this. It was more the case that both private/public and western/non-western discourses were held in conjunction.

Only one woman within the study talked about postnatal depression. The doctor put her on anti-depressants for it:

> **Charlotte:** I'm a lot calmer person now. I went through horrendous postnatal depression with my first and then after the caesarean I was really upset because I hadn't come to terms with it. I went to the doctors and he put me on medication and I couldn't believe it I was like, 3 months down the line and I

could see a tunnel. I could see things clearly for the first time in my life. I'm actually more focused than I've ever been.

Most women within the study seemed to experience pregnancy as a natural state or health problem. Pregnancy can also at times creep into the category of normal illness as women have symptoms which fit into this category e.g. indigestion. For most of the respondents pregnancy rarely went into the category of real illness however for a few women pregnancy became classified as a serious illness which required long term periods of hospitalisation, as Deepika's account shows:

> **Deepika:** During the pregnancy I was really ill. The last few months I had to stay in hospital. It was really frightening for a while both mine and my baby's health was really compromised

When pregnancy moved into the realm of serious illness, respondents' beliefs and behaviours ceased being syncretic and moved completely into the realm of western health care (this is something picked up later in the context of 'real' illness).

While women within the study were unlikely to use any type of health discourse for menstruation, for pregnancy and other related gynaecological areas they drew on syncretic discourses. Women drew both on Asian remedies and western health discourses. This use of particular discourses just as with depression often related in particular to women's religions. Muslim women in the study, in particular, focused on diet and the use of hot and cold foods. Hindu and Sikh women on the other hand, while observant of a healthy diet were not concerned with hot and cold food properties. All the respondents also had regular obstetric check ups with a biomedical doctor. In looking at the women's use of syncretic discourses during pregnancy it can be seen that their use of non-western discourses is completely located within the private sphere. Their use of western resources conversely is strictly located within public discourses. These two seem to run in conjunction within the women's accounts and I argue that they support earlier studies' suggestion of differences between views of pregnancy as a natural process and pregnancy as a biomedically managed process. This difference then

intersects with the interstitial positioning of pregnancy and its movement between categories of 'health' to 'normal illness' and 'real illness'. While supporting earlier studies on pregnancy, however, women within this study can be seen to have greater access to particular types of health discourse through their position as British Asian. As Asian women who are part of a globally dispersed ethnic group, respondents have greater access to certain non-western discourses. As 'British born' they can be seen to have greater bargaining power within biomedicine than those who have migrated more recently to Britain from India and elsewhere. Through this, health problems can be seen to occupy interstitial spaces, moving in between different discourses both western and non-western and private and public.

3.4 Managing illness(es): Shifts to western discourse

Cornwell's (1984) third category of illness is termed 'real illness'. The model for real illness is established by the major and 'modern' disabling and life threatening diseases (i.e. cancers and cardiovascular and coronary heart diseases). The reality of the illness is established by the poor prognosis and by the impact it makes on the patient. Epilepsy, diabetes and other chronic disabling diseases, which require constant medication, are included. 'Real' illness definitely falls within the province of medicine but that is not to say that all illness in this category is treatable (Miles 1991). The definition rather refers to the severity and therefore the 'stature' of the condition rather than to whether or not medical help actually exists or is successful.

There has been much writing within the sociology of health and illness on 'chronic illness'. Much of this has focused on chronic illness as a disruption to everyday life exploring that disruption in a plurality of ways from socio-economic to the symbolic meanings (Bury 1982, Williams 2000). Bury (1982) has been at the forefront of British developments in the area since his classic sociological formulation, in 1982, of the notion of chronic illness as 'biographical disruption'.This has been coupled with a proliferation of subsequent work around issues such as narrative construction (Williams 1984) and styles of adjustment (Radley and Green 1987). Other research fitting in with the recent upsurge of interest in embodiment (Turner 1992), have moved these into the realms of corporeality (Kelly and Field 1996). Studies on chronic or real

illness have also shown a significant use of non-western/alternative discourses for a range of conditions (Andrews et al 1998, Boon et al 1999). In exploring popular forms of alternative health therapies (Chiropractic, relaxation therapy, acupuncture and therapeutic massage), it is generally agreed that most patients attend for chronic rather than acute conditions, notably health problems where biomedicine cannot offer a panacea (Cant and Calnan 1991, Cant and Sharma 1999, Saks 1992).

Within the study women make a similar categorisation of serious illness along the lines of Cornwell's (1984) 'real illness'. In the accounts of the women here, however, there was also an inclusion of manageable illness. This is illness which is not necessarily life threatening but which required medical management of some kind on a day to day basis. As argued within the introduction, women within the study were not giving detailed accounts on their experiences of particular illnesses. Rather respondents were talking about what discourses they would or had used for particular 'real' illnesses. What seemed to be the case with these more threatening illnesses was that women might draw on 'syncretic discourses' but this would be in a looser sense. Women within the study were much more likely to draw solely on western medical discourses located within the public realm. If we go back to the category of normal illness we can see that women's beliefs were much more likely to be located within non-western private health care. Western medicine, and particular public discourses were really only drawn on as time passed and illnesses got worse. When looking at serious illness this model can be flipped on its head. For illness which was perceived to be more serious respondents were more likely to visit the GPs as the first port of call, to access public western medicine. Non-western medicine, as will be demonstrated, was generally sought only if biomedicine was perceived to prove ineffective over time. Within this section of the chapter I have focused on four types of manageable and serious illnesses prevalent within the women's accounts: asthma, diabetes 'amorphous' illnesses, and cancers and fatal illness. As we shall see, the more serious the illness the more the above becomes the case.

3.4.1 Asthma and eczema

Particularly strong links have been made regarding the benefits of 'alternative' medicine for diseases such as diabetes and asthma (British Medical Holistic Association 1992). Within this study, for illnesses, which required daily management, such as asthma and eczema women drew much more heavily on western discourse; although at times they might use Asian discourse there was an ultimate deferral to western discourse. This went for illnesses such as asthma, eczema, and diabetes. Within the study asthma seemed mostly to be prevalent among the women's children. I will explore respondents' attitudes towards childhood asthma in more detail within the next chapter.

With eczema and asthma women would try and control it themselves as Surinder suggests:

> **Surinder:** My eldest she has a touch of eczema, very mild. We control it ourselves.

Women within the study did try to control these types of illnesses at home to a certain extent because most of them were not happy about children's long-term use of steroids either in treatment for eczema or of inhalers for asthma. Respondents often related this 'home treatment' to having particular types of diet to reduce the prevalence of asthma attacks. Donovan's (1986) study also suggests this. Her respondents drew on ideas about hot and cold foods, which were supposed to be used in the treatment of asthma. Too many cold foods and drinks could have very serious side effects for asthmatics. Many of her respondents felt that cold things like ice cream and cold drinks in winter led to illnesses such as pneumonia. Inder's account within this study about her daughter's asthma supports this. She was quite keen to control the asthma through diet rather than have her daughter dependent on an inhaler:

> **Inder:** My eldest daughter seems to be getting a touch of asthma and eczema. The doctor recommends an inhaler but I've said no.... I've found

that when she's having problems with her breathing, drinking tea and things helps, so she just has tea and coffee and other warm drinks rather than coke.

Some women in the research did use non-western practitioners such as Hakims for things like eczema and asthma. Although respondents often complained that these treatments were too expensive. Regarding such illnesses a conflict in treatments often develops between western and non-western discourses leading to a focus on western medicine. I will go onto explore this in more detail in the next chapter.

Within the women's accounts in most cases they used western medicine in treating such illnesses. Most women who had asthmatic children went to the doctor's about it, and used inhalers. Charlotte's attitude in the quote below was quite a common one among the women researched:

Charlotte: Regarding asthma, no I'm not a doctor. I would always seek medical advice.

3.4.2 Diabetes

There have been a number of studies which have looked at minority use of different types of discourses for the management of diabetes. Armstrong and Pierce (1996) argue in their study on diabetes among Afro-Caribbean populations in Brixton that there was no mention of folk remedies. The converse is found to true in other studies on Afro-Caribbean beliefs and behaviours (Donovan 1986). Regarding studies on diabetes among Asian populations in Britain, Kelleher and Hillier (1996) in their study of Bangladeshis in Tower Hamlets found a minimal use of non-western discourses.

Women within this study held attitudes about diabetes which were similar to those held about asthma. If anything they even more reluctant to use non-western products in order to try and control it. Many women had some family member who was diabetic and felt that they would only really trust GP and, western medicine.

Kishwar: I would find it sensible to go to the doctor's if I were suffering from anything like diabetes or high blood pressure.

Only one woman Gurinder, knew of someone who had tried Asian medical products for diabetes and this was during a trip to India and it did not help at all.

Gurinder: My mum, she has diabetes and she tried herbal tablets in India. The treatment for diabetes is free and you have to take it for 40 days and apparently you're supposed to cut out on a lot of things. You have it for 40 days and you're supposed to get rid of diabetes and my mum didn't do it properly and didn't get rid of hers.

Other studies on the incidence of diabetes among Asian populations in Britain have pointed to the control of diet and particularly the use of Karella, a bitter vegetable in the management of diabetes. Kelleher and Islam (1996) in their study of the Bangladeshi community in Tower Hamlets found that Karella, a bitter vegetable was widely used. In their study some of the respondents said that they had been told by doctors to use Karella and claimed that it was on the hospital diet sheet, which is an interesting example of doctors being able to work with lay ideas. There is some evidence that Karella does help to lower blood sugar levels, which helped to persuade doctors to accept it (Kelleher and Islam 1996). Diet control though was in all cases used in conjunction with insulin dependence.

Within the study women were aware of Karella. Some women did at times try and 'help' diabetes through diet and some talked about the use of Karella to help lower sugar levels. Samina discusses the uses of Karella:

Samina: There's this long vegetable, like long cucumbers with horrible skin (Karella). They're really horrible and bitter the juices out of that; they (diabetics) have the juices out of that. To prevent, well to make sugar levels low. Having a teaspoon of that every morning before your breakfast because my dad has diabetes and he uses that.

Within the women's accounts on diabetes however there did not seem to be such a significant interconnection between GPs and the home use of Karella. On the whole the respondents in Kelleher and Hillier's (1996) study saw their diabetes as a problem which had to be managed medically. They did not appear to think that forest or folk remedies had much to offer them apart from the widely used Karella. Neither did they think that the wearing of amulets had much power to control diabetes although some thought that they were useful for things like belly pains and for some external psychological illness, which had divine causes. Women in this study generally held similar views preferring to draw almost completely on western medicine for the treatment of diabetes. Rambha's quote below supports that argument:

> **Rambha:** He (her brother in-law) was quite recently diagnosed then the daughter. They knew what it was as soon as they got the symptoms, starting to go to the loo and stuff a lot. Yeah, she's going to the doctor's all the time because she's insulin dependent. She has to be careful what she eats, you feel sorry for her but yeah; it has to be treated by the doctors.

3.4.3 Amorphous illness

Women within the study often talked about developing illnesses, which they just could not fathom, which seemed to them to have strange symptoms. Respondents were worried that these might turn out to be something serious and in these cases the women went straight to western medicine, to their GP. Miles (1991) argues that there is a temptation to ignore symptoms, which might indicate a fearful, frightening or stigmatising disease, thus for example, hallucinations, or a lump on the breast will be disregarded, at least for a while because madness or cancer is too frightening to contemplate. While fearful about inexplicable symptoms women seemed always to consult their GP about a whole catalogue of symptoms from those associated with irritable bowel symptoms to easy bruising, as Sakeena's account shows:

Sakeena: I get bruises very easily, if I bumped into anything. I was a bit worried that there was anything wrong with me. So I asked the doctor and he sent me to the hospital and put me under obs, was very worried about whether my blood was clotting properly or not. We had a test and everything was OK, nothing wrong with me.

On being diagnosed for such symptoms women within the research often then went on to find other non-western or home remedies or through diet. Surinder suffered stomach problems, which were ongoing and did not seem to fit into the normal category of sickness and diarrhoea, on visiting the doctor for such symptoms she then tried to control the condition herself:

Surinder: I just make sure I eat on time. I try to eat healthy you know, not just junk food, and with the kids we know we're all going to sit down and eat together. You've got a meal at the end of the day in your stomach.

3.4.4 Serious Illness

Regarding children's health, studies have shown a high incidence of use of alternative medicine for serious illnesses such as cancer (Bridgen 1995). Within this study, regarding serious illnesses such as cancer, respondents were reluctant to speak about them and appeared surprised when I asked whether they would consider using non-western health care. Respondents would talk in a roundabout way about cancer within the family but this was always talked about in terms of western care. Women within the study seemed to have ultimate faith in western care. This concurs with some of the attitudes of respondents in Donovan's (1986) study, all her respondents are afraid of getting a serious illness, strokes, cancer, losing a limb. Many of the informants cite cancer as an incurable disease but reveal great faith in western medicine and doctors. Acceptance of what happens and faith in western medicine comes through in some women's statements.

As argued in the introduction of this section, in cases such as cancer women would go directly to western health care. Non-western healthcare would be sought out only

occasionally if western medicine proved ineffective over a certain period of time. This can be seen in an account from Shahnaz about her brother in-law. He had been really poorly with his stomach and had failed to be properly diagnosed in the UK so went to India to be diagnosed and have treatment; (this was using western health care there though). He went to India and was diagnosed straight away with stomach cancer and given chemotherapy but unfortunately this treatment failed to save him:

> **Shahnaz:** He got the tumours removed in India. He was prescribed a dose of chemotherapy there. He came home to Leicester and they wouldn't give him the dose prescribed in India. Within 3 months his symptoms were back.

This man also did use some 'alternatives' in India relating to Asian medical systems but this seemed like it might be a last ditch attempt in the face of such unsatisfactory treatment and was not wholly relied upon. In studies focusing on the use of alternative medicine for cancer, reasons for using alternative medicines for cancer have fallen into two main categories: (a) patients are "pushed" toward alternatives because of bad experiences with conventional medical treatment, and (b) patients are "pulled" toward alternative medicine because of their belief in the alternative paradigm (Furnham and Smith 1988).Within this study, reasons for using non-western discourses definitely fell within the first category and it appeared that using non-western discourses was a last resort. To go back to the example given from Shahnaz:

> **Shahnaz:** I mean you can see with my brother in-law, he did actually get some medications from India, religious. But I think you do tend to use them but you can't rely on them.

When talking about both manageable and serious illnesses respondents are more reticent about drawing on syncretic discourses. For manageable illness the women may draw on non-western discourses but the main form of management of illness comes from western medicine. We can see a general progression from the use of mixed discourses to purely western discourses as respondents move from talking about

manageable to serious illness. The focus on western medicine becomes even more pronounced regarding serious illness. It seemed from women's accounts that in the context of serious illnesses such as cancer and heart problems women's beliefs and behaviours would be almost completely located within western discourses. Within this study we can see that regarding serious illness such as cancers women attempt to use non-western medicine only in very extreme cases when western medicine fails to work over time. This goes in opposition to women's beliefs and behaviours for 'normal illness' where women draw more heavily on non-western remedies within the private realm, and can be seen as distinct to the interstitial category of health problems as they shift in and out of these two categories of illness.

3.5 Conclusion

Within the chapter I have focused on respondents' uses of particular and syncretic discourses regarding particular illnesses. Within this chapter I have taken a micro view of illness to show how the women's syncretic use of discourses varies according to particular illnesses. Again taking a closer look at categories of illness themselves suggests that we must recognise the parallel processing of syncrecy seeing it as dual layered, women's accounts locating syncrecy in both private and public domains at differing times and contexts.

In analysing the women's accounts on illness I have found it useful to draw on Cornwell's (1984) three categories of ill health. These include the category of 'normal illness', which includes general health problems from colds to sickness; the category of 'health problems' which includes those illnesses which seem to fit into neither, 'normal' illness nor 'real' illness. This includes problems such as mental health to pregnancy; finally the third category 'real illness' which in Cornwell's classification focuses on those illnesses which can prove fatal such as cancers (I also include more manageable illness such as asthma and diabetes). I have developed this classification further in the context of this research by looking at how it relates to the use of different discourses and in particular their use of syncretic discourses by the British Asian women within the study.

What became clear within the women's accounts was that while they may draw on more than one discourse for most illnesses there is a higher trend towards syncrecy among normal and less serious illness. For normal illness women are much more likely to draw on syncretic discourses that draw on both western and non-western beliefs and practices with a particular focus on the non-western. For real illness this model is overturned as respondents focus almost wholly on western medicine. This use of different types of discourses for normal and real illness intersects with use of healthcare within the private and public realm and also operates along conceptualisations of what I have called illness time.

For 'normal illness' respondents focus on using non-western discourses within the private realm. Public western health discourses are sought only when these private discourses prove ineffective over time as illness worsens or does not improve. Within the study, women's beliefs and behaviours about normal illness also shift over broader temporal contexts as they move through the life course and as times change, normal illness takes on new meaning. In opposition to this for real illness women draw mostly on western public discourses electing to use non-western private or public discourses only when western ones prove ineffective over time. With the possible exception of one respondent, women's beliefs and behaviours seemed less susceptible to changes in time in relation to real illness, where most held the ultimate faith in western medicine.

Health problems within the study had particular resonance for many of the women researched. This was in particular because, as with the respondents in Cornwell's (1984) study, the category includes menstrual and reproductive health which were significant issues within my respondents' lives. Normal and real illness can be seen to hold extreme polar positions in the context of syncrecy. Health problems on the other hand, seemed to hold an interstitial position between the two. Health problems are neither one thing or the other but can be both, moving in and out across time. Because of the amorphous nature of health problems syncrecy seemed somewhat eclectic. While mental health problems were associated by many women within the study with spiritual health discourses, pregnancy was associated with a whole host of discourses both western and non-western particularly related to diet. Pregnancy also seemed to shift

between categories of health and ill health and this was reflected in beliefs and behaviours. It seemed though that for both types of health problems religion was particularly influential on the women's accounts. While I am not suggesting the other two categories are fixed they appear to be more heavily situated in concrete terms within the women's accounts. Health problems move in between the two depending. Mental health problems such as anxiety and depression are controllable but there is always the potential for escalation into something more serious. Pregnancy, as demonstrated by other literature can be seen as a healthy state but can also lead to complication and at times fatality. Because of this I would argue it is very difficult to be wholly firm about the relationship to syncrecy and just as health problems move between different categories of illness so do they move between different discourses and differing forms of syncrecy.

The accounts of the women researched have highlighted the uses of the framework of syncrecy. In highlighting the ways in which syncrecy ranges according to different illnesses these accounts have again displayed the need to recognise the fluid and processual nature of beliefs and behaviours. These have been captured here by taking a dynamic approach to illness categorisation drawing on Cornwell's (1984) classification system and situating this within the wider context of plural medicine. In demonstrating the significance of particular illness on respondents' beliefs and behaviours within this section I have begun to touch on the importance of other contextual and material circumstances on respondent's beliefs and behaviours. Family, generation and life course also influence respondents' beliefs and behaviours. It is to these I will now turn.

Chapter 4
Situating Syncrecy : Family, Generation And The Life Course

4.1 Introduction

Within the last chapter I focused on the way in which beliefs and behaviours of women within the research are syncretic according to particular types of illness. This involved a micro view of both the concept of syncrecy and also illness. Respondents' beliefs were seen to be syncretized in different ways according to different types of illness. Within this chapter I want to explore the role of families in informing women's beliefs and behaviours and their use of syncretic discourses. Women within the study talked at length about the family, about the influence of marriage on their beliefs and behaviours, about their attitudes and practices regarding their children's health and about generational influences on health beliefs and behaviours.

Marriage seemed to encourage syncrecy within beliefs and behaviours. When respondents became mothers there were shifts in their syncretic use of discourses from the [1]public to private domain. There were also marked generational differences in syncrecy between family members. These beliefs and behaviours were not fixed but rather reflected family members' positions within the life course. It is the aim of this chapter to explore this influence on the respondents' use of syncretic discourses. It explores the way in which family influence on beliefs and behaviours intersects with respondents' position as 'British Asian', as women of a particular ethnic and generational group. The chapter explores this influence recognising the importance of women's particular position within the life course, acknowledging potential changes in beliefs and behaviours as women grow older.

[1]As with the previous chapter, the terms private and public domain are used to refer to distinctions between the home and the public realm, not to private and public health care systems.

Research has demonstrated women's reticence when talking about their own health. Studies have found that far more can be gained from women about their own health when they talk also about family health (Graham 1984). Researchers also talk about the important role of women as mediators in family health (Blaxter and Paterson 1982). Drawing on this argument the research aimed to find out not only about women's health beliefs and behaviours but also about those of their families. In light of this, the chapter focuses not only on the families' influence on women's beliefs and behaviours about women's own health, but also their beliefs and behaviours surrounding other members of the family and the reported beliefs and behaviours of other family members. It is recognised here though that a woman's role as mother is only one aspect of her life and only one part of the life course.

There has been a significant amount of feminist research within sociology which has focused on women and health and illness (Doyal 1995). Research has highlighted the gender bias of the health profession, both in terms of research and practice (Bayne-Smith 1996, Kirchstein 1991). Studies have also highlighted the tendencies within research to equate women's health purely with reproduction (Raftos, Mannix and Jackson 1997). Research has also shown differences in men and women's health status, women's being in general significantly worse than men's (Blaxter 1990, Graham 1993). Broadly speaking, the belief held in developed countries suggests that women live longer than men but appear sicker and suffer more disability (Doyal 1995, Macintyre 1996). In assessing the gendered nature of health, researchers have also cast their gaze to the influence of marriage and co-habitation on the health status of men and women. Some research indicates that women's health behaviour differs according to their marital status (Jones 1994, Popay, and Jones 1990). As Arber (1997) argues, many studies of the 70's and 80's suggested that while marriage appears to be beneficial for men's health it seems to be less beneficial for a woman's. However she suggests that such patterns may no longer hold in light of recent changes in marriage patterns reflected in an increase in divorce rate and growth of cohabitation. If we look at research on lone mothers the picture appears bleak. Such

research has highlighted how lone mothers are more likely to have worse health than those who are married or cohabiting mothers (Popay and Jones 1990).

Research on family health also focuses on the connection between women's activities as primary caregivers in the family and in society at large and as primary consumers of health care for themselves and others (Graham 1993). Women urge their loved ones to seek medical care: they make the doctor's appointments for their family members and they purchase and replenish over the counter medicines for the families' bathroom cabinet. Similarly they are more likely than men to monitor the health status of extended family members, to become caretakers to the elderly, infirm and sick children. Many studies have concurred with this (Bowes and Domokos 1993, Stacey 1988) arguing that women can be counted as unpaid health workers. Finally, health research has attempted to explore the influence of family health beliefs and behaviours on women's health beliefs and behaviours. Taking a generational approach studies have focused on looking at if (and, if so, how) health beliefs get passed on from generation to generation. This research has mostly been carried out between mothers and children (and in particular daughters). Studies have tended to suggest (Blaxter and Paterson 1982, Campbell 1975a, Mechanic 1964) that while mothers (like the rest of us) transmit health messages, their children do not necessarily absorb them. Instead the learning process is mediated not through the family's health culture but more directly through experience.

All three bodies of women's and family health literature relate to the findings of this study. However, these debates have yet to really explore the role of family influence on women's use of plural discourses. They also over-simplify issues regarding the role of the family and neglect the processual changing nature of this role. While studies on the family and health fail to explore women's use of plural medicine, studies on plural medicine, and even on ethnicity and health, skim over the surface of family influences. The family has been a central focus on studies on ethnicity and identity (Woollett et al 1994) but only alluded to regarding health. Studies on pluralism in both Asia and Britain have also been couched in terms of wider social processes, and have not really explored the role of the family. The

aim of this chapter is to explore within women's accounts the influence of the family on their use of syncretic health discourses. This chapter draws on the above literature but takes a more complex processual approach.

First, the chapter will explore the influence of marriage on syncrecy within the women's health beliefs and behaviours. Within the study, the women's accounts show that while marriage might have a negative effect on women's health outcomes this is not necessarily the case for women's beliefs and behaviours. Regarding beliefs and behaviours, marriage in most cases actually opens up new possibilities as partners introduce women to different types of discourses previously unknown. This can be seen as beneficial and promotes a syncretic use of discourses. Conflict between women and their partners mostly occurs over children's health and choice of discourse. Women, however maintain their position as gatekeepers of family health. In-laws also have a role to play in influencing women's beliefs and behaviours; this will be explored.

Secondly, the chapter explores the use of syncretic discourses regarding children's health. On the whole, although women might try different types of health discourses for their children, ultimately they are more most likely to resort to western medicines. Women's choice of discourses for children is also affected by husbands and partners and by the lay referral network which includes broader family and friends. Within this section I will explore the differences between women's attitudes to younger and older children and their use of syncretic discourses. Here I will explore the resistance of teenage children to non-western discourses, situating this resistance as resistance to their parents' culture. I will move on to explore the role of generation on women's use of syncretic discourses, looking at their own mothers' influence on their beliefs and behaviours, and what they hope to pass on to the children. Rather than taking a straightforward generational approach as other literature has I will explore the convergence and conflict between gender and generation in women's use of different discourses.

Finally, these findings are situated within a life course approach. Other studies have shown that there are differences in the way women talk about health according to their age and place within the life course (Charles and Walters 1998). A life course approach recognises how women's situation in life and use of discourses captures a specific moment within the life course, one which is continually changing as women progress throughout the life course. I recognise that I capture women's beliefs and behaviours at a particular time (mothers with small children) and that their beliefs as such are processual and will continue to change as the family does. Within this framework I will argue that women move in and out of, and use, different discourses at different times in the life course. I will begin the chapter by exploring the influence of marriage.

4.2 On marriage, a healthy disclaimer

Marriage is a significant point for the women within the study when discussing their health, and their health beliefs and behaviours and there was an overall influence towards syncrecy within the women's accounts. All except one woman within the study was married (the one exception was divorced). In exploring the role of men and marriage one must recognise the diversity of marriage and its meanings within the South Asian tradition (Bhopal 1999). For instance, for Hindus and Sikhs the importance of marriage is primarily based on a sacramental union whereas for Muslims it is primarily a contractual union. While this is so, Bhopal (1999) argues there are significant similarities between the three groups in terms of relationship of individual to the family, the social and economic importance attached to marriage, the family structure and the possibilities for mate selection, all of which are important. There is a need also to mention that one of the respondents was Catholic. For Catholics, matrimony is both contractual and sacramental. Catholicism emphasises the importance of marriage and family for the renewal of society (Knight 2000). Despite these religious differences between the women within the study, the commonality of the influence of marriage on health beliefs and behaviours and general health seemed to override these differences.

Within the study, some women were married to men from India or Pakistan but others were married to British Asian men. Marital and family influences on women's health beliefs and behaviours needed to be explored along local and global lines because of this. Women also often still had family in India. As Menski (1999) argues, marriage of women from British South Asian diasporas transcends national boundaries as many women marry men from India, East Africa, the Americas and elsewhere. This demonstrates that Britain's ethnic minorities are today part of global social structures, and these in turn influence beliefs and behaviours (see chapter six).

Arber (1997) has demonstrated the links between the institution of marriage and the differences in the health status of men and women. She concluded that while marriage is beneficial to men's health and mental well-being it is hazardous to women. Women within this study felt that their general health altered on marriage. Women did see marriage as having quite a negative effect on their health involving more visits to the doctor. As Samina, a Muslim woman from Blackburn explained:

> **Samina:** Well I do tend to go more now for myself since I've been married because I can hardly remember going to the doctor for anything before I was married. I hardly ever used to get ill then, compared to now.

Within the research, women talked about the gendered division of labour between themselves and their husbands regarding their health status, suggesting men made more of a fuss of being ill than women. This was mostly said tongue in cheek and was compared to the women's own stoic attitudes towards health and illness. As Inder, a Sikh woman pointed out:

> **Inder:** With my husband, I find that, if he's got a cold he's quicker than I am to get something from the chemist. He's always like "oh I'm dying", but we can both have exactly the same cold.

Many other studies have found similar results (Currer 1986). Cornwell (1984) for instance in her study on working-class communities in East London found that the gender division of labour impacted upon women's response to illness, in that whilst men could take time off work women could not. As one respondent in her study notes:

> Men they're like babies. You don't know what I put up with from him. Women they get on with it...I'd say women have more aches and pains than men but, as I say, when you've got a family you will find a woman will work until she's dropping. But she'll do what she's got to do and then she'll say, "Right, I'm off to bed". Whereas it is all-right for a man he's got nothing to do, he just lies there doesn't he? (Quoted in Cornwell, 1984: 140).

This is related to the argument that women don't have the time to be ill, as they are the principal carers for the rest of the family (Charles and Walters 1998, Popay 1992). Women within this study felt that they were too busy to be ill. What was interesting was that women often saw men's stereotypically gendered attitudes to health status within marriage as being passed on to the children. In this sense children were seen to repeat the attitudes of their parents. As Harpreet points out:

> **Harpreet:** My daughter's OK, she's got a bit from me, my son's got a little bit from his dad. Like if he's got a headache or hangover, it's like he's had seven babies all at once (laugh), you know he says "oh my head, someone get me a tablet" and I think, "oh get up and get it yourself".

Gender divisions in attitude were also reflected in respondents' and their partners' consumption of public health care. In talking about visits to the doctors, while women in the study all went frequently, very few of their husbands did. Rambha's view over this was quite typical:

Rambha: My husband has been to the doctor's recently, to be honest he'd never been to a doctor's before. In fact the doctor used to say, we don't see you that often, we hope to see you once a year, just to make sure.

Again many other studies which exemplify women's role as caregivers within the family support this (Doyal 1995, Graham 1984,1993).

As shown, within the research women's accounts emphasised a deterioration in the overall quality of their health on getting married. However, the effects of marriage on women's actual beliefs and behaviours was not quite so negative. Within the study, men influenced women's use of syncretic discourses. Husbands clearly influenced women's use of Asian medical products and systems particularly when the husband came from India as an adult. Men's influence on women's use of non-western discourses opened up a number of possibilities for the women enabling them to try remedies on themselves and their families that were previously unknown to them. This was seen in most cases to be beneficial. Surinder, a Sikh woman from Birmingham talked about how she had learnt a lot about Asian medical practices from her husband:

Surinder: His (her husbands' family) are from India so there are other things that I've picked up from him. Like all kinds of remedies and things that I never knew before.

This influence occasionally even overrode the influence of respondents' mothers and other members of the family. As Rabinder suggests:

Rabinder: I only use mild herbal things. I wouldn't say that I've got them off my mother either, I'd say that I picked them up more in general, from my husband.

In the majority of cases within the study husbands will tell their wives about various non-western remedies but there is no pressure for women to use these. Respondents often then use them in conjunction with western remedies and health care as they see fit. As Rambha's account shows:

> **Rambha:** Oh well he (her husband) tells me about all these different types of remedies from India and stuff. Sometimes I use them, other times I just go straight to the chemist but mostly I will try both.

For one woman in the study, however, this encouragement to use non-western discourses became somewhat forceful and ended up making the woman in question quite ill. This was emphasised by Samina, a Muslim woman from Blackburn who was married to a man from India:

> **Samina:** My husband he's really into Indian remedies and things. I was suffering from hay fever about two weeks ago, badly, and I was gasping for breath and that's how bad I was. He said go and do this. There are these little seeds you get and they're really strong and I give them to him (her child) when he has asthma and his cough and everything. I said to him (her husband) that won't help me 'cause it's for chesty things and he's just "do it".... I had to do it just to get him to keep his mouth shut and it made me really bad, I had to go... to hospital.

For this particular respondent these differences in attitudes reflected more general conflicts of identity between being born in Britain and being married to an Indian born man. Such differences in this particular case also contributed to feelings of depression:

> **Samina:** I actually put up with a lot from him. I've adapted to his ways a lot so he should be doing the same for me you know. He just doesn't listen and it's hard.

This resulted in Samina going straight to western medicine for solutions and comfort.

> **Samina:** I tried to get my husband to understand. I talked to my doctor permanently because I knew he would understand and I felt that he could relate to me whereas my husband, he just couldn't because he's from back home. That's the only thing I can say because that's the only reason I can think of because we're not the same.

This negative effect of a husband's influence on his wife's beliefs and behaviours can be seen as an example of what Gardner (1990) sees as the social control of women. Men's influence on women's beliefs and behaviours and health in general helps to sustain the power of men and elders.

Within the research, men and marriage were influential on both women's health outcomes and their health beliefs and behaviours. Women in the study, however talked little about their effects on men's overall health although they were implicitly doing the majority of caring work for the men. They did, however, talk about their 'lack' of influence on men's beliefs and behaviours. What is interesting here is that men's friendship networks seemed in some ways to be more influential on men's beliefs and behaviours than women's influence. As Raminder points out:

> **Raminder:** My husband went to a healer, one of his friends told him about it, not me. He got some pain in his knee but it helped, it's all right now.

An area within the study where women and men's ideas about health clashed was over the children. Men were often far more flexible about health care regarding women's health than they were the children. Men were quite cynical about women

using Asian medical products and care on the children and were often strongly against it. Zahira, a Muslim woman discussed her husband's resistance to her using alternatives on their daughter:

> **Zahira:** No my husband's never let me use Asian remedies. If I wanted to do something that my mum did. No he wouldn't let me do that. He will say why are you doing things like this. Like the salt remedy my grandma told me about which gets inflammation down. He said no, it doesn't matter because only antibiotic medicine can help with that. I do them myself you know and he doesn't mind, for her he doesn't let me.

As this quote demonstrates while the husband was resistant to her using alternatives on their daughter it was acceptable for her to use it on herself. However, despite men's cynicism, the ultimate decision on what to do about children's health was left to women. As Shahnaz shows:

> **Shahnaz:** He's like, oh aren't you taking them to the doctor's or have you taken them to the doctor but then I'd make the final decision as to whether it's necessary to take them or not.

This again supports the literature on women's role as caregiver and gatekeeper of family health. While men like to have a say in the decision making process regarding children's health, ultimately it is women who are responsible for it. As Graham (1984, 1993) argues, as principal caregiver the mother acts not only as the home nurse, doctor and tutor she is also the person in contact with the professionals who perform these roles in the public domain. Typically it is the mother and wife who seeks out the health professionals for both husbands and children; she is the one who is also sought out by them.

Within the research, marriage and men can be seen to influence women's use of syncretic discourses, in particular their use of non-western discourses. Whilst in the general context

of women's health marriage could often be seen to have negative effects, regarding actual beliefs and behaviours men's influence could in most cases (except for one) be seen to open up possibilities for women. Ultimately, marriage did not prevent women from using the discourses they wanted to particularly regarding their own health. Women within the study 'act' on their desire to use non-western and syncretic discourses (Rajan 1993). As such it can be argued that respondents use various health discourses in response to but also as part of a negotiation of gendered spaces within the private domain. Women assert and maintain their position as primary caregivers and gatekeepers of family health, as well as asserting their own health choices. The use of plural discourses was less pronounced regarding children's health where women remain more widely influenced by their partners. It is possibly useful to draw on notions of the lay referral network here (see chapter 3). Women seem to draw on a number of sources when making their decisions about health and these different sources seemed to inform tendencies towards syncrecy within the women's accounts. The next sections will explore some of these broader influences in the form of in-laws.

4.2.1 Outlawed by in-laws

Within the study, in-laws also influence women's syncretic use of discourses after marriage. Influence was tempered by whether women lived with, or close to in-laws. Many women, particularly Muslim women lived with their in-laws on marriage. Accounts demonstrated how constraining in-laws could be on the women's lifestyles in general and specifically in relation to health and beliefs and behaviours. Many women were at odds with their in-laws and related this to their being from India. Samina, who moved in with a whole group of her husband's family on marriage felt this:

> **Samina:** My in-laws when we were living together we would never see eye to eye because they're all from back home (India).

This in turn had negative effects on women's health. In the case of Samina, on moving in with her in-laws she became extremely depressed:

> **Samina:** I had him (her child) but I had a lot of pressures from my in-laws and my father-in-law and he quite often made me cry.

Other research has supported the argument about the difficulty women face on marriage when opinions of in-laws differ significantly from their own (Bhopal 1999). What was interesting within this research was that many women saw their in-laws as somehow more backward, particularly those from India, Pakistan or East Africa. They often contrasted this to their own parents (though they were from India as well) who were more forward looking. Women within the study portrayed their own parents as more 'westernized'. These notions also intersect with national space (see chapter 6), relating to where in-laws come from in Britain. As Gurinder puts forward:

> **Gurinder:** All Asians are the same. Same crap. I think my in-laws a lot more than my parents, my parents are more westernised. But the fact that they live in London, my parents. My in-laws came over here and settled in the north, that makes the difference.

This not only affected women's actual health outcomes but also their health beliefs and behaviours. The Asian remedies and products women might have used had they been at home with, or close to their mothers they were unable to. This was because women felt that in-laws and particularly mothers-in-law lacked knowledge about Asian behaviours. Shahnaz, a Muslim woman who had moved from Blackburn to London to Leicester, felt particularly constrained regarding use of certain Asian remedies because her mother-in-law was not in favour of them and her own mother was in London:

> **Shahnaz:** I think, to be honest, my parents used to be more into that than they are here because you know I said about things like bed wetting and

everything's there, I remember my mother used to make something for that and I asked my mother in-law about that and she hadn't even heard of it.

This illustrates the important role the respondents' own mothers had on mediating their beliefs and behaviours (Blaxter and Paterson 1982). This again carried a spatial dimension; women were prevented from carrying out certain alternative practices because they were reliant on their mother's help and their mothers often resided in other places.

Within the study, women felt pressure from husbands to use certain discourses regarding their children's health and in-laws put even more pressure on women. Women talked about how they felt as if in-laws thought they weren't looking after their children and their children's health needs properly. To go back to the example of Samina:

Samina: My father-in-law, I was living with him. I was giving my baby bottle milk, what with all the demands of the household, housework and cooking etc. it was too much pressure to breast-feed. Then he got colic and they all thought it was something I was doing.

While respondents' experiences of in-laws was diverse, in-laws in the most part were seen to have a negative effect on women's health, particularly on women's emotional well-being. They also seemed to have constraining effect on women's health beliefs and behaviours, particularly regarding the use of Asian medicines and particularly regarding children's health. Such a directing influence over women however was only a temporally specific measure. Women lived with in-laws for a short period of time when married but then moved out to a place of their own. While in-laws remained influential on women's beliefs and behaviours they weren't quite as constraining. This is reflected in their choice and uses of health discourses as they move into spaces of their own and become freed up regarding their syncretic use of discourses.

4.3 Placing Children's Health: use of plural discourses

As already demonstrated in the first section, women are ultimately the principal carers within the family (Graham 1985,1993) and particularly of children (Blaxter and Paterson 1982). Women are not just mediators in children's health in terms of gaining appropriate professional care for their children, and conducting activities directly related to health care procedures. Women also, through housework, and cooking and cleaning are directly responsible for children's health (Graham 1985). Within the study some women were engaged in paid employment while others were not. Regardless of this women were the ones taking primary responsibility for the health of their children on a day to day basis.

It can be argued that health can be seen to be a 'moral category' when ascribed to the carer (Graham 1984). This relates to the argument put forward by Radley and Billig (1996) that health accounts put forward by people actually signify their position in relation to the world and others and forms a significant part of their identity. This has been reflected in health studies which focus on children. As Blaxter and Paterson (1982) argue in their study on mothers and daughters, women were reluctant to define their children as unhealthy, seeing it as a negative reflection on their mothering skills. Within this study women were initially reticent when talking about their children's health, readily defining children as healthy. As the interviews progressed and rapport was built women talked more intimately about their children's health and ill-health. This reflects Cornwell's (1984) argument about shifts from public to private accounts within the research situation.

Many women talked about their children's health in relation to their own. They noted how they were more likely to visit the doctor for their children's health. Rambha's response to differential use of services for herself and her children was quite a common one:

> **Rambha:** Myself, I try and wait for 5 days before I go to the doctor's because I tend to but with the children I never take the risk because you never can tell.

As we saw in the section on marriage, women in the study seem to go to the doctor's more once they are married. This changes when they have children and become mothers. They go to the doctor's more for children's health and less for themselves. Women were also more likely to use private health care such as BUPA for the children's health than for their own. Children's health becomes the focus of family concerns. As Surinder put it:

> **Surinder:** I'd say that for the kids I have to go quite regularly (to the doctors), it used to be for me mostly but that was before the kids.

Regular use of the GP for children was temporally specific and altered as children got older and as women had more children. Women's attitudes changed over the life course; in general they became more relaxed.

> **Inder:** Children are such an experiment. My eldest daughter, I used to take her to the doctor a lot. After a while all I knew was that she got colds quite a lot. I just stopped taking her and kept her at home and used more things from home like honey and lemon.

Respondents also spoke on the subject of sex and gender of children. While the biological sex of the child was of importance to wider family, women themselves did not mind whether they had male or female children. Women did not seem to treat the health of male and female children differently, they used the same remedies (whether western or non-western) on both and had the same attitude about GPs and practitioners of Asian medicine. Other research has highlighted similar attitudes to the health of boys and girls among South Asian populations in Britain. In exploring immunisation rates and gender among South Asians in Newcastle, Martineau, White and Bhopal (1997) found no differences in attitude towards the immunisation of male and female children. They suggest that the converse is found within the Indian sub-continent where differences are more pronounced. Within this study, however, women did place gendered concepts of health and illness on to

boys and girls. Boys' health was perceived to be different to girls' in the sense that they would be more accident-prone, as 'boys will be boys'. As Priya, a Hindu woman who has both a son and daughter, argued:

> **Priya:** Yes, he had stitches, here he fell off his bike and fractured his skull. It's the boys, they are rough, not like the girls.

Within the study, while women focused more on their children's health their own health deteriorated on having children. Many women attributed this to lack of time to actually look after their own health because so much of their time was taken up by children. As the quote from Surinder, a Sikh respondent, shows :

> **Surinder:** Just in general I could be doing a lot more for myself but I think it's really hard when you've got kids, it's hard to keep up. Running around after them. I want them to be well fed and well looked after and then I tend to forget myself and my own health.

As with marriage, as the accounts of the women researched showed, while having children might have negative effects on women's health women's access to a plurality of discourses was not closed off on having children. Because of the time constraints placed on women by children women seem to increase their own use of home remedies both Asian and western. Thus children do not put constraints on women's use of syncretic discourses for themselves. They lead rather to a shift of focus from women's public use of syncretic discourses to a greater use of discourses within the private realm. What was particularly interesting to explore though, through women's role as carer and mediator, were women's attitudes to children's use of alternative and plural health discourses. This is something explored within the next section, first concentrating on mothers and younger children, then moving on to look at teenagers.

4.4.1 Asian Medicines and Children

There is evidence that in general, alternative therapies are being employed by parents to help children with a range of chronic illnesses for example, recent studies have reported that 11% of children attending a general paediatric outpatient clinic, 40% of children with cancer and 70% of children with chronic juvenile arthritis had used alternative therapies (Andrews et al 1998). Other research on children and alternative health has come in the form of guidebooks to various alternative practices (Price and Parr 1996), or has focused on the influence of western assimilation on migrant women's child rearing practices (Gupta and Gupta 1985-1986). Within the study while women's views on using Asian medical products or services for young children were quite mixed, some women did use some remedies. Women were quite keen to use herbal home remedies on the children. Charlotte, for instance, a Catholic woman, quite liked to use home remedies from the Caribbean on her children:

> **Charlotte:** I take ginger and massage their heads with oil. I do that with my kids give them a good massage; it helps when they have headaches.

Women liked to use Asian balms such as tiger balm on their children, for general ailments such as colds and' flu. As Shahnaz, a Muslim respondent observed:

> **Shahnaz:** I like to use tiger balm on the kids quite often.

Some women within the research used these remedies on children because they felt they were milder and more natural and less risky than western remedies. In this sense, their use of Asian medicines can be seen to fit in with the general increase in use of alternative medicine in general (West 1992). As much of the literature on alternative health demonstrates, many people are turning to alternative health care because of a disillusionment with western health care and the much publicised long-term side effects of drug use (Worsley 1997). This is also linked implicitly to the wider debates concerning

risk, health and lifestyles (Beck 1992, Giddens 1991a, Turner 1991). Certain lifestyles are deemed to carry more health risk than others, for instance the person who eats badly and does not take regular exercise increases their chances of suffering from heart disease (Nettleton 1995). In lay terms, regarding risk and health, not even expert systems can be deemed to save us which is why people now look to alternatives in a variety of realms. In talking about environmental risk Giddens (1991) exemplifies this well:

> Widespread lay knowledge of modern risk environments leads to an awareness of the limits of expertise and forms one of the 'public relations' problems that has to be faced by those who seek to sustain lay trust in expert systems....[R]ealization of the areas of ignorance which confront the experts themselves, as individual practitioners and in terms of overall fields of knowledge, may weaken or undermine that faith on the part of lay individuals (Giddens 1991a: 130-1)

Women within the research generally liked to try alternatives on children because they perceived it in many ways as more natural and better for overall long-term health. Regarding asthma, many women talked about the use of non-western discourses. Research has shown that a substantial proportion of children with asthma who attend paediatric clinics use alternative therapies (Andrews et al 1998). Within the study, some women would rather try alternatives rather than have their children dependent on long-term use of inhalers or steroids. As Inder's argument demonstrates:

> **Inder:** My eldest daughter seems to be getting asthma. The doctor wants her to get an inhaler but I've said no. She's got some medication for the cough that she's got. But I've found that giving her hot rather than cold drinks helps and changing her bed linen everyday helps. I'd rather do that than her use an inhaler.

The women researched did quite often like to use Asian remedies because they seemed more 'natural' than biomedical ones. Women did worry though if their children were already on medication with the GP. While women would continue to use Asian home remedies, they were quick to resort to a use of western medicine if non-western discourses were not working. This was despite the risks involved. Ultimately they had more confidence in the overall success of western medicine. As Samina suggests:

> **Samina:** Like I said he suffers from asthma and I've got to be careful with him, I've got to, I have to take him to the doctor. He's been in hospital once. I treat him at home with Asian remedies and then with him having asthma I have to take him to the doctor's.

This attitude did vary according to illness (see chapter three). Within the study, women also took their children to visit Hakims and Vaidas for various illnesses. Illnesses such as asthma, diabetes and eczema which required long-term treatment but quite often found that these clashed with treatments from GPs. Again women were ultimately happier to stick with western medicine. As Sakeena's trip to a Hakim for her daughter's asthma demonstrates:

> **Sakeena:** I took my daughter for eczema. What happened is they stopped her other doctor's medication for asthma, her inhaler. What happens if she has an attack? You know, these Hakims they treat from the root so they take a longer period and take a 'holistic' approach. It enhances the illness then cures it. We didn't want to take the risk.

Hillier and Rahman (1996) reported similar findings in their study on parental perceptions of emotional and childhood development among Bangladeshis in East London. They showed that while the Mullah (Moslem spiritual Healer) and prayer played an important role in times of illness among children, GPs were the most favoured source of help. It appeared in this study that while women were willing to use both Asian home remedies

and practitioners for their children's health, they were happier using Asian home remedies than seeking out Asian medical practitioners. Women within the study did take their children to visit Hakims and Vaidas but were more sceptical about this and ultimately would rather take them to the GP. Women differentiated between their own health and that of their children. On the whole while it was acceptable for them to use alternatives and Asian remedies they were not as happy for the children to:

> **Pryia:** We take things like ginger and remedies; for me, I do this, for the children I go straight to the doctors. Because if I don't gave the right medicine to the kids it's not good, for me it's less important.

This may reflect back on men's role in the decision-making process regarding childrens health, even on the 'lay referral network'. It also may in part be related to the imposition of biomedical models on the women by community health workers during the antenatal period (Karseras and Hopkins 1987). The findings support the argument that while women in the research still draw on syncretic discourses regarding children, they are less confident in doing so for the children than for themselves. Their gendered positioning within the family constrains their active seeking out of other discourses. There appeared less of a feeling of resistance to both their gendered positioning, and to biomedicine.

4.4.2 Teenage Resistance

In much of the literature, young people are seen to look more to peers than to parents for confirmation of maturing identity. Parents are seen to have a negative effect on adolescent identity and adolescents will identify themselves in direct opposition to parental desires (Apter 1990). Research on adolescent health (Brannen et al 1994) has demonstrated that, on the contrary, while conflicts do exist between young people and parents, parents and particularly mothers still have a significant role to play in mediating teenage health. While young people begin to visit the GP unaccompanied, mothers are still seen to be active in identifying signs of illness in their young people, helping them decide what to do, making

GP appointments etc. This is seen to be particularly the case for daughters (Brannen et al 1994). Husbands' roles regarding teenage health are viewed as becoming negligible.

A number of women in the study had eldest children who were teenagers. Women felt that regarding children aged up to about 12, they had ultimate control and sanction over administering health decisions. Regarding teenage children, however, women's role became much more contested. Through the accounts of the women researched it appeared that teenage children's beliefs and behaviours were far from syncretic. On the whole teenage children felt the need to go to the doctor on a regular basis and would rather go to the doctor than try anything at home, Asian or otherwise. In talking about her teenage daughters, Raminder argued:

> **Raminder:** Oh my god they are fussy, always to the doctor.

Concurring with Brannen et al (1994), women within the study still took a major role in making appointments, and mediating with health professionals. However, women's suggestions about health were not always taken on board. Teenage children tended to be cynical of use of Asian medical systems and would refuse them. On trying to get her children to use various Asian herbal remedies, Rambha argued:

> **Rambha:** I've tried that with the children and they're a bit sceptical. They wouldn't try this, they wouldn't touch it. They say are you sure this is all right. They would rather go to the doctor.

Women in the study associated this with the impatience of adolescent culture. Teenagers often felt that they wanted the quick fix from the doctor and as already argued as Asian remedies and healers take a holistic approach to health, many practices take longer. Teenagers do not seem to have time for this. Sakeena found her teenage daughter particularly resistant to using Asian remedies and health practices:

Sakeena: Yes, but she is so unco-operative. Straight away she goes to the doctor and she's so fussy. I've tried to get her into aromatherapy and things because she's so hyper but she won't listen.

This stands in opposition to other research on generational differences in health beliefs and behaviours within families. In a study on the health and health behaviours of migrant South Asians and younger generation (mostly British born) Asians, Williams and Shams (1998) argue there are few differences in health behaviours between generations. They argue that this is the case despite pressures to conform to teenage norms. They relate this tentatively to factors in teenage socialisation within British Asian families seeing factors such as high levels of parental protection, religious beliefs, and value placed on school work as influential. At the very least they suggest that this is an indication of the strength and vitality of British Asian cultures.

Overall, within the study women gave the impression that teenagers were happy for their mothers to continue to do informal health work for them, and continue to act as mediators with professionals. They were however resistant to women's suggestions of use of Asian medical practises and systems and wanted to locate themselves completely within western discourses. In the case of women with teenagers in this study, peer pressure seemed to take significant precedence over parental influence. Also, rather than taking an oppositional stance to dominant cultural forms as youth culture has been traditionally viewed as doing since the Second World War, according to the mothers, teenagers located themselves firmly within western consumer culture (Carter 1984). This could be linked to the overall identity of teenagers and may be temporally specific, altering as teenagers progress through the life course.

Donovan (1986) argued in her study on south Asian and Afro-Caribbean women's health in London, that some informants wanted to adopt more western ideas in order to keep up with the children. Within this study, however, children's beliefs did not seem to affect women's use of syncretic discourses, and in turn women's use of syncretic discourses was

not seen to be translated down to the "next generation". Whether and in what ways children's beliefs and behaviours will become syncretic as they get older is yet to be seen. These interactions and influences of generation on use of health discourses will be further explored in the next section.

4.4 Generating health: passing syncrecy down the line

As argued within chapter one, little research has focused on the influence of generation on the health beliefs of minorities and migrants. Taking what Goldberg (1993) calls an ethnic reductive approach; studies have failed to recognise the importance of generational specificity on beliefs and behaviours. Some studies on migrant and minority health have alluded to generational differences based on patterns of migration, length of settlement, and generational positioning (Kraut 1997). Studies have also explored the differences in general health between British born and migrant generations noting a general improvement over generations in health (Williams and Shams 1998). This has been related to changes in health behaviours focusing on issues such as diet (Williams and Shams 1998). However research has yet to explore the impact of generation thoroughly, particularly in regard to its intersection with the life course. There are studies, which focus on the impact of generation, which are situated in significant moments in the life course. These studies have focused on looking at the influence of mothers on the health beliefs and behaviours of children (Blaxter and Paterson 1982, Campbell 1975a, Mechanic 1964). Such research has failed so far to make any kind of direct correlation, suggesting instead that a more informal learning process between women and children takes place. These studies have tended to focus on ethnically white and indigenous members of communities and countries.

Within this study the focus is on British Asian women, who are mothers. With this focus the aim was to explore the influence of generation and its interactions with notions of length of settlement also recognising the temporal specificity of women's position within the life course, capturing women at a particular time and recognising that this position changes over time.

4.4.1 Mother knows best

Many women within the study, talked about the importance of their own mother's health beliefs and behaviours and their influence on the respondents' themselves. Many women's use of herbal and Asian remedies came from their mother's own usage. Women within the study really trusted their mother's judgement about alternatives, as Musarat, a Muslim woman, points out:

> **Musarat:** Yes sometimes you have to go to the mother, they know what's better, they know this is a good cure. They've done it for years and it's been like a good cure. Even now, the use of balms and things I was telling you about, I learnt that from my mother.

In fact some women felt that they would use non-western care only if their mothers had recommended it. In talking about Chinese herbal remedies, Gurinder, a Sikh respondent, said:

> **Gurinder:** Only because my mum brought it and made it up. I wouldn't do it otherwise, wouldn't go off on my own and do it.

Many women felt that their general ideas about health were the same as their mothers'. Within the research while beliefs and behaviours were perhaps not necessarily passed on from mothers in a directly straightforward fashion, mothers' influence on health beliefs and behaviours was far stronger than being a mere informal learning process. Women quite often seemed to take the same route in health seeking behaviour as their mothers, as Sakeena points out:

> **Sakeena:** My mum and me do the same things regarding health. First we use a remedy from home, if it's not working then we go to the doctor.

Within the study, women felt very strongly about this and often stated that their mother's recommendations regarding health and health care worked better than doctors'. Recommendations were strongest around issues of pregnancy, but mothers also gave advice about grandchildren, which the women often heeded. As Priya, a Hindu woman, argues:

> **Priya:** Yes, with the children she (her mother) says like, use certain types of herbal powders so we try that. Sometimes they don't work and we take them to the doctor.

While the women themselves were eager to learn new health behaviours from their mothers, grandchildren (the women's children) were even more resistant to grandma's advice than they were to their own mother's. As Rambha, who has a teenage son and daughter, demonstrates:

> **Rambha:** My mother has tinned powder, a mix of herbs. She has it once a week, as a precaution rather. It clears the stomach and gets rid of bugs. It's bitter, I've tried it on my children and they say never again ,no way, they'd rather take paracetemol.

Blaxter and Paterson (1982) studied a group of mothers and their married daughters who are themselves mothers. Their data suggest that attitudes are not transmitted in any simple way from generation to generation. Instead Blaxter and Paterson (1982) found that similar attitudes existed only when and to the extent that, the mothers and daughters shared experiences born of a common environment. This relates to some of the findings within this study not regarding attitudes but practices. While ideas about health seemed to translate from mothers to the women, in some cases actual practices recommended by the mothers could not always be carried out because women were located in different geographical areas to their mothers. This prevented women from using some Asian health practices. Some Asian remedies particularly those of a spiritual nature when practised on

children often required the involvement of the mother's mother, particularly those associated with practices against the evil eye (see chapter 3 and 5). Women were prevented from carrying out these practices because their mothers were not geographically close. Shahnaz, a Muslim woman with two children, talked about how she would like to carry out some health practices associated with the 'evil eye' but couldn't because her own mother lived in London:

> **Shahnaz:** I would do rituals associated with the 'evil eye' more often. I do try and do it but it's better if a grandparent does it, but my mum's in London.

At times women were constrained by the fact that their mothers were in India which was even worse than their being in another part of the UK. This also put extra worry on respondents about their own mother's health. As Priya's account shows :

> **Priya:** My parents are in Africa and my husband's family is in Madagascar. (Do you miss them)? Yeah, mum and dad. Especially as mum is not feeling well. So I miss my mum.

Within the study, it seemed that women's dislocation from their mothers on marriage acted as a constraint particularly regarding the use of Asian medicine. Women talked about the influence of their mother's beliefs and behaviours on their beliefs and behaviours. They also however focused on generational influence on their state of health, again focusing particularly on mothers. Some women talked about this in terms of their mothers passing on a strong constitution of health, through to them. As Harpreet, argues:

> **Harpreet:** I've definitely got that from my mum I reckon. I mean, she had a hysterectomy recently and she was strong over all that, the only thing she didn't do was picking her things up. Women who have that operation don't do those things for a few weeks but not my mum. She's quite strong.

And also in terms of generational fears of particular illnesses:

> **Inder:** I was actually worried, my mum had cancer. She had chemotherapy and everything and she's better now. I thought, if she's got it I'll get it and my children will get it. Now I know that's not necessarily the case, that there are other factors involved.

Within the research, grandparents and other relations such as aunts and uncles also seemed to have a role to play in influencing the women's health beliefs and behaviours. This came mostly from grandmothers and was particularly focused on the issue of advising women about herbal home remedies. While influential though, grandmothers' influence on health beliefs on a day to day basis was limited. Some women's grandmothers had passed away and others lived in India. In the latter case women were often dependent on visits to India to gain any new advice. This did not stop women ultimately from using remedies passed on to them, and in fact gave them links to an [2]'imagined homeland' as both Sita and Charlotte point out:

> **Sita:** Again it goes back to my roots. Like you know I was very close to my grandma and she was my heroine really. I would take all kinds of things from her.

> **Charlotte:** My grandma used to make bush tea for health, so I have that.

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[2] 'Imagined homeland' here is a play on Anderson's (1991) ideas of imagined communities. Anderson talks of the nation as an imagined political community. He sees it as imagined because the members of even small nations will never know of their fellow members, meet them, hear them. However according to Anderson in the minds of each lives the image of communion. Drawing on Anderson, imagined homeland within the research is then used to denote in a spatial context, the women's relationships to India or Africa. They may never have lived in these places (or have any intention of doing so), or visit them that frequently, know many people there. However, in the minds of many respondents these places still maintain the quality of mythical homelands.

Teenage resistance to their mother's beliefs and behaviours within the research is something I have already explored in the section on children. This resistance did not prevent women from talking about ideas they would like to pass on to their children, as their own mothers did, and did not stop them from worrying about illness which they might pass on. The last question in the interview schedule was based around ideas of what the women felt they would pass on to their children in order to look at whether women thought that syncretic views would hold with the next generation. Women did talk about how they would like to pass things on to their own children, particularly to their daughters. This was related to both western and non-western remedies. Sakeena, whose teenage daughter had shown so much disdain for her mother's 'alternative' beliefs and behaviours, was keen to try and pass on some of her ideas:

> **Sakeena:** Actually, I wanted her to know and prepare when she goes away (to university). She should prepare a folder of what to do when. Please I ask her, and she says mummy prepare it and give it to me.

Ultimately, though, women within the study still emphasised the importance of the doctor to their children. Women wanted to point out that, ultimately, GPs know best:

> **Rambha:** Well, I wouldn't mind explaining to them the basics and tell them that some of these natural cures would work. Like inhaling mint that you have grown in the garden and just steam. That will help you breathe properly, if they've got a cold or something but I would also tell them that look, if you find that you're not better, have it checked out, never take that risk.

Overall, generation seemed to play a pivotal role within the women's accounts regarding family health beliefs and behaviours. Mothers' influence on the women's use of particular discourses was significant and seemed to heighten their use of syncretic discourses. The women's mothers seemed to have more knowledge about Asian medical practices than the

women themselves, and the women seemed eager to learn from them and to a lesser extent from their grandmothers. It did seem that women were drawing on their mothers' beliefs and behaviours more since they had became mothers themselves. In this sense many women did talk about resistance to parent culture when they were teenagers, locating themselves more with western culture. This changed on marriage where women's views became more syncretically located as they took on more ideas from parent culture. This recognises the changes in women's beliefs and behaviours over the life course. Such a processual approach takes us beyond approaches which view British born minorities statically 'between two cultures' (*see* Watson 1977). Despite the difficulties in some women's accounts, for instance regarding geographical location, women seemed to see their mother's influence on health beliefs and behaviours, as enabling them to carry out new practices. It seemed that this was perhaps something women would like to do for their children, hoping that certain beliefs would pass on and open up possibilities, giving children a wide access to a number of health discourses. In drawing on some of these issues, I want to move on now to explore and situate more thoroughly family influence within the life course.

4.4.2 Life course and generation: temporal localities

Health beliefs and behaviours, as argued in the Introduction, are dynamic. They are specific to time and space and move as we progress throughout the life course. Studies on migrant and minority beliefs about and use of plural medicine are located in particular temporal contexts. Studies capture beliefs and behaviours at only one moment in time but acknowledge that these are fluid and vary as people pass through the life course. In exploring women's health Raftos, Mannix and Jackson (1997) emphasise the multiple points within women's life course and argue that it is important to recognise that there are differences between these points in terms of women's health. In their study on ethnicity and identity, Woollett et al (1994) argue that one must recognise the ways identity changes over time during the life course. Focusing on a study of Asian women in London, Woollett et al (1994) argue that women's identity is an on going process changing developmentally

in terms of transitions in the women's lives as they marry and become mothers. Identity also changes as children grow up and go to school. Such a processual life course approach to identity can be translated in this study to generational influence on health.

Taking this on board, the study recognises that it focuses on women only at a particular time, as British Asian mothers with dependent children. However, whilst recognising such specificity it was interesting to see that throughout the accounts women seemed to reflect on family beliefs and behaviours both in the past and future in terms of life changes which they had gone through. Generation and the life course seemed to intersect influencing women's beliefs and behaviours, as did length of generational settlement. Beliefs and behaviours change with each successive generation becoming more socialised within British culture, and as women's life circumstances themselves change.

Within the study, women's mothers' beliefs and behaviours changed over time, through length of settlement and progression through the life course. This was often reflected by a decrease in respondents' use of Asian remedies, as Rambha argues:

> **Rambha:** Originally my mum used a lot of balm and herbs that came from India, but less so over time. I don't tend to use them a lot.

The women researched also recognised the changes in their own health beliefs and behaviours as they progressed through the life course. Gurinder referred to a change in beliefs and behaviours on getting married and getting older, being more likely to use alternatives as she got older:

> **Gurinder:** A few years ago I would have thought no need. You need hospital, a doctor, whatever. Over the years I don't think the same thing. I think I would seek alternative medicine. I would pass that on to my children too. I wouldn't mind trying what my mum's tried some herbal remedies and stuff you know. I would try some of the things my mum did.

Within the study, women not only located their own beliefs and behaviours in a temporally specific context but also those of their children. Women felt that even children were most likely to take on some of their ideas when they became older and took on the role of parent. As Sakeena says:

> **Sakeena:** OK, if I leave all these things, if I tell her this, she will follow them when she comes into the role of mother you know. At this age 17, they hate their mother but you don't realise how much like their mother they are until they become a mother.

The influence on teenagers' beliefs and behaviours of their position as younger generation women remains unknown. The trend towards their current affiliation with westernization may be transcended when they reach adulthood, particularly when they become parents themselves. Perhaps there is the potential for their beliefs and behaviours to become syncretic then, but this may not be in the same way as their mothers' beliefs and behaviours are syncretic now. As Gilroy (1993) argues, syncretic forms are rarely the same in different times and contexts but are rather re-worked and re-inscribed. Ultimately, influence of generation was very important to the women and they would like to see things being passed on from generation to generation. Such a tradition is however also couched in notions of choice and time, particularly where their children are concerned. As Raminder argues in reflecting on passing beliefs and behaviours onto her children:

> **Raminder:** It's about time, how do I know what I will tell my children. I believe that I don't want to force them into certain things. They have to make choices themselves.

Within this study, women do seem to have a clear sense of the impact of change, both generationally and as they progress throughout the life course and are faced by different stresses and strains. It appeared that the women's mothers' use of Asian remedies

decreased, while theirs were syncretic and their children's were mostly western. This emphasised women's position under their current place within the life course and as British Asian women, socialised within the west but with parents who were migrants themselves. However this is not to suggest or reinforce a 'between two cultures' approach from the women's accounts. Rather, there is a need to situate family influence on the women's beliefs and behaviours within a life course approach. This recognises the processual nature of family influence. Family and generation affect women's beliefs and behaviours differently at differing times as women move throughout the life course. For instance as young women certain discourses are drawn on. However, as women get married they shift to a syncretic use of discourses. As women become mothers they continue to draw on syncretic discourses but shift in their focus from discourses within the public domain to those within the private realm. Women also discussed how they felt that as their children grew older and even as they become grandmothers themselves their beliefs and behaviours will be transformed again.

Charles and Walters (1998) in their study of the health accounts of women of different ages in South Wales emphasised the importance of women's position in the life course with regard to their health. Women's accounts demonstrate that their experiences and explanations of health, while showing certain commonalities vary with age and stage in the life cycle and are shaped by wider structural changes in employment patterns and gendered division of labour. Thus structural and cultural change shape the discourses that women drew upon when talking about health and illness and help explain the similarities and differences in ways of talking about health between women of different generations. This study supports their argument within the context of syncrecy. Within the study family and generation influence women's beliefs and behaviours. These must also be situated within the women's life course. However, as I will go on to show in later chapters there are broader influences at work here. Other contextual circumstances intersect with these to influence women's beliefs and behaviours.

4.5 Conclusion

Within this chapter, through the accounts of the women researched I have explored the impact and role of the family in influencing women's health beliefs and behaviours, on their use of both western and non-western health discourses. Through focusing on mothers it has also been possible within the chapter to explore not only the family influences on women's beliefs and behaviours, but also the beliefs and behaviours of other family members and women's beliefs and behaviours surrounding family members. This enables us to take both a gendered and generational approach which is then built into a life course framework.

In concurring with other research, this project supports the argument that women's overall health status deteriorates when they become married (Stacey 1985). While supporting this argument the research also demonstrates the significant impact of men's influence on women's use of non-western discourses. Through husbands, women engage with new non-western health discourses which are by and large regarded as beneficial to women's health. The chapter also demonstrates a conflict between men and women over children's health regarding the use of different discourses and also explores the constraining roles of in-laws. The findings highlight that on the whole marriage fosters women's use of syncretic discourses. It must also be recognised that marriage stands as a contested domain for the women and suggests the findings require a more complex framework than developed in much previous research. What is needed is a framework which looks at the impact of husbands on women's beliefs and behaviours not just on their health status, one that explores husbands' influence on women's use of non-western products, and also the role of wider family and children.

Within the study, having children was part of another significant transition within the women's lives and alters their beliefs and behaviours. Women's focus on children's health and child care responsibilities in general meant less of a focus on their own health. However, women still drew on syncretic health discourses. There was a shift within this

syncrecy though. When women became mothers they shifted their use of syncretic discourses from public to the private realm, mostly drawing on remedies at home for themselves. The chapter recognises differences in the respondents' attitudes to younger and older children. Regarding the younger children in general women seemed more ambivalent about using non-western practices on their children. While women did use Asian remedies on their children, they put greater faith within western medicine and were ultimately happier for their children to see a GP when ill. Syncrecy was weaker regarding children. For teenagers it seemed women wanted their teenagers to learn something about non-western and in particular Asian medical discourses because they were old enough to make a choice about their health. These teenagers were resistant to using Asian remedies and firmly located themselves with western health and western culture, resisting parent culture and alternatives completely.

Finally drawing on from this the chapter explored the influence of generation on women's beliefs and behaviours. Respondents' mothers' beliefs and behaviours were particularly significant for the women, especially regarding use of Asian remedies. Women's mothers knew a lot about Asian remedies and healers and passed ideas onto them. Mothers seemed to be the most important influence on women's use of alternatives but sometimes they were constrained in behaviours because of dislocated geographical location. Grandmothers and aunts also had a role to play in women's use of non-western discourses but again many constraints were placed on their influence. Women did hope that some of their ideas about Asian remedies and practices would be passed to their own children despite their current resistance. Generation played a pivotal role in influencing the women's beliefs and behaviours but this is also placed within the context of the life course. It is not just a case of women's beliefs and behaviours being passed on from generation to generation but also that they change as women progress through the life course, as women marry and become mothers. They also change for the whole family over time and relate differently to each coming generation and with longer length of settlement. The processual nature of these influences within the women's accounts emphasises the need to move away from

approaches which either fix beliefs and behaviours in time or locates their position as somehow falling between two stools.

Regarding the family, generation and the life course, the accounts of the women researched highlight the complex interweaving of contextual circumstances with the women's position as British Asian. Such an intersection can be seen to contribute to respondents' syncretic beliefs and behaviours. The family thus plays a significant role in influencing women's use of discourses for themselves and others. This influence transcends national boundaries which is something I will go on to explore in chapter six as women's beliefs and behaviours are globally mapped. While women's syncretic use of discourses is significantly influenced by illness and by the family, they are also influenced by respondents religion and community. These contextual circumstances also intersect with broader issues of identity. The influence of religion and community within the context of identity will be explored within the next chapter.

Chapter 5
Religion, Community and Syncretic Identity

5.1 Introduction

Within the last chapter I focused on the way in which beliefs and behaviours of women within the research are syncretic in relation to family, generation and the life course. The chapter explored the respondents' beliefs and behaviours within the context of the family, beliefs and behaviours changing on marriage and with the arrival of children. This chapter also highlighted the differences between generations and emphasised the importance of life course. Within this chapter I want to explore the influence of respondents' religion and community on syncrecy within their beliefs and behaviours. I also want to explore this influence within the context of health and identity. Research has highlighted the significance of religion on health beliefs and behaviours (Porter and Hinnells 1999). There have also been many studies exploring the 'ethnic' community, as well as studies on community health. Finally there have been a number of studies on ethnicity and identity and identity and health. Research in this tradition has yet to explore the interrelationships between such categories.

Within the accounts of the women researched for this thesis these categories intersect to influence as well as reflect trends to syncrecy. This chapter explores the influence of these intersections on syncrecy. It highlights the importance of respondents' position as 'British Asian' and in doing so emphasises the need to move beyond approaches which locate British (born) minorities between west and non-west. The chapter also deconstructs the category of non-western medicine. Overall, the chapter explores the influence of religion and community on beliefs and behaviours over time, reflecting on this influence in the context of identity.

Porter and Hinnells (1999) argue that the intersection between religion and health is universal throughout recorded history. They meet at the great turning points of life, at birth, at moments of acute suffering and at death. Religion is far more than a mere set of beliefs, or an optional way of life, it is also a conditioning, a powerful expression of

identity: the embodiment of a received tradition of world views, of personal understanding, of values priorities, hopes and fears. Within studies on beliefs and behaviours religion is often explored in its therapeutic capacities. Singh (1999) points to the positive effects of Sikh prayers on stress related illness. Donovan (1986) in her study on the beliefs and behaviours of Asian and Afro-Caribbean women in East London found that religion was particularly influential regarding health. Most of the women within her study are religious, religious beliefs and faith in God gave the women a great sense of peace and contentment and helped to ease the burden of worry, depression and loneliness. Religion can also be seen to influence health more directly. Certain rituals associated with religion are influential on the maintenance of good health. Marks and Hilder (1997) look at the influence of religious practices on health status. They look at low levels of infant mortality rates among Jewish children at the turn of the century. The stress that Jewish teachings placed on personal hygiene, cleanliness, and rituals associated with kosher food helped prevent food contamination, and illnesses such as diarrhoea.

Within this study, from the outset, religion has played a central role. At the beginning of the study there were methodological concerns surrounding religion during the sampling process. I was faced with the question should I focus on women of one religion or research across different types of religion (see chapter two). In earlier substantive chapters I have also already shown the importance of religion, for instance in exploring illness itself (chapter three). Within the current chapter I show how religion informed women's use of particular types of discourses. While women within the study talked less about religion as a source of comfort, religion held a general influence. Differences in beliefs and behaviours appeared according to women's religion. This signifies not a difference in syncretic use of discourse but in the type of non-western discourse used.

The term 'community' has been used and explored in studies on health, and on race and ethnicity. Its conceptualisation remains open to a wide and diverse range of meanings, imaginings and competing definitions (Crow and Allan 1994). Within discourses on health alone the term has been used in a dual context. It is used both as a shorthand term for services and organisations which are 'locally based and organised'

and as an ideology conveying notions of accessibility, local autonomy, responsiveness, social solidarity and shared benefits (Jones 1994). If we expand further the term 'community' in fact the range of meanings is wider still, it may refer to groups with common interests, values, beliefs, experiences on whatever scale they operate both spatially and non-spatially (Jeffers, Hoggett and Harrison 1996). Hahlo (1998) talks of community as consisting of a wide range of social exchanges between members. Taken as a whole this leads to a view of community as a socially constructed reservoir of scarce resources. This includes the maintenance of ties between groups based on marriage and allows for the maintenance of cultural, social values and attitudes, structures of political support and a range of social relations including kinship and friendship (Hahlo 1998).

On the whole projections of community have created the illusion of fixity and absolute identification. In talking about the black community Alexander (1996) argues for more fluid and layered notions of community. Drawing on the findings of her study among black male youths in South London, she argues that community exists on a variety of levels, and the individual's reaction to it can be seen to be multilayered and multifaceted. Within the context of my research, community worked on a number of levels, from religious community, through to broader identifications with Asian communities and spatially located communities. Women's accounts emphasised the intersecting influence from differing levels of community on their use of particular types of discourses both western and non-western. Taken as a whole this multiple layered influence led to an overall move to women's use of syncretic discourses.

Both religion and community influence respondents' use of syncretic discourses. This influence is situated in a temporal context, religion influencing beliefs and behaviours at particular times, broader community at others. These influences tie in with issues relating to identity and health. A number of studies have focused on the relationship between health and identity. As shown within the Introduction of the thesis, Radley and Billig (1996) argue that people's accounts of health and illness are more than views about what people in society should do to avoid disease, they also articulate a person's situation in the world and indeed articulate that world in which the individual will be accountable to others. When women within the study talked about health and illness

they also talked in more general terms about their identity and their situation within the world. Through their accounts on health women discussed their position as 'British Asian'. Respondents' beliefs and behaviours often reflected their syncretic identity. Different aspects relating to women's identity such as religion, community and family (see chapter 4) became more prevalent at particular times as does their influence on beliefs and behaviours.

Within this chapter I will explore the influence of religion and community on beliefs and behaviours as well relating this to more general issues of identity. As with previous chapters the accounts from the women within the study highlight the usefulness of the framework of syncrecy. In particular the women's accounts highlight the uses of syncrecy in contrast to approaches which suggest this generation of migrant children are caught 'between two cultures', both west and non-west. The accounts highlight the complexity of the respondents' positions, emphasising the significance of contextual circumstances on syncretic use of discourses. Within this chapter, unlike previous studies, the accounts highlight the need to recognise the intersections between contextual categories such as community, religion, identity and health situating these within a dynamic temporal framework.

5.2 'We're in it the spiritual way': Religion and Health

As already argued within chapter three, religion played an important role in influencing respondents' beliefs about and use of syncretic discourses. In chapter three I showed how religion was influential regarding particular illnesses. For instance, it appeared that for Muslim women within the study religion played an important role regarding beliefs around pregnancy and mental illness in opposition to both Hindu and Sikh women for whom religion played a more minimal role. Within this section I want to explore the influence of religion in a little more detail. I will focus on the more general influence of religion on respondents' beliefs and behaviours, moving on to explore differences in beliefs and behaviours between respondents of different religions. I will focus on particular practices such the 'evil eye' and situate religious influence in a temporal context. Throughout the section the overall influence on syncrecy will be explored.

Many women within the study talked about the importance of their religion and its general influences on health. Many women within the study felt that religion had a general role to play in good health and felt a connection between their spirituality and health. As Samina's quote suggests, many women felt that they approached health issues in a spiritual way:

> **Samina**: We (Muslims) believe in spiritual healers, we're in it the spiritual way.

While respondents talked in more general terms about the influence of religion on health, they also often used religious metaphors to signify their health. This is exemplified in an account from Charlotte, a Catholic respondent. She talks about the body as a 'temple':

> **Charlotte:** Your body is a temple and how you look after that temple is what you get out of it. If you let a lot of rubbish go into that temple, that temple will deteriorate and be destroyed but if you look after that, your body as a place to worship, somewhere to clean, somewhere to respect, not to abuse I believe you should look after that.

Overall it was quite common for most of the women within the study to make general connections with health and religion at some level. Religion often acted as a general guideline on health behaviours. This is something which has been common in previous studies on health beliefs and behaviours. Religion was an important influence on the health behaviours of diabetes sufferers in Kelleher and Islam's (1996) study of Bangladeshi Muslims in Tower Hamlets. Religious ritual and festivals directly informed their diet. Authority of the doctor came second to the authority of God, for some fasting included not taking tablets for diabetes. Religion was also influential in Donovan's (1986) study, her respondents drawing on religion for issues of general illness.

5.2.1 Syncrecy, *difference* and religion

In looking at the influence of religion on respondent s' beliefs and behaviours we can see a distinction between women of differing religions and their use of particular types of discourse. In relating to syncrecy this was not to say for instance that Muslim women's beliefs were syncretic but Hindu and Sikh women's were not. Rather, religious differences were highlighted within the women's accounts regarding the extent of religious influence, influence on public health care consumption and types of discourse used. Muslim women seemed to draw on religion much more than Hindu and Sikh women who used religion much more as a general frame of reference. If we refer back to religious differences relating to particular illnesses we saw how Muslim women drew very heavily on religion during pregnancy and for mental health problems. While Muslim women were very specific about eating hot or cold foods at particular points in pregnancy Hindu women were much more concerned about associated religious traits and their impact on health. This exemplifies the split in the extent to which religion is drawn on. If we look at this quote from Samina, a Muslim respondent, we can see clearly the significance of religion, particularly surrounding issues of pregnancy:

> **Samina:** Yes, I draw on my religion a lot for health. It is particularly influential during pregnancy, in terms of food, prayer and everything. It means a lot.

The quote from Samina can be held in contrast to some of those in chapter three from Hindu women who seemed to draw on religion less, and in differing ways. As Rambha's quote shows:

> **Rambha:** Yeah I'm Hindu, and I am a vegetarian. My whole family is, and it does make a difference. When I was pregnant for the first or second time, I can't remember which one I was told that I was low on iron, very anaemic and no matter how many iron capsules they gave me it didn't work, mum told me I had to drink ribena.

As well as varying according to the extent of influence there were also religious differences in women's accounts relating to their consumption of public health care. There seemed to be much more of a concern within the Muslim women's accounts surrounding the sex and religion of doctor. This related to respondents' use of health care for gynecological and obstetric issues. For instance this is apparent if we look at Samina's account. She cannot visit her local GP for gynaecological issues because he is the same religion and it would not be right for him to see her unclothed.

> **Samina:** Yeah, I like to have a woman doctor. Just the other day, well a couple of months ago, I had to have the coil fitted. My doctor's Asian as well as he's Muslim that means we are the same religion and I don't want to open my legs to him and say put a coil in. I had to ring St Peter's clinic and arrange something there you know with a female doctor (both laugh), could be Asian could be white, don't mind as long as she's female.

This view was supported by a number of the Muslim respondents. However, Hindu and Sikh women within the study were much less concerned with the sex and religion of their doctor. Although some preferred an Asian doctor, few worried about the religion of the doctor and while gender was at times an issue, women within the study preferring to consult women doctors over gynecological issues, attitudes on the whole were far more relaxed, as Sita, a Hindu woman's account shows:

> **Do you prefer to have an Asian GP or don't you mind?**
> **Sita:** Oh, I'm not bothered about that
> **Do you prefer a woman doctor?**
> **Sita:** Sometimes, but I don't mind. It's good with my practice because there are equal amounts of men and women so you can see whoever.

Respondents' beliefs and behaviours also varied across religion in relation to the type of religious discourse used. Eade (1997) highlights the diversity among religious health discourses in his research on Muslim Bangladeshis in Tower Hamlets. As well

as biomedicine he identifies Islamic models, based on Unani, teachings grounded in the Quran and the Hadith and subsequent authoritative texts. He also identifies folk systems located in syncretic customs, often (but not exclusively) based on magic/sorcery. These systems are not seen to be bounded, models can be presented as different for analytical purposes. This is not necessarily the case in lay accounts, where they may not be so separate.

Many of the Muslim women within the study talked in particular about notions of the evil eye and utilised practices surrounding that. Notions of the 'evil eye' and spiritual possession can be found in most cultures throughout history (Worsley 1997). In talking about Southern Italian immigration to the USA at the turn of the century, Kraut (1997) talks about the predominance of beliefs about the influence on illness of one who had the *'jettatura or mal occhto'* (evil eye), a belief that had no basis in the Roman Catholic theology and which the church succeeded in supplanting. Within this research whilst Hindu and Sikh women referred to equivalent phenomena such as the Sikh concept of *'nuzza'* it was mostly Muslim women who talked about this in a specific health context. This was often specifically but not exclusively in relation to issues associated with mental health such as anxiety and depression. Illness attributed to the evil eye can be caused by a number of things and there are believed to be certain tests that can be done to see if illness is caused by the evil eye or not, as Shahnaz demonstrates:

> **Shahnaz:** Like I said if a child has a fever I mean, my sister the first thing she would do is a little ritual to see if it's an actual illness or whether it's just someone giving them the evil eye... You know children if they catch someone's attention. If they like, you know, (pause) just being jealous of someone not in a nice way, that can cause illness.

Shahnaz went on to talk about the rituals of how to tell if something is caused by the evil eye or whether it is real illness. If something is caused by the evil eye this particular ritual will get rid of it:

> **Shahnaz**: She (her mum) just says these prayers then what they do is they get these salts. There are quite a few variations on it but she usually gets a handful of salt and then while she says the prayer she circles the body of whoever she's doing and then at the end of it she puts it in a cup of water and they say you know it helps, 'cause you know salts are, supposed to do the opposite and that will tell you the implication for what it is, if it's just a normal illness or something brought on by the evil eye.

This can be applied to a whole number of illnesses not just mental illness:

> **Shahnaz:** My husband had irritable bowel syndrome so we suggested that he might just have the evil eye, so my mother in-law's sister was actually here at the time and so he got her to do it on him. She did it and has said that somebody had been giving him the eye but it wasn't that which was causing his pain, it wasn't to that extent that it was causing him to feel bad.

In light of the illness not being caused by the evil eye Shahnaz's husband then consulted a western doctor exemplifying a use over time of syncretic discourses. Kraut (1997) notes the temporally located nature of ideas relating to the evil eye. He focuses on Italian immigrants to the USA during the turn of the twentieth century. He argues the relationship of Italian immigrants and their children to modern medicine did not remain stagnant; customs, traditions and beliefs altered with each succeeding generation raised in the USA. There were differences between younger and older generations. At times traditional beliefs associated with the evil eye as the cause of illness still found expression among all generations but such beliefs were not pervasive and their prevalence was linked to an individual's class position. Within this study some women engaged with behaviours surrounding the evil eye. Alongside this women also drew on other non-western and western discourses reflecting syncrecy in beliefs and behaviours.

The argument put forward by Kraut (1997), perhaps unwittingly, seems to suggest an argument of assimilation, the younger the generation and the longer the length of

migrant settlement the more westernized beliefs and behaviours will be. This type of approach seems to suggest a process of assimilation among this generation's beliefs and behaviours with a starting point of non-western beliefs to an end point of westernization. As the accounts of the women researched show this was certainly not the case within this study. The respondents' accounts highlight their syncretic use of discourses. This does not mean they were between two discourses but rather held discourses in tension favouring one or the other at different points in time. They did not slowly progress from one discourse to another in a unilinear fashion as time progressed. As argued previously, beliefs and behaviours reflected respondents' generational position and their position as 'British Asian'. These beliefs and behaviours also changed over time according to illness type and as women progressed throughout the life course this was not in any sense through becoming 'more assimilated'. Rather, many respondents felt they may draw on non-western discourses more as they get older.

Within this section I have suggested that religion holds a general significance for most women within the study. It influences all of the respondents' beliefs and behaviours to some extent. However within the accounts of the women interviewed it became clear that there were differences between women of differing religions and their use of particular health discourses. Muslim women within the study were more likely to draw on religious discourses in all senses while both Hindu and Sikh women seemed much less focused on religion and health. Hindu and Sikh women seemed to draw on religion only as a frame of reference regarding their health. This does not mean that Muslim women's beliefs are syncretic while Hindu and Sikh women's are not, rather it draws our attention instead to different types of syncrecy and diversity within non-western/religious systems themselves. As argued by Porter and Hinnells (1999) religious systems themselves are far from internally coherent. Women draw on different types of non-western discourses, not just those associated with religion. As we have seen in previous chapters, different discourses become prevalent for the women at different times, and in differing contexts, changing as they move through the life course. Certain categories such as religion or community are influential at particular times and in differing contexts. As shall be shown these come to reflect the differing layers of women's identity.

5.3 Layers of Community

Within the study, syncrecy within respondents' beliefs and behaviours was also influenced by community. As argued in the introduction to the chapter, community remains a contested term and has come to mean a number of things. As Jeffers, Hoggett and Harrison (1996) argue, the term community denotes social groupings bound together either by shared identity or shared interests or both. Specifically a community appears to be bound by a shared idea of what its members have and how they differ from others. Its members may have in common a shared sense of belonging to a particular spatial area in which case we may think of the existence of the spatial community. Alternatively a group may find unity in the sharing of culture, religion, lifestyle or other characteristics.

Taking these different types of community into account we can see the multiple levels upon which community operates. Within the accounts of the women in the research, community works on a number of levels. Women within the study most significantly talked about the influence of religious community and of the influence of the more general Asian community. Alongside this they talked about socialising across different communities, both Asian and white, and the influence of this socialisation on health beliefs and behaviours. Within the study, women identify their position as 'British Asian', as women of a particular generational and ethnic group as situating them within a particular way in relation to community. Through this positioning respondents were not 'caught between' differing community types but moved in and out of them. This is reflected with influences on the respondents' beliefs and behaviours, differing layers of community affect the women's use of different types of discourse marking an overall syncretic effect. Within this section I will take each layer in turn to explore their overall effects.

5.3.1 Religious community: the importance of elders

In chapter four I explored the significance of older generations within the family context and how they influenced women's beliefs and behaviours. Women within the study also drew advice from older women within their religious community. Respondents referred to the important influence of these elders on their use of non-western discourses, as Musarat's quote demonstrates:

> **Musarat:** Yes, sometimes you go to the community members particularly elders. They know what's better, they know this is a good cure. Now the Vicks thing I told you about earlier, I learnt that from a community elder.

In this sense community influence can be seen to be an extension of family influence. The community elders of the women within the study were particularly influential in relation to gynaecological and obstetric issues, again this was particularly focused around use of non-western discourses, as Jameela points out:

> **Jameela**: Another thing old ladies from the community tell you is when you are in the later stages of pregnancy, you should eat hot foods. That means foods that are, you know hot and slippery.

While women within the study often draw on their religious community, they also quite often found community to be quite constraining and so influence tended to be sporadic. Inder's quote shows how constraining religious community can be. Inder works in a Sikh community centre and our interview took place there. This was of great concern to other members of the community. This highlights some of the difficulties of interviewing in a community centre context (*see* chapter two; Reed 2000) but also shows the constraints placed by community on women:

> **Inder:** I mean here now. They'll not say, "oh she's got someone with her" (means us in Inder's office). They will still come in wanting to know a) what are you doing here, b) what are you saying to me (both laugh). But they want to know all the bits and bobs, what's going on. They're nosy, let's give them something to talk about!

Within the study, there seemed to signify a diversity within religious community and women often distinguished between generations within the community (like with family). Respondents recognise that there was generational change and felt more at home with members of younger generations. Women within the study identify changes

over time with each different generation and identify feelings of insularity with older generations. This is demonstrated in another quote from Inder:

> **Inder:** But with this generation it's changing,... well the centre itself we've got an elderly centre, an under fives, a disabled group and other activities. It can be very hard at times. I find that people that have been born here or like our (my and her) age are O.K. to talk to, you know but the ones who have actually been born in India or wherever they've come from, they've been brought up in those countries and they're different.

Within women's religious communities, while elders were useful for advice on issues such as health, British born members were much easier to socialise with although these did not seem to have a direct influence on beliefs and behaviours. Respondents' socialisation across second generation women of other religions seemed more significant in terms of influence on beliefs and behaviours. This highlights the multiple layering of community and the many levels of influence on beliefs and behaviours. While community elders' advice was influential (particularly surrounding pregnancy) women also looked to the broader Asian community for general health concerns.

5.3.2 'Asian' communities, crossing religion

Many women within the study socialised regularly with Asian women of other religions. Respondents' health beliefs and behaviours in turn were often influenced by women of other religions. Most of the women within the study had Asian friends from other religious communities, as Sita, a Hindu woman, points out:

> **Sita:** I mix with all types of people here (at the centre). We have a couple of Muslim ladies, a couple of Punjabis, Gujarati, we just mix in fact, and a lot of my best friends are Muslim girls.

While respondents acknowledged conflict across religion as an important historical component of religious history they did not let this stop them from mixing across communities, as Harpreet, a Sikh woman, points out:

Harpreet: Yeah, a lot of people say that we're not supposed to mix with Muslims because of what happened a long time ago, and what happened with our Gods and all that, but you can't take that out on anybody.

This socialising across religions often influenced respondents' use of non-western discourses. Through making friends with other women, women within the study learnt and tried new non-western discourses, this often went alongside the influence of women's own religions, as Sakeena, a Muslim woman, points out:

Sakeena: I have built up quite a social group of women who are Hindu and Sikh. I learn so much from them. They tell me all sorts of remedies specific to their religions and I try them. Some I use regularly. My own religion is also very influential on my beliefs and behaviours. There are so many remedies I have learnt from my mum, and, yes, they are specific to the Muslim faith.

This influence was also extended to giving advice on various western remedies.

Sakeena: My Hindu and Sikh friends will also tell me about western remedies that I hadn't heard of before, they'll say 'oh have you tried such and such from the chemists for coughs.

Within the study, women's friendships with women of other religions can thus be seen to be quite substantial and influence women's syncretic use of discourses.

5.3.3 Inside out, 'Asian' community influence

This socialisation across religions can also be situated into respondent s' position within the wider 'Asian' community. Women within the study at times talk in terms of their religious community and about socialising with other religious communities, at other times they talk much more generally about being part of an 'Asian' community. Ballard (1994) argues that to talk of an 'Asian' community is often to reinforce a fiction. He highlights diversity among South Asian populations

within Britain and argues that any meaningful solidarities between groups must be grounded in active networks. 'Real' communities in his terms are much more parochially organised. Women within this study did talk about an 'Asian' community and as Espiritu (1992) argues this community ranged from localised affiliations to a larger pan-Asian affiliation. The Asian community for respondents within this study was made up of people with Asian backgrounds of various religions. Within the research, this sense of community was both 'real' in the sense that Ballard (1994) suggests, being locally contextualised. It was also both 'real' and 'imagined' in a more global context. This draws on Anderson's (1991) arguments of 'imagined communities' (see chapter 4), connections between Asian diaspora in various contexts at a face to face level remaining mostly within an 'imaginary' realm. However, through the globalization process, with its emphasis on the deconstruction of borders and boundaries, respondents' visits to Asia and Asian diaspora in other contexts can enable connections to become 'real' at certain times. This will be explored in more detail in chapter six.

Within this chapter I will explore the influence of the Asian community in its localised context. Women within the study talked in quite holistic terms about this community and would compare beliefs and behaviours of the community with those of 'white' community members. Gurinder talked about how all communities have their folk remedies, Asian communities being no different :

> **Gurinder:** Asian communities have the same sort of old wives' tales and things as western culture you know, try this remedy or that. If you have a bruise put a chapati or something cold on it. Basically, you know, we have the same sorts of remedies, you know, but I'm one of these people that, you know, I'm going to say oh you shouldn't do this or you shouldn't do that but, if I think it will work I will have a go.

In this sense the Asian community influence was connected to use of folk remedies and advice from older members of the community. Respondents also talked about the Asian community and health care in much more general terms. For instance some women

talked about the inefficiency of 'community' in a health care setting. Sakeena for instance felt that treatment from the community within a health care centre was bad:

> **Sakeena**: ... it's experience, if "your" (Asian community) people are not very helpful. Sometimes you feel that white people are doing the job better and I'm sorry to say that, but this is the way.

When women within the study talked about an 'Asian community' they also emphasised the changing nature of the community with the next generation. Such changes within the community were at times difficult to take. Women related this to general health issues as Sakeena's quote shows:

> **Sakeena:** County hall was looking for an Asian social worker and I applied and got the job. I worked there for 3 months in the family and maternity unit so that was another experience, about how teenage pregnancy was in the Asian community. Our people think this doesn't happen, it's such an eye opener... shocking because girls are pregnant and not a single family member knows, it's a hidden pregnancy... Now communities are accepting that Hindu girls are wanting to marry Muslim boys, but not this.

Women within the study socialised with women across religions and this often affected and increased their use of different types of 'Asian' non-western and at times western discourses. This socialisation across different religions also related to their identification with a much broader sense of an Asian community. Sometimes respondents seemed to see themselves as part of this community and the community influenced their beliefs and behaviours. Women within the research, however, did distinguish between different generations, associating rigid notions of community with their parent's and grand parents' generations. They saw these notions as changing over time and while older generations played a role in influencing their beliefs and behaviours, within this study, women of the same generation were more influential. Women within the study discussed not only socialising across religion, but also the influence of white communities on their beliefs and behaviours.

5.3.4 'Other' influences and the spatialisation of community

Hahlo (1998), in his study on Gujaratis in Bolton, looks at the low number of friendships formed between Gujaratis and white people. He argues that what must not be overlooked are the class differences between those in power and those who labour under them. Women within this study talked primarily about socialising with other Asian women, of the same and/or different religions. However, they did also socialise with women from white communities although, as with Hahlo's study, socialisation was relatively low, as Samina's quote demonstrates:

> **Samina:** Yes, some of my friends are white, I mean I have Asian friends as well.

Women within the study did talk about white friends at times influencing their beliefs and behaviours. Friends often told the respondents about various remedies to use including folk, alternative and biomedical, as the quote from Samina points out in talking about the influence of one of her white friends:

> **Samina:** My friend Jane is white, yeah she sometimes gives me all kinds of health advice.

These friendships and influences often changed as respondents progressed through the life course. Women within the study felt that they socialised with white women more at school and at work; once married, particularly if a woman had given up work, this socialisation decreased. After marriage, women within the study socialised more within an Asian community context, as the quote from Shahnaz, shows:

> **Shahnaz**: I did used to feel more part of that (western culture). But now because I'm not mixing so much, with western culture. I don't feel as if I am part of that any more because it doesn't come into my life as much at the moment.

Do you mix mostly within the Muslim community in Leicester now?

Well I don't even feel as if I'm mixing among Muslim community, just within the family.

Consequently this decrease of contact impacted on white women's influence on the respondent's beliefs and behaviours. At the time of research women's white female friends seemed less influential on women's beliefs and behaviours than other Asian women, or those from the same group. In his study, Hahlo (1998) also distinguishes between degrees of friendship. A relationship based on acquaintanceship carries fewer demands than those imposed by close friendship. Within this study it appeared the case that while women might have white friends these were not close friends. Their friendship also decreased over time which in turn seemed to lessen their influence on beliefs and behaviours. This again emphasises the need to recognise complexity of the positions of the women within the study and the impact of this on their beliefs and behaviours. As argued in previous chapters, influences on women's beliefs and behaviours shift over time as do beliefs and behaviours themselves. Concurring with findings of recent studies on ethnicity and identity (Parker 1995, Woollett et al 1994), respondents within this study are not caught in a process of increasing 'assimilation'. Rather, their position as British Asian enables them to move in and out of differing positions, creating new spaces. In this sense, the respondents' accounts highlight the benefits of the framework of syncrecy which recognises tensions between categories and captures the processual nature of beliefs and behaviours.

Jeffers, Hoggett and Harrison (1996) as noted previously, identify two types of community, those based on people sharing beliefs and values and those configured in spatial terms. Regarding this research, I have so far explored the former through women's accounts. I now want to move on to begin to explore community influence in more spatial terms (space is explored more thoroughly in chapter 6). In talking about beliefs and behaviours, women within the study made reference to neighbours' influence and the importance of geographical context. Here respondents drew on community knowledge from those living close by. Neighbours were sometimes, although not exclusively part of the same religious community. Neighbours seemed to

offer a plethora of advice and respondents seemed to offer them advice both western and non-western. Rambha discusses her husband who has an abscess on his back and consequently suffers a lot of back pain. His doctor recommends when he feels the pain that he lies on a plank of wood. This apparently does the trick and so he passes this information on to a neighbour:

> **Rambha:** Yeah, any time he feels the pain now I've got that wood there and he can just lie on it. I mean my neighbour's said that he's been given this medicine for his back, my husband says to him if you want my advice you'll get a plank of wood and lie on it, so he did and he feels much better!

For the women within the study, while neighbours may not always be influential on beliefs and behaviours, and may be more of a peripheral part of the 'lay referral network', an absence of such was often felt itself to lead to ill-health, as Sita's quote demonstrates:

> **Sita:** Women suffer from depression because they feel lonely and isolated without close neighbours ... You know when you're cooking and making chapati and accidentally you burn one and you feel upset for a while, but then talking to your neighbours you'll say, "Ohhh I burned my chapatis", see then it's out of your system. Well there are times I've noticed no matter how big the problems you have, if you can express it to others, it's on your mind less.

Neighbourly influence also tended to change over time as community groups moved in and out of different areas, as Rukshana's account shows:

> **Sakeena:** Yes, what has happened is because there is a mosque here so even other people like the Sikh community they all sell, moving from here and it is a highly Muslim dominated area now. Wherever the mosque is near, I know that Muslim people find it very handy

because their children are young and they are having to send them there every day.

In her study on working-class communities in the East End of London, Cornwell (1984) found that the importance of community waxed and waned according to account type. In public accounts people emphasised community characteristics of friendliness and concern for others. Their private accounts however, highlighted the overriding importance of looking after oneself and underlined the diversity of community. Her argument is relevant for women's accounts here (although they cannot be split so crudely into public and private accounts). At times community seemed important within the women's accounts at other times this was not so. Within the study, women's accounts highlighted the diversity in extent and type of community influence on their beliefs and behaviours.

In an empirical sense the term community cannot be used holistically. As the accounts of the women show, it incorporates and broadens their family networks and involves a multiplicity of layers including religion, the broader Asian community, socialising across communities, and spatial and other community influence. These all influence respondents' use of particular discourses in differing times and contexts, and to differing extents. Taken as a whole they influence respondents' syncretic use of discourses. Community influence highlights the importance of women's position as 'British Asian'. Through this position of being raised in Britain but being part of a broader Asian diasporic network, women are able to move within and between the layers of community, generation intersecting with community. This in turn influences the respondents' use of syncretic discourses. As argued within this section of the chapter, respondents' relationships to 'community' emphasise the need for an approach which is dynamic and processual, one which moves beyond 'between two cultures' type approaches. Through their position as British Asian, respondents, felt that they actively engaged with differing layers of community. The respondents engage with and draw on these layers, re-inscribing them through their syncretic beliefs and behaviours.

Religion and community influence women's syncretic use of discourses, by process they also reflect the multiple layers of women's identity. It is with this final section of the chapter that I will explore the connections between identity, health and syncrecy.

5.4 Identity and health

As argued within the introduction of the thesis in researching people's attitudes to health we not only get their accounts on health but also people disclose information and make general claims about their overall identity. As Radley and Billig (1996) argue, people do not merely 'have' health beliefs. They also construct their state of health as part of their ongoing identity in relation to others, as something vital to the conduct of everyday life. Health and illness are a significant part of people's identity and the onset of illness often involves a renegotiation of that identity (Mathieson, Henderikus and Stam 1995). Accounts given of health and illness are therefore more than a disclosing of an internal attitude. In offering views, people are also making claims about themselves as worthy individuals, as more or less 'fit participants in the social world. Within accounts personal and social conditions of identity formation continuously interconnect. Autobiographical reflections constantly draw on wider social developments which are framed and understood in terms of personal and familial narratives, cultural identities are constructed through the alignment of personal and collective memories and stories' (Parker 1995: 242).

Within this section of the chapter I want to try to untangle this interaction within the women's accounts to explore the relationship between identity, syncrecy and health. I will explore this mostly within the context of community and religion but will also draw on arguments made in chapters three and four. My aim is first to explore the relationship between respondents' use of syncretic discourse and with a wider sense of syncretic identity. Secondly using arguments made surrounding community and religion I want to explore respondents' shifts in identity over time and the effects on beliefs and behaviours. Different aspects of respondents' identity become more prevalent and more influential at particular times. This in turn affects the beliefs and behaviours of the women within the study at specific times and in particular contexts. As argued in talking about respondent s' identity, their positions within the family and also their conceptualisation of illness are both significant. While these aspects will be reflected

upon here, the decision to focus upon identity in the context of this chapter arose because with issues of community and religion one gets a real sense of respondents' identity as 'British Asian', as argued throughout the chapter.

5.4.1 Syncretic Identities, syncretic beliefs and behaviours

In the Introduction of this thesis I developed a theoretical framework of syncrecy, drawing on approaches used within the study of ethnicity and identity. As Solomos (1988) demonstrates, in much of the literature children of postwar migrants were seen as problems, stranded between two cultures, in conflict with their parents facing the difficulties of two incommensurable value systems. Within studies on identity, dissatisfaction with 'between two cultures' approaches and identity conflicts has led to a move away from static and rigid attributions of identity to a conception of identity less as a fixed entity, a readily measurable attribute or construal and more as a process, an ongoing construction (Griffin 1989).

There is a general reconception of identity through the analysis of diasporic cultures. With this in mind, in talking about the positioning of second generation Asians within Britain Kelleher (1996), suggests that rather than being situated between two cultures, this generational group draws on both parent and western cultures in different ways and in differing contexts. As argued throughout this and other chapters, the concept of syncrecy is used in this context to explore and denote crossovers and tensions between categories of difference, both British/Asian and western/non-western (Parker 1995). With a focus on both crossover and tension between categories the concept of syncrecy, rather than fostering a 'between two cultures' type approach, is a transformative concept allowing for fluidity and change.

Within this study, as women were talking about syncretic beliefs and behaviours, they also talked about their syncretic identity. Many women within the study identified themselves as both British and Asian at the same time, as the quotes from Surinder and Gurinder show:

Surinder: I am British but then I'm Asian at the same time but I wouldn't say I'm totally westernised not like some women my age. I know some of them are English in the way they dress.

Gurinder: A mix of both... I think I class myself as Asian. I'd say I'm Asian because that's the upbringing I've had and the culture I've had but I've had western influence as well. I've had the best of both worlds. Yes, I'm British Asian, I wouldn't say that I was Asian wouldn't say I'm British. I'm British Asian, a mix of both.

This identification as British Asian has multiple layers. While women within the study sometimes liked to identify as British Asian at other times they talked in much more religious terms, for instance identifying more as British Muslims with an Asian background, as Samina's quote stresses:

Samina: Yeah, that's right and I'm a Muslim, yeah I'd like to be a strong Muslim you know and do what we're supposed to do but because we've been born here and brought up here and we've socialised in a way with children of different religions and we're seen everything and so want to be a part of it 'cause that's where we've been from the beginning.

This layering of identity again highlights the need as Solomos (1988) argues to move away from approaches which do try and fix the identity of children of post-war migrants, allocating them 'between two cultures'. As the accounts of the women researched here suggest, identity is much more processual and syncretic.

Hahlo (1998) in his study on ethnicity, community and politics among Gujaratis in Bolton highlights this multiple layering of identity. He argues that in relation to members of other ethnic groups or white communities, Gujaratis often describe themselves as Gujaratis. However when differentiating themselves and other Gujaratis they distinguish between belonging to a community such as a caste community and others belonging to other caste communities. Women within this study differentiate

themselves in similar ways although this is not necessarily based in spatial terms as with Hahlo's (1998) respondents. Rather women move in and out of categories of religion to broader categories of Asian identification. Again this is reflected in beliefs and behaviours as demonstrated earlier through religion and the multiple layers of community.

In chapter four, I looked at the clash in beliefs and behaviours between women within the study who identified as British Asian and husbands who were from India. This clash often led to health problems for the women. This can be translated into general conflicts in identity between women born in the U K and husbands from India, as Samina's quote demonstrates:

> **Samina:** Yeah, I'd say I was British Muslim, that's what I'd like to say 'cos that's the way that I can identify myself because that's what it is you know like. I'll say to my husband when we're having a row or something you know or if we're talking I say "shut up, I'm British you know" and he will say "look at you you're not exactly English are you", and you know it's your mentality that's the way it is because my husband he's from back home (India). We do have a lot of differences. You know 'cos that's when I realise that there is a lot of difference between people from back home, no matter how long they've lived here they still go back to India.

As argued previously in earlier parts of the thesis, respondents' beliefs and behaviours change over time as they progress throughout the life course. This is reflected in the identity of the respondents , their identification as 'British Asian' changing as they get married and have children. Woollett *et al* (1994) in their study on gender, ethnicity and identity among South Asian women in London focus on changes in ethnic identity over time as women marry and have children. They argue that over time women adopt a lifestyle of the dominant culture but this is not just about increased familiarity with culture. Changes are also related to the women's own position within the life course, changing in particular on becoming a mother. Within the accounts of the women I researched, women identified changes

in their identity over the life course. This involved a pull to and away from westernisation emphasising a syncretic tension, a position more fluid and complex than one couched between two cultures. Some women often identify their identity as changing over time as they progress from young working women through to marriage and motherhood (chapter 4). Often this involves moving through different states of influence, as Shahnaz shows:

> **Shahnaz:** I think as I've got older and especially since I've stopped work and I've got kids and everything. At this moment in time I see myself more as a Muslim person with an Indian background. Whereas whilst I was still working and before I was married and everything I saw myself as British Indian you know. I tended to feel more British. I feel 'now' more (pause) my lifestyle's changed especially since I've finished work I'm usually at home. I'm very restricted in my social circle. It tends to narrow the field a lot and it does obviously alter your outlook on how you see yourself and how people see you.

In talking about their health beliefs and behaviours women within the study made claims about their identity. In general most women identified as British Asian, at times this varied in specificity, women often identifying themselves by religion. For women these differing categories can come into conflict, particularly for women married to men born in India, East Africa etc. These categories also transform themselves as women progress throughout the life course.

In moving through time different layers of respondents' identity become more central to them at certain times, and this translates down to their health beliefs and behaviours. For instance, religion sometimes as shown in the previous section is a particularly significant part of the identities of the women within the study. Sometimes being 'Muslim' or 'Sikh' overrode other aspects of women's identity. This was reflected in respondents' beliefs and behaviours and became a central influence on their use of different types of health discourses. As already argued, in some women's accounts at particular times, such as during pregnancy and

childbirth, religion seemed very important in influencing their health beliefs and behaviours. The consumption of 'hot' and 'cold' foods at certain points of the pregnancy seemed to be particularly important for Muslim women in the research. The Hindu and Sikh women within the study were less focused on diet in pregnancy and did not talk about food in terms of 'hot' and 'cold' properties. At other times differing factors appeared more prevalent parts of the respondents' identities than religion. For example, in looking at community influence, sometimes women identified with a much broader category of 'Asian' and this was reflected in women's beliefs and behaviours (this will be discussed further in the conclusion). On occasion women within the study drew heavily on advice from Asian women of other religious communities. This enabled women to use non-western discourses not necessarily associated with religion.

Women within the study move through these different states of identity and differing influences on their beliefs and behaviours. These influences are in dialogue with one another. They also conflict and contradict one another as differing contextual influences fight for recognition. Differing contextual circumstances influence syncretic use of discourses in differing contexts determined historically, locally and personally. This point is explored more fully in the conclusion. These parts of the respondents' identities and influences on beliefs and behaviours are not seen as fixed but as continually shifting and being reconfigured in the light of change, depending on what they were talking about, who they were talking to, and their temporal location. It is important to recognise that any one part of the respondents' identity, such as class or religion, may be more important at any one time, and that these interrelate across the women's accounts fostering syncretic identities and beliefs and behaviours.

5.5 Conclusion

Within the chapter I have focused on the influence of religion and community on syncretic use of discourses by the women researched. I have explored this in the context of health and identity looking at how religion and community intersect in differing temporal contexts reflecting syncretic identities. Within chapter three I took a micro view of syncrecy and illness. I explored how respondents' syncretic use of discourses varied according to particular illnesses. Respondents' beliefs and

behaviours were seen to be more syncretic for some illnesses and less for others and also types of syncrecy varied according to illness. Similarly within chapter four I explored the significance of family context and positionality in the life course on respondents' beliefs and behaviours. Within the study, women's syncretic use of discourses varied according to women's position within their family and within the life course. Within this chapter, I have drawn on arguments raised in both previous chapters to explore the influences and reflections of religion, community and identity on the women's health beliefs and behaviours.

In analysing women's accounts on health what has become clear is the influence of women's religion on their beliefs and behaviours. Religion played a significant role for many of the women within the study at differing times and contexts. Many of their beliefs and practices were directly related to religious rituals. However, the extent and type of religious influence and discourse used varied according to women's religion. For instance Muslim women seemed to draw both directly and indirectly on religion for health whereas Hindu and Sikh women were much more likely to draw indirectly on their religion. Differences in religion influence respondent s' consumption of public health discourses. This does not mean that within the study, Muslim women's beliefs and behaviours are syncretic while Hindu and Sikh women's are not. Rather, that respondents may draw on both western and non-western discourses but they do not all draw on the same types of discourses. The diversity within the category non-western must be highlighted here. It must also be recognised that religious influence is temporally specific, often changing over time and context.

Community also influences the beliefs and behaviours of women in the study. The women's accounts highlight the multiple levels upon which community operates, including religious communities, the broader Asian community, not to mention socialising across religious and racial communities. Women within the study identified their position as 'British Asian', as enabling them to move within and between these categories, different types of community influencing beliefs and behaviours at differing times and contexts. Again with regard to community this highlights the complexity of respondents' positions and shows the inadequacy of 'between two cultures' type approaches. Respondents were not in particular community positions, between

generations, between parent and 'western' communities. Rather, women within the study moved in and out of community experience and influence. Within the study, community influence varied in extent and type. For instance influence from the respondents' religious communities came mostly from female community elders and focused on rituals and remedies associated with pregnancy and other gynecological issues. Influence of women from other Asian communities seemed to come from women of a similar age and advice focused on folk remedies (both non-western and western) of differing kinds. Influence from white communities existed but played a more minimal role in influencing beliefs and behaviours. The operation of community on a multiplicity of levels has the overall effect of pushing women towards using syncretic discourses.

Religion and community (along with other categories e.g family) are interlinked and come to form part of the multiple layering of respondents' identities. The influence of both on beliefs and behaviours can be seen to be temporally located and form part of women's multifaceted and syncretic identity. This relates to the disclosure within the women's accounts of the broader processes of their identity construction. As Radley and Billig (1996) argue, when people talk about health they are not merely articulating knowledge about health and illness but also their identity and situation in the world. Within the research, as women talked about health they also articulated how they felt as 'British Asian' women drawing on syncretic categories for identity formation, again transcending the 'between two cultures' binary. This was particularly felt during women's accounts on religion and community although, as already argued, family and women's conceptualisation of illness itself are also significant. Different parts of the respondents' identities were prevalent at differing times and contexts, some times religion was important, other times family, other times illness, or community. Similarly, different categories influenced respondent s' beliefs and behaviours at different times and in different contexts: at some times it was religion, at other times community. Women within the study moved through differing aspects of identity, just as they move through differing influences.

In demonstrating the significance of religion and community on beliefs and behaviours, and the reflections of identity in health accounts, I have also begun to explore the importance of spatial context on the respondents' use of syncretic discourses. Within the women's accounts women's location in Leicester and also their connections with Asian diaspora in India and other contexts is very influential on beliefs and behaviours. It is to these I will now turn in the fourth and final substantive chapter.

Chapter 6
Mapping syncrecy: local/global spaces of health

6.1 Introduction

Within the previous chapter I explored the influence of religion and community on the respondents' health beliefs and behaviours. I argued that both influenced respondents' syncretic use of discourses at different times and contexts and situated this use within the wider context of identity. Within the section on community I also began to explore the influence of space and location on respondents' beliefs and behaviours. Within this final substantive chapter I will explore these influences in more detail. Space, geographical location and the reciprocal nature of globalization are all significant variables of influence within this study. What has become apparent within women's accounts is the importance of their location in Leicester and their connections and resources within India. Within the study women identify their location in Leicester as giving them access to a variety of health discourses. Respondents' connections with India also geographically extend their access to a plurality of discourses. These connections are strengthened by processes inherent within globalization, fostering the transcultural flow of syncretic health goods and enabling the respondents' syncretic use of discourses within India. Syncrecy is then opened up in local and global contexts.

Existing literature on space and geographies of health has come from two very broad approaches. The first takes a top down approach and focuses on the globalization of health systems (Turner 1987). This focus maps the globalization of health systems in political terms, focusing on free enterprise systems, welfare forms, transitional and socialist types and maps these systems in different geographical contexts. In this approach medicine in the modern period is mapped along the world economic system which has become the common basis for a number of common institutional responses to illness and mortality. Taking a slightly different angle, other top ended approaches have focused on

geographical inequalities in health, and health care. Such studies in geographical inequalities have often been based on epidemiological type studies. These studies have often focused on inequality along gender, race and class lines as well as on divides in health between northern and southern countries (Doyal 1995).

The second approach, takes the opposite focus which is more anthropological and historical and focuses on geographically mapping plural medicine. Its takes a historically comparative approach to the issue of plural medicine in different countries. The approach includes historical explorations of the existence of plural medicine in various geographical locations, for instance, the co-existence of Unani Tibb, Ayurveda, Sidha and western medicine in India and their spread to other parts of the globe through migrants (particularly to the Arab world). The spread of these systems is diverse. As Meade, Horin, and Gesler (1988) argue, some medical systems tend to be spatially static while others have diffused over wide areas. In either case the result is that various systems overlap in the same space and that most people have choice of medical systems.

This focus on plural medicine also fits in with current debates on the growth of alternative medicine in the west, and the re-emergence of plural medicine in so called western contexts. As West (1992) argues, alternative medicine is witnessing an increase on a global level particularly, in western countries. Worsley (1997) argues that today western medicine has become the single most influential kind of medicine globally. It has achieved a degree of cultural hegemony which enables powerful states and corporations to extend their global reach and influence. At the same time, traditional kinds of medicine not only continue to exist but have spread outside the areas of origin, and the new ones are constantly spreading and developing. In the medical sphere then, culture and structure are by no means congruent with the nation state. These types of approaches are further diffused through qualitative studies already referred to in the introductory chapter, those that follow migrant and minority beliefs and behaviours and experiences of health and health care, and plural medicine in western contexts.

Both of these approaches touch on the findings relating to space and health in this study, particularly the latter. The latter approach highlights the ways in which medical systems become diffused over geographical areas both past and present. This helps us to explore respondents' potential access to plural discourses in Leicester and elsewhere through their membership of a particularly mobile diasporic group with associated medical systems. These approaches however do not really enable us to explore how these connections between diasporic groups and contexts are so readily possible for the respondents within this study. In order to explore this more thoroughly I also draw on a third body of literature which focuses more heavily on wider debates on globalization. One cannot talk about respondents' use of health care in India and the transcultural flow of health products without referring to these debates. Massey (1994) has argued that we are now living through a period of intense spatial upheaval, an era of new and powerful globalization, of instantaneous world wide communications, of the break up of what was once local coherence, of a new phase of time/space compression. There is emerging it is argued a new global space of electronic information and power relations.

More generally, it is argued that culture is being globalized through the emergence of global products, the popularity of world music etc. The link between culture and place it is argued is being ruptured. Each geographical 'place' in the world is being re-aligned in relation to the new global realities. Their roles within the wider whole are being reassigned, their boundaries dissolve and they are increasingly crossed by everything from investment flow, to cultural influences, to satellite networks etc. This is reflected in women's accounts through their frequent travel within the UK and to India for health reasons. It is also reflected in the transcultural movements of health goods. There appear to be no barriers to respondents' access to plural health care in plural contexts enabling them to carry out syncretic practices in a plurality of locations.

However what is apparent in the accounts of the women researched, is that at the same time as the move to the global, there is also a return to the local and place bound traditions.

Freidman (1994), argues when looking at global process one can not just talk about a move to globalization in terms of cultural decentralisation. He argues what is important to recognise is the interplay between the world market and cultural identity, between local and global processes, between consumption and cultural strategies. The local and in particular women's location in Leicester becomes particularly important within this study in influencing respondents' syncretic use of discourses. As Hall (1996) argues, we must not simply condemn globalization as cultural homogenisation. He identifies the oppositional nature of postmodernity; the return to the local as a response to the seeming homogenisation and globalization of culture and argues that this can work for social change only if it does not become rooted in exclusivity and defensive enclaves, local as purer than the global. In following Hall (1996) I argue, it is important to recognise the interplay of these two, both local and global within women's accounts and seeing not one or the other as in some sense purer but as equal.

This chapter continues many themes prevalent throughout the thesis but situates these within a bigger picture. Within the chapter, I will explore the influence of the respondents' location in Leicester on their syncretic use of discourses. The women within the study feel that their location in Leicester gives them access to a variety of discourses which they then draw on syncretically. The respondents' employment of such products again will be explored within the context of their position as 'British Asian', as women socialized within the west who are also part of a wider globally dispersed ethnic group. Again the dynamism of this position is emphasised against static between two cultures approaches. This section will also explore the respondents' use of other non-western discourses, particularly in the context of global increases in alternative medicine in general. Secondly, within the chapter, I will explore the way in which women within the study take and bring back a plurality of health goods to and from India. This transcultural flow of goods highlights the significance of the South Asian diasporic network, enabling women the potential to draw on syncretic discourses in a multiplicity of locations. This potential to draw on these discourses in different locations is then made easier through the globalization process. In its emphasis on

the deconstruction of borders and boundaries, globalization makes possible the movement of goods between the local *and* global. Drawing on arguments made in the previous chapter, such processes of globalization open up the possibility for connections between diaspora in differing contexts to become real, that is based on face to face interaction. These connections once only imagined become real when respondents visit India and other Asian diasporic contexts.

Within the last section of the chapter I will explore the respondents' syncretic use of health products and services within India. Again this emphasises the respondents' connections through diasporic networks and the fostering of such links through globalization. Women within the study are able to connect regularly with members of the South Asian diaspora in other locations. This has opened up access for women within the study to health products and services. However, this use of discourses among the respondents is not straightforwardly unanimous. Within this section, I will also explore the influence of respondents' locational background (i.e. respondents with an Indian background, those with an East African background) on their use of syncretic discourses in India. East African women within the study being less likely to draw on syncretic discourses in either India or East Africa.

6.2 Localizing the global, Leicester in a national context

As argued within the introduction, according to 1991 census data (Leicester City Council 1991) Leicester ranks fifth in terms of absolute numbers of all ethnic minorities; second for all Asian groupings; first for its population of Indian origin but only thirty fifth for those who classified themselves as black. However, outside the London area it is the local authority with the highest percentage of all ethnic minorities. According to the same census data 23.7% of the population of the district of Leicester are of Asian origin. This is compared with 71.5% white, 2.4% black, and 2.4% ethnic other (Leicester County Council 1991).While Leicester's Asian population includes Ugandan, Kenyan, Tanzanian, Punjabi, Pakistani, and Bangladeshi, the population is heavily weighted towards East African

Asians and Gujarati people, both Muslim and Hindu). As argued in chapter three, several women within the study had moved from other parts of England to Leicester to marry. Such women came mostly from Blackburn, Birmingham and London. The women from Blackburn were all Muslim, those from Birmingham were Sikh and those from London were Sikh, Muslim and Hindu. The majority of women who had been born in Leicester were Hindu. Within the study, there were 6 women with an East African background, 22 within an Indian background (two of whom had migrated to the UK via other parts of Europe), one respondent with a Pakistani background and one with a background in the Carribean. Within the study, 14 women (those not British born) had migrated to Britain initially from either East Africa, India or Pakistan, with one respondent from Trinidad. Women within the study from countries other than Britain had quite frequently moved through several places in Britain before marrying and settling in Leicester.

Jeffers, Hoggett and Harrison (1996) argue that Leicester is a city where boundary crossing interactions between various minority and white populations are significant. It is also argued to have a close-knit traditional Asian community as compared to other areas such as Blackburn and London, which have smaller and more scattered populations (Jeffers, Hoggett and Harrison 1996). Because of the significant amount of people moving to Leicester to marry, these regional differences become mixed. Respondents tie this in with the large South Asian population and its concentration in particular areas of Leicester. As Gurinder's quote suggests:

> **Gurinder:** Yeah, there's a lot of Asians here like they've kept their traditional values whereas if you're scattered around you've got no option but to mix in and let go with a lot of your culture, so I think that does make it difficult but I mean in London they have their towns that are just like Leicester, you know with lots of Asians. But where we lived in London, it was just mixed.

Many women within the study talked about how racially mixed Leicester is and how this impacts on choice and use of (western) health care. On discussing the respondents' preference of either a white or Asian doctor, some women within the study preferred to have a white doctor. However, because Leicester has a large Asian population and because Asian communities were housed within the same locations (*see* Appendix A pp 212-214) Asian doctors were often the only option. As Samina, a Muslim woman originating from Blackburn and living in Leicester commented:

> **Samina:** No actually I prefer a white English doctor yeah, but here, since I've moved to Leicester in the last six years I think I've seen more of the Asian community, well I think that 80% of the population is Asian, that's what I've noticed. I mean Blackburn's a little town there, but there's a lot of Asian people there but at school you see white children. In the doctor's surgeries you see white people, whereas here, if I do see a white person I think, yeah, hello.

Such an emphasis on Leicester's significant South Asian population as compared to other places in Britain is reflected in the census data. If we look at the total Asian population in Birmingham it stands at 13.5%, the population of Bradford at 13.3%. Both areas are known to have large South Asian populations. In terms of total Asian population, Leicester stands second only to Tower Hamlets with an Asian population of 24.7% (Leicester City Council 1991). Respondents as will be shown, also identified this large Asian population in Leicester as affecting their health beliefs and behaviours.

6.2.1 'Don't forget the tiger balm': syncrecy in Leicester

Women within the study felt that their location within Leicester gave them access to a plurality of health discourses, both in terms of products and services. This enabled them to draw on syncretic health discourses. Within the study however, a distinction was made in terms of use of services and products with respondents drawing more heavily on products.

In terms of Asian medical services, Leicester has one Ayurvedic clinic. There are also a number of Hakims who practise the Muslim medical system Unani, a faculty of Tibb eastern medicine. While being aware that Vaidas and Hakims' (Hindu and Moslem healers') clinics existed in Leicester, views on the availability of, use of the services and satisfaction with them were mixed. Hakims were quite widely talked about and many women knew of clinics and practitioners. Sakeena talks about her knowledge of alternative practitioners:

> **Sakeena:** I know one Hakim in Leicester, up on Evington road. I also know an acupuncturist, our doctor's surgery is now including acupuncture.

Most of the women within the study were quite cynical about them though and saw Hakims and Vaidas as unsatisfactory, and too expensive. Sita's account was not uncommon among respondents:

> **Sita:** There was this guy, this Vaida, he charges you £25 per session and after 4 sessions he will tell you if you are going to be fully cured or not. I mean he's got a £100 out of me and after that he says you're not going to be cured, why should I, you know, throw my money away in the bin as well as my confidence?

Many women within the study were worried about coming into contact with someone who was not properly qualified. This applied to both Ayurvedic clinics and Hakims. As Sita remarked:

> **Sita:** Yes, now that holds me back, what if I come into contact with someone who isn't fully qualified? People practise and they say they are qualified but I don't know, somehow I'm reluctant to use it.

This line of argument is supported by Karseras and Hopkins (1987) who suggest that, while healers in the subcontinent must be qualified, this is not so in Britain. Anyone can call themselves a Vaida or a Hakim with the obvious danger that patients suffering from a serious but potentially treatable condition could be consulting an untrained person with little experience. Women within the study were less likely to hold these types of views about western medical practitioners in Leicester.

Within the study, access to Asian products appeared to be far more important than use of Asian medical services. Women were much more likely to use Asian products than they were to actually visit official Asian medical healers. In talking about the availability of products in Leicester, Samina, a Muslim woman originally from Blackburn, argued:

> **Samina:** In Leicester I've seen it [laughs], you can get everything in Leicester, where I come from, in Blackburn, we always get them sent down from India. Tiger balm, don't forget the Tiger Balm!

This was a quite commonly held view, particularly when women within the study talked about balms for general health. Women within the study also talked about the availability of 'Asian' herbs within Leicester for general health. As Kishwar shows:

> **Kishwar:** Highfields or Melton Road, there are lots of like herb shops, selling Asian herbs you know to use for general health, Jaipur mill etc, cash and carry's and places like that, it's easy to get that stuff in Leicester.

Respondents related this issue of significant availability of health products in Leicester with the multi-cultural nature of the city. As Sakeena's quote highlights:

Sakeena: I think the reason is, it is easier to get here because it's very multi-cultural in Leicester and Leicester is not a very big city. I suppose if you don't find one thing in Evington area about a ten minute drive and you can, or Highfields you can find it. Say you were living in London and you live in the East, you have to go up west and get your products and that takes ages.

Women within the study appeared very proud of their knowledge of these products and even of Asian health care within Leicester. I would argue this gives us our first example of what Clifford (1997) calls 'Diaspora discourse' which blends together notions of both host and homeland, connecting members of the South Asian Diaspora in a number of locations and aiding access to a plurality of products and services. Health goods flow between members of the South Asian Diaspora in different locations, from Leicester through other national and international contexts.

Many respondents talked about the use of other health products or health care which were neither western nor south Asian. Women within the study also went to visit alternative practitioners such as those practising acupuncture; this was mostly for general illness, such as hay fever, and bodily aches and pains. Kishwar talked about her husband's use of other alternatives:

Kishwar: I have taken my husband to a Chinese herbalist just off Evington Road. It was to do with his hay fever.

Women within the study went to other cities in order to get certain treatments or visit particular healers. Respondents found out about alternative practitioners and clinics in other contexts through friends' recommendations. They often sought out healers in other places when they had exhausted health care resources within Leicester. Kishwar discusses going to visit other healers in other places:

Kishwar: Someone at lunch mentioned that there is a herbalist in Manchester who is from Saudi Arabia and I've said yes to going to see him.

Indian health care services and more importantly health care products are reasonably widely available in Leicester. Other types such as traditional Chinese medicine, though available, are less easy to find in Leicester. Cant and Sharma (1999) argue that many British studies have shown that there are regional differences in the use of alternative health care. The north of England has much lower levels of consultation (Mori 1989), this may however reflect the greater number of practitioners and training schools in the south (Thomas 1989). Southern bias regarding some alternative therapies such as reflexology, chiropractors and homeopaths perhaps affects respondents' use of some therapies (Cant and Sharma 1999). Respondents' position as 'British Asian', as members of an ethnic group in a location with a significant South Asian population with broader diasporic connections, gives them access to Asian medical discourses. A small Chinese population in Leicester (22% Indian compared to 0.3 % Chinese Leicester City Council 1991) may also limit the availability and use of traditional Chinese medicine by the respondents.

Respondents' use of a broad range of non-western products is related to their dissatisfaction with western health care services within Leicester as Lata, a Hindu respondent, suggests:

Lata: Well we weren't happy about the care we were getting with the GP or at the Royal (Leicester Royal Infirmary) so we decided to try some alternatives, it made sense to.

This reflects the broader picture of an overall growth within Britain in the use of alternative health care. It fits in with general arguments (made throughout the thesis) about

dissatisfaction with approaches in western health care. As Worsley (1997) argues, many people in Britain, after consulting their GP, feel dissatisfied and turn to experiment with non-western medicine. Women in the study were on the whole quite keen to replace use of western health care with alternatives, although none expressed a desire to utilize only alternative practices. As Gurinder explained, women also linked increased use of alternative health care with more general shifts in the National Health Service, and western society in general:

> **Gurinder:** I think it is age but it is also with the way society is. I mean it is not always the answer and the doctors don't always diagnose you the right way. I think it is the way the NHS is going.

It is important to recognize power dynamics within this global spread of non-western discourses. It must also be located within the argument of the wider issue of the power of global marketing and health (Morley and Robins 1995). The marketing of cultural products through the electronic mediascape is important. This indicates a celebration of ethnic difference in a very post-modern sense, making difference not only acceptable but also fashionable.

Despite the scepti cism of respondents towards western health care in Leicester, they did tend to use non-western discourses syncretically with western discourses at different times and for different reasons. As Jameela's quote shows:

> **Jameela:** Well you know it's good because I can get my balms and stuff in Leicester, like tiger balm and that. But I do go to my doctor and get stuff from the chemist, you know, like paracetemol.

As argued throughout the thesis, respondents identified their position as 'British Asian', as giving them access to a range of cultural resources not readily available to other

populations in Leicester. This relates to their membership within a wider diasporic network. As 'British Asian', women in the study occupy a unique position more dynamic than one caught between two cultures. Respondents have access to both western and non-western health discourses through western socialization and as part of an ethnic minority group, which is geographically dispersed. Because of the ability of diasporas to connect multiple communities, women within the study are able to access a whole range of products and services within Leicester. In particular, respondents' location in Leicester and their position as British Asian women enabled them to draw on syncretic discourses, drawing on both western and 'Asian' medical discourses. While other 'alternative' discourses were not quite so available within Leicester, women within the study still drew on them when feasible. This also highlights, at a general level, the increase of alternative medicines. Within the next section I will look at how the use of these syncretic products is extended from along local and national lines to global contexts, focusing on the transcultural flow of goods and capital.

6.3 From here to India (and back): the transcultural flow of health products

Much of the literature on globalization (Clifford 1997) looks at how separate places become effectively a single community through the continuous circulation of people, money, goods and information. This culturally homogenizing type of argument has been heavily criticized; as Grewal (1994) argues, such reference to transcultural flows of goods should be seen instead as scattered hegemonies which are the effects of mobile capital as well as the multiple subjectivities that replace the unitary European subject. As other authors have pointed out, the movement of any forms of capital in a global era should not be seen as one way. Relating to health, Worsley (1997) argues that today, so great is the flow of people and ideas across the globe, cultural exchanges overcome political barriers. He argues that though western remedies may diffuse particularly rapidly, the traffic is not all one way. Within the context of diasporas, globalization with its deconstruction of borders and boundaries makes it possible for products and people to traverse diasporic networks particularly efficiently. This current phase of globalization enables the possibility

for connections between Asian diasporas in the UK, Asians in Asia and diaspora in other locations to become 'real' at certain times, that is, based on face to face contact. These connections for first generation migrants, initially on migration during the 1960s and 1970s were mostly only 'imagined'.

This is reflected in respondents' accounts when they talk about how they buy health products both western and Asian from other contexts, and bring them back to the UK and also taking certain things out to other countries. Women within the study move syncretic products reciprocally between India and Britain. This occurs when respondents are on holiday or visiting family. Such exchanges mostly take place between Britain and India. I argue that rather than seeing this as evidence of either cultural renaissance or homogenization, it relates rather to the push and pull of both local and global forces, which form part of the process of globalization as national boundaries are opened. Women within the study go over to buy non-western *and* western health products, which are then circulated within the local context. At the same time the reciprocity of the local/global process is emphasized through taking goods over to India and dispersing them within family networks there. As Sita explained:

> **Sita:** I take multi-vitamin tablets, my family in India really like us to take them if anybody's going over (to India).

Women within the study took health products from the UK over to family in India and various other places because family members saw them as better than the things available there. These were mostly things like vitamin tablets and pain killers. Women within the study also talked about certain products they went to India to buy. In discussions on cultural pluralism, India is often cited as a premier example (Meade, Horin and Gesler 1988). It has many variations in language, religion and social status and other cultural traits. Such pluralism is also reflected within health care in India, Ayurveda, Sidha and

Unani being prevalent from about 15th and 16th centuries followed by the subsequent implementation of biomedicine (Meade, Horin and Gesler 1988). Women within the study drew on such plural health systems in India, syncretically. Respondents' need to draw on these resources in India depended on their location in the UK and for women in Leicester, as already demonstrated, they could access most South Asian balms from Leicester. Women within the study went over to buy non-western goods already available in Leicester, mostly because it was cheaper to get them from India, as there you do not pay VAT. As Kishwar's quote shows:

> **Kishwar:** Oh yeah, I always stock up on everything when I go over there (India). I mean it's cheaper there. You probably pay a few Rupees over there and £3 for the same thing here (UK). My stock comes mostly from there, but if I was desperate I know that I could still buy things from here if it was a problem.

Respondents had to go to India to obtain some Asian balms. There were also other non-western health products relating to skin products that women within the study bought in India which are unavailable in Britain. As Gurinder, a Sikh woman, argued:

> **Gurinder:** My dad has psoriasis and he's had medicine from India for that. There's this special tablet that I think is specifically for people with eczema and psoriasis. It worked on him; it is like a little herbal remedy you get from India.

Other goods that respondents went to India to buy specifically were herbal tablets for diabetes. Some women also went to India for specific western health products, because certain things are available there that are not in Britain. Ramila, a Hindu woman, talked about going to India for diet pills:

Ramila: Next time I go (to India) I want to get a diet pill that makes you lose weight, that you can't get here. You can get that there. You know amphetamine, what you used to be able to get here but are banned now.

Again within the research, women's position as 'British Asian' affected their access to a plurality of health resources. This was most notable in two different ways: British Asian women appear to have greater access to Asian medical products and services because they are part of an ethnic group with greater access to products and services through the South Asian diasporic network as argued previously. It is also the case that the women's status as part of a mobile group with a significantly globally dispersed network, also heightens access to both western and non-western products in other contexts. This again illuminates the respondents' position as one which is dynamic. It enables women within the study to draw on syncretic discourses within contexts other than the U K. These types of cultural exchanges on a global level have been demonstrated in other research on diasporic communities, not however relating to exchanges in health products. Parker (1995) argues in his research on British Chinese that their connections to places of origin are made through material exchanges. Cultural commodities from Hong Kong are exported within days to distribution companies in France, North America and London.

Some women within the study felt quite cautious about either sending things over to India or bringing them from India back to Britain. This is because they were cautious over the content of products bought in India. This could also be related to respondents' caution about breaking the law regarding non-payment of tax duties and importation of banned goods. In this sense sometimes women within the study would talk about buying and bringing things back only when someone else had already tried it.

Gurinder: If I, or my husband, had an illness such as psoriasis and someone told me "oh there is this medicine from India", I would try it. If I

knew someone else that had used it and I knew that it had benefited them then I would try it.

Women within the study also talked about the flow of labour between countries (in this case India and Britain) and the way in which people received work qualifications in different countries. When talking about biomedical doctors in India, many women talked about how they got their medical training in the UK or America.

Musarat: But you know, sometimes even the doctors there (India), I'm not saying they're qualified here (UK) and not there, they get their training over here. Yeah, then they go back. Most people come over here, London or Cambridge.

This often impacted on whether or not women trusted doctors in India.

Within the study, women's position as 'British Asian' as part of a globally dispersed group gives them the connections enabling them to draw on a plurality of discourses in other contexts. Globalization with its emphasis on time/space compression, deconstruction of borders and boundaries, global telecommunications, cheap air travel etc fosters connections between them and diaspora in other contexts and India. It enables the respondents to spatially extend their syncretic use of discourses, making 'imagined' connections between diaspora in different times and contexts (and homelands) become 'real'. Through such positions and processes women within the study were able to draw on syncretic discourses cross-nationally, moving products between India and Britain. It must be recognised here that women within the study make these trips regardless of socio-economic position. All women within the study had made trips to India at some point.

Within the next section, I will extend some of the arguments made here, to explore the way in which women within the study, through similar processes, use products and services syncretically within India.

6.4 Using syncretic health products and services in India

Many women within the study were open to using western health care in India, or had used health care there generally if they needed to when visiting. It was also common for respondents to use health facilities in India for specific treatments. Musarat talks about someone going to India from Britain specifically for eye treatments:

> **Musarat:** When we went over to India we met up with this guy. He had an eye problem and he went over there specifically because of this eye problem and he was a lot better. He had an operation in India and he was a lot better, he lived here (UK) in Walsall.

Some women within the study even had a family doctor in India, in case they needed to use one when they visit family. Respondents often explained this use of health care in India by reference to its cheapness. However, it also appeared that women used it because of marked differences in care between Britain and India and in some respects treatment seemed better in India. This reflects Worsley's (1997) argument, that despite the internationalism of western medicine, marked cultural differences persist in each country. Women within the study talked about how you could go private in India and pay a lot less but get good treatments; Gurinder related this to being viewed there as being 'from abroad':

> **Gurinder:** To them 100 or 200 rupees, it is like private so, and getting your best treatment just for a little bit more so I would prefer to. You know that

little extra care, particularly if you're from abroad; they do treat you a lot better in India.

Women within the study went to India for various treatments because they felt that they performed them better there.

Many women within the study talked about how they used health care in India when they felt they were not being treated properly in the UK. As discussed in chapter three, Shahnaz talked about how her sister in-law's husband died of cancer. He had been mis-diagnosed in the UK so went to India and was treated more promptly, albeit too late to save his life.

Shahnaz: He wasn't actually seen until the September of 1996, they said there wasn't anything wrong with him. In December he was getting worse. He changed GPs and the new GP realized it was bad and finally got things rolling. The state of his health deteriorated so much that he eventually went to India. Within the first doctor, the first examination he had, they diagnosed him as having cancer.

Shahnaz felt that if her relative had finished his treatment in India he might have survived. Such dissatisfaction with western health care was located in the women's accounts around more general arguments about poor standards within the National Health Service. Women within the study on the whole complained about waiting lists, inability to get appointments and poor or wrong diagnosis. While many authors have talked about the poor treatment of minorities and migrants generally within the health service, relating this to racism (Ahmad 1993), women within the study were reluctant to talk about inadequacies as a result of racist practices (*see* chapter 3). This may or may not be related to the problematic nature of interviewing across race. Respondents were keener to attribute unhappiness with the health services to a general deterioration in health care.

In this sense using health care both generally and for specific reasons and in emergencies in India can be seen as a pragmatic alternative for British Asian women within the study to health care in the UK. India can be interpreted as a site open only to Indians or Diasporic Indians because of connections; it is not open in the same way to white British people. Rather than seeing this move to health care in India as a quest for authenticity, we must analytically reframe such quests amid a widening field of available positions of pragmatism (Bausinger 1990, Narayan 1996). As Shahnaz demonstrates, India opens up possibilities for women as consumers of health products and services, which are not as accessible for white Britons and other populations:

> **Shahnaz:** You shouldn't need to go to India to get treated. We (Asians) have got some place to go to but what about white people who are born here. They haven't got another country to go to, you know.

However, women within the study often argued that although they would use biomedicine within India and were glad they had that option if needed, they would nevertheless prefer to use health care in the UK if they had the choice. As Samina's quote shows, she would ultimately rather be treated in Britain because she was born in Britain:

> **Samina:** I'd rather be treated over here (UK) personally. I don't know why, I've just got this thing with them. Because I was born here.

Mostly when respondents talked about using health care in India it was to use western health care. However, women within the study did use some non-western discourses within India marking an overall syncretic use of discourses there. One woman had used a Hakim while in India and some women went to practitioners who used herbal remedies and religious and spiritual healers. Sita argued that whether you used non-western health

care in India depended on what kinds of family contacts you had within a wider diasporic context, whether for instance you had Ayurvedic practitioners in your family.

> **Sita:** What sort of background they have, like I was saying, my grandfather was very much into Ayurveda but still once he passed away we would rather stick to a normal (western) doctor over there. In India your GP is like your family member, it's literally like, you know it's called a family doctor.

When possible women within the study did draw on a variety of discourses in India. Respondents' accounts again highlight the way in which their syncretic use of discourses has a global dimension, transcending local specificity. Kishwar, a Muslim respondent, illustrated this as she talked about using health care for fertility problems in many diverse contexts:

> **Kishwar:** Due to having problems having children, the doctor diagnosed that there was a problem with him (her husband). So we had to go to various herbalists from India, people's recommendations and things, and we've also been to like private and medication like BUPA and even like to Harley Street in London.

Women within the study draw on syncretic discourses in contexts beyond national boundaries. Women within the study also draw on discourses from different places syncretically, as the quote from Shahnaz shows:

> **Shahnaz**: I mean it doesn't matter whether it's a GP here (in Leicester) or a GP there (India), or a religious or herbal healer here or there. Whatever, you keep them in conjunction and use them at different times.

Such use of health care and products in a variety of contexts can also be related to Giddens' formulation about reflexivity and health (1991). He discusses the increase in patient reflexivity, knowledgeability and choice in relation to health care. He identifies choice in many aspects of life as an obligatory part of post traditional society (Giddens 1991b). Whilst respondents chose to draw on health care in a number of contexts many of them were also very wary of using health care (just as they were with health products) in India, either western or non-western. This places caution on the extent of respondents' health choices. They were fearful as they felt doctors and other medical professionals might not be properly qualified there. As Gurinder commented:

> **Gurinder:** If I was there, I wouldn't go, personally, because you are dubious in India because doctors aren't, you know, qualified. You know here because they've got their medical certificates and stuff, but in India I don't know doctors scare me a bit because you hear stories. That patients go to the doctor's and they're not very literate. They go to the doctor's and they get told they have to have this major surgery, they end up with a kidney missing and obviously the doctors have sold it on as transplants without the knowledge of the patients you see.

This reflects arguments made earlier in chapter four about risk. Knowledge of risk as Giddens (1991b) argues leads to a distrust of expertise and a potential deconstruction of the lay/expert relationship. Some women within the study had even had bad family experiences leading to fatal consequences with health care in India. This had in the long run put them off. In talking about her fears about using health care within India, Kishwar draws on family experience:

> **Kishwar:** The hygienic side of things is not very good and from the cases about which I hear, they don't sterilise their tools like we do and with AIDs

> going round. With somebody actually contracting AIDs, a family member through that. It has put me off a bit, you know, using health care there.

This was quite a commonly held view among respondents which exemplifies their superficially paradoxical view of health care products and services in India. Women within the study felt pleased that they had access to health care both western and non-western and felt that this gave them opportunities not open to other British populations. Women within this study however did see these opportunities through a lens of caution. Their desire to draw on such resources often related to family and other contacts in India. In particular this related to whether these contacts had used various services before and also whether they had family or friends who were medical practitioners in India. In contrast to the story of one of Shahnaz's family members as outlined earlier, most women quite often felt that health care was better in the UK, with better-qualified staff and better facilities. Many women within the study often related mistrust to particular geographical areas of India, and said their use of health care there depended on what area they were in. Meade, Horin and Gesler (1988) argue that India's heterogeneity and plurality of health care results in spatial and social imbalance in the quantity and quality of available health care. Regional differences in health care system mixes and health outcomes create huge inequalities in health care delivery systems and this was reflected in the women's accounts.

Within the study, many respondents used health products and care within India. Respondents drew mostly (although not exclusively) on western discourses in India. Some women within the study used these only in times of necessity when visiting India. Others went to India specifically for treatments. In the case of one respondent, Shahnaz, health care in India was used when health care in the U K proved ineffective. Within the study, women did also draw on non-western discourses in India although this was to a lesser extent, highlighting their overall syncretic use of discourses within India. Again, respondents' position as 'British Asian' is a position more dynamic than one located

statically between two cultures. Through their position as British Asian, as women of a particular generational and ethnic group, women within the study have access to a plurality of discourses which they draw on syncretically. As members of a mobile group women within the study have access to diasporic networks in differing contexts. Such access is then fostered through processes inherent within globaliztion. Through such connections and processes women within the study are able to draw on discourses within (and between) India and Britain syncretically, making imagined connections with diasporas in other contexts (and homelands) become real. It is to some of the respondents' 'other' diasporic connections that I will now turn.

6.4.1 Decentralising diaspora: syncrecy in other spaces

The South Asian diaspora argues Ghosh (1989), is oriented not so much to roots in a space/place and a desire to return as around the ability to recreate culture in diverse locations. The transnational connections linking diaspora need not be articulated primarily through a real or symbolic homeland. Decentred lateral connections may be as important as those formed around a teleology of origin and return and a shared ongoing history of displacement; suffering, adaptation or resistance may be as important as the projection of specific origin. Within this chapter I have talked about respondents' use of health discourses in India. In discussing this, it is important to recognise that not all respondents share the same relationship to India. Women within the study are part of a broader decentralized Asian diaspora with connections in places like North America and backgrounds in East Africa, Europe and other diasporic contexts. Several respondents, as argued earlier, have East African backgrounds, other respondents have Pakistani or Caribbean backgrounds. There are also those respondents with Indian backgrounds who have migrated from other European contexts to Britain. This spatial heritage does influence the respondents' use of discourses, both western and non-western, within India and other non-British locations.

Within the study, there was a split between women visiting India as if it were part of a 'homeland' and those who felt like they were 'foreigners' there. This tied in with respondents' identities in general and whether they saw themselves as British Asian women, as Indian women, Muslim women or something else. The split was mostly keenly felt between those who had roots, or family origins in East Africa, the Caribbean, or other parts of Europe and those families who were more directly from India. The latter on the whole were far more comfortable with visiting India and using health care there. This did not automatically stop those from other countries using health care in India and in fact they were more likely to do so than use health care in countries from which their families or they originally came. For instance, Rambha, who migrated to the UK from East Africa when she was three, talked about her feelings for East Africa and India:

> **Rambha:** No, we haven't been back to East Africa, not for anything really. Health care there is very different. We used to live in a village where Madwani (sugar plantation owner) ruled the whole village like and he, he provided the health service for all his workers and all the people who lived in the village worked for him anyway so... he's still got it going, the plantation, but I never go back, particularly not for health, oh no. I do visit India though, quite regularly.

This also translated down to respondents' health beliefs and behaviours. While women from East Africa felt comfortable using health care in India and transferred syncretic health goods between the two countries, they were less likely to visit India specifically for health reasons. They were also less likely to draw on non-western and syncretic discourses while visiting India. As Reena, another East African respondent, shows:

Reena: Oh, well I would use health care in India but only if I really had to, you know. I mean way back we have family there but I don't really know them. I definitely wouldn't use non-western care there.

This mostly relates to differences between respondents of East African and Indian origin. As Jeffers, Hoggett and Harrison (1996) argue, the East African Asian population in Leicester marks its difference from other Asian populations in Britain. They argue that the East African Asian community, had by virtue of the particular colonial role it played in East African history, become partially anglicised The difference in respondents' accounts may relate to this. However, I would argue that the respondents' accounts also reflect Worsley's (1997) argument that certain elements of culture are spatially diverse and that this affects health beliefs and behaviours. He gives the example of religion and argues that Hindus everywhere are assumed to subscribe to the same religious beliefs and the same medical theories. But, for example, Ayurveda in India differs from Ayurveda in Sri Lanka, doctors practise different parts and interpret texts differently. It is interesting to note within this study that women with East African backgrounds were both Hindu and Muslim, respondents with a background in the Indian subcontinent were Hindu, Muslim and Sikh. This highlights the way in which variables of influence on beliefs and behaviours are spatially located. In contrast to respondents with an East African background, the respondent from the Caribbean had very different views. She did visit Trinidad frequently and identified it as home even though she had lived in Britain from the age of five. This respondent was also committed to herbal remedies in general, and alternatives and spiritual remedies and did visit the Caribbean to use these remedies:

Charlotte: In the Caribbean as well we have a lot of things, yeah there are a lot of things that we use, just simple things like ginger tea and it really works, a lot of root substances are good for getting rid of allergies and colds

or keeping them at bay anyway. Oh I love to go back so I can use all these things. I just wish I could be there more often.

Within the study, respondents had many connections with Asians in India as well as with members of the 'decentralised' Asian diaspora in other contexts. As argued, for many of the women within the study their syncretic use of discourses was opened up cross-nationally from their context in Leicester to India. This opening up of syncrecy however was not a uniform process. Respondents with an East African background in particular were less likely to draw on syncretic discourses within either East Africa or India. While they were more likely to visit India than East Africa they were less likely to do so for health reasons than other respondents were.

6.5 Conclusion

Within this chapter I have explored the way in which space, geographical location and globalization influence the respondents' use of syncretic discourses. Within chapter three I explored the way in which syncrecy related to particular types of illnesses. In chapter four I explored the way in which family generation and life courses affected respondents' syncretic use of discourses. In chapter five the influence of religion and community on syncretic use of discourses was explored. This was then related to wider debates surrounding identity. Within this chapter I have extended some of the issues raised within the previous chapter relating to community. I have continued with the themes of the research, exploring the influence of contextual circumstances (in this case, space, geographical location and globalization) on respondents' health beliefs and behaviours.

In analysing the respondents' accounts, the influence of their location in Leicester on their health beliefs and behaviours has been clear. Women within the study identified their location in Leicester as giving them access to a plurality of western and non-western products and services. Leicester is a place where a plurality of health products and services

are both produced and consumed. Many of the women within the study had moved to Leicester from other places in the U K such as Blackburn or London and compared these places with Leicester. In particular, respondents talked about the availability in Leicester of non-western discourses. Women within the study felt that you could get anything in Leicester. Consequently many of the women within the study drew heavily on non-western discourses. There was a split within the women's accounts between use of products and services, with the respondents feeling more reticent about using non-western services. Women within the study also drew more minimally on other 'alternative' health discourses in Leicester. This reflected regional differences in availability of alternative medicine. On the whole, respondents relate the availability of non-western discourses to the multi-culturalism of the city and the particularly large number of South Asians within Leicester. This was also related to their position as 'British Asian'. Through their position, women within the study had access to both western and non-western discourses through western socialization and as part of an ethnic minority group, which is geographically dispersed (although concentrated in particular locations). Because of the ability of diasporas to connect multiple communities, women within the study had access to a whole range of products and services within Leicester.

Within the study, some women also transferred syncretic health products, both western and non-western, between Britain and India. Respondents took a variety of goods from Britain to India such as painkillers and vitamins. These were then circulated among local networks in India. This transcultural flow of goods is a two way process as women within the study also brought health products (both western and non-western) back to Britain. Women within the study often stock up on a variety of products from India because they are cheaper there. They also went over to India to get particular non-western products which they could not get in the UK, for instance tablets for psoriasis. This transcultural flow of syncretic goods was made possible by respondents' connections with members of Asian populations in India and elsewhere. It related to the respondents' position as 'British

Asian', as part of a mobile group with a significantly globally dispersed network. Access to such networks and health products is then opened up through the globalization process. Globalization with an emphasis on the deconstruction of boundaries makes it possible for respondents to move goods transculturally. As argued, this shifts connections between Britain, diaspora in various places and populations in India from 'imagined' to 'real'.

Respondents' location as British Asian and broader processes of globalization as outlined above also enabled respondents to utilize syncretic health care and products in India. Women within the study drew on health resources, both western and non-western, when visiting India. Women within the study used health care in India out of necessity when visiting. They also however went to India for specific treatments. In the case of one respondent, Shahnaz, health care in India was sought out through dissatisfaction with western health care in Britain. While respondents mostly drew on western products in India this was not exclusively the case. Some women within the study used Hakims and healers, and drew on non-western products. Decisions to draw on non-western discourses in India related to the contacts that respondents had there. Some women within the study did exercise caution in drawing on health discourses in India, both western and non-western. On the whole, however, respondents drew on these resources in India which gave them an alternative to western health products and care in Britain. However, there were differences between respondents of different spatial backgrounds. In particular respondents with backgrounds in East Africa were less likely to draw on syncretic discourses in either East Africa or India than those respondents with Indian backgrounds. In this sense respondents' accounts highlight the decentralized nature of South Asian diasporas (Ghosh 1989) in all their diversity and this was reflected in their beliefs and behaviours.

In broad terms this chapter highlights the need for globally dynamic and processual approaches to medical pluralism. These approaches emphasize the argument that pluralism is built upon multiple transnational networks, networks which can be regionally situated

but transcend national boundaries. As argued within the conclusion of the thesis, this is something worth exploring within new research, focusing on different diasporas in other national and international contexts. The chapter has also again highlighted the significance of the framework of syncrecy for exploring the health beliefs and behaviours of women within this study. It also highlights the dynamic position of the respondents as British Asian. It shows that this is a position which transcends two cultures, rather moving in and out of fixed categories in differing contexts. In exploring syncrecy and context in relation to the findings of the study it can be situated alongside the other substantive chapters. I will now go on to evaluate these findings of the research as a whole within the conclusion, reflecting back on usefulness of the theoretical frameworks.

Chapter 7
Conclusion: The Transformation of Syncrecy

7.1 Introduction

This thesis has involved a study of the health beliefs and behaviours of thirty British Asian mothers situated within the midlands town of Leicester. The research is based on semi-structured interviews with British Asian mothers. The initial aim of the research has been to explore the idea that the beliefs and behaviours of British Asian women within the study are syncretic. The concept of syncrecy has been used to explore and denote crossovers between categories of difference (Fitzpatrick 1984, Parker 1995). The benefit of the concept within this research lies in its potential to avoid classifications that are fixed and rigid but at the same time it does also offer a basis for resistance to the complete collapse of categories of difference. Whilst recognising crossovers, syncrecy also allows the potential for tensions between different categories. Within the study the concept of syncrecy has been used to look at the way in which west and non-west are mixed both locally and globally, in a reciprocal context. The aim was to look at the tension for the women within the study between west and non-west, situating respondents position as 'British Asian' as a dynamic one transcending 'between two cultures' type approaches advocated by Watson (1977). In order to avoid the relativism of existing studies on identity, or the culturalism of studies on race and health, the research also aimed to explore the role of material and contextual circumstances on respondents' beliefs and behaviours, to ask, how does this affect their use of syncretic discourses?

The findings of the research suggest that respondents' beliefs and behaviours are indeed syncretic. However, they are syncretic according to respondents' contextual and material circumstances. In particular within the study women's beliefs about, and use of syncretic discourses relates to their family, to particular types of illnesses, to their ethnic community and religion, to their location in Leicester and to their access to a broader South Asian diasporic network. These contextual influences relate to respondents' gendered, generational and ethnic locations. Within the study, women's

position as 'British Asian' played a significant role in influencing moves to syncrecy. Through membership of a particular ethnic group respondents had access to a whole range of non-western health discourses both locally and globally. Their position as British born or having lived here since the age of five also gave them access to western discourses often less accessible to older generations due to problems associated with linguistic barriers. Whilst beliefs and behaviours are relative to contextual and material circumstances and respondents' position as British Asian, they are also temporally specific, changing over time. The temporal significance of these contextual circumstances makes us question whether syncrecy is itself a temporally specific concept which provides a stepping stone to a new paradigm when exploring the beliefs and behaviours of younger British Asian women.

In drawing together and evaluating the aims and findings of this study the conclusion will be split into three sections. The first and main body of the conclusion will be concerned with the theory and findings of the study. Here I will reflect on the relationship between syncrecy and context and their influences on respondents' use of syncretic discourses. The findings will be situated in a temporal context and issues of categorisation and contingency will also be explored. The second section will be concerned with addressing broader questions and issues raised at the beginning of the thesis. This will focus firstly on research contributions and reflections. The findings will be situated in a broader context of research on gender, generation, ethnicity and health and plural medicine. Secondly within this section I will explore the difficulties associated with the empirical operationalisation of broader conceptual issues within the study. Finally the third section of the conclusion will ask what happens now, where does this research leave us? Are there further uses for the theoretical framework? What are the projected trends of the beliefs and behaviours of women within the study? What do the findings indicate for future research? What kinds of predictions can we make from the findings about the beliefs and behaviours of younger generation women or Asian diaspora elsewhere? Can the theoretical framework of syncrecy be used to explore younger generations and comparative diasporas? I will argue that the framework of syncrecy is dialectical in its process and that this point together with the findings of the study, provide a springboard for future research.

7.2 Theory and findings: the significance of syncrecy and context

Beliefs and behaviours of women within the study were syncretic but these varied according to women's contextual and material circumstances. First, respondents' syncretic beliefs and behaviours were related to particular illnesses. This emphasises the importance not just of women's contextual circumstances on their beliefs and behaviours but also highlights the significance of the specificity of illness itself. Cornwell (1984) in her study among working-class people in East London showed how her respondents classified illness into roughly three categories. The categories were broken up as 'normal' illness, 'health problems' and 'real' illness. Normal illness is taken to mean general illnesses that we all suffer at some point or another (e.g flu, childhood illnesses). Health problems signified conditions such as menstruation and those associated with natural life processes. Real illnesses are those which are classified as serious, ranging from illness such as diabetes to cancer.

This type of categorisation can also be applied here in the context of syncrecy. Respondents' beliefs and behaviours are more syncretic regarding some illnesses and less so for others. In taking a more micro view of health and illness, we can also see that syncrecy itself is multi-layered. From the women's accounts, it becomes apparent that the extent of syncretic beliefs and behaviours varies according to type of illness. For general health problems respondent s' beliefs and behaviours tend to be weighted towards a use of non-western discourses whereas the more serious conditions are, the more women are likely to use mostly western medicines. The category of health problems including conditions such as depression and pregnancy occupied an intermediate position between categories of normal and real illness moving in and out of these categories. Just as health problems move between different categories of illness so do they move between different discourses and different forms of syncrecy. This intersects with notions of private and public healthcare. Within the study, while respondents' beliefs and behaviours may be syncretic according to specific illnesses this syncrecy is also located in either private or public domains depending on illness. In highlighting the ways in which syncrecy ranges according to different illnesses, these accounts have again displayed the need to recognise the fluid and processual nature of beliefs and behaviours. These have been captured here by taking a dynamic approach to

illness categorisation.

Secondly, family, generation and position within the life course all influenced respondents' syncretic use of discourses. The research supports existing studies which emphasise a deterioration of respondents' health on marriage (Stacey 1985). However within the accounts of the women researched, marriage also influenced respondents' beliefs and behaviours and their syncretic use of discourses. Through husbands, women within the study engage with new non-western health discourses which are by and large regarded by them as beneficial to their health. Respondents' accounts also highlight a conflict between men and women over their children's health and use of different discourses and also the constraining roles of in-laws.

Within the study, while marriage increased respondents' ability to draw on syncretic discourses, this altered on having children. Because of time constraints placed on respondents by children, respondents seemed to increase their own use of home remedies, both western and non-western. Thus children do not place constraints on respondents' use of syncretic discourses for themselves. They lead rather to a shift of focus from respondents' public use of syncretic discourses to a greater use of discourses within the private realm. With regard to children's health, women were also more likely to draw almost exclusively on western discourse as they felt that ultimately they could place more trust in western medicine. The findings highlight that on the whole marriage fosters their syncretic use of discourses. As shown it must also be recognised that marriage stands as a contested domain for the respondents, suggesting that the findings require a more complex framework than that developed in previous research. Previous research on women and men's health has focused mostly on measuring differentials in health status (Doyal 1995). While this is important, what is needed (as the research here shows) is a framework which looks not just at women's health status in comparison to their husbands' but which also explores husbands' influence on beliefs and behaviours, and use of western and non-western discourses. The wider role of the family and children could also be included in such investigations.

Generation and position in the life course was also influential on respondents' use of

syncretic discourses. Women within the study identified differences in generation and syncrecy. They identified their own parents' (particularly mothers') beliefs and behaviours as being located mostly within non-western discourses. They identified their own beliefs and behaviours as syncretic and their children's as located mostly within western discourses. This emphasises the intersection of generation with length of settlement in the women's accounts. Finally, in talking about family we can see that respondents also identified their position in the life course as influencing syncretic beliefs and behaviours. Women within the study saw themselves at a particular point in their lives, as mothers with dependent children. Most of the respondents felt that their beliefs and behaviours had changed on becoming adults, getting married and becoming mothers. As younger single women they were much more likely to draw on western discourses. Women within the study felt that this would change as they got older and became grandmothers themselves. They felt that they would be more likely to draw on non-western discourses. This trend can also be situated within the wider context of increases in the lay population's access to alternative health care as globalization of plural medicine increases (Worsley 1997). Overall, the processual nature of influences of family, generation and the life course on respondents' beliefs and behaviours emphasises the need to move away from approaches which either fix beliefs and behaviours in time or locate their position as somehow falling 'between two cultures'.

Thirdly, respondents' relationship to their community and religion (both locally and globally) influences their ability to draw on syncretic health discourses. Many health beliefs and behaviours are associated with religious rituals and there are differences between respondents of differing religions. Community is also influential. Here the focus is on what Ballard (1994) calls 'real' communities, that is communities which are geographically and contextually specific as opposed to the imagined 'community' of India or diasporic connections in other parts of the globe. Community within women's accounts was multiply layered. Women within the study talked about different types of community ranging from identification with a particular religious community such as 'Muslim' or 'Sikh' to identification with broader notions of an 'Asian' community. Women within the study also talked about socializing with other communities such as with white communities. These different types of community all influenced

respondents' beliefs and behaviours. Some influenced respondents' use of western discourses, others their use of non-western. This gave an overall influence towards syncrecy. Respondents' overall identity as 'British Asian' also both influences and reflects their use of syncretic discourses. This highlights the importance of their positioning as British Asian women with access to a number of different types of discourse and in doing so emphasises the need to move beyond approaches which locate British minorities between west and non-west. It also reflects the intersection of this location with other contextual circumstances such as community, family, religion and space. Just as these aspects influence respondents' use of syncretic discourses at particular times, so too do they come to form parts of respondents' identity at specific times and in particular contexts.

Finally, space, geographical location and the reciprocal nature of globalization are all profoundly important within this study in influencing women's syncretic use of health discourses. Respondents' accounts highlight the importance of their location in Leicester, their connections and resources within India, the movement of health products between countries and the use and access to health care in other western and non-western contexts. Women within the study identify their location in Leicester as enabling them to have broad access to syncretic discourses. Many women within the study had come to Leicester from other parts of the U K to marry and felt that within Leicester they had access to discourses unavailable to them in other British contexts. Respondents' connections with India (and more minimally diasporas elsewhere) also geographically extend their access to a plurality of health discourses, both western and non-western. These connections are strengthened by processes inherent within globalization, fostering the transcultural flow of syncretic health goods and enabling the respondents syncretic use of discourses in India. This opens up women's access to syncretic discourses in diverse locations. As argued, it also shifts connections between Britain and diasporas in various places and populations from 'imagined' to 'real'. Again this section emphasises the significant influence on use of syncretic discourses of respondents' position as British Asian, as part of a mobile group with a significantly globally dispersed network. This position is a dynamic one which transcends between two cultures approaches, rather moving out of differing categories in different contexts.

The spatial mapping of syncrecy must also be centred within the current phase of globalization, reflecting an increased globalization of alternative health discourses and of ethnicity. While respondents' beliefs and behaviours were syncretic according to these contextual and material circumstances they were also situated in particular temporal contexts. I will move on to explore the significance of temporality next.

7.2.1 Temporally locating beliefs and behaviours

In researching health beliefs and behaviours it is important to recognise that one can capture these only at a particular time and in particular contexts (Radley and Billig 1996). In the Introduction I argued that people do not simply 'have' health beliefs and carry out certain behaviours in a fixed manner. Rather, like the process of identity construction itself (and as part of that identity construction) beliefs and behaviours are fluid and change over time. This is similar to Parsons' (1951) account of the sick role. People take on the 'sick role' i.e the social role of the sick person but it is expected that people will move in and out of that role at particular times and contexts. Studies on migrant and minority beliefs about and use of plural medicine are located in particular temporal contexts. Studies capture beliefs and behaviours at only one moment in time but acknowledge that these are fluid and vary as people pass through the life course (Kraut 1997). The intersection of time with contextual and material circumstances was influential on women's use of syncrecy within this study. The findings highlighted a temporal quality to respondents' syncretic use of discourses, that within the study women's beliefs and behaviours were syncretic in particular contexts and also at particular times.

We can situate women's accounts on 'particular' illnesses within a temporal framework. From the women's accounts it became important to recognise that while their beliefs and behaviours might be syncretic for particular illnesses this cannot be fixed in time as beliefs and behaviours change over 'illness time'. Respondents may treat an illness in a particular way, drawing on syncretic discourses. If they fail to get better over time, then they shift their use of discourses from one to another. This also often coincides with shifts in the women's accounts from use of health discourses mostly within the private realm to use of them mostly within the public realm.

Respondents' attitudes to particular illnesses also might shift over time as they become more familiar with that illness. Illnesses where respondents would perhaps at first draw only on western discourses before shifting over time with familiarity to that iilness led some respondents to move to a syncretic use of, or particular use of non-western discourses.

When talking about family and life course, women within the study often talked about how beliefs and behaviours changed over time. While respondents identify their beliefs and behaviours as syncretic during this particular phase of the life course they have different projections for syncrecy in the future. Beliefs and behaviours might still be syncretic but women within the study feel that they will draw more heavily on non-western discourses when they get older. They seemed to have a clear sense of the impact of change, both generationally and as they progress throughout the life course and are faced by different stresses and strains. As argued, generation was also a relevant dimension here, respondents identified differences in the beliefs and behaviours of different generations over time. It appeared that the respondents' mothers' use of Asian remedies decreased, while theirs were syncretic and their children's orientations were mostly western. These beliefs and behaviours were not fixed but rather reflected family members' positions within the life course. It would be interesting to see how respondents' beliefs and behaviours changed as they became older and become grandmothers themselves. Religion, community and identity can be placed in a temporal framework. Identity itself is temporally located and through it respondents' beliefs and behaviours are captured at a particular time, again reflecting their position as 'British Asian' mothers. Religion and community influence women's use of particular types of discourses at specific times. While religion seems a constant influence on respondents' beliefs and behaviours in some way, they identify the influence of different aspects of community as changing over time. This does not suggest an 'assimilation' type approach where respondents' beliefs and behaviours are subject to westernization over time. Rather, respondents' position as 'British Asian' enables them to move in and out of different community positions, creating new spaces.

Finally, the importance of the intersection of time with space is highlighted within the

respondents' accounts. Respondents' beliefs and behaviours are syncretic at particular times and in particular spaces. Space and time intersect in two different ways within the research influencing beliefs and behaviours in a local/global sense. First, women's migration within the UK over time influences their beliefs and behaviours. Secondly, the many processes associated with globalization, such as time/space compression, and opening up of national boundaries enables women within the study to gain easy access to Asian diaspora in other geographical contexts. This is reflected by shifts in respondents' locations, 'real' and 'imagined' communities becoming interchangeable at different times and in differing contexts. Both these local/global influences can be seen to hold timely qualities as women use them syncretically over different times and spaces.

Having emphasised the significance of contextual circumstances and their temporal locations within the findings, we are left with two further questions surrounding the framework and findings of the research. Firstly, in highlighting the significance of temporal locations and contextual circumstances what are the broader implications for the theoretical framework of syncrecy? If beliefs and behaviours are temporally located does this mean that the framework of syncrecy is too? This is something which will be picked up and explored further in the last section in the context of future research. Secondly, the findings of the thesis clearly highlighted respondents' syncretic use of discourses. However, in situating respondents' syncretic beliefs and behaviours in contextual/material circumstances which are specific to time, are we suggesting a complete contingency within women's accounts? Can we develop categories from the research which show that certain respondents were more disposed to syncrecy (or types of syncrecy) in their beliefs and behaviours? If not then how do we frame the findings in a way which avoids endless categorisation and contingency, understanding findings only at the level of individuals and having no group reference point. I will move on to explore this next.

7.2.2 Contingency and categorisation: developing a dialectical framework

From the findings then, was it possible to categorise women within the research, to relate syncretic use of discourses to particular groups of women? Or were respondents'

beliefs and behaviours syncretic only according to individual context and time? And if so how can a coherent argument be made without recourse to an endless sea of diversity within the women's accounts? If we go back to the epistemological and methodological aims and framework we can see that there was a resistance to categorising respondents from the outset. The fear was of creating categories which both essentialise and fix respondents into particular groups. Within the findings, while there was a use of syncretic discourses in all the women's accounts there were no overriding clear-cut groups into which women could be categorised. For instance while religion seemed to be a defining feature of respondents' beliefs and behaviours in some cases, for example when talking about certain illnesses, this was not so in others. It would be impossible to group respondents of the same religion together in their use of syncretic discourses in any fixed sense. Similarly, respondents of like ages could be seen to hold comparable beliefs and behaviours at particular times with regard to particular illnesses, but again this was not the case all of the time. It seemed from this that women could be loosely categorised but that these categories shifted according different themes and therefore could not be fixed. In light of this, how do we build a framework for the findings which allows for this type of fluid and partial categorisation without either fixing categories or completely deconstructing them?

This difficulty can be dealt with through situating the issue of categorisation within a dialectical framework. From the accounts of the women researched at certain times, it became possible to see that particular categories were strongly influential, at other times other categories were privileged and there was significant commonality across different categories. There were also often contradictions in these categories. It is therefore helpful to see such categories as polyvocal, allowing for plurality within them and within respondents' accounts. The differing categories of analysis employed by me in order to explore respondents' accounts were not necessarily mutually exclusive, there was communication across categories and they were held in dialogue. Such communication meant that categories at times informed and connected but at others they clashed and contradicted one another. Seeing such accounts through a dialectical framework means that different categories can be seen as being held simultaneously in tension with one another, at different times and in different contexts. This need not lead

to the creation of a new more advanced 'synthesis' of categories which merge together. It should not be seen as a necessarily sequential process. The dialectical approach is an analytical not a chronological one and the categorisation of women should be located at different times according to historical, local and personal context (Reed 1998, Shrijvers 1993). By adopting this dynamic and processual dialectical framework to the research findings it is possible to recognise more fully the multiple, shifting and sometimes hierarchical forms of categorisation that are influential on syncrecy.

Taking a dialectical approach here I proceed from a recognition that there are both similarities and differences within and between each of these groupings. It appeared from the respondents' accounts that they moved from one type to categorisation to others. Taking this approach means that I must recognise that any one part of respondents' identity, such as community or religion, may be more important at any one time, and that these interrelate across the women's accounts, fostering other commonalities and difference. This allows for the possibility of categorisation but recognises that this is shifting. For example, in some women's accounts at particular times, such as during pregnancy and childbirth, respondents could be grouped along religious lines in terms of influence on syncrecy. For instance, as argued in chapter five, the consumption of 'hot' and 'cold' foods at particular points of the pregnancy seemed to be particularly important for Muslim women in the research. The Hindu and Sikh women within the study were less focused on diet in pregnancy and did not talk about food in terms of 'hot' and 'cold' properties.

Through the analysis of respondents' accounts, it appeared that they move from one type of categorisation to another. At other times for example, other factors appeared more relevant grounds for categorisation than religion. For example, if we look at East African women within the study who were either Hindu or Muslim, their sense of space and place can at times be seen to influence their use of syncretic discourses in non-western contexts in contrast to those with the same religion who came from different places. On the whole these respondents are less likely to draw on syncretic discourses in non-western contexts. These categories are in dialogue with one another. They also conflict and contradict one another as differing contextual influences fight for

recognition. This is where through a dialectical approach we can see that differing categories may be influential simultaneously. For instance, Sakeena, a Muslim respondent, discusses the influence of Asian women of different religious denominations on her syncretic use of discourses. At other times, however, she feels a strong influence from the Muslim community of which she is a member.

In recognising the processual nature of the dialectic, these categories of respondents are not seen as fixed but as continually shifting and being reconfigured, depending on what they were talking about, to whom they were talking, and their temporal location. This enables us to recognise some form of categorisation into which women's accounts of syncrecy could be placed. Women within the study could be grouped together at particular times and in particular contexts. This allows us to group respondents avoiding endless forms of categorisation. It also enables us at the same time to move away from fixed forms of categorisation which essentialise women by locating them within particular groups throughout the research. Respondents could not be rigidly fixed, into categories for everything. By taking a dialectical approach we can see that categorisation is feasible but that categories are not fixed and change according to time and context.

Within this section of the chapter I have explored the theoretical framework of the study and the findings. I now want to move onto to situate these findings within a much broader context, reflecting on issues raised at the beginning of the thesis relating to ethnicity, gender and generation, plural medicine and wider conceptual issues.

7.3. Broader research reflections

The aim of the study was to explore the intersection of ethnicity, gender and generation within health beliefs and behaviours. I want to explore in more detail here the contributions of the study to the area of ethnicity, gender, generation and health, and more generally to debates on plural medicine. One of the main aims of the study was to take up Eade's (1997) call for more qualitative research into migrant and minority health beliefs and behaviours. The research in particular aimed to contribute to the small body of existing literature on the health beliefs and behaviours of minority

women. As noted in the Introduction, the specificity of the experiences of black women has received little attention in the literature. We know that they are more likely than white women to be disadvantaged in terms of health in a range of identifiable ways (Douglas 1992), however there have been very few studies which have explored the beliefs and behaviours of women of colour. Although there is a growing literature on 'race', ethnicity and health, gender has remained quite peripheral within this literature. Work on gender and health on the other hand has paid insufficient attention to ethnicity.

This study contributes qualitative data on Asian respondents' experiences and perceptions of health and health care. It situates women's beliefs and behaviours in contextual and material circumstances. However, it also highlights the possibility of respondents having beliefs, values or interests in common through trends to syncrecy. In highlighting the significance of conceptualisations of health and illness; family, generation and life course; religion and community; location and globalization, the study recognises that the beliefs and behaviours of British Asian women within Leicester must be contextualised within a framework which emphasises the importance of both culture and social structure. This supports Bayne-Smith's (1996) argument, that the health of women from black and minority groups cannot be separated from their roles as wives, mothers, daughters, sisters, employees and community participants. Similarly, their experiences of morbidity and mortality cannot be understood outside the broader institutions of culture and social structure such as the education system, housing provision, health and welfare services, religion, family patterns and the economy.

The study has highlighted and deals with the difficulties of researching "women's" health avoiding the danger of over-general universalism and over-detailed particularism. Rather than suggesting the infeasibility of research on gender and difference, the thesis emphasises the need to proceed with sensitivity. As noted in the Introduction, Ahmad (1993) has identified two (both inadequate) approaches to the study of race, ethnicity and health. The first involves large-scale epidemiological studies which singularly fail to get at perceptions of health and illness. The second is

the culturalist approach, which locates health and illness purely within cultural explanations. Throughout the study, from developing the theoretical framework to reporting the findings this study has aimed to transcend these. On the one hand social and cultural explanations are taken into account where appropriate. However, the study has also been mindful of diversity recognising that these should not be used in a way that imposes homogeneity on a group of people while ignoring variations in religion, ethnicity, class and gender. Nor have cultural explanations been used to obscure the importance of material factors.

The aim of the study from the outset was also to explore the health of women who had children. By focusing on the health of mothers, the research in particular wanted to pick up on findings of previous studies which focused on the role of women as mediators of family health (Blaxter and Paterson 1982). As argued in the Introduction, a prominent area of research regarding women's health has been on women's activities as caregivers, in families and in society at large as primary consumers of health care for themselves and others (Graham 1984, 1993). The aim of this research was to focus on women with children with the hope that women's accounts would contain not just views about their own health but also that of their families, husbands and children. Within the research women did talk about the beliefs and behaviours of other members of the family and it seemed that through talking more generally about 'family' health respondents were much more able to talk about their own health. From the women's accounts it became apparent that women within the study were also the mediators of family health. In most cases women took on the major responsibility for their family's health. Women within the study were also the major consumers of health care. This was the case even in differing contexts when health products and health care were used in India. Respondents also quite often had negative perceptions of their own health in comparison to their husbands', which again is consistent with previous studies on gender differentials and health (Blaxter 1983).

The research aimed to explore the impact of generation on health beliefs and behaviours of the British Asian women within the study. Little research has explored the importance of generation on migrant and minority health beliefs and behaviours

(Greenslade, Madden and Pearson 1997, Kraut 1997). As argued earlier, studies on identity (e.g Parker 1995) have focused on the unique identity of various diasporic groups born or raised within the west. In recent years they have moved away from 'between two cultures' type approaches advocated by Watson (1977) to explore the syncretic, multiply-located and changing identity of this particular generation. It was the aim of the study to draw on these frameworks, applying them within a health context, to look at the influence of generation and length and settlement on beliefs and behaviours and to explore the beliefs and behaviours of British Asian women within the study, those born/raised within Britain. This study supports arguments made in identity studies. Respondents' beliefs and behaviours were syncretic and this relates implicitly to their position as 'British Asian'. Being part of this generational group with both roots and routes in Asian and English culture opened up access to both western and non-western discourses. Rather than being 'between two cultures', respondents actively engaged at differing times and in particular contexts with different cultures. This fosters a syncretic use of discourse which is fluid and multiply located, just like identity.

Finally, in the Introduction of the research I situated the exploration of respondents' beliefs and behaviours within the wider context of debates on plural medicine. A number of authors have shown how the use of alternative medicine has increased significantly in the last decade (Cant and Sharma 1999, West 1992). Worsley (1997) argues that many people in Britain after consulting their GP feel dissatisfied with the symptom-oriented approach in western medicine and turn to alternatives. Within the research the respondents' accounts reflected these trends. As argued, respondents' position as 'British Asian', as part of a particular ethnic and generational group, along with various contextual circumstances and broader global processes influenced their syncretic use of discourses. This use can also be related to general increase in lay use of alternative medicine. However it is important to recognise that this influence relates mostly to respondents' use of Asian medical discourses. Reflecting back on the typology of alternative medicine as outlined by Cant and Sharma (1999) in the Introduction of the thesis we can recognise the diversity in the category alternative. Within the study women also draw on a number of other alternative non-Asian discourses, and this reflects broader more general trends in lay use of alternative

medicine.

The study highlights the importance of health research on ethnicity, gender, generation and plural medicine. The health needs of women, their consistent lower assessments of health, their beliefs and experiences of health and health care need to be heard and explored. The women's accounts emphasised the need perhaps for a more significant integration of alternative health behaviours into mainstream health care systems. The findings of this study also emphasise that more should be done to support and take pressure off women's role as mediator and caregivers within the family. Gender differentials in health status are also reflected in the research findings. These point to a need for further research in the area and greater policy sensitivity towards such differentials. Within this context it would be useful to explore gendered differentials further by focusing on syncrecy in Asian men's beliefs and behaviours.

The research also highlights the need for future epidemiological studies on ethnicity and health to be sensitive in its categorisation of women from ethnic minority groups. The diversity of health experiences among 'South Asian' women within the study suggests a need to diversify categories of research. This would enable research to capture more broadly women's health needs. The research also supports previous claims (Douglas 1998) that the health care needs of women from black and minority ethnic communities need to be addressed strategically by policy-makers, practitioners and researchers. We need to see more translation of research in practice in health care provision, teaching and education programmes or health promotion materials. International connections highlighted within these research findings emphasise the need and feasibility of dissemination and exchange of information to women on an international level (Doyal 1995). The research also highlights the importance of inter-generational research. It shows the differences in health needs between generations, enabling us to see which populations are in particular need and deserve to be targeted. It also opens up new possibilities, paving the way for further inter-generational research which I will go on to explore in the final section of the chapter. Finally, the research highlights the need for more research in lay increases in the use of plural medicine. Such approaches will need to be globally dynamic and processual and emphasise the

argument that pluralism is built upon multiple, transnational networks, networks which can be regionally situated but transcend national boundaries.

The research explores the intersection of ethnicity, gender and generation in beliefs and behaviours of British Asian women within the study. This is also situated in the wider context of debates on plural medicine. The focus is on both beliefs and behaviours and their incorporation of health systems and discourses. The meaning and use of these terms and others was problematised at the outset of the study. It is to a more full exploration of the uses of these concepts that I now turn.

7.3.1 Difficulties and dilemmas: transgressing conceptual tensions

From the outset of the research a series of tensions were present within the conceptual framework. Despite attempts to build a fluid theoretical framework of syncrecy and context there were nevertheless problematic concepts which were difficult to render empirically operable. For instance there were difficulties with concepts such as beliefs and behaviours, discourses, and western and non-western. Were beliefs and behaviours separate? If they were how could they be separated and operationalised empirically? What is meant by respondents' use of health discourses? Finally what about the key categorisation of western and non-western, could these be seen as separate? How could they be operationalised? I was faced with this set of problems from the outset and I felt it insufficient to create and fix false categories of concepts when the aim of the thesis was in trying to transcend them. My approach to this initially was to recognise crossovers between categories but also to acknowledge that they do not completely converge (as with syncrecy). What I really wanted to do was explore these conceptualisations within the fieldwork. Did women within the study make these distinctions themselves within their accounts? It was only after completing the fieldwork that I was able to really situate these concepts and their relationships to one another. In many senses the respondents' accounts emphasised the difficulties of trying to situate these concepts and the relationships between some categories were easier to disentangle than others. I will explore these sets of concepts in the light of an evaluation of the findings of the research.

7.3.2 Health Beliefs and Behaviours

As argued in the Introduction, there is a recognised difference between health beliefs and behaviours within research on health. McAllister and Farquhar (1992) distinguish between the two. They see beliefs as feelings about lifestyles and health behaviours as health related activity. However, as I argued at the beginning of this study, while this distinction was recognised it was not seen as fixed and the aim was to see if a clear distinction between the two could be drawn from respondents' accounts. In analysing the data no clear-cut distinction could be made and it became very difficult to separate the two. While at times it appeared that women were talking about health behaviours these were inextricably tied up with their beliefs. How can these be clearly separated in respondents' accounts? How can they be separated when Gurinder talks about using brandy as part of a belief system for general ailments or when Niru talks about the belief in religion as a cure for illness?

In light of this, rather the seeing beliefs and behaviours as entirely distinct, it has been more fruitful to think of them as in some way constitutive of one another. In much of the work of Foucault, binaries are situated in a constitutive relationship (Foucault 1972). One of the most significant examples of this is Foucault's configuration of the power/knowledge relationship (Smart 1995). For Foucault the relationship between power and knowledge is a constitutive one. Knowledge is inextricably associated with networks of power, power produces knowledge. Power and knowledge directly imply one another; there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. This strong interrelationship between the two concepts can also be applied here to beliefs and behaviours. While both are separate in their own right within the research they are also inextricably linked with one another and it is impossible, and unnecessary within this analytical framework to split them apart.

Following on from this, the second issue raised around these two concepts initially was whether behaviours follow beliefs. If, as Foucault (1972) argues, one category informs and constitutes the other it is not merely that beliefs inform behaviours, as much research has focused on exploring (Calnan and Rutter 1986). Rather, behaviours also

inform beliefs. This is definitely the case within this research as women within the study might try something or utilise a particular type of health resource and that may alter their whole belief system. For instance we can think of the case of Shahnaz's brother in-law (chapter 6, pp 143). Negative experiences associated with health seeking behaviours in western medical care led him to change both beliefs and behaviours, utilising diverse forms of health care, both western and non-western, in diverse contexts. Within the study some respondents also tried practices to see if they worked, not necessarily believing in them before trying them The research also supports McAllister and Farquhar's (1992) argument that a number of factors induce people to seek medical assistance (e.g peer group pressure, family). On the whole, the research points to the constitutive relationship of beliefs and behaviours, emphasising their role as part of people's active constructions of identity and situates them within contextual and material circumstances.

7.3.3 Discourses and Systems

A second conceptual problem within the research relates to the concept of discourse. As argued within the introduction the concept of discourse is a central concept in Foucault's work (Shilling 1993). It is primarily concerned with, although irreducible to, language (Foucault 1972; Poster 1984). Discourses can be seen as sets of deep principles incorporating specific grids of meaning which underpin, generate and establish relations between all that can be seen, thought and said (Dreyfus and Rabinow, 1982; Foucault, 1972). The conceptualisation and use of the concept has been heavily critiqued for its denial of the embedded and embodied subject. As Radley and Billig (1996) argue, to focus on discourse alone is to miss out on the fact that it proceeds as part of a relationship that is situated in time and place. Similarly Mcnay (1994), highlights the necessary social embeddedness of discourse critiquing Foucault's rejection of the notion of the subject.

Discourse is used within this research to signify systems of knowledge; as with previous usage these are related to structures of language but are not exclusive to language. The use of the term within this context carries with it similar tensions between the discursive and the material. It is unclear within the work of Foucault just to

what extent discourse can be used in realms other than linguistic ones. This presents certain problems within this research. To focus on respondents' use of health discourses seems to deny a material existence to women's beliefs and in particular to behaviours and the significance of social structure. From the outset of the research, there has been a recognition that discourses themselves are embodied and socially embedded. Our embodied existence forms a vital part of the shared socio-cultural experience upon which our systems of language and meaning are shaped. However while this gives us a more embodied view of discourse it does not deal adequately with the socially embedded nature of discourse. As argued in the Introduction, this tension between the discursive and the material (as social) has been seen as part of the conceptual framework to be explored dialectically through respondents' accounts.

In exploring respondents' accounts it seemed that they talked about their use of western and non-western health resources in both abstract and concrete terms. In trying to make sense of the shifts in respondents' accounts from what seemed like shifts from the discursive to concrete I turned to the notion of health system. The term system appears to take us beyond a reductionism to the linguistic realm into the material. As Turner (1987) argues, there are a number of ways in which health care systems can be classified. For instance, Roemer (1977) draws a valuable distinction between free enterprise systems, welfare-state forms of health care, the health systems of the underdeveloped societies, the health systems of transitional societies and finally socialist health systems. These vary along a continuum from private to public provision (Turner 1987). One can also differentiate the various levels of health systems; these would include the economic base for the support of health care, the organization of manpower resources, the health care facilities, the numerous systems by which medical care is delivered, the system of preventative services, the political regulation of health care, and finally the various methods for the planning and administration of health systems (Turner 1987). From this the term medical system appears to make concrete what is only ever shifting and relational in the term discourse. However, the term system comes with its own problems. While it may be more socially and structurally embedded than the term discourse, the use of system implies a reductionism to health care services. It does not really seem to address issues which relate directly to health

beliefs, or to issues of home health care.

Once beliefs and behaviours had been situated as constitutive within the women's accounts it became easier to conceptualise and situate the term discourse alongside that of system. Within the study, women's accounts of health are layered across levels of health resources from discourses to systems, from private to public. Within the women's accounts, discourses and systems can be seen roughly to represent both discursive and material aspects of health resources. They can also be seen to correlate indirectly (although not exclusively) to beliefs and behaviours, and health care within the private and public domain. While these can be seen to roughly represent the discursive and the material as with beliefs and behaviours, they cannot be seen as wholly separate there are crossovers between the two. While the relationship is not as mutually constitutive as beliefs and behaviours, the two do influence and inform one another. Because of this it seemed most appropriate that the two concepts be used interchangeably through the research. Used in such a way one is able to recognise the significance of the socially embedded nature of health resources, without being fixed, recognising discursive elements and whilst also filtering through both local/global levels over time.

7.3.4 Non-western/Western

Finally, the last conceptual tension relates to the use of the terms western and non-western in relation to medical discourses/systems. Can western and non-western be seen as completely distinct? As noted within the Introduction, Brady, Kunitz and Nash (1997) argue that western and non-western medical systems should not be looked at separately. They argue that both merge together and are not in fact polar opposites. Leslie (1992) suggests that medical systems are in themselves syncretic, incorporating into their centres a mix and match of different principles which makes them far from coherent and bounded. However, this conceptualisation also carries with it difficulties. Looked at in this way, the moment intercultural contact takes place the notions of separate western and non-western cultural sources becomes blurred (Holton 1998) and there appears (as Frith [1989] argues in relation to world music) no such thing as a cultural purity.

Again initially I was reluctant to completely separate western and non-western from one another. I felt that one cannot look at systems in simple isolation from one another, since systems often share a common feature. However, I also felt that to see systems themselves as syncretic or blurred, as only ever a mix and match of difference, denies that systems have characteristics that are specific only to them. A denial of difference between systems also fails to take into account the long history of unequal relations between biomedicine and non-western systems. In the eyes of the state, biomedicine, a perceived [1]logocentric discourse is still viewed as superior to any alternatives, which have to strive for official recognition (Cant and Sharma 1999, Fox 1993). Again, while I held certain ideas about the relationship between western and non-western, I wanted to see how women themselves distinguished western and non-western health discourses/systems, if they did at all.

Within the women's accounts, the concepts of western and non-western communicate and enter into dialogue with one another and can actually at times crossover. For instance, women's use of remedies for general illness highlights the cross overs between medical systems. Some remedies were found in both western and non-western medical discourses. Sakeena's comments about honey show this. The healing properties of honey can be claimed by many medical discourses but she talks about them in the context of the Quran. These systems also contradict and conflict with one another, as Sakeena's accounts of her daughter's eczema shows (see chapter 4 pp 105). In this sense the women's accounts also emphasised how the systems were seen as separate. Again in this case western and non-western both inform and cross over one another yet are still separate. They inform one another but are not wholly constitutive. Can one system be set up in precedence over the other? Within the women's accounts non-western health discourses might be drawn on more heavily in some times and contexts, and western ones at others. Each system was privileged in the women's accounts at differing times and places.

After reflecting on the research and its findings in such detail, I will now move on to

[1]Logocentrism here is used to refer to authority grounded in access to knowledge of reality (Fox 1993).

the last section of the conclusion to look at where we might go from here in terms of future research and the uses of the theoretical framework. Questions to be posed include, how far can syncrecy extend as a framework? What about the future beliefs and behaviours of respondents? What about potential uses of syncrecy in future health research in a variety of contexts?

7.4 The Transformation of Syncrecy

The theoretical framework has been useful for exploring beliefs and behaviours of women within this research. In areas other than health the concept of syncrecy has also proved useful. As Holton (1998) argues, in terms of issues of cultural identity, the very fluidity of syncretic cultural forms is very important to sustaining identity in an epoch of globalization. In talking about syncretism and world music he argues that music and its rituals can be used to create a model whereby identity can be understood neither as a fixed essence nor a vague and utterly contingent construction to be reinvented by the will. This is a useful concept and framework, but we need to ask whether it has limitations. While recognising that syncrecy is useful for exploring many issues within this phase of globalization in varying contexts, is it a concept with which we can generalise? In looking at identity in various parts of the global field, ethnic and other kinds of cultural boundaries are being re-erected to the point of promotion or enforcing purity by various means. For example, there remains support for bounded primordial constructions of cultural identity both among white and black, western and non-western. This highlights the limitations and specificity of the term. On the other hand, some writers suggest terms such as 'hybridity' and 'syncrecy' are unhelpfully too generalisable. Baucom (1996) argues that in a world in which we inevitably discover that everything is 'hybrid' (as it is in his vision) we might as well shut up shop.

I would argue, however, that the beauty and potential of the framework of syncrecy lies in its creation of a tension between these two approaches. Syncrecy does allow for tension between the universal and the particular, between the personal and the social, between the local and the global. This is why the term has been so helpful in the context of this research. This tension is always changing and is processual. In this sense syncrecy is rather like a dialectic process itself as the accounts of the women researched

here show. For instance, at times certain discourses are privileged within respondents' accounts, sometimes western discourse over non-western. At other times the findings show there might be significant commonalities across western and non-western discourses. The framework of syncrecy can be seen, therefore, as fluid and polyvocal, allowing for plurality. There is both commonality and contradiction within the framework, respondents' accounts suggest that at particular times and contexts, discourses come to be held simultaneously in tension with one another. Does this mark an end point to syncrecy? Do categories eventually merge? I would suggest not, syncrecy will not necessarily be transcended and replaced by a new more advanced 'synthesis' of discourses which merge together. It is also unlikely that a move away from syncrecy to focus on just one discourse would provide an adequate framework.

To go back to Fitzpatrick's (1984) argument as made at the start of the thesis, in the context of health, beliefs and behaviours will always be syncretic in the sense that they will continue to be drawn from distinct and disparate sources. Syncrecy in this sense will continue to be a useful framework. However, to echo the words of Gilroy (1993) syncretic forms are never repeated in the same way but are contextually specific. The importance of this specificity is emphasised by viewing syncrecy as a dialectical process. As a dialectical process syncrecy offers an analytical framework not a chronological one. As shown within this research, it is rooted in the contexts of respondents' lives. Therefore we must recognise that the type of syncrecy will change according to historical, local and personal context (Reed 1998, Shrijvers 1993). This directly addresses both sides of the above critique of syncrecy. Rather than being over specific (Holton 1998) or over generalisable (Baucom 1996) syncrecy can assist with avoiding both of these problems. It is a transportable framework but only once it has been contextualised. It can be exported but in a form relevant to context. Syncrecy therefore has the potential to be 'transformed' and used again in various contexts although not in the form taken within this research. The use of non-western and western discourses 'syncretically' by the women within this research will not be repeated in quite the same way by other groups. Within future research undertaken with other respondents, syncrecy will be re-worked and re-inscribed differently according to context. By adopting this dynamic and processual dialectical framework it is possible to

explore more fully the potential use of syncrecy as a theoretical framework in various contexts. The final section of the conclusion will explore how, and in what forms a syncretic framework might be used in future research and what trends might be predicted.

7.4.1 Extending theoretical frameworks: New beliefs, behaviours generations and contexts?

The theoretical framework of syncrecy has proved very useful in exploring the health beliefs and behaviours of 'British Asian' women. It seems to capture the beliefs and behaviours of these women at a particular time. It relates to their position as 'British Asian' and contextual circumstances such as: family, generation and life course; particular illness; religion, community and identity; and space, geographical location and globalization. As I have shown, though, these influences are temporally located. What will happen as respondents progress throughout the life course and contextual circumstances change? Will their beliefs and behaviours still be syncretic?

Many of the women within the study talk about their increased use of non-western discourses as they get older and progress throughout the life course. This can also be related to the wider trends towards increases in availability and use of alternative medicine by lay populations (Cant and Sharma 1999 Worsley 1997). Certainly if recent media coverage highlighting the incompetence of biomedical doctors is anything to go by we should come to expect a dramatic increase in lay use of alternative medicine. However, this can also be placed within the women's accounts alongside the increasing need in light of hectic life-styles to draw on quick-fix solutions to health problems. Bearing this tension in mind I would suggest that respondents' beliefs and behaviours will continue to be syncretic but that this syncrecy will be re-worked and re-inscribed as respondents' circumstances change. As for the continued influence of respondents' position as 'British Asian', this is difficult to predict. While respondents' accounts highlight changes over time in their position this does not relate to a position of increased assimilation. Rather, respondents seem to suggest an active engagement with categories of west and non-west, moving in and out of each at different times and contexts. On the one hand respondents' appear to be moving towards drawing more on

non-western discourses advocated by their mothers while at the same time they are being influenced by younger generations and other populations and communities. Again this suggests a continuance of a dynamic position drawing on a number of discourses and going beyond a location 'between two cultures'.

What does all of this mean for younger generations of women, the children of the women within the study? The way to explore this and the further uses of the framework of syncrecy is to carry out additional empirical work exploring the beliefs and behaviours of women in subsequent generations. The research has highlighted the use of the framework for British Asian women in Leicester. What about younger generations of Asian women who will have been more exposed to western culture? The women's accounts suggested clear differences in syncretic use of discourses between generations. Women with teenage children often talked about how their children's beliefs and behaviours were more likely to be located within western discourse. This would take an exploration of the framework one step further. As shown, the concept of syncrecy is a more appropriate way of capturing the dynamic and fluid positioning of British Asian women within this study than the 'between two cultures' type approach advocated by Watson (1977). However, is syncrecy itself a phase, is it a way of coping in this particular era as Holton (1998) argues? Or are there aspects of syncrecy relevant for subsequent generations, in particular they themselves grow older? How does syncrecy change?

A second issue worth exploring would be to see how geographically transportable the concept of syncrecy is. Many women within the study came from other parts of Britain, mostly Blackburn, Birmingham and London. They alluded to differences in access to various health discourses and talked about an increased use of non-western discourse on moving to Leicester. It would be useful to explore the health beliefs and behaviours of British Asian women within other regional contexts. Does the concept of syncrecy translate to other contexts within Britain? Similarly this could be transposed cross-nationally. Gilroy (1993) talks about the Black Atlantic as an intercultural transnational formation linking Blacks in the UK and France as well as those in the USA and the Caribbean. This is a formation that is intermediate between the global and the local, and

which has a dynamic history in which slavery, colonization and migration all play a part. As argued, within this study women talked about connections with Asian diasporas in other contexts. Again it would be worth exploring these connections through studies of Asian diaspora in America, Africa, Europe and elsewhere, to see how syncrecy compares. As Gilroy (1993) argues, while the Black Atlantic is transnational/transcultural it generates local manifestations that are not identical with one another, but are re-worked and re-inscribed differently in different contexts. Is this the case for syncrecy in health beliefs and behaviours of Asian women in the USA?

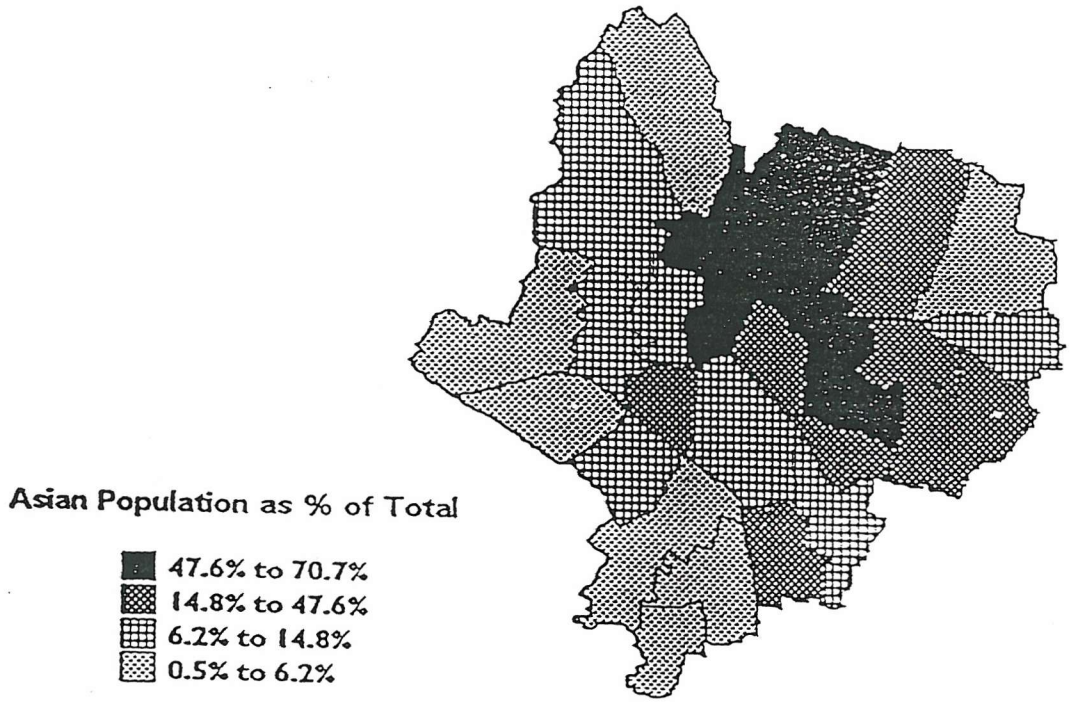
In assessing the continued relevance of a post-colonial conceptual framework, Mani (1992) has argued that concepts and frameworks such as this must be adequately localised before extending or exporting them. Within the context of this study the conceptual framework of syncrecy has been adequately localised, it can now be extended and exported. We can see then, if and in what ways syncrecy has a broad relevance in different personal, social and historical contexts.

Appendix A: Maps of Leicester

Map 1 Shows the ward boundaries of Leicester city centre.

Leicester *Key Facts*
Ethnic Minorities 1991 Census
Leicester City Council

Map 2: Location of Leicester's Asian population as a percentage of the total population by ward.



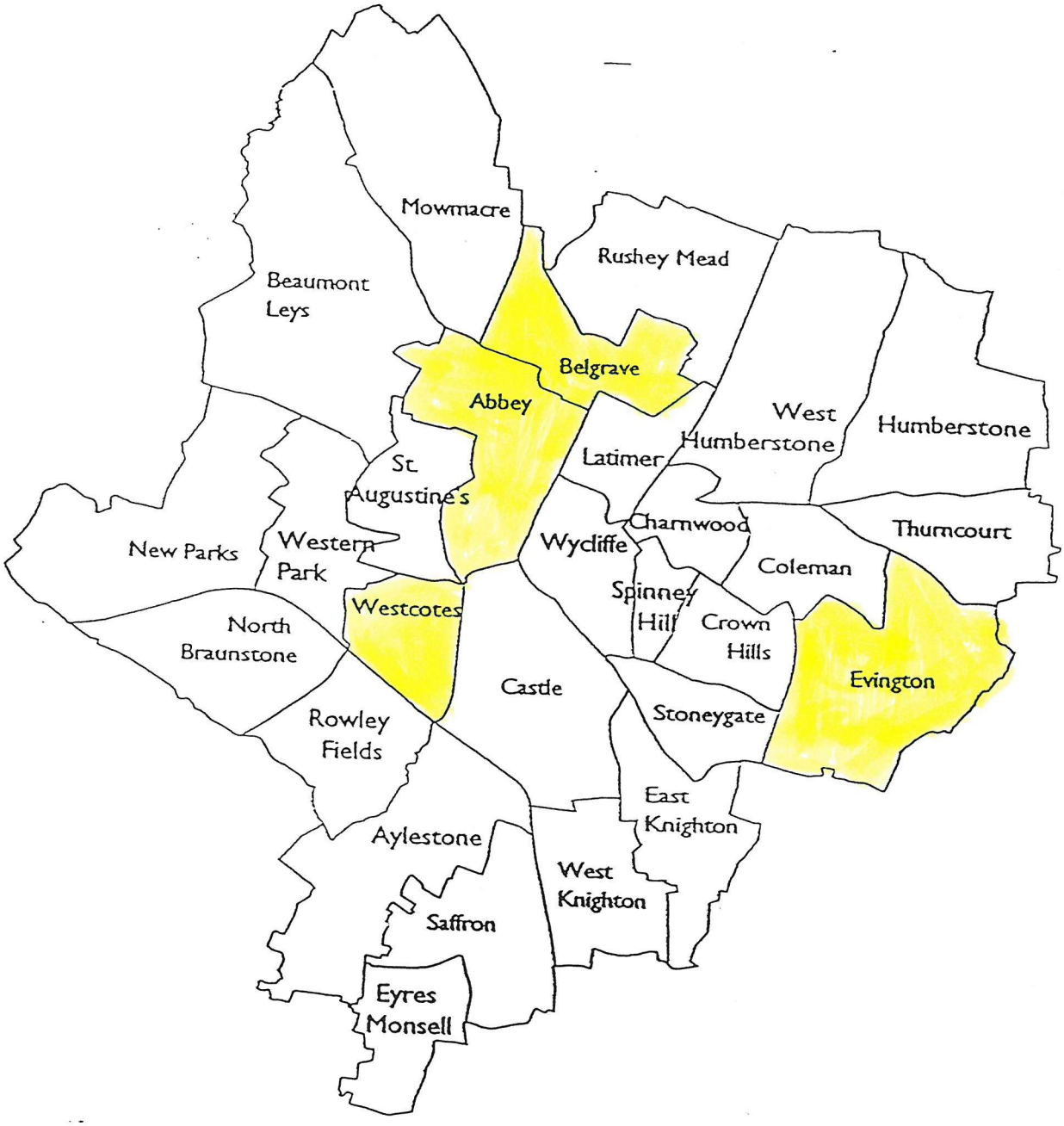
Map 2 shows the distribution of Leicester's Asian population by ward. The Asian population of Leicester is concentrated mostly in the areas of Abbey, Belgrave, Latimer, Spinney Hill, Charnwood, Crown Hills and Rushey Mead Wards.

Leicester *Key Facts*

Ethnic minorities 1991 Census

Leicester City Council

Map 3 is a map of Leicester city centre by ward. It indicates the wards from which the respondents in this study came.



Map from:

Leicester *Key Facts*

Ethnic Minorities 1991 Census

Leicester City Council

Appendix B: Pen Portraits

Charlotte: Charlotte is Catholic. She is married with two children both girls. One is aged 7 the other is almost 1. Charlotte is aged 33. She works part-time as a customer service clerk for a retail company. Her husband works at a bank. She was born in Trinidad and came to Britain aged 5.

Deepika: Deepika is Hindu. She is married with 3 children. One girl aged 12, a boy aged 7 and a boy aged 3. She is aged 34. She stays at home to look after the children. Her husband works in a factory. She is British born. Her family comes from India.

Gurinder: Gurinder is Sikh. She has one child, a boy aged 5. She is aged 27. She works as a manager at a community centre. Her husband is in business. Gurinder is British born. She grew up in London and moved to Leicester to get married. Her family are originally from India.

Harpreet: Harpreet is Sikh. She is married with two children a boy and a girl, aged 13 and 12. She is aged 32. She works in a creche at a community centre. Her husband works in a factory. She is British born and grew up in Birmingham. She came to Leicester to marry. Her parents are from India.

Inder: Inder is a Sikh woman. She is married with four children. She has three girls aged, 13, 9 and 6. She also has a boy aged 1. She is aged 33. She is the part-time manager of a community centre. Her husband is an accountant. She is British born but her parents are from the Punjab, India. She grew up in Birmingham but moved to Leicester 14 years ago to get married.

Jaipreet: Jaipreet is Sikh. She is married. She has two children, a boy and a girl aged 6 and 8. She is 29. She works in the creche at the Sikh community centre. Her husband works in a restaurant. She is British born. She grew up in Southall and came to live in Leicester when she got married. Her family are from India.

Jameela: Jameela is Muslim. She is married with 3 children. She has two girls aged 13 and 9, and a boy aged 7. She is 38. She stays at home to look after the children. Her husband works in a restaurant. She is British born from Leicester. Her family comes from Gujarat, India.

Jaya: Jaya is Hindu. She is married with 1 child, a girl aged 1. She is 27. She is an accountant. Her husband is a bank worker. She is British born. Her family are from India.

Kishwar: Kishwar is Muslim. She is married. She has one child a girl aged 5. She is aged 41 She works with the under fives at a local play group. Her husband is a solicitor. She is from India and moved to Britain aged 3.

Lata: Lata is Hindu. She is married and has one child a girl aged 2. She is aged 26. She stays at home to look after the daughter. Her husband works in business. She is British born, her family come from India.

Rambha: Rambha is Hindu. She is a Uganda Asian. She is the sister in-law of Sita. She is aged 42. She has two children a boy who is 14, a girl who is 12. During school terms she works at the local school as a special needs support worker. She also works as a receptionist at a local FE college. Her husband is a postman. She was born in East Africa and came to Britain aged 5.

Maya: Maya is Hindu. She is married with two children, a boy aged 11 and a girl aged 8. She is aged 30. She works part-time at a local creche. Her husband works in retail. She is British born. Her family come from India.

Mira: Mira is Hindu. She is married with 1 child, a boy aged 2. She is aged 29. Both she and her husband are solicitors although she works part-time. She is British born, her family come from India.

Musarat: Musarat is Muslim. She is married with one child, a girl aged 4 and a half.

Musarat is aged 31. She stays at home to look after her daughter. Her husband works as a presser in a factory. Musarat is from East Africa. She moved to Britain aged 2.

Nandita: Nandita is Hindu. She is married with 2 children, two girls ages 6 and 2. She is aged 28. She works in a factory as does her husband. She is British born and her family are from India.

Niru: Niru is Hindu. She is married with 3 children, 1 girl aged 10, another girl aged 8, and a boy aged 3. She is aged 33. She stays at home to look after the children. Her husband is in business. She was born in Gujarat, India, she came to Britain aged 2.

Pavani: Pavani is Hindu. She is married with 3 children, 2 boys aged 8 and 6 and a girl aged 2. She is aged 29. She stays at home with the children and her husband works in a restaurant. She is British born. Her family are from India.

Priya: Priya is Hindu. She is married with two children. I boy aged 7 and a girl aged 3 and a half. Priya is 37 years old. Her husband is an accountant. She stays at home to look after the children. She is an East African born Asian from Madagascar. She came to Britain aged 3.

Ramila: Ramila is Hindu. She is married with one child, a boy aged 4. She is aged 23. She stays at home to look after her son. Her husband is off work sick at the moment. She is from India and moved to Britain aged 5.

Raminder: Raminder is a Sikh woman. She is married with two children, a boy aged 15 and a girl aged 13. She is aged 32. She works part-time with the disabled groups at the Sikh community centre. She also works with the elderly at age concern. Her husband is a bus driver. She was born in India and migrated at age 5 to Britain via Germany.

Reema: Reema is Hindu. She is widow. She has a son aged 17. She is aged 42. She works in a community centre full-time. She was born in East Africa and came to Britain

when she was 5. Her family are all from East Africa.

Rohini: Rohini is Hindu. She is married with 2 children, boys aged 8 and 7. She is 33. She stays at home to look after the children. Her husband is a postman. She was born in East Africa and came to Leicester aged 5.

Roopinder: Roopinder is Sikh. She is married with one child, a boy aged 2. She is aged 23. She works in a bank. Her husband is a pharmacist. She is British born but her family are from India.

Sakeena: Sakeena is Muslim. She is a divorced mother with one daughter aged 17.She is aged 43. Sakeena works as a translator for a Local health authority. She works alongside Sita. She also runs various night classes for women wanting to learn English. Sakeena was born in Pakistan. She came to Britain aged 4.

Samina: Samina is a Muslim woman. She is married with two children, she has a boy aged 4 and one aged 18 months. She is aged 24. She stays at home to look after the children. Her husband works in a factory. She is British born. She grew up in Blackburn but moved to Leicester on getting married. Her family are from India.

Seema: Seema is Hindu. She has 2 children, a boy aged 8 and a girl aged 6. She is aged 28. She works as a machinist. Her husband is a taxi driver. She was born in East Africa and came to live in Britain when she was 3.

Shahnaz: Shahnaz is Muslim. She has two children, a boy aged 7 and a girl aged 4. Shahnaz is 29. She stays at home to look after the children. Her husband is in business. Shahnaz is British born. She grew up in Blackburn, then moved to London. She came to live in Leicester on getting married. Her family are from India.

Sita: Sita is Hindu. She is married with 3 children. She has a girl aged 17, a boy aged 14 and another girl aged 7 She is aged 41. She works as an interpreter for a local health authority. She also works freelance as an interpreter at a community centre. Her

husband is an accountant. She was born in India and came to Britain aged 5.

Surinder: Surinder is a Sikh woman. She is married with two children. She has two girls aged 3 and 7. She is aged 30. She works part-time in the creche at a community centre. Her husband works in insurance. She is British born and comes from Leicester. Her family are from the Punjab, India.

Zahira: Zahira is Muslim. She is married with one child aged 3. She is aged 28. She stays at home to look after her daughter. Her husband is a dentist. She was born in India but moved to Britain via Turkey and Sweden when she was five.

Appendix C: Interview Schedule

This schedule was used as a guide and questions were adapted to women's specific circumstances. Some questions were added as the interviews progressed.

Section 1: Background Question

1) Name
2) Age
3) Education/occupation
4) Husbands occupation
5) Place of origin (e.g Britain, India)
6) Languages spoken other than English
7) How many children do you have?
8) What are the ages and sex of the children?
9) Do you know any other women who would be willing to take part in the study?

Section 2: General Questions about Health

1) Do you see yourself as healthy at present?
2) Are you actively utilising health care services at present? If so what are these?
3) When thinking about health and health services, do you make a distinction between western and Asian health systems? (I define what I mean by these).
4) If so what do you see as the difference between the two and do you see the two as (in) compatible?
5) Do you draw on Asian systems at all? (Define)
6) What form do these take?
8) How readily available are these systems to you?
9) Taking that further, do you see a distinction between official Asian medical systems (Ayurveda, Unani) and folk systems? (Define)
10) If so do you draw more on one than the other? (if yes, specify which).
11) In what circumstances would you use each?
12) Is one more available locally than the other?
13) Are you reliant on visits to India (East Africa, Pakistan) to obtain some of these remedies or in order to consult a South Asian healer?
14) How satisfied are you with the health care facilities in your area?

15) Do you prefer a female doctor? (Also prompt for race)
16) If you had a number of different types of health care available to you which would you choose?
17) Have you ever used, or would you use , private health care? If so in what circumstances.

Section 3: Specific Questions on Health

1) When you have a cold/minor illness (e.g stomach bug/infection) which you could treat yourself, how would you treat it? Can you tell me the kinds of remedies that you would use?
2) If your children were suffering from colds or minor illness how would you treat them?
3) Would you treat your children in the same way that you would treat yourself?
4) What about your (and his) attitude to your husbands health (is that the same as your attitude towards your children's health)?
5) Can you tell me about remedies that you might use around other health issues, say for instance around period pains, pregnancy and childbirth?
6) If self-treatment failed, where would you turn to next? Would you go to a friend, relative, alternative healer or GP? What options are available to you?
7) What about other illnesses, those that require management on a day to day basis such as diabetes and asthma. What kinds of remedies would you use to manage such illnesses.
8) What about more serious illness. Long term illnesses such as cancer. Would you go straight to using a western doctor or would other treatments be sought out at all?
9) In thinking again about more general health. Many people talk about the influence of the spirit world and the effects of spirits on health. That sometimes health or ill health are related to possession by spirits, what do you think about that. Do you believe in this?
10) If so do you ever draw on Hakims or Mullahs?

Section 4: General Questions on Identity and Health

1) Do you see yourself as westernized (define), as more associated with Asian culture or as drawing from different types of cultures (times and contexts)?
2) Do you mix mostly within the South Asian community or among other communities (white or black)?

3) If you mix mostly within the south Asian community, is this particularly among the Hindu, Sikh or Muslim community?
4) In terms of attitudes, do you see yourself as different to your parents and grandparents generation. In what ways?
5) How do you think this affects your views on health and health care in comparison to those of your parents and grandparents?
6) Do your beliefs and behaviours change when you are around members of the older generation?
7) How do you think that a persons household affects her beliefs and behaviour? By that I mean do you think that someone is more likely to hold beliefs and practices that are Asian if she lives with her in-laws or parents?
8) What about if someone lives alone with her partner and children. How do you think this affects her likelihood of holding beliefs and carrying out practices which are Asian?
9) Would you describe your diet as mostly consisting of Asian foods, western foods or something else?
10) Do you see diet as related to health? What foods do you connect with good or bad health?
11) Some people have suggested that foods carry certain properties. That certain foods are termed 'hot' and 'cold' and that you must eat certain foods for certain illnesses and ceratin foods to keep healthy. What do you think about that, is it something you practise and identify with?
12) Overall, do you see your health beliefs and behaviours as more influenced by western or Asian medical ideas?
13) Do you think that you would like to pass some of your ideas about health onto your children? (What sort if things).

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