

DECLARATION

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Signed By

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Date

SUMMARY

Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland

Background:

Childbirth as a process fundamental to human existence is one of the most significant cultural, social, psychological, spiritual and behavioural events of any woman's life. Whilst the physiological act of giving birth is a universal phenomenon, it is greatly affected and predetermined by the culture in which the woman has been socialised. Beliefs, rituals, perceptions and behaviours vary across the globe resulting in a unique birthing experience within every culture. Thus women's childbearing behaviours are shaped by the specific attitudes and values of that culture. For women, displaced from their country and culture for whatever reason, it becomes all the more crucial that they experience care during childbirth that is sensitive to their needs. Perceived best practice in childbirth is increasingly associated with the technological model of birth that forms the bulk of mainstream maternity care in advanced economies. Women, particularly those coming from different cultural backgrounds can find that their full range of needs require an individual approach within a model that does not easily cater for them.

Immigration and asylum seeking have become important social phenomena in Ireland since the mid-1990s. Approximately half of all asylum applicants in Ireland are women, a significant proportion of whom are pregnant on arrival and experience childbirth here. Their experience is usually set against a back-drop of their own personal suffering, hardship, and isolation from everything that is familiar to them. Women seeking asylum in Ireland are likely to experience social and economic marginalisation. A number of factors contribute to this, not least of which is the fact that by the time they reach these shores many women will have experienced profound loss, of home, family, support structures etc. Other factors that militate against integration in society include language difficulties, poverty and the inability to join the workforce. Under the 'direct provision system' introduced by the Irish Government in 2000, asylum seekers are housed in accommodation centres across the country. These centres are geographically removed from the community being positioned outside of towns or suburbs. Whilst many individuals and communities in Ireland have been

supportive of people seeking asylum in Ireland, a large proportion of the Irish population lack basic information to understand the asylum issue, which can in itself lead to suspicion and racism.

Aims:

To explore the physical, emotional and social experiences of refugee and asylum seeking women during pregnancy and childbirth in Ireland.

Methodology:

The study was guided by a feminist epistemology. Twenty-two women's narrative accounts of their childbirth experiences were included in the final analysis. Narrative analysis of data was employed using Burke's pentadic cartography with Bruner's (1990) sixth element of Trouble. Ethical approval was granted from three agencies and permission was given by the Department of Justice, Equality and Law Reform to access women in the accommodation centres.

Findings:

This analysis highlighted significant 'trouble' in the women's experiences. Findings emerging from the study detail the difficulties these women face on a daily basis, including communication and language difficulties, barriers to antenatal care and childbirth education, fear and anxiety related to technological birthing practices, and issues related to nutrition and breastfeeding. Hardship related to living in direct provision and being subject to dispersal was raised also, and increased complications related to pregnancy and childbirth were noted for both mothers and babies within the participant population.

Conclusion:

Women who give birth while seeking asylum in Ireland have a specific set of needs as outlined above that are not currently being met. Substantial implications for provision of maternity care have been raised as a result of this study and future research needs have been highlighted.

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Chapter 1

Childbirth in Exile: Framing Asylum Seeking Women's Experiences of Childbirth in Ireland

1.1 Introduction

The purpose of this chapter is to situate asylum seeking women's experiences of childbirth in Ireland within the wider context of national and international issues that directly affect them. The inward migration of women into Ireland was seen in unprecedented numbers from 1995 onward, peaking in 2002 with 11,634 applications for refugee status, with numbers in 2009 of 2,689 the lowest since 1997 (Office of the Refugee Applications Commissioner 2010). Movements of women in such large numbers do not occur in isolation. International forces related to the move toward globalisation have had a direct impact on the global movement of women; the new found Irish prosperity meant there was a pull factor for migrants fleeing untenable situations to consider Ireland a viable option. Other issues that directly affect asylum seeking women who give birth in Ireland are related to the organisation of the Irish maternity service, our understanding of culture as it relates to childbirth and with that the imperative towards culturally competent care. Towards this end I consider the issues as they relate to the women who took part in the study and the wider population of asylum seeking women under four distinct headings. These are culture and childbirth, globalisation and its effect on the migration of women, immigration and asylum in Ireland and finally the maternity services in Ireland.

1.2 Culture and childbirth

Childbirth as a process fundamental to human existence is one of the most significant cultural, social, psychological, spiritual and behavioural events of any woman's life (Jordan 1993, Callister 1995, Nicholas 1996, Callister 2004, 2005). Whilst the physiological act of giving birth is a universal phenomenon, it is greatly affected and predetermined by the culture in which women have been socialised (Ottani 2002b). Beliefs, rituals, perceptions and behaviours around childbirth vary across the globe resulting in a unique birthing experience within every culture (Steinberg 1996, Ottani 2002a). For women, displaced from their country and primary culture for whatever reason, it becomes all the more crucial that they experience care during childbirth that is sensitive to their needs. Perceived best practice in childbirth is increasingly associated with the technological model of birth that forms the bulk of mainstream maternity care in advanced economies (Davis-Floyd 1992). Women, particularly those coming from different cultural backgrounds, can find that their full range of needs require an individual approach within a model that does not easily cater for them (Liamputtong Rice and Naksook 2003, Callister 2005, 2006).

The ground-breaking work of Brigitte Jordan first published in 1978, and then revised three times to the last edition in 1993 (Jordan 1993), drew our awareness to the very different realities of childbirth experiences in other cultures. One of the most significant findings was that in a given culture, guardians of childbirth practice and ritual can interpret similar behaviours in very different ways and with very different outcomes for a woman's childbirth experience. For example, the use of oxytocic and pain relieving drugs in low risk births would be considered utterly inappropriate in Holland, yet these two interventions are common place in American (and sadly most western) hospital births, and failure to avail of them would be considered equally inappropriate in that setting (Jordan 1993). This example shows how acceptable behaviours are open to interpretation. Interpretation of what is considered risky behaviour in childbirth is central to the debate in contemporary childbirth practices (Downe 2008). In most societies

childbirth is seen as a time of vulnerability for the mother and child. This concept of birth as a 'life crisis event' has made childbirth itself vulnerable to societal shaping and regulation (Jordan 1993:4). Unfortunately the western approach to childbirth has been dominated by the medical or technocratic model of childbirth that renders women passive and their bodies defective. This dominant technocratic medical system has done a good job of convincing women of the defectiveness and dangers inherent in childbirth (Brettell and Sargent 2001). Thus women have been marginalised and alienated from themselves and their childbirth experiences through what Jordan (1993) termed authoritative knowledge that renders a woman's own knowledge irrelevant at best and problematic at worst. The authoritative knowledge is held by the health professional and the woman's knowledge of her own body simply does not count. There is a need therefore to go outside of the dominant medical model of birth to home birth environments and to developing countries to gain insight into and to generate viable alternatives (Jordan 1993, Davis-Floyd 2000, Murphy-Lawless 2003). There is a wealth of anthropological studies that have shown indigenous systems of maternity care to be viable, healthy alternatives to the technocratic medical model (Davis-Floyd and Sargent 1997). Yet the greatest concern is the wholesale export of the western medical model of childbirth to developing countries, despite the fact that those very policies are deeply contested by women and some health care providers in developed countries, and perhaps more importantly have not shown a comparative decrease in maternal and neonatal mortality and morbidity in relation to increasing levels of medical interventions. Indeed the widespread application of the medical model has been seen as unhelpful and even dangerous in remote areas where there is a lack of resources and training to sustain such interventions (Murphy-Lawless 2003). Moreover, it is widespread poverty and the ever deepening divide between rich and poor that is the number one killer of women in developing countries and not the indigenous knowledge of local midwives (Davis-Floyd and Sargent 1997). Murphy-Lawless (2003) makes a compelling argument in relation to the wholesale importing of western standards often 'pushed' by the World Health Organisation, but without sufficient investment or recognition of marginalised indigenous midwives which is detrimental and in itself speaks to the greater issues

of what constitutes authoritative knowledge. The biomedical interventionist model is seen not merely as undermining women's knowledge as valid but as exerting ultimate control over women. However, the issue of control in childbirth is complex, when considered in terms of whether the technocratic models of childbirth and reproduction serve to empower or to disempower women, with both sides to the debate finding support from women and feminist scholars (Klassen 2001). These divisions have led to a kind of stratification of reproduction where some women are empowered to give birth and nurture while others are undermined (Ginsburg and Rapp 1995). The control women believe they have in the use of technology in childbirth has been termed an illusion, as the losses incurred by wholesale surrender to the techno-medical model far outweigh the gains (Davis-Floyd 1994a, Davis-Floyd and Cheyney 2009). In the technocratic system women have lost power; the loss is seen in terms of their intuitive knowledge of their own bodies and of how to give birth. Instead, this power has been handed over to obstetrics and is now seen as the standard approach of 'best practice' in westernized societies. This dominance of the medical model has shaped and controlled women, and successfully socialized them to a point where the majority of women no longer believe they have the knowledge or power to give birth outside of a highly medicalised environment. The lesson the biomedical model teaches women through the technological birthing experience is a profound lesson about the weakness and defectiveness of their bodies and about the power of technology (Brettell and Sargent 2001). Thus women can find they are left with a birthing experience where they cannot experience any fragment of agency, indeed are barely required to be present, hooked to several different machines, it appears that providers are more closely tuned to the technology rather than the women herself. Providing emotional support for women in labour is key to good practice, however, when technology becomes the focus of care women and midwives miss out on crucial emotional aspects of childbirth (Hunter 2004, Hunter *et al* 2008). Women are therefore often left with a childbearing experience bereft of any spiritual or emotional element, let alone any sense of fulfilment. The message given to women from proponents of the biomedical model of childbirth is clear, as Murphy Lawless

(1998:10) states ‘you can escape death if you follow us. But you must hand over your role as the central player in childbirth’.

The current state of childbirth and reproduction is a mine field of managed emotions, ignorance and arrogance on behalf of the dominant medical system (Hunter 2004, McCourt and Stevens 2008). This system is challenging for any women seeking to have a safe and meaningful birthing experience. For women who come to Ireland to seek asylum it is all the more challenging. When speaking of culturally appropriate care we understand that while it is reasonable to expect providers to have an understanding of a woman’s cultural beliefs and needs in childbirth, what is paramount is respect for her dignity (Women's Health Council 2006). Unfortunately as we have seen in a brief overview of the literature, dignity in childbirth in a technocratic model of care is not a priority. It is not surprising then that women, who are already compromised by travelling long distance under terrible conditions, having experienced profound levels of loss and violence in some instances, are traumatised as a result of their experiences (Lyons *et al* 2008, Mbugua 2010).

However, there is some hope of agency for asylum seeking women as they access maternity services in Ireland and this may be echoed in what (Hall 2006) has termed globalisation from below. In the context of an interview with Pnina Werbner, Stuart Hall (2006) outlined globalisation as a deeply contradictory process where people are driven by forces outside of themselves, such as war, famine, ethnic cleansing, poverty and ecological disaster to seek a better life. In this process refugees have the possibility of engaging as it were ‘from below’, if not always by choice, with the same aspects of globalisation as global entrepreneurs would from ‘above’. For example, refugees travel to new countries, learn new languages, and skills, deal in different markets, (markets in people as opposed to financial) etc., but it is a global life out of necessity and as such brings to our awareness the under belly of the globalisation movement. This notion of

defining and illuminating a system from below resonates in terms of the light that refugees and asylum seeking woman have brought to bear on the crisis in the Irish maternity system, again not through choice, but necessity. I wish to look at this issue more closely but first I want to consider the effects of globalisation on the migration of women.

1.3 Globalisation and the effects on migration of women

The last decade has seen unprecedented migration as people move across countries or continents in search of a better life, whether fleeing wars, famine, political or economic upheaval. International migration grew rapidly in the 1990's, reaching an estimated 135-140 million people by 1997 including thirteen million UNHCR recognised refugees(Castles 2000). Migrants compose a variety of groups including temporary labour migrants, highly skilled workers, returning emigrants, as well as refugees and asylum seekers. Migration is also seen as an integral part of globalisation that is apparent in the rapid increase of cross border movement of all kinds, including finance, trade, ideas, media, and people. The vast growth in information technology, access to television and relatively cheap air travel has made movement across the globe more accessible for those with the means to avail of it. Castles (2000) argues that cross border mobility of commodities are inextricably bound to population mobility but while governments welcome the flow of capital commodities they are less welcoming of people as the cultural differences are seen as a threat to sovereignty of nation states. Typically movement is from areas of relative poverty to countries that are wealthy and provide opportunities for employment and stability. However, to suggest that people move simply because of poverty is an over simplification of an often complex set of circumstances. Often little regard is given to the reasons why refugees are forced to flee (Cullen 2000). In fact the very poorest people are less likely to move because of lack of resources, except in times of desperation such as war or famine, and then their movement is limited and often under conditions of

extreme hardship. Decisions of where to go are usually influenced by prior links with the receiving country. This may be through colonisation, political influence, investment or cultural ties, or simple proximity as in the case of Rwanda when people fled across the border to the Democratic Republic of Congo. The link has been made between Ireland's past 'investment' of missionaries in Africa and the current choice of many African migrants coming to Ireland (Inglis 2008). Once a community of migrants have been established in a country, it makes it easier for others from their homeland to join them, with a migrant industry emerging including lawyers, agents, smugglers who may just as easily exploit immigrants as help them, 'illegal' or the more acceptable term, irregular immigrants, are particularly vulnerable to exploitation (Siddiqui 2003). A recent trend in migrant populations has been the feminisation of migration with women forming a large proportion of migrants, many of them travelling independently. The reasons for the growing numbers of women seen in this category have been shown to be directly linked with the effects of globalization on developing economies (Dumont *et al* 2007). Specifically the policies of the World Bank and the International Monetary Fund (IMF), in the Structural Adjustment Programs (SAP's)¹ have resulted in a number of damaging consequences for developing

¹Structural Adjustment Policies are economic policies which countries must follow in order to qualify for new World Bank and International Monetary Fund (IMF) loans and help them make debt repayments on the older debts owed to commercial banks, governments and the World Bank. Although SAPs are designed for individual countries, they have common guiding principles and features which include export-led growth; privatisation and liberalisation; and the efficiency of the free market. SAPs generally require countries to devalue their currencies against the dollar; lift import and export restrictions; balance their budgets and not overspend; and remove price controls and state subsidies. Devaluation makes their goods cheaper for foreigners to buy and theoretically makes foreign imports more expensive. In principle it should make the country wary of buying expensive foreign equipment. In practice, however, the IMF actually disrupts this by rewarding the country with a large foreign currency loan that encourages it to purchase imports. Balancing national budgets can be done by raising taxes, which the IMF frowns upon, or by cutting government spending, which it definitely recommends. As a result, SAPs often result in deep cuts in programmes like education, health and social care, and the removal of subsidies designed to control the price of basics such as food and milk. SAPs hurt the poor most, because they depend heavily on these services and subsidies. SAPs encourage countries to focus on the production and export of primary commodities such as cocoa and coffee to earn foreign exchange. But these commodities have notoriously erratic prices subject to the whims of global markets which can depress prices just when countries have invested in these so-called 'cash crops'. By devaluing the currency and simultaneously removing price controls, the immediate effect of a SAP is generally to hike prices up three or four times, increasing poverty to such an extent that riots are a frequent result (Structural Adjustment Participatory Review International Network (SAPRIN) (2004) Structural Adjustment Participatory Review International Network (SAPRIN) The Policy Roots of Economic Crisis

countries, most noticeably in the insurmountable and crushing debt that itself bears negative outcomes for those societies and for the women in particular (Sassen 2002).

Sassen (2002) argues that the conditions associated with SAPs, for example opening up the countries to foreign firms and eliminating state subsidies, often impact directly on the health and wellbeing of families. Redirecting of manufacturing away from production for national benefit to a focus on international exports had resulted in increased unemployment, particularly in rural areas. Countries that became deeply indebted in the 1980's have not been able to dig their way out. The IMF and World Bank promised growth and security to countries that submitted to the structural adjustment programs but all of these countries are still in debt. North African payments to the World Bank reached \$5 billion in 1998 which means that for every \$1 in aid that was given by the World Bank, Africa paid \$1.4 in debt service interest. Sassen (2002) argues that rather than improve these economies the SAPs have raised the debt dependence of these countries and contributed to the increase in unemployment and poverty. The resulting poverty has led to the demoralising of men who cannot find employment and resulted in pressure on women to become the main breadwinner and to find ways to survive for themselves and their families. These women often leave their homes and families behind to find employment in richer western countries, many of them in traditional caring or service roles as nurses, child care providers or sex workers.

Ehrenreich and Hochschild(2002) depict the unprecedented movement of women as a worldwide gender revolution, where women from both rich and poor countries are becoming equal breadwinners and providers. However, they highlight the irony that while wealthy western women may have an average of twenty minutes a day to commute to their place of employment, the cost of the 'commute' for women coming to the west from developing countries is yet to be fully realised. As women in western countries work longer hours and compete

and Poverty: A Multi-Country Participatory Assessment of Structural Adjustment. Washington, DC SAPRIN.

with male counterparts for scarce positions at the top, it is women from poorer southern countries who have taken over the traditional caring roles that richer women no longer have time to fulfil. In their book *'Global Woman: Nannies, Maids and Sex Workers in the New Economy'* Ehrenreich and Hochschild(2002) highlight the dilemma for women as they leave their own children, often for many years returning for brief visits perhaps just once a year. They suggest that while poor women lavish love on western children, who now have two 'mothers' their own children are left motherless. Ehrenreich and Hochschild liken this to previous periods of colonisation where imperialist Northern countries pillaged poorer countries of their natural resources, this modern colonisation is extracting emotional resources, as though the wealthy nations were running out of natural emotions, they are now extracting from poorer countries ' something that can look very much like love' (p. 4).

Inequalities in wages between rich and poor countries have also resulted in a brain drain with some countries most educated women leaving, often the best educated women leave the poorest countries, and while the same trend is seen in men in recent years the trend has been more noticeable in women migrants (Callister *et al* 2006). This has detrimental effects on education, health and nutrition of those areas left with a dearth of knowledgeable women (Dumont *et al.* 2007). Migrant women are a significant source of foreign currency for developing countries and this has led some governments to actively encourage the immigration of its women to richer states. One of the biggest exports of women has been the Philippines where overseas migration is seen as doubly beneficial in that it eases unemployment and is a source of revenue from money sent back into the country by migrant workers. Highly educated women often work in menial jobs because the pay is far better than they could earn in a profession back home. Sending money back to educate their children feed and house families provides a valuable source of revenue for the family, wider community and ultimately the State. According to the International Labour Organization (ILO) migrant workers send remittances to their home countries of US \$73 billion dollars every year, usually

from modest earnings. Migrant workers' remittances represent the second biggest international monetary trade flow, exceeded only by petroleum exports. For many countries, remittances represent greater sources of foreign exchange than total foreign direct investment or foreign aid (International Labour Organisation (ILO) 2000). To this end some developing countries have targets for emigration. Indonesian and Thailand government strategies include targets for sending workers overseas (Wickramasekara 2002).

There is significant discussion in the literature on the link between globalisation and the increase in trafficking of women and children (Hughes 2000, Sassen 2002, Andrijasevic 2003, Schrover *et al* 2008). Women on the move alone are vulnerable to not just violence and rape but to traffickers for the sex trade. Alarming numbers of women disappear each year into sex trade via criminal gang activity. The trafficking of women and children is a profitable criminal business and one that the shadow global economy fuels. The UN estimates for 1998 suggested that approximately four million people were trafficked producing a profit of US\$7 billion dollars for criminal gangs (Sassen 2002). Women are seen as valuable commodities in a global sex trade worth an estimated seven to twelve million dollars a year and is seen as a less risky source of criminal activity than drugs or arms (Hughes 2000). Traditionally, countries such as Thailand and Philippines were the largest exporters of women to the sex trade but in recent years ex-soviet countries such as the Ukraine, Belarus, Latvia and Russia have become the major sending countries, with women from the Ukraine and Russia being considered most valuable (Hughes 2000, Andrijasevic 2003). However, more recent discussion highlights the complexity of the trafficking issues acknowledging that women usually have some level of agency or choice (with the exception of kidnapping cases) even when being recruited to the sex industry. Schrover *et al.* (2008) argue that the panic seen around the trafficking of women has been used by governments in a number of ways to subjugate women, with women's migration seen as trafficking of passive, vulnerable women while men are seen as being smuggled into countries through choice. This has had

detrimental impact for women with increased surveillance of women's movements and in extreme cases, for example Bangladesh, Indonesia, and Nepal where emigration for women has been banned or restricted due to concerns regarding trafficking. While there is much discussion about the complexities of choice and coercion of those trafficked or smuggled, there is still a consensus that caution and protection of migrants is paramount, and the reality of trafficking as a process detrimental to women is still apparent (Taran and Geronimi 2002, Andrijasevic 2003). Women are on the move in large scale global migration not seen before. While sending and receiving countries have been shown to benefit, the women themselves often occupy a contested space of vulnerability and empowerment as they seek to make a better life for themselves and their families. It is perhaps not surprising then to find that it is women and pregnant women in particular who find themselves at the centre of the controversy in the debate on immigration in Ireland.

1.4 Immigration and asylum in Ireland

Immigration and asylum seeking have become important social phenomena in Ireland since the mid-1990s. Approximately half of all asylum applicants in Ireland are women; a significant proportion of whom are pregnant on arrival and experience childbirth here (Murphy 2005). Their experience is usually set against a back drop of their own personal suffering, hardship, and isolation from everything that is familiar to them (Kennedy and Murphy-Lawless 2003). Women seeking asylum in Ireland are likely to experience social and economic marginalisation (Manandhar *et al* 2006). A number of factors contribute to this, not least of which is the fact that by the time they reach these shores many women will have experienced profound loss, of home, family and support structures (Kennedy and Murphy-Lawless 2003). The government introduced the direct

provision system², whereby asylum seekers are housed in government funded ‘accommodation centres’. Standards vary across the country and the system has been criticised for inhumane conditions. The geographic location of these centres adds to the social exclusion and isolation experienced by many asylum seekers (Fanning 2002). Other factors that militate against integration in society include language difficulties, poverty and the inability to join the workforce. Basic needs for food and shelter are provided and a weekly community welfare payment³ of just €19.10 per adult and €9.60 per child is made. Whilst many individuals and communities in Ireland have been supportive of people seeking asylum in Ireland, a large proportion of the Irish population lack basic information to understand the asylum issue, which can in itself lead to suspicion and racism (Fanning *et al* 2000).

A number of research studies have been commissioned to investigate the needs of refugees and asylum seekers in Ireland (Begley *et al* 1999, Fanning *et al.* 2000, Visser and O'Connor 2004). Begley *et al.* (1999) was the first study undertaken to consider the public health consequences of those in the ‘asylum process’ for extended periods of time. The study had a qualitative design and a sample size of eighty participants. The major findings of the study were psychological ill-health as a major concern for asylum seekers, anxiety, depression and sadness as recurrent themes compounded by unemployment and prolonged application processes, racism and public hostility fuelled by negative media coverage, lack of coordinated translation services, lack of training and information in refugee culture and needs for health providers and finally welfare dependency, boredom and loss of skills resulting from prohibition of the right to work. These issues are

²The system of Direct Provision Accommodation Centres for asylum seekers was introduced by ministerial circular of the Department of Justice, Equality and Law Reform in April 2000, with a separate circular introducing compulsory dispersal. Asylum seekers are dispersed to full-board accommodation in one of 56 centres managed on behalf of the government by private contractors Bartlett, H. (2009) Peer Health Workers in Direct Provision Accommodation Centres for Asylum Seekers in Galway - an ERF Intercultural Health Project. In *Translocations: Migration and Social Change*.

³A community welfare payment received from the HSE. A weekly payment of €19.10 per adult and €9.60 per child, or €2.73 & €1.37 per day, respectively. (AkiDWA, 2010)

sadly still relevant and unresolved today. The main limitations of the study were that the participant group was almost entirely made up of men with just one woman respondent. Kennedy and Murphy-Lawless (2003) conducted the first commissioned study that explored specifically the maternity care needs of refugee and asylum seeking women. Women in the study highlighted the inadequacy of accommodation, the impact of poverty and difficulties in the antenatal period associated with access to clinics, language, and social support. While standards of physical care were good, women reported insufficient time on the part of maternity care providers to respond to their emotional and support needs during labour. Poor standards of nutrition and cases of postpartum malnutrition resulting in the need to abandon breastfeeding were also identified, and there were also some muted experiences of racism.

Women coming to Irish shores in recent months do not necessarily meet the typical, or as Krulfeld (1998) refers to it, the 'idealized' notion of refugees. The legal definition of a refugee that we use today stems from the 1951 United Nations definition of a refugee written at the height of the cold war entered Irish legislation as:

A person who, owing to a well-founded fear of being persecuted for reasons of race , religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable to, owing to such a fear, is unwilling to avail himself or herself of the protection of that country, or who, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it (Office of the Refugee Applications Commissioner 2010).

Uehling (1998) challenges the assumption in this definition that migration is of necessity forced or involuntary and that the refugee would return home if possible

and suggest that, in reality, the issues are often more complex. The term asylum seeker is now the established term used to describe an individual seeking refugee status, however, it is a somewhat contested term (Kennedy and Murphy-Lawless 2003). The term asylum seeker replaced that of refugee in common use in the mid nineteen nineties as countries in the west tried to limit their responsibilities to taking in refugees as defined by the 1951 UN definition. Hyland (2001:1) states 'whereas a 'refugee' implies an active attempt at flight from a threat or privation, 'asylum seeker' suggests a purely passive, supplicant creature on whose essence as a 'genuine' or 'bogus' supplicant the 'host' State must decide'. In this way the 'proof' of being a 'genuine' refugee is placed on the individual person seeking asylum, leaving them open to being considered 'bogus' until a legal review process deems otherwise. The lives of the women I have encountered suggest that the conditions that drove them out of their homeland to seek refuge in Ireland are complex and at times contrast the idealized Cold War version of the refugee with the more realistic complexities of multi-layered decision making and choice. Yet, the element of choice does not negate the loss or suffering just as the issue of whether or not Ireland is the first shore these women may have landed on in the long journey from their own country should negate their right to shelter here. I was very conscious of this as I began to engage with the literature. In the early stages, this involved a brief search of the literature to provide a context to the study for grant applications and ethics committees. Initially, the women themselves became secondary to the form filling that occupied so much of my time, and yet I found myself acutely aware of obviously non-Irish women, in daily life, for example, in supermarket queues, in traffic jams etc. Travelling back and forth between Ireland and America I seemed to spend a lot of time in taxis, and inevitably the conversation turned to Ireland's experience of immigration. Negativity towards immigrants was overwhelming, especially towards Nigerian immigrants. I was regaled with stories as to how 'they' fiddle social security and leave new pushchairs on the side of the road when they will not fit into taxis because they can easily get a new one from social services'. I was met with bafflement regarding my study and why it should be done when so many other issues in Irish society need to be addressed. There appears to be a denial that this

is an Irish issue. Fanning (2002) argues that despite the fact that Ireland is now a multicultural society, our current response to asylum seekers is based on long developed historical policies and legislation of exclusionary practices, posing Irish society as a homogenous entity under threat by absorbing too many 'non-nationals'. This is evident in the exclusion of asylum seekers from the remit of policies aimed at the inclusion of new black and minority groups into Irish society as it is in the response of some Irish citizens to the stranger in their midst.

1.5 Historical perspective

Ireland has a long history of emigration which is very much part of the Irish 'story', almost every family in Ireland has been touched by emigration. We understand what it means to be the new comer and to experience racism and hostility. One would perhaps expect that Ireland as a nation would be more welcoming and understanding of immigrants but the opposite would appear to be true. Ireland also has a long history of immigration, from the ancient invasions of Celts, Normans, English, Scots, Huguenots and Jews to more recent newcomers. However, Ireland's treatment of refugees has historically been less than exemplary. Cullen (2000) provides a comprehensive overview of Ireland's past record with providing shelter to refugees. In 1956 Ireland hosted 560 Hungarian refugees who were housed in a disused army camp, and their poor treatment led to the refugees staging a hunger strike to draw attention to their plight. In 1973 one hundred and twenty Chileans were given refugee here but left as soon as possible. Other groups include twenty six Iranian Baha'is, seven hundred and seventy Bosnians in 1992, and approximately one thousand Albanian refugees in 1999. However, the numbers of immigrants coming into the country have always been small and the welcome a measured one (Cullen 2000, Fanning 2002, Garner 2007). Ireland's history as a multicultural society has also been problematic, as evident in Traveller communities, and among protestant and Jewish communities

that have historically been marginalised from main stream Irish culture (Fanning et al. 2000, Fanning 2002, Crowley *et al* 2006).

A number of factors appeared to pre-date the new wave of immigrants in the mid 1990's. Ireland's unprecedented economic success, coupled with the 1998 Peace agreement in the North meant Ireland became an attractive option for people fleeing from their native lands for reasons of war, unease, or personal hardship. The third factor in this picture is the unprecedented worldwide movement of people from troubled and impoverished countries often destabilised by the push toward globalisation that necessitates migration to industrialised countries in order to find employment. The Irish response to the new immigrants was mixed at best and decidedly suspicious, unwelcoming and racist at its worst. Crowley *et al*, (2006) comment that it is deeply ironic that Ireland, given its long history of emigration is actively seeking to limit and resist immigration into Ireland.

1.6 Government response

'Ireland's response to the arrival of large numbers of asylum seekers has been shameful. The Department of Justice, politicians, and the media have at various times abused a vulnerable group of people for selfish gain or to cover up inaction or incompetence on their own part.'(Cullen 2000:24)

The Government response to the new wave of immigration was to use the legislature to tighten the Irish borders and make it more difficult for people seeking asylum here to make a case to stay. Ireland did not enact its own legislative policy for dealing with asylum seekers until 1996, relying instead on

international and EU policy for handling refugees. In the 1995 Fakih Case procedures were put in place for handling asylum applications. In this case, the courts determined that three Lebanese asylum seekers were wrongfully denied a full hearing. The court found that failure to provide asylum seekers with due process was in contradiction with directives from the United Nations High Commission for Refugees. There followed a number of legislative acts in an effort to show that the government was able to manage the perceived 'Asylum problem'. These included the Refugee Act (Office of the Attorney General 1996), the Employment Equality Act (Office of the Attorney General 1998), the Immigration Act (Office of the Attorney General 1999), the Illegal Immigration Trafficking Act (Office of the Attorney General 2000) and the Equal Status Bill (Office of the Attorney General 2002, 2004a). The Refugee Act (Office of the Attorney General 1996) which was seen as progressive legislation to protect the rights of refugee and asylum seekers was dogged by party political infighting and failure of the new government to enact a law that had been introduced by their rivals now no longer in power (Cullen 2000). Increasing numbers of asylum seekers in the mid to late 1990s led to a range of punitive legislative measures by the government. These included the Immigration Trafficking Bill (Office of the Attorney General 1999), and an amendment to the Refugee Act (Office of the Attorney General 2000). These measures taken together served to effectively make seeking asylum in Ireland much more difficult and to increase deportation rates (Crowley *et al.* 2006).

Perhaps the most significant of the new legislative acts was the 2004 citizenship referendum that reversed the *jus soli* ruling⁴ making it impossible for children born in Ireland to claim citizenship unless they were born to Irish parents. In a perhaps bizarre and one could argue overtly racist move, the government deliberately retained the right of children born outside Ireland with Irish born grandparents to retain the right to Irish citizenship (Lentin 2007a). The government has been criticized for its part in sensationalising reports of an influx of immigrants, particularly pregnant women coming very late into their pregnancy

⁴ Birth right (*jus soli*) citizenship was in existence since the establishment of the Free State in 1922.

for the sole purposes of giving birth here and gaining citizenship for their children and therefore gaining a foot-hold into Ireland for themselves (Brown 2004). The government of the day argued there was immense overcrowding in Dublin maternity hospitals as ‘proof’ of the need to curtail immigration and cited several of the ‘masters’⁵ of the three main maternity hospitals who later tried to distance themselves from the alleged comments (King 2004). The reality was that the government misquoted figures referring to the total number of immigrants including returning Irish citizens who came back to Ireland in their droves with the promise of the new prosperity opening up opportunities to succeed perhaps for the first time in Irish history (Brennock 2004a, Garner 2007). However, the media frenzy that fed off government minister’s hype had serious detrimental effects in terms of escalating racism and mistrust of immigrants who were portrayed as bogus. This was particularly true for pregnant women, who were accused of coming to Ireland in the late stages of pregnancy simply to rip off the country’s social security system and gain citizen-ship for their children (King 2004).

1.7 Irish Maternity Services

Women coming to Ireland to seek asylum unfortunately find themselves in the centre of a maternity service in an on-going state of crisis (Tussing and Wren 2006). The crisis in the maternity services in Ireland is well documented and multi-faceted (Tussing and Wren 2006, KPMG 2008, Kennedy 2010). Women coming from other countries to seek asylum in Ireland have a particular set of individualised needs that require a maternity service that offers an approach to women’s maternity care needs that is caring, competent, individualised and culturally sensitive (Kennedy and Murphy-Lawless 2003). However, this kind of service remains extremely limited in the current climate of medically dominated

⁵Master’ the title used for the chief executive officer/the senior obstetrician(CEO) of the Dublin Maternity hospitals

hospital based provision and only a very small group of women currently have access to this kind of care.

The perceived crisis in the Irish Maternity hospitals came to the attention of the public when politicians began to highlight it ahead of the citizen referendum in 2003. At this time Ireland was experiencing unprecedented numbers of inward migration, a significant portion of which could be attributed to Irish citizens returning home and to immigration from non-EU countries such as the US and Australia.

Irish citizens voted 1:4 in support of the amendment; the masters of the three maternity hospitals later retracted their statements and distanced themselves from the minister's alleged extrapolation of their comments (Brennock 2004b). The shameless scapegoating of asylum seekers was a cover up for a maternity service that has been in crisis for years, suffering years of consistent under investment from public funds, operating in ancient hospital buildings that can no longer provide for the volume of women coming through and yet there is no viable primary health care strategy to ease the burden (Tyrell 2004, Burke 2008, Kennedy 2010).

Ireland lags behind the rest of Europe in terms of offering women choice in childbirth. While small number of independent midwives operated around the country they were largely unsupported as demonstrated by the unanimous ruling in the Supreme Court that there was no statutory obligation on the health service to provide a home birth service (Devane *et al* 2005). A limited number of DOMINO⁶ schemes operate in sites around the country; these provide a level of continuity of care as midwives work as a team linking community and hospital based care. Domino schemes currently operate in Dublin, Cork, Galway and Waterford but access to these schemes are restricted to a close radius around the

⁶ DOMINO – refers to domiciliary services - DOMiciliaryIN and Out, where ante and postnatal care is in the woman's home but birth is in hospital

hospital and therefore could only be accessed by the elite few who are lucky enough to live in proximity to the service.

The current hospital based, consultant led care model is patently untenable but continues to be a lucrative source of income for a powerful lobby of consultant obstetricians that are not accountable to anyone in matters of clinical or financial audit (O'Connor 2006). Kennedy (2010) suggests that changes occurring in the maternity services are as a result of local demands and not because of any cogent national development plan. The local and national outcry at the loss of the Monaghan General hospital and Louth County hospitals, combined with the public's already thin patience as a result of public acknowledgment of crimes against women performed by the obstetrician Michael Neary who had worked for twenty five years in the North East and was struck off for performing unnecessary caesarean-hysterectomies (McCarthy *et al* 2008) caused the North East Health Service Executive (NEHSE) to commission a new report looking to the development of future services. The initial report by Condon (2000) was rejected by the NEHSE as it did not offer an innovative approach and supported the consultant led service model. A new report was commissioned that recommended a quality maternity service with the focus on women centred care that was safe and accessible (Kinder 2001). This paved the way for the development of a maternity services task force that resulted in the commissioning of two midwife led units in the North East of the country, providing women with a viable alternative to hospital based consultant led care for the first time in history in that part of the country (Devane *et al.* 2005). These units have been carefully audited in a randomised control trial (the MidU study⁷), conducted by midwife academics

⁷The MidU study aimed to provide high quality evidence on which to base decisions with regard to the organisation and provision of maternity services in the Health Service Executive-North East, and the rest of Ireland. Known as 'the MidU study,' where MidU stands for 'Midwifery Unit' Begley, C.M., Devane, D., Clarke, M., McCann, C., Flannagan, B., Maguire, R., Molloy, K., Higgins, S., Ahmed, S., Finan, A. & Vaughan, D. (2009) Begley, C.M., Devane, D., Clarke, M., McCann, C., Flannagan, B., Maguire, R., Molloy, K., Higgins, S., Ahmed, S., Finan, A. & Vaughan, D. An Evaluation of midwifery-led care in the Health Service Executive North Eastern Area: The report of the MidU study. School of Nursing and Midwifery, Trinity College Dublin, and Health Service Executive.

at Trinity College Dublin (Begley et al. 2009). The results of this trial show midwifery led care to be cost effective, safe, resulting in less medical intervention and providing increased levels of satisfaction to women (Begley et al. 2009). It is hoped that the Health Service Executive⁸ (HSE) will develop plans for a national maternity policy based on the findings of the study. Other changes in the maternity service provision have been proposed in response to the KPMG⁹ report commissioned by the HSE in 2007. Findings of this report highlighted over reliance on consultant led care, sub-optimal infrastructure, lack of choice, lack of privacy and dignity, increased risk of infection and inadequate community and primary care provision. Recommendations include the relocation of the three Dublin maternity hospitals to sites of large regional general hospitals with dedicated midwifery led units in place adjacent to maternity hospitals from the (KPMG 2008). The roll out this type of midwife led care for low risk pregnant women to other areas of the country will be a welcome and long awaited innovation.

While change is occurring in the Irish maternity services, this change is slow and women currently still have very little choice as to where they will give birth. A survey carried out by AIMS Ireland¹⁰ (AIMS 2010) confirmed that women want a maternity system that is flexible and offers choice and continuity of care for childbearing women, however this is not what women are experiencing. The findings of the survey report suggest women still have difficulty finding information about childbirth options with many GP's only offering information about shared care between GP and hospital consultant or private care.

⁸The Health Service Executive (HSE) acquired full operational responsibility for the management of the country's health and personal social services on 1 January 2005. The HSE was established as the first body charged with managing the health service as a single national entity (KPMG, 2008).

⁹KPMG, a partnership, is a member of KPMG International, a Swiss cooperative commissioned to undertake the Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area (2008)

¹⁰AIMS Ireland is a consumer-led voluntary organisation that was formed in early 2007 by mothers dissatisfied with the maternity care system in Ireland. Their mission is to highlight and campaign for normal birth and mother-friendly birth practices which are supported by evidence-based research and international best practice.

Information about DOMINO schemes, midwifery led care or home birth is hard to find and not readily available. Whilst women in urban areas have more choice there is inequity in the quality of choice and women choosing a home birth often find they are totally unsupported by their family doctor. Overcrowded, poor quality antenatal classes were also highlighted as an issue by women. In short, issues of respect, informed consent, implementation of evidence based research practice and support for normal birth, staffing levels and infrastructure were all issues that need to be addressed (AIMS 2010).

As we have seen, the current maternity services are inadequate for the needs of all women in Ireland. For asylum seeking women hoping to access this service the challenges are enormous in an already overstretched system where staffing levels are below par for all grades of providers (KPMG 2008, Burke 2008, Kennedy 2010), and the one size fits all approach simply cannot meet the complex needs of asylum seeking women. The Government-funded Baleskin Centre¹¹ that housed the only dedicated antenatal clinic for refugees and asylum seekers, was deemed too expensive for the reduced numbers and ceased to function in its role as a maternity health centre for asylum seekers (Baker 2006). The consequences of this for women and midwives were significant. The Baleskin Centre had offered a unique service for asylum-seeking women in that it provided a variety of services such as social workers, psychologists, medical and maternity services under one roof. The same team of midwives went out several times a week to hold antenatal clinics there and this provided some level of continuity of care for the women who accessed these services.

A number of studies conducted in recent years both in Ireland and the UK address some of the specific needs of these women. These studies have highlighted a

¹¹Baleskin Reception Centre was a 380 bed accommodation centre for asylum seekers and their families in Finglas, north Dublin. It was purpose built in 2001 and had a well-functioning medical unit, providing specialist health screening and medical care to the residents of the centre.

litany of issues. There are overarching concerns with communication, including language difficulties, difficulties accessing interpreters, cost and levels of training for interpreters and availability of interpreters during off peak hours. These issues have been shown to have serious consequences for women who do not have English as a first language with implications for access to services and poor outcomes as a result of poor communication (McLeish 2002b, Kennedy and Murphy-Lawless 2003, Lyons et al. 2008, Ukoko 2005, Women's Health Council 2006, Jentsch *et al* 2007, Pieper *et al* 2009, Briscoe and Lavender 2009, Raleigh *et al* 2010a, McLeish 2002a). Issues related to access to services have been discussed by Kennedy and Murphy Lawless (2003), McLeish (2002) Lyons (2008) and Raleigh (2010), these studies have shown that asylum seeking women have difficulty understanding how our maternity system works, often book late, which in itself can cause tension, lead to judgemental attitudes and erect further barriers to care provision. Issues related to accommodation including unsanitary and cramped conditions, unsuitable and overcrowded accommodations have been highlighted by many of the studies cited above. The impact of living in direct provision system and the policy of forced dispersal has been shown to have serious detrimental effects on health, including increased stress and depression, loneliness and isolation, barriers to health care, and substandard care as a result of delays in transfer of patient records in two recent Irish studies, Pieper *et al.*(2009) and Mbugua (2010), and one UK study Briscoe and Lavender (2009). The direct provision system has been highlighted in two further studies as a violation of human rights (Cotter 2005, Stewart 2006), and in recent Irish Times articles (Smyth 2010b). Yet this inhumane policy continues in the most senseless fashion, on July 3rd 2010 it was reported in the Irish Times that at least 150 people are to be moved from Mosney to various parts of the country, despite the fact that many of these men women and children will have lived in Mosney for years and it is the only home they know here (Smyth 2010a). Other issues of concern have been raised related to child care for older children when a mother is hospitalised, which is much more likely in this population group as they have much increased maternal complications in pregnancy and childbirth (Jentsch 2007; Raleigh 2010) with ethnic minority women experiencing three times higher maternal mortality

over the past two decades in the UK according to the Confidential Inquiry into Maternal and Child Health (CEMACH 2007). The level of racism experienced by this group of women when accessing maternity care is also significant (Kennedy and Murphy-Lawless 2003, Lyons et al. 2008, Pieper et al. 2009).

1.8 Conclusion

In this chapter I have attempted to show the link between globalisation and the migration of unprecedented numbers of women across the globe. I have discussed the global export of the technocratic medicalised model of childbirth, particularly the export of this model to developing countries under the guise of the World Health Organisation, itself a medically dominated organisation. This wholesale export of an interventionist approach to childbirth continues despite being contested in developed countries. I have provided an overview of the Irish maternity services and highlighted the current inadequacy to meet the maternity care needs of all women in Ireland. I have considered the particular challenges encountered by asylum seeking women as they attempt to access and avail of services here. Finally, I have discussed the immigration and asylum system as they operate within an Irish context. This system has been shown to discriminate against asylum seekers in a number of ways. Through legislation designed to discourage and deny access to citizenship in Ireland, through increased refusal to allow entry at Irish ports, and through the introduction of the direct provision system and the government policy of dispersal, both of which have been shown to be inhumane and extremely detrimental to the health and wellbeing of an already vulnerable population. Within this complex context the childbirth experiences of asylum seeking women offer us an insight into the confluence of affects these issues have in the lives of women, as we participate at whatever level, in the provision of maternity services to this population. These experiences are an indictment of the nation of Ireland in the twenty first century and will form part of

a larger picture of Irish society at this moment in history. In retrospect and with the value of hindsight it may not be a moment in which we are proud to be Irish.

In the following chapter I detail the journey towards asylum seeking women and the process of gathering their stories of childbirth in Ireland.

Chapter 2

Positioning narrative: the story of gendered lives: A Methodological Framework

2.1 Introduction

Feminist researchers from a wide variety of disciplines have embraced a feminist epistemology and therefore seek to apply feminist methodology to their work. The plurality of feminist epistemology and the diversity of disciplinary backgrounds of feminist scholars make description of a single feminist methodology difficult.

The emphasis on uncovering the practices and abuses of power in society and in the research process has led feminists to a careful consideration of how best to undertake research that seeks to empower participants rather than exploit them. This task is complicated by the fact that much feminist scholarship is concerned with women in oppressed and marginalized positions, often poor women of colour in developing countries.

Whilst these issues make undertaking feminist research a challenging option, for me it provides the only ethically viable one. The women who took part in this study, while strong and determined, live deeply contested lives. They have all fled from difficulties; some have experienced torture, rape and the death of those near and dear to them. In Ireland, they live a life on the margins. Socially and geographically isolated they are barred from paid employment and higher education, they wait in some cases for years, in the hope of gaining refugee status and the possibility of a better, more peaceful future. The overt aims of feminist research toward uncovering inequalities in social life and working toward the explicitly political goals of consciousness raising and social action make this a suitable methodological choice for this study.

In this chapter I will discuss more fully the challenges to developing a distinct feminist methodology. I will explore the characteristics of feminist methodology that provide an ethical basis for undertaking research practice that seeks to minimize the effects of power and authority in the research relationship and provide a theoretical basis for social action and political transformation.

2.2 Is there a distinct feminist methodology?

A research methodology is the framework for the practical implementation of a given epistemology. It is the ground where ‘philosophy and action meet’ thus providing the impetus for how our research design gets worked out (Sprague 2005: 5). Therefore feminist methodology must reflect the values and tenets of feminist epistemology. In the development of feminist epistemology, feminist scholars sought to challenge existing research methodology, questioning the assumptions of mainstream science and the politics of knowledge creation. In so doing they challenged ‘the very epistemological foundations of science’(Fonow and Cook 2005:2211). Harding and Norberg (2005) challenge the concept of value free science and state that ‘researchers, like the societies in which they live, cannot detect-much less correct-the assumptions and practices that shape the interests, conceptual frameworks and research norms of social sciences’(p.2010). Harding (2004) suggests that this is because dominant groups find it difficult to detect the oppressive features of their own beliefs and practices. Therefore, the specific methods we choose are profoundly shaped by our epistemological stance, and this also defines our role as researchers and what we consider ethical research practice (Naples (2003). In choosing a feminist approach to research design and implementation, researchers are aware that they themselves are likely to be situated in privileged positions. In embracing a feminist perspective it is contingent upon the researcher to attempt to view knowledge production from the view point of those positioned as marginalized or as ‘other’ in society. In this way hegemonic practices are challenged and undermined.

Feminists have argued that the conventional research practices, that is, their methodologies and methods, have compounded the effects of unequal power structures in society. Feminists argue that these approaches help to support the dominant constructs of modern society, such as education, welfare, health care, as well as legal, economic and military policies, that make relations of privilege and disadvantage seem natural (Harding 1998). A classic example of this kind of hegemonic dominance is reflected in the area of childbirth research and practice. We see the wholesale export of westernized, medically dominated and technologically focused childbirth practices, being exported to developing countries under the auspices of the World Health Organisation, when these very practices are highly contested within the countries they emanate from (Davis-Floyd 1994b, Murphy-Lawless 2003).

Dorothy Smith (1997), extending the argument about science to include social science, argued that in claiming to carry out impartial or value free research, social science was actually helping to construct what she referred to as 'conceptual practices of power'. In uncovering that practices of power at work in mainstream social science research, feminists began to question how research knowledge influences social life, in order to expose the hidden research agenda by questioning who benefitted from research and whose interests did social research serve. In this way, methodology began to be considered in terms of its social and political context and its consequences on people's lives (Sprague 2005).

There is no one precise feminist methodology just as there is not a single feminist epistemology. Feminists operate across a broad spectrum of disciplines and therefore some features of feminist methodology will be specific to the discipline in which it is practiced. However, despite these differences there is an overarching feminist methodology based on the assumptions of a feminist epistemology and these are the guiding principles or commonalities of feminist research. Fonow and Cook (2005) describe these principles as; ⁽¹⁾ the necessity of

continuously and reflexively attending to the significance of gender and gender asymmetry as a basic feature of all social life, ⁽²⁾ the centrality of consciousness raising as a specific methodological tool and as a general orientation or way of seeing, ⁽³⁾ challenging the norm of objectivity that assumes that the subject and object of the research can be separated from each other and that personal or grounded experiences are unscientific, ⁽⁴⁾ concern for the ethical implications of feminist research and the exploitation of women as objects of knowledge, and ⁽⁵⁾ emphasis on the empowerment of women and the transformation of patriarchal social institutions through research and research results. Socially engaged research that upholds the principles of ethical and political accountability achieves results. We see this in examples such as research on violence against women, women's double day of work, and the costs to men of maintaining norms of masculinity. Harding and Norberg (2005) suggest that the history of the social sciences makes clear that feminist research projects have often advanced social science understanding and knowledge, bringing fresh perspectives to bear on old questions and asking new questions about ourselves and our social worlds. Feminist researchers have clearly shown that conventional research practices in the social sciences show systematic patterns of bias. Sprague (2005) argues that feminists were working to de-centre the position of researchers and give voice to their participants for decades before these ideas were embraced by non-feminist postmodern researchers.

I would like to consider in greater detail the guiding principles or commonalities that inform feminist methodology.

2.3 The impact of gender, race and class.

‘Gendered fields provide gendered opportunities, however gendered fields also provide gendered obstacles.’(Sprague 2005:122)

Current concerns in feminist epistemology and methodology include how to understand the intersectionality of race, class and gender (Harding and Norberg 2005). A number of different challenges present in the consideration of these issues, these are; concepts of difference, issues of power and control, and approaches to analysing these concepts.

In 1991 Patti Lather argued that feminists see gender as a basic organizing principle which profoundly shapes the concrete experiences of our lives. In order to correct the invisibility and distortion of women’s unequal social position, feminist researchers positioned gender as a fundamental category for understanding the social order and women’s oppression within it. However, it became apparent early on that there was no universal experience of womanhood from which feminist theorists could build, more importantly attempts at essentialist representations of women’s experiences drew deservedly sharp criticism from feminists of colour, as merely representing a white, middle class female as understood by privileged academic feminists in what was then referred to as the ‘West’. Understanding women’s differences called for a broader category of analysis that takes into consideration the complexity of women’s lives including issues such as, race, class, ethnicity, nationality, sexuality and the issues that proceed from these such as poverty, access to education, health care etc. In grappling with issues of difference and representation’ Lather (1991:104) offers a definition of science that really resonates with me. She sees science as a ‘much contested cultural space, a site of the surfacing of what it has historically repressed’. The focus of feminist scholarly work in this reading is in highlighting the gendered nature of politics and the use of power in everyday lives of men and women. However, this does not solve the problem of feminist researchers have in

judging between competing accounts of difference. Ramazanoglu and Holland (2008) refer to the problems feminists encounter in negotiating the politics of difference in researching 'otherness'. They argue that feminist researchers are caught in methodological and political dilemmas in wanting to tell better stories of gendered lives across people's differences. Attempting to explore women's lived realities brings feminist researchers up against conflicts of interest between women and also challenges how they conceptualize gender and difference. This can and has led to increasing fragmentation in feminist epistemological and methodological debates, but has also led to innovation and diversity in feminist methodological strategies. Those who have personally experienced 'otherness', in other words, those who have experienced what it means to be marginalized, disadvantaged or subordinated to dominant cultures, have greatly impacted feminist research. Feminists have written extensively about experiences of subordination and lack of privilege that experiences of being considered as 'other' can create. However, women from just such positions of subordination have expressed anger at privileged women (including other feminists), who are considered complicit in their exercise of power, whether or not they are fully aware of that power, just as feminists contend that women are subordinated to men by virtue of historical structures of social hierarchy whether or not they are consciously aware of it. This is a point made explicit by feminist writers of colour such as Hills Collins (2004), and hooks (2001) and continues to be a source of particular challenge to feminist researchers. Leslie McCall (2005) suggests that the emergence of the study of intersectionality, the term used to describe the intersections of multiple dimensions of difference that constitute the 'self' in any given social location, is one of the most important theoretical contributions made by feminist scholars. Yet McCall argues despite its importance, there is little discussion on how to study intersectionality. She suggests there are three types of analytical approaches. The intra-categorical approach is the earliest approach and is exemplified in narrative studies where an individual or group was the focus and intersections of various forms of oppression formed the context of the study. The major criticism of this approach is whether it can adequately respect the complexity of lived experiences. The second approach was the anti-categorical

approach that emerged at the same time as Post-structural critiques and, according to McCall (2005), has been the most influential and successful at challenging the validity of analytical approaches based on simplistic and misleading categories. In deconstructing 'master narratives', the aim of the postmodern feminist project was to deconstruct inequality itself. For example, challenging the concept of gender as a single binary opposite of male/female led to the consideration of other possible readings of gender such as transgender, bisexual, queer and questioning individuals. Similarly narrow categories of racial differences have broadened to incorporate multiracialism to a point where the category of race is considered to be virtually indefinable (Omi and Winant 1994). However, critiques of postmodern discourse analysis argued that dissolving analytical categories of oppression, such as race, class, gender and sexuality, did not dissolve the reality of their existence which requires analysis and political engagement, (Mohanty 1997, 2000, 2009, Ramazanoglu and Holland 2008). The third possibility McCall (2005) offers for analysis of intersectionality is an inter-categorical approach. The approach takes into consideration the complexity of people's lives and acknowledges the limitations of adopting categories of analysis. It proposes using existing categories to document inequalities among social groups, highlighting changing configurations of inequalities along multiple and conflicting identities. McCall argues that this approach, while lending itself more to quantitative methods (in taking into consideration all possible variables of difference), has the potential both for interdisciplinary work and a political impact on public policy. However, a high proportion of feminist research is still carried out in qualitative 'field work' usually involving face to face interviewing often over extended periods of time, where the researcher is considered instrumental in the research process and the research relationship is considered crucial. This raises the challenges of how to minimize differences and balance hierarchies of power within the research relationship. Issues of gender, race and class of researcher and participant contribute to the complexity of the researcher/participant relationship as they raise issues of power and the problems of representation. Here differences between women can be problematic for feminist researchers as they resist reliance

on false assumptions of shared experiences based on gender alone (Ramazanoglu and Holland 2008).

Feminist researchers have long acknowledged that the best way to minimize these effects is to acknowledge them and so practices of reflexivity and reciprocity are overarching features of feminist methodology and methods, and leads us to a consideration of one of the fundamental, dynamic aspects of feminist research methodology.

2.4 The research relationship

Feminist researchers have resisted the objectification of research participants through development of participatory research design where the connection between the researcher and participant is actively developed. This is achieved through a number of strategies, such as seeking to build reciprocal relationships, developing friendships with participants, drawing on researchers' own life stories to build connections, and increase trust and empathy. Other strategies include sharing information in a mutually educative process, involving participants in the researcher design and analysis and using emotion as an analytical guide (Sprague 2005). While these strategies have proved effective in challenging the objectification of research 'subjects', they have also been problematic for feminist researchers. The goal of reciprocity is perhaps most difficult to achieve. Issues such as false friendships that ultimately exploit participants have been widely discussed (Kirsch 2005). For example, the use of self-disclosure can be problematic, in that it can create a false sense of equality particularly when relationships end once the research is finished. The use of emotions and sharing of information can also result in the researcher dominating the interview, and research analysis where the voice of the researcher is heard over that of the participant. Sprague (2005) argues that relationships can be both a resource and an obstacle, where expectations are unrealistic the researchers can find themselves experiencing undue stress, especially where researchers disagree with core values

of the participants. Adopting a middle ground appears to be the best strategy, being open about how much you can really offer, (which may not necessarily be long term friendship) being a good listener who is sensitive to power dynamics and offer what Reinharz and Chase (2002) refer to as an adequate level of rapport. In my own experience of undertaking research, sharing similar backgrounds in terms of class and privilege undoubtedly makes forming bonds with participants easier, as I discovered when undertaking research into women's experiences of childbirth in Oxford (Tobin 1996). Building reciprocal relationships with my participants was easy because of the similarities in age, class, education, shared interests (I was also pregnant at that time and had two previous caesarean births). Mutual sharing of information and ideas that influenced my own childbirth choices was part of the experience and I still maintain friendships with a couple of those women fifteen years later. However, this present experience has been a very different one for me. While I have built up rapport and a kind of fragile friendship with some of the women participating in this study, I have been deeply aware of the gulf of difference between us. This is not necessarily in terms of education, as some of the women are highly educated and articulate women, but more so because of their sense of disempowerment as asylum seekers and the cultural differences between me as a white Irish woman and most of them as black African women. However, while these differences undeniably exist, there are also some shared understandings between us, of being mothers, of what it is like to be away from friends and family, or perhaps of what it is to experience loss. Those glimpses of commonality make empathy, that ability to listen without judgment or to reach out to comfort them when they became distressed in the interviews, a natural gesture of understanding and solidarity. However, ultimately at the end of each day of interviews, I was also aware that I was the only one free to go home. My comfort then is not in trying to forge friendships to make myself feel like a better person or a better feminist researcher, but rather as Mohanty(2003) suggests seeing solidarity as a political as well as an ethical goal. It is also important to acknowledge that participants are never totally disempowered, and individuals can and do find ways to resist and subvert power relationships within the research process. There are many of examples of this in the literature. For example,

research undertaken by Taylor and Rupp (2005) highlights the complexities of gender and power dynamics in their study of drag queens in Key West, Florida. Whilst they argue that power differences cannot be totally eliminated, they found that participants used power in various ways to gain agency in the research process. Taylor and Rupp found that participants used both their male gender and their status as stars of the show to exert their own power and authority throughout the research. The fact that the research relationship occurs within the context of personal and social power is well documented. While feminist researchers have acknowledged that it is impossible to eradicate power in the research relationship, they have devised methodological approaches that seek to minimize the effects of power. One such approach is the use of full reflexivity throughout the research process.

2.5 Issues of validity and reflexivity; challenging the ‘norm’ of objectivity

Power differences are constructed in research processes as researchers have power to decide what questions to ask, who to address such questions to and how the answers (data) are analysed and disseminated. While the elimination of power differences is impossible, reflexivity in the research process is crucial if the goals of participation, non-exploitation and dare I say empowerment, are to be even partially achieved. Feminist researchers have established the futility of achieving objectivity in scientific enquiry, including the inadequacy of bracketing procedures, as if we can simply lay our prejudice to one side while we undertake months of research on one topic or another (Harding and Norberg 2005). Rather, they espouse the use of reflexivity, as central to the research process, to document reactions, tensions, breakthroughs and challenges in an effort to acknowledge difference and work through it to attempt to find places of shared understanding and also to draw attention to those issues that have been ignored or silenced in traditional methods. Using reflexivity to acknowledge differences rather than trying to gloss over them helps to bring greater awareness and perhaps minimize

the tendency to perpetuate power dynamics but again sensitivity and balance is required here too, as Thorne (1994) cautions that too much self-disclosure and attendance to our own internal emotional processes can lead to self-indulgence and narcissism. In this respect, Lather (1991:71) describes the feminist methodological task as one of innovation where researchers searched for ‘pattern and meaning rather than for prediction and control’, in order to analyse experience in a way that still grants full subjectivity to the participant Lather posed the question, ‘How do we explain the lives of others without violating their reality?’. Harding’s (1993) solution was to propose an entirely innovative consideration of objectivity within the research process, arguing that strong objectivity requires strong reflexivity in order to counter the cultural blindness and hegemonic interpretations of the dominate, privileged groups. Harding (1993:136) expresses her concerns in her thesis entitled ‘*rethinking standpoint epistemology*’, where she states ‘Objectivism impoverishes its attempts at maximizing objectivity when it turns away from the task of critically identifying all of those broad, historical social desires, interests, and values that have shaped the agendas, contents, and results of the sciences much as they shape the rest of human affairs’. The core of Harding’s argument is that by failing to see that a researcher comes to every research project with culturally value laden presuppositions that are magnified when left unacknowledged, this failure ultimately serves to maintain the status quo. She suggests six steps to maximize strong objectivity, and while they are not meant as a control of bias, they do provide researchers with guidelines for practice. These are:⁽¹⁾the knowledge production process is included in the research, ⁽²⁾the agendas for research questions should be grounded in the experiences of those who are ignored in dominant beliefs and activities, ⁽³⁾strong objectivity resists relativism, ⁽⁴⁾strong objectivity means treating the researcher and the subjects of knowledge as embodied and visible, and also as sociologically heterogeneous, ⁽⁵⁾feminist knowledge is located within an explicit, historically specific community, ⁽⁶⁾strong objectivity entails a commitment to liberatory knowledge. Harding suggests that using strong reflexivity is a ‘resource for objectivity, in contrast to the obstacle that de facto reflexivity has posed to weak objectivity’, p.138. However, Ramazanoglu and Holland (2008) argue that

Harding, in an effort to validate the truthfulness of feminist knowledge, blurs the lines between understandings of objectivity and validity, as she takes the view that not all feminist stories are equally true or valid. In contrast Haraway (2004), while agreeing that not all stories are equal, shifts the concern for objectivity from issues of what is valid knowledge in terms of how we understand scientific validity, to a political stance, 'how telling the truth occurs rather than how to be more or less objective'(p 52), thus challenging the notion of objectivism and Cartesian dualisms for the concept of situated knowledge's and the 'privilege of partial perspectives'. The struggle for a definitive answer to the issue of what constitutes valid knowledge is as long as the history of feminism itself. Previously in this chapter, I traced the development of feminist thought and inherent in that development has been the quest for how to validate feminist knowledge. The journey from modernist through postmodernism to the current post-postmodern positions reveal a lack of consensus in terms of a single feminist position. But that is not to say we have not benefitted from the extensive debates on knowledge production and these have helped us to challenge political and social power structures in the process of their development.

2.6 Ethical practice

'I emerged from interviews with the feeling that my interviewees need to know how to protect themselves from people like me'(Finch 1984:80)

'Foucault argued that ethics is not based on or constrained by any legal or religious system but evolves from reflectivity and is indivisible from the self and an aesthetic of existence'(Dreyfus & Rainbow 1982 in Halse and Honey 2005)

The goal of ethical practice in feminist research seeks to dissolve the notion that approval from ethics committees will result in ethical research practice and calls

for ethics as a way of being rather than a process to be endured in order to gain access to participants. Ethics committees grew out of the positivist tradition of biomedical research model. The frame of reference of these committees is based on Kantian moral theory that presumes a universalized subject that takes for granted that the experiences of the dominant social group can be generalized and taken as true for all (Halse and Honey 2005). This is problematic for feminist researchers for a number of reasons, firstly because it does not acknowledge the individual differences among participants. It has the potential to perpetuate power dynamics between participants and researcher, and it can overlook questions of moral and ethical responsibility to individual participants in favour of conformity to existing protocols. Instead, feminists propose an ethic of care and responsibility towards participants as an alternative to an ethics of justice. However, Halse and Honey (2005) based on their work with anorexic teenagers, suggest caution at the notion of an ethic of care in the absence of a moral framework and argue for a discourse of ethics based on an interdependence of both concepts, an ethic of care and justice where specific cases are considered within a moral framework but ‘multiple epistemologies’ may be taken into account. In other words this should be a collaborative effort that is responsive to individual cases but guided by principles of justice. In this kind of ethical practice the researcher is an active ingredient in the research process who through the use of reflexivity attends to ethics as a political action, rather than as a set of professional ethical codes.

However, those of us undertaking clinically based research, particularly projects that are externally funded, are required to submit to ethics committees both in our universities and related clinical sites. Viewing the work of the ethics committee as a support to ethical research, provided me with an opportunity to be less frustrated by the bureaucracy and patriarchal power structures that were evident in some committees more than others. I had three ethics committees to satisfy before I could begin the study. The main concern of one that particular meeting was the letter of support given by my feminist sociologist supervisor, whose passionate

wording they found not to their taste! At another ethics board I remember racist and classist comments from a member who commented that '*these people may not know what a PhD is*', to which I responded that while that may be the case for some women, others may indeed already hold a PhD themselves. It was a deeply frustrating exercise at times. Aside from the frustration of such meetings, I found the ethics procedure provided me with a valuable opportunity to reflect on issues related to gaining access to participants in a way that could not be construed by them, or anyone else, as coercive. It also provided time to consider issues such as informed consent and confidentiality and anonymity. Ethical approval was gained from the three committees (appendix I, II and III).

2.6.1 Issues of beneficence, non-maleficence and minimising risk of harm:

Muecke (1992) highlights the ethical problems of undertaking a research project with vulnerable groups such as refugees and asylum seekers, and stresses the importance of gaining truly informed consent. In order to protect the interest of the potential participants and ensure voluntary participation, gatekeepers were employed. A named midwife was identified at both sites. Both midwives were senior clinicians who ran specific services for refugee and asylum seeking women. The gatekeepers dealt directly with the participants at the recruitment phase, ensuring that there was no undue pressure placed on women to participate.

All information was given in a sensitive and unhurried manner. Written informed consent was sought from each participant (appendix IV). An information pack (appendix V) in English and/or the appropriate language was offered and a reply slip, which sought some biographical information including expected date of delivery, contact details, preferred language for the interview, and use of interpreter was returned to the researcher in a pre-paid stamped addressed envelope.

Each participant had an opportunity to have an interpreter present at the data collection stage, if they so wished. In order to protect the rights of the participants, the researcher met with each potential participant and ensured that they fully understood the following;

- the nature, purpose and process of the study
- the independence of the researcher from government agencies
- the implications of participating in the study and that it would not in any way affect their applications, favourably or otherwise
- that the researcher would not be identifying any individual or specific case within the study.
- that participants would have the opportunity to ask questions
- that information would be given both verbally and in writing in the language choice of the participant.
- that the researcher would check the participants' understanding so that any further queries could be addressed.
- That permission was being sought to incorporate the women's experiences and stories as part of the data, which, while not identifying any one person, institution or healthcare provider, would form part of the analysis and thus the study and its dissemination.
- that the actual interview transcripts or data files would not be made available to anyone outside the study. Transcripts would be adapted to maintain anonymity; for example, pseudonyms would replace real names, and names of places or other identifiers would be changed or removed, and data would be stored by the researcher on a personal computer, which was password-protected.

A free counselling service was made available (appendix VII) to provide counselling and follow up after the interview should the participant wish to avail of it. Information regarding this service was provided to all participants at the time of the research interview.

However, having all of these measures in place and gaining ethical approval did not alleviate any of my concerns about the possibility of subtle or even subconscious coercion where participants might hope to gain advancement of their cases through participation, even though I was very clear on all consent forms (appendix IV), study information sheets (appendix V) and again verbally at the time of the interview that participation could not help individual applications for asylum. I had sleepless nights about it, most especially because I decided to give gift tokens as thank you gifts for the women's time. I did this having spoken with another colleague who was carrying out similar research but with a research population that was made up exclusively of Irish nationals. She had offered €40 gift cards to the women as a thank you and I realized I would not have a problem with giving gift tokens if I was working with her participant group instead of mine. On reflection I felt it would be wrong not to offer something, and then I had the dilemma of how much. Forty euro is little enough to an Irish woman, but to an asylum seeker it is two weeks money. It seemed like a disproportionate amount. However, I could not cope with the idea of giving them less, especially as I knew they would get little for it when they came to redeem it at the department store. I never made any reference to gift tokens in the literature requesting participation and just gave it to the women as a surprise at the end of their interview. I was hesitant knowing that some of them had so little and I did not want €40 to be the incentive to talk about some of the most painful experiences of their lives. While it felt good to have something to give at the end of the interview as a token of appreciation, I was never fully comfortable with the thought that it could have been an incentive to participate, perhaps especially because they were always so grateful to receive it.

I admit that while it is a value I aspire to, I never managed to achieve the aspiration of Mauthner *et al.*(2002b) that ethics becomes part of our interactions, shared values and our sense of belonging in community, in the sense of being able to enter into my participant's daily lives. There are perhaps a number of reasons for this. The women's incarceration in accommodation centres meant they were physically removed from the community and also my own bi-location between Ireland and the U.S. made it harder to spend more sustained intervals of time with them. Fragile friendships have formed over the years with some women more than others. I made efforts to keep in touch via email and still do, and I attend African women in Ireland support meetings when I can (although these were only available in Dublin). I have returned on numerous occasions to visit with the women, and invariably relationships develop with some women more than others; this is true in life as well as in research relationships. While I feel the differences between us looms large, I take some comfort in Hill Collins' (1990) assertion that ethical knowledge is created and validated within an ethics of care and accountability that are rooted in values of personal expressiveness, emotions and empathy. Feminist theorists suggest that we accept an 'asymmetrical reciprocity', that is, accepting that you cannot always put yourself in the other's position, but rather enable dialogue that helps you to understand across differences, rather than ignoring or blurring power positions, ethical practice needs to pay attention to them, (Young 1997). Beyond empathy and caring, feminist research calls for the political role and intentions of the researcher to be made explicit. To this end the researcher needs to be open about her own personal and political assumptions and goals for the research being reflexive about impact of the 'findings' to ensure she does not work against the interests of the participants, clarify objectives and attempt to account for personal understandings and assumptions and provide justification for judgments made (Mauthner *et al.* 2002b). This leads me to a consideration of feminist research goals of consciousness raising and emancipation.

2.7 Consciousness raising and emancipation

‘Our goal was to reveal what had previously been hidden about women’s lives, experiences, and contributions and, in the process, to produce the kind of knowledge that would liberate them’(Fonow and Cook 2005:2211)

The notion of research as more than an academic exercise but rather a politically focused project that can ultimately change society and women’s lives for the better has been a central tenet of the feminist researcher. Over the past twenty years of the women’s movement there appears to have been a shift away from the more explicit assertion that most feminist research projects can really change women’s material existence, Feminists seem almost embarrassed by the notion of empowerment. This may be the result of many feminist researchers undertaking research projects with vulnerable or much disempowered groups, as Harding (2004) asserts that the dominate groups cannot identify oppressive features of their own beliefs and practices. Mauthner *et al.* (2002), caution against naive and simplistic notions of empowerment and equality, arguing that it may lead to further disempowerment where real change is not an outcome of the research. This shift also appears to have coincided with the rise of post-structural discourse analysis and its concomitant cynicism and emphasis on intellectual as opposed to political outcomes. It is undoubtedly a feature of the crisis of representation that feminist researchers have highlighted in relation to attempting to undertake ethical research, and is perhaps most problematic in relation to work with poor women of colour or women from what is referred to as the third world. One of the strategies that feminist researchers have used to address power imbalances has been to transfer power to research participants in terms of maximizing involvement with the research process from research design to dissemination. Sprague (2005) argues that simply transferring power to research participants fails to take into consideration that research participants already have some power, for example, power to refuse to participate, power to control how much to disclose or what

stories to tell. These strategies can also obscure the fact that the researcher still holds power to choose what questions to ask and also ignores selection biases built into this kind of strategy, for example the types of skills necessary to carry out research. Sprague states that simply transferring power to research participants in this way takes a limited, simplistic view of research that is in danger of romanticizing the oppressed. In his paper *'Rethorizing Empowerment-through-Participation as a performance in Space: Beyond Tyranny to Transformation'*, Mike Kesby(2005) argues for a reconsideration of participatory approaches that make a strong case toward the possibility of empowerment and emancipation for participants. Kesby(2005) argues that while critics of participatory approaches have brought a valuable critique to some of the problems, for example, highlighting the dilemma of empowerment to impose external priorities and agenda while claiming to enhance communities, they have not offered any solutions. Rather, they have left readers depressed by the revelation that participation can be used as a form of power over participants. He states 'the philosophy of perpetual deconstruction as ignorant of its own privileged situatedness' (p. 2049), and argues for a more optimistic position that sees the possibility of a participatory approach that both men and women could draw on to in order to challenge the status quo. While acknowledging that power cannot be escaped, Kesby calls for sustained participatory projects that he claims can open up a permanent space in which empowerment can be continually developed or 're-performed'. Opening up spaces for discussion where participants can construct themselves as reflexive agents, providing the possibility for them to constitute and therefore represent their opinions and experiences to themselves and others. In this way he argues that participation can 'constitute and facilitate the performance of empowered agency' (p. 2055).

Mohanty(2003) argues for feminists to re-embrace the notion of solidarity in support of anti-capitalist and anti-globalization movements, as these are the current sites of political resistance. She argues that the effects of globalization are to be seen in patterns of migration, and on movements of refugees and asylum seekers and as the infrastructures of smaller less developed nations are collapsed, the effects are seen in particular in the displacement of girls and women.

Mohanty(2003) revisits her 1986 essay '*Under Western Eyes*'(Mohanty 1986), and reinstates her original vision of a common feminist political project a 'feminism without borders', that calls for a framework of solidarity and shared values. This requires consideration of the local and particular, with the global and the universal that positions questions of justice and equity in trans-border terms, and one that begins its analysis in the most marginalized communities of women, as she argues that this is where the most inclusive paradigms for thinking about social justice are to be found. I found Mohanty's persistent vision of the possibility of change a refreshing antidote to some of the more cynical and ambivalent positions that appear to settle for the impossibility of social transformation that is a short step from complacency and acceptance of the status quo.

In terms of how I specifically sought to ensure the goals of emancipation and consciousness-raising as part of this study, I will attempt to outline the issues as they arose for me and as I have outlined throughout this written account of the research process. The goal of emancipatory knowledge is evident in the overt politicisation of the research process, in terms of the methodological choices made; that is, how the study was framed, undertaken, written up and how it will be reported. To a large extent this is challenging for me as a nurse and a midwife because it meant engaging with a much wider literature of sociology and anthropology in order to be able to understand the wider social and political issues that provide a context for this study and, more importantly, the study findings. The emancipatory goals are seen to be met when the women's experiences are shown to be of value and importance. This occurred from the initial research question, through to the way in which the research was carried out in an ethical and respectful way that valued and facilitated the active participation of the women, for example, in the workshops that sought to include the women's ideas of data collection design (see section 3.2). Through participation in the study, some of the women themselves (some for the first time), began to see their own stories as valid and valuable in a process. This is often the first step in consciousness-raising, when people begin to find their own voice and realise that what they have to say is important and highlights crucial issues for Ireland's maternity service

provision. Also, as the study findings were disseminated, I was made aware of the reactions of my colleagues to the data being presented and how the women's stories raised awareness of issues of concern to midwives, such as racism and ignorance within the professional community. Consciousness-raising was also seen in the interpreters who took part in the study, in their reactions to the women pre and post interview, and how their perspectives changed as a result of hearing the women's stories for themselves. As midwives begin to critique our own contribution to current maternity services in Ireland, awareness is raised around issues of choice and control for all Irish women, and this study shows the particular set of needs women seeking asylum have within that context of limited choice and medically dominated services. In this way, the study raises awareness of how these issues impact on care and on women's childbirth experiences. The continued dissemination of findings within women's groups such as AkiDwA will also aim to ensure maximum exposure of the study findings to women who may be in similar circumstances or have had similar experiences. As the study is disseminated in professional journals, it is envisaged that more health care providers will be challenged to think about the issues faced by the women who took part in the study. It is hoped that they will then see the need to engage with policy and politics of health care provision in order to effect change.

2.8 Conclusion

The concept of a distinct feminist methodology is a contested issue and feminists have struggled to justify and validate their knowledge production in the often hostile world of social science and in light of the differences in women's various experiences of oppression and indeed in the very concept of what it means to be a woman. What makes feminist research distinct is the emphasis on gender and a desire to uncover unjust hierarchies of power with a view towards transformation, emancipation and social change. This does not mean that feminists exclusively study women, or gender is always the primary focus of feminist research. However, feminist projects are framed by feminist theory and aim to produce knowledge based on ethical research practice that can challenge injustice and

provide a basis for transformation (Ramazanoglu and Holland 2008). Whilst methodological approaches vary, there are a number of overarching characteristics of feminist research, central to which is the concept of ethical research practices that employ a fully reflexive approach that values the researcher/participant relationship and seeks to minimize power imbalance in the research process.

In the next chapter I describe this process in some detail; I consider the challenges of making initial contact with the women, the process of gathering the women's stories and the issues related to co-production of the narratives.

CHAPTER 3

Constructing Narrative: Gathering Women's Stories

3.1 Introduction

This chapter is written in two parts. The first part is concerned with providing a detailed description of the preliminary ground work that was undertaken prior to conducting interviews including two workshops, the pilot interview, and the process of making contact with the study participants at the two sites where interviews were conducted for the study. The second part of the chapter will focus on the interview process and the challenges of gathering women's, stories, that is, the construction of the narrative accounts.

The importance of documenting in some detail the decisions made and the rationale for these decisions is central to the credibility of the study. Qualitative researchers often refer to the importance of the audit trail as a tool to demonstrate the rigour of a study (Lincoln and Guba 1985). However, terms such as 'audit trail' and 'rigour' may give a false impression of a research process that is tidy, linear and lacking in personal investment. Birch *et al.*(2002:1) highlight how 'the complexities of researching private lives and placing accounts in the public arena raise multiple ethical issues for the researcher that cannot be solved solely by the application of abstract rules, principles or guidelines'. However, as this is a PhD study it is important to demonstrate that the study has been carried out to the highest standard in a manner that is consistent with its philosophy and ethics. To this end it is more 'fitting' as Birch describes above, to discuss the very political and personal issues and challenges that presented in undertaking a study such as this. Undertaking research with groups considered to be vulnerable or 'less powerful' poses particular challenges as one endeavours to bridge differences in order to make even a fragile connection with the women who are to participate in the study, and then

once they are involved, to ensure that they are not coerced, devalued or dehumanised in the process at the very least, and at best possibly strengthened by it. The challenges and dilemmas of speaking for or ‘giving voice’ to others have been much debated in feminist literature, especially where difference of class, race or privilege compound the already problematic position of representing others, and these have been explored in some depth in the previous chapter. However, Gilles and Alldred (2002: 42) state ‘that not to speak about or for ‘others’ encourages silences and gaps, which marginalize and exclude, while cementing the privilege of those with the more powerful voices’. However, when we choose to engage in this type of research, it becomes imperative that we ensure transparency in the research process and also offer a high degree of openness and honesty in our reflexivity. To this end I endeavour to employ the four criteria discussed by Hill Collins (1991) for interpreting truth and knowledge claims as a ‘blue print’ to inform the detailed description of the research process that I offer in this account. The criteria are as follows:

1. Primacy of concrete lived experience
2. Use of dialogue in assessing knowledge claims
3. An ethic of caring
4. Ethic of personal accountability

Edwards and Mauthner (2002: 25) suggest that Hill Collins’ criteria are rooted in an ethical model of research that values ‘personal experiences, emotions and empathy’. In this way an interactive dialogue is set up between researcher and participant that challenges the need for an ‘expert’ voice instead leads to a discussion that pivots back and forth between researcher and participant and which acknowledges that ‘experience and knowledge are partial at the same time as they are valid’.

This study began almost four years ago in October 2006, since then I have spent much time meeting and interviewing refugee and asylum-seeking

women about their experiences of giving birth here in Ireland. The aim of this study was to explore the physical, emotional and social experiences of refugee and asylum seeking women during pregnancy and childbirth in Ireland. It has been a time of intense emotion for me as I listened to women's stories of their flight from home, their journey to Ireland and their experiences of giving birth here. As a woman, a midwife and a mother myself I have felt undone at times by the enormity of the task I had undertaken and the feelings of responsibility towards the women who had entrusted me with their stories. I was concerned from the beginning of this study to aim for a participatory approach that emerged from relationship with the women who took part in the study. As I have discussed at length in the previous chapter, this notion of reciprocity is a central tenet of feminist research but also a contested and complex goal. Nevertheless in an attempt to make relationship with the women and a participatory approach to the study a reality I undertook two workshops to gain an insight into the women's needs and their ideas on a study design they felt most comfortable with.

3.2 The workshops

In the autumn of 2006, I held two workshops with a total of six women who had responded to letters of information (appendix VI) and information packs (appendix V) placed in antenatal clinics in two large maternity hospitals. The rationale for the workshops was to provide an opportunity for potential participants to contribute to the design of the study and to develop a sense of ownership and participation in the study beyond being mere informants.

My previous research experience involved exploring women's experiences of caesarean birth with a group of women in Oxfordshire, England (Tobin 1996). A snowball technique was used to draw a sample from a 12 mile radius around Oxford town centre. Consequently the participant group was

made up of mainly white, middle class women who were very educated and articulate. They made my job as a researcher appear easy in terms of power-sharing and reciprocity. The exchange of information and experiences enriched my life and even led me to make different choices for my own caesarean birth.

I was aware that this study would be more challenging not least because of the vulnerability of the women; however, nothing could have prepared me for my experience in the first workshops. I had readied a meeting room, prepared tea and coffee, had an outline agenda typed and had made several copies. I also had several copies of consent forms (appendix IV, XI, and XIV) and study information sheets to hand (appendix V, XII, and XV). The women would have already received these with the initial letter of invitation (appendix VI, X, and XIII) but I wanted to have some on hand in case anyone requested them. The weather was very bad that day with rain, hail and snow. I paced up and down the reception area of the hospital where we agreed to meet, feeling anxious and awkward. Two women arrived with three children between them, each with pushchairs and holding small babies. Given the weather conditions, I was amazed they had come. I remember feeling embarrassed as I led them in the rain across the hospital grounds to the meeting room because it was so baby unfriendly, with steps to negotiate and no ramps to make the building pushchair accessible. I offered tea or coffee; both women declined but accepted the offer of water. As we sat down to the table together, there was no eye contact from either. The women were shy and slow to speak and I quickly realized I would need a different approach. I abandoned the agenda and got down on the floor to play with the toddler who was full of fun and mischief. The women slowly warmed and began to open up and talk about their birth experiences and asked me questions about their babies as I played with them on the floor. They began to ask more questions about the study and slowly the conversation came round to the interviews. We talked about a number of issues, for example, their views on confidentiality, the use of interpreters,

the venue for interviews, the timing of interviews after the birth of the baby. They talked about the lack of privacy in the hostels which would make holding interviews there virtually impossible. They felt strongly that confidentiality and the use of translators should not be an issue as people 'had nothing to hide'. They seemed more concerned that their stories be told than concerned about keeping their identities secret. This was an interesting contrast to the media hype that portrayed asylum seekers as bogus. As stated above, pregnant women in particular, had suffered badly in the aftermath of the citizenship referendum in 2004, as they were portrayed as 'bogus' by coming to the country late in pregnancy in order to gain Irish citizenship for their unborn babies(Garner 2007, Lentin 2007b).

Over an hour went by while the toddler ate various snacks, the babies fed and the women talked, and when the time came for them to leave, I offered money to pay for their bus fare. They both refused to take any money from me. Again, this was in sharp contrast with the notion popular in the Irish media that all immigrants, and especially asylum seekers were out to get anything they could(Brady 2002, O'Sullivan 2003, Donaghy 2003). The women had in fact had gone out of their way to come in to town in terrible weather to keep an appointment with me.

Afterwards I questioned if I would have come out in such weather with a small baby and a toddler on public transport to take part in a research project. As I reflected on the meeting later that day, I acknowledge the feeling of almost panic when I realized this was different to anything I had previously experienced. I was humbled by their willingness to go out of their way to tell their stories and the urgency of their need to do so. I was perplexed by the enormity of what I had taken on and deeply challenged as to how I could begin to make any kind of relationship with these women, given that our worlds are so entirely different. I feared they would be nothing more than informants in a study that ultimately would prove of no benefit to them and one in which they had invested something very costly

to them, their experience, their story. I was so conscious of the vulnerability of the women and also how easy it is to further exploit them for my own ends, in terms of my need to recruit and interview them in order to complete my study and my PhD. I have found Ruth Krulfeld's work here helpful and challenging. Krulfeld (1998) discusses issues of power imbalance between those who carry out the research and those who are the focus of it. Issues such as ownership of research, and knowledge as power are explored as they relate to anthropological research with refugees. I am challenged around the concept of true participation which goes beyond paying lip service, to that of real partnership where participants are valued as co-researchers, co-publishers and co presenters. The second workshop was held approximately a week later. I expected three women who had expressed their intention to take part in the workshop but only one woman arrived on the day. The young woman Eve (a pseudonym), who came to the second workshop was very articulate. She came to Ireland five years previously to escape an abusive domestic relationship. She had no relatives or friends in Ireland beyond three women she shared a room with in the hostel where she lived. Eve helped me to explore the agenda items but mainly she wanted to talk. She talked about her loneliness and the continued uncertainty of her position in Ireland and the fear of being moved away from Dublin, or worse still being sent home. She spoke of complications in her pregnancy and how she was uncertain if she would be 'allowed' to have a vaginal delivery. She had been told that the medics would make the decision about how she would give birth. She was not given any other information. She said it felt good to talk, she felt lighter. I suggested she avail of the free counselling service which is available to her as part of this study (appendix VII). I remember feeling a mixture of fury and frustration that a woman was treated so badly with no midwife acting as her advocate. In fact there was no mention of the midwife at all which points towards the invisibility of midwives in many clinical settings and perhaps also to their lack of voice in the current medically dominated childbirth culture in Ireland (Murphy-Lawless 1998, 2003, Kennedy

2010) This encounter again raised issues of how to connect with this group of women given the differences in our lives. I felt there was no common ground between us, and I was concerned about the possibility of letting them down. If I misrepresent them, or fail to allow their voices to be heard for any number of reasons, or neglect to highlight the real issues for these women, then will I have failed them and left them in a much worse position than they perhaps are now? Krulfeld (1998:25) suggests that ‘relationships between ethnographers and others are complex often lacking in reality the coherence and consistency that we tend to attribute to them when we write about or discuss our fieldwork.’ However, Warner (1998:19) argues that work with refugee communities requires a level of commitment which necessitates a move away from a position of neutrality to one of ‘advocacy, emotion and engagement’. She does however admit that this is not easy to achieve. This resonates with me particularly in light of my discussion with Eve and my belief that as midwives, our work with all women at all times must encompass these three elements (Hunter *et al.* 2008). Warner (1998) also discusses the use of narrative as a means of empowerment in her work with women in a Guatemalan refugee camp in Mexico. She describes the trauma often associated with women’s stories but also touches on the possible therapeutic aspects of story-telling.

3.3 The pilot interview

Monica (pseudonym) agreed to come to talk about her experiences for the pilot interview. She arrived with her three children, having driven round for twenty minutes looking for parking which is virtually impossible to find in the city centre. I had arranged for my eldest daughter to look after the children during the interview as Monica had no other childcare arrangements and otherwise would not have been able to attend. Monica had been in Ireland for four years and has refugee status. When she first arrived in the country, she was pregnant with her third child and she was four months into her fourth pregnancy when we met. Monica explained

that she had had her own business in Africa. She described the anxiety of being an asylum seeker, the worry about her application and how she would fare being pregnant in a foreign country. She had no friends or relatives in Ireland. She spoke of the loneliness and isolation she experienced in the hostel and her need to connect with others she met there. This is how she expressed her concerns:

‘Am I going to be successful here? In my condition, being pregnant, it’s not easy in the first place. When I first came I didn’t know anybody. We used to call ourselves family...people from the same area.’

Monica was ultra-positive when talking about her experience of care in Ireland. She repeatedly said how happy she was to have her baby here instead of back in Africa, how much safer childbirth was here compared to her experience back home. She kept reiterating that she was in a new country and it was up to her to adapt to this country. She seemed fearful of being seen to complain or of saying anything negative about the care she received. This issue of a women’s story being tied up with the vulnerability of no safe legal status resonates with earlier work of Patricia Kennedy and Jo Murphy –Lawless into the maternity care needs of refugee and asylum seeking women in Ireland (2003). Early on in the interview Monica explained her strategy during labour:

‘I wanted to cooperate with the midwife, I always follow instructions, I don’t want to complicate matters. I told her just tell me whatever you want me to do. I just behaved and tried to cooperate with that. She had time for me, she was there for me’

She went on to explain, or rather to hint that her first encounter with a different midwife here was a little more intimidating:

‘I learned before I had my baby...[pause] the midwife I saw was very....you know....so I was thinking what kind

of person am I going to meet, so that's why I said to her [the midwife she met in labour] 'just tell me whatever you want me to do and I am going to do it'. She was so calm for me, I had a chat with her, she was not afraid to answer, she answered so many questions I asked her'.

It does not take much skill to read the underlying anxiety evident in this account. It was not until the last few minutes of the interview, a good hour into our discussion, that I asked Monica about the differences between that first experience and her current pregnancy:

'I'm settled I have so much more confidence. I can't really say, I know on the inside of me that I am more relieved. When I had my first baby there was no one there for me. Now I have people. I was five days overdue, but I kept quiet. I stayed quiet because I was worried who would look after these two children. Then the neighbour [at the hostel] said 'don't worry its Saturday, I can look after them'. I was 3-4cm, thank God I had the baby that night and I was home by Monday. I was so concerned about what was going to happen to them, they had never been separated from each other, thank God he answered my prayer'.

I asked Monica about the differences between antenatal care with this pregnancy and the last one. She responded:

'In the first place you can't choose, you don't know anything, just have your baby and go back to your hostel. They need to be more enlightened [referring to current asylum seekers]. All we are told is go to the maternity hospital; we don't really know what is happening. When they come maybe they have low esteem, they don't ask, like me I didn't ask questions, like me I didn't ask, maybe they are shy, they might be afraid that oh he is going to say 'no'. In the clinic I didn't know who to go to, what I was told was you see a doctor, do this do that'

I asked for clarification, 'Nobody spoke to you?'

Monica replied:

‘... no and at times we used to feel left out, we used to feel there’s only me there, because I am coloured ...[pause] I used to feel like that, you don’t have the confidence, you just think it’s normal. They are so busy and they work so hard they cannot sit down with you’.

There are many more examples of Monica’s praise for the midwives she met here than those I have shown. Yet I felt there was an unguarded quality to those final moments of the interview that gave me a real glimpse of what her early experience was like. Her loneliness and isolation comes through so powerfully along with her need for reassurance and empathy, yet these needs appear subsumed by the overriding need for acceptance, and to show that she is grateful for the care she is being given.

After the interview Monica went to retrieve her three children from my daughter’s care. She refused the offer of money for the parking meter, but I insisted. The children had pictures they had drawn for their mother. I noticed the eldest boy had drawn pictures of people and all his people had blue eyes. Later I learned that he told my daughter that he wanted blue eyes like hers.

When reflecting on that initial interview, I was hyper-critical of myself and my interview skills. The interview felt stilted for what seemed like the best part of an hour before Monica began to relax by which time it was nearly over. Listening to myself on the tape I felt that I had been saying ‘good’ ‘good’ too many times and this may have been interpreted by Monica that I wanted her to continue being positive about everything, almost as if there are right answers. It raises for me the challenge of holding the cultural differences that exist between us, and all that this means, in terms of trust, understanding and even truth. By truth I mean true representation in terms of what I understand to be true in what the women are saying. These issues to truth and partial knowing are discussed at length in previous chapters as

they are at the heart of feminist research and narrative analysis. At this point in the work I was utterly frustrated by my own inadequacies, my own lack of insight and understanding. I listen but that listening is filtered through my own cultural understanding. Monica hears my questions and they are filtered through hers. This underlined for me that much of what we understand as communication goes beyond words alone. Body language, eye contact, posture are open to misinterpretation. It occurred to me that while we were using English to conduct the interview, at the same time we were speaking two different languages. Omidian (1994) describes a similar experience in her work with Afghan refugees in America, ‘throughout the study I was often struck by the feeling one has when one steps into the middle of a conversation and hears a statement that makes no sense because the context of the statement is missing. Listening to refugees describe their lives in America gives this same sensation: their lives are taken out of their cultural context as their expected life courses have been disrupted. This also hints at a much deeper issue of the women’s own sense of being disorientated in the disruption of their life and this too has a bearing on communication in the interview. Lather (2002) suggests that the use of member checking may help in this respect, where participants view the written account to ensure correct understanding and representation and have power of veto over what appears in the final report. This is something I have endeavoured to do in this study. Initially all the women were given the transcripts of their interviews to review and ensure they were happy. This was followed by transcripts of the analysis but these were only available to those women still left in the country as several had been deported in the course of the study.

Warner (1998) suggests that feminist anthropology offers a conceptual framework for addressing some of these problems by stressing intersubjectivity above oppositional understandings of difference, whether in terms of gender or culturally constructed differences. She identifies key elements in this as a concern for involvement, social change and praxis and

suggests that the relationship between researcher and participant creates a discursive space for the exploration of social inequality and oppression and leads to the production of texts that limit the authority of the 'ethnographer'. Issues of trust, confidentiality and advocacy underline the need for relationship and engagement that goes beyond the interview. I had concerns about the relative powerlessness of the women as I experienced it in these meetings. In the pilot interview the willingness to please and appear to be positive about life in Ireland, suggested it would require a long process of trust building within the research process/relationship in order for the women to feel safe enough to be honest with me. What was perhaps surprising for me was that some women in the main study opened up easily, over the course of those first initial days of spending time with them in the accommodation centre and doing the interviews with them. Perhaps this was because they had taken the time to have my credentials checked out and were satisfied that I was there to represent them and make their stories known? However, for other women it was a much longer process of trust building that has strengthened over the four years of the study.

3.4 Gathering women's stories: making contact

The data collection did not go as I had initially envisaged. Gaining access to this particular group of women was not easy for a number of reasons. The women are usually housed in government accommodation sites that are often located in geographically remote areas outside of the local towns. Access to the accommodation centres is restricted and permission from the Department of Justice, Equality and Law Reform was required in order to gain access (appendix VIII). Women who are seeking refugee status are not easily identifiable, they are often invisible as they do not understand our health care system, may have language barriers, may be feeling lost, lonely and isolated and very vulnerable as they access maternity services.

I had proposed that I would contact women via antenatal clinics in two large maternity hospitals, with senior antenatal clinic managers acting as gatekeepers (appendix IX). To this end I had compiled information packs for women that included a letter of invitation to participate in the study, information on what the study was about and a consent form. Packs were translated into three languages besides English; these are French– Letter of Invitation (appendix X), consent form (appendix XI) and Information pack (appendix XII) and Portuguese Letter of Invitation (appendix XIII), Consent Form (appendix XIV) and Information Pack (appendix XV) and also Russian (which were not required). These languages were chosen as appropriate based on advice from clinicians as to prevalence of languages needed in relation to their need to call translators. Given the possible vulnerability of potential participants, I placed a lot of emphasis on the voluntary nature of participation and the fact that taking part in the study would in no way influence individual applications for asylum. I spent approximately two months conducting information sessions with groups of midwives at the two sites, explaining the aims of the study, answering questions, gaining their support and promoting the study to them.

Immigration into Ireland appeared to occur in waves and just as I began my study in 2006, the numbers of asylum seeking women who were pregnant reduced in numbers as a result of legislative measures introduced by the government to make it increasingly difficult for those seeking asylum to gain refugee status here. As described in Chapter One, this included legislation that removed the right of Irish born children of non-nationals to gain citizenship here¹². When this service was lost, asylum seeking women came to the antenatal clinics in the large inner city maternity hospitals where midwives had no way of identifying them unless the women offered that information. Far from being an empowering experience for the women,

¹²In 2004 automatic citizenship for children born in Ireland ceased as the result of a constitutional amendment that dissolved previous entitlement to citizenship available through *ius soli* Office of the Attorney General (2004b) The Twenty-Seventh Amendment of the Constitution Bill on citizenship rights. House of the Oireachtas.

this often meant they were isolated and did not get the support they needed, such as referral to social workers, psychologist etc. The consequences for the study were that it became increasingly difficult to recruit women to the study via antenatal clinics. The weeks of work I had invested in travelling to two sites were not a total waste of time in that it was an opportunity to meet with midwives and raise awareness of the study. It also provided a valuable opportunity for me to witness first- hand the conditions that midwives and women experienced on a daily basis. The atmosphere and receptiveness of the staff at the two sites were very different. This may have been due in part to being more familiar with staff at one site and already having good working relationships there. The openness and receptivity of this environment was very encouraging but did not help to prepare me for the realities of the other site. In some ways, the second site may have been a more realistic experience of trying to drum up support for research on the ground. Staff there appeared busy and preoccupied and while they did come in twos and threes to the information session, there was not much enthusiasm evident for the project. It was not difficult to understand why. Mine was just one in a long list of research projects being undertaken and was yet one more study where researchers were relying on clinical staff to recruit participants. The physical clinic environment was challenging in that it was too small for the numbers of women, there was no natural light in the waiting areas. There was not adequate office space for staff to do their work and it looked equally unpleasant for the women who waited in what seemed like endless lines to see the midwives and doctors. Staff were polite and friendly towards me but I could feel the resistance and frustration as I talked about the study and asked them to hand out information packs to eligible women. My fears were realized when the weeks went by and no women were recruited from that site. When I revisited several weeks later, a slightly embarrassed midwife eventually located the pile of information packs in one of the back rooms. I write this not as a criticism of those midwives or that unit but more because it gives a very real insight into the challenges facing individuals working in such

environments. It appeared that huge effort was required just to get through the day as evidenced by newspaper reports around that time(Haughey 2003) and there was certainly nothing left over for getting involved with research.

It became increasingly obvious to me that I needed to adopt a different approach in order to make contact with potential participants. To this end I approached another contact I had made early in the study preparations with a public health nurse at one of the accommodation sites. We met again and I discussed the possibility of meeting with women who were residents at the centre. I remember that first meeting clearly I was so impacted by this woman's approach to her work and her obvious care and interest in the mothers' with whom she worked. She talked about her work at the centre and the various constraints and rewards as she perceived them and the way she dealt with whether asylum seekers claims were authentic or not. She simply said she chose to believe them. That was the position she adopted and it informed her work in an obviously positive way.

In order to work within the accommodation centres in this way, I had to get approval from the Department of Justice as the accommodation sites were Government property. I made telephone contact with the relevant justice official, sent along details of the study proposal and ethics approval and waited several weeks and eventually received approval to carry out recruitment within the accommodation centre(appendix VIII)

I planned to hold information sessions at the centre's education centre. I did this with the support of the education centre's director who asked the women in advance if they would like to hear about the study. So at the end of class one morning, I held a very informal information session with about fifteen women. Some were more vocal than others as in any group, but they seemed to have a hunger for knowledge around childbirth and asked all sorts of questions about what happens after a woman is sterilised, after a hysterectomy, after a male sterilization to name a few. One woman talked

about her lack of knowledge and preparation for childbirth and the experience of having an epidural and caesarean section when she had no clue as to what was happening. This sparked discussion with several women around the room who identified with this and provided an opportunity to discuss antenatal care and preparation and this gave the public health nurse an opportunity to promote her classes. The women really responded to the information, taking the opportunity to ask questions and five signed up for further information. Signing up at this point did not mean a commitment to participate, just an interest in getting more information on a one to one basis. In this way I recruited approximately half of the participants' from that site. I also made contact with some women directly through the public health nurse. She suggested a couple of women she thought might be interested and approached them on my behalf. Any woman who expressed an interest was given an information pack as per the research protocol.

Twenty-two women were included in the study. They ranged in age from 18 to 40 years. Thirteen were multiparous and 9 primiparous. Their educational background went from very little 'formal' education to several with post-graduate degrees. Their occupations were varied from full-time mother to local government worker and they represented refugees and asylum seekers from nine different countries.

3.4.1 Site A the North East

'Do they get to use the amusements?'

The two sites were very different. One situated in the North East of the country was well established and considered to be a 'flagship' for such institutions. In a very ironic and incongruous twist of fate, the site had been a holiday camp in the 1960s'. The following is my account of that first visit as recorded in my field notes.

'Memories of that first visit to 'the site', or rather the first time I walked down to the accommodation, the women's homes. It was a bleak winter's day. Grey, wind and rain

swept over large expanses of grass towards the sea. I was heading to the far corner of the camp. The homes, more like rows of wooden huts, were positioned starkly against a wild grey Irish sea that provided a boundary on the outside edge of the camp, just beyond the railway line. I noticed a pair of bedraggled swans on the grass, the incongruity of their presence there somehow mirrored what I was seeing and feeling. A holiday village, in its heyday it was a fun filled holiday experience. I remembered going there as a child for a holiday in the early 60s'. Its glory had long faded but those same rows of chalets remained, now a place of confinement and a temporary uncertain home to a band of bewildered and, in some cases, battered humanity. It was an emotional day. I needed to reconstruct, rewind and reframe the mental images, the contrasts of what that place represented then and now. A question I had been asked echoed in my head. 'Do they get to use the amusements?'

The question was asked of me by a woman near my own age who also had memories of holidaying there. Memories of fairgrounds, amusement parks indoor swimming pools left some people with the impression that asylum seekers were living in the lap of luxury, having an unpaid vacation on the Irish taxpayers. The answer is they did not have access to any of those things with the exception of two hours or so once a month when the owner of the former holiday site would open up the merry go round free of charge for the children to use. Apart from that time, everything was closed up. Once a year community sports games are held on that sports grounds adjacent to the site and for that weekend the whole place is opened up: the swimming pool, the fairground rides and amusements, as this is a weekend where the local Irish citizens come to use the facilities. Once the weekend comes to an end, it is all closed up again to await the next 'community' visit.

It is in this place then of incongruity and contrasts that approximately six hundred asylum seekers live in sometimes years of uncertainty about their future. Despite these contrasts, the site is seen as one of the better accommodation centres as many of the women I interviewed attested to and

my own experiences appeared to confirm. The site was well organized and well run. As one of the oldest accommodation centres, it offered a variety of classes in English and a number of VTOS¹³ courses in subjects such as communication, childcare, basic math's and English. Women expressed gratitude at being able to access such courses if only to relieve the boredom of endless days with little to do, as paid work is forbidden. Access to third level education is also barred to asylum seekers and their children so opportunities for study or self-improvement here are severely limited. There is also a medical centre with a dedicated public health nurse that provided continuity of care for women with young children where there is access to a medical doctor, social workers and counselling services. Everyone has her own living space, and although tiny, this provides privacy that many other accommodation sites around the country do not. Privacy crucial to peace of mind, family life, and successful breastfeeding as highlighted in a number of studies (Kennedy and Murphy-Lawless 2003, Steward 2006, Pieper et al. 2009). The chalets tend to be one or two bedroomed, depending on the size of the family. There is usually a tiny kitchen area and a bathroom. No cooking is allowed in the chalets. Everyone is required to eat in a communal dining hall where all meals are cooked on site and provided at set times in the day. Many women expressed finding this hard especially when they had just given birth as their time-tables and their babies did not always coincide with 'normal' mealtimes. Laundry facilities are in a communal launderette. All the basic requirements are provided for by the State, such as clothing, toiletries, nappies, cleaning materials, food. In addition to this adult asylum seekers are given €19.10 per week and €7.50 per child. Asylum seekers are not eligible to claim child benefit or any other State benefit. Toys, books, birthday cards, any

¹³ Adult aged applicants are not entitled to places in State funded third level education, post leaving certificate courses (PLC), Vocational Training Opportunities Scheme (VTOS) and FAS courses. They are eligible for part time English language classes and other part time courses (e.g. computer courses) provided by voluntary groups. Under the Back to Education Scheme Initiative, asylum seekers are entitled to attend classes which provide language and literacy support, these classes are run through the VEC colleges which are located all over Ireland, and are free of charge. To find out about of the courses contact the local VEC college, or the local Citizens Information Centre (Irish Refugee Council).

other extras have to come out of this money. Whilst every woman I spoke to almost without exception in this site expressed gratitude at being there I could not help but wonder what the impact of this was on the children I saw growing up in this environment. I watched in the afternoons as the children streamed into the camp coming from their schools ‘outside’ in the community. They wore the same uniforms as the local children and many of the older ones spoke with the local Irish accent. I wondered what it must be like for them. Not all of them experienced poverty. One thing I learned early on is that status as an asylum seeker does not necessarily equal poverty, but many had very little. Yet they would mix with Irish children who had all the latest gadgets and gizmos. How did they make sense of their lives? I asked one mother of teenage girls if they ever asked anyone ‘home’ after school. She just said ‘No, they never want to have anyone here’. So while the site provided basic necessities and support structures, it was also a source of terrible isolation from the community, from higher education and employment and from being permitted to live life in any measure of freedom as many Irish citizens understand it. The incongruity of the setting, green fields, the smell of newly mown grass, the salty sea breeze, all conjuring up images of freedom, beauty and peace, contrast sharply with the reality of the women’s lives there: a holiday camp that is really a place of containment and constraint, a holding place where women described living their lives while holding their breath. They were afraid for the future where they might not get their papers, or their leave to remain, where dreaming of a new life is a risky business, as no plans can be made with any degree of certainty. Until they have refugee status, they live a life on hold endless days of waiting, some daring to hope, others trying to cope with the scars left from the lives they fled. Whether or not they were ‘allowed’ to ride the fairground really did not figure. The following excerpts from some of the narratives provide insight into what the experience of living in an accommodation centre is like.

‘ No, we are not allowed to do anything, even when you know you can do something, even when you know that you

can be of relevance to the society, but yet you are not allowed to do that, you know, it's like we are wasting you know. If you can be given an opportunity you know to just contribute to the society, it's better than just sitting down here sleeping away, you know day out, day in you know'.

'Yes, you are caged because you can't work, the only thing you can do is wake up, eat, that's all, wake up, eat, that's all, but we are not used to that kind of living, we are not used, even that's while you are pregnant, you must do something to make you more healthier, that is the way we see it. But when you come to seek asylum you cannot work, you cannot do anything, you cannot, you can't decide on your own on what you want to do, the government decides for you or the hostel decides for you when to go out, when to come and eat and when to sleep and things like that. All those things I think they're not all that good because we are not used to it. And one thing about [inaudible 4.09] is that no matter how you are, you are a little bit hard working, compared to Irish women. So when you now come to Ireland and you have people saying you have to stay here, sit down, they will feed you, it is a mental stress on its own.'

'Yeah I really wanted to go further, [cough] but they said there's no, except you have to stop at this level for, they won't allow any more than, asylum seekers any more to go further into education. So I have nothing to do but sit and wait'.

'But I just felt ... [pause]... and I always yearned to go back, just to face whatever, you know, slow death is more painful than fast death. If death, if I go home and get killed once its better than staying here slowly suffering mentally, emotionally, ah anything.'

The following narrative is from a woman who fled from an African country and found after she gave birth that her baby daughter had hydrocephalus. She has been here now almost two years and is still waiting to hear if her application for asylum has been granted. I have purposely deleted the researcher's voice in this excerpt as I feel the narrative takes on almost a

poetic rhythm as M (not her real initial), returns time and again to the 'chorus' 'Yeah it's tough while you are waiting'.

'Yeah it's tough while you are waiting.

You're not imprisoned but when you're going out its just to go to [local town] and come back, just window shopping, nothing, yeah, you leave this place here, my goal is to go back to school, yeah.

My goal is to look for a job, I'd be working towards that but now I have no goal, I'm just....

It's because, well you're not allowed to go to school, to work when you're an asylum seeker, so that's the problem, so you can't work and you can't go to school.

You can't make plans, you're just stuck waiting and it's really frustrating.

Yeah, for now there's nothing, nothing is happening, you just have to wait.

I'm so, last month I was so depressed all day, I had to take antidepressants, yeah I had big time depression, very big time yeah, just fighting to cope now, I have very big time depression.

Yeah it's very I cannot sleep I cannot eat so it's just, I'm beginning to get somewhere, it was really rough for me, it was really rough, very, very bad time you know.

Yeah.

Maybe for now I have the problem of choosing a career [laughs], yeah it's a really hard one you know.

I studied about chemistry at university.

Yeah so I was like thinking if I should go to, being a technician or a laboratory technician, so that is.

Yeah or just choosing a new career yeah, maybe choosing a career that would favour my child.

Yeah.

You just wait.

No nothing.

No, you just wait.

Yeah.

You come, when you make the application you go for the interview and if it's negative you go for the appeal and after the appeal you have to wait for your results.

There is no time limit for that, just have to wait.

I went for appeal last November; yeah I waited for 1 year to get the appeal done, so last November I went for the appeal so I'm still waiting.

No I'll be 2 years in August.

Yeah, so I'm still waiting.

Yeah it's very tough.

You can't leave Ireland, you just have to be within, you can't travel, you can't do anything.

Yeah, you just have to wait and one day you hear yes or no.

If you heard no, you are given the opportunity to apply for leave to remain.

Yeah it's a long journey.'

3.4.2 Site B the West of Ireland

The accommodation centre I visited in the West of Ireland had been opened for three weeks before my first visit. I learned from a friend who was a service provider in the area that upwards of sixty women had been transferred there having recently given birth in Dublin. The accommodation centre was a converted low budget hotel, more like a hostel. I contacted the manager to talk about my research and to seek permission to talk to the women there, with their consent. The manager was very open to the idea and invited me to come over. I travelled from Dublin to the west coast unsure of what the outcome would be. On my first visit I met with the centre's manager and the residents' representative who was very keen to establish what my identity and my agenda was. Once she was happy with me, she got word out to the women who had recently given birth that I was coming to give an information session about the study. I held the information sessions in the dining room and had a large turnout of women. I went to great lengths to explain that participation was voluntary and could not influence their individual applications for asylum. I stressed that confidentiality and anonymity were paramount and they would never be identifiable in any published papers afterwards. I had some mixed reactions. A small number of women agreed to participate initially and then more approached me as news spread via word of mouth from women who had taken part. I stayed in the west for two weeks and undertook approximately 13 interviews with women there. It was a very stressful experience, the nature of the women's stories coupled with the chaotic atmosphere of the place, as described previously, and women's own unsettledness at being uprooted yet again made for a very intense experience as evident in my field notes at the time.

3.4.3 Field notes

'Feeling very overwhelmed by the task. The hostel is overflowing with people, it seems too many. Some women are sharing a small room with another woman, not of their

family, along with their babies. The two beds take up most of the space. The rooms contain a small wardrobe or dressing table. Personal items piled everywhere. Not room to turn around. I can't imagine sharing such a small, oppressive space with your new baby and another woman, a total stranger and her baby. One woman told me just as her baby falls to sleep the other baby wakes up and cries. I remember having young babies myself; the desperate need to sleep when the baby sleeps. I cannot imagine how these women are coping under these living conditions. The women seem dazed in some ways, traumatized, readjusting to another new city, new living arrangements, new rules; negotiating life in survival mode. Their stories break my heart. I fight back the tears listening to them, looking in their eyes. The atmosphere in the hostel is chaotic. Trying to find a quiet area to conduct interviews is virtually impossible. At the end of the first day I found a quiet area on the third floor. The constant noise and chaos is so draining for me and I can't imagine what it must be like to live in these conditions. No facilities to cook your own food, restricted to prescribed mealtimes, food that is unfamiliar and difficult. A lot of the women seem to have strong religious beliefs; this seems to help them cope.'

I came 'home' to my friend's house exhausted, drained, I felt overwhelmed'.

As I spent time in that centre I got to know the place and the women better. The representative who had initially been very sceptical became a great ally and was invaluable in acting as a gatekeeper for me with regard to introducing me to the women, but she was also a wonderful source of information and support for me. I quickly realized that many of the support structures that had been readily available in Dublin just did not exist in the West of Ireland. There was a refugee support agency that visit and do what they can but organizations such as Akidwa¹⁴, the African women's support agency, did not have a branch outside of Dublin. Many of the women felt the loss of such groups. Travel to Dublin was expensive, and women

¹⁴Akina Dada wa Africa (AkiDwA; Swahili for sisterhood) is an authoritative, minority ethnic-led national network of African and migrant women living in Ireland. The non-governmental organisation with charitable status was established in August 2001 by a group of African women to address the needs of an expanding population of African and migrant women resident in Ireland (<http://www.akidwa.ie>).

needed to get permission to leave the centre for an overnight visit. One woman (who later became a friend) seemed quite aggressive towards me and negative about the research. She was eager to let me know she was educated to masters level herself and understood the research process. It took some time and much discussion for her to see that I had no desire to rape and pillage their experiences purely for my own gain. I could and still do understand and share her concerns and I can see how I would have felt and probably acted exactly as she did if our roles were reversed. She was stressed out and frustrated, an educated women and a writer with no access to a computer and no outlet for her skills and talents. The following is a diary entry I made during that time.

'Here at S's for R & R. and some much needed peer support. I almost fell into her house. It was certainly not too many minutes into chatting that I was crying and pouring out my heart, feelings of helplessness, pain, guilt, the uselessness of the research process in general and the PhD in particular etc. Copious amounts of red wine and a good dinner and good night's sleep have helped me to gain perspective again, until the next round tomorrow..... Documenting my emotions is not easy. The conflicted emotions I experienced in the day's work, interviewing four women, continue to disrupt even my attempts to write this account. Part of me doubts the legitimacy of what I am feeling? The depths of my reactions, tears running down my cheeks, feeling extremely embarrassed by this and yet knowing it's appreciated by the women in some way. Another example; yesterday when almost I almost completed an interview with F.: an interview I found particularly difficult because she is a highly intelligent and educated women who is used to being extremely busy and she is going crazy with the forced inactivity that is the lot of an asylum seeker, a writer with no computer because she cannot afford one and there is no access to one at the centre. We negotiated her story of coming here, her birth experience, her move to the west of Ireland, all fairly impartially in a way, helped by her brisk (almost brusque) professional approach but then right at the end I asked her how she coped without her two sons that she had left behind in Africa, she turned her head to one side the tears coming too fast for her to control. I felt terrible, like my

question undid her, I felt I had betrayed her. I quickly turned off the tape recorder, apologized to her. That was just one incident, each and every interview has been so tough. It is emotionally and physically draining, exhausting. Feeling guilty, voyeuristic, fraudulent, helpless, ineffective, questioning the value of mining the depths of human suffering to what end? Feeling the weight of all those stories coming to bear on what I do with them. The conflict of the vouchers, 'the thirty pieces of silver', questioning if the need for money takes priority over the need to avoid the pain of the past. Yet some women express lightness, a therapeutic effect of telling their story? I am left feeling like I am walking a tightrope of managed emotions, what is the right tension between not caring enough and caring too much? Why have I chosen this research subject? Do I have a masochistic need to vicariously experience this terrible suffering? Have I not experienced enough suffering of my own or is it because I have experienced suffering that I am drawn to the suffering of others? What influences a researcher's decision to undertake a particular project?

These notes can provide just a glimpse of what doing the foot work of this study entailed. These descriptions are from my first visit to both sites. I have revisited both sites many times over the four years of the study's duration. Site B settled down a little from its chaotic early days, as it became more established as an accommodation centre, but issues of overcrowding, lack of privacy, no access to cook one's own food, no power over one's daily living still remains.

3.5 Narrative construction

Eliot Mischler (1999) defines narrative as a natural cognitive, linguistic medium through which we attempt to make sense of our experiences. Riessman (2008) suggests narratives can be discrete stories told in response to a single question or can be a series of stories told over a longer period of time, as in Eliot Mischler's (1999) study of identity development among groups of artists. Interviewers can ask directly for stories, as in this study and many like it that aim to elicit

particular experiences (Kvale and Brinkmann 2009), or interviews can elicit stories from narrators unexpectedly as in Riessman's experience when undertaking research into infertility in women in rural India (Riessman 2005). Kvale and Brinkmann (2009) suggest that once a researcher invites a participant to tell their story the role of the interviewer is to abstain from interruptions, except for the occasional question for clarification. This requires a very different approach to interviewing than I had previously experienced. Initially in the study, I had devised an interview schedule to provide a boundary for the interviews but ended up with a question and answer type response in the pilot stage, resulting in transcripts that did not lend to narrative analysis at all. In attempting to structure the interview, I did not provide adequate space for participants to tell their story. I knew they had powerful stories to tell but I needed to find a way to access those stories. At that point that I had completed just five interviews so I knew I needed to revise thoroughly my approach to interviewing. I asked the women concerned for permission to do another interview, explaining that I had done too much talking the first time round! They were all very gracious in allowing me more time. Second time round I simply invited the women to share the story of their experiences of giving birth in Ireland and to start at whatever point made sense to them and they felt comfortable talking about. According to Riessman(2008), the goal in narrative interviewing is to generate detailed accounts rather than brief answers or general statements. Giving women the freedom to tell their stories unbounded by an interview schedule made the course of the interview less predictable. This meant that some women did not share anything of their flight from home or the reasons they left but concentrated more on their childbirth experiences, while others gave lengthy accounts of the reasons they had to leave. I found that women in the older more established accommodation centre were less likely to share their reasons for leaving, although this was not the case for everyone. In contrast, the women I interviewed who had just been relocated to a new site were more likely to talk about their reasons for leaving. Some women talked freely and openly and in those situations I just needed to maintain eye contact and nod and give the odd word of encouragement. Where the narrator was less forthcoming, less


trusting, less talkative, I found it harder not to do more talking to try to ease the flow of the interview and attempt to build relationship and rapport throughout the interview. The resulting transcripts were much more satisfactory in that I now had actual narratives that could be analysed, however, I am still very much a novice researcher and I appear far too regularly on the pages of the transcripts.

Feminist scholars have highlighted a number of other important considerations when undertaking interviews with women, particularly women who are perceived as vulnerable or traumatized, (Mauthner *et al* 2002a, Sprague 2005, Halse and Honey 2005, Ramazanoglu and Holland 2008, Birch and Miller 2002). Rienharz and Chase (2003) explain that for some women who have been silenced by cultural and societal norms, the process of the interview can be a kind of ‘epiphany’, and cautions researchers to be aware of possible radical effects of ‘finding her voice’. While I am not aware of such an epiphany occurring in the course of this study I am reminded of the responses many of the women who participated made when I gave them the transcripts of their interviews. So many responded how they were shocked at how long they had talked or how much they had to say. Some talked of feeling sad and upset at seeing their pain in written words on a page, and it seemed that for some reading the transcripts was as cathartic an experience as the interview itself. This highlights the very real challenges of uncovering traumatic experiences in the interview and the importance of ensuring there is adequate support for women (and indeed researchers and interpreters) who need it. Both interviewer and participant need to be aware of the potential for distress and anxiety such interviews can elicit and have suitable supports in place (Reinhart and Chase 2003, Riessman 2008). I had anticipated the need for counselling support for participants and was able to get two agencies on board on the east coast that were willing to provide support and free access to any participants who needed it. To my horror, I discovered that no such services exist on the west coast of Ireland and that despite the government’s active policy of ‘dispersal’ of asylum seekers, there are few services available to meet their needs. In terms of the need

for support of the rest of the research team, namely myself and any interpreters that helped, I was less prepared for the traumatic experiences of being the recipient of harrowing stories. I found I had to debrief one translator, who was visibly moved, shocked and upset by the interview as I had no other recourse. I devised ways of debriefing for myself, relying heavily on my journal, and the support of my peers and supervisor to try to make sense of raw pain I bore witness to on a daily basis at one point in the data collection. Near the end of period I also took steps to contact an old clinical supervisor from my days as a counsellor. I felt the need for more than academic supervision or what friendship or peer support could offer me. Clinical supervision is a relatively new concept in nursing, although Chris Johns (2002) successfully used this model in Oxford in the mid-90s. It requires a certain level of trust and accountability that has long been used in social work and psychotherapy but I believe has a place in helping researchers process some of the challenges of working with victims of trauma and abuse. Accessing clinical supervision when undertaking ‘sensitive research;’ is supported by the work of Dickson-Swift *et al.*(2007) who highlight the benefits of this kind of supervision but state it is yet to be adopted by the wider research community. The following excerpt from my research journal outlines the benefits of the process for me.

‘...It was good to see K. again. We took up where we left off, or so it seemed. It was hard to believe it had been two years since I had seen her. We chatted over coffee, general stuff, catching up and then touching on some of the issues for me. Then we got down to the work. Went into her office and had an hour of focused supervision. It was fabulous as always though somehow easier than I remembered when I was a student. I felt a confidence I didn’t used to have back then and K. noticed it too. I talked about why I was there, feeling this need to address the emotional impact of the women’s stories and the gap I perceived in academic supervision. I talked about one or two of the stories and how they impacted me. We talked about the impact of letting tears flow or come into one’s eyes in an interview, the importance of being ‘real’ and being a ‘real presence’ in the interview. The need to balance one’s emotional

reaction so that the needs of the participant are always paramount-it's all about them-comes back to the same balance in reflexivity in the final report and the need to ensure that it is the women's voice who is heard the loudest and that the discussion does not become a vehicle for the researchers ego. However, being fully present to the women will mean the tears will come, this can change the interview, bring trust, bring it deeper. One thing that came out loud and clear was the need to trust myself, trust my instinct and follow that...'

 The impact of the interviewing process and the stories researchers bear witness to is discussed by Paul Rosenblatt (2003) in his paper, 'Interviewing at the Border of Fact and Fiction'. Rosenblatt suggests that researchers are affected by the stories they hear and the impact of these stories have reverberations long after the interview has ended. He goes further to suggest that what lies beneath the surface of the interviewer's personal consciousness influences the interview, the rapport, the quality of the work. The inference being that interviewers who are 'comfortable with under-the-surface emotional matters'(2003:231), make for more effective interviewers, drawing out from interviewees stories they would be uncomfortable telling most other people. In my experience women given an opportunity to tell their stories often confide things not previously divulged, 'I say things out loud I have never said before' (Reinharz and Chase 2003:77). Such conversations can awaken previously buried loss, anger and confusion. I found this to be true on many occasions, but one woman's story stands out in my mind. The following is an excerpt from the rough transcript of one woman's interview. It was a long interview and this story emerged in the last couple of moments. You will see from the excerpt that we are discussing an entirely unrelated issue to do with her son who had been traumatized in the journey from Africa (he had been present when his mother was raped) and had been in treatment before their sudden transfer to the other side of the country as part of the Irish government's policy of 'dispersal' of asylum seekers from the capital city, Dublin. To my embarrassment, you will also see my naiveté at this point as

I still could not imagine that there were no services available for this woman in the West of Ireland.

W So we couldn't finish the course, I even called there when I got to Galway, that maybe they have, I personally have interest, maybe they have something like that in Galway.

R They would have, I'm sure they have.

W But they say no.

R No?

W They say there is no ISPCC or whatever in Galway here.

R But the social worker will have a link, there will be child... there'll be a health board child psychologist I'm sure.

W Ok I will try.

R So that might be a good one and you can explain that you were to start this course with him and then you had to leave so he never got to do it.

W Ok.

R But it just might be worth doing you know because he seems to be adjusting well but, and it may be that if you take him to see the psychologist the psychologist will say he's fine, but it would be good to get him checked out wouldn't it?

W Ok.

R If you feel that might be something.

W I will, thank you very much.

R You are welcome, thank you for sharing all your story with me and so much of your personal life.

W Sometimes he make me to get depressed, that you have to be going and taking medicine but now I'm trying to get right.

R **Yeah**

W That I used to get migraine all the time, all the time, but don't go now, I'm trying to get right, I don't just want to put the same kind of feeling on my children.

R **I know.**

W Especially on my son because he knows, because he's over 4 years when we left home and he can still remember, you understand me.

R **Yeah**

W He still remember, sometime I have to tell him forget about that, let's talk about another thing, he keep on asking me questions, sometimes the question that I can't know even how to answer the question, it's very difficult for me.

R **Yeah, but you sound like you're doing a good job.**

W Yeah.

R **You're doing a good job.**

W It's very difficult for me sometimes to answer the question, when he's getting like that, sometimes even [inaudible 46.11] I have to dress her, let's go out, just go to Dunnes Stores here, come back, but they will get to that Dunnes Stores, still continue asking that question from me.

R **I think the best thing is just to be as honest as you can, you know, but sometimes with children you can't tell them everything you know but sometimes it's just to be as honest as you feel you can be with them, to answer his questions as honestly as you can, that's all you can do but he looks great, they both do and I think you've done a good job.**

W I don't even know I'm going to have a baby girl, I don't know that Princess is going to be a girl because I never go to hospital, did scan because I [inaudible 47.05] so I don't even know that I'm going to have a baby girl, I was even praying to have a baby boy because in our family they do the circumcision, which happened to me before, they did for me fine but you know that my son is not my first son, I

had a girl before him but she's no more, it was about 1 ½ to 2 years, they just did the, going to 2 years they now say they want to do the circumcision for her, they did it, so that's really fine, after a while just [inaudible 47.57] the girl was still bleeding, was bleeding and they say we should be using one local medicine for her.

R Local medicine?

W Yes, when I use the medicine for her, it was somebody that came to visit my husband and I was telling my husband, what's wrong with you, why don't you carry this girl to teaching hospital, we now carry the girl to the teaching hospital, they were stopping the bleeding, it stopped today, maybe we be thanking god [inaudible 48.32] 3 days start again, in short the girl bleed to death, she bleed to death [Crying]. She be about 10 years now, each time seeing the age group it was like maybe I can say it's me that kill the baby [inaudible 49.01, at this point she is visibly upset] the family of my husband that killed the baby. Any time seeing the age group was like ah, you know our baby girl used to crawl [Crying]

R Tissue, it's very hard.

W I have to go [Crying].

R I'll turn this off...(end of recording).

This was the end of a very long interview and long day of interviews and it is obvious I was trying to bring the interview to a close before her disclosure, but she persisted, she needed to tell that story. Riessman (2008) describes this in her work where women tell their story sometimes despite and not because of the efforts of the researcher. I was taken completely unawares by her sharing such deeply personal information. There was nothing that could be said, I turned off the tape and put my arms around her and she cried.

3.6 Conclusion

As recipients of storied lives our job as researchers and students of human inquiry is to try to make sense of those stories. In effect we are challenged with writing the story of stories. In doing so we balance a number of often competing needs. The need to carry out the work of analysis in a way that honours the personal investment of the narrator, the contextual challenges of situating those stories in order to illuminate their deeper meanings, to provide an answer to our research questions and to fulfil the requirements of our academic institutions. The challenge of finding the correct tool for this job becomes paramount in this part of the research journey.

CHAPTER 4

Deconstructing Narrative: Analysing Women's Stories

'We must create links. Join the dots. Tell politics as a story. Make it real. Present impassioned polemics. And refuse to create barriers that prevent ordinary people from understanding what is happening to them' (Denzin 2009:231)

4.1 Introduction

Human stories are powerful vehicles of social commentary, drawing out inequalities that exist in our world. Many feminist scholars would argue that the stories of the most vulnerable in our societies play a particular role in revealing the least palatable aspects of our world (Mohanty 1986, 2003, Reinharz 1992, Mauthner et al. 2002a, Harding 2004, Fonow and Cook 2005). Many of us espouse an equal and just society where the vulnerable are cared for, where people matter more than systems and institutions, however, the narratives of the least powerful among us often tell a different story. In this study we see time and again how the rational instrumental organization of maternity care overrides individual women's needs. For this very reason I chose to collect women's narratives of their childbirth experiences in Ireland while seeking asylum here. At the outset of this project, indeed in the very early stages when I first discussed the idea with my advisor Dr. Jo Murphy Lawless, Jo's comment was 'this needs to be done, but it will break your heart'. She was right. The stories of women are harrowing. I never fail to cry when working on them. No matter how many times I revisit these stories they have a powerful effect on me. The challenge for me was finding a method of analysis that was 'fitting', for the project, that is, one that would be considered rigorous for the purpose of meeting the requirements of a PhD, but at the same time a method or approach that would be 'true' to the essence of these powerful stories.

I first developed an interest in narrative analysis when taking a course in advanced qualitative methodology at the University of Connecticut with Professor Cheryl Beck in 2007. I was immediately drawn to the method and

could see how it would provide a systematic approach to analysis that would meet the academic standards of the degree, but more importantly, the method is entirely compatible with the feminist epistemology that guides and informs the study. Narrative methods and the structural approach to narrative analysis have been employed by a number of feminist writers, for example, Susan Bell (1988, 1999, 2000), Faye Ginsburg (1989), Margaret Sandelowski (1991), Shulamit Rienharz (1992, 2003) and Catherine Riessman (1987, 1989, 1990, 1991, 1993, 1997, 2000a, b, 2002, 2003, 2004, 2005, 2005) who is also a major contemporary theorist in narrative methods. For me, one of the most compelling features of narrative analysis was the opportunity to keep the narratives intact while allowing the voices of the women themselves to speak. I immediately felt this was a better path to take than Krippendorff's (2005) content analysis as I was particularly loathe to divide the women's stories into themes or categories as I believe the power of the narrative is in letting the stories speak for themselves. One of my biggest challenges as a novice feminist researcher is in keeping a balance between inclusions of the voice of the researcher as an essential part of the transparency required for good quality research, while at the same time not wanting my voice to be heard louder than the voice of the women themselves.

Burke's (1969) method of structural analysis presents the researcher with a number of perspectives from which to view the narrative, Burke refers to these as 'terministic screens'. These terministic screens offer the researcher alternate perspectives from which to view the narrative that also help to bring to the fore and even challenge the researcher's previously held impressions of what was occurring within a given narrative or scene (Burke 1969). However, the notion of 'letting the stories speak for themselves' is an over simplification of a complex process of co construction of narrative accounts that I will return to in the course of the chapter.

In this chapter I aim to discuss what is meant by narrative inquiry, to consider how stories are used as vehicles of human expression, meaning making tools and prisms into wider social and political issues. I consider the construction of narratives and the role of researcher in accessing storied

lives. I discuss approaches to narrative analysis and provide detailed account of the approach adopted for this study. I describe the challenges of doing narrative analyses and strategies I employed in the course of this study. Finally I attempt to critique truth claims in narrative inquiry and consider how research students can strengthen the persuasiveness of their accounts.

All sorrows can be borne when you put them in a story

(Isak Dinesen)

4.2 Narrative Inquiry

We are all familiar with the concept of a story. Storytelling is an intrinsic part of our social and cultural life. Story telling is a universal experience. As Barthes stated in his 1975 publication ‘An Introduction to Structural Analysis of Narrative’, storytelling is ‘present at all times, in all places, in all societies; indeed narrative starts with the very history of mankind; there is not, there has never been anywhere, any people without narrative; all classes, all human groups, have their stories....like life itself it is there, international, trans-historical, transcultural’(Barthes and Duisit 1975:237). We tell stories for a number of reasons. For example, to pass on knowledge, keep traditions and cultures alive, to articulate and keep memories to the fore, to justify or defend our actions, to entertain, to name just a few. Story telling is an intrinsic part of what it means to be human; it can be a vehicle to communicate our greatest joys, losses and our deepest fears. It is perhaps one of the primary ways in which we make sense of our experiences, our lives (Riessman 2008, Gubrium and Holstein 2009). It is this meaning making function of narrative that social scientists appear to find so compelling and has fostered what Riessman (1993, 2008) among others has termed ‘the narrative turn’ in research inquiry in a wide variety of disciplines. Riessman suggests that narrative inquiry is particularly suitable for feminist research projects because it provides a measure of human agency to the narrator while revealing social, gender and other inequalities that may be taken for granted by the individual, but are brought to light

when analysed in the context of social and historical contingencies (Riessman 1993). Also the reciprocal style of interviewing required for narrative inquiry where the researcher must be willing to follow the narrator's story rather than impose their own agenda in the interview, builds on the work of feminist scholars such as Susan Chase, and Shulamit Reinharz(2003) who 'paved the way' for contemporary narrative researchers in their ground breaking work on the centrality of reciprocity and reflexivity in the research process (Riessman 2003). Whilst Riessman has used narrative inquiry to explore the effects of disruptive life events such as divorce (1989, 1991), infertility (2000a, b) and chronic illness (2003), she offers an extensive list of the functions of the story or narrative in research use. She argues that stories are not only useful for individual meaning-making related to life experiences, but also for illuminating wider social issues. She claims that storytelling can promote consciousness raising and emancipation as communities are dialectically connected through the stories they share about their experiences, particularly 'identity' stories of marginalized groups,(Riessman 2000b). She quotes Plummer (1995) to illustrate this point, 'For narratives to flourish there must be a community to hear, for communities to hear there must be stories which weave together their history, their identity, their politics'(Riessman 2003:332). Narratives can be used to form identity, and while identities can be revised and reconstructed over time the story can function as a tool to reveal the self to others. Riessman claims narratives do political work, that stories compel listeners to enter the perspective of the narrator encouraging others to act, 'major resistance movements of the twentieth century (including civil rights, feminist, and gay and lesbian movements) were born as individuals sat together and told stories about small moments of discrimination'(Riessman 2008:8). Earlier, Bruner (1990) argues that narratives are like a bridge between individuals' construction of identity and the 'deeper structures' about the nature of life in a particular culture. However, it is widely acknowledged by narrative scholars that all stories are socially, culturally and historically positioned and it is the context of the stories that are as powerful as the stories themselves (Riessman 1991, 1993, 2003, 2008,

Gubrium and Holstein 2003, 2009, Hollway and Jefferson 2002, Kvale and Brinkmann 2009, Denzin 2009).

4.3 Positioning Narrative

We understand that the stories women tell about their lives are like everything in life, partial and positioned. Their telling and my listening, understanding and interpretation, are filtered through the screens of culture, education, values and beliefs. There can be no impartial telling just as there can be no unbiased listening. Sandelowski (1991: 161) addresses this issue of ‘truth’ in the stories we tell about our lives, ‘analytical problems involve the ambiguous nature of truth.....the temporality and liminality of human beings interpretation of their lives....the inherently contradictory project of making something scientific out of everything biographical’.

Narrators and narrative analysts are socially and culturally positioned. In the West stories are meant to be constructed with a beginning, middle and an end. There is a plot that directs the ordering of the events, as in ‘what happened next?’ and also provides the ‘life blood of the story’, awakening emotion and evoking strong responses such as fear or dread (Riessman 2008). In my experience of gathering women’s stories of their childbirth experiences and their flight from home, and their journey to Ireland I found that women did not always follow this custom. Even those women who spoke English fluidly often started in the middle of their story and worked back, or zigzagged back and forth between events. It was as though in the telling of their tale they were struggling to make sense of their journey, struggling to bring a sense of coherence and meaning to fragments of experience, of pain, loss and little gain. Riessman (2000a) found a similar experience when interviewing Indian women about their experiences of miscarriage. She attributed this to Indian culture and a non-linear style of

storytelling. Something of what Sandelowski(1991) articulated rings true in the sense that what constitutes a story to be told in one culture, may in another constitute a story to be resisted. Stories of female circumcision may be a good example here. Such topics are seen differently through different cultural lens and demonstrates what Sandelowski refers to as ‘the metaphoric nature of language and the ambiguous nature of truth’, (Sandelowski 1991:161).It occurs to me that an important context of the narratives of the women in this study is the ‘in between’ nature of their daily lives. This is all the more relevant for women who are survivors of abuse or torture (Riessman 2008). They occupy a ‘liminal’ space, a place of holding, where their identity lies somewhere between the ‘no longer’ and ‘not yet’. The power of the narrative for them may be as a tool to make peace with their past, the ‘no longer’, and form or shape the ‘not yet’. Writing this reminds me of a game my children played when they were younger. To relieve the boredom of a long trip, every time we came to tunnel they would see who could hold their breath the longest, the aim being to hold it until they got out of the tunnel. So many of the stories I heard seemed to have the same quality of quiet desperation, of women holding their breath while they wait for the light at the end of the tunnel.

Narrative analysis is embraced by scholars who position themselves in constructionist and postmodern paradigms. Narratives are considered less as a description or mirror of reality and more as a means whereby the narrator ‘constructs’, creates or recreates their history and the stories that they tell and in so doing construct a ‘self’ or an identity. The truth in absolute terms is less important than the motive or passion that moves the narrator to tell a particular story (Burke 1969). That is not to say we discredit the narratives we are privileged to record. Rather, we acknowledge that all truth is partial and positioned firmly within the individual’s culture and life experiences, and perhaps more crucially, is also co-constructed with the listener/ audience/ researcher (Riessman 2008, Kvale and Brinkmann 2009). The ‘work’ of co-construction is apparent not only in the analysis of

the narratives but more importantly in a very active way, in the creation of the narrative itself. We do this in every stage of the project, from the very inception of the idea to formulation of a research question, letters of invitation, to the questions we ask in the 'interview', right through the research process to the final analysis. It is in the questions we ask, the 'truths' we seek to probe, and the threads of experience we choose to catch hold of, that we co-create the stories that are told. Kvale and Brinkmann (2009:179) argues that it is 'analytical naivety' to consider personal accounts or records as 'merely their own story'. This is not to say we are never surprised by the turn a narrative can take unexpectedly or to say we are not shocked, moved or taken unawares. However, we must also acknowledge the influence we bring to bear in order to come full circle, to fully appreciate the impact, the essence, the 'truth' of every story, the power of the narrative as a vehicle for individual exploration of life events, meaning making, debriefing and perhaps the therapeutic power of storytelling. Because we do not have direct access to others' experience, but rather we 'deal with ambiguous representations of it'(Riessman 1993:8), it is necessary to have a means whereby we can analyse the stories we receive. Riessman (2008) also cautions against what she terms 'the tyranny of the narrative', and argues that not all talk can be considered narrative; rather, the researcher must create the conditions for development of narrative accounts. This requires a definition of narrative and leads to a consideration of approaches to narrative construction and narrative analysis.

4.4 Narrative analysis

Narrative analysis is a systematic approach to analysing narrative data or stories, and can function to connect personal biography and society, (Barthes and Duisit 1975, Riessman 2008). There are several approaches to narrative analysis and these tend to be largely influenced by the disciplinary background of the researcher and the aims of the individual project, (Riessman 2008, Kvale and Brinkmann 2009, Gubrium and Holstein 2009).

Riessman (2008) details four broad approaches to narrative analysis and these include thematic analysis, structural analysis, dialogic and performance analysis and visual analysis. In thematic analysis, emphasis is placed purely on the content of the narrative. Narrative thematic analysis apparently differs from classic content analysis in that researchers keep the narrative intact by theorizing from the individual case rather than from themes or categories developed across cases. Dialogic, performance and visual art tell stories about individual lives, society and history in powerful ways that are not usually text based. Researchers have developed a variety of analytical methods to interpret these kinds of narratives that reach across a broad spectrum of fields including using visual images, photographs, paintings, art, theatre and film. Finally, structural analysis focuses on how narratives are organized or put together. Attention is given to the content and context of the narrative but also to the narrative itself. Narrative structure and sequence has traditionally been the field of linguistic theory. However, the development in social constructionist theory since the late sixties has generated interest from the human sciences in the use of narrative or stories, as meaning making and identity forming tools (Gusfield 1989, Mishler 1995, 1996, 1999). This interest has continued to blossom into what Riessman identifies as a continuum of research uses for structural analysis of narrative ranging from the most restrictive definition of social linguistics where the narrative is a discrete unit of discourse, topically centered and temporally organized, to the other end where applications to social history and anthropology use narrative to refer to entire life stories. She locates sociological research somewhere in the middle of this continuum as here ‘narrative encompasses long sections of talk-extended accounts of lives in context that develop over the course of single or multiple research interviews or therapeutic conversations...that are framed in and through interaction’(Riessman 2008:6). There are also a number of different approaches to structural analysis. The work of William Labov and Joshua Waletzky (1967) is widely acknowledged as the first in the field of social linguistics of narrative. Labov and Waletzky’s work with participant observation of teen gangs in Harlem is considered paradigmatic. Their method involves interrogation of narrative under a number of headings, as a

fully formed narrative in their view must contain six characteristics. These are; 1) The abstract or summary of the narrative, 2) The orientation, this includes the time, place and persons present in the narrative, 3) The complicating action or sequence of events, 4) The evaluation, or significance or meaning of the action. 5) The result or resolution, that is, what happened in the end, and 6) The coda, where the story ends and the perspective returns to the present(Beck 2004). According to Riessman (2008) Labov's work (1967, 1972, 1982, 1997) continues to be a 'touch stone' for narrative analysts.

James Gee (1991) uses a more poetic, linguistic approach to structural analysis of narratives. He considers the narrative in terms of pitch, pause and punctuation, identifying or dividing the text into strophes, stanzas and lines, which Gee considers as the building blocks of discursive language (Beck 2006). The power of Gee's approach is in highlighting the poetic rhythm of narrative sections, extraneous words are shaved away, and the essence of the narrative comes to the fore. While the main body of the analysis in this study employs Burke's method, I have used Gee's approach in places to illustrate the poetic rhythm in the narrative that helps us to feel the power of the women's account. For example in 'It's tough while you are waiting' [see chapter 3 page 63].

However, I chose to use Kenneth Burke's (1969) dramatic pentad as the primary analytic method for this study as I believe it provides the best 'fit' for a number of reasons. Burke's dramatic pentad is one of the structural approaches to narrative analysis, and as such allows for a certain level of systematic scrutiny that I feel is sometimes lacking in narrative accounts but at the same time is consistent with the epistemic and philosophical premise of feminist research that I outline as the basis of this study in previous chapters. I was attracted to Burke's method of analysis as it seeks to reveal the relationship between language, thought and action, or in the words of Gusfield, 'the motives of human behaviour as expressed in the stories we tell about ourselves' and others'(Gusfield 1989:32). Burke's method is a

potent tool, not least because of its eloquence and simplicity in highlighting the essential 'elements' of the narrative, but in powerfully drawing our attention to the number of elements at play. The scenes within scenes, motives within plot, that form and illustrate the complexities of human thought and behaviour. Burke's dramatism is essentially a method to help us understand human motives. It focuses on the moral consequences of our actions as evident in the stories we tell about ourselves and others. It is in the stories of our experiences that we endeavour to interpret the meaning of those experiences. It is this focus on meaning making in the narrative that endows our stories with not just a moral status but an epistemic one (Bruner 1990). The illumination of ambiguity within our stories makes alternative explanations possible, thus giving the narrator a measure of agency. Fox(2002:368) argues that Burke positions language as neither neutral nor completely deterministic, rather 'it is a tool with which subjectivities (and agency) are constituted and reconstituted. For both Burke and critical theorists, language is a site of struggle for competing representations of reality and subjectivity'. In this way Burke makes possible a sense of agency for the narrator, and the issues of truth as an absolute term is contested. Rather, the meaning that the individual applies to the story is privileged in terms of our reading both as a moral commentary and an epistemic position or insight.

Burke built his work on the theories of John Dewey (1922, 1958) who considered language as a vehicle by which we bring order to our thoughts about things. Bruner argues that language is constitutive of thought if not of language itself, 'the very form of human thought is imposed upon by the nature of language'(Bruner 1990: 78). As children mature, language is internalized until it becomes inherent or inextricable from thought. Burke, a literary theorist, explored the role of narrative in the regulation of perception, memory and thought (Gusfield 1989). The emergence of social constructionism as a dominant ontology made possible the merging of linguistic and cognitive disciplines that lead to the blurring of distinctions between art and science, or at least made such distinctions more difficult to

prove. This in turn made the notion of partial realities, and partial knowing a possibility and with it the role of imagination and human motive in the construction of reality. This was quite a departure from the tradition of the human sciences that depicted life in 'scientific' terms as 'true' representations of the 'real world'.

Gusfield credits Burke's emphasis on the importance of symbol and language in defining experience as the precursor to the contemporary emphasis on cultural forms in the construction of reality, including the social structure itself, and goes on to identify four aspects of Burke's work that have had a major impact on sociology and social sciences. These are:

1. An understanding of language as a form of action. The assertion here is that the modes of symbolizing experience are a central part of human behaviour. Symbolic representations constitute the ways in which experience is made possible, and different forms of symbolic usage create different experiences. Action responds to meanings of situations, and those meanings are reflections of the language frames we use.
2. An understanding of human action as dramatic in form and, consequently, as amenable to analysis in the same framework as literary work. Burke's emphasis is on the performative character of much of human action and communication as well as the ritualistic and symbolic nature of much human interaction and institutional forms.
3. An understanding of human actions as rhetorical; as strategies developed to cope with situations involving a performer and an audience.
4. A program for analysis of human behaviour which is pluralistic and dialectical. In its focus on the partial character of perspectives, Burke's method emphasizes the values of dialogue among diverse

perspectives and the unities that exist across the boundaries of the social sciences and the humanities.

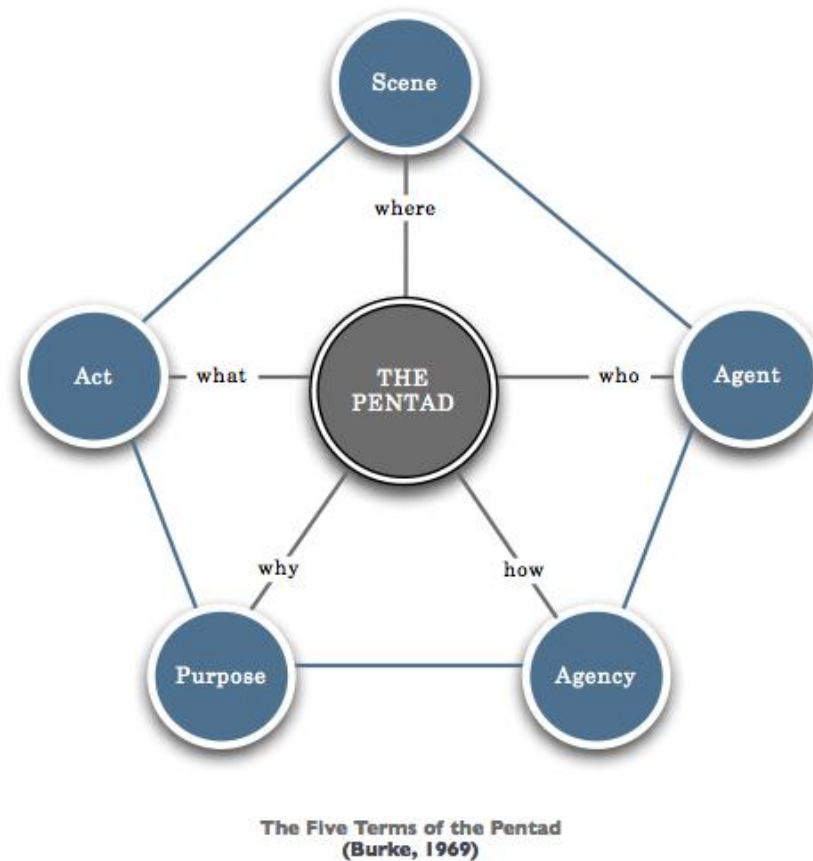
Burke made the distinction between the semantic and poetic meanings of words and in doing so revealed the language we use to be a ‘screen and not a windowpane..... it is his recognition of the ambiguities and multiplicities inherent in human action that makes Burke’s critique of positivism in science so powerful’(Gusfield 1989: 38).

Burke’s (1969) dramatic model of narrative analysis involves consideration of five basic questions. According to Burke (1969), these five elements or terministic screens offer the possibility of viewing the same narrative from a variety of different perspectives, the five terms of the pentad answer the following questions; what happened?(Act), where did it happen? (Scene), who did it? (Agent, there may also be co-agents present in any given scene, for example, family members, care givers etc.), how did they do it? (Agency) and why (Purpose). These five key elements, Burke argues, provide the ‘complete explanation of any human motive’, and help to ‘demonstrate the full muscularity of the text’. (Burke 1969:xv). Thus, the five principles or terms of the pentad are the Scene, Act, Agent, Agency and Purpose (Figure 1).

Burke (1968:445) states ‘ Dramatism is a method of analysis and a corresponding critique of terminology designed to show that the most direct route to the study of human relations and human motives is via a methodological inquiry into cycles or clusters of terms and their functions’. The terms of the pentad help to illuminate the meaning of the narrative, but it is the relationship of the terms to each other that provide the key to the analysis of the narrative. The real power of the pentadic terms is not in the individual terms themselves but rather when considered in pairs or ratios, as they occur in any given narrative. Considered in this way the five key terms have ten possible pairings. These are scene: act, scene: agent, scene: agency, scene: purpose, act: purpose, act: agent, act: agency, agent: purpose, agent:

agency, and agency: purpose (Burke 1969). Burke refers to the terms in this sense as ‘principles of determination’.

Figure 4:1: The Five Terms of the Pentad



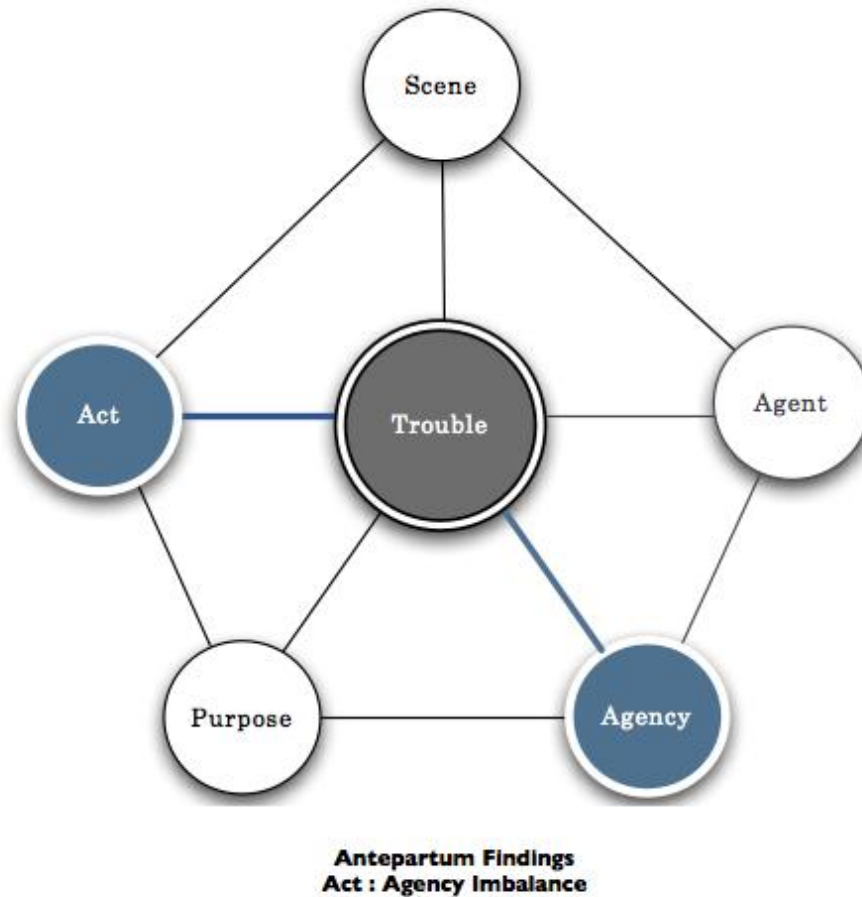
In her paper entitled *'Pentadic cartography: Mapping Obstetric Medicine and Traditional Midwifery'*, Ropp (2002) describes the five elements as 'principles of consistency', that any description of 'scene' carries within it implications of how the elements will be defined. This is what Burke refers to as the 'God term', the underlying philosophical principles that guide any individual's actions. Burke offers examples of 'god terms' such as; God, nature, history, the environment, means of production, (we can add to that list the ubiquitous scientific method and ever dominant bio-medical model of contemporary obstetric practice) that may be found in a scene, and argues that the ambiguities that such terms create in the narrative, form the basis of

any possibility of transformation. These very ambiguities appear to form the basis of the Burkean pentadic method, in that rather than try to iron out or avoid ambiguity, the task is rather, to understand and clarify the dissonance in human experience, as Burke states 'it is in the areas of ambiguity that transformations take place. Therefore the areas of imbalance or dissonance in the narrative provide the focus of the analytical lens.

Bruner (1990) took this a step further adding a sixth element to Burke's pentad of terms that he called Trouble with a capital T. Bruner argued that 'trouble' is detected in the narrative at the point where ambiguities of motive are most apparent. With the addition of Bruner's sixth element, any interrogation of the narrative will easily show a number of issues. First, it reveals if there is an imbalance or discontinuity within the narrative, secondly it clearly shows the point where that dissonance occurs, in other words the ratio imbalance is the point where trouble exists in the narrative, and lastly it is clear when there is no trouble present; that is, when there is no ratio imbalance evident in the narrative (Figure 2). The application to this study of no apparent ratio imbalance is where the story turns out as one would expect given our understanding of what constitutes ethical practice, or morally acceptable behaviours, including respect and dignity for others. Unfortunately there are very few examples of no imbalance in the women's accounts, on the contrary, there are many examples of complex unethical and culturally unacceptable (in the broadest sense) behaviours, evident in the presence of trouble in the narrative. This concept of trouble in the narrative particularly appealed to me as I was aware that the women's stories were full of trouble, making this another reason why Burke's dramatism with Bruner's sixth element of trouble is a fitting choice for this study. In this reading trouble is evidenced by the presence of deviations from taken for granted or canonical cultural patterns. Burke argues that all stories appear to give exceptional behavioural meaning in a way that points out both the intentions of the protagonist in the story (the protagonist's belief or desire) and some canonical element of the culture (for example childbirth practices), thereby providing what Bruner (1990: 51) refers to as 'motive force' to the narrative. If Burke's dramatism, with application of the pentadic

terms highlights the dissonance in human behaviour. Bruner's sixth element of trouble, serves to underline it.

Figure 4:2: Antepartum Findings - Act : Agency Ratio Imbalance



Anderson and Prelli (2000) first coined the term pentadic cartography to describe Burke's pentad of terms in their paper entitled 'Pentadic Cartography: Mapping the Universe of Discourse'. Cartography is simply map making, Beck (Beck 2007) suggests that a map is a graphic depiction of an area in which the real-world features have been replaced by symbols in their spatial location at a reduced rate. Anderson and Prelli (2000) applied Burke's method as a means of challenging the dominant discourse of technological rationality in industrialized society. They used pentadic cartography to locate 'pivotal sites of ambiguity' that allows for the

emergence of ‘marginalized discourse otherwise excluded from expression when constrained to the dominant discourse of technological rationality’(p. 82). Anderson and Prelli used pentadic cartography to map the verbal terrain of narrative by applying Burke’s pentad. Using Burke’s five elements of the pentad as co-ordinate terms they ‘mapped’ the imbalances and ambiguities present within the verbal landscape of narrative accounts.

In a paper entitled ‘Pentadic Cartography: Mapping Birth Trauma Narratives’, Beck (2006) used Burke’s pentad of terms with the addition of Bruner’s sixth element of trouble to analysis the narratives of women who had suffered post-traumatic stress disorder following their childbirth experiences. Beck conducted a narrative analysis of 11 women’s birth trauma stories. The powerful descriptions of these women’s suffering are testament to Beck’s skill and sensitivity as a researcher and to the power of the pentad to illustrate the complexities of the women’s stories. Beck (2006:457) states ‘Trouble was checked for in all the narratives. Because of the nature of the narratives, namely, birth trauma, Trouble or imbalance was present in all of the narratives’.

4.5 Doing Narrative analysis: Practice in Applying the Pentad

In this section, I describe the application of the theoretical assumptions and positions I have outlined above. Riessman (2008) identifies a number of common threads in narrative research. These are; the use of detailed transcripts of interview excerpts, attention to structural features of discourse, analysis of the co-production of the narrative through dialogue between the researcher and participant and lastly, a comparative orientation to interpreting similarities and contrasts among participants life stories. I intend to use these threads as a loose framework for the discussion of the work.

4.6 Developing the transcripts

According to Sandelowski (1991) the goal of transcription is the translation of speech into printed text with the aim of accurate transcription of the data, is a crucial aspect of representation of what was said in the interview. Many researchers view this 'task' as purely technical, often passing it on to support staff to complete (Dickson-Swift et al. 2007). However, Riessman (2003) argues that transcription of the text is a form of an analysis and interpretation, as decisions about what gets left in and what is taken out influence how the reader will understand the narrative.

My decision to have the interviews transcribed by secretarial support staff was influenced by a number of factors. I was somewhat overwhelmed by the amount of data I had managed to collect, twenty-two in-depth unstructured interviews had generated hours of talk that I knew would take me weeks, if not months to transcribe. I was on a strict timeline for completion of the project and was keen to progress but was exhausted from the demands of completing the interviews. On reflection, there was a significant emotional factor for me. I found the interview process challenging on so many levels, as I described in a previous chapter. I knew going back into the material in transcribing the interviews would be equally tough and I was reluctant to go there again. This issue and others related to the ethical implications of the impact of sensitive material on unprepared support staff is outlined by Dickson-Swift *et al.* (2007). They found researchers in their study often experienced emotional responses to doing transcription work, some finding it harder than the initial interview.

However, handing over audio tapes for transcription to others is also fraught with difficulties (Riessman 2008, Gubrium and Holstein 2009). Transcribers can leave out crucial pieces of the narrative for reasons known only to them and it is important to closely read the transcript and check with the original audio tape to for verification of completeness. An example of this problem in my own study is a case in point. In the course of a very long and heart rending story one of the women told me how her 6 year old son

had started stealing toys from children in his class. Previously in the story we had learned of the trauma her son (who is called Doctor because he wants to be a doctor when he grows up) had endured with her on her long journey of escape, flight from home and the trauma of life as an asylum seeker in Ireland. When Doctor began stealing in school his mother was horrified and ashamed and, on talking with her son, she realized it was because he did not have any toys of his own. She made a promise that she would buy him his own toy if he promised never to steal again from his friends in school. She knew she could not afford to buy him a toy on her weekly allowance €19.10, she then confided in me that she got the money for his toy by saving on the younger babies' nappies that she got free from the accommodation centre, selling them to women outside the supermarket for €5.00 a pack. She saved this money for weeks and eventually bought him the toy she promised. There was a sense of confession in how she told me this story and a sense of shame at being reduced to this level and of doing something illegal herself. I clearly remember the sense of heart break in her account and her story stayed with me. When I reviewed the transcript of her interview, that story was missing. It had been wiped out as if it had never been told. I wondered why the transcriber had omitted it. I doubted it was pure error as it had been a long section of talk and would have been too long to simply miss. I wondered if the transcriber had felt afraid for the mother if this story would 'get out' would it have terrible consequences or maybe confirm some of the worst fears of 'bogus' asylum seekers trying to rip off the State. Whatever her reasons the story never made it to the transcript. The story clearly illustrates the need to carefully read the transcript and check it with the original tape.

There are variations in how the tapes can be transcribed in narrative analysis (Mishler 1991, Gee 1991, Riessman 2008, Kvale and Brinkmann 2009). These vary from verbatim transcription to line by line numbering of the transcript to facilitate identification of clauses and sequences within the spoken language. Riessman (2005) suggests the decision made about how the transcript is written is driven by contextual and ideological perspectives of the researcher. In this study the tapes were (with the exception of the

inevitable errors) transcribed verbatim from the original audio tapes. Notes were made of laughter, tears and pauses, in the raw transcripts all the errors, for example my talking too much is evident also! These raw transcripts were sent to one advisor for review and verification. Once I was happy with the content of the rough transcripts, I then set about the interpretive work of identifying the pentadic terms; the scene, act, agent/co-agent, agency and purpose within each transcript.

4.7 Attending to structural features

I set about the painstaking work of identifying Burke's pentadic terms to the individual women's stories. First I needed to identify the narrative sections within the text. This is essentially interpretative work that involves reading and reading the transcripts to identify where the narrative begins. I started with a notebook and initially wrote the key terms in the margin scanning the transcripts for the scene, the boundary or container of the story. At times I saw the act first and worked backwards; as Burke describes it 'In the course of the act we learn of a scene or situation, prior to the opening of the play, but central to its motivation' (Burke 1969:4). This relates in my mind to how the women often responded to my question to tell them about their childbirth experiences in Ireland by starting their stories with the reasons they had to leave their home, their journey to Ireland and the conditions of being an asylum seeker here, as a kind of back drop to their experiences of being pregnant and giving birth here.

I also identified whether scenes related to antepartum, intrapartum or postpartum experiences. At the beginning I sometimes physically drew a boundary around the scene on the page with coloured markers, giving a different colour to antepartum, intrapartum and postpartum scenes. I then identified the act, what took place, the agent or co –agents within the scene,

the agency, how the act was carried out, and the purpose. I then retranscribed into hand written notebooks the descriptions of each narrative. A third reading required an examination of each narrative for any imbalance or ambiguities evident in the pentadic terms. I thought of this as 'looking for trouble' in the light of Bruner's(1990) expression of the ratio imbalance as trouble with a capital T. All imbalances were noted, and scenes that did not appear to have ratio imbalance were noted also. Because of the volume of scenes, I undertook a final level of analysis that involved a summary of the narratives under the three headings of antepartum, intrapartum and postpartum experiences. It is perhaps important to note that it is at this point in the analysis that the researcher appears to become 'invisible' to the reader. There is a danger here in that it appears as though the narrative accounts are really 'speaking for themselves'. In truth, those accounts are always co- constructed. Even long stretches of narrative are usually made in response to a question. Also to reiterate once again, stories are told in particular moments in time to particular audiences and therefore are only ever partial representations of reality, crafted and constructed with the listener (researcher/audience in mind).

4.8 Critique of Burke's dramatic pentad with Bruner's sixth element of trouble

Mapping women's childbirth experiences using Burke's dramatic pentad, and Bruner's sixth element of trouble was challenging. The greatest challenge I encountered was the seeming imposition of the method which at times felt and indeed looked like the method was being privileged above the women's narratives. This was particularly difficult as my goal from the outset was to preserve the integrity of the narratives. Yet I believe Burke's method works to highlight dissonance in human interactions simply (and I think powerfully in a somewhat symbolic way) through the presence of Trouble. Trouble is apparent only where there are ratio imbalances. Ratio imbalances are only seen in narratives where there is a lack of continuity

between the five terms of the pentad; what happened, where it happened, who was there, how did it happen, why did it happen. Yet the terms of the pentad, scene, act, agent, agency and purpose, at times appeared a contrivance or distraction in the narrative account. Having said that, I also think one of the strengths of the method is that the analytical steps are overt, whereas less 'rigorous' approaches subsume much of the deductive and interpretive elements because they can appear problematic, so they are hidden, not spoken about and conveniently forgotten once a 'good story' is told.

Burke's method is a brilliantly simple tool that affords a systematic approach to analysis while allowing the full 'force' of the women's stories to come through in highlighting the discontinuities, dissonance, or ambiguities in their narratives and therefore in their experiences, albeit in a somewhat fragmented way. However, I feel any attempt to actually analyse narrative data is going to be intrusive; the only way to be unobtrusive is not to analyse the data at all and merely present the women's stories alongside a discussion of the issues. Ultimately, I think any attempt to actually apply an analytical method to qualitative data inevitably appears contrived. However, I do think the fact that the complexity, powerlessness and suffering that the women experienced comes through in the description of the findings is a testament to the effectiveness of the method. The disadvantages of presenting the narratives without an attempt at analysis are multiple. Simply presenting narrative 'findings' as though they emerge from nowhere can give an illusion of objectivity that is misleading, this is an issue that is discussed at greater length in the next section. Also using a 'credible' analytical tool further adds to the trustworthiness of the findings in that it provides alternate explanations or 'terministic screens' from which to view the data (Fox 2002). This has a doubly positive effect. It helps to illuminate the researchers own pre-determined understandings and positions and in so doing prevents the researcher from unconsciously imposing her own interpretations on the women's narratives.

4.9 Co-production of the narrative

The influence of the researcher in the co-creation of the narrative accounts pervades the study throughout the entire research process. Feminist writers and other qualitative researchers have documented the influences the researcher brings to her work effectively challenging the impossible and even undesirable illusion of objectivity (Harding and Norberg 2005, Frosh 2007, Denzin 2009).

This study is no exception. From the inception of the research idea, through the design and development of the study the values and beliefs of the researcher, the philosophical framework of the methodology, the disciplinary background of the inquirer, the context of time and history influence the story that is eventually told. However, this is not to say that there is no value then in seeking to make known the stories of others, as history and the work of numerous researchers across a wide diversity of fields have shown us the power of narrative to move an audience, to relate to a story as somehow personal to them and to galvanize a community to action (Labov 1997, Zingaro 2009, Riessman 2002, 2005, 2008). What is of importance here is that we understand and make transparent our understanding of how we as researchers impact the research process at every stage. Various approaches to ensure this kind of transparency will be discussed below. One of the difficulties in attempting to write about these issues is that many of them overlap and like a (somewhat poor) analogy of narrative inquiry, refuse to sit neatly in pre-determined categories!

4.10 Truth Claims in Narrative Inquiry

Burke (1969) fully understood the ambiguities of the narrative and the importance for the narrative analyst of understanding this and accommodating these ambiguities within the analytical process. Hence Burke's argument that the terms of the pentad not only allowed for this

ambiguity, but more than that, the pentadic terms when considered in dialectical relationship of the ratios, helped to bring those ambiguities to the fore and in so doing illuminate the heart of the narrative. It brings us to the essence of the story that explains however partially, the complexities of human experience. This leads to the consideration of whether we can or should make 'truth claims' to the authenticity of the narratives themselves. The 'truth' of these particular stories is not just a complex and thorny issue in an abstract intellectual sense. For these women, the truth claim of their stories is fundamental to their survival and to success in their fight to gain asylum. Their case lives or dies on whether the justice system upholds their stories as 'true'. It is difficult then for me to engage in a purely intellectual discussion of the meaninglessness of truth in the narrative. What does ring 'true' to me in this discussion is the work of Linde Zingaro (2009). In her book *'Speaking Out: Story telling for social change'*, Zingaro discusses the struggle for identity in health professionals who inhabit the 'borderland' between professional identity and personal experiences of abuse, violence or trauma that echo that of their clients. Zingaro (2009: 47) identifies this borderland as 'a continuum between two apparently oppositional states, where people inhabit an empty set: they are and are not members of the communities on either side'. Whilst Zingaro uses this analogy to describe how survivors of abuse operate between empowerment and victim states, I see the analogy as a powerful one for asylum seekers. I think of Amira's (pseudonym) shame at living in direct provision and dreading being asked for her address as she was then exposed as an asylum seeker when she desperately wanted to 'pass' as an ordinary citizen. The root of her fear is in anger and rejection of the wider society of all asylum seekers whose stories have been discounted, seen as 'bogus'. Interrogating the truth claims of 'witnesses', Zingaro suggests, creates a distance between the reader and the listener, from 'the dangerous knowledge of larger structures of power and privilege...if the witness cannot be believed, she can be 'theorized out of danger'(Zingaro 2009:14). She further quotes Oakley (2000: 298) to illustrate this point:

‘...there are particular problems in viewing reality as entirely personal and contextual...when the object is emancipation. If there are really no such things as ‘facts’ about the way people are treated, then there is also no such thing as discrimination or oppression...The enforced injustices of social inequities [are driven]...into the personal cupboard of privately experienced suffering.’

It is in the concepts of transition, of constant movement and change, of shifting and emerging realities that we can attempt to imagine a life lived in the borderlands, ‘in between’ experience and the articulation of that experience. The physical journey across borders that these women have made helps to provide an analogy for what occurs in any attempt to tell that story. Coming to a new country to find one’s emotional, internal life shifting, endless moving, no place of permanence, no home.

The trauma of being an asylum seeker, further complicates the suffering experienced prior to traversing continents and countries and the inner plains of their internal journey through trauma to remembering, to speaking out that suffering while still living marginalized lives, still inhabiting that borderland between citizen and non-citizen, legitimacy and illegitimacy, raw pain and the beginning of healing. The sense is of the terrain shifting continually, physically as they are moved from place to place, and emotionally as they strive to survive, to make meaning, sense of their experiences, to form a new identity not as an asylum seeker but as a citizen. Zingaro powerfully expresses the impact of these narratives on the story teller and the listener, ‘once we have encountered the limits of the sayable, we must acknowledge the existence of the unsayable things, and by means of a language somehow formed in silence, articulate that which cannot be grasped’(Zingaro 2009:17).

I am reminded here of Zita's story. Zita told her story via a translator. Zita had been taken prisoner months before from her home with her little sister. They were taken by the military into a camp in the mountains where they remained for months. The problems had started because her father was a Tutsi and her mother a Hutu. Her mother worked for an NGO which pushed for information about her father and when the mother gave information to the government they shot her father. Her mother died later of a lung condition. Zita escaped from the camp pregnant as a result of rape but her younger sister died there. Because of her level of distress and language barriers, so much of her story was left unsaid and yet her pain and suffering were visible, palpable in the room that day. Her presence conveyed so much more than the words that were said, translated and transcribed could ever tell. In her shuddered breathing, in her silences, I encountered the limits of the sayable and the existence of unsayable things. Rosenblatt (2003) appears to support the idea of blurred boundaries between fact and fiction in narrative accounts. He acknowledges that when participants tell him the stories of their lives they are expressing what is 'true' to them. While they may not be 'immutable truths', he believes he is hearing something that is real and true for them:

'This naïve realism influences me.... although I can write what people say to me in terms that are quite foreign to them but compelling to me...I often write...in ways that honour their real realities. I don't want them to read what I have written and wonder where their realities went'(Rosenblatt 2003:227-8).

I find Rosenblatt's position on truth in the narrative to be refreshing and convincing in that his motivation appears to be in respecting his participants enough to represent his findings in ways they can relate to.

4.11 Telling good stories: strategies to ensure excellence in narrative inquiry

While acknowledging the partial and positioned nature of truth and trustworthiness in the research process, most researchers aim to carry out research to the highest possible standards and novice researchers like me who are undertaking research in fulfilment of a PhD are required to demonstrate adherence to standards of quality in the work they do. Denzin (2009) argues passionately for qualitative inquiry that holds its ground in times of increasing global uncertainty and the dominance of conservative scientific regimes that enforce the bio-medical model as the gold standard for research. He states ‘We need stories about what it is like to hate and feel despair, anger, and alienation in a world bursting at the seams as it struggles to reinvent its dominant mythology. We need pedagogical discourses that make these feelings visible, palpable-stories and performances that connect these emotions to wild utopian dreams of freedom and peace. We need to bring about the collapse of the corporate, neoliberal globalization project, the death of old fashioned imperialism, the death of the new empire before it is too late’(Denzin 2009:35). Such an impassioned plea for a new way of doing research that it is all about engagement, emotion and political awareness calls for a new understanding of what constitutes ‘good stories’, or in the old language of quantitative methods, ‘rigour’ in research practices. I found the work of Gubrium and Holstein (2003, 2009) and Catherine Riessman (2008) on this subject helpful in crystallizing the essence of the challenges here. Gubrium and Holstein suggest four (loose) criteria that may help guide narrative researchers in developing ‘good stories’. These are: 1) Telling it like it is, the story resonates as ‘true’ with those who hear it, 2) Good stories are compelling or entertaining; ‘truth’ takes a back seat here to engrossment! 3) Good stories are richly articulated, this refers to the listeners need for detail, and 4) Less is more; stories are evaluated on how well the writer ‘gets to the point’. While this list is helpful it is also apparent that a number of these criteria are contradictory and the thrust of the criteria appears to suggest that to tell a good story, one needs to be a good writer!

Riessman (2008:189) uses concepts of coherence, persuasion and presentation to demonstrate 'truth' or trustworthiness of the narrative. She poses a number of questions; do episodes of a life story hang together? Are sections of a theoretical argument linked and consistent? Are there major gaps or inconsistencies? Is the interpreter's analytical account persuasive? However, she also cautions readers to understand that certain narratives, particularly those of victims or survivors can be fragmented and disrupted making the work of coherence challenging. A way of dealing with this Riessman suggests, is situating their personal narratives in the social and political context:

'Persuasiveness is strengthened when the investigator's theoretical claims are supported with evidence from informant's accounts, negative cases are included and alternative interpretations are considered' (Riesman, 2008: 192).

Riesman (2008) also encourages students to keep diaries or logs of their research journeys decisions made along the way to encourage critical reflexivity, jogging the memory and encouraging truthfulness, leaving an audit trail to strengthen persuasiveness.

In keeping with the feminist epistemology that informs the project, I have endeavoured to meet these criteria from the beginning. I have aimed to demonstrate the principles of transparency and authenticity throughout the written account to date and will continue to do so in the remaining chapters.

4.12 Outlining strategies I employed in this study

In keeping with the feminist tenets that inform the study I have sought to build trustworthiness and authenticity into the entire process of the study. I have achieved this in a number of ways, for example by focusing on

building relationships with the women who participated at both sites and through prolonged engagement over three years. I did this by visiting the women every time I was in Ireland, and through contact on email. I returned transcripts to them for their approval and met with them afterwards to discuss their responses. Some women were surprised at the length of their transcripts stating 'I didn't realise how long I had talked for', others also expressed feeling impacted by seeing their own story on the printed page. Everyone said they felt the transcripts reflected their actual story. I maintained detailed field notes and reflective journals and included excerpts from these in the thesis where appropriate, to document my reactions and decisions made; examples of this are the workshops I undertook at the beginning and how these impacted the data collection design and also my decision to offer vouchers to women who participated in the study. I endeavoured to create an atmosphere of respect towards the women who participated in the study and sought to 'position' the participants as active agents in the co-construction of the narrative and therefore as more than passive 'respondents' to an interview question. I also sought to highlight the social and political context of the women's narratives, through detailed discussion of the wider issues that impact and inform their current experiences, through an extensive review of the literature and through detailed excerpts from their narratives. I engaged in regular supervision at a number of levels, from peers, from academic supervisors and also in clinical supervision because of the intense nature of the data collection, all of which is further detailed in chapter two.

4.13 Conclusion

In this chapter I have discussed narrative analysis as the analytic method of choice for this study. I have attempted to demonstrate the fittingness of this approach for the current study in that it complements and strengths the epistemological underpinnings of the research methodology and therefore provide a consistency throughout the study that is itself considered an

essential element of integrity within the work. Moreover, Burke's dramatic pentad has been interrogated and shown to be an adequate tool to illuminate the ambiguities within the narrative accounts, and to map the childbirth experiences of asylum seeking women living in exile in Ireland. In the following chapter I aim to describe the women's stories in detail, inviting the reader to enter their world, gaining insight into their experiences and ultimately developing a new understanding of what that experience entails.

CHAPTER 5

Childbirth in Exile: Presenting Women's Stories

'Its terror... I was eight months pregnant...it's one of the worst thing you can ever do... going to a foreign place where there is nobody.'

5.1 Introduction

In this chapter I present the stories of the women who participated in this study. The women generously shared some of the worst experiences of their lives and this has resulted in a wealth of comprehensive material that cannot be included in its entirety here. While I am so conscious of wanting to 'tell' every woman's story I am constrained by the very length and richness of the narratives. This account contains in excess of thirty five thousand words and I fear only begins to scratch the surface of their experiences, providing us with a brief glimpse into their lives here in Ireland. Several difficult decisions were made in order to present the material in the most effective way. The women's stories are presented in three ways. In this chapter I provide a detailed summary of the women's childbirth narratives under three headings of antepartum, intrapartum and postpartum phases, illustrating the most frequent ratio imbalances, as described in the previous chapter. Extensive excerpts from the original transcripts are included in the text to bring to life the summaries, to illustrate the ratio imbalances, and most importantly to give space for the women's voices to be heard as they were spoken. Secondly, in the proceeding chapter I include five individual case studies, where the narratives are seen as a whole, and this affords us a somewhat deeper insight into what these women experienced in our maternity services and the asylum process in Ireland. Finally I include as an appendix, a sample transcript of one of the interviews (appendix XVI) and a summary of every woman's transcript showing application of the pentadic terms and the 'Trouble' the ratio imbalances highlight in the narrative (appendix XVII).

To give context to the stories I provide a brief overview of the biographical details of the women who took part. Because of the tenuous nature of these women's legal status in Ireland and also because of the situations many have escaped from, it is important not to expose individual women with detailed biographical information. In the final analysis twenty-two narratives were included from thirty interviews. There are a number of reasons why some stories are not told here. One example is of a woman who had a very bad speech impediment. I did not know this until the day she turned up for her interview and while I realized very early in the interview that I would not be able to decipher the tape or transcribe her story, I felt it crucial for her sense of self and her dignity to tell me her story. Another example is a woman from the Middle East who was extremely worried about being recognized and withdrew permission to participate after the interview.

Not all of the women's stories are sad or bad, as many women experienced genuine friendship and compassion, not only in health care providers but in Irish citizens in the wider community. However, to my mind these stories because they are few, seem to stand out in relief against many more stories of poor standards of care, lack of communication, racism and bigotry. The most disturbing for me were the times when the women themselves did not understand that the treatment they received resulted in increased maternal and neonatal morbidity related to their childbirth experiences.

5.2 A brief picture of the women's backgrounds

The women who took part in the study came from a wide variety of countries and continents, for example; Nigeria, Cameroon, Burundi, South Africa, Zimbabwe, Sierra Leone, Iran, Iraq and Zaire. Their ages ranged from eighteen to forty years of age, the average age was thirty years. Approximately half of the women described themselves as married. The majority of the women were alone in Ireland without their partners. Their education and occupational backgrounds varied widely, from women with very little formal education to women with several post-graduate degrees.

Occupations varied from housewife, trader, security manager, banker, clothing designer, business, sales, receptionist secretary, and nursing, local government and NGO worker. The length of stay in Ireland varied from as little as nine weeks to as long as three and a half years. Six women who took part had been here for less than one year. There were six women who had been here under two years and ten women who had been in Ireland over two years, five of whom had been here for three years or over. Of the twenty-two women whose stories are told here, thirteen were multiparous and nine women were primiparous. Many women had older children who travelled with them and children were also left behind because of lack of funds or conditions that meant their mothers had to leave them behind. This was a source of constant worry and heart ache for the women affected. All of the women had been moved on at least one occasion to different accommodation centres, often being moved back and forth across the country several times.

Table 5.1 Antepartum Narrative Summary¹⁵

<i>Participant</i>	<i>Scene</i>	<i>Antepartum Experience</i>	<i>Ratio Imbalance</i>
1.	1.	First antenatal appointment: <i>'my first antenatal was very, very dreadful here'</i>	Act: Agency
	2.	Awaiting Amniocentesis: results <i>'it was really terrible, the experience was dreadful'</i>	Act: Agency
2.	1.	Antenatal Visits <i>'When I was going for the antenatal what I experienced, what I did experience I didn't like it'</i>	Act: Agency
3.	1.	Antenatal admission with protein urea and raised blood pressure.	Scene: Act
	2.	Admitted for PIH and awaiting news of a decision regarding her delivery.	Act: Agency
6.	1.	She is left at a shopping centre in Dublin somewhere and she spends that night sleeping outside with her children.	Scene: Agent
7.	1.	Regional hospital where D. was admitted on arrival to Ireland for sickle cell crisis.	None apparent
	2.	She is transferred to a maternity hospital where she is admitted as doctors have no antenatal history for her. She has nothing, just the hospital gown, no underwear or slippers.	Scene: Agent
8.	1.	She is admitted to hospital in early labour. Had previous caesarean section and found this labour long and hard.	None Apparent
9.	1.	Having just arrived in Ireland the taxi leaves her outside a hotel. She is unaware that there is blood running down her legs.... She is 26 weeks pregnant and a woman calls an ambulance and she is taken to hospital.	Act: Agency Scene: Agent
	2.	She is admitted to hospital as she is threatening pre-term labour. She is	

¹⁵ I have included some quotes to illustrate particular scenes in the narrative summaries but have not included them for every scene as the volume becomes unwieldy. However, extensive quotes are used to illustrate the findings in the text.

		bleeding badly and told that because of the baby's weight it may not live.	Scene: Agent
12.	1.	She escapes a violent marriage in Nigeria but has left her two children behind in the care of her pastor; there was not enough money to bring them all. Her children are 2yrs and 11 years	Scene: Agent
14.	1.	Fled Nigeria with her husband and two children for fear of female circumcision of her daughter	Act: Agency Scene: Agent
	2.	<i>'You feel like an outcast'</i> She went to an antenatal clinical for a check-up, while waiting to be called another Irish woman came in and was called before her	Act: Agency
16.	1.	Long into the interview she reveals that after she became pregnant with her longed for baby, she became depressed. She felt lonely and hopeless; she missed the support of family and friends.	Scene: Agent
	2.	She makes friends with an older Irish couple who live in nearby town. They become like parents to her. They write a letter to the visa office inviting her parents to visit for the baby's birth but their request is denied.	Act: Agent Scene: Agent
18.	1.	Z. was sent to hospital by her GP because her blood pressure was raised. She was living in a hostel at the time and had to leave her two older children back in the centre.	Act: Agency Scene: Agent
19.	1.	Admitted five weeks prior to birth because of raised blood pressure. She finds this experience very difficult as she has never been in hospital before	Act: Agency Scene: Agent
26.	1.	.She met the Father of this baby in Ireland, he is from the Congo he is not an Asylum seeker.	Act: Agency
27.	1.	Her due date was January 19 th but her waters broke on January 10 th . She tried to explain that her waters had gone but no one would listen to her.	Scene: Act Act: Agency
29.	1.	The woman who interviewed her in the justice department was also pregnant and was kind to her, she told her she would need to go to the maternity hospital for a check-up.	Scene: Agent Act: Agency
30.	1.	. Most of the time she spends alone, she doesn't feel well, her pregnancy feels 'like a stone weight on her body'.	Act: Agency Scene: Agent

5.3 Antepartum Findings

‘Every week I was going for scans to check...how the baby was doing. so I never got to the antenatal classes, anything, I never got to do all those things because ..by the time I go home I'd be tired....I was stressed out being alone in the country I was stressed out having a problem with my first child it was a lot of things for me to do at the same time... the justice form to fill up, that big form to say all the things which happen, appointments, not just for hospital for the social, for accommodation, it was just a lot of things. So I had no idea what was happening, even on the day when I was having labour pains I didn't know that they were labour pains.’

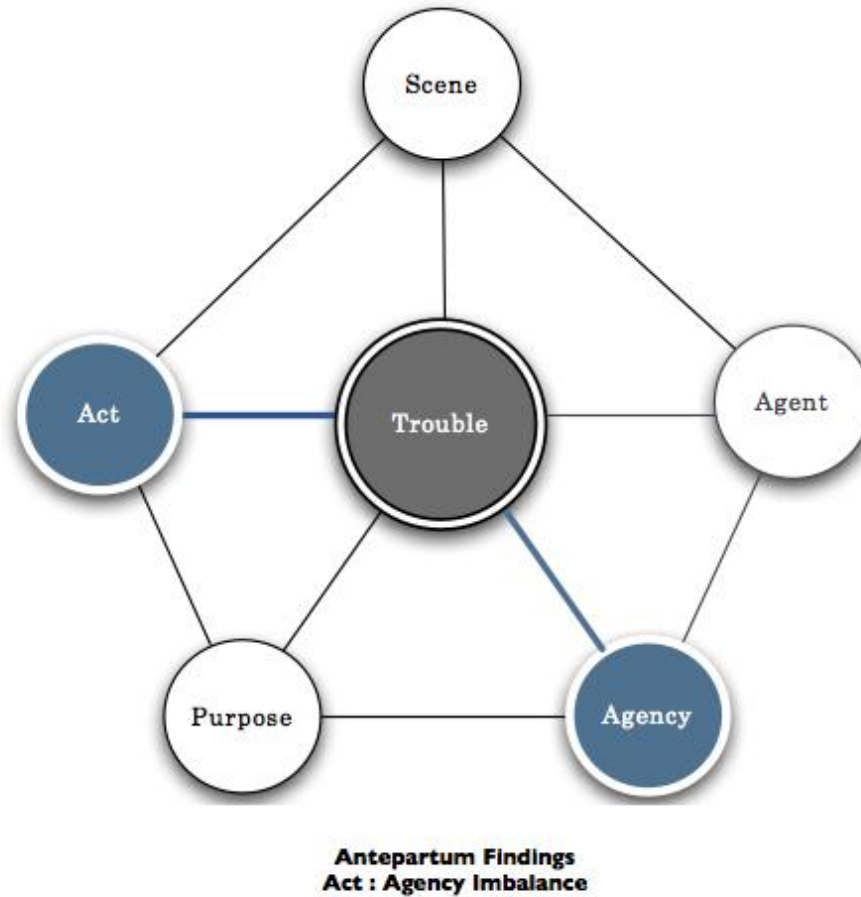
There were a total of twenty-two narratives that included antepartum scenes. The most frequently occurring ratio imbalances in the antepartum narratives were in the Act: Agency ratio (Figure 2), with thirteen examples. The second most frequent imbalance occurred in the Scene: Agent ratio (Figure 3) with twelve episodes. There were eight incidences of double ratio imbalances in the antepartum narratives¹⁶. Just two narratives had no apparent ratio imbalance. Because of word and time constraints, I offer a sample of the narratives to illustrate the most frequently occurring imbalances.

5.3.1 Act: Agency Ratio Imbalance

The Act Agency ratio is a pairing of the two elements Act (what happened?) and Agency (how did it happen?). The Act: Agency imbalances occur again and again in many of the women's narratives throughout the antepartum, intrapartum and postpartum phases of their childbirth experiences. This ratio imbalance highlights the inconsistencies between how an act would expect to be carried out and how it actually was. The Act has a dominant relationship to Agency. In other words the Act dictates how we believe or expect it should be carried out, as in Acts of kindness, Acts of mercy, random Acts of violence. In common usage we understand that certain acts will be carried out in a particular way. The imbalance in the act: agency ratio highlights those encounters where Act is carried out (Agency) in an inappropriate or contradictory way to how it should be done, or how we expect it to be done given the scene that contains both the Act and Agency. The following are some examples taken from the women's stories that illustrate the Act: Agency imbalance in the narratives.

¹⁶Illustrated later in the final case study (Figure 12).

Figure 5.1: Act : Agency Ratio Imbalance



Ruth agreed to share her experiences with me and she was very angry about how she had been treated. Most of her story was negative; nothing seemed to go well for her. She talked about being left waiting until 3pm for an 8.30am appointment. She felt like people who came after her were seen before she was and she expressed the feeling that she received poor treatment because of her ethnic origin. The first couple of times this happened she said nothing, but eventually she asked why she was kept waiting, but there were no explanations given for the delays.

‘So I wait and wait and wait and at times some people that met me, they were called in before me. The first time I didn’t react, I kept quiet but the second, third time I reacted, I went to make it known, I say why, at least I know the people I used to, I came before, but they are calling them before me, why, the nurse say I will be called, I should go and sit down. So most

times I'd almost be the last person to leave, even though, second or third person to leave, so I wasn't happy with it...'

The Act: Agency imbalance is apparent in being left waiting over six hours for her appointment with no explanation.

Ramie had been in Ireland three years when we met. She expressed terrible frustration at not being allowed to work, she felt she was caged up and found not being allowed to do simple things like cook her own food very difficult. She was not used to being idle and felt the enforced inactivity was 'a mental stress on its own'. Her experience of antenatal visits was very similar to Winn's with regard to the racism she feels she experienced. She recalls going to an antenatal clinical for a check-up, and while waiting to be called, another Irish woman came in and was called before her. She complained at being left waiting and one of the women said 'What are you complaining for, if your country is so good why did you leave it?' Ramie expected the midwife to intervene on her behalf but she did not. She just smiled which made Ramie feel they were all laughing at her and this made her feel depressed and unsafe.

The Act: Agency ratio imbalance is evident in racist comments made by other pregnant women (Act) and the inappropriate way the midwife handled the situation (Agency).

'You feel like an outcast, for example there was one time in the (hospital) that I went for a check-up and I was on the queue, the midwife (clinic) have its own queue, as I was sitting there I see that they came to call some other white women that were even behind me and they attended to them first, I was like, but this is not your country, not the midwife but the women they called to come for our own service before me, said what are you complaining for, if your country were good would you leave there. So I was expecting the midwife to say no this place has nothing to do with whether black or white or green, that its normal thing, wait for your turn but she didn't say anything, she was just like, all of them were just smiling, laughing, they were making jest of you, all those things brings you down, it counts you to nothing. And when you are in a community like that most of the time you feel unsafe because (inaudible 6.04) somebody that might want to help you but that first impression you've got might put you off...'

Tarra's story is an example of double ratio imbalance (trouble) in both the Scene: Act and Act: Agency imbalance. Tarra was 5 months pregnant with her second child when she arrived in Ireland. She was told at her first antenatal appointment that she had hepatitis B

(Scene). Her due date was January 19th but her waters broke on January 10th. She tried to explain that her waters had gone but no one would listen to her, (Act). She went to see the midwife and said she was worried about complications because the waters had been gone now for two weeks, and no one had done anything about it, (Act). The midwife sent her for a scan which confirmed that the waters had gone, so they asked her to come back that evening for induction. When she returned for induction they still tried to rupture the membranes (Agency), causing undue worry and stress to the mother and totally disregarding her knowledge of events and the previous scan findings.

'I told them that you can see that I have no more water because I have been saying this to you for a long time now, over 2 weeks now and you've not done anything. I want you to induce me so that I can have this baby, to avoid complications or implications. Then she said, I should go and do a scan upstairs, I went to do the scan and the scan told them that there was no more water. So they asked me to come back that evening so that I would be induced on the 26th. So while I was in the labour or delivery suite, is that what they call it? Yeah, they tried to, they inserted the gel to induce the labour. And, that was very early in the morning, around 6 or 7 but there was nothing happened, around 2 o'clock a doctor came, they said they were going to try and burst the water and I told them that there was no water to burst. And they kept forcing to burst the water and I told them that I was in pain because there's no water and the place is dry. You might keep on doing that and pierce my baby's head because there is no water...'

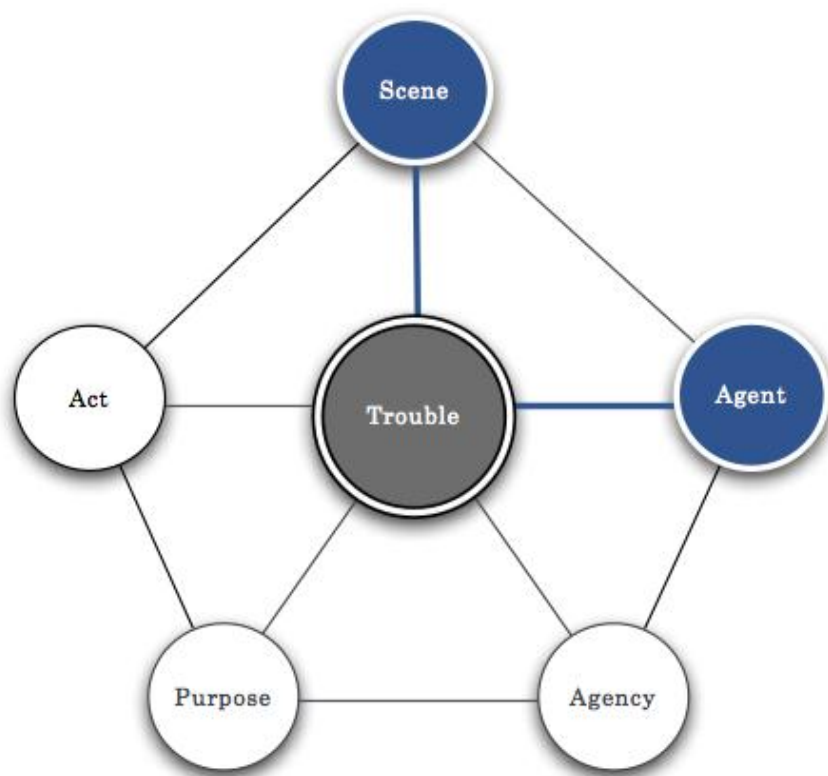
5.3.2 Scene: Agent Ratio Imbalance

The Scene: Agent ratio is one of the most commonly occurring ratios according to Burke (1969). The Scene provides the background or context for the narrative acting like a 'container' for the Act and the Agent. The scene sets up our expectation of how the story will unfold; we assume in agreement with Burke, that the act will be consistent with the scene. The Scene: Agent imbalance in the narrative alerts us to happenings within the story that are contrary to accepted norms of behaviour given the nature of the scene. Burke states 'It is a principle of drama (in this instance, storied lives) that the nature of acts and agents should be consistent with the nature of the scene. And whereas comic and grotesque works may deliberately set these elements at odds with one another (this).....reaffirms the principle of consistency in its very violation'. In this way ratio imbalance between Scene and Agent highlight the Trouble in the narrative while remaining true to the principles of the pentad. We see how the pentadic terms work as principles of consistency while at the same time

illuminating ambiguities and inconsistency within the narrative. With this insight, we understand why Burke refers to the pentad as ‘miraculous in its simplicity’. However, I find the simplicity of the pentad sometimes at odds with the extraordinary suffering it exposes so eloquently in the narratives of the women who opened their lives to me in this study.

The following are examples of the scene: agent ratio imbalance. The scene provides the context for the story and therefore sets the stage for how we anticipate the story should unfold and conversely sets up the conditions for imbalance in the scene.

Figure 5.2: Scene: Agent Ratio Imbalance



**Antepartum Findings
Scene : Agent Ratio Imbalance**

Scene: Having fled Nigeria leaving her husband and eldest son behind whom, Winn (Agent) reports, have been kidnapped by secret police, she is abandoned in Dublin airport by the person who took her into the country. She is already pregnant and has two of her younger children with her. She approaches a black woman in the airport to ask where she should go. The woman is visiting the country and does not know but offers her a lift into town. The

woman drops her off at a shopping centre in Dublin somewhere and Winn spends that night sleeping outside with her children.

The following morning Winn (Agent) is approached by an African man who hears her scolding her children and asks her if she is new in the country and that she is not allowed to speak to her children like that here because children have rights in this country. She explains her situation to him and he offers to let her stay with him while his wife is away in London.

Winn stays with him but once his wife returns she is told she has to leave. She pleads to stay but they refuse. She goes into labour and the man calls an ambulance to take her into hospital. She has her baby and the next day they bring her bag and her children to the hospital and leave them with her and go. Hospital staff complain to her asking 'who owns these children?', she explains she has nowhere to send them so staff arrange for social services to come and they are taken into temporary foster care.

'... so they bring my children back to me in the hospital, the hospital is telling me, the nurses that who owns this kid, I say (inaudible 6.37) they can't stay, I say I have no home to go, they have no place to go, that they should get me, I don't know where to keep my children, I don't have anywhere'

Winn then explains that social services come and take her children into care as she must stay in hospital.

'I'm in the hospital for 1½ months, my children they are with foster parents'.

The discontinuity in the Scene: Agent ratio occurs because we expect that Winn will not be simply made to leave the only shelter she and her children have on the return of the man's wife. This is made more urgent by our knowledge of the scene, the fact that we know she has travelled a long journey and been abandoned by the trafficker with two young children, not knowing what to do or where to go. It appears the stress of her situation causes pre-term labour and an extended stay in hospital. The tragedy of the scene is that the two children are now alone without their mother in a strange country living with foster parents.

Zita's story is an example of both Scene: Agent and Act: Agency imbalances. Zita escaped to Ireland from her home in Africa, she is severely traumatized from her experiences. Her father, mother and sister are dead. She is pregnant as a result of rape in a military camp where she was held for six months prior to her escape and where her younger sister died.

Because she cannot speak English, communication is difficult. She shares a bunk in the hostel with a Chinese woman and finds it hard to connect with her. Most of the time she spent alone, she did not feel well, her pregnancy felt 'like a stone weight on her body'. She went into labour, started getting pains and bleeding a week before her due date. The hostel called for an ambulance to take her to hospital. When she arrived in the hospital the doctor looked at her file, did not examine her and told her to come back in a week's time when it was her due date. She did not know how to get back to the hostel because she came in an ambulance. She went to the reception desk but nobody could understand her. She left the hospital but was feeling weak so she lay down on a bench outside in the street. She spent the day there not knowing where to go. She fell asleep on the bench and when she woke up she was distressed and started trying to ask passers-by for help but no one could understand her and did not help her. She began to vomit when a French speaking woman came by and she explained to her what had happened. The woman noticed blood on her clothes and told her she would have to go back to the hospital. The woman called an ambulance, they took her back to the hospital, her waters broke and she was taken straight to the delivery unit. The following is an excerpt from the interview transcript that was undertaken with the help of a translator.

'the ambulance ... brought her to the nursing maternity. (hospital). When she arrived she was feeling really bad. She understood nothing when she arrived at the hospital. The doctor he didn't touch her. He just looked at her files. He didn't look, she knew she was bleeding. (He told her) go back to the hostel and come back on the 28th (This was the 21st and her due date was 28th). She was very bad and bleeding badly. He said no this is not the day its going to happen go back to the house. Because she went by ambulance she had no contact number for the hostel, she didn't know where she was going. She went to the reception desk and of course they didn't know what she was asking. (*Zita Crying*) She asked was there anybody who spoke French. They just said no. If she could have talked to somebody maybe somebody would have listened. Yeah. She started to go round... (*Zita Crying*) ...she found some long like chairs on the street and she went to lie down because she was feeling so bad. When she started feeling a bit better she fell asleep. She was just so distressed she just didn't know what to do, she asked people passing could they help, did they speak any French and no, nobody could help ... she stayed there the whole day. She was really feeling sick. She started to get sick and apparently a woman arrived ... Yeah, she saw her getting sick. She said why are you getting sick? I'm not well they told me to go back to (Area where the hostel is) but she said she didn't know where (that area) was. She took ... she must have had a paper like with the hospital paper so the woman took it from her. She was already showing signs of blood on her clothes ... (*Zita Crying*) ... she said the woman said we'll have to go back there. So the woman said to her as you can't walk I'll get an ambulance. Ah she

spoke French. So they went back to the hospital. She started to explain everything to the staff, the lady. So they took her straight to the labour ward.’

The Scene: Agent imbalance is apparent here in Zita (agent) going to the hospital (scene) in search of care as she knew she is bleeding and in pain but being turned away. The Act: Agency imbalance apparent in the doctor reviewing her notes and sending her away without examining her, therefore not finding that she was bleeding and possibly contracting. The language barrier meant Zita could not communicate any of her symptoms or worries to the doctor or indeed anyone in the hospital. It appears there was no attempt made to communicate with her by any staff that day. The shocking lack of care and indeed dereliction of duty could have ended in a far more tragic way had Zita not been ‘lucky’ enough to meet a compassionate Good Samaritan on the streets of Dublin that day.

Table 5.2 Intrapartum Narrative Summary

<i>Participant</i>	<i>Scene</i>	<i>Intrapartum Experience</i>	<i>Ratio Imbalance</i>
1.	1.	Induction of labour at 42 weeks.	Scene: Agent
2.	1.	Admitted in early labour with rupture of membranes: <i>'The midwife I met wasn't friendly at all'</i>	Act: Agency
3.	1.	She is in recovery following Elective caesarean section under epidural.	Act: Agency Scene: Agent
4.	1.	M. was induced at 38 weeks because of gestational diabetes with history of previous still birth.	Scene: Agent
6.	1.	Once she arrived in the hospital her labour progressed quickly and she gave birth quickly without any pain relief or tears.	None Apparent
7.	1.	D. does not realize she is contracting, calls her friend M to tell her <i>'my tummy is coming up and going down'</i>	Scene: Agent
10.	1.	She comes to hospital in early labour and wants very much to have a vaginal birth. However, P. has been circumcised and staff is concerned about her giving birth vaginally.	Act: Agent
11.	1.	Pregnant with her first child she is scared because of all the stories she has heard back home. . At 41 weeks her waters broke and after 3 -4 days labour is induced.	None Apparent
12.	1.	She has 'water on her body', and tells the hostel manager she needs to go to the hospital. The manager wants to call an ambulance but she refuses thinking the walk there might help her labour advance.	None Apparent
13.	1.	Husband refused to participate in pagan rituals associated with being king of his tribe when his Father died, these rituals involve sacrificing of the first born child. His wife is already pregnant so they sold everything to raise money for the passage to Ireland.	None Apparent
14.	1.	At one point she ran away from the system and went underground because there was a deportation order out against her.	Act: Agency

15.	1.	She and her son were dropped by the trafficker outside an off license (liquor store), in Dublin at night. Someone was to meet her but they never showed up	Scene: Agent
16.	1.	Her pregnancy has been difficult, complicated by sadness and depression.	Scene: Agent
19.	1.	She is induced at 39 weeks because her B/P is still very high. It is a long day, she is alone with no friends or family support.	Act: Agency
	2.	The induction is not successful and she must have a caesarean birth.	None Apparent
27.	1.	She returns for induction of labour	Act: Agency
	2.	<i>'Exhausted from crying, I was tried,, I was very very weak then...it was a really sad thing to go through all by yourself'</i>	Scene: Agent Act: Agency
28.	1.	A.. had a very long labour, over 3 days of contractions. She has an epidural for pain relief and eventually delivers her baby. She remembers the doctor who assisted here was unkind to her.	Act: Agency
	2.	She is transferred for manual removal of placenta.	Act: Agent
29.	1.	She is overwhelmed by everything that has happened to her, she wishes she was still at home, <i>'dying would have been better than going through all these things alone'</i> .	Scene: Agent
30.	1.	She doesn't remember much about the birth. The woman who helped her stayed with her to interpret. 'It hurt so much she never wants to have another child'.	Scene: Agent

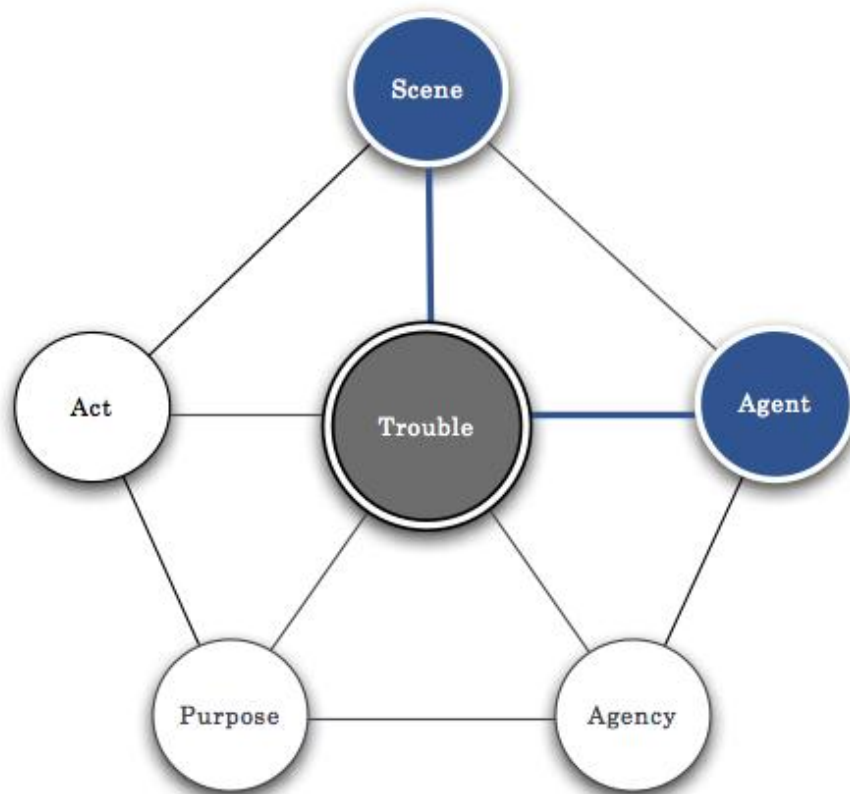
5.4 Intrapartum Findings

‘I was now emotional because I was now so worried what was happening. I'm worrying and I don't have anyone to tell, you know.’

There were twenty-one narratives related to intrapartum experiences. The most frequently occurring imbalances were Scene: Agent (Figure 4) with nine examples, Act: Agency (Figure 5) with seven examples and five examples where there was no ratio imbalance detected in the narrative. There are two incidences of double imbalances in the narratives.

5.4.1 Scene: Agent Ratio Imbalance

Figure 5.3: Scene : Agency Ratio Imbalance



Intrapartum Findings
Scene : Agent Ratio Imbalance

The first example of scene: agent imbalance occurs in Lola's story. She is overwhelmed by everything that has happened to her, she wishes she was still at home, 'dying would have been better than going through all these things alone.' One week past her due date, she started to bleed and goes to the hospital. They discharge her, but several hours later she has to return because she is contracting and passing blood clots (Scene). She is extremely scared, afraid to talk or make even a sound (Agent). She has a friend from the accommodation centre with her and asks her to speak for her as she is too scared to speak to staff herself. She states that back in her country if you make a sound the nurses beat you and she was afraid this would happen to her here. She is given an epidural for pain relief and she is glad to have it but is shocked at the paralysis in her legs. They want to take her for a caesarean section but she pleads with them for the opportunity to try to have vaginal birth. The midwife is supportive and teaches her how to push as she cannot feel anything. She gives birth 1 hour later. I include a long section of her narrative because of the very powerful content.

'I overheard that I was getting epidural because I'm going to the theatre. So I was asking my friend what is an epidural? Then she told me it's something they will put in your back so that you can have an operation. So I said I'm not going to have an operation, I'm going to give birth normally, my mammy had convinced me that I give birth normally. So I wanted them to understand that I'm not getting (inaudible 19.54) I wanted to give birth normally. And then I was telling the nurse that I don't want it, then she was telling me to go on a ball. A ball! I'm in pain you tell me to get off the bed and go on a ball. I did not agree to that. All these things I was telling my friend to tell them all instead of myself. Then they were talking about oxygen, already I had drips, yeah already needles everywhere. So I was telling them I don't want, I'm breathing normal way, I thought maybe if they put that thing they were going to operate on me, I didn't want to be operated. So the doctor finally came and asked if I had been put on epidural or something so the lady said she, she is dilated. She doesn't need to, to go to theatre and then I say I insisted that I'm going to push and I'm going to, I kept on insisting on that, and then the doctor burst the water, so that it can come, the baby was not coming. I was still in pain, the pains and pains, so now they convinced me that if they put epidural on me I won't have the pains. But they wanted me to have operation. So with the pain I ended up agreeing and I did get it, I was in so much pain. I had been told it was just to stop the pain, they didn't tell me what was going to happen after. How it's going to be like, how it's going to make me now, paralyse my legs. It was just like, like a stop pain. So if I'm in labour, labour pains and you are offered this stop pain no normal person would refuse. So I got it, all those big, big things going into my back and my friend was so devastated she made me more scared because she was saying the thing is too big, the needle is so big. And I'm thinking you are supposed to be minding me, at least for once in your life so that you can't tell me the

needle is too big, what do you want me to do, can't you lie. So they put it in, a few minutes later the pain stopped. But I couldn't feel my legs. The doctor came in again, told me that I had to go to the theatre. I said I'm not going to the theatre I'm going to push. So when the doctor was gone out the lady was really nice, I told her that you know I cannot really push I really want to have my baby normal, I can push, I don't have to go for an operation. So she said okay we'll see how you are doing. She asked me if I knew the contractions, I was feeling nothing. Not a thing, I was paralysed. So she said how are you going to push if you can't feel the contractions. Then she said you see the line on the computer thing. So I don't know how she could tell its contractions. And then that's when I'd push. But then I would have no idea how to push, push what, where? After all I was not, I was paralysed so I didn't know how to, so she said imagine you are having, doing poo-poo, so when I imagined doing poo-poo that would be pushing. So that's how I did, we started at around 4 and finally I pushed around 5. It was but it was, the lady was very nice, the midwife. She was very, really encouraging and she kept on asking me like, she found it weird that I wasn't, she never, she didn't even know if I can really talk because I was so scared of them. And I was, my friend did tell them everything, I don't want to speak, I thought they would beat me the same way if I scream or if I cry. So in labour I don't (L) so that I don't upset them. Like (inaudible 24.16) but so if I make their tempers high they'll just kick me, then I thought maybe I have to be nice so that she doesn't send me to theatre. So at least she didn't send me to theatre and they kept me, and I got the baby just as good.'

The scene: agent ratio imbalance is also apparent in Lola's fight to have a vaginal birth in a technological birthing 'scene'. Lola's vaginal birth is a testament to her personal strength in the face of terror and uncertainty in a situation where she literally did not understand what was happening to her, what to expect, or what would happen next. It powerfully shows how midwives and other health care providers do not have any insight into the internal fears and feelings of a woman in their care, particularly a woman from another culture and most importantly, one who has suffered much in the months preceding her birthing experience. Lola was fortunate that she had a midwife who was caring and supportive and helped her to achieve her desire for a vaginal birth. However, her story graphically describes the alien nature of the technological birthing environment and the way in which modern maternity and obstetric practice pushes intervention on women when there is no apparent need for it. Lola's story, while heart-breaking to hear provides us with a fresh perspective, a new pair of eyes. It is as though we too are seeing the horrors of unnecessary intervention and the alien nature of technological child birth that unfortunately has become the norm in western countries.

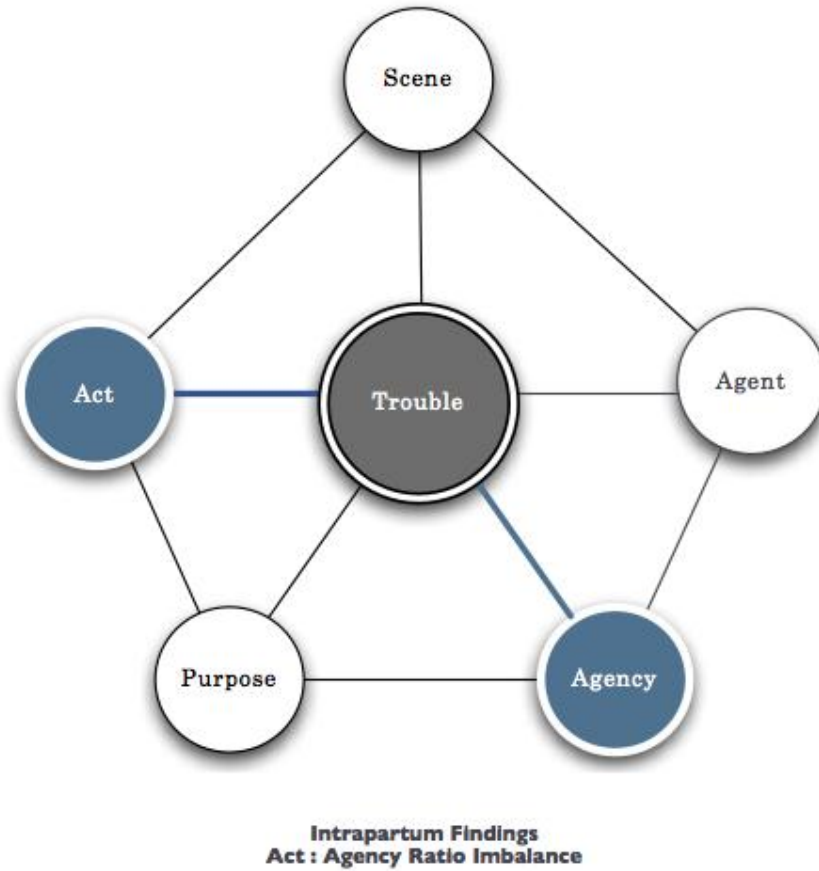
Mimi was induced at 38 weeks because of gestational diabetes with a history of previous still birth. She had a long painful labour with no family or friends to support her.(Scene) She is anxious to express that the hospital staff was good to her but the loneliness is so evident along with the strangeness of her experience of being ‘tied to the bed’.(Agent)

‘They gave me a drip, one hand with insulin and the other hand induced and I was tied on the bed like that, monitoring the heart beat of the baby, monitoring the contraction levels and, oh I can’t explain that pain but thank god, I give god the glory, I had my baby, normal delivery and everything was ok ... It was only me because I knew nobody here, nobody, my husband is not here, nobody you know, I had to keep my baby with somebody in the hostel, minding her for me and you know, nobody. Very, very, very, very you know, when one is just (inaudible 12.23) but they are so good in the hospital, they try their best, they gave me full attention and everything you know but I thank god, everything went well. Very, very scared you know, painful, ah, I think my husband is around at least, if you see somebody around you just think sorry, sorry and all that and there was me looking at other people there because its not only me on labour that day you know, visitors coming to greet and you know I was down but I just thank god, I know god is with me. Yeah I was all alone, nobody came to say oh, to say hello, anything, it’s you know but I just thank god. I don’t mean the workers there. Yeah you know you feel so bad, even when I went back, when I was discharged from the hospital, when I got back to the hostel, I met up with my baby, loads from the hospital, nobody to help you up to your room, oh you know, I felt bad but I just thank god that all is going to be well, you know all will be well, that’s the short story I have.’

5.4.2 Act: Agency Ratio Imbalance

In following narrative both Act: Agency and Act: Agent imbalances are present, representing the double horrors of what was done, how it was done, and the detrimental effect on Ademi, the Agent.

Figure 5.4: Act : Agency Ratio Imbalance



Ademi was in labour with her first child. She had a very long labour, over 3 days of contractions. She has an epidural for pain relief and eventually delivers her baby. (Act) She remembers the doctor who assisted here was unkind to her. The placenta does not detach following the baby's birth and the doctor becomes impatient with her. She is tired and cannot push any more, the doctor gets annoyed with her and tells her she is being lazy. He pulls on the cord and the cord snaps. (Agency) Ademi is angry at being called lazy and very scared. The midwife is in the room but does not say anything. Ademi is taken to operating theatre for manual removal of placenta.

The one I don't like, the one that wanted to draw the placenta out from my body and he say. I'm too lazy, I don't like that word. Yeah he's a doctor, he's (doctor's nationality). He was trying to remove with force and the thing cut and he said I'm so lazy I can't push the placenta, I don't like that kind of word. I had just give birth, now you ask me to push out this kind of thing. And I can't, maybe I can't do it, he said we now have to draw it with force. He can't draw it with force he say I'm so lazy, using

that word, I can't ... I was just so scared. he wanted me to start pushing and pushing, it's not easy, I'm was three days with pains, so yeah I'm so lazy, someone use that kind of word, I said it's not very good ... I feel so angry. Because it was his fault, he had to take it with care, he had to drag it, you can't drag it, you have make it, do it easily, he said push it, he's asking, telling me I'm so lazy. I still remember I was so angry no it's not easy. Maybe it's because is it mmaybe another woman goes through.'

Perhaps the saddest part of this story is the last sentence where Ademi doubts herself, even though she knows what happened to her is not right, there is a part of her that wonders if maybe other women manage to deal with this kind of appalling behaviour.

5.4.3 Act: Agent Ratio Imbalance

One month after her arrival in Ireland, Peace finds out she has a raised white blood cell count.¹⁷ She comes to hospital in early labour and wants very much to have a vaginal delivery as her previous birth in Africa was by caesarean section. However, Peace has been circumcised and staff is concerned about her giving birth vaginally. Doctors and midwives try to persuade her to have a caesarean section or an epidural as they fear her birth canal is 'very tight'.(Act) She resists their pressure and gives birth vaginally (Agent).

'...It's like the pain is coming it is hard because my other baby I use operation, so that place is very ... the first one. It was ok, so they said if it's like going through the same, I said no, I don't want to pass it, I want to go normal....Yeah because if I go through that it's very painful (caesarean birth). Yeah, so I was there with the pain and everything, it's not coming; it's very hard. So they sent me upstairs, I deliver in the hospital, they sent me upstairs, I was there with the pain and everything, walking up and down, so the nurses said stop walking, I didn't know what to do, I started praying, talking. Because the thing is coming that I cannot stay, because I said they should give me the oxygen so that, or they should give me the injection, then later the other lady said the head is very close, it's just for you to push and then I told them (inaudible 6.03) is very tight. So she said the baby's head is there, I'm not sure if you can pass there

¹⁷ This is significant for Peace on many levels. It is the first time she has heard that she may have a life threatening illness with all the implications of this for her life in Ireland should she gain refugee status here. Even more worrying for Peace is the prospect of being sent back to Africa, where she would not be able to afford treatment. She is afraid that if she is sent home she will die and there will be no-one to take care of her children.

because that place they sewed before is very painful. She said I should try, as long I said I want to try, I should try. The other doctors came and said they should give me epidural, I said I don't want epidural because if I let this, I will deliver (inaudible 6.33) don't worry I will give birth. I was there till around 1 am in the night by the time I deliver. Yeah, very determined, delivered my baby... '

Female circumcision is a relatively new challenge for health care providers in Ireland. This narrative shows how providers' fear of the unknown led them immediately to suggest caesarean birth, although the mother did not want or need surgical intervention.

Table 5.3 Postpartum Narrative Summary

<i>Participant</i>	<i>Scene</i>	<i>Postnatal Experience</i>	<i>Ratio Imbalance</i>
1.	1.	Baby is ill: 'The trouble started again	Scene: Act Agent: Act
	2.	Baby transferred to regional neurology centre: '...still living with fears and worries because I knew nothing about it, I was so ignorant, no information at all	Act: Agency
	3.	Shunt blocked: 'They told methere would be no space for me (to go with the baby) in the ambulance.	Agent: Act Act: Agency
	4.	Emergency Surgery: 'Do what you can to save my baby'	Act: Agency
	5.	Current realities: 'Yeah, it's tough while you are waiting'	Scene: Agent
2.	1.	Care was O.K. food was not: 'We should be treated equally we are all human'	Act: Agency
3.	1.	On the postnatal ward one midwife stood out as being supportive	None apparent
	2.	She is admitted again with PIH. She has to leave her older son who is under two, in the care of a fellow asylum seeker in the hostel, as the only alternative is to have the child taken into temporary foster care. She is feeling traumatized, stressed and worried.	Act: Agency Scene: Agent
	3.	Following the birth of her second child she is transferred from Dublin to Kerry, three days post discharge following a caesarean section. (approx. 5 hours travel time). She had to pack all her own things and carry all her stuff, baby, buggies etc.	Scene: Act
	4.	Challenges of living in the compound	Act: Agency
	5.	Expresses fears about losing friends when they get their 'papers'.	Scene: Act
4.	1.	Postnatal ward following delivery	Scene: Agent
	2.	Back in the hostel with her baby	Act: Agency

6.	1.	After discharge she is sent to a hostel in the city. She slips in the bathroom and fractures her hip.	Scene: Agent
	2.	She lives in fear of being sent back home as her brother has been killed and she still does not know what has become of her husband and eldest son.	Scene: Agent
7.	1.	She is discharged to a hostel and meanwhile continues her friendship with M. She also volunteers in local charity shop and is taking a computer course the hostel organizes.	Scene: Agent
	2.	New accommodation centre, D. explains what conditions are like for her.	Scene: Agent
8.	1.	On discharge from hospital feeling lonely and isolated, misses having family and friends to support her. Finds conditions in the hostel where she lives stressful, for example having to share a public toilet and bathroom with up to 30 other people	Scene: Agent
	2.	She is now transferred to new accommodation and is finding it difficult getting used to living in a new system.	Act: Agency
9.	1.	Having given birth to her daughter the day she arrived in Ireland She. is discharged from the hospital on the following Monday without her baby who is in Neonatal Intensive Care Unit (NICU).	Scene: Agent
	2.	Baby is discharged home with an apnoea monitor, but F. is scared to leave him. Bathroom and shower are public shared with 30 others and means she has to leave the baby alone in the room if she needs to use the bathroom.	Scene: Agent
	3.	She is transferred across the country with one nights notice despite having an appointment with the baby's paediatrician the next day. 3 months later, she is still waiting for the baby's files to be sent to new address and for an appointment with a new consultant paediatrician	Scene: Agent Act: Agency
	4.	The hostel is overcrowded, she is forced to share a small room with another Mother and baby	Scene: Agent
	5.	Professionally educated and a writer, S. is frustrated that she is not allowed to work and cannot write as she has no access to a computer.	Scene: Agent

10.	1.	..after giving birth she becomes very weak and cannot raise her arms or legs. She goes to her doctor who prescribes painkillers.	Act: Agency
	2.	Diagnosed with leukaemia she finds it hard but is grateful to be on treatment and her hope is to see her three children grow up.	Act: Agency
	3.	She is to be transferred to a more ‘permanent’ accommodation, but her friends are sent elsewhere.	Scene: Agent
	4.	On arrival at the new accommodation she finds it very stressful. The place is disorganized and there is fighting and squabbling on a daily basis. ‘It was very rough’.	Act: Agency Scene: Agent
	5.	Things settle down.	None Apparent
11.	1.	She is discharged on the 3 rd day as the hospital ‘is very very busy’, and before she could pack her things there is somebody there to take the bed. She is discharged back to the hostel and, ‘that was the hard part of it’..	Scene: Agent
	2.	Since transferring to new accommodation finds sharing a small room very difficult.	Scene: Agent
12.	1.	Following the birth of her baby she misses not having anyone to congratulate her	Scene: Agent
	2.	She had blood tests taken at the hospital for herself and her baby (she does not say what for), she is anxious because the day she was to go to the hospital for the results she is transferred across the country.	Act: Agency Scene: Agent
13.	1.	She is ready to go home, bag packed when the nurse asks to check her blood pressure	None apparent
	2.	Two weeks after discharge from hospital they are transferred to new accommodation on the other side of the country.	Scene: Act Act: Agency
	3.	She spends a lot of time alone in her room. She does not join in with activities in the hostel. She misses home and misses having people to congratulate her. She does not like the canteen food they are given.	Scene: Act
14.	1.	R. is very angry because she thinks Irish people think Nigerians come to this country just to have babies and get government hand-outs.	Act: Agency

15.	1.	After 5 days in hospital she is ready to be discharged. She is visited by a social worker whose name she still remembers, 'she did a great thing for me '.	Scene: Act
	2.	After several transfers to different places she has recently been transferred to current accommodation. She is worried about her son as she feel she is still traumatized from everything he experienced in Africa. He also asks where his Father is and if he will ever see him again.	Act: Agency
	3.	At the end of the interview she suddenly opens up and tells me that her son was not her first child. She had a daughter back in Africa.	Scene: Act
16.	1.	Breastfeeding is difficult. The baby does not latch well and is crying constantly. Every morning she apologizes to the other women in the ward because he makes so much noise during the night.	Scene: Agent Act: Agency
	2.	After discharge from hospital she is in a lot of pain and crying all the time. Although her husband is supportive she finds it hard to adjust	Agent: Act
18.	1.	When it came time to return to hospital she was afraid to go but she did it anyway. She was there for 28 days in total. It was very hard time for her and her children who didn't get to see her during this time. Eventually she had a caesarean section as they could not control her blood pressure and the baby had IUGR.	Act: Agency Scene: Agent
	2.	She is afraid and intimidated by NICU staff. She spends her time crying, she believes her baby is going to die.	Scene: Agent
	3.	She makes a link with a local African church and they befriend her. They visit her at the hospital and help translate for her.	None apparent
19.	1.	Her blood pressure is still very high post-delivery. She is put in a side room alone to rest. The midwife looking after her explains she needs total rest and is very caring towards her. The shift changes and the new midwife is unkind and uncaring.	Act: Agency
26.	1.	Her labour went well because she had her partner with her and her baby was born in 'good condition'.	Scene: Agent

27.	1.	The baby is sent to NICU for observation and she is sent to the postnatal ward. She is in a lot of pain and can't walk to the bathroom by herself.	Act: Agency
	2.	The baby is in NICU, she has to be taken in a wheelchair to see to see him. Sometimes if no one is available she would push herself in the wheelchair to see the baby. She is worried about the baby but glad he is being taken care of in NICU as she feels he is getting good care there.	Scene: Act
	3.	When she was taken into hospital for induction of labour she had to leave her 2 year old in the care of a virtual stranger at the accommodation centre. It was either that or give her child to social services to be placed in temporary foster care and she was afraid she would not get her back. She asked the woman she was sharing the house with and she agreed to care for her daughter.	Scene: Agent
	4.	She finds life in Ireland hard with no friends or support. Everyone has their own troubles so she feels she cannot burden them with hers. She feels people in Ireland think Asylum seekers lie about life in Africa but she is afraid to return even though she left her son there. She worries she will die if sent home as she will not be able to get treatment for Hep. B, and there will be no one to take care of her children.	Scene: Agent
28.	1.	Not long after discharge she hears she is to be transferred	Agent: Agency Scene: Act
29.	1.	While she is happy to have her baby she is very sad not to have any family around her to share her joy. She worries she is depriving her daughter of the love of the extended family.	Act: Agency
	2.	The next morning the baby is taken for surgery for the hydrocephalus that was diagnosed in antenatal period.	None apparent
	3.	That first morning she goes for a shower not realizing how weak she is and collapses.	Scene: Agent Act: Agent
	4.	The paediatrician tells her she must supplement her breast feeding with bottle milk.	Act Agency
	5.	She feels she experienced racism from kitchen staff who did not offer her food when others were.	Act: Agency

	6.	On discharge 'home' to her accommodation she became very depressed. Did not leave her room or care for herself	Scene: Agent
	7.	She is transferred to more 'permanent' accommodation and is sharing a 2 bedroom chalet with another woman from Zimbabwe	None apparent
30.	1.	She is without support. The social worker arranges for baby clothes etc. She is discharged back to the hostel but cannot sleep with the baby in a bunk bed so they give her a cot.	Scene: Agent

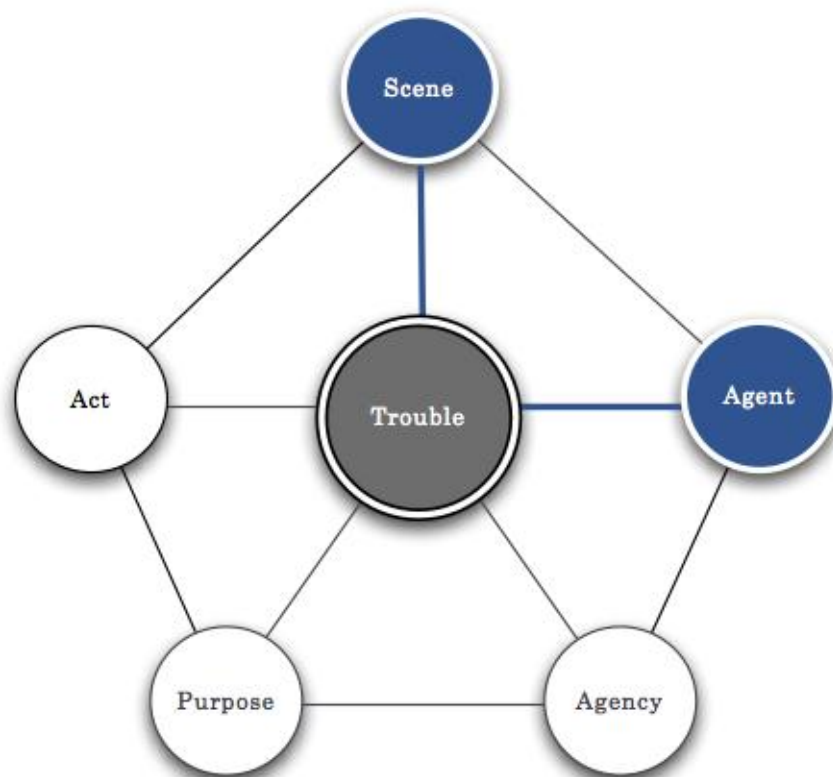
5.5 Postpartum Findings

‘I cried,it was sad because I'm not sharing the joy, some people like my mam, my husband, my friends were not there to enjoy that moment with me.so it was really painful and I felt maybe I'm depriving you of some, of some love she should be getting someway but at the end of the day it wasn't my fault’.

There were a total number of sixty postpartum narratives. There were six different ratio pairings; the most frequently occurring imbalance was the Scene: Agent ratio (Figure 6) with twenty-eight examples. There were twenty-three examples of the Act: Agency imbalance (Figure 7), nine of Scene: Act, four of Agent: Act and one of Agent: Agency. There were six examples of narratives with no imbalance and ten incidents of double narrative imbalances.

5.5.1 Scene: Agent Ratio Imbalance

Figure 5.5: Scene : Agent Ratio Imbalance



Postpartum Findings
Scene : Agent Ratio Imbalance

The following are two excerpts from Tarra's postnatal narratives. Both narratives illustrate the scene: agent ratio imbalance.

When Tarra was taken into hospital for induction of labour, she had to leave her two year old in the care of a virtual stranger at the accommodation centre. It was either that or give her child to social services to be placed in temporary foster care and she was afraid she would not get her back. (Scene) She asked the woman she was sharing the house with and she agreed to care for her daughter. She worried while she was in hospital about her daughter as she did not know the woman well and she was also concerned for how the woman was coping as she had her own 3 month old baby to care for also. The day she left for hospital her daughter was crying and so was she. (Agent)

'Well I was really happy to see my daughter again because ...I actually left my daughter with a stranger I got to know in (centre)...that is it because for somebody to be willing to take care of your child for days you know it's not easy. No, no. Well you wouldn't know what they are capable of. Some people can tend to be nice when you are around but when you are away you will not know whether they are nice or something else. Yeah I just got to know them a few months and I didn't think that was enough time for me to get to know her very well. I had no option because I asked the health care nurse here and she, I asked her because I was really worried, the day when I am in labour where am I to leave my daughter. And I knew nobody in (centre) then. I was here just for 2 months and she told me that the only option they have that I should look for a minder for myself or the social will step in and take care of the baby and that if they take my daughter away that would be, before I can get her back it will be a long process. So I was worried that I didn't want to go through that process, I already have problems that I'm thinking of my stay in Ireland if my asylum would be approved. I know that then coming to fight, start running after having my baby again, I don't want to go through that ... and I have a health problem to think of so I didn't want to go through that but I had to sacrifice, make that sacrifice to leave my daughter with her, and at the end of the day I was grateful because she was willing to do it.'

Tarra finds life in Ireland hard with no friends or support. Everyone has their own troubles so she feels she cannot burden them with hers. She feels people in Ireland think Asylum seekers lie about life in Africa but she is afraid to return even though she left her son there (Scene). She worries she will die if sent home as she will not be able to get treatment for Hepatitis. B,

and there will be no one to take care of her children. She is very grateful for the €19.10¹⁸ she gets because to her it is a lot of money. She saves it up and if she wants to buy a dress for her daughter buys one in the charity shop for one euro. She is grateful for the accommodation she has and wishes for a better life for her children. She has taken all the education courses available and would love to do more study but this is not an option for asylum seekers¹⁹. She fights off worry about her future and the future of her children by trying to keep busy (Agent).

'It's really, really, it's very, very hard., very, very hard. Nobody to talk to, nobody to, (Pause) this is just a place you wouldn't know anybody and how, everybody has got their problems so you can't take your own problems to them and start putting stress onto them with your problems. So sometimes you just, your problems just died within you, you just keep them to yourself.....You know thinking back (Crying) only having Hepatitis B and going back to Africa having nobody to turn to. Sometimes they might think some of us will come here we lie, but there's more of us that we come with genuine reasons and we have not lied. You know going back to Africa, I left my son back in Africa because I had no option but I had to. And if I go back (Pause) with Hepatitis B no relation will take care of me even if maybe I'm sick and all that, no medicines, how can I afford to take care of my health and take care of children? I just think that going back is just like wishing you into my grave. (Crying) and who would take care of my kids. (Pause)...'

Both these scenes illustrate the level of isolation, loneliness and stress asylum seeking women experience. The extra burden of illness or complicated pregnancy stretches their already sparse support systems.

The same themes of isolation, loneliness and stress are evident in the following two excerpts from Demy's story that illustrate the scene: agent imbalance. Two weeks after discharge from hospital Demy, her husband and baby are transferred to new accommodation on the other side of the country. (Scene) The notice that they are being transferred is posted late at night. They lost some of their possessions and a lot of their clothes in the rush to pack, (Agent).

¹⁸ A community welfare payment received from the HSE. A weekly payments of €19.10 per adult and €9.60 per child, or €2.73 & €1.37 per day, respectively. (AkiDwA, 2010)

¹⁹People seeking protection in Ireland are denied access to full time third level education programmes, and only have very limited opportunities to access vocational training and education schemes (Mbugua, 2010:22).

‘Though when we were coming we lose so many of our things because they told us very late in the night that we would be transferred and very early, we started rushing so we lose some of our clothes’

This scene also has Act: Agency imbalance because of the way the act, the transfer to another accommodation centre, was carried out, with very little notice (agency), that meant they lost some of their few possessions.

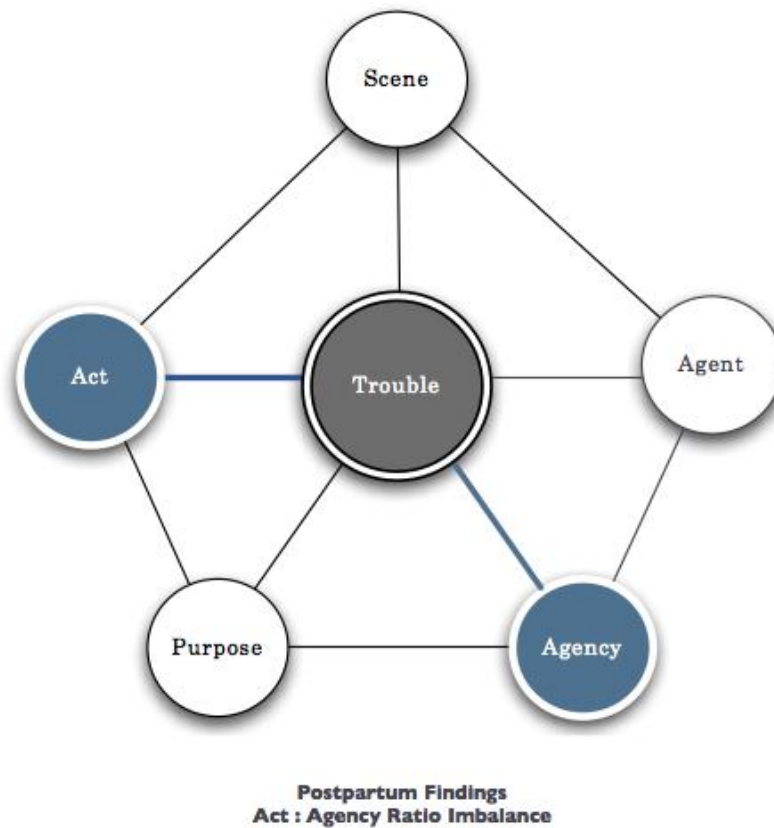
Although they are both in their late twenties, Demy explains that she has high blood pressure and her husband suffers from headaches. She attributes their illness to the stress related to the situation as asylum seekers. She explains she spends a lot of time alone in her room. She does not join in with activities in the hostel. She misses home and misses having people to congratulate her. She talks about how she especially misses her sister. Her parents died in a fire when she was two. She does not like the canteen food they are given. The food is very different to what they are used to eating. One day someone prepares an African dish. Word gets out and everyone is excited as a big queue forms outside the canteen!

‘It’s ok,... it’s ok, the only thing is that you know the food they cook at times is not our own food, you just manage to eat it, at times you eat some just be like ah what's this, don’t like it and there’s nothing we can do, just have to. I don’t feel like joining that (residents group), because I think that’s not why I’m here. I don’t feel like, I don’t feel like, just in my room I think, no I don’t want to join them, I’m ok on my own (Pause) but there was a time in the hospital that I was just crying, when I had this baby because I was just thinking about home, I think if I was in (country of origin) many people will come to me to congratulate me, I was just crying, so my husband was encouraging me ...’

5.5.2 Act: Agency Ratio Imbalance

The act agency ratio was the second most frequently occurring imbalance in the postpartum narratives; denoting inconsistencies between what took place and how it happened.

Figure 5.6: Act : Agency Ratio Imbalance



Joy is induced at 39 weeks because her blood pressure is very high. It has been a long day, she is alone with no friends or family support. She is crying loudly and the midwife tells her to stop screaming and shouting. Her waters break and she is ashamed because she thinks she has urinated on the floor. She apologizes to the midwife, but the midwife does not explain to her that her waters broke instead she says the waters broke because she was screaming so much, *'you've been screaming, I've been telling you to stop screaming because you are disturbing others'*. The induction is not successful and Joy must have a caesarean section. She is afraid that she or the baby will die, or that she may not be able to have more children. The doctor, a woman, comes to speak to her. She explains that everything will be OK, she and the baby will be safe and future pregnancy will be possible. The baby is born without complication and she is happy to see her baby and to have survived the operation. The following is the postnatal scene; Joy's blood pressure is still very high post-delivery. She is put in a side room alone to rest. The midwife looking after her explains she needs total rest

and is very caring towards her. The shift changes and a new midwife who is unkind and uncaring arrives. When Joy rings the bell the midwife does not come, when she does come, she tells Joy that she is disturbing her too much and she is not the only patient. When she calls her again because she is bleeding, her pad and bed are wet and need to be changed, the midwife raises her voice at Joy. This continues for the rest of the shift. She asks to be moved to another ward. Later Joy needs a blood transfusion because of the amount of blood she has lost. She herself does not make the link between the wet pads and bed and haemorrhage.

‘She say she want me to rest, I need rest, I need rest, I need relaxing, if I can sleep I will sleep but if I don’t want to sleep I should just try and relax, then I took it, if I said I want to do anything by then I cannot get up, if I want to change they will change me. So after, then the next, when that one [midwife] change duty, they brought another one, oh that lady was just like, I don’t know... when I ring the bell she cannot, she doesn’t stay with me the way the other one was staying, when I’m ringing my bell to call her she say oh you disturb too much, are you the only one here, when I’m ringing, ringing, ringing she won’t come, if I see somebody passing, please help me to call this nurse, she won’t come, when I saw her pass I say please, what did you want (shouting), you know she was shouting and I say please it’s because I am feeling pains, I want to change my pad, I’m wet, my bed is wet, because the other one is taking me up every time, she just sit with me, if she see I’m wet, because I can’t get up, she will take me up, she will change under, she put something under, she would do that regularly. So for her she doesn’t do it when I’m wet, the bed is soak, I am soak and don’t feel comfortable, I am trying to call her, please you should help me, she shout, stop shouting, you are not the only one here so I can’t (inaudible 2.30) attend to the others, I say no, just because this thing I am not comfortable with it. It’s irritating me and it’s not good, I just want, I can’t lift up myself, I am helping her to lift me up so it can let me to change. So I started crying, I say please they should take me to the other ward ... [the next morning she tells the doctor what has happened and she is transfer her to another ward] ... when I was in the other ward they now see that I need a blood .So when they now check my body, now check my BP ..I needed blood, they say I needed blood, I say why, so that means I’m short of blood, they say yes and they don’t know how. I needed blood.’

These scenes show the discrepancy in midwifery care from one provider to the next, from one shift to the next. The shocking disregard for a woman who was sick enough to warrant a single room even more apparent in a context of deeply overstretched resources, because she needed total rest is unconscionable, and is a theme sadly evident in many of the women’s narratives.

One of Lola's postnatal narratives illustrates the same kind of unthinking disregard for a woman's request that results in dangerous complications, this time for the baby. The Act: Agency ratio imbalance is apparent here. Lola spent most of her pregnancy believing that her baby has hydrocephalus as doctors apparently diagnosed this on an antenatal scan. The morning after Lola gives birth the baby is taken to theatre for corrective surgery, they bring the baby back and say there is nothing wrong, no operation needed and that the issue had resolved itself. Lola saw this as a miracle. The paediatrician does however appear to have concerns for the baby and tells her she must supplement her breast feeding with bottle milk. When Lola asks the midwife for milk the midwife refuses to give her some (Act), telling her because she is breastfeeding she cannot have it and she must make the baby suck (Agency). She tries to feed the baby all through the night. The next day the doctor returns and questions her about why she is not supplementing the feeding. She tells the doctor she asked the midwife but was refused a bottle. The doctor gets really angry and wants the name of the midwife who refused to give her the milk. The doctor comes back three times to see if she remembers the name. She does remember but is afraid to tell in case the midwife loses her job. The baby is taken to NICU because of dehydration and is there for 2 days.

'Then they ask me what I want to do, did I want to breastfeed or bottle feed. So I wanted to breastfeed but the baby was too weak to depend on my breast. So the doctor said I should give the bottle and the breast. So when the doctor was gone the milk had finished, one lady, you know the racism isn't only on the black and white, it can be blacks on each other, because the lady was giving out to me, it was a black lady. She was (midwife's nationality) and I told her that I had ran out of milk and she told me you are supposed breastfeed and I said yes I am supposed to breastfeed but the doctor said I should, I should give the baby because I don't have enough milk. She said she wouldn't give me, I should make my baby suck so that I will get more milk. I was trying to make the baby suck but there was nothing so when I didn't get milk that whole day until the next morning when the doctor came my baby was there because she had not eaten enough. So the doctor asked me why I wasn't feeding my child I said because my milk is not really coming out when, then he said but you are supposed to be giving it milk, I told him I was, the lady refused to give me the bottle. He was so, so angry then. He asked me to show him the lady and then I was thinking this lady one thing for sure she was black if she gets into trouble for her to get another job in this country I mean so I really wanted to stop her but I knew if I told the doctor she might be in some sort of trouble. So I, I didn't tell the doctor who it was but I just told, then the doctor brought more milk. And the baby had to go to the intensive care for two days. She was really dehydrated. So that's why the doctor was mad, he came back three times asking me if I'd had seen the lady and I kept on saying I haven't, but she was still the same lady and she

was really scared. But I, you know the same way I felt for her she could have felt for me and given me the milk. But people are not like that so racism normally is not only blacks and white, it can be black people, maybe if I was a [same nationality] she would have treated me nice I don't know but the other people like the nurses and everything they were nice'.

Being caught up in this drama that was not of her making is a pointless added stress to Lola, on top of an already incredibly stressful pregnancy due the misdiagnosis of hydrocephalus for her baby. On discharge from hospital Lola went back to the hostel but became very depressed. She did not leave her room or care for herself. She was visited by a family support worker who visited her regularly and became like a friend to her, and she gradually recovered over several months. She misses her friend now (family support worker) and wishes she could see her but since she has been moved out of Dublin she has not seen her. However, her overall mental state has improved since she is transferred to more 'permanent' accommodation and is sharing a 2 bedroom accommodation with a woman from Zimbabwe. This woman is very outgoing and really cares for her and helps her to gain confidence and they become like sisters. She hates the time she spent at the first accommodation centre and cannot even bring herself to go near that part of Dublin. She still misses her family and longs to be able to return home some day in safety.

5.6 No Ratio Imbalance

There were a total of thirteen scenes where no ratio imbalance was detected. Of these, two occurred in the antepartum narratives, five in the intrapartum narratives and six in the postpartum narratives. The implications of finding no ratio imbalance suggests that the narrative had a continuity or cohesiveness in respect of taken for granted norms of what one would expect to happen in a given situation. In other words, in the narratives where no imbalance is detected, the story developed in an acceptable and expected manner, given the unique set of circumstances described by the women in the narrative in question. For the sake of representativeness of the data I will provide a brief example from each section to illustrate the point.

5.6.1 No ratio imbalance in the antenatal narrative

Tawa was admitted to hospital in early labour. She had a previous caesarean section and found this labour long and hard. She has an artificial rupture of membranes, and an epidural and manages to have a vaginal birth. She felt supported by the midwife and her baby was born safely.

“... the midwife that was with me and she was a (midwife’s nationality) woman, very nice woman, the way she was, so I was happy, I was really happy....She was giving me courage, encouraging me to just have patience...”

5.6.2 No ratio imbalance in the intrapartum narrative

Joy was admitted to hospital five weeks prior to the birth of her baby because of raised blood pressure. This experience was very hard as she had never been in hospital before. She arrived in Ireland on the 19th and was admitted to hospital on the 23rd. She had no friends and no visitors and found it very difficult. She had a total of two intra-partum scenes, one with a ratio imbalance and the one described below that had no ratio imbalance. The induction of labour was not successful and she needed to have a caesarean. She was afraid that she or the baby would die, or that she may not be able to have more children. The doctor, a woman, comes to speak to her. She explains that everything will be OK, she and the baby will be safe and future pregnancy will be possible. Joy’s baby was born without complication and she was happy to see her baby and to have survived the operation.

“They told me now you have to go for operation, you want to sign, anybody to sign for you, I say I don’t know anybody, I say I will sign myself, I ask can I survive it with my child they say yes I will survive it and then I ask can I be (inaudible 10.17) because she’s my first child, can I have another child (inaudible) they said yes (inaudible) another child..... so I was scared anyway... the doctor, she was a lady, she now said no problem.....Reassured me, I should put my mind at rest that she show me to make my baby survive and I will survive...”

5.6.3 No ratio imbalance in the postpartum narrative

Isobel had had a difficult time. She was admitted with pregnancy induced hypertension (PIH) in the antenatal period and had to leave her son who was under two in the care of a woman back in the hostel. She had no money and nothing for the baby and that was a source of worry to her. She had also experienced conflicting advice and lack of support in the antenatal and intrapartum periods. On the postnatal ward one midwife stood out as being supportive. She was caring towards her, asking if she was OK,

“I don’t know, when she was on duty she would just come to you and she will ask, like I said she will ask you if you need something, if you’re ok, do you need anything, can I do anything for you, she just said that little extra and it was not as if it’s her duty to do it, it’s as if she really enjoyed doing, being there and being able to help”.

This account of Isobel’s positive experience of meeting a truly caring individual is perhaps particularly poignant as it appears to stand out in such sharp contrast for her, against her previous experiences.

5.7 Conclusion

In this chapter I have provided an overview of the women’s experiences. These were represented as antepartum, intrapartum and postpartum summaries. The most frequently occurring imbalances as highlighted by Burke’s dramatic pentad were discussed and illustrated with extensive excerpts from the women’s narratives. The next chapter will present a more detailed presentation of five individual case studies.

CHAPTER 6

Childbirth Narratives: Five Women's Stories

6.1 Introduction

Choosing just five women for more in-depth case studies was really difficult. The five women I include here had differences in terms of the country of origin, and different challenges related to their childbirth experiences that together seemed to provide a valuable insight into the problems women in the asylum process experienced in general. Four of the five women were multigravida. Some had their older children with them and some had to leave their children behind in their home country. Two of the women were here with their husbands and older children. Just one out of five had a vaginal delivery and that was a hard-won victory as she had been pressurized to have a caesarean section but had resisted out of fear and worry because she had two older girls and knew that recovery from a surgical operation would complicate her postpartum recovery. All of the women had complications either in their pregnancy or post-partum or related to their child, many had all of the above. Three of the five women had pre term caesarean births. Two of the babies had admission to Neonatal Intensive Care Unit (NICU) due to prematurity and intrauterine growth retardation. One of the babies had hydrocephalus that was diagnosed on scan but appears not to have had adequate follow up and developed severe complications and then needed lifesaving intervention. One woman did not speak English and her story shows the devastation of coping with a pre-term infant in intensive care while being unable to communicate with the hospital staff. In an attempt to balance out individual women's representation in this account I purposively did not include excerpts from any of the five case studies to illustrate points made elsewhere.

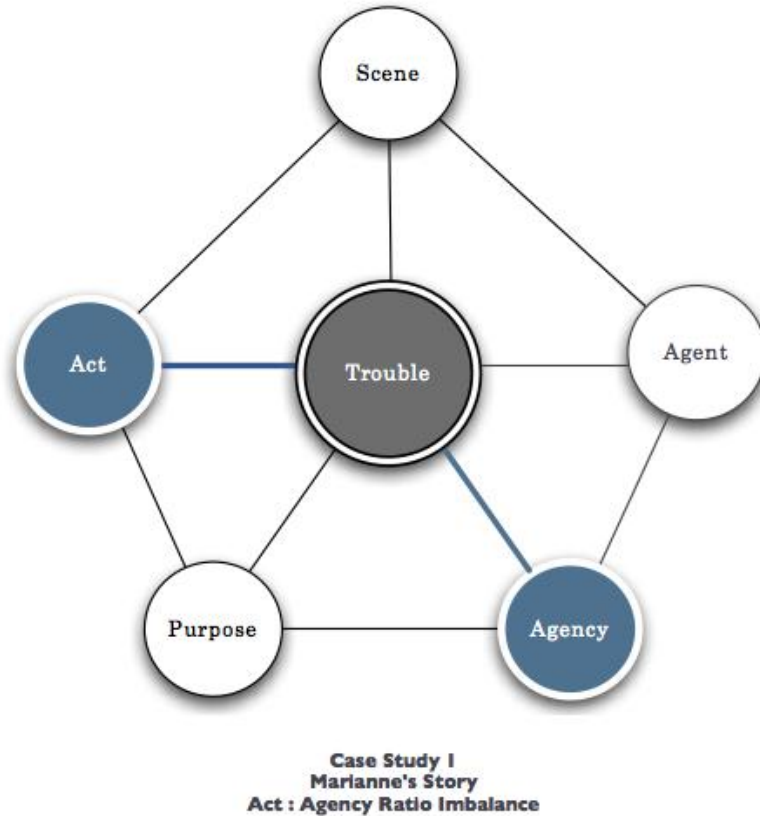
Table 6.1 Marianne’s Narrative Summary

		Ratio Imbalance
	Antepartum	
Scene 1	First antenatal appointment: <i>‘my first antenatal was very, very dreadful here’</i>	Act : Agency
Scene 2	Awaiting Amniocentesis: results <i>‘it was really terrible, the experience was dreadful’</i>	Act : Agency
	Intrapartum	
Scene 1	Induction of labour at 42 weeks	Scene: Agent
	Postpartum	
Scene 1	Baby is ill: <i>‘The trouble started again’</i>	Scene: Act Agent: Act
Scene 2	Baby transferred to regional neurology centre: <i>‘...still living with fears and worries because I knew nothing about it, I was so ignorant, no information at all’</i>	Act: Agency
Scene 3	Shunt blocked: <i>‘They told methere would be no space for me (to go with the baby) in the ambulance’</i>	Act: Agency
Scene 4	Emergency Surgery: <i>‘Do what you can to save my baby’</i>	Act: Agency
Scene 5	Current realities: <i>‘Yeah, it’s tough while you are waiting’</i>	Scene: Agent

6.1.1 Marianne's Story

Marianne (pseudonym) is a young woman from West Africa. Our first meeting was in November 2007 when I went to her accommodation to meet with her; she had been one of the first women in that particular accommodations centre to agree to talk to me about her experience of giving birth in Ireland. Marianne's two older children, both girls, under ten years were living with her in Ireland. Marianne's soft spoken and gentle persona was a stark contrast to the trials she had experienced. She did not choose to speak about her reasons for leaving her home or about her journey to Ireland and she also never spoke about her husband who was not with her. Marianne's story is all about her baby Emma, who was born with hydrocephalus. Her story begins with her memory of her first scan, which was a traumatic event. Doctors appear to have found something wrong but did not give a diagnosis of hydrocephalus and when baby Emma was born looking normal and healthy appeared not to arrange any follow up postnatally despite all the concern about the baby antenatally. Consequently Marianne's story is all about her battle to get her child the appropriate medical care and shows the barriers to treatment that uninsured and marginalized groups face in the Irish health care system. Marianne had a vaginal birth following induction of labour for post maturity at forty two weeks gestation. There are a total of eight scenes or mini narratives identified in her story. The most common imbalance or site of 'Trouble' was in the Act: Agency ratio imbalance (Figure 8). This shows the relationship between what happened (The Act) in the scene, and (Agency) what was done/ how it happened. In the eight scenes there were five Act: Agency ratio imbalances. This ratio imbalance tends to highlight discrepancies between how something was *actually* done and the way it *should* be done.

Figure 6.1: Case Study 1 - Act : Agency Ration Imbalance



6.1.2 Antenatal Experience:

‘It was really terrible, the experience was dreadful.’

Marianne begins her story when she arrives in Ireland twenty eight weeks pregnant and goes for an ultrasound scan. The following is an abstract from her first antepartum narrative and describes the Act: Agency imbalance that led to Trouble in the narrative;

‘... my first antenatal visit was very, very dreadful here, so because after the scan, the very first scan they told me the baby had a problem, so I was like, it was better if I didn’t know anything about that or I had a lot of doubts and a lot of worries and that is where the journey begun. So every week I had to go for a scan and the gynaecologist I met was not quite sure, because he told me he’s not specialized on unit so you just have to send to

(name withheld) University Hospital. So I went the following week and met a different person and after this guy told ‘me ah everything is ok, everything is fine’so I was like oh it’s good news, I was so happy, I called my friend, ah this scan today looks good. Just as I left the hospital gates, at the bus stop, the hospital rang me, where are you, I said I’m just at the bus stop, said no you have to come back next week because there was a mix up somewhere so I had a dreadful one week hoping that the news would still be good, yeah. So when I went the following week they told me no, the baby has a problem and I have to wait until it gets to [large city hospital], that same day. So it was on a Thursday, on Friday the Hospital called me and gave me an appointment on Monday (inaudible 2.36) was fine, I said maybe it was a mistake in (local) hospital, maybe in [large city] they are more specialized and the scan will be more detailed. So when I went there for the scan and the way the scan was interpreted, it was more dreadful than the way it was interpreted before. So at felt so depressed, I cried, cried, cried.’

We can see, how that situation was mishandled by the health care professionals and further complicated by poor communication and the constant referrals back and forth between the local hospital and the larger regional centre. This particular issue was a constant one throughout her narrative and proves nearly fatal in one postnatal account. This story of those harrowing first weeks in Ireland shows the heightened effect of hearing such bad news while being alone in a new country with two young children to care for, living in shared accommodation in a hostel and worrying about her tenuous legal status in the country.

6.1.3 Intrapartum Experience:

‘I said no I prefer a natural birth’.

The Act: Agent ratio imbalance in her intrapartum narrative highlights the inconsistency or contradiction between, (Act) and the hospital staff who pressurized her to consider an epidural and surgery her (Agent) insistence on a trying for a vaginal birth;

‘They told me but I never expected it to be so painful yeah it was sore. And later on the pains increased yeah, at one point I could not cope, I was like ah the pains are too much, they proposed epidural if I would like epidural, I said provided the pains would not be, because before then they proposed surgery, C.S, I told them I would like to try if I can. Yeah naturally but the baby’s head is a bit bigger, I said no I prefer a natural birth, if at one point I can’t cope then we can go to CS. So after epidural I fell asleep, I thought at good labour .I was dozing, at one point I

got a very sharp pain and I woke up and struggled for quite a long time. Yeah, at 7.15 the baby was born, a very long time in stressful labour. Yeah was very, very hard, but I was determined, within hours I'll have to do it too, I wish they would tell me to do it because I knew the consequences after the CS, I'm alone with other children in a hostel, you have to go and look for everything so.

6.1.4 Postpartum Experience:

‘Yeah, she was very, very sick, she was very, very sick.’

Marianne's postnatal narratives are a testament to mismanagement. Her story is one of constant worry over her sick infant in the face of indifference, ignorance, poor communication and at times apparent inhumanity. When the pentad was applied to the first scenario it highlighted two different imbalances, Scene: Act and Agent: Act within the scene, one might refer to this as 'Double Trouble'.

‘... about 2 or 3 weeks after (the birth) the trouble started again, as the days go by the head size was growing bigger and bigger and she was not, she would eat and everything would come out of her, she was getting weak so I went to the public health nurse and I told her my baby is throwing up and I've discovered the head is growing, she was like no it's a big baby, maybe the head is proportionate to the body.

Marianne then describes numerous visits back and forth to the nurse before she could convince her that her baby was sick enough to be referred to a paediatrician.

‘... And I waited for another, maybe a month, the first letter they sent got missing on the way and they had to send another oneYeah, I was so worried because as the days go by the baby's head was growing bigger and bigger until finally I got an appointment after 6 weeks, when she was very, very sick, very, very sick...She was very weak and the head was very big, she could not lift up, no head movement, no head control, before you lift her up you have to physically carry the head, yeah, she was just running temperature.

When Marianne finally got to see a paediatrician her baby was transferred to a children's hospital in Dublin. By this time the baby had a chest infection and so could not be operated

on immediately. Marianne talks about watching her baby's head expand daily as doctors tried to get the chest infection under control. The Scene: Act imbalance is apparent in the lack of appropriate care from Marianne's discharge from the maternity hospital with no follow up visit organized; to the reluctance of the public health nurse to believe the mother that her child was ill; which led to weeks of delay in getting a referral (Act) for the baby by which time the infant was critically ill. The Agent: Act imbalance is accounted for by the inappropriate response of the hospital doctor (Agent no referral) and the public health nurse (Agent whose inability to act caused an almost fatal delay in treatment). Her story continues;

After 5 weeks, that's when they decided to had to do, put the shunt and from the MRI scan they said there was a cyst in the brain and with that cyst they can't do it in [Children's hospital], she has to be seen by a neurosurgeon also, so went to [Regional neurosurgery] hospital with her, the surgery was done.

Yeah, and after that came home, even though still living with fears and worries because I knew nothing about it, I was so ignorant, no information at all. Nobody gave me any information...Nothing, nothing.... Yeah they gave me just the leaflet; they gave me in [hospital] about the baby shunt that was all. Yeah, just about the shunt that was all they gave me. And before the surgery I met one doctor who tried to explain what it was like, yeah, what hydrocephalus is, about the diagram of the brain, explain you know. So I was not worried at that moment, my worries were what will happen next, those are my worries, and that's the worries I still have now'.

The Act: Agency ratio here highlights the imbalance between the Act, the surgery, and the Agency, her lack of preparedness and support throughout the whole experience. Her final postnatal narrative depicts her relentless battle to advocate for her daughter to get appropriate care. Again, add to this Marianne's isolation, lack of family support (although she did have the support of two friends at the centre), uncertainty about her future, on-going legal battle to prove her case, the language difficulties, transport issues and money worries not to mention her two older daughters who were left behind in the hostel being looked after by virtual strangers for the five weeks she was in hospital with the baby and the scene becomes unbearable. There are so many examples of poor communication, between health professionals and hospitals and from providers to parent. The following story highlights the now recurrent theme of Act: Agency ratio imbalance in scene after scene that illuminates the mother's confusion and exhaustion after weeks of doing battle to have her daughter's deteriorating condition taken seriously.

‘Very hard and the worst experience was in January when the shunt got blocked,...called the GP on call, the off hours GP service here so he told me I don’t have treatment for you, take her to the hospital... There’s no treatment for Emma, so I should take her to the hospital, he has nothing to do with a shunt. So I went to the hospital, it was on a Saturday and I was there Saturday, Sunday, Monday, so they said they don’t know what to do, they had to contact the [neurosurgical] hospital.

No they told me she, the doctor told me I’m happy with how she is, so maybe there was a little pressure on the brain and the fluid just missed its track so it happens at times, she’ll be fine, told me she’ll be fine, so we came home. The following day she started throwing up, she was getting sick, I went to the GP, the GP told me it was the winter bug.

So he said off dairy products for 8 hours and see what happens next, so I was off dairy products, they gave me hydration solution, the more I give the more she would get sick.

For almost a month, I went back to the GP, he told me now she’s O.K., and it’s just the winter bug, just off dairy products for another 8 hours. At one point I went back to the hospital, I was getting worried’.

Marianne describes a month of going between her GP and the hospital emergency room and each time she was told there was nothing to worry about, meanwhile she was becoming exhausted. Then one morning Emma seemed to deteriorate, was very weak, but Marianne did not have the energy to take her back to the hospital to wait six hours to be told there was nothing wrong with her baby. She asked her friend to come and help her so she could get some rest, when her friend saw the baby she immediately said they must take her back to the hospital. They waited in the emergency room from 11.30pm to 3am and when they eventually got to see a nurse they were met with a lack of clinical competence that could be described as dereliction of duty.

‘Yeah I saw the nurse, she said it’s just vomiting and it’s not worth coming here just for vomiting but I’ve called the doctor, I said I called the doctor on call and he told me I don’t have treatment for you, anyway you have to wait at least 4 hours.

Yeah they saw the record, I was always there every week, they say it’s just vomiting so why did you call the GP on call, go to your local GP, I said I’m asking my GP, the GP told me the baby gets worse I should go to the hospital because they can’t do anything because of the shunt.

Yeah, they can’t do anything [inaudible 23.25] they can’t do anything, it’s just for them to refer her back to [neurological centre]. So they told me no, you have to wait for 4 hours because vomiting is not worth coming here in the night, I said no problem I’ll wait for 4 hours. So when it was around 3am they told me they can’t send her home because she has been

having this for a month and just have to observe her for that night to see what it will be like tomorrow. So as she was there, she was going worse and worse and worse.

Weaker and weaker, she could not respond, just no strength, even threw up again in the hospital and her head now went behind [note: the baby began to fit and as the back arched it appeared the baby's head was going backwards towards her back], I don't know, I've never seen that, she was not in the (inaudible 24.13) but backwards.

So at one point they were like, it seems she's having a tetanus attack, they were not sure it was a shunt issue, she's showing signs of tetanus and I said no she had all her vaccines (inaudible 24.35) she's gotten all her vaccines so I don't think...nobody even thought of the shunt and this side was really swollen, nobody thought of the shunt, maybe it's meningitis, maybe tetanus attack.'

At this point the medical staff began to take some notice of the desperately ill baby and decided to call the neurosurgical unit at a larger hospital, which told them to do a C.T. scan and x-rays where they found the shunt was blocked. The baby then began to have another seizure and was taken to the intensive care unit to be stabilized before she could be transferred to the neurosurgical unit in the city hospital several hour's journey away. The medical staff tell Marianne the baby must be anaesthetized to make the journey, but meanwhile she would need to find her own way to the hospital in Dublin.

'Yeah it was very hard; they just told me to get myself going to Dublin because there would be no space in the ambulance for me'.

As Marianne had no means of transport to Dublin she called the family support worker from the Hydrocephalus Association a charitable agency set up to support families with children who have the condition. The family support worker took her back to the accommodation centre to pack some things and then took her to the hospital in Dublin. She got there ahead of the ambulance as Emma had not been stable enough for transport and when she arrived she was taken immediately to the operating theatre. Marianne describes the conversation with the neurosurgeon who was to operate on Emma.

'So they could not wait for her own, for Mr. (inaudible 28.58) that attends to her always, so there was another neurosurgeon and he was so hard, he told me normally I'm not supposed to operate this baby in this condition because they gave anaesthetic in [local hospital] which was not right, because it was [inaudible 29.16] to carry the baby like that to Dublin. So he said he's not sure of the condition, the baby had a seizure, he's not sure,

he doesn't know the damage this seizure has caused to the brain, he doesn't know anything about the child and he's just taking a risk to operate but he'll do what he can do.So I said do what you can do to save my baby'

Thankfully Emma survived the operation, and recovered fully, something for which Marianne is very grateful. However, the strain of caring for Emma is constant and Marianne is concerned about the lack of time for her other children and for Emma's physical and mental development and her future.

'Yeah Emma's been through a lot a very hard journey so Yeah it's very, very, very difficult, very, very difficult. And very stressful, the environment is stressful, your own issues are stressful, life is...'

In the last scene in Marianne's narrative she turns to the current realities and challenges of living life as an asylum seeker. She talks about the endless waiting for life to begin again, to be able to work or go to school. I used part of this narrative in a previous chapter to illustrate the loneliness frustration and boredom of living life 'on hold', so I will not repeat that excerpt here. Instead I would like to give an example of Marianne's grace and the hope she finds in the fact that her children are all alive.

'With Emma [had she been born in Africa] it could have been a tough time, because in my country I never heard the name hydrocephalus before and I don't think they even know anything about that because, but when I was small I remember I used to see children born with big heads, now I start to digest those things, that there is hydrocephalus in my country but they don't have a name for it and they just say it's witchcraft.

Yeah so if a child's head starts growing they will just abandon the child and nature will take its course very slowly.

Yeah, the child is left to die, I can remember 2 or 3 cases like that. I know it's just like a freak show, like we always go and peep, where the child is, nobody is allowed to see, they say it's witchcraft, if you go near the child maybe you'll give birth to that type of child so.

Yeah... yeah lots of....

If I should go back to [home country] I'd have a lot to do. To teach people yeah, I have lots because that's living, that ignorance, they don't even know there is an illness, it's an illness, that is normal, that there's a name given to it, it's just it's a big head, witchcraft so. It would have been very tough really, I wouldn't have Emma...'

When I last visited Marianne and her family in January 2010, Emma was doing well, she is tall and strong and meeting all her development milestones. Her health is a testament to her mother's love and perseverance. Marianne is delighted and relieved at Emma's progress but her talk that day was all about the government's escalation of deportation orders. She talked of people whose names appeared on the list living their days in the very present fear of being deported and pointed to doors across from hers where whole families had been taken without further notice, there one day, gone the next. Although Emma was no longer in danger for her life, Marianne is 'still living with fears and worries'.

Table 6.2 Amira's Narrative Summary

	Antepartum	Ratio Imbalance
Scene 1	Long into the interview she reveals that after she became pregnant with her longed for baby, she became depressed. She felt lonely and hopeless; she missed the support of family and friends.	Scene: Agent
Scene 2	She makes friends with an older Irish couple who live in nearby town. They become like parents to her. They write a letter to the visa office inviting her parents to visit for the baby's birth but their request is denied.	Scene: Agent Act: Agent
	Intrapartum	
Scene 1	She did plan the pregnancy although her husband was hard to persuade because he felt it was a bad idea because of their situation as asylum seekers. Her pregnancy has been difficult, complicated by sadness and depression.	Scene: Agent
	Postpartum	
Scene 1	Breastfeeding is difficult. The baby does not latch well and is crying constantly. Every morning she apologizes to the other women in the ward because he makes so much noise during the night.	Scene: Agent Act: Agency
Scene 2	After discharge from hospital she is in a lot of pain and crying all the time. Although her husband is supportive she finds it hard to adjust	Agent: Act
Scene 3	Shunt blocked: <i>'They told methere would be no space for me (to go with the baby) in the ambulance'</i>	Act: Agency
Scene 4	Emergency Surgery: <i>'Do what you can to save my baby'</i>	Act: Agency
Scene 5	Current realities: <i>'Yeah, it's tough while you are waiting'</i>	Scene: Agent

6.2 Amira's Story

Amira (pseudonym) and her husband had been in Ireland for just over two and half years when I met her. They were from the Middle East and both had professional backgrounds. Amira started her story in the postnatal period and worked backwards to her antenatal experiences, which is perhaps understandable given her baby was still only 19 weeks when I met them and she was living that reality at the time of the interview. Amira did not want to talk about their reasons for leaving their home but did talk about missing her home and her family and friends. She struggles greatly with her status and feels very ashamed of her life here as an asylum seeker. Amira was very open about her struggle with depression throughout her pregnancy and early postpartum.

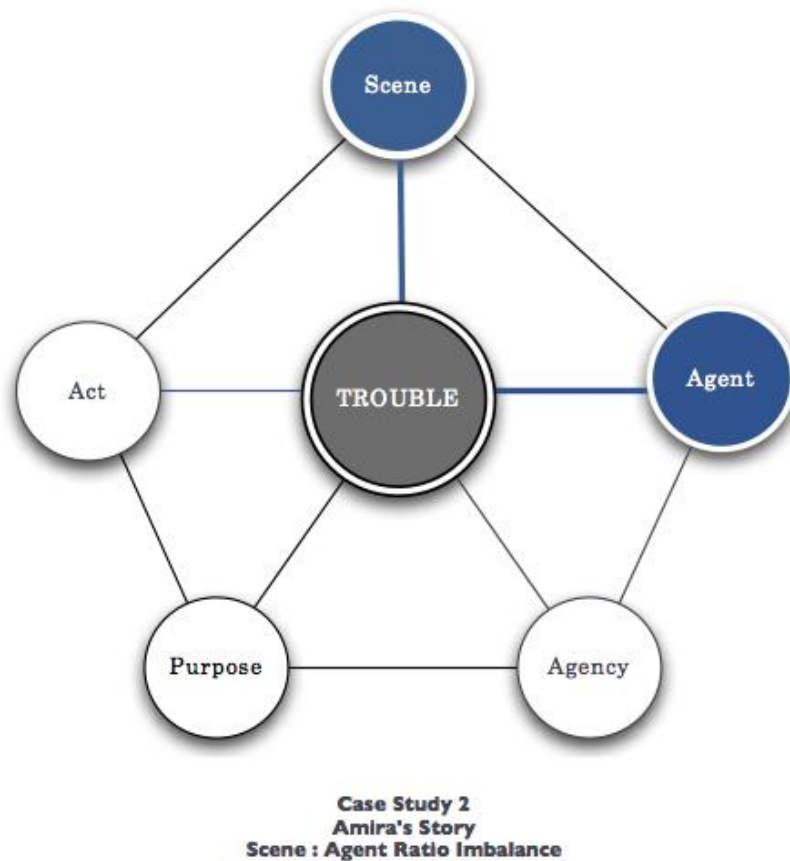
‘...I just cry for nothing, for no reason and I go and just cry, cry and I put my glasses nobody see I’m crying, I keep telling myself what I’m doing in here, why I’m in Ireland, why I don’t have anybody around myself, I hate, it was so bad ...even now I remember when I was pregnant, in first 3, 4 months, every time I like to kill myself, I just crying, crying. Several times I decided the railway station is here, I go and kill myself, I don’t know why. Now I’m thinking that time I was crazy but I don’t know.... I said why I get pregnant, there is no hope in this country, why I get pregnant, why I have to bring another person in this world, that’s why I was crying, crying, so bad...’

6.2.1 Intrapartum Experience:

‘And I remember it was very, very hard, very hard and I just cry, cry, cry...’

Although she had wanted a baby for some years her husband had been reluctant as he felt their situation in Ireland was hard enough without having a baby to care for too. Amira won him over and she gave birth to a beautiful baby boy in 2008. In the five scenarios in Amira’s narrative, two scenes have double ratio imbalances. There are four instances of Scene: Agent ratio imbalance (Figure 9) which is indicative of the environment’s (scene) impact on Amira’s (agent) happiness.

Figure 6.2: Case Study 2 - Scene : Agent Ratio Imbalance



There appears to be multiple elements in the first scene. Amira talks about her labour being induced and then needing a caesarean birth, but this is not the focus of her narrative. She frames that information in the background (scene) that depicts a turbulent pregnancy overshadowed by depression. Her joy at meeting a nurse in the operating theatre who speaks her language appears to exacerbate her loneliness as she comments;

‘It was nice to hear and I haven’t seen any [country of origin] lady, I’m the only one in this camp even somebody just to speak my language’.

6.2.2 Postpartum Experience:

‘Tomorrow I’m going to sell you if you are still bawling.’

In the first postnatal scene Amira talks about her difficulties breastfeeding her baby. The baby was 4.5 kilos, she has difficulty getting him to latch well and he cries a lot. Amira is very concerned about her baby keeping other women on the ward awake and every morning apologizes for her baby crying in the night. She rings the bell to ask for help but it is hard to get attention of the midwives because they are all so busy! One midwife tells her she has to try herself, but Amira knows she still needs help and worries about going home on her own with no mother or family to help her. She is very relieved to find one of the night staff really supportive and helpful with breastfeeding. She feels relieved and grateful and ‘so happy’ when she knows this midwife is coming on at 9pm;

‘... said you have to try by yourself but I didn’t, really I didn’t, I couldn’t do that, I need some help, just in the day time the midwife and nurse, I know they are so busy but the night time I had, there was a lady,I remember there was a lady, she name was [withheld], she’s so, so good, she came in night time and when the night time start about 9 o’clock I was so happy. I said thank god she’s here, she never ever be upset any time I call her and come very, very calm, very good and she put him in my breast and help me, she was so, so nice, I never ever can forget her, I know she was so, in the night time I know they are so busy, they are not too much, just 3 or 4 person, staff but she was so good, so good’.

This scene is complicated by double ratio imbalances in the Act: Agency imbalance (what was done, support with feeding and (Agency) how it was done (badly) by day staff. It is also complicated in terms of Amira’s (Agent) response to her situation (Scene), her concerns about the midwives being too busy and disrupting the ward with crying baby.

When Amira is discharged home her situation appears to disintegrate. She experiences ‘a lot of pain and sadness’. Although her husband tries to be supportive, she misses her mother and family support and two or three weeks after the birth she feels she hates the baby, cannot let her husband out of her sight and once the sun goes down she cries and cries. The doctor offers her antidepressants but she does not want to take them as she is breastfeeding. She also does not take up an offer of counselling because she feels she cannot express why she is so sad. The imbalance between Amira as agent who cannot accept help and the act, crying

and feelings of hatred for her baby, highlight Trouble in the narrative. Amira is still putting a brave face on her situation and asserts that she is feeling much better now. The baby was 19 weeks at the time of the interview.

‘I am happy now, before I didn’t have any hope, but now I’m happy, I have, I know it’s not easy in this situation, you don’t have any job, I miss my family a lot, I’m the only girl....Yes but after I have my baby I’m much better’.

Her situation is not helped by the refusal of the government to grant her parents access to the country to visit her during this time. Although an older Irish couple who had befriended her write to the visa office inviting her parents to visit them for the birth, their request is denied. Amira talks at length about the shame she feels as an asylum seeker, how she hates lining up for food or welfare payments, and she is embarrassed when giving her address as she believes people do not trust asylum seekers.

‘They think everybody come here, just come here for food or for €19 to take from post office, my husband shamed to go to post office to take money, but he has to go, I remember the first time when we came here, all of us fighting, you go to the post office, I can’t go, I said I can’t go, I can’t go just leave it but you have to go, if you don’t go they don’t know you are here, you have to go, you write, you sign your name, you have to go every week, if you don’t go for 2 week or 3 week they stop that giving you. I don’t know everybody come here, every person, maybe some of them just come for better life in here but really I have a very good life in my country, really good life, I don’t want to tell here is not good, I know you are Irish, it’s your country and you love here but I can’t compare here with my country, I can’t really, everything is different for me, everything. It’s not easy being here, to come here, my husband in my country he was always busy, after he came here just to sit at home, do nothing, do you know it’s not really [inaudible 33.56] I try to keep myself busy in the crèche but for my husband it wasn’t real easy. I know it was so hard, he was so desperate but we can’t do anything, we have no choice. ‘

In this final scene both Scene: Agent and Act: Agency ratios are problematic, showing the complexities of her problems as she struggles as a new mother, with depression and loneliness and isolation and also the stigma and marginalization of bearing the label of an asylum seeker.

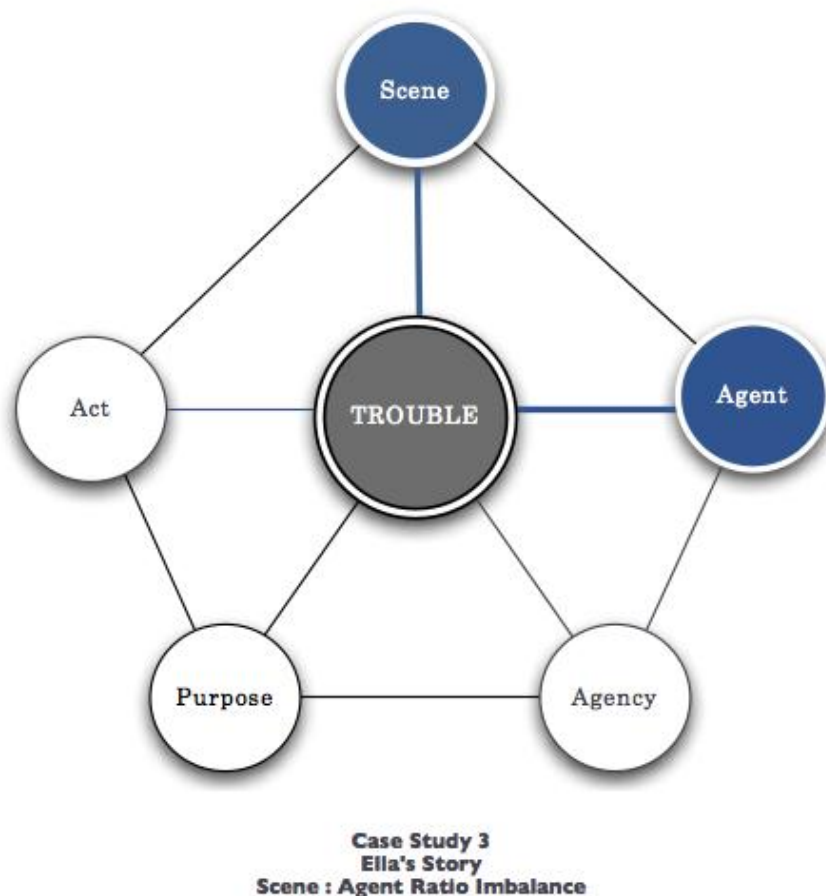
6.3 Ella's Narrative Summary

	Antepartum	Ratio Imbalance
Scene 1	E. was sent to hospital by her GP because her blood pressure was raised. She was living in a hostel in Dublin at the time and had two older children back in the centre.	Act: Agency Scene: Agent
	Postpartum	
Scene 1	When it came time to return to hospital she was afraid to go but she did it anyway. She was there for 28 days in total. It was very hard time for her and her children who didn't get to see her during this time.	Act: Agency Scene: Agent
Scene 2	She is afraid and intimidated by NICU staff. She spends her time crying, she believes her baby is going to die.	Scene: Agent
Scene 3	She makes a link with a local African church and they befriend her. They visit her at the hospital and help translate for her.	None Apparent

6.3.1 Ella's Story

Ella's baby was 18 months old at the time of the interview. She had been in the 'system' for a couple of years and had three older children. She is a single mother. This is Ella's first baby here in Ireland. While Ella speaks Portuguese and French she does not speak English. There are a total of four scenes in Ella's narrative. Two of those scenes have double ratio imbalances, which suggest complex difficulties for Ella on many levels. The most frequently occurring ratios are Scene: Agent (Figure 10) occurring in three of the four scenarios, followed by Act: Agency occurring in two of four scenes. The final scene has no ratio imbalance and therefore no apparent 'Trouble' in that scene.

Figure 6.3: Case Study 3 - Scene : Agent Ratio Imbalance



Ella, like many of the women I talked to, did not say very much about her actual birthing experience. There appears to be a number of reasons for this. Some women say they are

happy with their birthing experience compared to what they would have experienced back home. Some women feel safe in a hospital that offers technology should they need it, although many women express a fear of surgery and wish to try for a 'natural' birth. Lastly, and I would suggest most importantly, many of the women are completely traumatized by their journey to Ireland, they are terrified and feeling very vulnerable and so often have little memory of their actual labour and birthing experience as evidenced by their lack of memory of events or the lack of priority given to the childbirth experience when compared to other areas of concern. These may be pre or post migratory stressors such as day to day survival, concern for older children left in the care of strangers, or children left behind in the country of origin. Ella's memory of her birth is captured in a few sentences;

'...in the end I had to have a caesarean section and it wasn't easy at all. But in the hospital they really treated me very well. She said the day she was leaving she wasn't feeling well and the only abrupt lady she met was the day she was leaving and she asked her for something for pain and the lady said no, no you'll have to get out and buy something.'

Unfortunately this rude and abrupt treatment has been repeated in many stories in this study.

6.3.2 Antepartum Experience:

'I can't wait because I've nowhere to leave my children.'

Ella was sent into hospital by the doctor at her accommodation centre because her blood pressure was raised. She waited from 4pm to 7pm to be seen at the hospital. Her friend phoned the reception to explain that she would need an interpreter. At 10pm she decided to leave because she was tired and hungry and worried about her children when the lady called her back. Together with the interpreter and the doctor's letter they figured out what was wrong. She was told she would have to stay in hospital but she could not as she had no one to take care of her children. Overnight she found someone, a girl from Zaire, who agreed to take care of them and she went back in to hospital. She was there for 11 days and she felt nothing was happening. She was meant to be resting for raised blood pressure but she was woken every night by the woman in the next bed, but could not tell anyone because of the language barrier. She insisted on being discharged on December 24th to be with her children

for Christmas, and before discharge, a French doctor came to see her. When she explained she was not getting any rest at night, the doctor asked why she did not tell someone and she explained she could not because of the language barrier. The narrative is fraught with her anxiety over her older children, the communication barriers that meant she could not communicate her broken sleep every night due to the woman in the next bed. The frustration and contradictions in being forced to 'rest' in hospital and getting more worried and exhausted by the day are apparent in double ratio imbalances of Scene: Agent, the detrimental effects of the environment or Scene on Ella as the Agent. The Act: Agency ratio imbalance, brought about by her hospitalization and lack of rest, is also apparent, once again illuminating the complexity and chaos of the experience.

6.3.3 Postpartum Experience:

'...everything was strange to me then, it was very difficult and you know I just couldn't communicate; it was very difficult to communicate..... I felt a great sadness, a very big sadness.'

When it came time to return to hospital Ella was afraid to go but she did it anyway. She was there for 28 days in total. It was a very difficult time for her and her children who did not get to see her during this time. Eventually she had a caesarean birth as they could not control her blood pressure and the baby had intra uterine growth retardation. Her baby was in the neonatal intensive care unit (NICU) in an incubator and she could not communicate with the staff. She was frightened and intimidated and did not know what was happening to her baby or how he was doing as she couldn't communicate with NICU staff. She tried to ask a nurse on the unit to call her friend so she could interpret for her but the nurse refused;

'I asked them in the hospital to ring my friend and explain to my friend so that she could explain, she [nurse] said no, no they hadn't money for that but if she [Ella] put money on her mobile and rang her friend and then gave it to the nurse she could explain to her. She said they could have done better because everything was strange to me then, it was very difficult and you know I just couldn't communicate, it was very difficult to communicate'.

The lack of insight, ignorance and outright lack of empathy in this scene is shocking, more so given that Ella's baby was so ill and she was desperate to get information on the baby's condition. Again the depth of 'Double Trouble' is starkly evident in the double ratio imbalances of Act: Agency and Scene: Agent.

In the next scene Ella is understandably afraid and intimidated by the NICU staff. She spends her time crying, and as she has no way of knowing how her baby is doing. She believes at this point that her baby is going to die. In her desperation she manages to get a phone call between her friend who can interpret and an NICU nurse. The nurse begins to understand her situation and shows her kindness. The nurse takes her by the hand and shows her photos on the wall of babies worse than hers who progressed and made full recovery. This helps her to have hope and her outlook becomes more positive. Her baby does improve and now is 'big and he is great'. I am struck here by Ella's gratitude to the nurses who showed her some kindness, but only when she could get enough credit on her phone to make a call to a friend who could translate for her, alerting the nurse to her complex situation. It may have been kindness but it was at Ella's expense in more than monetary terms. The Scene: Agent imbalance highlights this incongruence.

Ella experienced great distress during the time her baby was in the NICU, because of her language difficulties and the staff's inflexibility and lack of empathy.

'.... in spite of my distress and, I had now got hope that he would recover. And now he is big and he is great'.

Ella also made special mention of a young French midwife she met on the labour ward who came to visit her on occasion. Sometimes on her day off she would come in to visit with Ella and update her on the baby. Ella tried to explain how she felt when some staff were offended because she could not speak to them or understand what they were saying;

'It was very difficult ... it was really difficult when I couldn't talk. Some of them were, you know hurt when she didn't speak the language, when she couldn't express herself, made it very difficult, yes it was. The most difficult were the first days when I was there. She said I didn't have a friend I could ring and I'd nobody to ring to ask. She said I couldn't communicate with anybody'.

In the final scene, Ella meets some African ladies in the post office. They are all linked with a local African church and they befriend her. They visit her at the hospital and help translate for her. The ladies from the church visit her on Tuesdays, Thursdays, and Sundays, and so on these days she gets information on her baby's progress. They would tell her how the baby was, when he was good and not so good '*...that was her salvation*'. The absence of ratio imbalance in this scene illustrates the cohesion and flow of a story with a good outcome where the pentadic terms were in balance. As discussed in the previous chapter, when there is no apparent ratio imbalance, the story turns out as one would expect given our understanding of what constitutes ethical practice, or morally acceptable behaviours, including respect and dignity for others.

Ella's story was told in Portuguese and translated into English at the time of the interview by an interpreter. The interpreter, who was a senior health care provider, had known Ella for a number of years and had made some mildly disparaging comments about her before the interview, for example, that her accommodation was chaotic and there were men coming and going from her place. I struggled with my own apprehension as we walked down to her room, wondering if this was going to work out and yet knowing how difficult it would be to get a different interpreter, also aware that Ella had given consent to work with me and the interpreter ahead of time. When we arrived at Ella's room we found her baby sleeping peacefully, everywhere tidy and no evidence of any other people around. Ella appeared to me to be a kind and caring woman and willing to give of her time to talk about her experiences. I was not prepared for the effect her story had on the interpreter. At the end of the interview the interpreter visibly moved by what she had heard said, 'I have known you all these years Ella and yet I never heard your story until today.' She thanked Ella and seemed to have shifted entirely in her views of Ella. To me this was a testament to the power of narrative. The interpreter hearing Ella's story appeared to shift in recognizing her as like herself rather than as 'other'. Hearing Ella's story told first hand in this way appears to have enabled the interpreter to empathise with Ella in a way she previously had not been able to. However, while I was delighted that Ella's story had impacted the interpreter in a powerful way, it left a bitter sweet taste in my mouth as I thought of all the other stories waiting to be told, some perhaps that would never be told.

Table 6.4 Fola's Narrative Summary

	Antepartum	Ratio Imbalance
Scene 1	She is 26 weeks pregnant and the woman calls an ambulance and she is taken to hospital.	Act: Agency Scene: Agent
Scene 2	She is admitted to hospital as she is threatening pre-term labour. She is bleeding badly, and told that because of the baby's weight it may not live.	Scene: Agent
	Postpartum	
Scene 1	Having given birth to her daughter the day she arrived in Ireland, she is discharged from the hospital on the following Monday without her baby who is in NICU. <i>'That was the most painful day of my life, leaving the hospital without going with a child, leaving my baby behind and nobody to go to, nowhere to go'</i> .	Scene: Agent
Scene 2	Baby is discharged home with an apnoea monitor, but Fola is scared to leave him. Bathroom and shower are public shared with 30 others and means she has to leave the baby alone in the room if she needs to use the bathroom.	Scene: Agent
Scene 3	She is transferred across the country with one night's notice despite having an appointment with the baby's paediatrician the next day. Three months later, she is still waiting for the baby's files to be sent to new address and for an appointment with a new consultant paediatrician.	Scene: Agent Act: Agency
Scene 4	F. is transferred to Galway. The hostel is overcrowded; she is forced to share a small room with another mother and baby.	Scene: Agent
Scene 5	Professionally educated and a writer, F. is frustrated that she is not allowed to work and cannot write as she has no access to a computer.	Scene: Agent

6.4 Fola's Story

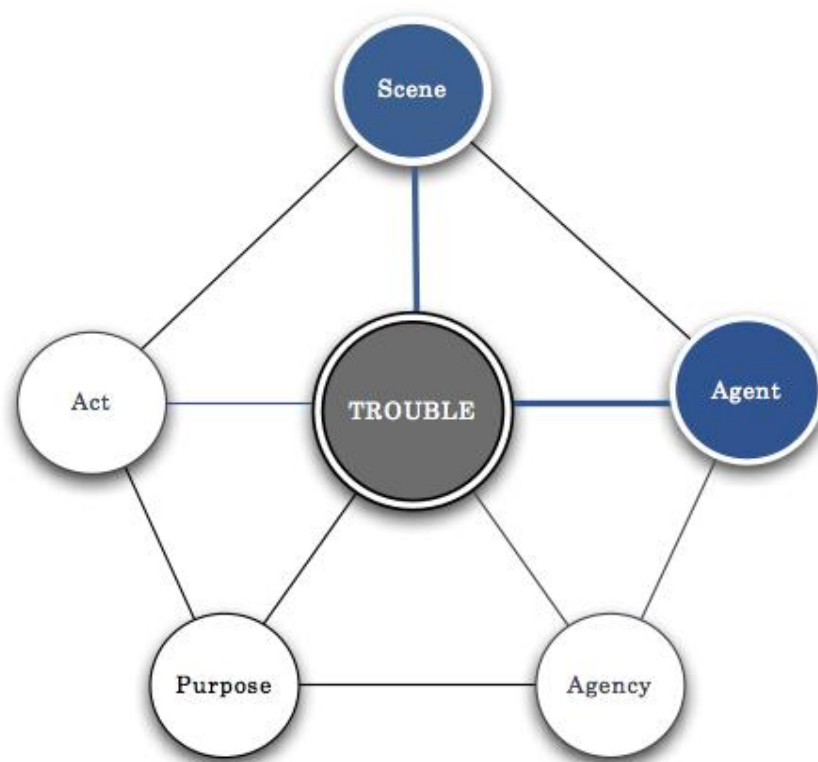
I first met Fola (pseudonym) when I was giving a general information session about my research to women in a newly opened accommodation centre. The women had arrived just days before, sixty of them transferred from various centres in Dublin to the West of Ireland as part of the government's policy of 'dispersal'. The 'dispersal' policy, as it is referred to in official documentation, is designed to insure that asylum seekers are not all concentrated in the capital but are located throughout the country. Women are usually given notification that they are 'on the list' to be transferred but never know the actual day or time until late, usually around 9pm the night before they are transferred. The way this policy is implemented causes untold additional stress to the people affected by it²⁰. The centre these particular women were sent to was very chaotic in those first weeks. Women reported fighting and arguments in the reception area on a daily basis for the first weeks while communication issues were addressed. There was severe overcrowding, two women and babies typically to one small room. The centre had been a hostel-type business hotel and the rooms were small for one person. The women were strangers to each other and yet were expected to live in extremely confined space together. There were also some families there and many men. There was a general feeling of unrest, in those early days, and also heightened stress and anxiety evident in the women who were struggling to re-adjust to another new, foreign environment.

Fola came to the information session and was almost hostile towards me in that first meeting. She was suspicious of my motivation and expressed her feelings openly to the group.

²⁰The government policy of dispersal was introduced at the same time as direct provision in 2000. The rationale behind forced dispersal of asylum seekers is to share the burden of resource capacity and administration (Mbugua 2010). Women in this study reported being transferred up to six times, often crossing the country on several occasions and each time having to start from scratch with building community and settling into a new area. The way in which the dispersal policy is carried out is also problematic. Women are usually told they are 'on the list' to be moved but usually the list of names is not posted until late the night before dispersal is due to take place. This gives people usually just a matter of hours to gather their things together before they are transported often to the other side of the country. The policy of dispersal of people who have lived for months or years in a particular location is utterly detrimental to their wellbeing, their ability to settle and to build social relationships, relationships that are crucial to mental health and wellbeing (Steward, R. (2006) Steward, R. The Mental Health Promotion Needs of Asylum Seekers and Refugees: A Qualitative Study in Direct Provision Centers and Private Accommodation in Galway City. Galway City Development Board. Health promotion Services, HSE West, Ryan, D.A., Benson, C. & Dooley, B. (2008) Psychological Distress and the Asylum Process: A Longitudinal Study of Forced Migrants in Ireland. *Journal of Nervous & Mental Disease*, **196**(1), 37-45..

However, once she was happy that my credentials were checked out by their residents' representative²¹ she agreed to participate. Over the last couple of years, we have formed a kind of fragile friendship, made difficult by numerous barriers but a friendship none-the-less. Fola was an educated and articulate woman. She has a degree in business administration and a master's degree in management and is a writer. Her background in her country of origin in Africa had been in banking. She left the country under threats to her life because she had sued the bank officials for unfair dismissal as they had fired her because of corruption she had uncovered. She described starting from scratch as a teller in the bank and quickly working her way up to branch head which was when the problems began for her. When she started having threats on her life, she left her two older sons back in Africa with family members and travelled alone to Ireland. She came to Ireland because she felt she would be safe as the bank had no branches here and she had heard that Ireland was a good country in which to live.

Figure 6.4. Case Study 4 – Scene : Agent Ratio Imbalance



**Case Study 4
Fola's Story
Scene : Agent Ratio Imbalance**

²¹The resident's representative is elected by the residents of the accommodation centre to liaise with the centre's management on their behalf. The representative understandably holds a level of respect and trust and it is therefore crucial that I satisfy her as to my credentials, and credibility as gaining her trust and respect is key to gaining the trust and respect of the residents she represents.

Fola was 26 weeks pregnant on arrival to the country and went into pre-term labour on arrival to Dublin and was taken by ambulance to the nearest maternity hospital. The opening antenatal scene reveals Act: Agency and Scene: Agent imbalances (Figure 1) as she is exhausted from travelling, it is late at night and she is scared and alone. She is left waiting in the hospital reception area for a long time.

‘...when we got into the hospital I expected that one would be attended to immediately first, you know, because I was bleeding, but then I was first of all left in the reception area for long time and the pain was so much ...nothing to eat and nobody to even bring me food, I was so hungry then you know and I didn’t eat anything all through the night ...’

Hospital staff did not know she had literally come from the airport and ask her for insurance information and other documentation which she did not have. They took swabs and did numerous tests but never told her what they were for and she never gets told any results. In the second scene Fola describes how the staff tried to prevent a pre-term birth,

‘...they called in so many people, so many different kind of doctors and they were also trying to explain to me that [inaudible 9.52] and the baby may not live because of weight’.

Eventually she is bleeding so much she has to have a caesarean birth. The baby is 750 grams and the smallest thing she has ever seen in her life. The baby is in good condition and is transferred to NICU.

In the first postnatal scene, Fola describes the pain of leaving the hospital without her baby. The Scene: Agent imbalance is apparent in her (Agent) loneliness and isolation against the backdrop of her baby being in NICU and her travelling to and fro from her solitary existence in the hostel, (Scene).

‘...she was in the incubator and she was in the hospital for 4 months you know. But I was discharged, I had her on Friday and I was discharged on Monday that was the most painful day of my life, leaving the hospital without going with a child, leaving my baby behind and nobody to go to, nowhere to go’

The hospital social worker explains she must register with the Department of Justice, and she is given accommodation in a hostel in the city. She describes how she leaves the hostel early every morning and goes to the NICU until late at night. She talks about her helplessness when the baby would stop breathing and how the nurses were very nice and took good care of the baby. But she also refers to the loneliness of being on her own with her baby sick in NICU:

‘It was hard, very, very hard, it was very hard, most nights you are so alone, nobody to assist you, most times I just sit by her, you know in the hospital and I weep and weep and weep. Then later one of the nurses would just call me and talk to me, Fola you have to be strong for the baby, you have to be strong for her, you have to take care of yourself for her. And then, from then when I come in and I will sing to her, I will talk to her, I will call her name, I will sing to her, talk to her, talk and talk and talk for hours, you know or leave her to sleep or sing to her, talk to her, just as if she can hear and respond to me gradually like that.... and she did, it got to a time that when I come in and I say hello she just would open her tiny eyes to see that this voice is here again’.

The trouble escalates when the baby is discharged home to the hostel with an apnoea monitor. The room is upstairs away from the dining room and laundry and the only bathrooms are outside in the corridor so Fola must leave the baby alone in the room as she cannot take her into the bathroom. She describes the stress of this, that means she is missing meals and afraid to shower in case the baby stops breathing when she leaves the room. Once again the Scene: Agent terms are the noted imbalance in the narrative.

‘And then the hostel that we were in, the toilet - there was no toilet in the room , you have to go to the house toilet and have to lock her alone in the room because I cannot take her to the toilet, about 30 people were using the toilet, about 30 people were using the bathroom, we share it, if I don’t go very early then the water would get cold and when I’m leaving, I have to leave her in the room alone, a baby that came home with a monitor, a premature baby. And I was afraid, the laundry was downstairs, the dining room was downstairs and I cannot carry her like that with the monitor, so sometimes it was a lot of stress for you. I have to miss meals, I don’t eat and for me to take my bath, I’m always afraid, I go in to take my bath and the monitor is on and I don’t even know that she’s stopped breathing....’

Eventually with lots of complaining she is transferred to a self catering room in the hostel that makes it easier for her to function and monitor the baby safely. She feels happier that she has this new accommodation and it is not too far from the hospital, as she has numerous follow up visits with the paediatrician.

The next scene Fola describes is being transferred across the country with one night's notice despite the fact that the baby had a follow up appointment with the paediatrician scheduled for the next day. Her doctor back in Dublin calls her to ask why she missed the appointment and is angry that she has been transferred and asks her to come back to Dublin to have the baby seen. She explains that she is not allowed to travel back for appointments and must wait for a referral in Galway. Three months later, she is still waiting for the baby's files to be sent to her new address and for an appointment with a new consultant paediatrician. The Scene: Agent and Act: (transfer) Agency (without sufficient notice and no follow up) show the level of disharmony evident in the narrative as a result of this inappropriate transfer.

In the last two scenes the Scene: Agent ratio imbalance (Trouble) occurs again and again, highlighting the difficulties the environment (Scene) is having on Fola (Agent). Fola talks about the difficulty she is having readjusting once again to life in a new environment. She struggles with the overcrowding and having to share a small room with another mother and baby. She has no freedom to bathe or sleep. When she has a migraine one night, her roommate is watching TV until 1am, but Fola feels she cannot ask her to turn off the TV and suffers in silence.

'... the whole place is full though and even health wise, it's not even good for the babies, when one baby is coughing the other one starts to, all through the night, you don't even get to sleep, when one baby is crying the other one wakes up, you know, the other one wakes up and you sit all through the night, you don't even have to sleep, you don't get good night rest at all...'

Although professionally educated and a writer, she has no access to a computer. She is bored and frustrated and feels like she is wasting away with the boredom and stress of aimless days with nothing constructive to do.

‘...not allowed to do anything, even when you know you can do something, even when you know that you can be of relevance to the society, but yet you are not allowed to do that, you know, it’s like we are wasting you know. If you can be given an opportunity you know to just contribute to the society, it’s better than just sitting down here sleeping away, you know day out, day in you know....’

I last saw Fola in January 2010, she is still at the same centre and still waiting for progress on her case.

Table 6.5 Isobel’s Narrative Summary

	Antepartum	Ratio Imbalance
Scene 1	She is feeling the loneliness of having no friends or family support in Ireland, feeling scared and isolated.	Scene: Act
Scene 2	Admitted for hypertension and awaiting news of a decision regarding her delivery. <i>‘ You don’t know when you are going to have your caesarean because, I mean you know eventually you will have one, whether you want one or not... ’</i>	Act : Agency
	Intrapartum	
Scene 1	She is in recovery following Elective caesarean section under epidural.	Act: agency Scene: Agent
	Postpartum	
Scene 1	On the postnatal ward one midwife stood out as being supportive	None Apparent
Scene 2	She is admitted again with hypertension. She has to leave her older son who is under two, with a stranger.	Act: Agency Scene: Agent
Scene 3	Following the birth of her second child she is transferred from Dublin to Kerry, three days post discharge following a caesarean section. (approx. 5 hours travel time). She had to pack all her own things and carry all her stuff, baby, buggies...	Scene: Act
Scene 4	Challenges of living in the compound	Act: Agency
Scene 5	Expresses fears about losing friends when they get their ‘papers’.	Scene: Act

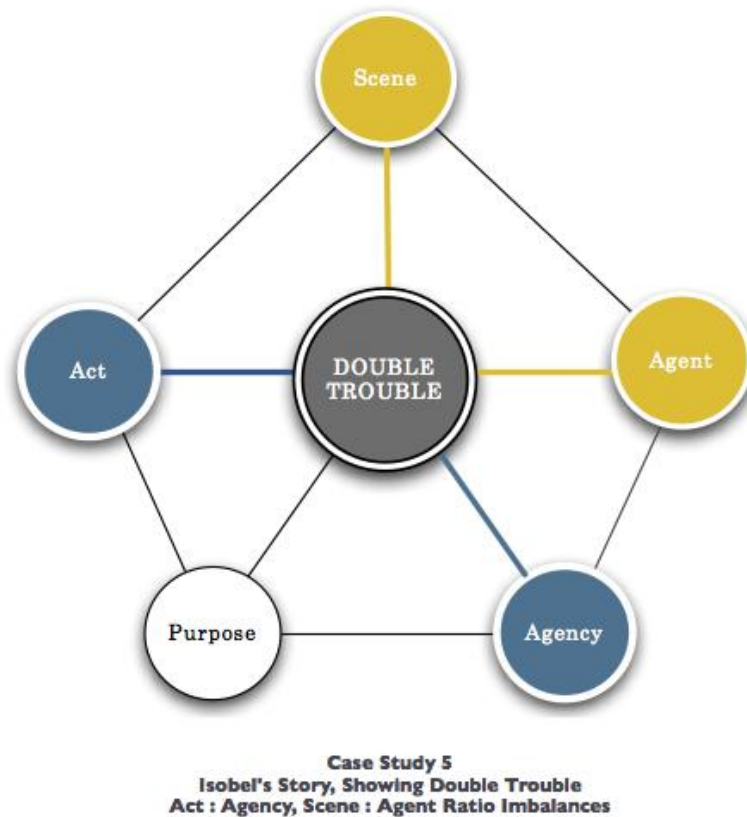
6.5 Isobel's Story

Isobel is a South African woman in her thirties; she had been in Ireland for three years when we met in 2008. She is here with her husband and has had two children here. Her second child is 14 months at the time of the interview. She is anxious and depressed when we meet, very tearful, and while she expresses gratitude for all she has been given in Ireland; shelter, food, she talks at length about the difficulties of bringing up her children in 'direct provision', her worries about the future, whether their case will be successful or the consequences of being sent back for them as a family. She laments that lack of friendship and family support and talks of the difficulties of building relationships with other asylum seekers. She feels people have so many of their own worries and fears, and difficulty trusting others; it is hard to make friends. She says once people get their 'papers' they leave the centres and never look back, they put that period of their lives behind them and the relationships they made there too. This seems to be a source of great sadness for her, and she cries a lot during our interview. She describes the difficulties of those first days in Ireland when she was living in a hostel and travelling to the hospital for antenatal care. She says she had high blood pressure and protein in her urine and found trying to learn her way around the city difficult.

'... so you had to travel with a bus to make an appointment to the hospital so that part was not easy because you were tired, you were scared because you don't know the busses, you don't know the roads and then I found out that I have high blood pressure and protein in my urine and things., so also in and out, in and out of hospital.'

There are a total of eight scenarios within Isobel's narrative. The most frequently occurring ratio imbalances are Act: Agency, the imbalance between what was done (Act) and how it was done (Agency). There are two incidences of Scene: Agent imbalances, showing trouble between the context of the act or general environment and the impact on the agent, in this case Isobel. The further two Scene: Act ratios highlight dissonance between the scene or context, and what was done, the act. There are two examples of double ratio imbalances (Figure 12) in Isobel's narrative with both Act: Agency and Scene: Agent being the imbalances noted.

Figure 6.5: Case Study 5 - Double Trouble - Act : Agency & Scene : Agent Ratio Imbalance



6.5.1 Antepartum Experience:

‘Because it didn’t seem as if the staff members ...really understood that you’re alone.’

In this first scene Isobel has had an antenatal admission with protein urea and raised blood pressure, she is feeling loneliness of having no friends or family support in Ireland, feeling scared and isolated. She has to ask for money from social services for baby clothes and other items. She has been referred to the social worker by midwives at the hospital because she needs money to prepare for the baby and for day to day living costs in hospital.

‘No visitors, nobody to visit or just come in and say ‘Hi’. And that’s the part that is really difficult because it didn’t seem as if the staff members that was there really understood that your alone and you're not there because, well you want to be there, you there because of a fear of

something [Crying]. They really don't understand that you don't want to be dependent on them; you don't want to ask them for things because I had to see the social to help me arrange for clothes for my child [Crying]. ‘

The ratio imbalance in this Scene is between the Scene (in hospital, no support, lonely and scared, feeling like a burden to staff), and the Act (of having to ask for money from the social worker).

The second antepartum scene centres on Isobel's anxiety about her birth. Feeling like a caesarean birth is inevitable, yet getting conflicting advice regarding her baby's condition and how/when she will 'be delivered'. The sense of disempowerment and lack of any decision making on her part is evident. She is at the mercy of a team of doctors who apparently cannot decide how or when she will 'be delivered'. There is no sense of Isobel having any active part in the process what so ever. The Act: Agency ratio imbalance speaks to this incongruence.

6.5.2 Intrapartum Experience:

‘... we are also human beings’

In the intrapartum scene, Isobel is in recovery following elective caesarean birth under epidural. She wants to breast-feed her baby but there is no one to help her, and because she is numb from the epidural, she cannot get the baby herself. She desperately wants to feed her baby but cannot. She feels the hospital staff see her as a burden and, she experiences the lack of support and understanding as a dehumanizing process.

‘I just wish people can explain to the staff member that is at hospital that we are also human beings, we don't want to be there because we want to be dependent on the government or the social, because we don't. If we have friends that can come in and bring us our things we will be happy to do that, it's just we don't have that family unit that we can rely on’.

The double ratios of Act: Agency and Scene: Agent draws out the complexities of the trouble in this scene.

6.5.3 Postpartum Experience:

‘... she really did care, at least that is what it felt like...’

Isobel remembers one midwife that stood out for the kindness she showed. Isobel’s description of this one caring midwife is in stark contrast to the many other memories of indifferent and uncaring encounters.

‘I don’t know, when she was on duty she would just come to you and she will ask, like I said she will ask you if you need something, if you’re ok, do you need anything, can I do anything for you, she just said that little extra and it was not as if it’s her duty to do it, it’s as if she really enjoyed doing, being there and being able to help. Yeah she really did care, at least that is what it felt like, even maybe she didn’t really but that is what I felt like, she really was, for some of them it’s just as if they can’t get away fast enough, they just want to get it over with, but with her she will take time and she will hold your hand and say don’t worry, everything will be ok, it will be over soon, she was very good..’

This scene where the midwife is kind and caring shows no ratio imbalance as there is a balance and cohesion between the pentadic terms.

In the final three postnatal stories the recurrent themes of poor care, difficulties with being transferred with little notice three days post discharge after a caesarean birth and her worries and concerns about life are worked through. The recurrent imbalances of Scene: Act, Scene: Agent and Act: Agency work to illustrate the difficulties she experienced. I include a final quote from Isobel’s narrative transcript as I feel it sums up her frustration and fears.

‘Maybe they can just educate the people more about asylum seekers and not having the support, maybe give them just a little bit, not much but just that little extra support. We don’t want them to be there next to us 24/7, it’s just come and ask us do you need anything, can we do something for you because sometimes we will feel too ashamed to ask for help [Crying] because we don’t want to be a nuisance or we don’t want to stop the people from their work or interfering, I don’t know how to explain it exactly in my language..’

6.6 Conclusion

In the course of this chapter I have endeavoured to describe the childbirth narratives of asylum seeking women in Ireland. I have sought to do this in three ways, by providing an analysis of antepartum, intrapartum and postpartum narratives in the form of summaries, highlighting the most frequently occurring ratio imbalances and providing extensive excerpts from the original transcripts to illustrate the ratio imbalance or 'Trouble' in the narrative.

I have presented five case studies to provide a more comprehensive insight into these women's childbirth experiences and to facilitate a greater understanding of the challenges and complexities of the women's lives in general. I have included as an appendix the narrative summaries of all of the women's stories included in this study, showing the application of Burke's (1969) dramatic pentad with Bruner's (1990) 'sixth element of trouble' (appendix XVII).

These stories raise many questions, questions about our understanding of what culturally sensitive care in childbirth actually means. They raise questions about choice, continuity and control for asylum seeking women as they attempt to access our maternity services. Examples of racism, marginalization, bigotry and ignorance are rife in the women's stories in this study.

The impact of migration is seen on women in the high levels of maternal and neonatal morbidity starkly evident in this study. Issues related to mental health are visible as many women speak of the loneliness and isolation, the terrible loss of spouse, children, family and friends, of their former lives and everything that is familiar to them. The stories show many women coping with the effects of violence, brutality and fear related to their reasons for leaving their own country. The loss of their sense of self as they spend long days, weeks, months and years in enforced unemployment. The humiliation and indignity of living in the direct provision system is apparent, while many women still insist they are grateful for the shelter it provides, the cost of that safety is extremely high. The impact of contemporary 'obstetrics' seen in the incredibly high levels of intervention and the

impact of this on women who are not accustomed to technological models of childbirth is vividly portrayed. The inadequacy of the Irish maternity system is also apparent on many other levels. The lack of health provider communication skills that has been shown to prove nearly fatal in so many of these women's stories is to my mind criminal in the twenty first century in a 'developed' country. Finally the dehumanizing process that is the asylum seekers life sometimes for years on end is shown in its bleakness, lack of compassion and absence of due diligence in many of the stories told here.

In the final chapter I will explore these issues in depth, in order to highlight the implications of these powerful stories for childbearing women seeking asylum in this country, for the health care providers who are charged with their care, and for future maternity services in Ireland.

CHAPTER 7

Hearing Women's Voices

7.1 Introduction

Narrative analysis using Burke's dramatic pentad clearly highlighted problematic elements of women's experiences of childbirth in Ireland. The large amounts of data generated from twenty-two in-depth unstructured interviews was challenging in terms of how best to represent the findings. The narratives were considered under three headings of antepartum, intrapartum and postpartum experiences. Five case studies were also presented. This had both positive and negative effects. Placing the narratives under three headings meant the main issues emerging from the women's stories could be easily visualized with the use of a table (Table 5.1, 5.2 and 5.3). It was also a practical solution to the problem of representation of copious amounts of data; ideally case study representations of each narrative would be optimal but not practical for a PhD thesis, because of word and deadline limitations. The constraints of this solution were the further fragmentation of the women's stories under the three headings, yet it is still possible to see the continuation of individual narratives if the three summary grids are viewed together.

In this chapter I intend to revisit the main findings as highlighted by the most frequently occurring ratio imbalances as they emerged from the application of Burkes' dramatic pentad, that is-, the structural analysis of the narratives. The ratio imbalances brought to light a number of issues for discussion. For example, issues such as language barriers, lack of trained interpreters, poor communication, increased maternal and neonatal complications, problems with childcare of older children when the mother was hospitalized, experiences and perceptions of racism, feelings of loneliness, isolation and fear. Other issues included anxiety about the future, extreme challenges of living in direct provision accommodation and the negative consequences of the dispersal policy.

Issues related to the fear and lack of understanding of a technological childbirth model, increased health challenges, especially related to mental health, such as increased anxiety and depression. Also the boredom and lack of stimulation as a result of barriers to work, education and meaningful integration into the community were identified as problematic.

The number of maternal complications experienced by asylum seeking women was fifty per cent of the participant group. Eleven out of twenty-two women experienced complications. These included two cases of diabetes, two antepartum haemorrhages, one case of shoulder dystocia, and one woman had sickle cell anaemia. There was one case of Hepatitis B, and one case of leukaemia. Two women had retained placentas, two women had raised blood pressure, and one woman had complications associated with female circumcision. Five women experienced pre-term labour. Two babies had a prenatal diagnosis of hydrocephalus although one case appeared to be a misdiagnosis. Twelve of the twenty-two women had vaginal deliveries, five had caesarean sections and five women did not state their mode of delivery. There were two inductions of labour and one vacuum delivery. Nine out of twenty-two infants were admitted to NICU.

Providing a 'list' of issues like this whilst it may be useful as an overview cannot convey the depth of emotion behind every 'issue' identified here. It is only in the voices of the women themselves that we can begin to gain any insight into what it is like to experience these issues in reality. Therefore each issue will be considered in turn, in the light of other research findings and using excerpts from the transcripts to illustrate the women's experiences where appropriate.

7.2 Telling better stories: Strengths and limitations of the study

The study provides but a brief snapshot into the childbirth experiences of twenty-two women who gave birth while seeking asylum in Ireland. The

challenges of speaking about childbirth experiences with women recently traumatized by pre and post migratory stressors meant that sometimes the focus of the interviews was less about the women's experiences of accessing and availing of the maternity services and more about the flight from home, the reasons why they left and the challenges of their lives in Ireland. In this way, some of their childbirth narratives were fragmented and it was necessary to piece together the lived reality of a childbirth experience in exile. However, the aim of the study was to explore the physical, emotional and social experiences of refugee and asylum seeking women during pregnancy and childbirth in Ireland, and in so doing to gain insight into women's experiences of birth, to hear through the voice of the women their first-hand accounts of what giving birth in Ireland is like for women who are also seeking asylum here. This study has provided that insight, as women shared their stories; we have been given an insight into our maternity services from the perspective of asylum-seeking women. This perspective of a marginalized group has enabled us to see a picture of maternity service provision from the viewpoint of women seen as 'other', a position that feminist scholars view as privileged in its ability to focus a critical lens on hegemonic practices often invisible to providers who participate in and often perpetuate them. The emerging picture is a challenging one for maternity care providers in Ireland who are committed to providing a quality service that is women centred and accessible to all.

7.3 Birth Experience in Ireland compared to country of origin

Many women in this study described their childbirth experience in Ireland as compared to their country of origin as more positive. Women described barriers to care particularly in parts of Africa as being predominantly financial. Women feared going to hospitals because the treatment they received in their own countries had been brutal. In comparison many women talked about the care and attention they received here as being very good. Women were impressed at the standard of care they received and most women expressed deep gratitude for this care and shelter. Women were grateful for the kindness of many of the staff

they encountered here and for the embrace of those many local Irish people who befriended them. While the following discussion appears to focus on the negative aspects of the women's experiences in Ireland and it is necessary to do so, it would be an incomplete picture without also acknowledging the excellent care some women received. There were many incidences and evidence of genuine compassion, and woman-centred care experienced by individual women. I know the women who took part in this study would want to acknowledge the kindness, compassion and commitment of some truly excellent practitioners they encountered here.

7.4 Language barriers, use of interpreters and effects on communication

Language and communication barriers have been described as having detrimental effects on the health and well-being of ethnic minority women in several qualitative British studies, McLeish (2002a), Ukoko (2005), Jentsch et al. (2007), Briscoe and Lavender (2009), and one U.K. national survey (Raleigh et al 2010a). These barriers were also noted in the first ever Irish study into the maternity care needs of refugee and asylum seeking women in Ireland (Kennedy and Murphy-Lawless 2003). Barriers to communications were widespread in the women's accounts. Communication issues were apparent across educational levels and fluency in English, although the most worrying examples of poor communication occurred when women had no English language and were entirely reliant on interpreters. From the stories of the women in this study, the interpreter service appears to be a scarce resource, with restricted accessibility because of cost issues. Access to the interpreter service seemed to be on an ad hoc basis. There was difficulty gaining access to interpreters when needed and at other times it appeared staff did not call for an interpreter or 'rationed' interpreter services because of the expense incurred.

A recent qualitative Irish study by Lyons *et al.* (2008) into the experience of maternity care providers when caring for ethnic minority women, reported that communications issues were the most common difficulty identified by health

care workers. Despite this concern Lyons *et al.* found that the interpreter service was inadequate, with many health professionals concerned about professional standards of interpreters currently in use. There appears to be no standardized approach to accessing interpreter services, especially out of hours. This leads to inappropriate reliance on staff members who speak the language in question, as and when they are available, or relying on family members or friends often speaking on mobile phones. All of these practices have been highlighted as inadequate and inappropriate and not in line with current international best practice (Women's Health Council 2006). Jentsch *et al.* (2007), in a critique of existing international guidelines intended to address inequalities and outcomes for migrants, asylum seekers and refugees, highlight that poor communication between the woman and her provider can lead to a mismatch between needs, expectations and availability of services that lead to poor outcomes for ethnic minority women. Some of the women in this study had specific education needs, with one woman not being able to read or write and not having English as a first language. A recent UK national survey that examined the ethnic and social inequalities of women's experiences of maternity care found that ethnic minority women, single mothers, and those with an earlier age at completing education have poorer outcomes and report poorer experiences across a number of dimensions of maternity care (Raleigh *et al.* 2010b). Good communication is central to effective care on many levels. Communication impacts women's access to maternity services and their ability to fully participate in their care. This has implications for informed consent and increased levels of fear and anxiety experienced by women as the avail of maternity services. High levels of fear and anxiety apparent in the intrapartum accounts bear witness to the inadequacy of communication between women and providers. Poor communication has been linked to more complex issues of over-worked staff and inadequate intercultural training which can lead to bias and ignorance (Lyons *et al.* 2008). This is evident in the accounts of harsh and inhumane treatment of some women in this study. Various accounts of neglect led ultimately to increased complications either for the mother or baby as evident in at least three clearly articulated scenes. One, where a baby needed transfer to

NICU following a dangerous drop in blood sugar as a result of a midwife's refusal to give a mother bottle milk, another where an umbilical cord snapped as a result of a doctor's rough treatment, that necessitated a surgical removal of placenta (this doctor also verbally abused this woman during her labour). Finally a woman who described being neglected by the midwife taking care of her, apparently because the woman was too demanding and the midwife too busy; this resulted in a postpartum haemorrhage going unnoticed and the woman needing a blood transfusion. The experiences of the women in the study are not unique as evident in the findings of other Irish studies referred to above. However, the issues are a product of a much greater and more complex problem in our maternity care services. The dominance of the medicalised model of 'active management' that is based on throughput of large numbers of women rather than on a quality service that is tailored to the women's individual needs simply cannot meet the complex needs of asylum seeking women in particular as indeed it cannot meet the needs of all Irish child bearing women (Kennedy and Murphy-Lawless 2003, Kennedy 2010).

The Irish maternity service has been shown to be in crisis for many years now and, while change is occurring slowly, it would appear that the recent downturn in the economy brought to a halt plans for improvement of the service and increase in choice for women accessing the maternity services in Ireland as reported in the media (Burke 2008) and in the academic literature (Kennedy 2010). Staff in a study undertaken by general practitioner Hans-Olaf Pieper and colleagues entitled 'The impact of Direct Provision Accommodation for Asylum Seekers on Organisation and Delivery of Local Health and Social Services: A Case Study' and funded by the HSE Primary Care Department, have acknowledged the need for intercultural training (Pieper *et al.* 2009), but it remains to be seen if adequate investment will be made in this crucial area. Women who are identified as having multiple needs must have access to a maternity service that is cognizant of their complexity.

7.5 Loss, Isolation, Loneliness and Depression

In a recent Irish study, risk factors for psychological distress were identified as female sex, an insecure legal status, and separation from children, discrimination, and post migration stress. Protective factors include social support, and the presence of a partner (Ryan *et al.* 2008). Experiences of loneliness and isolation were universal in the women's accounts in this study. Every woman expressed feelings of loss at some level. For many women loss of everything familiar, of home, of family and friends was key. Partners, mothers and older children were especially missed around the birth of the baby. Many women expressed feelings of isolation when hospitalized; anxious about their condition, often worried about children left behind in their country of origin or of children left in the care of strangers either at the hostel or in state provided foster care. Women expressed concerns about depriving their babies of the love of the extended family. There was a lot of concern about lack of support in the postpartum period. For many of the women in the study the norm in the postpartum period is to have an enormous level of family support. Extended family members take care of older children; cook the family meals, do laundry, shopping and cleaning, essentially allowing the new mother to rest and breast feed. For many of the women in the study this loss of family support following the birth of their baby was a huge source of stress and anxiety. This was especially evident where women had a caesarean birth. Women spoke of the difficulties of having to do everything themselves without the support of their families, this strain was exacerbated by living in direct provision where there are set meal times, and often inadequate and inappropriate foods available. There were many expressions of the pain and isolation of having no one to visit when a woman was hospitalised, in some cases for extended periods of time. Women described their longing for expressions of love, of empathy and understanding and the loss of having people to share the joy of the birth and admire their babies. One woman was so desperate she went to Boots department store regularly just to walk around because she found women would stop and talk to her and admire her baby. It is in fact difficult to convey the depth of loss expressed by the women in this study. Sr. Breege Keenan (2008), writing for

Metro Éireann, articulates the level of loneliness experienced by asylum seekers as a kind of spiritual poverty with loneliness and the feeling of being unwanted as the worst kind of poverty. Also, these experiences are often set against a backdrop of extreme suffering, including violence torture and rape for several of the women in this study. It is perhaps not surprising then that many women seeking asylum here develop clinical depression. Five women in the study expressed having moderate to severe clinical depression, although the actual number of women suffering from depression could be a lot higher than this. Several studies have acknowledged that asylum seekers are a high risk group for the development of depression (Steward 2006, Mc Mahon 2007, Amnesty International Irish Section 2008). Stewart et al (2006) considered 'The Mental Health Promotion Needs of Asylum Seekers and Refugees' in a qualitative study undertaken in direct provision and private accommodation centres in Galway city, and found that there are a number of reasons for this. Experiences of past trauma, fears for the future, the length of time living in the direct provision system, and language barriers were found to have a negative impact on mental health (Steward 2006). These findings were supported by a report in the Irish Medical Journal showing that asylum seekers were five times more likely to be diagnosed with a psychiatric illness than Irish citizens (Mc Mahon 2007), and by a report of Amnesty International Irish section (2008). Women expressed mental health concerns in a recent study undertaken in Ireland with one hundred and twenty one women living in ten direct provision accommodation centres, in six focus groups across six counties. Findings suggest that mental health concerns were related to the stress of living in poor accommodation and having to share a room with total strangers, and the stress related to inactivity and the ban on work and third level education for asylum seekers (Mbugua 2010). There was also an increase in anxiety for women caused by the way in which the policy of dispersal is carried out, particularly due to the loss of social supports and anxiety related to health issues for the women themselves or their children, findings that are supported by a British longitudinal multiple case study of three women who were asylum seekers and one woman who was a refugee (Briscoe and Lavender 2009). Pre-migration factors such as torture and abuse also play a

significant factor in mental health risks as reported by Norredam et al (2005) in the findings of their large, multi-country, comparative study into access to health care for asylum seekers in the European Union.

Relationships are transient due to dispersal, refusal of applications and deportations. While women rely on each other for support with children, deep relationships are very rare. Many women expressed the loneliness and isolation of having no one to talk to. Many women expressed that they did not feel free to talk about their worries with other asylum seekers. The reasons for this are complex. Issues of trust are significant and also awareness of the fact that everyone has their own burden of worry and fear for the future, people are reluctant to add to that. The lack of trusted friends and family is an added stressor. The loss for the women who participated in this study occurred at a number of levels. These losses include not only loss of family and friendship, loss of partners and, in some cases, older children who were left behind in the country of origin. Women also talked about the loss of not being able to care for elderly parents. There was a sense of constant worry and stress related to loved ones left behind. The loss of control over their lives, the inability to plan for their future or their children's future featured large, as neither asylum seekers nor their children are allowed to access third level education in Ireland no matter how bright or able they might be. The loss of the possibility to make plans while living a 'life on hold', with endless waiting to hear the outcome of applications and appeals took its toll on many of the participants in this study. Loss of contribution to society through paid work was also key as supported in the findings of two key Irish studies by Begley et al (1999) and Fanning et al (2000). This also has implications for future generations in terms of loss of good role models, as children grow up seeing their parents spending endless days in boredom and stress and unemployment, and in that sense it is hard to know the depths of the effects of loss that will only become evident in the future as these children grow and try to make sense of their own lives and contribution to society. The losses outlined above are extensive and pervasive and yet it may be the loss of personhood associated with having no citizenship that is most demeaning for these women. Women expressed feeling like a non-person, while

they wait for what they refer to as their ‘status’ to come through, and this relates in no small part to the connotations of bogus status associated with being an asylum seeker in Europe and indeed most Western countries today. The status of refugee brings with it not only the legal rights of citizenship, but on a psychological level the sense that the person has been justified in their flight from home, they are authentic, believable and affirmed.

7.6 Agency and Resilience and Resistance

The women in this study never ceased to amaze me at their resilience in the face of extreme hardship, loss and sorrow. Despite increased levels of depression, sorrow and uncertainty in their lives, despite being marginalised and made vulnerable not only by pre and post migratory stressors but also by the asylum process in Ireland, there is strength apparent in all of the women I spoke to and got to know in the course of this study. Many of the women appeared to draw strength from religious beliefs and held on to a persistent hope for a better future for themselves and their children. This strength and resilience was seen in various ways, in the way Marianne (pseudonym) fought for care for her sick baby and persisted over months of being turned away from health centres and hospital emergency rooms, while her baby’s health deteriorated. Yet she did persist and her baby got the surgery she needed, and is now over three and meeting all of her developmental milestones, but J. still fights for her to get the care and support she needs. Resistance is seen in a woman’s story of going underground to avoid deportation, so great was her fear of going back and her fear for her children. She went on the run for months, moving from place to place, having no means of income or home to live in, she relied on the charity of others to survive, although this resulted in her having no access to antenatal care for her entire pregnancy. Resistance is also seen in another woman’s story of selling her baby’s disposable nappies to buy her older child a toy because all the other children in his class had toys and he did not. Resistance was not directed at government agencies, for many women expressed gratitude for the shelter they had been given and, particularly, gratitude towards the justice department

who they saw as their hope of a better life, of not being sent back to whatever they were fleeing from in the country of origin. Rather, their resistance is seen in their ability to keep going, not to be worn down by repeated dispersal and having to start trying to integrate into a new community each time. It was also seen in how some women coped with the extreme lack of peace and privacy that was their reality in some accommodation centres.

The women displayed individual agency in their fight to be heard. They achieved this in a number of ways. By taking part in research studies such as this, often coming out in terrible weather with small babies in order to take part. In their membership of groups like AiKidWa, which is Swahili for sisterhood, and is a national network for African and migrant women in Ireland, and also in their participation in voluntary work with charities and in running crèches in some of the hostels. In attending training classes provided by some of the better run accommodation centres and also being active members of their churches. In these small ways, the woman in this study resisted the isolation and marginalisation forced upon them and determined to provide good role models for their children and to integrate and participate in society in whatever way they could.

7.7 Direct Provision System

The direct provision system was introduced by the government in 2000 at the same time that asylum seekers right to work and access to social welfare ceased, and unprecedented legislation undermined the right of Irish born children to citizenship. Direct provision was in part seen as a deterrent to the large numbers of asylum seekers both here and in the U.K. (Briscoe and Lavender 2009). Fanning (2009:83) argues that in this way ‘the hatches were battened down’ against the new guests of the Irish nation, making the Ireland of a thousand welcomes something of an ironic myth. The difficulties of living in direct provision have been widely acknowledged in a number of Irish and international studies (McLeish 2002a, Kennedy and Murphy-Lawless 2003, Steward 2006, Briscoe and Lavender 2009, Pieper et al. 2009, Mbugua 2010). Piper *et*

al.(2009:7) argue that direct provision is a violation of basic human rights, 'living in direct provision is linked with poverty, poor physical health, and negative mental health and with specific problems for women in relation to pregnancy and child health'.

Direct provision accommodation centres are largely privately owned and run, with only seven out of fifty-two centres nationwide being government owned. Standards of accommodation vary greatly with Mosney being seen as a flagship centre. Mosney, a disused holiday camp that had largely fallen in disuse and disrepair in the eighties has housed upwards of eight hundred residents, as reported in the media (Forum on Migration and Communications 2008). Some residents have been there for years. The children go to local schools and have known no other community. Little is known of the impact of growing up in direct provision on these children but the consequences of growing up as 'other' living in a 'camp' to all intents and purposes, never seeing your parents go to work or cook a family meal, coupled with the constant worry and fear of the future has to have an enormous toll. Yet most asylum seekers would prefer to live in Mosney because it is possible for families to have their own small chalet. Although not allowed to cook raw food, residents must eat in a communal dining room at set times. Laundry facilities are also communal and this requires new mothers, particularly single mothers to bring their infant out to do every day chores. Laundry must be carried long distances in some cases and this is challenging for women who have had caesarean births, particularly in the first six weeks after birth. Having a place to call their own provides families with much needed privacy and space to be together as a family unit. It provides a measure of peace to people who have been traumatized in their past and live a daily struggle with an unknown future. However, recent reports in the Irish Times newspaper revealed that the government were planning on dispersing over a hundred people some of whom had been living in Mosney for years (Smyth 2010a). This senseless upheaval of individuals and families makes one wonder at the rationale behind it.

In contrast to Mosney, some of the other hostel type accommodation centres have appalling conditions as reported recently in the Irish Times and Irish Examiner newspapers (Millar 2010, Duncan 2010). Families are expected to share a small room with another family of total strangers, (usually two single mothers and their babies). Women must sleep with their babies in the bed with them as there is no room for cots. Despite widespread recognition of the risk of sudden infant death with co sleeping, something all new women are educated about antenatally and prior to discharge, these guidelines are totally ignored. Women expressed the increased stress of sharing such close quarters with virtual strangers. The lack of privacy, noise and disturbance of each other's children makes a difficult life intolerable. Privacy for breast feeding is non-existent. As babies grow women expressed fear as there is no floor space for babies to crawl. One woman expressed her anxiety of not taking her eyes off her baby in case he fell off the bed. It cannot come as any surprise then that women in these dreadful conditions have increased mental health and other physical health issues. What is more appalling is that these conditions have been highlighted as totally unacceptable in studies since 2003 (Kennedy and Murphy-Lawless 2003), yet nothing has been done to address them. Recent pieces in the Irish Times newspaper have highlighted the unacceptable standards of living conditions (Smyth 2010b). Food related issues have also been highlighted in several studies, in particular in an Irish study into food nutrition and poverty among asylum seekers in the West of Ireland, sponsored by the HSE Western Area, and the National University of Ireland, Manandhar *et al.* (2006) found unacceptable levels of food poverty, poverty of choice and poverty of connection for asylum seekers living in direct provision. All of these issues highlight the direct provision system as wholly unsuitable for mothers with young babies. Lack of integration into the wider community was also an issue for several of the women. Feelings of isolation from the town's people coupled with a level of shame at being in direct accommodation centres exacerbated the marginalizing effects of living in direct provision. The geographic location of many accommodation centres increase the sense of social isolation and makes integration of asylum seekers extremely difficult.

7.8 Policy of dispersal

The government policy of dispersal was introduced at the same time as direct provision in 2000. The rationale behind forced dispersal of asylum seekers is to share the burden of resource capacity and administration (Mbugua 2010). Women in this study reported being transferred up to six times, often crossing the country on several occasions and each time having to start from scratch with building community and settling into a new area. The way in which the dispersal policy is carried out is also problematic. Women are usually told they are 'on the list' to be moved but usually the list of names is not posted until late the night before dispersal is due to take place. This gives people usually just a matter of hours to gather their things together before they are transported often to the other side of the country. The policy of dispersal of people who have lived for months or years in a particular location is utterly detrimental to their well-being, their ability to settle and to build social relationships, relationships that are crucial to mental health and wellbeing, findings supported by Stewart et al (2006) in a study described earlier and also by Ryan et al (2008) in their study of the psychological distress suffered by one hundred and sixty two forced migrants during the asylum process. Several women talked of being separated from their only friend. One woman talked about the importance of friendship and how friends take the place of family members when there is nowhere else to turn. The importance of these friendships cannot be underestimated.

The dispersal policy has implications for women travelling with very young babies, sometimes just days after a caesarean birth. Single mothers with no family members to help them must carry suitcase and baby equipment when they should be resting. They are then required to start the physically and emotionally exhausting work of settling into a new centre. These experiences can be intimidating and frightening as there is often chaos in the early days of new hostels opening up, due to the lack of planning and preparation of the local community, the local health services and the hostels themselves (Pieper *et al.* 2009). In one hostel women talked of daily confrontations that were frightening and intimidating for them that went on for several weeks until management

started to hold meetings with residents and then things began to settle down. The stress of these experiences coupled with being a new mother, perhaps having had a complicated birth and the impact of pre-migration stressors contribute to an untenable position for women faced with this reality.

The dispersal policy also has serious implications for women who have health issues or children with health issues. Several women in this study were affected by delays in clinical notes being transferred, and in getting referrals to local specialists. Often these are very ill or vulnerable cases. One mother whose extremely pre-term infant was being followed up by several health professionals in Dublin on a monthly basis was due to see the paediatrician the day she was transferred to the opposite side of the country. The policy that does not give women adequate notice of transfer means doctors and other health professionals cannot be notified. The paediatrician in question called the mother to see why she did not keep her appointment and was insistent that the women travel to Dublin to see him. The woman tried to explain she did not have permission to do so as she was told she must wait for a local referral. I spoke to her three months after the transfer and she was still waiting, no notes had been sent and the baby had not been seen. There may also be no comparable specialist service in the area to which women are dispersed. One mother talked of her older child who was in therapy in Dublin due to the trauma of events he witnessed in Africa. The child was transferred out of the area and his treatment was discontinued as there was no comparable service in the locality where they were sent. This was also an issue for all women who took part in the study in relation to free counselling services. The greater Dublin area is well serviced with counselling centres for women who need referral to them but no comparable service exists for women who are transferred to the west of Ireland. Access to counselling and mental health services is crucial to women in the postpartum period who have experienced pre and post migratory stressors. Transporting women to areas where these services are not available is totally unacceptable and a dereliction of duty in terms of provision of basic health needs. Finally, a recent British study that draws upon doctoral research on the social exclusion of

asylum seekers as a result of dispersal, suggests that a dispersal system negatively impacts restoration of trust for asylum seekers and this may have long term effects on the resettlement of asylum seekers who do gain refugee status (Hynes 2009). It would appear that the dispersal policy not only has a negative impact on the daily lives of those subjected to it but may also be storing up more problems for the future.

7.9 Racism

‘Racism denies people their basic human rights, dignity and respect. Racism is a multifaceted concept, ranging from small, everyday acts of discrimination, through the barriers and omissions that may be inadvertently established at an institutional level, to acts of threatening behaviour and violence.’(National Consultative Committee on Racism and Interculturalism and IHSMI 2002).

The unscrupulous focus on pregnant asylum seekers by government ministers and some journalists ahead of the citizenship referendum in Ireland in 2004 imprinted an image of pregnant ethnic minority woman as ‘bogus’ abusers of Irish maternity services who were coming into the country in large numbers simply to avail of Irish citizenship for their unborn babies as described by Irish sociologists Lentin (2007b, a) and Fanning (2009). This stirred up a level of racism towards pregnant ethnic minority woman perhaps never before seen in Ireland. Women were spat at on the street (Lentin 2007b). Experiences of racism are a reality for ethnic minority women in Ireland. There were many examples of racism referred to by women in this study. One woman made excuses for a group of male youths who shouted abuse at her from a car; she said it was probably just youthful high spirits and too much drink. It is the sense of the inevitability of experiences like this that is so disturbing.

Women experienced racism on many levels. Some had experiences of overt and covert racism in hospital. Lyons *et al.*(2008:263) in an Irish study into the

experiences of maternity care providers when caring for ethnic minority women found that ‘racism is a very real issue within the health and maternity services, which can have tangible effects but is rarely explored’. Women in this current study described experiences of racism in both hospital and community services and across all grades of providers including doctors, nurses and midwives, and housekeeping staff. There were numerous accounts of being left waiting for hours in antenatal clinics and Irish women being seen before them. Findings from a study in the west of Ireland showed similar resentment from locals waiting to see their GP. The perception was that asylum seekers are not going to work and therefore should not mind having to wait until the end of the clinic (Pieper *et al.* 2009). There were many accounts of not being listened to or being ignored by providers when concerns were expressed for their own health or the health of their babies. Concerns that later proved to be correct but the delay in treatment proved near fatal for one child suffering from hydrocephalous. The accounts of inhumane treatment of pregnant and sometimes very ill women are disturbing. Women’s lives and the lives of their babies were put at risk in this study as result of this kind of racist behaviour. Racism in the maternity services has the potential to seriously affect the quality of care women receive, and can lead to an increase in perinatal and maternal morbidity. This was evident in the stories of the women in this study although they were not always aware of the impact of poor care on the complications they developed. Women also experienced racism in the community, with accounts reminiscent of the immigrant Irish in Britain in nineteen fifty’s where signs read ‘no dogs no Irish’, one woman who wished to volunteer at a charity shop in the Dublin area was told ‘we don’t take blacks.’

7.10 Breastfeeding

A recent national infant feeding survey found that non-Irish women were more likely to breast feed their babies than Irish women. Breast feeding initiation rates for non-Irish women were reported at 76% compared to Irish women at 50% (Begley *et al* 2008). Given the benefits of breastfeeding this is an

encouraging finding. However, there is a perception that African women in particular are ‘natural’ breast feeders who ‘just get on with it’ in comparison with their Irish counterparts (Lyons *et al.* 2008). While most of the women in this study did not express problems with initiation of breastfeeding one woman had extreme difficulty and felt unsupported particularly by the day staff while in hospital. One night staff stood out as being kind and patient and the women looked forward to 9pm when she knew she could count on support.

The real challenges for women who are breastfeeding occur postnatally when discharged back to cramped and overcrowded accommodation where privacy for breastfeeding is non-existent (Manandhar *et al.* 2006). The need for adequate sleep, rest and nutrition is paramount for breastfeeding women. Living in direct provision hampers a new mother’s need for rest and food. Having to use a public dining room at set times of the day may result in women missing meals and certainly impacts on their need for rest. Feeding a new-born infant requires being awake at erratic times in the night and demand feeding, which is the optimal feeding pattern for breastfeeding, requires a mother to arrange her schedule around the baby’s feeding pattern. This is impossible for mothers living in direct provision who are forbidden from cooking their own food. Women also expressed other food related challenges around breastfeeding, in particular not having access to traditional foods a breastfeeding women would typically eat back home. Kennedy and Murphy Lawless (2003) found lack of good nutrition to be a factor for women in giving up breast feeding.

7.11 Technological birthing culture

The drive toward medicalisation of childbirth has been an increasingly dominant feature of western childbirth culture over the past forty years. In Ireland the technological birthing model is the dominant culture. This model that focuses on consultant led hospital based birth and active management of labour is seen to be untenable in view of the crisis in the Irish maternity services and the increasing demand for more choice and control by women who are the consumers of the service and by need for more midwifery led service which is

considered best practice for women who have no medical or obstetric complications (Devane *et al.* 2005). Despite the fact that the medical model of technological childbirth is being forced on developing countries (Murphy-Lawless 2003) many women coming to Ireland from these countries are not accustomed to technological birthing experience. This type of birthing experience can be an intimidating, frightening and alienating experience for western women who are not also coping with language barriers and other pre and post migration traumas. For many women in this study the experience of being 'tied on the bed' by technology, having an epidural anaesthesia and operative birth was terrifying and utterly alien to them. Perhaps more worrying was a recent finding by Lyons *et al.*(2008) that providers preferred it when ethnic minority women had an epidural as this kept women quiet and made the workload easier. The following quote is from a midwife who took part in Lyons' study:

'The culture is that they are not into epidurals, only a few of them (ethnic minority women) have epidurals. So it sounds really bad, but its true-when you have a full labour ward and you have two women, one with an epidural and the other one without the epidural, you spend more time with the woman with no epidural. The other one is happy there, smiling, talking...and you go back to the woman who is shouting and breathing and pushing....'(Lyons *et al.* 2008:267).

These remarks speak volumes not just about the lack of intercultural understanding but the pressure on midwives in overcrowded hospital labour wards, the low morale of midwives working in these conditions resulting in a lack of any commitment or compassion for the women apparent in this midwives response. It also raises the important issue of informed choice when women are cajoled into accepting epidural pain relief and the cascade of intervention that accompanies it. Many women in this study described experiences of fighting to resist intervention and for the opportunity for a vaginal birth. For most of these women the motivation was fear of operative delivery as many women die in operating theatres in Africa and also because of

the impact of surgery in terms of the delay in healing postnatally when they are alone with older children with no family to help or support them. Many women had older children left in the care of strangers in the hostel or in state foster care and they were desperate to get back to them as soon as possible, having a caesarean birth meant a longer stay in hospital and a longer recovery period afterwards. Other women talked about not understanding that their legs would be paralyzed with an epidural and fearing that this was permanent. The issue of informed consent was powerfully apparent when a woman described ‘overhearing’ that she was to have an epidural and a caesarean birth. She had no idea what an epidural was and asked her friend, ‘what is an epidural’? The woman described the relentless pressure placed on her by the health professionals to have an epidural. Although she was very frightened to have an epidural she was also in pain, and so she eventually gave in and consented to having it. Her comment was that ‘no normal person would refuse’ and opt to remain in pain when the only alternative being offered was an epidural. The remarkable feature of many of these stories was the strength that individual women found to resist the pressure placed on them to submit to intervention. Despite all the trauma and anxiety, many of the women managed to get their way and have a vaginal birth. This is a testimony to their own inner conviction of the normality of the birthing process and their belief in their body’s ability to birth their baby, a belief that many western women have lost. There is an urgent need for greater choice of birthing options for asylum seeking women. Options for midwifery led care where technology is kept to a minimum and where physiological birth as a natural part of the life cycle is valued, would benefit women who struggle with technological birthing environments.

7.12 Antenatal care and childbirth preparation

Antenatal care is a somewhat contested area of care for migrant women and especially asylum seeking women. Many of the women in this study had little antenatal care. There were a number of different reasons for this. Some came to Ireland in late stages of pregnancy and there was no time to provide much

antenatal care and certainly no educational preparation for birth or motherhood. A significant number of women went into premature labour virtually on arrival in Ireland due to the trauma and stress of the journey. For other women the exhaustion of the asylum process, complicated by transport issues and adjusting to a foreign environment resulted in women being overwhelmed and feeling unable to access care. Some women who did access antenatal clinics felt alienated and discriminated against. Language barriers, geographic and social isolation mitigate against women accessing antenatal care and education. Yet in one large workshop type information session I conducted with postpartum women in this study, it was apparent that women had a host of questions and valued the opportunity to ask them in a supportive environment. Migrant women and particularly asylum seeking women who do access antenatal clinics in maternity hospitals are not identifiable as asylum seekers. This has disadvantages in terms of access to services of social workers and psychologists; unless the women volunteer the information, their specific care needs may not be known. The findings of Kennedy and Murphy Lawless (2003) that there were no dedicated antenatal education classes and women did not attend those provided remains unchanged. These findings are also consistent with research undertaken in Britain (Jentsch et al. 2007, Briscoe and Lavender 2009, Raleigh et al. 2010b). In Britain dedicated antenatal services have been set up in response to the particular needs of refugee and asylum seeking women (Ukoko 2005).

7.13 Fear of the future

A universal feature of the women in this study was fear of the future. Women talked of living their lives in a state of constant fear and anxiety of being sent back. The uncertainty of the women's future impacts greatly on their peace of mind, their motivation and levels of anxiety and depression. For women with medical conditions or those whose children had medical conditions fear of being sent back was even greater. Worry about access to medicines and medical treatment was significant. One woman with leukaemia worried that she would

die if sent back and was concerned about who would then take care of her children.

Women expressed feelings of powerlessness and being treated like children with no say in their day to day lives as demeaning and a source of constant stress. Living largely in isolation from the community around them with no freedom of movement, no choice of food, no ability to buy and cook familiar foods is a daily fact of life. Lack of privacy and for some women appalling overcrowding and unsafe conditions overshadowed their daily existence. The boredom of endless days with no opportunity for paid employment while many of the women are highly educated is a source of deep frustration and a cause of depression especially given the level of poverty and deprivation in which many live. Their hope is in the Irish justice system, their longing for a better life some day in the future keeps these women going, yet the fear of never seeing that day is a kind of living hell.

7.14 Conclusion

In this chapter I have highlighted areas of concern for women seeking asylum in Ireland who also gave birth here. Findings emerging from the study detail the difficulties these women face on a daily basis. Their childbirth experiences are overshadowed by language and communication issues, barriers to antenatal care and childbirth education often exacerbated by social and geographic isolation. The trauma of living in direct provision accommodation and being subjected to the dispersal with little notice increases their stress. This adds to the significantly increased mental issues experienced by this group of women. Widespread experiences of racism add to this stress also. While a number of women describe their experiences of childbirth in Ireland as being more positive than previous experiences in their country of origin, a significant number of women expressed fear and described feelings of anxiety and alienation in the highly interventionist, hospital based model of maternity care that is prevalent in Ireland.

CHAPTER 8

Implications and Recommendations

8.1 Introduction

The aim of this study was to explore the physical, emotional and social experiences of refugee and asylum seeking women during pregnancy and childbirth in Ireland. The study design was informed by a feminist epistemology. The women's narratives were analysed using Burke's (1969) dramatic pentad with the inclusion of Bruner's (1990) sixth element of trouble. This analysis highlighted significant 'trouble' in the women's experiences, as evidenced in the discussion in the previous chapter. A central tenet of feminist research is that of social and political change. In the following chapter I outline a number of areas where change is most urgently required.

In the section on recommendations for future research I indicate a number of possible areas for further inquiry as we urgently need data related to these issues if we are to provide an evidence based approach to best practice, and indeed to provide an ethical response to the needs of asylum seeking women who give birth in Ireland.

8.2 Choice and continuity in childbirth

Continuity of care and choice of a community based social model of midwifery care are crucial for this population. Continuity of care would provide women with much needed relationship and support from her maternity care provider, improving communication and reducing the risk of adverse effects of poor communication. It would also provide emotional and spiritual support for women who have been severely traumatised, making their childbirth experience a potentially healing one.

Options for midwifery led care would afford women low tech birthing experiences where the emphasis is on normal physiological birth.

8.3 Access to antenatal care and childbirth education

There is a need for dedicated antenatal education and care to meet the needs of this culturally diverse group. Women who are seeking asylum while pregnant cope with issues of alienation, isolation, language barriers and other pre and post migration stressors that require an individualized approach to care that cannot be met in large antenatal clinics.

Dedicated on site antenatal care and education would make access easier and provide a small group approach that would enhance trust building and promote access to care.

8.4 Breastfeeding

Women who are breastfeeding require good nutrition, sleep and rest. Women who are feeding infants often have erratic sleep patterns as they seek to accommodate the needs of their infants. Women who are breast feeding their infants must have access to culturally appropriate food. They must not be held to set meal times in public dining rooms as this impedes their access to rest and nutrition. Women who are breastfeeding their infants must be given access to raw food and have permission to cook their own food to facilitate adequate rest and nutrition.

8.5 Communication, language barriers and interpreter services

Good communication is a central component of good care. Women who do not have English as their first language are at increased risk of miss-communication, barriers to informed consent and increased maternal and neonatal morbidity.

Information leaflets in several languages on relevant topics for example; induction of labour, epidural analgesia, operative birth, should be widely available as interventions such as this are particularly stressful for women unused to technological models of childbirth and informed consent may be difficult to obtain for these procedures without the use of trained interpreters.

The current system of ad hoc access to interpreters is unacceptable. Reliable, professionally trained interpreters who understand the importance of confidentiality must be widely available to women who need them.

There must be policy and procedure in place for appropriate use of interpreter service. Access should be over a twenty four hour period. The service should be audited regularly to ensure it meets the needs of non-English speaking women.

Barriers to informed consent must be identified to ensure informed consent for non-English speaking women in particular are put in place.

8.6 Cultural competence

Cultural competence requires providers to have an understanding that pregnant women seeking asylum here are already traumatized and fearful and coping in an environment where everything is strange to them. Extra reassurance, comfort and compassion are required given that many women lack family and other support systems. Treating women with respect and dignity is crucial to providing culturally competent care.

There is an urgent need for programmes in cultural competence that emphasis emotional intelligence, self-awareness and reflective practice to equip providers the necessary skills to provide culturally competent care.

Such programmes should include on-going in-service training programmes for all grades of providers in intercultural understanding.

Emphasis should be placed on this kind of preparation in the future education of all health service personnel.

8.7 Direct provision

The system of direct provision and dispersal is in contravention of human rights, (Pieper *et al.* 2009).

Pregnant women and those in the immediate postpartum period must be given accommodation that is safe and provides privacy and dignity.

Breastfeeding women and new mothers must have access to nutritious and culturally appropriate food.

Women with infants and small children must be given access to raw food and given permission to cook their own meals.

8.8 Policy of dispersal

Women must not be dispersed in the immediate postpartum period or prior to their six week post natal examination.

Women who have medical complications must be given adequate notice prior to dispersal and must only be transferred to new accommodation once a new specialist has been put in place and the first appointment made ahead of transfer.

Women with infants or children with medical or neonatal complications must not be dispersed to areas without comparable health services. They must also be given adequate notice of transfer. Appointments with specialists in the new area should be in place ahead of dispersal including the transfer of medical notes.

8.9 Recommendations for future research

Further research is suggested in the following areas;

1. A quantitative study to measure maternal and neonatal mortality and morbidity in non-English speaking ethnic minority populations in Ireland would be beneficial based on the findings of this qualitative study and on other international research findings.
2. A study into the effects of living in direct provision on the children of migrant women is urgently required. A whole generation of children are growing up in these very abnormal circumstances and currently there is no data into how this affects children developmentally and emotionally. A qualitative or mixed methods approach would lend to comprehensive data collection.
3. A study into the factors that affect breastfeeding in women living in direct provision is highly recommended. Given the adverse conditions

for breast feeding in most direct provision accommodation centres and the current efforts to encourage and maintain numbers of breastfeeding women in Ireland a qualitative study to gain insight into women's experiences of breastfeeding and reasons for discontinuing breastfeeding would be extremely valuable.

4. A study looking specifically at the antenatal care and childbirth education needs of ethnic minority women is urgently needed. This study would lend to a qualitative or mixed methods approach and would ideally include English speaking and non-English speaking women.
5. A study looking specifically at the barriers to communication and the utilisation of trained interpreters in the provision of effective care to non-English speaking ethnic minority women. This study would benefit from a qualitative or mixed methods design.
6. A mixed methods study is required to gain insight into the mental health needs of childbearing woman who are seeking asylum in Ireland.
7. A study into the education and preparation of midwifery and other healthcare providers is recommended given the specific and wide ranging needs of non-Irish ethnic minority women currently accessing the Irish maternity services and the less than optimal experiences of many of the women who took part in this study. A national survey of educational components related to cultural awareness and understanding would provide an overview of the deficits in current health provider education.

EPILOGUE/POSTSCRIPT

This study has taken almost four years to complete. During that time I have been privileged to meet and get to know a truly exceptional group of women. Women who have been forced to join the global Diaspora through reasons of war, terror or economic hardship. They have travelled long distances, often alone, sometimes heavily pregnant, with young children, leaving family, friends, partners and in some cases older children behind. Leaving everything familiar, they find themselves in a foreign land at a time when many women need extra support, they are alone without support.

Stories are powerful vehicles of human emotion and suffering and affect those of us who bear witness to these stories in quite profound ways. We are not and can never be the same people, bearing witness in this way changes one. In some way there is a loss of innocence. There is an inability to remain unmoved; there is no room for indifference. Hearing such powerful and heart-rending stories of loss, of abuse, of neglect, intolerance and indifference, and seeing the effects of those experiences in the lives of the women in this study has politicised my thinking around childbirth and midwifery practice in a deeply personal way. Prior to undertaking this study my teaching and practice have always focused on women-centred care. On supporting choice and control for women in childbirth, but not always on the pathologies of power that undermine that care. Midwives must begin to understand the age old rallying cry of feminists, ‘the personal is political’, as this applies so completely to childbirth and midwifery care in Ireland today. Denzin’s (2009) exhortation to politically relevant research practices echoes decades of feminist scholars who have committed to overt political goals in their work. As midwives we must find our voice in order to be an effective advocate for women and woman-centred care. On a personal level, the impact of bearing witness to women’s suffering, loss and courage has been both a wounding and healing experience for me. Holding another’s pain is something nurses and midwives do on a daily basis, and yet allowing oneself to

build relationship and continue in that over a period of years is quite shaping. There is a loss of innocence as one encounters atrocities vicariously and yet a renewal of hope in the ability of the human spirit to overcome enormous pain and still survive.

Twenty-two women's stories were included in the study, although I spoke to many more. The women were generous with their time and always eager for contact and the interest of strangers, possible friends. Many live in abject misery and a large degree of poverty. In cramped, overcrowded conditions where peace and privacy are denied them, they live out their days in hope of being successful and having an opportunity to make a new life in Ireland. These women are not without individual agency. They are strong and brave and this is evidenced in so many of their stories of survival, their fight to get care for themselves and their children, in an often overtly hostile society. They endeavour to make their voices heard, in their willingness to participate in research, and in organizations voluntary women's organizations such as Akidwa.

As this study draws to a conclusion the reality of their disrupted lives, lives lived on the margins, continues. Of the twenty-two women who took part in the study one woman Ella (pseudonym), has been granted refugee status during this time. Six women: Tarra, Mimie, Demy, Bola, Winn and Ramie (pseudonyms) and their children, have been sent back to their country or origin, at least two of them as deportations, one woman has had a major psychological breakdown requiring hospitalisation. The remaining fifteen women and their children still wait in ever increasing fear and anxiety to learn their fate.

Mimie's story of her deportation was told to me by her friend Fola on my last visit. When an asylum seekers case is first heard and denied there is the possibility of an appeal. If the appeal is turned down a choice has to be made. One can voluntarily decide to return home at this point and passage is given, the individual or family is then 'free' in their country of origin, notwithstanding the reasons that caused them to flee in the first place. The other choice is to stay and

apply for humanitarian leave to remain. This affords an extended stay while the case is being considered, but if denied the individual or family are deported. This means they are handed over into the hands of the police in their country of origin and put in prison, where they stay unless they have family members who can bail them out. Usually families are aware they are on the deportation list, but in much the same way as the dispersal policy, they never know the exact date it will happen, some go underground for fear of being sent back.

Mimie awoke in the early hours of the morning to find a stranger staring down at her in her bed. She was told to dress quickly she was being deported that morning with her child. Personal belongings were left behind. The officials always come before six in the morning. The lack of dignity and respect is the only continuity that these women can rely on in the asylum process. Fola was hoping to have contact with Mimie by mobile phone, but had not heard from her.

The weight of suffering, loneliness and despair evident in the lives of the women in this study makes the role of the person who bears witness to it a difficult one. However, Farmer (2005:28) eloquently puts this challenge into perspective:

‘Bearing witness’, like ‘solidarity and ‘compassion’ is a term worth rehabilitating. It captures both ways of knowing, both forms of silence. Bearing witness is done on behalf of others, for their sake (even if those are dead and forgotten). It needs to be done, but there is no point exaggerating the importance of the deed.....no matter how great the pain of bearing witness, it will never be as great as the pain of those who endure, whether in silence or with cries, the indignities described in these pages’.

REFERENCES

- AIMS (2010) AIMS What Matters to You? A Maternity Care Experience Survey. Dublin AIMS - Association for Improvement in the Maternity Services - Ireland
- Amnesty International Irish Section (2008) Amnesty International Irish Section Mental Health Lobbying Network: Background Note on Mental Health and Asylum Seekers/Refugees. Dublin
- Anderson, F.D. & Prelli, L.J. (2000) Pentadic Cartography: Mapping the Universe of Discourse. *Quarterly Journal of Speech*, **87**, 73-95.
- Andrijasevic, R. (2003) The Difference Borders Make: (Il)legality, Migration and Trafficking in Italy among Eastern European Women in Prostitution. In *Uprootings/ Regroundings: Questions of Home and Migration* (Ahmed, S., Castaneda, C., Forter, A.-M. and Sheller, M. eds.), pp. 251-272.
- Baker, N. (2006) Imminent closure of Baleskin Reception Centre, Dublin. Irish Examiner, July 7th Dublin.
- Barthes, R. & Duisit, L. (1975) An Introduction to the Structured Analysis of Narrative. *New Literary History*, **6**(2), 237-272.
- Bartlett, H. (2009) Peer Health Workers in Direct Provision Accommodation Centres for Asylum Seekers in Galway - an ERF Intercultural Health Project. In *Translocations: Migration and Social Change*.
- Beck, C.T. (2004) Birth Trauma: In the eye of the beholder. *Nursing Research*, **53**(1), 28-35.
- Beck, C.T. (2006) Pentadic Cartography: Mapping Birth Trauma Narratives. *Qualitative Health Research*, **16**(4), 453-466.
- Beck, C.T. (2007) Personal Communication - Mapping the Narrative Terrain. March 12th University of Connecticut
- Begley, C., Gallagher, L., Clarke, M., Carroll, M. & Millar, S. (2008) Begley, C., Gallagher, L., Clarke, M., Carroll, M. & Millar, S. The National Infant Feeding Survey 2008. Dublin University of Dublin Trinity College Dublin
- Begley, C.M., Devane, D., Clarke, M., McCann, C., Flannagan, B., Maguire, R., Molloy, K., Higgins, S., Ahmed, S., Finan, A. & Vaughan, D. (2009) Begley, C.M., Devane, D., Clarke, M., McCann, C., Flannagan, B., Maguire, R., Molloy, K., Higgins, S., Ahmed, S., Finan, A. & Vaughan, D. An Evaluation of midwifery-led care in the Health Service Executive North Eastern Area: The report of the MidU study. School of Nursing and Midwifery, Trinity College Dublin, and Health Service Executive

- Begley, M., Garavan, C., Condon, M., Kelly, I., Holland, K. & Staines, A. (1999) *Asylum in Ireland: A Public Health Perspective*, Department of Public Health Medicine and Epidemiology. University College Dublin, Dublin.
- Bell, S.E. (1988) Becoming a political woman: The reconstruction and interpretation of experience through stories. In *Gender and discourse: The power of talk* (Todd, A. D. and Fisher, S. eds.) Ablex, Norwood, NJ, pp. 97-123.
- Bell, S.E. (1999) Narratives and lives: Women's health politics and the diagnosis of cancer for DES daughters. *Narrative inquiry*, **9**, 1-43.
- Bell, S.E. (2000) Experiencing illness in/and narrative. In *Handbook of medical sociology* (Bird, C. E., Conrad, P. and Fremont, A. M. eds.) Prentice Hall, Upper Saddle River, NJ.
- Birch, M. & Miller, T. (2002) Encouraging Participation: Ethics and Responsibilities. In *Ethics in Qualitative Research* (Mauthner, M., Birch, M., Jessop, J. and Miller, T. eds.) Sage, London, pp. 91-106.
- Birch, M., Miller, T., Mauthner, M. & Jessop, J. (2002) Introduction to Ethics in Qualitative Research. In *Ethics in Qualitative Research* (Mauthner, M., Birch, M., Jessop, J. and Miller, T. eds.) Sage, London, pp. 1-13.
- Brady, T. (2002) State in fresh push to halt multi-million asylum scam. Irish Independent, Dec. 31st, Dublin.
- Brennock, M. (2004a) 'Citizenship Tourist' a tiny group statistics indicate. The Irish Times, Thursday, April 22nd, Dublin.
- Brennock, M. (2004b) Masters urge tighter control on immigration. The Irish Times, Thursday, April 22nd, Dublin.
- Brettell, C.B. & Sargent, C.E. (eds.) (2001) *Gender in Cross-Cultural Perspectives*, Prentice Hall, Lipper Saddle River, New Jersey.
- Briscoe, L. & Lavender, T. (2009) Exploring maternity care for asylum seekers and refugees. *British Journal of Midwifery*, **17**(1), 17-23.
- Brown, V. (2004) A pathetic and racist strategy. The Irish Times, Wednesday, April 28th, Dublin.
- Bruner, J. (1990) *Acts of Meaning*, Harvard University Press, Cambridge, MA.
- Burke, G. (2008) The Appaling State of Irish Maternity Services. In *Irish Left Review - Joined up thinking for the Irish Left*. Dublin.
- Burke, K. (1969) *A Grammar of Motives*, University of California Press, Berkeley, Los Angeles.

- Callister, L.C. (1995) Cultural meanings of childbirth. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, **24**(4), 327-329.
- Callister, L.C. (2004) Making Meaning: Women's birth narratives. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, **33**(4), 308-518.
- Callister, L.C. (2005) What has the literature taught us about culturally competent care of women and children? *The American Journal of Maternal Child Nursing*, **30**(6), 380-388.
- Callister, L.C. (2006) Making a difference: goals for improving the health of women and children globally. *The American Journal of Maternal Child Nursing*, **31**(4), 271.
- Callister, P., Bedford, R. & Didham, R. (2006) Callister, P., Bedford, R. & Didham, R. Globalisation, gendered migration and labour markets. Wellington, New Zealand Institute of Policy Studies
- Castles, S. (2000) International Migration at the Beginning of the Twenty-First Century: Global Trends and Issues. *International Social Science Journal*, **52**(165), 269-281.
- CEMACH (2007) CEMACH Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2003-2005. London Confidential Enquiry into Maternal and Child Health
- Condon, D. (2000) Condon, D. Report of the Review Group on Maternity Services in the North Eastern Health Board. North Eastern Health Board, Kells
- Cotter, G. (2005) Cotter, G. A Guide to Published Research on Refugees, Asylum Seekers and Immigrants in Ireland: Integrating Ireland. Dublin The National Network of Refugees, Asylum Seekers & Immigrant Support Groups
- Crowley, U., Gilmartin, M. & Kitchin, R. (2006) Crowley, U., Gilmartin, M. & Kitchin, R. Vote Yes for Common Sense Citizenship: Immigration and the Paradoxes at the Heart of Ireland's 'Cead Mile Failte'. Maynooth, Co. Kildare NISRA, Natitonal Institute for Regional and Spatial Analysis
- Cullen, P. (2000) *Refugees and Asylum Seekers in Ireland*, Cork University Press, Cork.
- Davis-Floyd, R. (1992) *Birth as an American rite of Passage*, University of California Press, Berkeley, CA.
- Davis-Floyd, R. (1994a) Culture and Birth: The Technocratic Imperative. *International Journal of Childbirth Education*, **9**(2), 6-7.
- Davis-Floyd, R. (1994b) The Technocratic Body: American Childbirth as Cultural Expression. *Social Science and Medicine*, **38**(8), 1125-1140.

- Davis-Floyd, R. (2000) Global issues in midwifery: mutual accommodation or biomedical hegemony? *Midwifery Today*, 68-69.
- Davis-Floyd, R. & Cheyney, M. (2009) Birth and the Big Bad Wolf: An Evolutionary Perspective. In *Childbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth and the Postpartum* (Selin, H. and Stone, E. eds.) Springer, Amherst, MA, pp. 1-22.
- Davis-Floyd, R. & Sargent, C.F. (eds.) (1997) *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives*, University of California Press, Berkely, CA.
- Denzin, N.K. (2009) *Qualitative Inquiry Under Fire: Towards a New Paradigm Dialogue*, Left Coast Press, Walnut Creek, CA.
- Devane, D., Murphy Lawless, J. & Begley, C. (2005) Childbirth policies and practices in Ireland and the journey towards midwifery-led care. *Midwifery*, **23**(1), 92-101.
- Dewey, J. (1922) *Human nature and conduct*, Henry Holt & Co, New York.
- Dewey, J. (1958) *Experience and nature*, Dover Publications, New York.
- Dickson-Swift, V., James, E.L., Kippen, S. & Liamputtong, P. (2007) Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research*, **7**(3), 327-353.
- Donaghy, K. (2003) Further arrests in bogus asylum seekers expected. *Irish Independent*, July 21st, Cork.
- Downe, S. (ed.) (2008) *Normal Birth: Evidence and Debate*, Elsevier.
- Dumont, J.-C., Martin, J.P. & Spielvogel, G. (2007) Dumont, J.-C., Martin, J.P. & Spielvogel, G. *Women on the Move: The Neglected Gender Dimension of the Brain Drain*. Bonn, Germany Forschungsinstitut zur Zukunft der Arbeit Institute for the Study of Labor
- Duncan, P. (2010) Centers must meet Mosney residents' health needs - TD. *Irish Times*, July 23rd, Dublin.
- Edwards, R. & Mauthner, M. (2002) Ethics and Feminist Research: Theory and Practice. In *Ethics in Qualitative Research* (Mauthner, M., Birch, M., Jessop, J. and Miller, T. eds.) Sage, London, pp. 14-31.
- Ehrenreich, B. & Hochschild, A.R. (eds.) (2002) *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*, Owl Books, New York.
- Fanning, B. (2002) *Racism and Social Change in the Republic of Ireland*, Manchester University Press, Manchester.

- Fanning, B. (2009) *New Guests of the Irish Nation*, Irish Academic Press, Dublin.
- Fanning, B., Loyal, S. & Staunton, C. (2000) *Asylum Seekers and the Right to Work in Ireland*, Irish Refugee Council, Dublin.
- Finch, J. (1984) "It's great to have someone to talk to": ethics and politics of interviewing women. In *Social Researching: Politics, Problems, Practice*. (Bell, C. and Roberts, H. eds.) Routledge, London.
- Fonow, M.M. & Cook, J.A. (2005) Feminist Methodology: New Applications in the Academy and Public Policy. *Signs: Journal of Women in Culture and Society*, **30**(4), 2211-2236.
- Forum on Migration and Communications (2008) Making a Killing. Metro Eireann, November 28th, Dublin.
- Fox, C. (2002) Beyond the "Tyranny of the Real": Revisiting Burke's Pentad as Research Method for Professional Communication. *Technical Communication Quarterly*, **11**(4), 365-388.
- Frosh, S. (2007) Disintegrating qualitative research. *Theory & Psychology*, **17**, 635-653.
- Garner, S. (2007) Babies, Bodies and Entitlement: Gendered Aspects of Access to Citizenship in the Republic of Ireland. *Parliamentary Affairs*, **60**(3), 437-451.
- Gee, J.P. (1991) A Linguistic Approach to Narrative. *Journal of Narrative and Life Histories*, **1**(1), 15-39.
- Gillies, V. & Alldred, P. (2002) The Ethics of Intention: Research as a Political Tool. In *Ethics in Qualitative Research* (Mauthner, M., Birch, M., Jentsch, B. and Miller, T. eds.) Sage, London, pp. 32-52.
- Ginsburg, F. (1989) *Contested lives: The abortion debate in an American community*, University of California Press, Berkeley, CA.
- Ginsburg, F.D. & Rapp, R. (eds.) (1995) *Conceiving The New World Order: The Global Politics of Reproduction*, University of California Press, Berkeley, CA.
- Gubrium, J.F. & Holstein, J.A. (2003) *Postmodern Interviewing*, Sage Publications, Thousand Oaks, CA.
- Gubrium, J.F. & Holstein, J.A. (2009) *Analyzing Narrative Reality*, Sage Publications, Los Angeles.
- Gusfield, J.R. (1989) The Bridge over Separated Lands: Kenneth Burk's Significance for the Study of Social Action. In *The Legacy of Kenneth Burk* (Simons, H. W. and Melia, T. eds.) The University of Wisconsin Press, Madison, WI, pp. 28-54.

- Hall, S. (2006) Cosmopolitanism, Globalization and the Diaspora: Stuart Hall in conversation with Pnina Werbner. In *Anthropology and the New Cosmopolitanism* (Werbner, P. ed. BERG, Oxford, pp. 345-360.
- Halse, C. & Honey, A. (2005) Unraveling Ethics: Illuminating the Moral Dilemmas of Research Ethics. *Signs: Journal of Women in Culture and Society*, **30**(4), 2141-2162.
- Haraway, D. (2004) Situated Knowledge: The Science Question in Feminism and the Privilege of Partial Perspective. In *The Feminist Standpoint Theory Reader: Intellectual & Political Controversies* Routledge, New York, pp. 81-102.
- Harding, S. (1993) Rethinking Standpoint Epistemology: What is 'Strong Objectivity'? In *Feminist Epistemologies* (Alcoff, L. and Potter, E. eds.) Routledge, New York, pp. 49-82.
- Harding, S. (1998) *Is Science Multicultural? Postcolonialisms, Feminisms, and Epistemologies*, Indiana University Press, Bloomington.
- Harding, S. (ed.) (2004) *The Feminist Standpoint Theory Reader: Intellectual & Political Controversies*, Routledge, New York.
- Harding, S. & Norberg, K. (2005) New Feminist Approaches to Social Science Methodologies: An Introduction. *Signs: Journal of Women in Culture and Society*, **30**(4), 2009-2015.
- Haughey, N. (2003) Working on low staff morale at Maternity hospitals. Irish Times, Feb. 27th, Dublin.
- Hill Collins, P. (1990) *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, Unwin Hyman, Boston.
- Hill Collins, P. (1991) *Black Feminist Thought*, Routledge, London.
- Hill Collins, P. (2004) Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought. In *The Feminist Standpoint Theory Reader: Intellectual & Political Controversies* Routledge, New York, pp. 103-126.
- Hollway, W. & Jefferson, T. (2002) *Doing qualitative research differently: Free association, narrative and the interview method*, Sage, London.
- hooks, B. (2001) *all about love: New Visions*, Harper Perennial, New York.
- Hughes, D.M. (2000) The 'Natasha' Trade - The Transnational Shadow Market of Trafficking in Women. *Journal of International Affairs*.
- Hunter, B. (2004) Conflicting ideologies as a source of emotion work in midwifery. *Midwifery*, **20**, 261-272.

- Hunter, B., Berg, M., Lundgren, I., Olafsdottir, O. & Kirkham, M. (2008) Relationships: The hidden threads in the tapestry of maternity care. *Midwifery*, **24**(2), 132-137.
- Hyland, M. (2001) 'Refugee Subjectivity: "Bare life" and the geographical division of labour'. In *The Physics Room. The Revolution Issue* Available from www.physicsroom.org.nz/log/arcg.../refugeesubjectivity.ht.
- Hynes, P. (2009) Contemporary Compulsory Dispersal and the Absence of Space for the Restoration of Trust. *Journal of Refugee Studies*, **22**(1), 97-121.
- Inglis, T. (2008) *Global Ireland*, Routledge, New York.
- International Labour Organisation (ILO) (2000) Director-Generals message on International Migrants Day. International Labour Organization, Geneva.
- Jentsch, B., Durham, R., Hundley, V. & Hussein, J. (2007) Creating consumer satisfaction in maternity care: the neglected needs of migrants, asylum seekers and refugees. *International Journal of Consumer Studies*, **31**, 128-134.
- Johns, C. (2002) Clinical Supervision as a model for clinical leadership. *Journal of Advanced Nursing*, **11**, 25-34.
- Jordan, B. (1993) *Birth in four cultures*, Waveland Press, Illinois.
- Kennedy, P. (2010) Maternity services in Ireland. In *Health Policy*.
- Kennedy, P. & Murphy-Lawless, J. (2003) The Maternity care needs of refugee and asylum seeking women in Ireland. *Feminist Review*, **73**, 39-53.
- Kesby, M. (2005) Rethorizing Empowerment - through-Participation as a Performance in Space: Beyond Tyranny to Transformation. *Signs: Journal of Women in Culture and Society*, **30**(4), 2037-2065.
- Kinder, P. (2001) Kinder, P. Report of the Maternity Services Review Group. North Eastern Health Board, Kells
- King, D. (2004) *Immigration and Citizenship in Ireland*, Children's Rights Alliance, Dublin.
- Kirsch, G.E. (2005) Friendship, Friendliness, and Feminist Fieldwork. *Signs: Journal of Women in Culture and Society*, **30**(4), 2163-2172.
- Klassen, P.E. (2001) *Blessed Events: Religion and Home Birth in America*, Princeton University Press, Princeton.
- KPMG (2008) KPMG Independent Review of Maternity & Gynaecology Services in the Greater Dublin Area. Dublin

- Krippendorff, K. (2005) *Content analysis: An introduction to its methodology*, Sage Publications, Thousand Oaks, CA.
- Krulfield, R.M. (1998) Exploring New Methods for Collaboration in Ethnographic Research: An Attempt at Overcoming Exploitation and Violation of Informant Rights. In *Power, Ethics, and Human Rights: Anthropological Studies of Refugee Research and Action* (Krulfield, R. M. and MacDonald, J. L. eds.) Rowman & Litterfield Publishers, Inc., Lanham, pp. 21-56.
- Kvale, S. & Brinkmann, S. (2009) *Interviews: Learning the Craft of Qualitative Research Interviewing*, Sage Publishers, Los Angeles.
- Labov, W. (1972) *Language of the inner city: Studies in the black English vernacular*, University of Pennsylvania Press, Philadelphia.
- Labov, W. (1982) Speech actions and reactions in personal narrative. In *Analyzing discourse: Text and talk* (Tanner, D. ed. University of Washington Press, Washington, DC, pp. 219-247.
- Labov, W. (1997) Some Further Steps in Narrative Analysis. *Journal of Narrative and Life Histories*, **7**(1-4), 395-415.
- Labov, W. & Waletzky, J. (1967) Narrative analysis: Oral versions of personal experience. In *Essays on the verbal and visual arts* (Helm, J. ed. American Ethnological Society/University of Washington Press, Seattle, pp. 12-44.
- Lather, P. (1991) *Getting Smart: Feminist Research and Pedagogy with/in the Postmodern*, Routledge, New York.
- Lather, P. (2002) Postbook: Working the ruins of feminist ethnography. *Signs: Journal of Women in Culture and Society*, **27**, 11.
- Lentin, R. (2007a) Illegal in Ireland, Irish Illegals: Diaspora Nation as Racial State. *Irish Political Studies*, **22**(4), 433-453.
- Lentin, R. (2007b) Ireland: Racial state and crisis racism. *Ethnic and Racial Studies*, **30**(4), 610-627.
- Liamputtong Rice, P. & Naksook, C. (2003) Life as mothers in a new land: experience of motherhood among Thai women in Australia. *Health Care Women International*, **24**(7), 650-668.
- Lincoln, Y.S. & Guba, E. (1985) *Naturalistic Inquiry*, Sage, Thousand Oaks, CA.
- Lyons, S.M., O'Keeffe, M., Clarke, A.T. & Staines, A. (2008) Cultural diversity in the Dublin maternity services: the experience of maternity service providers when caring for ethnic minority women. *Ethnicity & Health*, **13**(3), 261-276.

- Manandhar, M., Share, M., Friel, S., Walsh, O. & Hardy, F. (2006) *Food, Nutrition and Poverty Among Asylum Seekers in North West Ireland*, National University of Ireland, Galway.
- Mauthner, M., Birch, M., Jessop, J. & Miller, T. (2002a) *Ethics in Qualitative Research*, Sage, London.
- Mauthner, M., Birch, M., Jessop, J. & Miller, T. (eds.) (2002b) *Ethics in Qualitative Research*, Sage, London.
- Mbugua, S. (2010) Mbugua, S. 'Am Only Saying It Now': Experiences of Women Seeking Asylum in Ireland. Dublin AkiDwA
- Mc Mahon, J. (2007) A survey of asylum seekers' general practice service utilization and morbidity patterns. *Irish Medical Journal*, **100**(5), 461-464.
- McCall, L. (2005) The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society*, **30**(3), 1771-1800.
- McCarthy, J., Murphy, S. & Loughrey, M. (2008) Gender and Power: the Irish Hysterectomy Scandal. *Nursing Ethics*, **15**(5), 643-655.
- McCourt, C. & Stevens, T. (2008) Relationship and Reciprocity in Caseload Midwifery. In *Emotions in Midwifery and Reproduction* (Hunter, B. and Deery, R. eds.) Palgrave Macmillan, London.
- McLeish, J. (2002a) McLeish, J. Mothers in Exile Maternity experience of asylum seekers in England. London Maternity Alliance
- McLeish, J. (2002b) Mothers in Exile: Maternity experiences of asylum seekers in England. In *Maternity Alliance*.
- Millar, S. (2010) State is failing asylum seekers, finds committee. *Irish Examiner*, July 23rd, Cork.
- Mishler, E.G. (1991) Representing discourse: The rhetoric of transcription. *Journal of Narrative and Life Histories*, **1**, 255-280.
- Mishler, E.G. (1995) Models of narrative analysis: A typology. *Journal of Narrative and Life Histories*, **5**, 87-123.
- Mishler, E.G. (1996) Missing persons: Recovering developmental stories/histories. In *Ethnography and human development: Context and meaning in social inquiry* (Jessor, R., Colby, A. and Shweder, A. eds.) University of Chicago Press, Chicago, pp. 74-99.
- Mishler, E.G. (1999) *Storylines: Craftartist's narratives of identity*, Harvard University Press, Cambridge, MA.

- Mohanty, C.T. (1986) Under Western Eyes: Feminist Scholarship and Colonial Discourses. *Boundary 2*, **12**(3), 333-358.
- Mohanty, C.T. (2003) Under Western Eyes" Revisited: Feminist Solidarity through Anticapitalist Struggles. *Signs: Journal of Women in Culture and Society*, **28**(2), 499-535.
- Murphy-Lawless, J. (1998) *Reading Birth and Death: A history of Obstetric Thinking*, Cork University Press, Cork.
- Murphy-Lawless, J. (2003) How will the World be Born: The Critical Importance of Indigenous Midwifery. *Royal College of Midwives Midwifery Journal*, **6**(10).
- Murphy, J.F.A. (2005) Migrants' Rights to Health. In *Irish Medical Journal*, Vol. 98.
- Naples, N.A. (2003) *Feminism and Method: Ethnography, Discourse Analysis and Activist Research*, Routledge, New York.
- National Consultative Committee on Racism and Interculturalism & IHSMI (2002) National Consultative Committee on Racism and Interculturalism & IHSMI Cultural Diversity in the Irish Health Care Sector: Towards The Development of Policy and Practice Guidelines For Organisations in the Health Sector. Dublin Health Services Management Institute
- Nicholas, F.H. (1996) The meaning of childbirth experience: A review of the literature. *The Journal of Perinatal Education*, **5**(4), 71-77.
- Norredam, M., Mygind, A. & Krasnik, A. (2005) Access to health care for assylum seekers in the European Union - a comparative study of country policies. *European Journal of Public Health*, **16**(3), 285-289.
- O'Connor, M. (2006) Conjuring choice while subverting autonomy: medical technocracy and home birth in Ireland. In *Rish and choice in maternity care: an international perspective* (Symon, A. ed. Churchill Livingstone Elsevier, London, pp. 109-122.
- O'Sullivan, J.P. (2003) Time to stop bogus assylum seekers. Irish Independent, Feb. 2nd, Cork.
- Oakley, A. (2000) *Experiments in Knowing: Gender and Method in the Social Sciences*, Polity Press, Cambridge.
- Office of the Attorney General (1996) Refugee Act. House of the Oireachtas. Dublin.
- Office of the Attorney General (1998) Employment Equality Act. House of the Oireachtas. Dublin.

- Office of the Attorney General (1999) Immigration Act, 1999. House of the Oireachtas. Dublin.
- Office of the Attorney General (2000) Illegal Immigrants (Trafficking) Act. House of the Oireachtas. Dublin.
- Office of the Attorney General (2002) Equal Status Act. House of the Oireachtas.
- Office of the Attorney General (2004a) Equal Status Act. House of the Oireachtas.
- Office of the Attorney General (2004b) The Twenty-Seventh Amendment of the Constitution Bill on citizenship rights. House of the Oireachtas.
- Office of the Refugee Applications Commissioner (2010) (Refugee Status Determination ed. ORAC, Dublin.
- Omi, M. & Winant, H. (1994) *Radical Formation in the United States: From the 1960s to the 1990s*, Routledge, New York.
- Omidian, P.A. (1994) Life Out of Context: Recording Afghan Refugees' Stories. In *Reconstructing Lives, Recapturing Meaning: Refugee Identity, Gender, and Cultural Change*
- (Camino, L. A. and Krulfield, R. M. eds.) Gordon and Breach Publishers, Washington, pp. 151-178.
- Ottani, P. (2002a) Embracing global similarities: a framework for cross-cultural obstetric care. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, **31**(1), 33-38.
- Ottani, P. (2002b) When Childbirth Preparation Isn't a Cultural Norm. *International Journal of Childbirth Education*, **17**(2), 12-15.
- Pieper, H.-O., Clerkin, P. & MacFarlane, A. (2009) Pieper, H.-O., Clerkin, P. & MacFarlane, A. The Impact of Direct Provision Accommodation for Asylum Seekers on Organisation and Delivery of Local Health and Social Care Services: A Case Study. Galway Department of General Practice, National University of Ireland, Galway
- Plummer, K. (1995) *Telling sexual stories: Power, change, and social worlds*, Routledge, London.
- Raleigh, V., Hussey, D., Seccombe, I. & Hallt, K. (2010a) Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. *J R Soc Med*, **103**(5), 188-198.
- Raleigh, V., Hussey, D., Seccombe, I. & Hallt, K. (2010b) Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. *Journal of the Royal Society of Medicine*, **103**(5), 188-198.

- Ramazanoglu, C. & Holland, J. (2008) *Feminist Methodology: Challenges and Choices*, Sage, Los Angeles.
- Reinhart, S. & Chase, S. (2002) Interviewing Women. In *The Handbook of Interview Research: Context and Method* (Holstein, J. and Gubriun, J. eds.) Sage, Thousand Oaks, CA, pp. 221-238.
- Reinhart, S. & Chase, S.E. (2003) Interviewing Women. In *The Handbook of Interview Research: COntext and Method* (Holstein, J. and Gubriun, J. eds.) Sage, Thousand Oaks, CA, pp. 73-90.
- Reinharz, S. (1992) *Feminist methods in social research*, Oxford University Press, New York.
- Reinharz, S. & Chase, S.E. (2003) Interviewing Women. In *Insider Interviewing: New Lenses, New Concerns* (Holstein, J. and Gubrium, J. F. eds.) Sage, Thousand Oaks, CA, pp. 73-90.
- Riessman, C.K. (1987) When gender is not enough: Women interviewing women. *Gender & Society*, **1**, 172-207.
- Riessman, C.K. (1989) Life events, meaning and narrative: The case of infidelity and divorce. *Social Science and Medicine*, **29**, 743-751.
- Riessman, C.K. (1990) *Divorce talk: Women and men make sense of personal relationships*, Rutgers University Press, New Brunswick, NJ.
- Riessman, C.K. (1991) Beyond reductionism: Narrative genres in divorce accounts. *Journal of Narrative and Life Histories*, **1**, 41-68.
- Riessman, C.K. (1993) *Narrative Analysis*, Sage Publications, Thousand Oaks, CA.
- Riessman, C.K. (1997) A short story about long stories. *Journal of Narrative and Life Histories*, **7**, 155-159.
- Riessman, C.K. (2000a) "Even if we don't have children [we] can live": Stigma and infertility in South India. In *Narratives and cultural construction of illness and healing* (Mattingly, C. C. and Garro, L. C. eds.) University of California Press, Berkeley, CA, pp. 128-152.
- Riessman, C.K. (2000b) Stigma and everyday resistance practices: Childless women in South India. *Gender & Society*, **14**, 111-135.
- Riessman, C.K. (2002) Positioning gender identity in narratives of infertility: South Indian women's lives in context. In *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies* (Inhorn, M. C. and van Balen, F. eds.) University of California Press, Berkely, CA, pp. 152-170.

- Riessman, C.K. (2003) Performing identities in illness narrative: Masculinity and multiple sclerosis. *Qualitative Research*, **3**, 5-33.
- Riessman, C.K. (2004) A thrice told tale: New readings of an old story. In *Narrative research in health and illness* (Hurwitz, B. B., Greenhalgh, T. and Skultans, V. eds.) British Medical Journal Books/Blackwell, London, pp. 309-324.
- Riessman, C.K. (2005) Exploring ethics: A narrative about narrative research in South India. *health: An interdisciplinary Journal for the Social Studies of Health, Illness and Medicine*, **9**, 473-490.
- Riessman, C.K. (2008) *Narrative Methods for the Human Sciences*, Sage Publications, Los Angeles.
- Riessman, C.K. & Quinney, L. (2005) Narrative in social work: A critical review. *Qualitative Social Work*, **4**, 383-404.
- Ropp, C.C. (2002) *Mapping Obstetric Medicine and Traditional Midwifery*. National Communication Association: New Orleans, LA.
- Rosenblatt, P.C. (2003) Interviewing at the Border of Fact and Fiction. In *Postmodern Interviewing* (Gubrium, J. F. and Holstein, J. eds.) Sage, Thousand Oaks, CA, pp. 225-243.
- Ryan, D.A., Benson, C. & Dooley, B. (2008) Psychological Distress and the Asylum Process: A Longitudinal Study of Forced Migrants in Ireland. *Journal of Nervous & Mental Disease*, **196**(1), 37-45.
- Sandelowski, M. (1991) Telling Stories: Narrative Approaches in Qualitative Research. *IMAGE: Journal of Nursing Scholarship*, **23**(3), 161-166.
- Sassen, S. (2002) Women's Burden: Counter-Geographies of Globalization: The Feminization of Survival. *Nordic Journal of International Law*, **71**(2), 255-274.
- Schrover, M., Van Der Leun, J., Lucassen, L. & Quispel, C. (eds.) (2008) *Illegal Migration and Gender in a Global and Historical Perspective*, Amsterdam University Press, Amsterdam.
- Siddiqui, T. (2003) Siddiqui, T. Migration as a Livelihood Strategy of the Poor: the Bangladesh Case. Dhaka, Bangladesh The Refugee and Migratory Movements Research Unit
- Smith, D.E. (1997) Comment on Hekman's Truth and Method: Feminist Standpoint Theory Revisited. *Signs: Journal of Women in Culture and Society*, **22**(2), 392-398.
- Smyth, J. (2010a) 150 asylum-seekers in Mosney told to move hostels within days. The Irish Times, Saturday, July 3rd, Dublin.

- Smyth, J. (2010b) 'It was impossible to get any sleep or rest' says mother who miscarried. *The Irish Times*, Friday, June 18th, Dublin.
- Sprague, J. (2005) *Feminist Methodologies for Critical Researchers: Bridging Differences*, Altamira, Walnut Creek.
- Sr Keenan, B. (2008) Loneliness is the Most Terrible Poverty. *Metro Eireann*, Dublin.
- Steinberg, S. (1996) Childbearing research: A transcultural review. *Social Science and Medicine*, **43**(12), 1765-1784.
- Steward, R. (2006) Steward, R. The Mental Health Promotion Needs of Asylum Seekers and Refugees: A Qualitative Study in Direct Provision Centers and Private Accommodation in Galway City. Galway City Development Board. Health promotion Services, HSE West
- Stewart, R. (2006) Stewart, R. The Mental Health Promotion Needs of Asylum Seekers and Refugees. Galway Galway City Development Boardm Health Promotion Services, Health Services Executive West
- Structural Adjustment Participatory Review International Network (SAPRIN) (2004) Structural Adjustment Participatory Review International Network (SAPRIN) The Policy Roots of Economic Crisis and Poverty: A Multi-Country Participatory Assessment of Structural Adjustment. Washington, DC SAPRIN
- Taran, P. & Geronimi, E. (2002) Taran, P. & Geronimi, E. Globalization, Labor and Migration: Protection is Paramount. Geneva International Migration Program
- Taylor, V. & Rupp, L.J. (2005) When the Girls Are Men: Negotiating Gender and Sexual Dynamics in a Study of Drag Queens. *Signs: Journal of Women in Culture and Society*, **30**(4), 2115-2139.
- Thorne, B. (1994) Review of Science and the Self: Personal Essays on an Art Form by Susan Krieger. *Gender and Society*, **8**(1), 138-139.
- Tobin, C. (1996) *Marginalized Woman: The Experience of Caesarean Birth*. University of Leciester, Leciester.
- Tussing, A.D. & Wren, M.-A. (2006) *How Ireland Cares: The Case for Health Care Reform*, New Ireland, Dublin.
- Tyrell, F. (2004) Doctors call for No vote in referendum. *The Irish Times*, Monday, May 31st, Dublin.
- Uehling, G. (1998) Is there "Refuge" in the Refugee Category? In *Power, Ethics, and Human Rights: Anthropological Studies of Refugee Research and Action* (Krulfield, R. M. and MacDonald, J. L. eds.) Rowman & Littlefield Publishers, Inc., Lanham, pp. 123-146.

- Ukoko, F. (2005) Sure Start Midwife: Giving a voice to the voiceless. *British Journal of Midwifery*, **13**(12), 776-780.
- Visser, A. & O'Connor, J. (2004) *European Network Against Racism (ENAR) Shadow Report 2004 Ireland*, European Commission, DG Employment and Social Affairs and the Compagnia di San Paolo, San Palo.
- Warner, F., R (1998) The Testimonio Method in Refugee Research: Practicing Advocacy and Feminism in Ethnographic Encounter with Q'eqchi' and K'iche' Women. In *Power, Ethics and Human Rights: Anthropological Studies of Refugee Research and Action* (Krulfield, R. M. and MacDonald, J. L. eds.) Rowman & Littlefield Publishers, Inc., Lanham, pp. 73-96.
- Wickramasekara, P. (2002) Wickramasekara, P. Asian labor migration: Issues and challenges in an era of globalization. Geneva International Labour Organization
- Women's Health Council (2006) Women's Health Council National Intercultural Health Strategy: Submission to the Health Service Executive. Dublin The Women's Health Council
- Young, I.M. (1997) *Intersecting Voices: Dilemmas of Gender, Political Philosophy and Policy*, Princeton University Press, Princeton.
- Zingaro, L. (2009) *Speaking Out: Storytelling for social change*, Left Coast Press Inc, Walnut Creek, CA.

APPENDIX I

**Approval letter from the Faculty of Health Sciences Research Ethics
Committee, The University of Dublin, Trinity College, Dublin.**



THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci
Dean of School of Medicine
Deputy Provost for Medical Affairs

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School Administrator

Trinity College, Dublin 2, Ire
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email: fmcnamar@t

Ms Carolyn Tobin
Lecturer
School of Nursing & Midwifery
24 D'Olier Street
College

Friday, 01 December 2006

Study: Childbirth in exile: refugee and asylum seeking women's experience of childbirth in Ireland

Dear Ms Tobin

Further to a meeting of the Faculty of Health Sciences Research Ethics Committee in 2006, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Professor Chris Bell
Chairperson
Faculty of Health Sciences Research Ethics Committee

APPENDIX II

**Approval letter from the Research Ethics Committee
The Rotunda Hospital, Dublin.**

Telephone: 8730700 Fax: 8730932

The Rotunda Hospital, Dublin

Founded 1745

Incorporated by Royal Charter 1756

Not for Prescription Purposes

20th July, 2006.

Ms. Carolyn Tobin,
School of Midwifery,
Rotunda Hospital.

**Re: Childbirth in Exile: Refugee and Asylum Seeking Women's Experience
of Childbirth in Ireland**

Dear Ms. Tobin,

Thank you for coming to the Research Ethics Committee meeting this morning. The Committee noted that this project represents your PhD proposal and that it will be a fulltime project for three years. The Committee also noted that you will be interviewing ten patients that fit with your inclusion criteria in this hospital and ten in another hospital.

You will remember some of the points that were touched upon this morning including the fact that you felt nothing similar had been before. You will also recall that it is important that all language versions are similar and you will revert to us in due course when this has been done. We also noted that the interpreter will be funded out of your research grant.

The Committee was interested in how the individuals would be selected and noted that in addition to a certain element of self-selection and selection by the gate keeper there may also be some element of selection necessary on the part of the researcher.

The Committee would wish to see the final Trinity approval but have not ethical difficulties to this study starting.

With kind regards,

Yours sincerely,



Dr. P. McKenna.
Chairman.
Research Ethics Committee.

APPENDIX III

**Approval letter from the Healthcare Research Advisory Committee
Health Services Executive North East.**



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Copy

Dublin Road
Kells, Co. Meath

Tel: +353 (0) 46 9280500
Fax: +353 (0) 46 9241459

5th February 2007

Ms Carolyn Tobin
92 Burnell Square
Northern Cross
Malahide Road
Dublin 17

Re/ **Research Study Proposal:**
"Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland"

Dear Ms. Tobin

I wish to advise that Ms. Mary McCarthy (designated member of the Committee to review amendments from you) has now had an opportunity to review the amended documentation submitted by you and has advised me that your revised submission appropriately addresses the queries raised by the Healthcare Research Advisory Committee at their meeting on 4th January 2007 with regard to your above study.

I wish to advise that your study has been approved to commence.

Yours sincerely,

Dr. Declan Bedford
Chairman
Healthcare Research Advisory Committee
HSE Dublin North East

Copied to/ Ms Colette McCann, A/Director of Midwifery, Our Lady of Lourdes Hospital, Drogheda
Ms Roisin Maguire, General Manager, Louth Hospitals, Our Lady of Lourdes Hospital, Drogheda
Dr Jo Murphy-Lawless, Lecturer, School of Nursing and Midwifery, Trinity College, 24 D'Olier Street, Dublin 2

✓
all sent
13/2/07
DF

APPENDIX IV

Consent Form for Refugee and Asylum Seeking Women
(Translated in French, Portuguese and Russian)

Title of Research Study:

Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland.

Research's Contact Details:

Ms. Carolyn Tobin:

Telephone: 086 XXXXXX (dedicated phone line) Email: carolyn.tobin@gmail.com

Background and Procedures:

The purpose of this study is to describe refugee and asylum seeking women's experience of childbirth in Ireland and also the views held by practising midwives in Ireland in relation to the needs of refugee and asylum seeking women in their care. Participation will involve an interview which will be about one hour long. An interpreter will be present if you so wish. The interview will also be audio-taped with your permission. During the interview you will be asked some general background information. You will then be asked to describe your experience of pregnancy and childbirth in Ireland. After the interview the taped recording will be typed up and analysed by the researcher. You will have the option to meet up later to discuss the interview when you will have an opportunity to read the typed version of your interview. The findings of the research study will be written up as a report and parts of it may be used in future publications and/or presentation at a conference. At no time will actual names of people be revealed, your identity will be protected at all times. You are free to withdraw from this study at any time and this will in no way affect the standard of care you receive. Your application for refugee or asylum status will in no way be affected by participation or withdrawal from the study

Declaration (Please read and tick if you agree):

- I have read the study information sheet.
- I have read and understand this consent form.
- I have had opportunity to ask questions
- All my questions have been answered to my satisfaction.
- I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential.
- I understand that I will have access to the typed version of my interview.
- I understand that my individual application for asylum will in no way be affected by participating in the study.
- I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights.
- I have received a copy of this agreement and I understand the results of

this research study will be published.
I understand that I may withdraw from the study at any time.



PARTICIPANT'S NAME (Block Capitals):.....

PARTICIPANT'S CONTACT NUMBER:.....

PARTICIPANT'S SIGNATURE:.....

Date:.....

Statement of Investigators responsibility:

I have explained the nature and purpose of this study to the person named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and have freely given informed consent to participate in the study.

Investigators Signature:.....

Date:.....

For Investigators Use Only:
Code:.....

Participant

APPENDIX V

**STUDY INFORMATION SHEET FOR
REFUGEE AND ASSYLUM SEEKING WOMEN
(Translated into French, Portuguese, and Russian)**

**STUDY INFORMATION SHEET FOR
REFUGEE AND ASSYLUM SEEKING WOMEN
(Translated into French, Romanian, Russian and Portuguese)**

TITLE OF STUDY:

Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland

INTRODUCTION:

You are invited to participate in this study because of your experiences of giving birth in a country which is not your country of origin. The purpose of this study is to describe refugee and asylum seeking women's experience of childbirth in Ireland and to describe the views held by practising midwives in Ireland in relation to the needs of refugee and asylum seeking women in their care

PROCEDURES: WHAT WILL THE STUDY INVOLVE?

A midwife who is currently conducting the research study will meet with you for approximately one hour to talk about your experience of pregnancy and childbirth. During the interview you will be asked to provide some general background information. You will then be asked to describe your experience of giving birth here in Ireland. With your permission this interview will be audio-taped. After the interview the recording will be transcribed and analysed. You will be given an opportunity at a future date to read a transcript of your interview to ensure you are happy with it.

The findings of the interviews will be combined in a report. This report may be submitted for publication and or presentation at a conference and may be the basis for the development of further services for refugee and asylum seeking women's who require maternity care within Ireland.

WHO CAN PARTICIPATE IN THE STUDY?

You can take part in the study if:

You are over 18 years of age.

You are a refugee or asylum seeker in this country.

You understand the purpose and process of the research.

You are willing to voluntarily participate in the study.

BENEFITS:

To date, no study has been undertaken which focuses on the refugee and asylum seeking women's experience of giving birth in Ireland. The interview is an opportunity for you to tell your story and reflect upon your experiences.

It is hoped that this study will lead to greater knowledge of the experience of refugee and asylum seeking women as they access maternity care services. The study findings may also help influence the development of maternity service that are responsive to women's needs and committed to providing quality care which is flexible, respectful and culturally sensitive.

RISKS:

There are no known risks to you if you choose to take part in this study. Sometimes however talking about childbirth may be upsetting. Should you find this upsetting your wellbeing is a priority over the research study. We can stop the interview, can continue, if you wish at another time and or refer you to support services, if you so wish, available through the Psychological Services for Refugee and Asylum Seekers, St. Brendan's Hospital.

EXCLUSION FROM PARTICIPATION:

You cannot be included in this study if:

You are under the age of 18 years.

You are not seeking refuge or asylum in Ireland.

You do not understand the purpose and process of the research.

You are not willing to voluntarily participate in the study.

CONFIDENTIALITY:

All information collected in this study will be treated as confidential. Your identity will remain confidential. A code will be assigned to your interview. You will have access to your interview transcript, if you wish. Your name will not be published and will not be disclosed to anyone outside the study group.

COMPENSATION:

This study is covered by standard institutional indemnity insurance. Nothing in this document curtails your rights. There will be no payment for participation.

VOLUNTARY PARTICIPATION:

Your participation in this study is voluntary. You may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits which you had before entering the study. Participation in this study will in no way influence your individual application for asylum in this country.

WHO IS SUPPORTING THIS STUDY?

The study is being funded by the School of Nursing and Midwifery, Trinity College, Dublin and has been approved by the Faculty of Health Sciences Ethics Committee Trinity College Dublin, Rotunda Hospital Ethical Committee and Our Lady of Lourdes Hospital Ethical Committee, Drogheda.

FURTHER INFORMATION:

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Carolyn Tobin who can be telephoned at 086- XXXXXXX or e-mailed at carolyn.tobin@gmail.com. Alternatively you can contact the research supervisor Dr Jo Murphy-Lawless, School of Nursing and Midwifery, Trinity College Dublin by telephone at 01-6082692 or by e-mail jlawless@tcd.ie.

APPENDIX VI

**SAMPLE OF LETTER OF INVITATION TO
REFUGEE AND ASSYLUM SEEKING WOMEN
(Translated into French, Romanian, Russian and Portuguese)**

**SAMPLE OF LETTER OF INVITATION TO
REFUGEE AND ASSYLUM SEEKING WOMEN**

Dear

I am writing to invite you to take part in a research study entitled 'Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland'. This aim of this study is to provide refugee and asylum seeking women with an opportunity to talk about their experience of childbirth in Ireland. Your personal identity will never be revealed and will remain confidential at all times. Your personal stories and experiences are the most important aspect of this study and as your stories are told it is my hope that health care providers who look after you will better understand what your needs are and be able to offer the best possible care to women in the future. The study is funded by the School of Nursing and Midwifery Studies at Trinity College, and has been approved by the Ethics Committee at Trinity College Dublin and also the ethics committee at the Rotunda Hospital, Dublin and Our Lady of Lourdes Hospital, Drogheda.

This letter is being delivered to you on my behalf. I do not know who will receive this letter and will make no further contact with you, should you decide not to take part in the study.

Should you be willing to take part in the study I would like to talk to you about your experiences of pregnancy and childbirth here in Ireland. The discussion would last about 45 minutes to one hour, will be very informal and can be stopped at any time by yourself should you wish not to continue. An interpreter will be provided if you would like to have one present. With your permission, I would like to tape record the discussion as this will help me with the information and ensure that I have heard your story correctly. I will be the only person listening to the tapes and they will be destroyed once the research process is completed.

I have attached some further information about the research study, which I hope will answer any questions you may have. Please feel free to contact me on the numbers listed or return the 'Interested in Participating' slip in the enclosed stamped addressed envelope. If you do indicate an interest to participate, I will contact you and arrange a convenient time to meet.

I would like to assure you that the information given would be treated in strictest confidence. At no time will your identity, place of residence or links with any healthcare personnel or hospitals be exposed. All names will be changed to guarantee this. You will be free to withdraw from the study at any time should you wish. Withdrawal from the study will not affect the standard of care you receive in any way. Your participation in or withdrawal from this study, will not affect your application for refuge or asylum in Ireland in any way.

Thank you for taking the time to read this letter. I do hope you will consider contributing to this important study.

Yours sincerely,

CAROLYN TOBIN
Researcher

APPENDIX VII

Confirmation of Availability of Free Counselling Services to Women Participating in the Study



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Psychology Service for Refugees
and Asylum Seekers
Department of Psychology
St. Brendan's Hospital
Rathdown Road
Dublin 7

Telephone: [01] 869 3081
Fax Number: [01] 869 3087

27TH June 2006

Dear Carolyn,

Many thanks you for your research proposal, which sounds like a worthwhile piece of work. If while conducting your research you find it necessary to refer any of the women to our service we will offer them an assessment--- This applies to those living in the greater Dublin area only. Drogheda also has a designated Counselling Service for refugees and asylum seekers,

Good luck with your research,

Yours sincerely,

Maeve Stokes

Principal Psychologist

APPENDIX VIII

Permission from the Department of Justice, Equality and Law Reform to Gain Access to Women in Accommodation Centers



DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM
AN ROINN DLÍ AGUS CIRT, COMHIONANNAIS AGUS ATHCHÓIRITHE DLÍ

RECEPTION AND INTEGRATION AGENCY
ÁISINEACHT FHÁILTE, AGUS COMHTHÁITE

12 February, 2008.

Ms. Toibin,

Further to our recent telephone conversation and your interest in speaking to some of the mothers in our Accommodation centre at Mosney. I spoke to my Assistant Principal Officer - Ms Teresa Clarke - who has no objections to you contacting the Centre.

I have spoken with the General Manager at Mosney, Mr. Pat McKenna and he would have no problem with you visiting the Centre and speaking with some of the mothers there. We have an on site health centre at Mosney and I have also informed the staff there of your interest. Initial contact should be made with Mr. McKenna. Contact details below.

Regards

Grace Campbell, Reception and Integration Agency,

01 4193241.

Mr. Pat McKenna, General Manager, Mosney Accommodation Centre. Tel: 041 9829200/086 8098688

Frances McCardle, Public Health Nurse, Health Centre, Mosney Acc. Centre. Tel: 041 9829780

APPENDIX IX

**Letters of Request/Confirmation Sent to Gatekeepers at Two Maternity
Hospitals**

**Letters of Request/Confirmation Sent to Gatekeepers at Two Maternity
Hospitals**

Identifiers have been removed

Ms XXXX XXXX
CMM3
Outpatients Department
XXXXX Hospital
XXXX
XXXXXXXX1

27.07.06

Dear XXXX,

Following our discussion confirming your support for the research study entitled 'Childbirth in Exile: Refugee and Asylum Seeking Women's Experience of Childbirth in Ireland' and your willingness to assist in the recruitment of suitable women to the study.

Ethical approval has been granted from Trinity College (where I am s PhD Student), the Rotunda Hospital (my area of clinical/educational link) and HSE North East (which covers the Accommodation centre at Mosney).

Once again I would like to assure you that the information obtained will be treated in strictest confidence. At no time will your identity, place of employment or links with any healthcare personnel or institutions be exposed. All names etc. will be changed to guarantee this.

I am attaching a copy of the letters of invitation, information packs and consent forms to be used. All of these will also be available in French, Portuguese and Russian.

Yours sincerely,

Carolyn Tobin
Researcher

APPENDIX X

French Translations of Letters of Invite

**LETTER OF INVITATION TO
REFUGEE AND ASSYLUM SEEKING WOMEN (French)**

Date

Chère

Je suis sage-femme et je poursuis actuellement un doctorat au sein de la faculté des Sciences de la Santé à Trinity College Dublin. Mon sujet de recherche intitulé « Expérience de l'accouchement en Irlande des femmes réfugiées et demandeuses d'asile » est financé par l' Ecole des études d'infirmières et de sage-femme de Trinity College.

Je vous écris pour vous inviter à prendre part à cette étude. Vous avez été choisie par le responsable de la clinique où vous vous rendez pour vos soins maternels comme quelqu'un qui pourrait être intéressée de partager votre expérience concernant l'accouchement dans un pays qui n'est pas votre pays d'origine. Cette étude a été approuvée par le comité d'éthique de Trinity College Dublin, du comité d'éthique de l'hôpital Rotunda, et du comité d'éthique de l'hôpital Notre-Dame de Lourdes de Drogheda.

Cette lettre vous est adressée de ma part. Je ne sais pas qui va recevoir cette lettre et je ne prendrai pas de contact ultérieur avec vous si vous décidez de ne pas prendre part à cette étude.

Si vous souhaitez prendre part à cette étude, j'aimerais m'entretenir avec vous sur votre expérience de la grossesse et de l'accouchement en Irlande. L'entretien durera entre 45 minutes et une heure, sera très informel et vous pourrez décider de l'arrêter à tout moment si vous le souhaitez. Avec votre permission je souhaite enregistrer la discussion sur cassette ce qui m'aidera à m'assurer que j'ai entendu votre récit correctement. Je serai la seule personne à écouter ces cassettes et elles seront détruites une fois la recherche terminée.

J'ai joint quelques informations complémentaires concernant cette recherche, qui répondront je l'espère aux questions que vous pourrez avoir. N'hésitez pas à me contacter à l'un des numéros fournis ou à renvoyer la fiche « Demande de Participation » à l'adresse écrite sur l'enveloppe timbrée ci-jointe. Si vous souhaitez participer, je vous contacterai et nous conviendrons d'un rendez- vous à votre convenance.

Je souhaite vous assurer que l'information donnée sera traitée avec la plus stricte confidentialité. A aucun moment votre identité, lieu de résidence, ou relation avec aucun membre du personnel soignant ou hôpital ne sera révélé. Tous les noms seront modifiés pour garantir l'anonymat.

Je vous remercie d'avoir bien voulu prendre le temps de lire cette lettre. J'espère que vous accepterez de contribuer à cette étude importante.

Bien cordialement,

Carolyn Tobin
Chercheuse

APPENDIX XI

French Translations of Informed Consent

**SAMPLE OF CONSENT FORM
FOR REFUGEE AND ASSYLUM SEEKING WOMEN (French)
FICHE DE CONSENTEMENT POUR FEMME REFUGIEE ET EMANDEUSE
D'ASILE**

Titre de la recherche :

Accouchement en exil : Expérience de l'accouchement en Irlande des femmes réfugiées et demandeuses d'asile.

Contact:

Carolyn Tobin:

Telephone: 086 XXXXXX (ligne directe) Email: carolyn.tobin@gmail.com

Principe et procédure

Le but de cette étude est de décrire l'expérience de l'accouchement des femmes réfugiées ou demandeuses d'asile en Irlande et de mettre en lumière le point de vue des sages-femmes en Irlande concernant les besoins dans la prise en charge des femmes réfugiées ou demandeuses d'asile. Votre participation implique un entretien et la possibilité d'une visite ultérieure pour discuter de l'entretien lorsque vous aurez relu la transcription de votre entretien. Cette entretien durera environ une heure et sera enregistré avec votre consentement. Pendant cet entretien, on vous demandera de fournir quelques informations d'ordre général concernant votre passé. On vous demandera ensuite de décrire votre expérience de l'accouchement en Irlande. Suite à l'entretien, les informations enregistrées seront rédigées et analysées par le chercheur. Les conclusions de l'étude seront ensuite compilées dans un rapport et une ou plusieurs parties pourront ensuite être soumises pour publication et/ou présenté durant une conférence. A aucun moment ne seront révélées l'identité des personnes participant à cette étude.

Déclaration (cochez les cases si vous êtes d'accord):

- J'ai lu la feuille d'information.
- J'ai lu et compris la feuille de consentement.
- J'ai eu la possibilité de poser des questions
- J'ai obtenu une réponse satisfaisante à toutes mes questions.
- Je comprends que toute information récoltée dans cette étude sera traitée de façon confidentielle et que mon identité restera confidentielle
- Je comprends que j'aurai accès à la retranscription de l'entretien.
- Je comprends que ma participation à cette étude n'influencera en aucun cas l'examen de ma demande d'asile dans ce pays.
- Je participe volontairement et librement à cette étude qui ne va pas à l'encontre de mes droits légaux et éthique.
- J'ai reçu une copie de cet accord et je comprends que les résultats de cette étude seront publiés.
- Je comprends que je peux me retirer de l'étude à tout moment.

**NOM DU PARTICIPANT (en
majuscule):**.....

**NUMERO DU
PARTICIPANT:**.....

**SIGNATURE DU
PARTICIPANT:**.....

Date:.....

Déclaration de la responsabilité du chercheur

J'ai expliqué la nature et le but de cette étude à la personne ci-dessus, les procédures mises en oeuvre et les risques pouvant être encouru. J'ai proposé de répondre à toute question et répondu de façon complète à ces questions. Je crois que la personne ci-dessus a compris mes explications et a donné son consentement pour participer à l'étude librement et en connaissance de cause.

Signature du responsable:.....

Date:.....

**Pour le responsable uniquement:
Code:.....**

Participant

APPENDIX XII

French Translations of Information packs

STUDY INFORMATION SHEET

FEUILLE D'INFORMATION RELATIVE A L'ETUDE PORTANT SUR LES FEMMES REFUGIEES ET DEMANDEUSES D'ASILE

TITRE DE L'ETUDE:

Accouchement en exil : Expérience de l'accouchement en Irlande des femmes réfugiées et demandeuses d'asile.

INTRODUCTION:

Vous êtes invitée à participer à cette étude en raison de votre expérience concernant l'accouchement dans un pays qui n'est pas votre pays d'origine. Le but de cette étude est de décrire l'expérience de l'accouchement des femmes réfugiées ou demandeuses d'asile en Irlande et de mettre en lumière le point de vue des sages-femmes en Irlande concernant les besoins dans la prise en charge des femmes réfugiées ou demandeuses d'asile.

PROCEDURE: QU'IMPLIQUE CETTE ETUDE?

Une sage-femme conduisant la présente étude vous rencontrera pendant une heure environ afin de parler de votre expérience durant votre grossesse et votre accouchement. Pendant cet entretien, on vous demandera de fournir quelques informations d'ordre général concernant votre passé. On vous demandera ensuite de décrire votre expérience de l'accouchement en Irlande. Avec votre consentement, cet entretien sera enregistré sur cassette audio. Après l'entretien, l'enregistrement sera retranscrit et analysé. Vous aurez l'occasion par la suite de lire une retranscription de votre entretien afin de s'assurer qu'elle correspond bien.

Les informations continues dans les entretiens seront ensuite compilées dans un rapport. Ce rapport pourra être soumis pour publication et/ou présenté durant une conférence et pourra fournir la base pour le développement d'une aide aux femmes réfugiées ou demandeuse d'asile nécessitant des soins maternels en Irlande.

QUI PEUT PARTICIPER A CETTE ETUDE?

Vous pouvez participer à cette étude si:

Vous avez plus de 18 ans.

Vous êtes réfugiée ou demandeuse d'asile dans ce pays

Vous comprenez le but et le processus de cette recherche

Vous souhaitez de votre plein gré participer à l'étude

AVANTAGES:

A ce jour, aucune étude n'a été entreprise sur l'expérience des femmes réfugiées ou demandeuses d'asile donnant naissance en Irlande. Cet entretien est une opportunité pour vous de raconter et de faire partager votre expérience personnelle. Nous espérons que cette étude permettra une meilleure connaissance de l'expérience des femmes réfugiées et demandeuses d'asile lorsqu'elles accèdent aux services de maternité. Les résultats de cette étude pourront également aider à influencer le développement d'un service de

maternité adapté à la demande des femmes et visant à fournir un soin de qualité flexible, respectueux et adapté à la culture d'origine.

RISQUES:

Il n'y a pas de risque connu pour vous, si vous choisissez de participer à cette étude. Toutefois, il est parfois difficile de parler d'un accouchement. Si vous deviez trouver cela difficile, votre bien-être est prioritaire par rapport à l'étude. Nous pouvons arrêter l'entretien, le poursuivre à une date ultérieure, et / ou vous mettre en relation avec des services d'aide disponible.

EXCLUSION DE LA PARTICIPATION:

Vous ne pouvez pas participer à cette étude si :

Vous avez moins de 18 ans.

Vous n'avez pas encore donné naissance.

Vous ne comprenez pas le but et le processus de cette recherche.

Vous ne souhaitez pas participer à cette étude de votre plein gré.

CONFIDENTIALITE:

Toute information récoltée durant cette étude sera confidentielle. Votre identité restera confidentielle. UN code sera assigné à votre entretien. Vous aurez accès à la retranscription de votre entretien si vous le souhaitez. Votre nom ne sera pas publié et ne sera pas transmis à toute personne étrangère au projet.

COMPENSATION:

Cette étude est couverte par l'assurance d'indemnité institutionnelle standard. Rien dans ce document n'entrave vos droits. Il n'y aura pas de rétribution pour votre participation.

PARTICIPATION VOLONTAIRE

Votre participation à cette étude est volontaire. Vous pouvez vous retirer à tout moment. Si vous décidez de ne pas participer ou de vous retirer, vous ne serez pas pénalisé et vous garderez tous les bénéfices auxquels vous aviez droit au début de l'étude. Votre participation à cette étude n'influencera en aucun cas l'examen de votre demande d'asile dans ce pays.

QUI FINANCE CETTE ETUDE?

Cette étude est financée par l'Ecole d'Infirmière et de Sage-Femme de Trinity College, Dublin et a été approuvée par le comité d'éthique de la faculté des Sciences de la Santé de Trinity College Dublin, du comité d'éthique de l'hôpital Rotunda, et du comité d'éthique de l'hôpital Notre-Dame de Lourdes de Drogheda.

POUR PLUS D'INFORMATION:

Vous pouvez obtenir plus d'information ou des réponses à vos questions concernant cette étude, votre participation à cette étude, ainsi que vos droits en contactant Carolyn Tobin qui peut être jointe par téléphone au 086-XXXXXXX ou par e-mail carolyn.tobin@gmail.com. Alternativement, vous pouvez

contacter le responsable de la recherche Dr Jo Murphy-Lawless, Ecole d'Infirmière et de Sage-Femme de Trinity College, Dublin au 01-6082692 ou par e-mail jlawless@tcd.ie .

APPENDIX XIII

Portuguese Translations of Letter of Invitation

**LETTER OF INVITATION TO
REFUGEE AND ASSYLUM SEEKING WOMEN (Portuguese)**

Data

ExmaSenhora D.

Eu sou uma enfermeira parteira e, presentemente, estou a tirar um doutoramento na Faculdade de Ciências da Saúde no Trinity College. O título do meu doutoramento é ‘Dar à luz no exílio: A experiência de mulheres refugiadas e à procura de asilo que deram à luz na Irlanda’ e está a ser financiado pela School of Nursing and Midwifery Studies do Trinity College.

Escrevo-lhe para convidá-la a participar neste estudo. Você foi escolhida pelo encarregado da clínica onde vai às suas consultas pós-natal como alguém que possa estar interessada em falar sobre o facto de ter dado à luz fora do seu país de origem. Este estudo foi aprovado pelo Comité Ético da Faculdade de Ciências da Saúde do Trinity College, Dublin, pelo Comité Ético do Hospital da Rotunda e pelo Comité Ético do Hospital de Nossa Senhora de Lourdes, Drogheda.

Esta carta foi-lhe entregue a si em meu nome. Eu não vou tomar conhecimento de quem irá receber esta carta e, caso você não queira participar neste estudo, eu não terei qualquer outro contacto consigo.

No entanto, caso deseje participar neste estudo, eu gostaria de falar consigo sobre a sua experiência durante a gravidez e o parto aqui na Irlanda. A nossa conversa durará entre 45 minutos a uma hora, será bastante informal e poderá ser interrompida caso você não deseje continuar. Com a sua autorização eu gostaria de poder gravar a nossa conversa. Deste modo eu poderei recolher a informação mais corretamente. A única pessoa que irá ouvir essas gravações sou eu e as cassetes (fitas) irão ser destruídas quando o estudo estiver concluído.

Juntamente com esta carta irá encontrar mais informações sobre este estudo que, espero, irão responder a quaisquer dúvidas que você possa ter. Por favor, sinta-se à vontade para me contatar usando os números listados ou para devolver a folha ‘Interessada em participar’ que se encontra no envelope endereçado e de portagem paga. Caso tenha indicado um desejo em participar neste estudo, eu irei contactá-la e arranjaré uma data para nos encontrarmos.

Eu gostaria de assegurar-lhe que a informação dada por você será tratada com a maior confidência. A sua identidade, local de residência ou frequência de um centro de saúde jamais serão revelados. Todos os nomes serão modificados para assegurar total confidencialidade.

Agradeço-lhe muito por ter lido esta carta. Espero que você possa dar a sua contribuição para este importante estudo.

Com os meus melhores cumprimentos,

Carolyn Tobin
Investigadora

APPENDIX XIV

Portuguese Translations of Consent Form

**FOLHA DE CONSENTIMENTO
PARA MULHERES REFUGIADAS OU À PROCURA DE ASILO POLÍTICO**

Titúlo do estudo de investigação:

Dar à luz no exílio: A experiência de mulheres refugiadas e à procura de asilo que deram à luz na Irlanda

Contactos:

Ms. Carolyn Tobin:

Telefone: 086 XXXXXX (linha de telefone só para o estudo) Email:

carolyn.tobin@gmail.com

Enquadramento e procedimentos:

O objectivo deste estudo é descrever as experiências de mulheres que têm o estatuto de refugiadas ou que estão à procura de asilo e que deram à luz na Irlanda. Assim pretende-se melhor informar as enfermeiras parteiras da Irlanda em relação às necessidades destas mulheres que estejam ao seu cuidado. A sua participação irá incluir uma entrevista e a opção de se encontrar novamente com a investigadora para falar sobre a transcrição da entrevista. A entrevista irá durar uma hora, aproximadamente e, com a sua licença, será gravada. Durante a entrevista, ser-lhe-á pedido que forneça algumas informações sobre si. Em seguida, vai lhe ser pedido que descreva como foi a sua experiência de dar à luz na Irlanda. A gravação da entrevista será posteriormente transcrita e analisada pela investigadora. Os resultados das entrevistas vão ser compilados num relatório. Relatório este que poderá ser enviado para publicação ou apresentado numa conferência. Em nenhuma ocasião serão os nomes verdadeiros das participantes revelados.

Declaração(Por favor leia e ponha uma cruzinha caso esteja de acordo):

- Eu li a folha de informação do estudo
- Eu li e compreendi esta Folha de Consentimento.
- Eu tive a oportunidade de fazer perguntas.
- Todas as perguntas foram respondidas de forma satisfatória.
- Eu entendo que toda a informação recolhida neste estudo irá ser tratada com toda a confidencialidade e que a minha identidade permanecerá anónima.
- Eu compreendi que vou ter acesso ao transcrito da minha entrevista.
- A participação neste estudo não terá qualquer influência no meu processo de procura de asilo na Irlanda.
- Eu concordo em participar neste estudo de minha livre e espontânea vontade sem qualquer prejuízo para os meus direitos legais e éticos.
- Eu recebi uma cópia deste acordo e compreendo que os resultados deste estudo poderão ser publicados.
- Eu compreendo que poderei desistir deste estudo a qualquer momento.

**PARTICIPANT'S NAME (Block
Capitals:.....**

**PARTICIPANT'S CONTACT
NUMBER:.....**

**PARTICIPANT'S
SIGNATURE:.....**

Date:.....

Statement of Investigators responsibility:

I have explained the nature and purpose of this study to the person named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and have freely given informed consent to participate in the study.

Investigators Signature:.....

Date:.....

**For Investigators Use Only:
Code:.....**

Participant

APPENDIX XV

Portuguese Translations of Information Sheet

FOLHA INFORMATIVA PARA O ESTUDO DE MULHERES REFUGIADAS E À PROCURA DE ASILO POLÍTICO

TÍTULO DO ESTUDO:

Dar à luz no exílio: A experiência de mulheres refugiadas e à procura de asilo que deram à luz na Irlanda

INTRODUÇÃO:

Você foi convidada a participar neste estudo devido à sua experiência de ter dado à luz num país que não é a sua pátria. O objectivo deste estudo é descrever as experiências de mulheres que têm o estatuto de refugiadas ou que estão à procura de asilo e que deram à luz na Irlanda. Assim pretende-se melhor informar as parteiras da Irlanda em relação às necessidades de mulheres refugiadas e à procura de asilo que estejam ao seu cuidado.

PROCEDIMENTO: O QUE É QUE ESTÁ INVOLVIDO NESTE ESTUDO?

A parteira que está presentemente a conduzir este estudo irá encontrar-se consigo durante aproximadamente uma hora para falarem sobre a sua experiência durante a gravidez e o parto. Durante a entrevista, ser-lhe-á pedido que forneça algumas informações sobre si. Em seguida, vai lhe ser pedido que descreva como foi a sua experiência de dar à luz na Irlanda. Esta entrevista poderá ser gravada mas apenas com a sua permissão. A gravação da entrevista será posteriormente transcrita e analisada. Mais tarde, vai ter a oportunidade de ler a entrevista de modo a confirmar que você está de acordo com a informação escrita.

Os resultados das entrevistas vai ser compilado num relatório. Relatório este que poderá ser enviado para publicação ou apresentado numa conferência. Este relatório poderá também servir de base para o desenvolvimento de serviços de apoio futuros a mulheres refugiadas e à procura de asilo que necessitem de cuidados pré e pós natal na Irlanda.

QUEM PODE PARTICIPAR NESTE ESTUDO?

Poderá participar neste estudo se:

Tem mais de 18 anos de idade.

Tem o estatuto de refugiada ou está à espera de asilo político.

Você entende os objectivos e os meios desta investigação.

Está disposta a participar voluntariamente neste estudo.

BENEFÍCIOS:

Até à data, não existem trabalhos cujo o objectivo tenha sido o estudo da experiência de mulheres refugiadas que deram à luz na Irlanda. A entrevista será para si uma oportunidade para contar a sua história e reflectir sobre as suas experiências.

A nossa esperança é que este estudo possa contribuir para um maior conhecimento da experiência de mulheres refugiadas e à procura de asilo que procuram clínicas de atendimento pré-natal. Os resultados deste estudo poderão também auxiliar e influenciar o desenvolvimento de serviços pré e pós natal que são sensíveis às necessidades da mulher e que estão dispostos a fornecer cuidados de qualidade que são flexíveis, respeitadores e que se adaptam às diversas culturas de origem das pacientes.

RISCOS:

Caso decida participar neste estudo, não estará a correr nenhum risco. No entanto, por vezes falar do nascimento de uma criança pode ser uma experiência constrangedora. Caso você julgue que lhe é difícil falar deste assunto o seu bem-estar será uma prioridade para o nosso estudo. Nós podemos interromper a entrevista, recomeçá-la mais tarde ou pô-la em contacto com um service de apoio que se encontre disponível.

EXCLUÍDOS DESTE ESTUDO:

Você não poderá ser incluída neste estudo se:

Tem menos de 18 anos de idade.

Ainda não deu à luz.

Deu à luz um prematuro ou um bebé doente.

Não entende os objectivos e os meios desta investigação.

Não está disposta a participar voluntariamente neste estudo.

CONFIDENCIALIDADE:

Toda a informação recolhida no decorrer deste estudo será tratada com a maior confidencialidade. A sua identidade não será revelada. Um código será atribuído à sua entrevista. Se desejar, poderá ter acesso à transcrição da sua entrevista. O seu nome não será publicado nem será revelado a pessoas fora do grupo de estudo.

COMPENSAÇÃO:

Este estudo está protegido por um seguro institucional de indemnização. Nada existe neste documento que ameace os seus direitos. Não haverá qualquer pagamento pela sua participação.

PARTICIPAÇÃO VOLUNTÁRIA:

A sua participação neste estudo é voluntária. Se desejar, poderá desistir do estudo em qualquer ocasião. Caso você decida não participar ou se você desistir deste estudo, não sofrerá qualquer penalização por isso nem lhe serão retirados quaisquer benefícios que possa usufruir antes de participar no estudo. A participação neste estudo não terá qualquer influência no seu processo de procura de asilo na Irlanda.

QUEM FINANCIA ESTE ESTUDO?

Este estudo está a ser financiado pela Escola de Enfermagem e Parteiras, Trinity College, Dublin e foi aprovado pelo Comité Ético da Faculdade de Ciências da Saúde do Trinity College, Dublin, pelo Comité Ético do Hospital da Rotunda e pelo Comité Ético do Hospital de Nossa Senhora de Lourdes, Drogheda.

PARA MAIS INFORMAÇÕES:

Vocês poderá obter mais informações ou respostas à suas perguntas em relação a este estudo e à sua participação bem como em relação aos seus direitos. Para tal deverá contactar a Carolyn Tobin por telefone no 086- XXXXXXXX ou por email carolyn.tobin@gmail.com . Alternativamente, você poderá contactar o orientador do estudo, o Doutor Jo Murphy-Lawless, School of Nursing and Midwifery, Trinity College Dublin por telefone no 01-6082692 ou por e-mail jlawless@tcd.ie .

APPENDIX XVI

SAMPLE TRANSCRIPT OF AN INTERVIEW

VOICE029

Time: 48mins

R So (W) thank you for coming to talk to me today about your experiences here in Ireland and your journey so far and just like to invite you to talk and tell me your story in a way that is comfortable for you. So feel free to start wherever you would like to.

W I come from (name of country removed) as I've already said I left my country because I was suffering persecution. My husband was in the opposition party if you know the (name removed), it was during the elections and everything so he was taking part in, but then he managed to run away and they were giving him trouble but I was pregnant and I'd no thoughts of running away anyway with my pregnancy. First of all it was my first pregnancy; I just had been married, I just gotten married. So our, I couldn't run with my pregnancy and I only depended on my mum, when he was gone. So later on....

R So you went to live with your mum when your husband ran away because you were pregnant?

W Yeah I was staying in my house and I would go to my mum, I was just like...

R You stayed in your own house and you would go back and forth?

W Yeah. So then after some time I managed to get in touch with his friends, like they would come to the house and tell me whatever he was going through. I don't want to go into details. So they helped me out to go to South Africa. So when I went to south Africa I was hoping to be a bit safer there, since it wasn't (name of country removed) but then when we went to south Africa I found, that's where I met my husband.

R You met up with your husband in South Africa?

W Yes, so he was the one who had arranged the whole journey actually so I met up with my husband then and then he told me that it was not safe even to stay in South Africa because still it's near (name of country removed) and the connection is still the same. So I might as well be far, considering my condition I just wanted to be somewhere far away I could live in peace and stop running. So I don't know how it happened, you know when you remember, there are some agents, somehow they managed to help

you out if you are playing a big part, you can't just be helping just an ordinary person, you understand?

R Yeah

W So I was told I would be coming here. So I am here in Ireland.

R How did you feel about that, being told you had to come so far away.

W Its terror, you kind of just, I was eight months pregnant when I left so the whole thing was delaying and my pregnancy was getting later and later and later. So it was, its one of the worst thing you can ever do like to travel in an airplane, and going to a foreign place where there is nobody. At least if I knew there was somebody waiting for me here it would be better but there was no, going to a strange place, like you were going to be punished there because it's as good as punishment, till you get to know somebody whom you don't even know from before, it's quite strange. Just meeting a lot of new people and a lot of forms to fill and a lot of questions to be answered. It's something else.

R So what happened, somebody brought you here and then when you got to Ireland what was that like? You got off the plane and you went to the justice or what happened?

W We came here and then we slept in a B&B. At that time I didn't know I was in Dublin or what but I know now it was in Dublin. And then in the morning they got me into a bus and then I went to justice. So I was fortunate enough because the person who attended to me was also pregnant so she was very a bit nice.

R In the justice department?

W In the justice department, compared to what was happening next to me. You know, the person, and (Pause) she believed me because I was telling her the truth and I was telling her everything in detail. All I knew, I didn't have a problem with her like maybe she was saying you say this and now you've changed and I hear people go through that, I didn't go through that. Because all she wanted to know I said it and then after that I didn't have any problem with the justice because I came to seek asylum, I intended to, I said what they wanted to hear. What they asked me. I was given an accommodation place in an (named accommodation centre), that was, (L) also terror in a way because there was about 3 of us in a room, different nationalities in one room, you know, with single beds. And eh the food you know when you are pregnant you just don't eat anything, you throw up, I couldn't use the showers there, I didn't know how to open them. I think I spent that time, that time I came I didn't

even take a shower, I didn't even know how to open it, it's not like my shower back home, you have to continue pressing, pressing and water would be coming out at some point. But I met one lady from Ruanda, she was also pregnant but she was, I think she was early pregnant, she didn't even know she was. So she was nice to me, I got used to it, she showed be everything, even to go to the post office, to go to the social people, because I had no idea. I was just put in a room that was it. I didn't know what else to do. Well I was told; the lady in the justice actually told me you have to go the maternity to get a check-up, because you flew. Because of the flight you have to go in and get a scan, which I did the next day.

R And you went into Rotunda was it?

W Yeah, first there's a medical centre in (named accommodation centre), I went to the medical in there and then yeah.

R What was that experience like?

W It was (L) the worst moment of my life because I just walked in the medical centre, just looking scared to death. I was lying on the bed and then she was getting a scan, the next thing she went out, she didn't say anything to me, she just went out and called another doctor, he came in. they were all looking horrified. Like I don't know what was happening. And then I'm asking what's going on, they wouldn't tell me. They called another doctor and there was just doctors around me, worried about something that was happening to me but I'm not being told what is happening to me. And then I was sent to hospital.

R And nobody told you why you were being transferred to hospital?

W No, they said I need to go to hospital for a better scan, a 3D scan or something.

R Did they say why they were worried?

W No, that time they were not saying, I was, I was now emotional because I was now so worried what was happening. I'm worrying and I don't have anyone to tell, you know. So when I go to hospital they did the scan and the same thing again, doctors running and only telling me my baby has got fluid in the brain. And I was wondering how can that happen. So what's going to happen to the baby you know (children in background). So no one explained to me what, you can actually, we have to wait until you give birth and then have an operation because there's nothing we can do when the baby is inside. But to come to frequent, like every week I was going for scans to check how far the baby, how far, how the baby was doing. So I did that. So I never got to get like the antenatal classes, anything, I never got to do all those things

because all I was doing was to go to hospital for a scan and the hospital must have known I was going to see the doctor, carrying my files, I would go up stairs for the scan and come back down and I'd see the doctor. By the time I go home I'd be tired. And I wouldn't even have time to do all those things because I was stressed out being alone in the country I was stressed out being having a problem with my first child. It was just, I just worry about the next appointment because they said if I'm not going to the Rotunda I'd be going to the medical centre in (named accommodation centre) and then I was told I had to go in and see the social and go to the post office in Dublin to collect the allowances, because so many things at the same time for one person. And I just, it was too much, so my life then was just full of, if I'm not crying I'm eating, if I'm not eating I'm crying, if I'm not crying I'm sleeping.

R You were traumatised.

W Yeah, it was, at one point I was wishing to go back and face whatever I'm going to face, at least if I face it with the people I know it's better than to face this with strangers. It would have been better. But it was too late to make a decision. But if I'd have known I wouldn't even have come. I would have faced whatever, if its dying I would have died better than coming here to go through all these things alone.

R Yeah.

W It was terrible.

R And did they at any point offer you psychological support? You know counselling or?

W Yeah I got it after, I got it after my, after I had given birth. I did get it after I'd given birth but I wouldn't have, you know, I came late pregnant and the things which were happening were too much. If ever they had given me counselling I would have known because they come and look for me to go for an appointment, it was a lot of things for me to do at the same time. So I'm saying the justice form to fill up, that big form to say all the things which happen, appointments, not just for hospital for the social, for accommodation, it was just a lot of things. So if ever I was given before I wouldn't have known, I got things, things became better after I had given birth. Because before it was, I had no idea what was happening, even on the day when I was having labour pains I didn't know that they were labour pains. So I was getting period pains... (L) I had no idea what was happening to me.

R So you had no preparation for labour whatsoever, you didn't know the signs of labour?

W The signs of labour honestly I had no idea, it was my first pregnancy. All I did like what the nurse advised me, oh the social, when I went to fill up the forms they told me to get the money and go buy clothes for the baby. The preparation, I wasn't going to do it anyway. I thought I'd do it after I'd given birth which is not normal because back home I had prepared already but I didn't bring any of the things I had prepared. So I, I wasn't.

R You weren't really thinking straight.

W I wasn't thinking, why would I do it again, so actually like the social told me and then I did, with the help of this lady. I did get some preparation, and then one morning I'm sleeping, the next thing I'm bleeding, in the morning. So I told the other lady in my room, there was three of us, so I told the other lady she is also (name removed), that I was bleeding. So she asked me if the waters was breaking and I said no, after all I was five days overdue.

R Right.

W So the waters would not break because I wouldn't even know what they looked like, because up to now I don't even know what waters looked like. (L) so I went, she told me to go and shower, I depended on the closest person who could show me love, I would totally depend. This lady is telling me to go in and have a shower and yet I'm telling her I'm in pain and I'm bleeding, I went to shower because she had said it, do you understand? I was desperate for love, for help, for someone to, to help me so I thought if I don't do here, nothing I'm going to complain about, she told me you know.

R You said she wouldn't help you if you didn't do exactly what she said?

W Yeah so I went to shower in pain, I remember it, so many cramps and then I came back and then she told me to wait until the medical centre opened. So it would be around 9 or 10, yes and then I went there and the lady said I should go to hospital, I should take my bags and go to hospital. I went to hospital and we sit outside, but I wasn't really...

R How did you get to hospital?

W They got me a taxi, the medical centre. I wasn't really in pain, it was just the bleeding I was worried about. So we sit outside for some time, you know, you have to wait till 10.

R How much were you bleeding?

W Like period, like normal period amount.

R So a period amount.

W Period amount yeah. It wasn't really heavy but it was continuous bleeding.

R Constant.

W Then I was put in whatever room they were doing, they were putting all those funny cords around me which were so tight, so irritating, I didn't know what those were, I never had seen them before. It's like going to another planet and you are seeing all these things which are happening to you and you can't ask anything. Because you don't know how people are going to relate to you. (L) I was the only black there, so I was so scared I didn't want to make them, to put them off. You know sometimes you ask someone a question and you totally put them off. I had that belief so I just remained quiet. Then later on they told me I could go home and ?? (14.48) the bleeding had stopped. So I went home, when I was at home I started cramps like, and then I, I, I had my shower and the cramps continued now they were worse, I was telling the lady about my cramps were getting worse so she said then ?? (15.12) she told me she was going to ?? me and whatever, but then she called the ambulance.

R Who, which lady is this, is this the lady in the medical centre?

W No, my roommate (L) I think that was labour pains now because they were coming and going but when they come they were really painful. So coming and going in the bed, I would get down; the whole night actually I was having pains, the whole night until about 7 or 8 in the morning, again like the same time yesterday. And then she wanted the waters to break first before she does anything. And the waters didn't break, instead there was like a, I don't know how to put it; it was like a burst of blood, just like a lot of blood came out. Like someone had poured blood on the bed and everything, I was showing her. That is maybe the waters, the way it came out so that was when she got scared because it was too much. And then I went to hospital.

R They called the ambulance?

W Yeah. And then the ambulance I'm in pain and they are asking me questions, you know, I just wished if they could be another ?? (16.44)

R Like what questions?

W The names and the medical people were there, they could have just got the information from the medical database, everything. And I was getting impatient but I had serious pain, it's not fun, those pains are not fun. You don't want anything, you don't even want to talk to anybody. But anyway we got to hospital and then they,

they put me in the room again, they were putting those things. And then they said I dilated, dilated something like that.

R That's right yeah.

W So they had to book a bed upstairs and then I was taken upstairs, yeah I was taken up stairs and then the lady was really nice to me, the midwife, but still I was like in my country when you are having, if you are crying the nurses will beat you up.

R At home in your country?

W At home so I had that mentality. I was so scared and so much in pain but believe me I didn't make a sound. I was just groaning inside. I didn't even, they didn't even hear my voice, because was so scared that if people at home can beat what more can others do (L) you know I was so scared. Each time I went to think of something ?? (18.20) because it's a really painful experience but I don't want to keep it in my mind as a painful experience, I just want to relate it, something that happened, it is past. I'm just looking for improvements. So em, she put me on the bed and my friend, my roommate was with me, she was...

R She came with you to the hospital?

W She came with me and she was rubbing me, I was getting irritated why she's rubbing my back because it was like it was getting me more pains (L) but I depended on her so I couldn't, it just, it was terrible. You know so painful, labour is the painful moment ever ?? (19.05) So the doctors were coming in and out and then the other one I said I need to get the epidural. Because I have to go to the theatre.

R Somebody came in and told you that you had to have an epidural?

W They were talking to the nurse that I have to get an epidural.

R Sorry, (W) you overheard somebody say to the nurse that you had to, they didn't tell you?

W I overheard that I was getting epidural because I'm going to the theatre. So I was asking my friend what is an epidural? Then she told me it's something they will put in your back so that you can have an operation. So I said I'm not going to have an operation, I'm going to give birth normally, my mammy had convinced me that I give birth normally. So I wanted them to understand that I'm not getting?? (19.54) I wanted to give birth normally. And then I was telling the nurse that I don't want it, then she was telling me to go on a ball. A ball! I'm in pain you tell me to get off the bed and go on a ball. I did not agree to that. all these things I was telling my friend to tell them all instead of myself. Then they were talking about oxygen, already I had

drips, yeah already needles everywhere. So I was telling them I don't want, I'm breathing normal way, I thought maybe if they put that thing they were going to operate on me, I didn't want to be operated. So the doctor finally came and asked if I had been put on epidural or something so the lady said she, she is dilated. She doesn't need to, to go to theatre and then I say I insisted that I'm going to push and I'm going to, I kept on insisting on that. And then the doctor burst the water, so that it can come, the baby was not coming. I was still in pain, the pains and pains, so now they convinced me that if they put epidural on me I won't have the pains. But they wanted me to have operation. So with the pain I ended up agreeing and I did get it, I was in so much pain. I had been told it was just to stop the pain, they didn't tell me what was going to happen after. How it's going to be like, how it's going to make me now, paralyse my legs. It was just like, like a stop pain. So if I'm in labour, labour pains and you are offered this stop pain no normal person would refuse. So I got it, I those big, big things going into my back and my friend was so devastated she made me more scared because she was saying the thing is too big, the needle is so big (L). And I'm thinking you are supposed to be minding me, at least for once in your life so that (L) you can't tell me the needle is too big, what do you want me to do, can't you lie. So they put it in, a few minutes later the pain stopped. But I couldn't feel my legs. The doctor came in again, told me that I had to go to the theatre. I said I'm not going to the theatre I'm going to push. So when the doctor was gone out the lady was really nice, I told her that you know I cannot really push I really want to have my baby normal, I can push, I don't have to go for an operation. So she said okay we'll see how you are doing. She asked me if I knew the contractions, I was feeling nothing. Not a thing, I was paralysed. So she said how are you going to push if you can't feel the contractions. Then she said you see the line on the computer thing. So I don't know how she could tell its contractions. And then that's when I'd push. But then I would have no idea how to push, push what, where? After all I was not, I was paralysed so I didn't know how to, so she said imagine you are having, doing poo-poo, so when I imagined doing poo-poo that would be pushing. So that's how I did, we started at around 4 and finally I pushed around 5.

R That was incredibly well done.

W It was but it was, the lady was very nice, the midwife. She was very, really encouraging and she kept on asking me like, she found it weird that I wasn't, she never, she didn't even know if I can really talk because I was so scared of them. And

I was, my friend did tell them everything, I don't want to speak, I thought they would beat me the same way if I scream or if I cry. So in labour I don't (L) so that I don't upset them. Like ?? (24.16) but so if I make their tempers high they'll just kick me, then I thought maybe I have to be nice so that she doesn't send me to theatre. So at least she didn't send me to theatre and they kept me. And I got the baby just as good. it was really nice. And then they cleaned the baby, she was so big.

R Yes.

W 4.3.

R Wow! That was big.

W She was big.

R Because you are very slight.

W I know (L) and even at 9 months you would think I'm 4 months pregnant.

R Really! You are tall though as well.

W It wasn't really big, but anyway it was quite an experience.

R So how did you feel when you saw your little girl?

W I cried. It was sad because I'm not sharing the joy, some people here, we had pregnant and married and all the things, they would not celebrate with me.

R The people that you met at (named accommodation centre)?

W No at home.

R The people at home?

W Like my mam, my husband, my friends who had known me pregnant who are looking forward to seeing the baby they were not there to enjoy that moment with me. not just that moment, throughout, to see the child. They were not there, so it was really painful and I felt maybe I'm depriving you of some, of some love she should be getting someway but at the end of the day it wasn't my fault. So then she cleaned me and she took me to the maternity, I don't know what they call it, where every other woman is.

R Post-natal ward.

W Yeah, where they are given bed.

R Post-natal means after the birth. So the ward you go into after the birth.

W Yeah, I was so hungry. Really, really hungry but all the food had gone I think. So I had to wait for breakfast in the morning.

R So you got nothing to eat?

W No, no.

R Did you tell them you were hungry?

W Yeah I told them I was hungry and they did tell somebody to go, went to look for food for me but they never came back. That was very late, around 12 midnight. I never got anything to eat. But if I had somebody, like the lady to go you know you are not allowed stay in hospital, so probably if she was there she would have gotten me something to eat but she had to go because they didn't insisted she go. So in the morning she came, okay in the morning they take the baby for the operation. So they took the baby for a scan and everything and they brought the baby back and said there's nothing wrong. The thing had just disappeared. (L) it was a miracle. I then got the presents, I was really praying hard. So you know the worst thing they ever did to me that was because they didn't tell me the effects of an epidural. In the morning I went to take a shower not knowing I'm not yet strong enough. So when I was showering I felt dizzy. The next thing I woke up on the floor and the water is still running on me and you know the blood and the stitches, the stitches and then I couldn't stand up. I was calling for help but people were just passing outside. Its later on that I was told that one of those things is for an alarm. (L) but I had no idea. I had no idea what that was. So I stood up the first time I fell again, I think it took me about an hour in the bathroom. So I don't know why they were not worried where this person is and they should be in bed. I think they should at least worry about somebody who just gave birth last night you know. So when I stood up again I didn't bother to shower again I just washed off the blood. I went back to my bed. Yeah, you know, then I had my breakfast. And then they ask me what I want to do, did I want to breast feed or bottle feed. So I wanted to breast feed but the baby was too weak to depend on my breast. So the doctor said I should give the bottle and the breast. So when the doctor was gone the milk had finished, one lady, you know the racism isn't only on the black and white, it can be blacks on each other, because the lady was giving out to me, it was a black lady. She was Nigerian and I told her that I had ran out of milk and she told me you are supposed breast feed and I said yes I am supposed to breast feed but the doctor said I should, I should give the baby because I don't have enough milk. She said she wouldn't give me; I should make my baby suck so that I will get more milk. I was trying to make the baby suck but there was nothing so when I didn't get milk that whole day until the next morning when the doctor came my baby was there because she had not eaten enough. So the doctor asked me why I wasn't feeding my child I said because my milk is not really coming out when, then he said

but you are supposed to be giving it milk, I told him I was, the lady refused to give me the bottle. He was so, so angry then. he asked me to show him the lady and then I was thinking this lady one thing for sure she was black if she gets into trouble for her to get another job in this country I mean so I really wanted to stop her but I knew if I told the doctor she might be in some sort of trouble. So I, I didn't tell the doctor who it was but I just told, then the doctor brought more milk. And the baby had to go to the intensive care for two days. She was really dehydrated. So that's why the doctor was mad, he came back three times asking me if I'd had seen the lady and I kept on saying I haven't, but she was still the same lady and she was really scared. But I, you know the same way I felt for her she could have felt for me and given me the milk. But people are not like that so racism normally is not only blacks and white, it can be black people, maybe if I was a Nigerian she would have treated me nice I don't know but the other people like the nurses and everything they were nice. But then the lady was giving food, (L) rather than giving me food.

R Why?

W I don't know, at first I thought it was a mistake she would come in and ask what do you want for your sandwich, ham and cheese, chicken and whatever. When it's me she would skip, she wouldn't ask me so I thought maybe it's because she thought I was busy, so she didn't want to disturb me, a number of times she did that; like so now to tell them that I haven't got anything to eat. Then the nurse would give me some, they would get her to give me something to eat. She would skip me purposely, I know she skip me purposely.

R What did the nurse say when she realised you had no food?

W She would think maybe I was out when they were giving food or something like that; she would think maybe when I was in the bathroom they were giving food I didn't get it. But then the night nurses were very nice because if you like you know when they give you the over sleep I'd wake up and my baby is not there and they'll be carrying her. They really cared. Was it five, five to seven days I think, then I came out. (Pause) but coming out was, I was wishing to stay in hospital forever. Not to go back to (named accommodation centre) (L) I felt hospital was better than (named accommodation centre).

R Why?

W The atmosphere, the whole idea of being there, I nearly felt bad, I'm going back to that life again of questions and eh because when I went for my first ?? (33.21) go for

my internal. So I just didn't want to go to that life again, I wished I could stay in hospital to get all the help and the attention (L) but I had to go back. And then I was given my form for my ?? (33.46). It was, it was terrible because I would stay indoors and my baby was just, she was in the place to feed, so the midwife used to come in and help me. She thought I didn't know how to do it and for real I did know but the baby didn't want so she would help me try. We really tried I think for two weeks she would come every day, she was nice. But it wasn't.... then I wasn't going out of that room. Then they realised that I wasn't leaving the room, so that's when I got the ?? (34.33) what word.... (Pause) (L) because did have a problem with waking up in the morning, with my baby giving milk.

R You did have a problem waking up?

W I didn't have a problem, I had a problem of just staying in the room to feed my baby and when we sleep, that was my routine every day, I'd wake up give the food to eat, I used to eat breakfast and then I would eat dinner. I would give her milk, she used to drink a lot of milk, bottle. I give her milk and then we would sleep and wake up when she wakes up, I give her milk, we'd sleep, wake up when she wakes up, that was my life in Baleskin. Until I was getting, (Pause) em

R Anaemic?

W I don't know what it's called I didn't have any (Pause) any food in my body. They put me on Ensure (?) you know the Ensure.

R Ensure

W Yeah like milkshakes, instead of drinking those because I had a problem at the time to eat, I just didn't want to be awake for her. So if the lady comes and she's opening the curtains and maybe taking me out, making sure I've eaten something. And then later I would see the psychologist, first I was seen in the accommodation centre but then they made me go to see her in a hospital to get me out.

R Right.

W I didn't see a reason of life, of going out. After all it was cruel. So I just thought (Pause) I don't know but I was just waiting for an end to something in that room. and given a choice to just go sit in that room and go, just to sit not to go outside. I wouldn't go. And when we came here I was a bit better.

R How long was it before you were transferred here?

W (Pause) I think eleven months.

R How long?

W It would be eleven months.

R You are here eleven months but how long after the baby?

W No, I'm saying to be transferred from (named accommodation centre) I stayed in (named accommodation centre) for ten or eleven months I think.

R After the baby was born?

W Yeah, I stayed there for quite a long time.

R Did they eventually manage to persuade you to leave the room?

W The lady, the family support worker used to come and she would bath my baby, even if I could do those things my baby was very healthy you would believe it. I did everything for that care. I didn't care about myself. You know, wear the same clothes, it was terrible. I don't think about it, it was really terrible. I was in; it was like in a prison. It was so painful. Now I never used to leave that room only when that lady comes she used to come Tuesday and Thursday. Then she takes me to (nearest town) or McDonalds she really tried. Then I became friends with her so she would call me, we'd talk, her name was Debbie, I never forget this. She was, she used to talk about her family and her husband, she was a best friend for me. She was the only, I know people were around but the other lady took me into the hospital, that was it, I didn't see much when I moved because I was always in the house. Debbie really helped me a lot. When I came here I really wished I could see her again but I was given somebody else here. She was...

R And you lost touch with Debbie, she didn't keep in touch?

W She couldn't come to Co. (this location). She deals with ?? (39.07) yeah, but when I came here and I actually improved, now I'm okay (L). Now I'm, you know there was a time when I was ?? (39.21) someone asked me if I could really speak? That's really weird. Someone asked me if I could really talk.

R What? Who? Like?

W No just another person used to say to me in (named accommodation centre), she said sorry can you really talk? Then I started doing my hair, I started going for shopping, I would do my hair, instead of my hair because I was always waving my head, up to here, one time the manager in (named accommodation centre) asked me what was with the head. But I just felt, (Pause) and I always yearned to go back, just to face whatever, you know, slow death is more painful than fast death. If death, if I go home and get killed once its better than staying here slowly suffering mentally, emotionally, ah anything. The trauma is now put on this child which is just, that would be help

you know, they really try use people. Like say ?? (40.42) were really nice, nice to talk, she would sit with me, I would, I didn't know anybody would recognise this face, would sit for like an hour, I would sleep. (L) it was funny, I even wonder what about, I think I was going mental. But

R Sounds like you might have been depressed?

W I was depressed, I was on those anti-depressant.

R You took those for a while, do you think they helped you eventually?

W (Pause) yeah they did, I took those until, even here I was still on the course but I stopped myself from taking them.

R Why?

W Because just had ?? (41.29) and I, yeah I just, just take the minimum. I thought I depended on them to live the life. I just got tired of them.

R So when did you stop them?

W Maybe I think when I got here I took them twice, I took the course twice in the medical centre. Because they sent me these so I think I took them twice. then I stopped.

R Two courses?

W Two courses yeah.

R And that was a good few months ago now?

W Its, its...

R How long have you been here?

W I come probably over a year.

R So you started to get better when you came out here and you had your own little house?

W Yeah because I was sharing with a lady from Zimbabwe.

R Oh you were sharing?

W She was in (named accommodation centre) before but then I was not used to her there, so when I came here I was staying with her. She was very nice, very active woman. She would, she would do my hair, do my baby's hair, take me out, you know someone who's just too active when its not necessary. She was that kind of person. Then I started going, I go to school here so I became out more. And when you are out more by the time you come to sleep you think you are tired. So it clears me and I continue to do this school, up to now I'm in school but if I'm still here I'm hoping to go back and sit in with, its better when I'm doing something than life with nothing to do. Just

waking up, and I've never gained weight since I came here (L). I know I've lost a lot but I'm trying to gain weight.

R So how you are feeling now, I mean at this point in your journey? Your baby is how old?

W She is two and I think...

R Eight months?

W She will be three in September. She's really fine, we are fine, we write letters, she writes letters. She comes, I'm expecting even today she still comes to visit me, she stays in (nearest town). And then I go to get a place.

R So you kept that friendship with her?

W She's like a sister to me. I depend on her more than anybody. Even the management here they know her, she says she's here with me.

R Its brilliant.

W She's like my sister, I feel she's the only person I came with from (home country) she's got a little girl my baby's age. She's a nice lady. (Pause) she's been, they wanted her to stay in Dublin but she stayed here near in (nearest town) for my sake. You can see what friends can do, she's really good.

R That's great.

W Yeah (Pause) so that's it. but I still yearn to go home. I still wish I could go home. So at least somebody would, especially my mum would see my child. (Pause) but my mum.

R Have you been able to send her pictures on the internet or anything?

W I sent through post and I wonder if she got. But now I'm okay, very okay now. Compared to (here) was a big, big change. (door banging)

R A big what?

W Change.

R Oh right, in what way?

W Yeah, I don't know, (Pause) just that life in (named accommodation centre) it was horrible, it was terrible. That (named) area, I don't even go there now. I hate that place with all my heart. I hate it. I'll never go back there for anything. But when I came here it's been, it's been better. I'm actually okay here. Here I, I have got a life. I changed. A lot of things changed actually when I got here. I'm an outdoor person now.

R Pardon?

W I became an outdoor person now.

R Right.

W Friends and all (knock on door).

R You are a woman in demand.

W I think the lady was telling you about.

R She's here. Well I'll let you go. But (W) is there anything else before we go that you were just saying that things turned around.

W I'm just saying you know compared to (named accommodation centre) and its also time, the time I've been here I've managed to get used to I think the situation only to realise that I'm not the only one like this, in this situation. And as well they have a life. And until things work out and then I can be with somebody and definitely go home. One day really I want to visit home.

R Yeah.

W Because my idea of coming here was not to stay, so I, I just want, I look at things, you know, I know things are not settling in my country but the moment they do, I'd love to go back and the weather here is terrible (L).

R That's one thing that's not going to get any better.

W No. but anyway that's it.

R (W) thank you so much for telling me your story, I really appreciate it and for your honesty and I think it's going to make a difference for other people because I think there's a lot to learn. For us to learn from what you've told me today. So thank you very much.

APPENDIX XVII

Narrative Summaries of the Women's Stories, Demonstrating the Application of Burke's (1969) Dramatistic Pentad with Bruner's (1990) Sixth Element of Trouble'

Narrative Summaries with Application of Pentadic Terms

Narrative 1: Description of terms

Antenatal

Scene 1: First antenatal appointment

Act: Hearing bad news regarding the scan

Agent: Marianne (Pseudonym), co-agent Doctor

Agency: Miscommunication/ poor communication of bad news/conflicting information

Purpose: Determine Scan findings? Plan Antenatal care?

Ratio Imbalance: Act: Agency

Scene 2: Awaiting amniocentesis results

Act: Amniocentesis/ communication

Agent: M, co-agent Doctor

Agency: Doctor spoke of Down's syndrome, mental disability, chromosomal abnormality. : It was more than my head could carry'.

Purpose: Determine health of foetus

Ratio Imbalance: Act: Agency

Intrapartum

One scene: Labour induced at 42 weeks. M. wanted to avoid a caesarean section so she could get back to her other children who were being cared for by friends. She had an epidural but resisted pressure to have a C/S and delivered vaginally.

None Apparent

Postnatal

Scene 1: 2-3 weeks later, baby is ill.

Act: M took baby to public health nurse but because no follow had been ordered on her discharge from the maternity hospital everything had to be traced back to her antenatal notes and referrals made. The first referral letter was lost in the post; eventually the baby was seen 6 weeks later by which time she was very ill.

Agent/s: M, nurse, doctor

Agency: Long drawn out process which meant baby very sick by the time she was seen, admitted to hospital same day and transferred to regional children's hospital, several miles away.

Purpose: Get baby seen by doctor

Ratio Imbalance; Scene: Act & Agent: Act (Public Health Nurse Agent)

Scene 2: Baby transferred to regional neurological centre for shunt

Agent: M, co-agent Doctor

Act: Shunt operation

Agency: Minimal information, emergency procedure baby in compromised condition because of delays at local hospital.

Purpose: Relieve intracranial pressure, stabilize baby's condition.

Ratio Imbalance; Act: Agency

Scene 3: Shunt blocked

Baby became ill in January, GP refused to see her because of shunt, when Mum took her to hospital she was told baby OK but once home baby still not thriving, ensued back and forth to local hospital for one month being told it was the winter vomiting bug, eventually becomes

exhausted and asks friend for help who persuades to take baby one more time to hospital as she is concerned for baby.

Act: Takes baby to emergency room

Agent: M. co-agents friend V, nurses, doctors

Agency: Told she must wait for 4 hours as she should not have brought a bay who just has tummy bug. J says she will wait. Baby deteriorates over the 4 hours wait until she begins to fit. Staff thinks it may be tetanus! 'Nobody even thought of the shunt'. Baby taken to ICU Mum has to wait outside. Staff call the regional hospital where shunt was put in and told to do a CT Scan and X ray which reveals a blocked shunt. Mum told baby to be transferred to regional centre in Dublin 90 minutes' drive away. She has no transport but is told she must make her own way as there is no room in the ambulance for her to travel with her baby.

Purpose: To get baby seen by a doctor

Ratio Imbalance: Agent: Act & Act: Agency

Scene 4: Emergency Surgery

Baby transferred under anaesthesia from local hospital for emergency surgery to unblock the shunt, her own doctor is not available. Baby is already compromised because of poor care at local hospital.

Act: Emergency surgery to unblock shunt cannot wait for bay's doctor. The doctor on call tells J that 'I am not supposed to operate on a bay in this condition....he doesn't know anything about the child, taking a risk to do the operation but he will do what he can' j says, 'Do what you can to save my baby'. In OR for 4 hours the operation is a success the baby wakes up an hour later

Agent: Doctor, co-agent M, baby

Agency: Communicates urgency of situation, cannot not offer reassurance.

Purpose: To unblock the shunt

Ratio Imbalance: Act: Agency

Scene 5: Current realities

Realities of living in an accommodation centre while she waits to hear news of her asylum application. The struggle to care for her two older girls with the demands of a small baby with hydrocephalus. The stress, depression that the living like this brings.

Act: Challenges of institutional living while not knowing what the future holds, not being allowed to work or make any plans for the future.

Agency: Institutional rules. Government regulations & legislation.

Agents: M, co-agents her children, officials, both government and institutional

Purpose: Responsibility towards asylum seekers, but also control and containment.

Ratio Imbalance: Scene: Agent

Narrative 2: Description of terms

Antenatal

Scene 1: Antenatal visits.

Act: Experienced being left waiting until 3pm for 8.30am appointments. Felt like people who came after her were seen before she was. Expressed feeling she received poor treatment because of her race.

Agent: R, co-agents nursing/midwifery staff

Agency: there were no explanations given for the delays even when she asked.

Purpose: To receive antenatal care/ health promotion

Ratio Imbalance: Act: Agency

Intrapartum

Scene 1: Admitted in early labour with spontaneous rupture of membranes.

Act: The midwife looking after her was not supportive or friendly towards her and criticized her for holding on to the student during contractions although the student said she didn't mind as she had two children herself and understood what that was like. Midwife still said 'no no no we don't do that here'. This made her feel very un-relaxed but she was grateful to have the support of the student.

Agent: The midwife, co-agent R and the student midwife.

Agency: Verbally scolded by the midwife. Midwife physically withdrew from the room as much as she could.

Purpose: Safe fulfilling birth!

Ratio Imbalance: Scene : Act

Postnatal

Scene 1: Postnatal ward

Act: Care just O.K. and poor food.

Agent: Midwives, co-agents R and her friends

Agency: Friends had to bring food in for F as she was hungry and not given food she felt she needed having just given birth. Also, felt there was 'no love shown' by staff and she was eager to be discharged home.

Purpose: The receive good postnatal care

Ratio Imbalance: Act: Agency

Narrative 3 Description of Terms (A/N)

Scene(A/N)

Antenatal admission with protein urea and raised blood pressure, she is feeling loneliness of having no friends or family support in Ireland, feeling scared and isolated.

Act:

She has to ask for money from social serves for baby clothes and other items.

Agent:

I., co-agents: the midwives, social worker

Agency:

She was referred to the social worker by midwives at the hospital.

Purpose:

The need for money to prepare for the baby and for day to day living costs in hospital.

Ratio Imbalance:

Scene :Act

Scene (A/N)

Admitted for PIH and awaiting news of a decision regarding her delivery.

' You don't know when you are going to have your cesarean because, I mean you know eventually you will have one, whether you want one or not you know.. '

Act:

Seeing 3 or 4 different doctors and getting conflicting advice regarding her baby's condition and what was going to happen regarding her delivery.

Agent:

I., co agents: doctors

Agency:

Conflicting advice, lack of continuity.

Purpose

Knowing what was going to happen regarding her delivery

Imbalance:

Act: Agency

Scene (L)

She is in recovery following elective caesarean section under epidural.

Act:

' Maybe they can just educate the people more about asylum seekers and not having the support, maybe give them just a little bit, not much but just that little extra support. We don't want them to be there next to us 24/7, its just come and ask us do you need anything, can we do something for you because sometimes we will feel too ashamed to ask for help (C) because we don't want to be a nuisance or we don't want to stop the people from their work or interfering, I don't know how to explain it exactly in my language, so. '

She wants to breast-feed her baby but there is no one to help her, because she is numb from the epidural she cannot get the baby herself.

Agency:

No one available to help her breast feed.

Purpose:

Desperately wanting to feed her baby

Imbalance:

Act: Agency

Scene: Agent

Scene (P/N)

On the postnatal ward one midwife stood out as being supportive

Act:

She was caring towards her, asking if she was OK,

'I don't know, when she was on duty she would just come to you and she will ask, like I said she will ask you if you need something, if you're ok, do you need anything, can I do anything for you, she just said that little extra and it was not as if it's her duty to do it, it's as if she really enjoyed doing, being there and being able to help.'

Agency:

Midwife was caring in her approach

Agent:

I., co-agent the caring midwife

Purpose:

Postnatal care

Imbalance:

None Apparent

Scene (P/N)

She is admitted again with PIH. She has to leave her older son who is under two, in the care of a fellow asylum seeker in the hostel, as the only alternative is to have the child taken into temporary foster care. She is feeling traumatized, stressed and worried.

Act:

When in hospital she has no money and is often hungry. She has no money to buy 'extras' like coffee.

Agents:

I., co-agents kitchen staff

Agency:

When she asked for extra food, she was refused and told she had already had breakfast/lunch etc.

Purpose:

Getting enough to eat

Imbalance:

Act: Agency

Scene: Agent

Scene (Postnatal)

Following the birth of her second child she is transferred from Dublin to Kerry, three days post discharge following a caesarean section. (approx. 5 hours travel time). She had to pack all her own things and carry all her stuff, baby, buggies etc.

Act:

It was good once she settled. Management was understanding and helpful. She had her own room and bathroom.

Agency:

She has good memories of being supported there. 'People there really went out of their way to try and help you and be supportive'.

Purpose:

To settle in 'permanent accommodation', in line with government policy of 'dispersal' around the country.

Ratio Imbalance:

Scene: Act

Scene (P/N)

Challenges of living in the compound

Act:

Trying to limit bad influences on her children, trying to be a good parent.

Agency:

She feels the example set by other parents in the compound is not always good

Purpose;

To bring up her children well

Imbalance:

Act: Agency

Scene (P/N)

Expresses fears about losing friends when they get their 'papers'.

'Yes I do, I don't know how they, people will, if they get their papers, if they will remember me, if they will still consider me as a friend because now that, its basically they're now on a higher social ladder basically now than us here, so.'

Act:

Her experience is that people who move out don't keep in touch.

Agents:

I., co-agents friends and neighbours

Agency:

She overheard a friend's child who had 'papers' say, *'you are an asylum seeker but I am Irish now'*.

Purpose:

Afraid of losing friends , losing equal status with her friends

Imbalance:

Scene: Act

Narrative 4& 5: Description of Terms

Scene:1 (L)

M. was induced at 38 weeks because of gestational diabetes with history of previous still birth.

Act:

She had a long painful labour with no family or friends to support her.

Agent:

M; co-agents: the midwives,

Agency:

The hospital staff was good to her but the loneliness was depressing

Purpose:

Safe birth

Ratio Imbalance:

Scene: Agent

Scene: 1 (P/N)

Postnatal ward following delivery

Act:

Staff did there 'work' but she missed having family members to care for her.

Agent:

M., co-agents: staff

Agency:

Feeling lonely and lacking support

Purpose

Recovery post delivery

Imbalance:

Scene: Agent

Scene: 2 (P/N)

Back in the hostel with her baby

Act:

The rules of the institution do not allow her to rest

Agency:

There are set meal times when she must go to the dining room and no flexibility to cook food and no culturally appropriate food makes life difficult for her.

Purpose:

Eat well to recover and build strength

Imbalance:

Act: Agency

Narrative .6: Description of Terms

Scene (A/N)

Having fled her home in Africa, leaving her husband and eldest son behind who she reports have been kidnapped by secret police, she is abandoned in Dublin airport by the person who took her into the country. She is already pregnant and has two of her younger children with her. She approaches a black woman in the airport where she should go, it turns out is visiting the country and does not know but offers her a lift into town. The woman drops her off at a shopping centre in Dublin somewhere and she spends that night sleeping outside with her children.

Act:

The following morning she is approached by an African man who hears her scolding her children and asks her if she is new in the country and that she is not allowed to speak to her children like that here because children have rights in this country. She explains her situation to him and he offers to let her stay with him while his wife is away in London.

Agent:

W. her children, the man and woman who help her.

Agency:

She stays with him but once his wife returns she is told she has to leave. She pleads to stay but they refuse. She goes into labour and the man calls an ambulance to take her into hospital. She has her baby and the next day they bring her bag and her children to the hospital and leave them with her and go. Hospital staff complain to her asking 'who owns these children?', she explains she has nowhere to send them so staff arrange for social services to come and they are taken into temporary foster care.

Purpose:

Finding shelter for her and her children

Imbalance:

Scene: Agent

Scene: (L)

Once she arrived in the hospital her labour progressed quickly and she gave birth quickly without any pain relief or tears.

Act:

It was a very easy labour, when they said push she found the strength from somewhere.

Agency:

She is happy when the baby is born and midwife places the baby on her chest. She compares it to her experience in Africa where her childbirths were much harder more traumatic events.

Agent:

W., labour ward staff, her baby

Purpose:

Safe birth

Imbalance:

None apparent

Scene: (P/N)

After discharge she is sent to a hostel in the city. She slips in the bathroom and fractures her hip.

Act:

She is taken to hospital and has a hip replacement.

Agent:

W., her children

Agency:

Her children are placed in foster care again for 6 weeks.

Purpose:

To recover from surgery

Imbalance:

Scene: Agent

Scene (present)

She has had many, many moves to various accommodation centres but does not have good news regarding her case. She lives in fear of being sent back home as her brother has been killed and she still does not know what has become of her husband and eldest son.

Act:

She supplements the money she gets from the State by doing small sewing jobs for people in the centre. She wishes she had freedom to work so she didn't have to collect money from the State.

Agency:

She is hoping to do some voluntary work with Vincent de Paul Society her in new city as she worked for them previously in Dublin.

Purpose:

Meaningful work

Imbalance

Scene: Agent

Narrative 7: Description of Terms

Scene (A/N)

Large regional hospital where D. was admitted on arrival to Ireland for sickle cell crisis.

Act:

She is given a private ward but feels lonely and isolated but the nurses comfort her.

Agent D., co-agent, staff caring for her

Agency:

Nurses come to sit with her, rub her back, try to comfort her.

Purpose:

Receiving care for sickle cell crisis

Imbalance:

None Apparent

Scene(A/N)

She is transferred to a maternity hospital where she is admitted as doctors have no antenatal history for her. She has nothing, just the hospital gown, no underwear or slippers etc.

Act:

She is noticed by a fellow patient who befriends her and one day goes out and buys her all the basics she needs, nightdress, slippers, underwear etc

Agent :

D., co-agent her new friend M.

Agency:

M. understands she has no one, never has a visitor, no family or means so she buys her what she needs and tells her she is her visitor that day!

Purpose:

To alleviate D\ her loneliness

Imbalance:

Scene: Agent

Scene (L)

D. does not realize she is contracting, calls her friend M to tell her '*my tummy is coming up and going down*'

Act;

She is now in labour and crying because she has nothing to dress the baby in, but she does not tell anyone that is why she is crying. However, the midwives tell her they have a surprise for her.

Agency

Her friend M. realizes why she has nothing. The midwives and her friend have put money together and M goes and buys a gift of clothes for the baby, they are all emotional when they present her with the gift.

Purpose:

To support her, alleviate her fears.

Imbalance:

Scene: Agent

Scene (P/N)

She is discharged to a hostel in Dublin and meanwhile continues her friendship with M. She also volunteers in local charity shop and is taking a computer course the hostel organizes.

Act:

She is transferred to a new hostel on the other side of the country. She is given one nights notice. She is meant to be going to her friend M for tea that evening but calls her to tell her she is being moved. M. is shocked and says you do not have to go but D. tells her she has no choice.

Agent:

D., co-agent,; her friend M, the authorities

Purpose:

Government policy of dispersal

Imbalance:

Scene: Agent

Scene (P/N)

New accommodation centre, D. explains what conditions are like for her.

Act:

She is sharing a small room with another Mother and baby. They share a bathroom; there is no space, no privacy. She is grateful that the woman she shares with is a mature person and they get along together. Agent:

D. co-agent; roommate

Agency:

Overcrowding in the hostel, conditions poor

Purpose:

Wants to convey to me the conditions they are living in here

Imbalance:

Scene: Agent

Narrative 8: Description of Terms

Scene: (A/N)

She is admitted to hospital in early labour. Had previous caesarean section and found this labour long and hard.

Act:

Add and artificial rupture of membranes, and an epidural and manages to have a vaginal birth.

Agent:

T., co-agents; doctors and midwives who care for her

Agency:

Felt very supported by the midwife

Purpose:

Safe birth of her baby

Imbalance:

None apparent

Scene: (P/N)

On discharge from hospital feeling lonely and isolated, misses having family and friends to support her. Finds conditions in the hostel where she lives stressful, for example having to share a public toilet and bathroom with up to 30 other people.

Act;

Became depressed and needed admission to psychiatric hospital. Her little girl (older child) is taken into foster care as she has no one to take care of her.

Agent:

T. co-agent; her daughter, social services, foster parents

Agency:

The foster mother gives her daughter things she could not give her, for example a bubble bath. This makes her feel more inadequate but she is glad her daughter is being well cared for.

Purpose:

Care for her child while she is in hospital

Imbalance:

Scene: Agent

Scene (P/N)

She is now transferred to new accommodation in the West and is finding it difficult getting used to living in a new system.

'Yeah, no its not like, its different, its not like (L), its not easy, its not really easy because you come into a new place, a strange country that you've not been before, meeting new people, you've not known in your life before, you know in this place everybody has their own problems, everybody has their own thinking, things that you are thinking of, maybe in the terms of your staying in this country, government or whatever so everybody likes being on our own, even if they come and help you just for some days, you still have your own problems.'

Act:

More and more new people are being accepted into the centre making overcrowding a problem. This means T. must share a room with a stranger.

Agent:

T, co-agent; the new mother and baby sharing her room, centre management

Agency:

Overcrowding, loneliness, stagnation, idleness

Imbalance:

Scene: Agent

Narrative 9: Description of Terms

Scene (A/N)

Having just arrived in Ireland the taxi leaves her outside a hotel. While she is standing there trying to get her bearings she feels 'very tired, really really tired and in some pain'. She is approached by a woman who is coming out of a nearby salon and the woman asks if she needs help. She is unaware that there is blood running down her legs.... She is 26 weeks pregnant and the woman calls an ambulance and she is taken to hospital.

Act:

She is admitted to the emergency room but left waiting in the reception area. It is late at night, she is totally alone, hungry, tired and in pain.

Agent:

F.; co-agent medical and midwifery staff

Agency:

Staff ask for her medical card (insurance), her home address etc., she tries to explain she has none of these things. They do many tests, swabs etc but she is never told any results or what the tests are for.

Purpose:

To get medical help.

Imbalance:

Act: Agency

Scene: Agent

Scene (A/N)

She is admitted to hospital as she is threatening pre term labour. She is bleeding badly, and told that because of the baby's weight it may not live.

Act:

The baby is born weighing 750g and is transferred to NICU

Agent:

Fola ; co-agent medical and nursing staff

Agency:

She is afraid and in pain but her faith carries her through

Purpose:

Safe birth of her preterm infant

Imbalance:

Scene: Agent

Scene (P/N)

Having given birth to her daughter the day she arrived in Ireland, she is discharged from the hospital on the following Monday without her baby who is in NICU.

'that was the most painful day of my life, leaving the hospital without going with a child, leaving my baby behind and nobody to go to, nowhere to go'.

Discharged to a hostel she travels back each day early in the morning until late at night. Most nights she feels so alone she just sits with the baby and weeps.

Act:

One of the nurses talks to her and tells her she needs to be strong, needs to take care of herself for her baby. After this she begins to talk and sing to the baby and the baby starts to respond.

Agent:

F, co agent; nursing staff, baby

Agency:

The nurse helped her to see the important role she plays in the baby's recovery.

Purpose:

Baby's progress

Imbalance: **Scene: Agent**

Scene(P/N)

Baby is discharged home with an apnoea monitor, but Fola is scared to leave him. Bathroom and shower are public shared with 30 others and means she has to leave the baby alone in the room if she needs to use the bathroom.

Act:

She leaves the baby alone in the room when using the bathroom, laundry room etc. but lives in fear of the baby stopping breathing while she is gone. As a result she misses meals, cannot bathe.

Agent:

F., co-agent baby, management

Agency:

F. requests a transfer to a room with a bathroom on the ground floor. and her request is granted.

Purpose:

Safety of the baby, her peace of mind.

Imbalance:

Scene: Agent

Scene(P/N)

She is transferred across the country with one nights notice despite having an appointment with the baby's paediatrician the next day. 3 months later, she is still waiting for the baby's files to be sent to new address and for an appointment with a new consultant paediatrician. Her doctor back in Dublin calls her to ask why she missed the appointment is angry that she has been transferred and asks her to come back to Dublin to have the baby seen. She explains that she is not allowed to travel back for appointments and must wait for a referral.

Act;

She is worried about the baby and tells the public health nurse who explains they are still waiting for her files.

Agent:

Fola. co-agent, her baby, paediatrician and PHN

Agency:

Baby has not had follow up appointment now overdue by 3 months

Purpose:

Prevent complications; ensure baby's safety and progress

Imbalance:

Scene: Agent

Act: Agency

Scene (P/N)

F. is transferred to Galway. The hostel is overcrowded; she is forced to share a small room with another Mother and baby.

Act:

There is no freedom to sleep or bathe when she needs to. She gets a migraine one evening and must endure the other woman watching TV until 1am.

Agent:

F. co-agent, her roommate, and their babies

Agency:

She doesn't ask the woman to turn off the TV, feels she must put up with it.

Purpose?

Imbalance:

Scene: Agent

Scene:

Professionally educated and a writer, F. is frustrated that she is not allowed to work and cannot write as she has no access to a computer.

Act:

She feels like she is wasting away with boredom and stress of aimless days.

Agent:

F.

Agency:

Cannot contribute, feels despondent and depressed about her situation.

Purpose:

To have a purpose!

Imbalance:

Scene: Agent

Narrative 10: Description of Terms

Scene: (L)

One month after her arrival in Ireland P. finds out she has a raised white blood cell count.

She comes to hospital in early labour and wants very much to have a vaginal delivery as her previous birth in Africa was by caesarean section. However, P. has been circumcised and staff is concerned about her giving birth vaginally.

Act:

Doctors and midwives try to persuade her to have a C/S or an epidural as they fear her birth canal is 'very tight'.

Agency:

She persists and gives birth vaginally.

Purpose:

To have a vaginal birth

Imbalance;

Act: Agent

Scene: (P/N)

Three months after giving birth she becomes very weak and cannot raise her arms or legs. She goes to her doctor who prescribes painkillers.

Act:

She asks for stronger pain relief but the doctor says no as she is breast feeding so she stops breastfeeding in order to get the pain relief.

Agent

P. her doctor

Agency:

The doctor sends her for further tests and she is diagnosed with Leukaemia.

Purpose:

Relief from symptoms

Imbalance:

Act: Agency

Scene (P/N)

Having been diagnosed with Leukaemia she finds it hard but is grateful to be on treatment and her hope is to see her three children grow up.

Act:

She calls Africa to tell her family. She tells her sister and her husband, who's only response is 'is it contagious'. She cannot bring herself to tell her elderly parents because she knows they will worry.

Agency:

Phone call home

Purpose:

Break news of her illness

Imbalance:

Act: Agency

Scene (P/N)

She is to be transferred to a more 'permanent' accommodation.

Act:

She is transferred to other die of the country. She is happy to have a more permanent place but sad that her friends cannot go with her.

Agency:

Her friends are sent to different parts of the country, Cork and Portlaois, so she is 'starting from scratch again'.

Purpose:

Move to more permanent accommodation, government policy of dispersal.

Imbalance:

Scene: Agent

Scene: (New Accommodation, P/N)

On arrival at the new accommodation she finds it very stressful. The place is disorganized and there is fighting and squabbling on a daily basis. 'It was very rough'.

Act:

They are told they must go to meet the 'social' in town. They are given directions but do not really know where they are going.

Agency:

It is raining but they must walk in the rain with their children

Purpose:

Register with social services to get their allowance.

Imbalance

Act: Agency

Scene: Agent

Scene

Things settle down.

Act:

Management held regular meetings with residents

Agency:

The feel listened to, communication improves

Purpose:

Harmonious living

Imbalance:

None apparent

Narrative 11: Description of Terms

Scene1 (L)

Pregnant with her first child she is scared because of all the stories she has heard back home. She is afraid of injections, but found her antenatal experience good in the Irish hospital. At 41 weeks her waters broke and after 3 -4 days labour is induced.

Act:

She had a long labour but a young medical student 'a boy', stays with her throughout. She is scared; she has an epidural for pain relief and is pushing for a long time. Eventually she has a vacuum delivery.

Agent:

W. co-agent, medical student, unit staff.

Agency:

'It was a great experience', the only sad thing was that the baby's father was not there.

Purpose:

Safe birth

Imbalance:

None apparent

Scene (P/N)

She is discharged on the 3rd day as the hospital 'is very very busy', and before she could pack her things there is somebody there to take the bed. She is discharged back to the hostel, 'that was the hard part of it'.

Act:

She has to move to a new room in the hostel. She has to move her stuff, take care of herself and her baby and finds it hard with perineal sutures and no help or support.

Agent:

W.

Agency:

Sense of having no family support post delivery is big for her.

Purpose:

Transition to motherhood/ early postnatal experience

Imbalance:

Scene: Agent

Scene 3 (P/N)

Transfer to West of Ireland. Since transferring to new accommodation finds sharing a small room very difficult.

Act:

At 6 months baby is starting to crawl. No room for baby except on the bed.

Agency:

She is constantly worried, afraid to take her eyes off the baby in case he falls off the bed.

Reiterates that she is very grateful for the accommodation and is very positive about her experience since coming to Ireland.

Purpose:

Care for her child effectively/developmental stages being met for baby

Imbalance:

Scene: Agent

Narrative # 12

Scene 1 (A/N)

Escapes a violent marriage in Africa but has left her two children behind in the care of her pastor as there was not enough money to send them all away. Her children are 2yrs and 11 yrs.

Act:

She is very grateful for everything she has been given in Ireland although she is very much alone and without friends.

Agency:

She is sent to hostel and is grateful for the refuge.

Agent

T.-justice department, government officials

Purpose:

Shelter while awaiting asylum case

Imbalance:

Scene: Agent

Scene 2 (L)

She has 'water on her body', and tells the hostel manager she needs to go to the hospital. The manager wants to call an ambulance but she refuses thinking the walk there might help her labour advance.

Act:

When she gets there staff check her and tell her she is not in labour, she is anxious because she feels something is happening but she does not 'want to shout or scream so I say please I am feeling something but I don't know how to shout'.

Agency:

The staff does a CTG and it seems the trace was non-reactive so they give her a glass of cold water to drink. After this her contractions get stronger and she delivers one hour later without pain relief. She marvels that a glass of cold water could do this!

Purpose:

Safe birth

Imbalance:

None apparent

Scene (P/N)

Following the birth of her baby she misses not having anyone to congratulate her

Act:

She loves going into Boots (department store), because people in there stop to admire her baby and this makes her very happy.

Agent:

T. women who talk to her in the store

Agency:

Strangers stop and talk to her and this helps alleviate her loneliness

Purpose:

Need for connection with other people

Imbalance:

Scene: Agent

Scene 2 (P/N)

She had blood tests taken at the hospital for herself and her baby (she does not say what for), she is anxious because the day she was to go to the hospital for the results she is transferred across the country.

Act:

She is transferred to a new centre on the opposite side of the country. She is adjusting to the new circumstances and having to share a room with a total stranger and her baby. She is worried about the blood results.

Agent:

T. ;co agent management in the centre

Agency:

She is transferred with just one evenings notice and has no time to make arrangements barely time to pack.

Purpose:

Transfer to more permanent accommodation, government policy of dispersal

Imbalance:

Act: Agency

Scene: Agent

Narrative 13: Description of Terms

Scene:1(L)

Escaped from Africa because of threats on her life and life of her husband. Husband refused to participate in pagan rituals associated with being king of his tribe when his Father died, these rituals involve sacrificing of the first born child. His wife is already pregnant so they sold everything to raise money for the passage to Ireland.

Act:

Labour was spontaneous in onset but progress was slow. She had an epidural and caesarean section.

Agent:

D., her husband and baby

Agency:

Her husband was present for the birth of her daughter by C/S under epidural.

Purpose:

Safe birth

Imbalance:

None apparent

Scene: (P/N)

She is ready to go home, bag packed when the nurse asks to check her blood pressure.

Act:

Her blood pressure is very high and she has to stay an extra night.

Agency:

She is given medication to bring her B/P down. She believes her blood pressure is high due to the stress of events in Africa.

Agent

D., her husband, and baby.

Purpose:

Control of blood pressure

Imbalance:

None

Scene: (P/N)

Two weeks after discharge from hospital they are transferred to new accommodation on the other side of the country.

Act:

The notice that they are being transferred is posted late at night.

Agency:

The lost some of their possessions and a lot of their clothes in the rush to pack

Agents

The couple and their baby, management/government policy

Purpose:

Imbalance:

Scene: Act

Act: Agency

Scene (current)

She explains she spends a lot of time alone in her room. She does not join in with activities in the hostel. She misses home and misses having people to congratulate her. Especially misses her sister. \her parents died in a fire when she was two. She does not like the canteen food they are given.

Act:

Someone prepares an African dish.

Agency:

Word gets out and everyone is excited a big queue forms outside the canteen!

Agent

The woman her co resident

Purpose:

Missing out on all things familiar; familiar food comforted her.

Imbalance:

Scene: Act

Narrative 14: Description of Terms

Scene: (A/N)

She fled Africa with her husband and two children for fear of female circumcision of her daughter.

Act:

Since arriving she experiences a lot of stress related to inactivity. She feels caged because she cannot work. She feels powerless as she cannot make any decisions for her life.

Agency:

Being told when to act, not being allowed to cook or work is a 'mental stress'.

Agent:

R.; co-agent her family, hostel management.

Purpose:

Wants to make a new life?

Imbalance:

Act: Agency

Scene: Agent

Scene:2 (A/N) Quote pg. 2 regarding racism

'You feel like an outcast'

She went to an antenatal clinical for a check-up, while waiting to be called another Irish woman came in and was called before her.

Act:

She complained at being left waiting and one of the women said what are you complaining for, if your country is so good why did you leave it....?

Agency:

R. expected the midwife to intervene on her behalf but she did not, she just smiled which made W. Feel they were all laughing at her and this made her feel depressed and unsafe.

Agent:

R; co agents the other women and the midwife

Purpose

Routine antenatal care

Imbalance:

Act: Agency

Scene: (P/N)

R.is very angry because she thinks Irish people think Africans come to this country just to have babies and get government hand-outs.

Act:

'Can Irish people not ask themselves how can someone leave their families have nobody to talk to, nobody to turn to, who would live such a life for no good reason?'

Agency:

‘Most Africans coming here have been educated, they have something to offer but are not allowed to contribute to society.’

Purpose:

To make a better life in this country, and to be understood.

Imbalance:

Act: Agency

Scene: 2 (L)

At one point she ran away from the system and went underground because there was a deportation order out against her. She moved from county to county, friend to friend with no permanent place to stay because she was afraid of being sent back to Africa.

Act:

She had been separated from her husband in Africa, but met him again in a church gathering in Ireland. She had not known where he was but he had been looking for her, but neither of them knew they were going to meet that day. She then became pregnant for the third time and did not seek any antenatal care because she was living underground and moving from place to place.

Agency:

When she came to give birth she perceived the midwives as very caring even though one said she deserved to be beaten for not accessing antenatal care for her unborn child! She perceived this as the midwife caring about her and her baby and valuing life above all else. When I questioned her about this she said they may not have been the words the midwife used it was how she felt as a result of what the midwife said.

Agent:

R.: co agent; midwife

Purpose:

Came back into system to give birth

Imbalance:

Act: agency

Narrative 15: Description of Terms

Scene:

She and her husband had to leave their village in Africa because he was to be made king of his tribe and this involves ritual sacrifice of the eldest child and they were not willing to do this. They went separate ways in Africa. She is already pregnant with her second child, she goes to Laos to a friend but was raped by the friend's brother. Her 3 year old son is in the room at the time and witnesses the rape. She is taken to hospital and bleeds badly but does not lose the baby. Relationship with her friend becomes untenable and eventually she was helped to leave the country and came to Ireland. She and her son were dropped by the trafficker outside an off license (liquor store), in Dublin at night. Someone was to meet her but they never showed up.

Act:

Her son is shaking with cold and hunger so she asks a white man where she is and he tells her it is a dangerous place. The man calls a taxi to take her to hospital because she is feeling unwell.

Agency:

She is in premature labour and the hospital staff are concerned the baby might not live as only 30 weeks gestation. She collapses and does not remember anything until she wakes up the following day. She has given birth, her baby in NICU and her son has been taken into foster care. She is told she is lucky to be alive; she is desperate to see her baby and her son.

Agent:

B., her son and man who helped them

Purpose:

Save her life and her baby's life

Imbalance

Scene: Agent

Scene: (P/N)

After 5 days in hospital she is ready to be discharged. She is visited by a social worker whose name she still remembers, 'she did a great thing for me', she gave her money and brought clothes and nappies for the baby. Also gave her a letter for the justice department and organized a taxi to take her there. From there she was sent to a hostel in the suburbs of Dublin.

Act:

When she got to the hostel it was very hard. The hostel was very over crowded, she shared a bunk with her children and there was nowhere to bathe them.

Agency:

They were transferred from there to another centre and it was 'wonderful' in comparison because she had her own room with her children. She felt like she was in a palace. She was there for 4 months before they moved her again.

Agent:

B and her children

Purpose:

To find adequate accommodation

Imbalance:

Scene: Act

Scene: (P/N)

After several transfers to different places she has recently been transferred to current accommodation. She is worried about her son as she feel she is still traumatized from everything he experienced in Africa. He also asks where his Father is and if he will ever see him again.

Act:

He had been having therapy with the ISPCC in Dublin, but because of the move he could not complete his treatment.

Agency:

She asked could he continue here in the new county but she was told no, those services are not available here.

Purpose:

Psychological Treatment for her son

Imbalance:

Act: Agency

Scene: (end of the interview)

At the end of the interview she suddenly opens up and tells me that her son was not her first child. She had a daughter back in Africa.

Act:

Between the age of 18 months to 2 years her daughter was circumcised according to the custom of her husband's tribe. The little girl bled badly and the tribe used local medicine rather than take her to the hospital.

Agency:

Eventually she persuades her husband to take the baby to the teaching hospital but it is too late and her daughter bleeds to death.

Agent:

B, her husband, the tribal leaders

(B. is distraught as she tells me this. She tells me she would be 10 years old now, she notices every little girl of that age and thinks of her daughter constantly. She feels totally responsible for her death. 'I can say it's me that killed the baby'.

Purpose:

Unburden her sorrow?

Imbalance:

Scene: Act

Narrative 16 &17: Description of Terms

Scene: (L)

Fled to Ireland from the Middle East with her husband, does not want to talk about reasons why they had to come here. Was here for a couple of years before getting pregnant, had not wanted to have children for a long time. She did plan the pregnancy although her husband was hard to persuade because her felt it was a bad idea because of their situation as asylum seekers. Her pregnancy has been difficult, complicated by sadness and depression.

Act:

She is admitted for induction of labour, but this is not successful. She eventually has a caesarean section under epidural, and delivers a large baby, 4.5kg

Agency:

She meets and nurse in the operating theatre that is married to a person from her country and speaks her language. While she is in hospital anyone with (her country) connections comes to speak to her. She is so happy to meet people she can talk to as she and her husband are the only people from Middle East in the camp.

Agent

A., the nurse she meets in the hospital.

Purpose:

Giving birth safely, making connections with others outside the accommodation site.

Imbalance:

Scene: Agent

Scene (P/N)

Breastfeeding is difficult. The baby does not latch well and is crying constantly. Every morning she apologizes to the other women in the ward because he makes so much noise during the night.

Act:

She rings the bell when she needs help to feed but some day staff tell her she must try herself; this makes her reluctant to ask for help, but at night there is one midwife who is very kind and patient with her. (Quote pg. 11)

Agency;

She feels relieved and grateful when she knows this midwife is coming on duty because she knows she will get the help she needs. She remembers her and took a picture of her when she was leaving!

Agent

A; Her baby and the midwife who was kind to her.

Purpose:

Establish breastfeeding

Imbalance:

Scene: Agent and Act: Agency

Scene: (P/N)

After discharge from hospital she is in a lot of pain and crying all the time. Although her husband is supportive she finds it hard to adjust.

Act:

Two or three weeks after delivery she feels she hates the baby, she cannot let her husband out of her sight, once the sun goes down she cries and cries.

Agency:

Doctors offer her antidepressants but she does not want to take them as she is breastfeeding. She refuses counselling because she feels she cannot express why she is so sad.

Purpose:

Suffering from post natal depression?

Imbalance:

Agent: Act

Scene (A/N)

Long into the interview she reveals that after she became pregnant with her longed for baby, she became depressed. She felt lonely and hopeless; she missed the support of family and friends.

Act:

A staff member from the accommodation centre who has become her friend offers to take her home to care for her for a couple of nights.

Agency:

During the visit she has suicidal thoughts but nothing comes of them. She does not accept treatment and within a month the worst of it has passed.

Agent:

A and her friend who tries to help her.

Purpose;

Attempt to support and cheer her

Imbalance:

Scene: agent

Scene: (general A/N)

She makes friends with an older Irish couple who live in nearby town. They become like parents to her. They write a letter to the visa office inviting her parents to visit for the baby's birth but their request is denied.

Act:

She feels nobody trusts you if you are an asylum seekers. She feels ashamed to give her address as (the accommodation centre). She hates lining up for food or welfare payments and is ashamed of living in direct provision.

Agency:

When asked where she lives she gives the name of the local town and not the accommodation centre because she feels ashamed to be living there.

Purpose:

Struggling with marginalization

Imbalance:

Scene: Agent

Act: Agent

Narrative: 18 Description of Interview

Interview conducted through interpreter

Scene: (A/N)

E. was sent to hospital by her GP because her blood pressure was raised. She was living in a hostel at the time and had two older children back in the centre.

Act:

She waited from 4pm to 7pm to be seen at the hospital. Her friend phoned the reception to explain that she would need an interpreter. At 10pm she decided to leave because she was tired and hungry and worried about her children when the lady called her back. Together with the interpreter and the doctor's letter they figured out what was wrong.

Agency:

She was told she would have to stay in hospital but she could not as she had none to take care of her children. She found someone, a girl from Zaire who agreed to take care of them and she went back in. She was there for 11 days and she felt nothing was happening. She was meant to be resting for raised B/P but she was woken every night by the women in the next bed, but could not tell anyone because of the language barrier. She insisted on being discharged on December 24th to be with her children for Christmas, and before discharge a French doctor came to see her. When she explained she was not getting any rest at night the doctor asked why she did not tell someone and she explained she could not because of the language barrier!

Agent:

E. co-agent non communicative hospital staff, the lady in next bed

Purpose:

Rest to bring down B/P

Imbalance:

Act: Agency

Scene: Agent

Scene: (P/N)

When it came time to return to hospital she was afraid to go but she did it anyway. She was there for 28 days in total. It was very hard time for her and her children who didn't get to see her during this time. Eventually she had a caesarean section as they could not control her blood pressure and the baby had IUGR.

Act:

Her baby was in NICU in an incubator and she could not communicate with the staff. She was frightened and intimidated and did not know what was happening to her baby or how he was doing as she couldn't communicate.

Agency:

She tried to ask a nurse on the unit to call her friend so she could interpret for her but the nurse refused saying they did not have money for this and she should put money on her cell phone and call herself and then they will speak to her friend.

Agent:

E., and the nurse on the unit

Purpose:
To get information on her baby's condition
Imbalance:
Act: Agency
Scene: Agent

Scene (P/N)
She is afraid and intimidated by NICU staff. She spends her time crying, she believes her baby is going to die.
Act:
She manages to get a phone call between her friend who can interpret and a NICU nurse. The nurse begins to understand her situation and shows her kindness.

Agency:
The nurse takes her by the hand and shows her photos on the wall of babies worse than hers who progressed and made full recovery. This helps her to have hope and her outlook becomes more positive. Her baby does improve and now is 'big and he is great'.
Agent:
E. her friend and the nurse who helped her
Purpose:
Communication, kindness and understanding
Imbalance:
Scene: Agent

Scene (P/N)
She makes a link with a local African church and they befriend her. They visit her at the hospital and help translate for her.
Act:
The ladies from the church visit her on Tuesday's, Thursday's and Sunday's and so on these days she gets information on her baby's progress.
Agency:
They would tell her how the baby was, when he was good and not so good. 'That was her salvation'.
Agents:
E. her church friends
Purpose:
Communication re baby's progress
Imbalance:
None Apparent

Narrative #.19,20,21,22: Description of Terms

Scene: (A/N)

Joy is admitted five weeks prior to birth because of raised blood pressure. She finds this experience very difficult as she has never been in hospital before. She arrived in Ireland on the 19th and was admitted on the 23rd. She had no friends and no visitors and found it very difficult.

Act:

One day she decided to go for a walk outside without permission from hospital staff. She walks for fifteen minutes or so and starts feeling some pain and then realizes she is lost. She has no money for a taxi so asks a man passing by how to get back, he offers to call a taxi but she refuses as she has no money to pay for this so he gives her directions and she finds her way back.

Agency:

The nurses are angry with her and say that she put herself in danger. She is crying and upset because she cannot go outside again, she finds it tough but eventually considers it is for her own good.

Agent:

W. co agent man on the street, the ward staff

Purpose:

To get fresh air, relieve boredom

Imbalance:

Act: Agency

Scene: Agent

Scene 2 (L)

She is induced at 39 weeks because her B/P is still very high. It is a long day, she is alone with no friends or family support.

Act:

She is crying loudly and the midwife tells her to stop screaming and shouting.

Agency:

Her waters break and she is ashamed because she thinks she has urinated on the floor. She apologizes to the midwife, but the midwife does not explain to her that her waters broke instead she says the waters broke because she was screaming so much, 'you've been screaming, I've been telling you to stop screaming because you are disturbing others'.

Purpose:

Support in labour

Imbalance:

Act: Agency

Scene (L)

The induction is not successful and she must

Have a caesarean section. She is afraid that she or the baby will die, or that she may not be able to have more children.

Act:

The doctor, a woman, comes to speak to her. She explains that everything will be OK, she and the baby will be safe and future pregnancy will be possible.

Agent:

J. co-agent doctor

Agency:

The baby is born without complication and she is happy to see her baby and to have survived the operation.

Purpose:

Safe delivery

Imbalance: **None**

Scene: (P/N)

Her blood pressure is still very high post-delivery. She is put in a side room alone to rest. The midwife looking after her explains she needs total rest and is very caring towards her. The shift changes and the new midwife is unkind and uncaring.

Act:

When she rings the bell the midwife does not come, when she does come she tells her that she is disturbing her too much and she is not eth only patient.

Agency:

When she calls her again because she is bleeding, her pad and bed is wet and needs to be changed, the midwife raises her voice and says 'what do you want, you know she was shouting and I say please its because I am feeling pains, I want to change my pad, I'm wet and my bed is wet'. This continues for the rest of the shift. She asks to be moved to another ward. (Later she needed a blood transfusion, she herself does not make the link between the wet pads and bed and haemorrhage).

Agent:

J. the midwife who does not care for her

Purpose:

Postnatal care of a high risk woman with PET following operative delivery!

Imbalance:

Act: Agency

Narrative #.23 – 25 was not included in the analysis as the women had a very bad speech impediment (as discussed earlier)

Narrative 26: Description of Terms

Scene(P/N)

She fled to Ireland after the death of her husband. She was in danger from her husband's family and fled the country leaving her two teenage children behind. She met the Father of this baby in Ireland, he is from the Congo he is not an Asylum seeker.

Act:

Her partner is supportive and accompanies to her appointments at the hospital. She worried about giving birth because she was diagnosed with a fibroid but thankfully she did not bleed.

Agency:

Since being transferred to her new accommodation she has not received any follow up care for her fibroid. She has an appointment before her transfer but has not heard anything and it has been several months now.

Purpose:

Follow up for fibroid

Imbalance:

Scene: Agent

Scene: 1. (P/N)

Her labour went well because she had her partner with her and her baby was born in 'good condition'.

Act:

Since being transferred to opposite side of the country she does not get to see her partner much

Agency;

She worries that her partner will find another woman because they don't get to see each other very often.

Agent

W., her partner

Purpose: Concern for her relationship

Imbalance: **Scene: Agent**

Narrative 27 : Description of Terms

Scene:(A/N)

On arrival in Ireland she was 5 months pregnant and told at her first antenatal appointment that she had hepatitis B after her first antenatal check. Her due date was January 19th but her waters broke on January 10th. She tried to explain that her waters had gone but no one would listen to her.

Act:

She went to see the midwife and said she was worried about complications because the waters had been gone now for two weeks, and no one had done anything about it.

Agency:

The midwife sent her for a scan which conformed that the waters had gone, so they asked her to come back that evening for induction.

Agent:

T. The midwives caring for her

Purpose:

To get someone to acknowledge her waters had gone and take action

Imbalance:

Scene: Act

Act: Agency

Scene: (L)

She returns for induction of labour

Act:

She is given a gel at 6 or 7 in the morning. At 2pm the doctor comes in and says they are going to try to rupture her membranes. She tells them there are no waters to burst, however they persist in trying to rupture the membranes.

Agency:

She tells them she is in pain and that there is no water there and that she is afraid they will pierce the baby's head so they agree to wait two hours and will start a drip if she is not contracting by then.

Agent:

T. midwives and doctors caring for her

Purpose:

Induction of labour

Imbalance:

Act: Agency

Scene (L)

Her labour starts without the drip but is very long and painful compared to her other births. She asks for an epidural but is refused. She has no pain relief throughout her labour. By the time she is fully dilated she is'Exhausted from crying, I was tired,, I was very very weak then'.

She also felt very alone and without support, 'it was a really sad thing to go through all by yourself'.

Act:

When she starts pushing the baby's shoulders gets stuck.

Agency:

They call others to help to pull back her legs (sounds like Mc Robert's manoeuvre) The baby is born but needs resuscitation. She is crying and afraid and feels pain but different to the pain she felt in labour.

Purpose:

Safe birth

Imbalance:

Scene: Agent

Act: Agency

Scene: (P/N)

The baby is sent to NICU for observation and she is sent to the postnatal ward. She is in a lot of pain and can't walk to the bathroom by herself.

Act:

She calls the nurse for painkillers and tell her the weakness in her legs will pass but she is worried, she has never had anything like this before and she worries that the weakness will be permanent.

Agent

T , the midwives

Agency:

No one took the time to sit and explain to her what had happened. She felt she needed someone to 'give her back her confidence' to explain things to her, but this did not happen.

Purpose:

Reassurance after traumatic birth

Imbalance

Act: Agency

Scene (P/N)

The baby is in NICU, she has to be taken in a wheelchair to see to see him. Sometimes if no one is available she would push herself in the wheelchair to see the baby. She is worried about the baby but glad he is being taken care of in NICU as she feels he is getting good care there.

Act:

The baby has paralysis in one hand. She notices this and asks the nurses about it.

Agency:

The baby is referred to a physiotherapist who explains that it should resolve with time but to go to her G.P. if it does not resolve.

Purpose:

Care of the baby following complications from shoulder dystocia

Imbalance:

Scene: Act

Scene

When she was taken into hospital for induction of labour she had to leave her 2 year old in the care of a virtual stranger at the accommodation centre. It was either that or give her child to social services to be placed in temporary foster care and she was afraid she would not get her back. She asked the woman she was sharing the house with and she agreed to care for her daughter.

Act:

She worried while she was in hospital about her daughter as she didn't know the woman well and she was also concerned for how the woman was coping as she had her own 3 month old baby to care for also. The day she left for hospital her daughter was crying and so was she.

Agent:

T., her daughter, the woman's own child

Agency:

She had no option but to leave her but was so relieved when she got back to find her safe. Her daughter had not been sleeping well while she was away and when she got home her daughter was taking a nap so although she wanted to hug her she didn't disturb her. When her daughter woke up and saw her she said 'Mammy'.

Purpose:

Safe care for her daughter

Imbalance:

Scene: Agent

Scene

She finds life in Ireland hard with no friends or support. Everyone has their own troubles so she feels she cannot burden them with hers. She feels people in Ireland think Asylum seekers lie about life in Africa but she is afraid to return even though she left her son there. She worries she will die if sent home as she will not be able to get treatment for Hep. B, and there will be no one to take care of her children.

Act:

She is very grateful for the 19.10 euro she gets because to her it is a lot of money. She saves it up and if she wants to buy a dress for her daughter buys one in the charity shop for one euro. She is grateful for the accommodation she has and wishes for a better life for her children. She has taken all the education courses available and would love to do more study but this is not an option for asylum seekers.

Agency:

She fights off worry about her future and the future of her children by keeping busy. She does not know 'what the world will be like for me and my kids'.

Purpose:

Struggle to make sense of life?

Imbalance:

Scene: Agent

Narrative 28: Description of Terms

Scene(L)

A. had a very long labour, over 3 days of contractions. She has an epidural for pain relief and eventually delivers her baby. She remembers the doctor who assisted here was unkind to her.

Act:

The placenta does not detach following the baby's birth and the doctor becomes impatient with her.

Agent:

A., co-agent midwife and doctor

Agency;

She is tired and cannot push any more, the doctor gets annoyed with her and tells her she is being lazy. He pulls on the cord and the cord snaps. A. is angry at being called lazy and very scared. The midwife is in the room but does not say anything. A. is taken to OR for manual removal of placenta.

Purpose:

Safe delivery for mother and baby

Imbalance:

Act: Agency

Scene 2(L)

She is transferred for manual removal of placenta

Act:

She is given more spinal block for the operation. She is terrified, and afraid she is going to die, she just wants to see her baby.

Agent:

A.,co-agents, OR staff

Agency:

Doctors successfully remove the placenta.

Purpose:

Manual removal of placenta

Imbalance:

Act: Agent

Scene(P/N)

Not long discharge she hears she is to be transferred.

Act:

She has to pack all her things and finds this very stressful with her new baby, because she is alone and this is her first baby.

Agent:

A. co-agent; her friends, management,

Agency;

Ten women are moved The same day but her best friend is moved to another county.

Purpose:

Transfer to more permanent accommodation/government policy of dispersal

Imbalance:

Agent: Agency

Scene: Act

Narrative 29: Description of Terms

Scene: (A/N)

Left her home because of persecution related to her husband. She was 8 months pregnant on arrival to Ireland and found Ireland scary. She was sent to a hostel and was terrified those first few days. She didn't even shower for days because she didn't know how to use the showers. The woman who interviewed her in the justice department was also pregnant and was kind to her, she told her she would need to go to the maternity hospital for a check-up.

Act:

She went to the medical centre and was given a scan. During the scan the midwife became concerned, 'looked horrified' and left to get a doctor to view the scan. She asked what was happening and they didn't answer. She is sent to the hospital for a 3 dimensional scan, where the same thing happens again, staff looking concerned leaving the room getting second opinions but nobody explaining why to her.

Agent:

L. co-agents; medical and nursing/midwifery staff at clinic and hospital

Agency:

She is told her baby has hydrocephalus but nothing can be done until the baby is born. She has to go for weekly scans. She finds this exhausting, she is very emotional and spends her time crying, eating and sleeping.

Purpose:

Ensure foetal wellbeing

Imbalance:

Scene: Agent

Act: Agency

Scene: (L)

She is overwhelmed by everything that has happened to her, she wishes she was still at home, 'dying would have been better than going through all these things alone'.

Act:

One week past her due date she starts bleeding and goes to the hospital. They discharge her but several hours later she has to return because she is contracting and passing blood clots. She is extremely scared, afraid to talk or make even a sound. She has a friend from the accommodation centre with her and asks her to speak for her as she is too scared to speak to staff herself. Back home if you make a sound the nurses beat you and she was afraid this would happen to her here.

Agency:

She is given an epidural for pain relief and she is glad to have it but is shocked at the paralysis in her legs. They want to take her for a c/section but she pleads with them for the opportunity to try to have vaginal birth. The midwife is supportive and teaches her how to push as she cannot feel anything. She gives birth 1 hour later.

Purpose:

Safe birth

Imbalance:

Scene: Agent

Scene: (P/N)

While she is happy to have her baby she is very sad not to have any family around her to share her joy. She worries she is depriving her daughter of the love of the extended family.

Act:

She is transferred to the postnatal ward and is hungry but its late, around midnight. Someone is sent to get her food but they do not come back. So she has to wait until breakfast next day to eat.

Purpose:

Postnatal care

Imbalance:

Act: Agency

Scene: (P/N)

The next morning the baby is taken for surgery for the hydrocephalus that was diagnosed in antenatal period.

Act:

When the baby is scanned there is no evidence of the hydrocephalus.

Agent;

W. her baby medical staff

Agency:

They bring the baby back and tell her there is nothing wrong. The problem had disappeared. She sees this as a miracle.

Purpose:

Correction of a problem diagnosed in pregnancy.

Imbalance:

None

Scene: (P/N)

That first morning she goes for a shower not realizing how weak she is and collapses in the shower.

Act:

She comes to on the bathroom floor but does not know there is an alarm she can use to get help.

Agency:

She calls out but no one hears her. She is not missed on the ward. It takes her over an hour to get back to bed. Later the midwife explains the alarm to her.

Purpose:

Postnatal care

Imbalance: **Scene: Agent and Act: Agent**

Scene:(P/N)

The paediatrician tells her she must supplement her breast feeding with bottle milk.

Act:

When she asks the midwife for milk she refuses to give her some, tells her because she is breastfeeding she cannot have it and she must make the baby suck. She tries to feed the baby all through the night.

Agency:

The next day the doctor returns and questions her about why she is not supplementing the feeding, she tells the doctor she asked but was refused a bottle. The doctor is really angry and wants the name of the midwife who refused to give her the milk. The doctor comes back three times to see if she remembers the name. She does remember but is afraid to tell in case the midwife loses her job. The baby is taken to NICU because of dehydration and is there for 2 days.

Agents:

L., her baby, the midwife and doctor

Purpose:

Postnatal care of the baby

Imbalance:

Act: Agency

Scene: (P/N)

She feels she experienced racism from kitchen staff who did not offer her food when others were.

Act:

The kitchen staff would give out sandwiches or whatever to the other women on the ward. At first she thought this was just coincidence, maybe they forgot her but it happened so often she believed it was on purpose.

Agency:

She told the nurse she had not been given any food and the nurse got some for her.

Purpose:

Postnatal care

Imbalance:

Act: Agency

Scene: (P/N)

On discharge 'home' to her accommodation she became very depressed. Did not leave her room or care for herself.

Act:

She is visited by a family support worker who visits her regularly and becomes like a friend to her.

Agent

L, the family support worker

Agency:

She gradually recovered over several months. She misses her and wishes she could see her but since she has been moved out of Dublin she has not seen her. However her overall mental state has improved since coming to Mosney.

Purpose:

Postnatal recovery from depression

Imbalance:

Scene: Agent

Scene(P/N)

She is transferred to more 'permanent' accommodation and is sharing a 2 bedroom chalet with a woman from Zimbabwe.

Act:

This woman is very outgoing and really cares for her and helps her to gain confidence and they become like sisters.

Agent:

L. her house mate

Agency:

She hates the time she spent at the first accommodation centre and cannot even bring herself to go near that part of Dublin. She has improved since being transferred to new accommodation but still misses her family and longs to be able to return home some day in safety.

Purpose:

Learning to adjust to life here

Imbalance:

None

Narrative 30: Description of Terms

Interview conducted with translator French to English

Scene:1 (A/N)

She escaped to Ireland and she is severely traumatized. Her Father, Mother and sister are dead. She is pregnant as a result of rape in a military camp where she was held for six months prior to her escape and where her younger sister died. Because she cannot speak English communication is difficult. She shares a bunk in the hostel with a Chinese woman and finds it hard to connect with her. Most of the time she spends alone, she doesn't feel well, her pregnancy feels 'like a stone weight on her body'.

Act:

She went into labour, started getting pains and bleeding. The hostel called for an ambulance to take her to hospital. When she arrived in the hospital the doctor looked at her file, did not examine her and told her to come back in a weeks' time when it was her due date.

Agent:

Z. co-agent doctor

Agency:

She did not know how to get back to the hostel because she came in an ambulance. She went to the reception desk but nobody could understand her. She left the hospital but was feeling weak so she lay down on a bench in the street. She spent the day there not knowing where to go, she fell asleep on the bench and when she woke up she was distressed and started trying to ask passers by for help but no one could understand her and did not help her. She began to vomit when a French speaking woman came by and she explained to her what had happened. The woman noticed blood on her clothes and told her she would have to go back to the hospital. The woman called an ambulance, they took her back to the hospital, her waters broke and she was taken straight to delivery unit.

Purpose:

Antenatal care?

Imbalance:

Act: Agency

Scene: Agent

Scene 2 (L)

She doesn't remember much about the birth. The woman who helped her stayed with her to interpret. 'It hurt so much she never wants to have another child'.

Act:

It seems she had an operative delivery. 'They said they were going to pull the baby.' once she had given birth they were waiting for the afterbirth but it didn't come.

Agency:

She was given an anaesthetic for removal of the placenta. She does not remember much. When she woke up she was happy to have the baby. The woman who stayed with her now had to leave. She was in hospital for 3 days but never had any visitors.

Purpose:

Safe delivery:

Imbalance:

Scene: Agent

Scene 3 (P/N)

She is without support. The social worker arranges for baby clothes etc. She is discharged back to the hostel but cannot sleep with the baby in a bunk bed so they give her a cot.

Act:

The public health nurse visits her and teaches her how to do basic care for the baby. She is eventually transferred to better accommodation at another location outside the city.

Agency:

Once in her new accommodation she is happier as accommodation is better but still very depressed. She is referred for counselling and finding that helpful, but 'each day is a struggle..'.

Purpose:

Coping with life postnatally

Imbalance: **Scene: Agent**