DOES CULTURE INFLUENCE THE BIRTH EXPERIENCES OF FIRST-GENERATION NIGERIAN WOMEN IN LONDON?

THESIS SUBMITTED IN REQUIREMENT OF THE UNIVERSITY OF GREENWICH IN PART FULFILMENT OF THE AWARD OF MASTER OF PHILOSOPHY (MPhil).

BY: PRISCILLA DIKE

Date: JANUARY 2018

DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of Master of Philosophy (MPhil) being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others.

Signatures

Dr Benjamin Bruneau (First Supervisor)……..

Professor Sally Glen (Second Supervisor)…….

Priscilla Dike (Candidate)
……..

ACKNOWLEDGEMENTS

I would like to pay a tribute to my father: Papa Thomas Ihematulam Okorowu Ejimkonye: an advocate of female education. You instilled the tenacity that gave me the fortitude to persevere in life's endeavours. I truly mourn your absence as I draw close to the end of this academic quest. *Papa, zuru ike n'udo, anyi ga ahu n'oche eze Chukwu; ebe aga ehicha anyi anya miri.* Brother Patrick Chikwem Thomas Ihematulam Ejimkonye, (nwanne Cila): I am still grappling with your unexpected and untimely death on 25th December 2013. *Nwanne, onwu elela gi ariri, ya diri Chukwu. Ndo, anyi g'ezuko ozo*. My dear mother also passed at the final huddle of this endeavour, mama your departure has left such a vacuum!

To my beloved family, there are no words to appreciate your support over the period of this work, but you know the depth of my love for each of you. Thank you all immensely for the endless encouragement that meant so much in this journey.

My informants: First- generation Nigerian women (FGNW) living in London, and midwives at two NHS Trusts in South London, Thank you all so much for being part of this study.

My supervisor: Professor Sally Glen and Dr Ben Bruneau, I am indebted to you for your guidance and support in the latter phase of this endeavour. Professor Rosalyn Corney, your consistent support meant more than can be expressed; so thank you immensely. Same gratitude is expressed to my Adviser: Dr Katerina Kolyva.

Finally, thanks are also due to my employer and sponsor: University of Greenwich, Professor Tom Barnes, Dr Lynne Jump, Ms Lynne Spencer, Ms Tina Heptinstall, Dr David Evans, Ms Deborah Isaac, and my ardent colleagues and friends within and beyond the University of Greenwich who offered support in divergent forms. I am truly grateful to you all.

ABSTRACT

The purpose of this study was to explore the influence of cultural practices on the birth experiences of first-generation Nigerian women (FGNW) living in London. FGNW's folk (*emic)* care practices were compared with midwifery (*etic*) perspectives to gauge the interplay with maternity care competency and congruency in meeting their needs. The objective was to highlight factors within *emic* and *etic* care that may influence birth outcomes of FGNW accessing maternity care in London. As midwifery does not have a specific culture care model, I have developed **Culture Care Midwifery Model** as a major contribution to underpin midwifery practice in providing care that is culturally congruent; to meet the care needs of first-generation Nigerian women during their birth experiences in London.

The study entailed an exploratory, descriptive, contextual and qualitative methodology. An in-depth literature review was undertaken to identify gaps in knowledge on FGNW's cultural practices as a trans-national population in London. The study had two stages. In stage one, focus group discussions and semi-structured interviews were conducted with six self-identifying first-generation Nigerian mothers with retrospective birth experiences in London and twelve (eight non-Nigerian and four Nigerian) midwives providing maternity care for this population in South London. The second stage of the study involved six first-generation Nigerian women prospectively studied at three intervals during a birth continuum. Edinburgh Postnatal Depression Scale (EPDS) was administered to screen for psychological health of the prospective sample to ensure data accuracy. The epistemologies adopted were a combination of culture, culture care and trans-cultural care theory. Data were analysed using thematic and ethno-nursing analytical approaches. This was achieved by identifying, analysing and reporting patterns and themes within the data. Confirmation and validation of data at intervals was undertaken to ensure accurate interpretation of data. Validation of findings was achieved through face validation and through member checking.

Findings of this study indicate that culture exerts a significant influence on birth and maternity care experiences of first-generation Nigerian women in London throughout the birth continuum. Care meanings for first-generation Nigerian women in London are embedded in cultural values and beliefs, economics of the family and other networks of support, their new environment as migrants, their historical / inherent culture of expectations, rituals and taboos, kinship of support, politics of family dynamics and immigration in their negotiation of maternity care provision in London.

Conflicts exist between aspects of *emic* care practices of first-generation Nigerian women and *etic* care approaches of midwives. This study uncovered that aspects of FGNW's cultural practices warrant preservation and/or maintenance, whilst aspects require accommodation and/or negotiation; with some aspects needing re-patterning and re-structuring to ensure continuing perinatal health and wellbeing. Therefore, **Culture Care Midwifery Model** is espoused as the first module specifically to guide midwives in meeting the cultural needs of first-generation Nigerian women in London, which could also be useful for informing cultural care of other BME populations accessing maternity care in London.

GLOSSARY

African time: The idea is that Nigerians will deliberately turn up for appointments or events several hours behind schedule, also described as "selective commitment and / or punctuality.

Animism: Holding a belief: in the existence of individual spirits that inhabit natural objects and phenomena or the belief in the existence of spiritual beings that are separable or separate from bodies and the hypothesis holding that an immaterial force animates the universe The Free Dictionary online).

Diaspora: a scattered population with a common origin in a smaller geographical area or a movement of the population from its original homeland (Carol et al 2004). Diasporas are broadly defined as individuals and members of networks, associations and communities who have left their country of origin, but maintain links with their homelands. This concept covers more settled expatriate communities, migrant workers based abroad temporarily, expatriates with the citizenship of the host country, dual citizens, and second / third- generation migrants. (IOM 2008 World Migration: Managing Labour Mobility in the Evolving Global Economy, page 493).

DSM-IV: (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition), are codes used by mental health professionals to describe the features of a given mental disorder and to indicate how the disorder can be distinguished from other similar psychiatric problems. They are the classification also known as DSM-IV-TR, a manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders.

***Emic* care:** those existing within a culture that are 'determined by local custom, meaning, and belief' and best described by a 'native' of the culture (folk).

***Etic* care**: generalizations about human behaviour that are considered universally true, and commonly links cultural practices to factors of interest to the researcher, such as economic or ecological conditions, those cultural insiders may not consider very relevant (professional).

'igwu ewu ikwu': Slaughter of goat to celebrate fertility at the birth of a tenth and subsequent child / ren in Igbo culture.

Omugwo: (specified rest period of about a month to three months) of the Igbo's of Eastern Nigeria is symbolic and similar to the Chinese ritual of 'doing the month'.

Post-term: baby that has not yet been born after 42 weeks of gestation, two weeks beyond the normal 40 weeks gestation.

Pre-term: is the birth of a baby of less than 37 weeks gestational age.

Puerperium: the period of about six weeks after childbirth during which the mother's reproductive organs return to their original non-pregnant condition.

Zuo yuezi: protective childbirth practice in Greece and India where women are relieved of most chores for the specified period in order to recuperate following childbirth.

CONTENTS

Tables

Figures

Does culture influence the birth experiences of first-generation Nigerian women in London?

1. Chapter One: Overarching introduction to the thesis

This introductory chapter sets out the context of the research and provides the aims, content, structure, purpose and the theoretical underpinning that inform the thesis, and gives an overview of all other chapters.

1.1 Contextualisation of the Research.

Care has a cultural and symbolic meaning as pregnancy and childbirth is one of the most significant life events for a woman and her family. Existing literature suggests a gap in knowledge of the cultural needs of FGNW in London. This thesis argues that there is poor understanding of the influence of cultural practices on FGNW's birth experiences and outcomes.

> "*Childbirth is a life changing experience within all cultures and ethnic groups. It provokes a wide range of responses that are influenced by a complex interaction of religion, culture, education, social status, economy and the perceived position of women within the society. At the centre of all these powerful forces is a unique individual with her own personality, needs, hopes and fears"* (Russel-Roberts, 2016:1) who is also bearing the expectations of her extended family and society. *"Since midwives have a professional duty to offer equitable care according to the client's need, it follows that an understanding of the client's cultural background is a requisite"* (Russel-Roberts, 2016:1).

This quote captures and sums up the essence of my study and assents the interplay of culture in birth experiences of women from diverse cultures, acknowledging the significance of culturally-informed care by midwives. This is so appropriate in the context of studying the influence of culture on the birth experience of first-generation Nigerian women as multiple factors influence care in ways that can lead to health and wellbeing or adverse outcomes. Effective and efficient holistic maternity care is integral for ensuring robust maternal and fetal wellbeing through the birth continuum and quality healthcare service needs to be based on cultural knowledge. Leininger (2006) assent that care has a cultural and symbolic meaning: such as care as protection, care as respect and care as presence. Nonetheless, UK Policy documents have highlighted lack of culturally-sensitive care and certain barriers to care as the reason for the poor care outcomes of the Black and Minority Ethnic (BME) populations in the UK. Blunt (2014) report that there is still dissatisfaction with maternity care due to health inequalities faced by Black and Minority Ethnic women, resulting in a decline in accessing early maternity care (Hollowell *et al* 2012) and other barriers. Such barriers on the part of maternity women are recorded as low level of education, their migration status, religion, and other social-cultural factors including barriers related to healthcare (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) 2014, Centre for Maternal and Child Enquiries (CMACE) 2011 and Confidential Enquiry into Maternal and Child Health (CEMACH) 2007 and 2004). It is suggested that on the part of healthcare professionals, barriers such as: cultural insensitivity, inadequate provision of appropriate accessible information, inadequate interpretation and translation service, insufficient continuity of care, little support and control, disrespect and racism serve to deter women from accessing maternity -care (Bharj and Salway 2008, Haper-Bulman and McCourt 2002). It is possible that these factors have resounding significance for first- generation Nigerian women (FGNW) who are the focus of the current study, as little if anything is known

about their cultural (*emic* or folk) care practices or their expectations of maternity (*etic* or professional) care while in London. *Emic* care practices are what the parturient woman and her significant others do to ensure health and wellbeing through the birth continuum, whilst *etic* or professional care are established professional care approaches of maternity care givers (Leininger 2004 and 2002).

Rienzo and Vargas-Silva (2015) report that the foreign-born population in the UK has increased from 3.8 million in 1993 to 8.3 million in 2001. Similarly, Institute of Race Relations (IRR) 2016) report that up to 55% of the population living in London are of Black and Minority Ethnic group whilst only 45% are White British. With migration on the increase and women continuing to extend their families, there is need for maternity services to gain an enhanced understanding of the divergent cultural needs of population they serve. First-generation Nigerian women living in Britain are transnational families - *conceived of as families with members living in different nation states* (Mazzucato and Schans 2011), who may retain aspects of their cultural beliefs and practices to counter significant stress resulting from pregnancy and birth (Cohen 2007, Bryceson and Vuorela 2002). Mazzucato and Schans (2011) note that,

"*understanding is lacking in studies that mainly assume a Western nuclear family model without explaining the culturally relevant notions of family that influence family relationships*…" in transnational families (Mazzucato and Schans 2011:707).

It has been documented that transnational families may select and bring together elements from the various backgrounds of family members and the places where they live in ways that give rise to new identities and cultural practices amongst them (Cohen 2007). Temström *et al* (2015) assert that childbearing women living away from their country of origin are three times more

likely to experience fear of childbirth than those national to the country of parturition, thus highlighting the vulnerability of transnational women upon entry to the UK. The researchers indicate the need for culturally sensitive care to identify women's components of childbirth related fear in various ethnic groups. FGNW in London may have care preferences that coincide with their traditional beliefs and culture, but philosophy, policy, protocols and procedures for maternity care in London may not be equipped to cater for such preferences although every effort may be made to customise care accordingly (Department of Health (DH) 2014).

World Health Organisation (WHO) (2012) advocate need for raising awareness and educating communities and maternity staff around the cultural diversity of society to ensure meeting the needs of clients (WHO 2012). The recent National Maternity Review (2016) highlights the importance of high quality maternity services and also affirms that birth is a crucial period for the family, advocating that health care practitioners have the potential to influence the family's lifestyle and maximise their life chances if their needs are supported.

Without an understanding of FGNW's culture as members of transnational families in London, and the reasons behind their decisions and expectations in maternity care, it can be difficult to make sense of their expectations, perceptions or points of view in care, and either come to terms with these or miss-judge them altogether. Therefore, an awareness of FGNW's cultural backgrounds, beliefs, religious and traditional customs is vital, in order to enhance compassionate, person-centred care driven by current agenda of the UK National Health Service geared towards compassion (NHS Compassion in Practice 2012) as well as midwives' philosophy of woman-centred care (Nursing Midwifery Council (NMC) 2015, Leap 2009 and Royal College of Midwives (RCM) 2001).

Culturally-sensitive and competent maternity care provision is core to achieving aspects of NHS core values in health and social care provision and also core to achieving holistic woman-centred midwifery care philosophy (Begley *et al*, 2011; Brocklehurst *et al*, 2012), and maternal satisfaction with birth experience (Sandall *et al*, 2009). The person-centred or woman-centred care philosophy espoused by midwives ought to address cultural expectations and needs of the woman, her emotional, physical, psychological, social and spiritual needs (Leap 2009, RCM 2001). However, person-centred or woman-centred care is very individualistic and takes a different approach to FGNW's trans-cultural extended family orientation to care, that requires the involvement of extended family and significant others (Nkwocha, 2007) within *emic* and *etic* care practices.

Although there has been an increase in the number of FGNW giving birth in the UK, there are no publishes UK-based studies in relation to exploring their cultural needs and / or how well they perceive their care needs to be met within current maternity services provision. The Office of National Statistics (ONS), 2012) reported an increase of foreign-born women of childbearing age from 1.8 million in 2007 to 2.2 million in 2011. According to Hawkins (2016), approximately 37% of the UK population were born abroad and a majority of these reside in London area. Of these, 196,000 of 808,000-recorded births in the UK are to non-UK mothers. Nigerian mothers in the UK account for 7,900 non-UK mothers who had live births in 2011. Of nearly nine million (8,174,100) people living in London, it is estimated that 485,277 (0.8%) are Africans and 93,000 (19%) of the Africans are Nigerians (ONS, 2012). With the continuing influx of refugees and immigrants escaping the brutality of Boko Haram Terrorism in Nigeria, this population living in London is likely to rise even more.

As this current study location are three NHS Trusts in South London, it is useful to consider the population of FGNW giving birth within the local Trusts. The Black and Minority Ethnic (BME) population in Bexley, Bromley and Greenwich in 2009 was estimated at 300,000 (ONS, 2009). Local statistics indicate that the NHS Trusts selected for sampling have a BME population of about 40% of whom 22% are said to be of African origin and a significant proportion of the 22% are Nigerians (Local NHS Foundation Trust Annual Report and Accounts 2009/10). Although Caucasians form the majority of the Greenwich population of 65% to 83%, ethnicity across the BME population in Greenwich was Black African 8.9% Asian Indian and 4.4%. In Bexley, the figures were 3.0% and 4.8% respectively, whilst Bromley consisted of 2.2% Black African and 2.1% Asian-Indian (ONS, 2009). These figures demonstrate a significant number of migrant populations accessing maternity care in the area, and hence highlights the need for healthcare professionals to ensure that their cultural needs are met within current healthcare resources. Nonetheless, there has been no exploration of the midwives' perceptions of the requirement to provide care that is culturally- sensitive to this population in London.

As individuals operate from unique individual and cultural identities, the midwife and FGWN may be approaching maternity care from different cultural understandings. The FGWN may have different expectations of care based on her established *emic* care practices whilst the midwives may operate from their professional (*etic*) culture of care. As a result, confusion may arise from lack of understanding of both care approaches. Therefore, an enhanced understanding of *emic / etic* care practices through a common cultural framework, and / or philosophy may enhance understanding of both the FGNW and midwives by enabling consistency, congruency and competency in care delivery.

As previously expressed, London is one of the most culturally diverse cities in the world and there has been a rise in the numbers of FGNW living in London (ONS, 2012). Whilst Social and demographic researchers frequently use the terms 'black African' and 'African' in their descriptions and analyses of BME populations, Kertzer and Arel (2002) contest that although this is the case in many censuses in Britain, it illuminates the recurring failure to distinguish race from ethnicity. Aspinall (2012) also question how the censuses measure ethnicity, especially the use of dimensions that many claim have little to do with ethnicity, such as skin colour, race, and nationality. Nevertheless, considering the ethnic mix of London, both terms can sometimes be unhelpful, given the huge diversity concerning country of origin, religion, language and culture that they encompass. The later highlights the ambiguity in respect of the populations that are described by different labels. Seemingly, NHS Trusts are required to self-evaluate their care provision in relation to meeting the care needs of the populations they serve (Aquino *et al* 2015, MBRRACE-UK 2014, Bharj and Salway 2008). Nonetheless, there has been no exploration of the midwives' perception of the requirement to provide care that is culturally sensitive to this population in London. Similarly, first-generation Nigerian women as a sub-group of BME population of London have yet to be researched in order to understand their specific cultural needs in relation to maternity care.

The ethics of research highlight that if healthcare providers fail to recruit hard to reach groups, their perspectives on care will not be represented (Bonevski *et al*., 2014). Currently however, there is little or no research related to the cultural needs of FGNW in maternity care nor is there literature relating to midwives' perceptions of their knowledge and competence in relation to providing care to this sub-group of the BME population as they experience pregnancy and childbirth in London. Marmot review which advocates effective evidence-based strategies for reducing health inequalities in England highlight that people in different socio-cultural

circumstances experience avoidable differences in health, well-being and length of life (Buck and Maguire 2015). Even so, evidence from Confidential Enquiries suggest that BME women in Britain (which includes FGNW) do not access maternity care until much later in their pregnancies, with the impendent danger of increased poor maternity care outcomes (CMACE 2011, CEMACH 2007 and 2004). Further details of these reports highlight that 28% of BME women who died in triennium 2004-2006 received substandard care as compared to 20% of their white counterparts. This predicament is said to potentially reflect the cultural factors and the social circumstances that compound the health and wellbeing of BME women. FGNW were portrayed as '*health tourists*' (the practice of travelling abroad in order to receive medical treatment) within the 2007-2010 triennial cohort (CMACE, 2011). What was amiss in the said reports is how far the human rights of BME women in general and FGNW in particular have been considered in the presence of such excessive morbidity and mortality. Moreover, greater dissension between expectations and experience of maternity care was evident in the care given to BME women (CMACE 2011). Furthermore, a plethora of evidence and literature exists to suggest that NHS Trusts do not provide culturally-sensitive care (Gil-González *et al* 2015, MBRACE-UK 2014, Horvat *et al* 2014, CMACE 2011, CEMACH 2007 and 2004 and Seibert *et al* 2002). It is therefore reported that, national policies will not work without effective local delivery systems focused on health equity in all policies (MBRRACE-UK 2014, CMACE 2011, CEMACH 2007 / 2004 and Marmot Review Executive Summary 2010).

Nursing Midwifery Council (NMC) (2015) stipulate that those receiving care from a registrant should expect to be treated with dignity and respect and that discriminatory attitudes towards clients should be confronted. Therefore, healthcare professionals cannot afford to be relativist in their approach to care so as not to disrespect people who have different approach (*emic* care) or operate from a different cultural perspective. Cultural relativism is the idea that each culture

or ethnic group is to be evaluated on the basis of its own values and norms of behaviour and not on the basis of those of another culture or ethnic group (Rosado, 2016). Midwifery Practice in London, much as it is based on the philosophy of woman-centred care (Leap 2009, RCM 2001), it does not currently have an established model for ensuring culturally-competent (proficient or adept professional care from midwives) and culturally congruent (harmonious and fitting culture care for client or patient) care provision for BME groups and specifically for FGNW in regards to their culture. Such model where if and where it exists, is non-specific to midwifery practice and non-specific to FGNW. To meet the care needs of this divergent cultural population in London, a specific care model geared at cultural competency and congruency in maternity care is vital. The need to fill this gap prompted the current study of evaluating two existing generic culture care models and amalgamating these to form a 'Culture Care Midwifery Model to guide midwifery practice in a focussed manner to fill this current gap. In this regard, Leininger's (2002) Culture Care Theory (CCT) is considered alongside Papadopoulos *et al*'s (2008) four-stage model for Cultural Competence (CC), (appendix: S and T) as both provide a holistic means to understand the range of factors that influence folk (*emic*) care practices and professional (*etic*) care provision. Leininger's model embraces the importance of discovery of care needs from the patient's ways of caring and gives credence to the professionals' way of delivering care (Leininger 2002 and 2006b). Thus CCT and CC theoretical frameworks, stimulates the researcher to focus on care similarities and differences among FGNW and midwives; to come to a convergence of approaches to care that is both competent and congruent to meet the cultural needs of FGNW. In this way, both Papadopoulos *et al* (2008) CC and Leininger's (2002) CCT share similarities that if integrated and applied in maternity care for FGNW may prove useful for ensuring care that is culturally-competent and congruent. Therefore, both models when integrated in a midwifery-specific manner has

potential to guide UK midwives to achieve culturally-competent and congruent care for FGNW and potentially other BME populations accessing maternity care in London.

Therefore, the two cultural models of care providing the theoretical underpinning of this thesis are the specific care models of Papadopoulos *et al* (2008) Cultural Competence Model and Leininger's Culture Care Theory (CCT) (2002) which focuses on cultural competence and cultural congruence respectively. Their suggested stages of developing culturally-competent and culturally-congruent care has potential to guide the practitioner to acquire cultural awareness, cultural knowledge and cultural sensitivity that enhances cultural competency on *emic* care practices of the client and to duly factor such into *etic* care to achieve culturally congruent care. Similarly, by adopting the proposed Culture Care Midwifery Module, midwives will be enabled to consider FGNW's culture care experience, their generic care approaches, the socio-political factors that influence their health and wellbeing, and to employ action and decision modes that enhance culturally congruent care. This all-encompassing approach to care is seen as necessary for contemporary maternity care provision, because partial knowledge or inadequate understanding of *emic* cultural practices of a group can lead to assumptions or adherence to stereotypes, which categorises cultural groups without attention to the diversity within them (Bhopal, 2014). The two models when integrated and used as a specific midwifery module has the potential for enhancing care that is culturally- competent and congruent. Culturally-congruent care is only possible when the care approaches of the woman (*emic*) and the care approaches of the midwife (*etic*) synchronise to meet both the expectations and needs of the woman and the desired outcomes of professional care. The synchrony of both care approaches is what Leininger (2006b) has framed *Ethno-Nursing* approach within her Culture Care Theory (CCT) and Papadopoulos *et al* (2008) framed theirs Cultural Competence (CC) in their four-stage model for Cultural Competence care. The

amalgamation of the two culture care models in the current study will enable exploration and comparison of *emic* care approaches of FGNW and *etic* care approaches of midwives as to consider similarities and dissimilarities of both towards achieving cultural congruency for FGNW.

1.2. Origins and Motivation for this study.

Factors that contribute to poor birth outcomes for FGNW in London may be linked to aspects of their cultural (*emic*) care practices which has so far not been studied as far as the existing literature that has been explored. Although numerous policy documents have highlighted poor outcomes in the birth experiences of this population and other BME populations in London, attention has not been given to their cultural practices in relation to birth, nor has the influence of such cultural practices been the focus of studies. This researcher has been contemplating the possible influence *emic* practices may exert on the reported poor birth outcomes for FGNW and has therefore taken on the task of exploring this matter in order to uncover the influence *emic* care practices may have on the birth experiences of FGNW in London.

Understandably, with increasing number of BME populations in London, it would be difficult for the NHS Trusts to meet specific needs of its divergent populations. Moreover, it might be difficult to identify first-generation Nigerian mothers in their statistics because of the categories they universally use. For example, in 2001 The Office for National Statistics estimated that black African people totalled 1.4% of the population of England and Wales in 2007 with no specific identification of the nations or ethnic groups comprised in this percentage. Essentially, a Trust would simply ask if a mother identifies as African or possibly British African. Nonetheless, NHS Trusts are required to understand the needs and provide care that is culturally sensitive to their local populations (Gil-González *et al* 2015, CMACE 2011 and

Confidential Enquiry into Maternal and Child Health (CEMACH 2007 and 2004). How would healthcare providers therefore, meet the cultural needs of the population without clear identification of their specific cultural expectations and / or needs during childbirth? Therefore, this research study seeks to explore *emic* care practices of FGNW, the influence of cultural practices on FGNW's birth experiences in London and to examine the midwives understanding of FGNW's cultural practices and the issues these may raise for midwifery care delivery.

There has been a flurry of directives over the last couple of years attempting to highlight and strategize measures for addressing the inequitable cultural care provision in the National Health Service (NHS), to ensure policy context and to highlight implications for care delivery (MBRRACE-UK 2014, CMACE 2011, CEMACH 2007 and 2004, National Service Frameworks (NSFs) 2007 and Psoinos *et al* 2011). The currently proposed study is timely to explore and highlight the cultural care needs of first-generation Nigerian women as a sub-group of BME groups served by local Trusts in South London and to explore midwives understanding of the expectation and needs of this population with regards to providing culturally-competent and congruent care.

Furthermore, the researcher as a Nigerian woman who experienced the birth of her first child in Nigeria observed a lack of acknowledgement of her cultural practices and needs by maternity care providers in the subsequent birth of her two children in London. There was such a significant contrast to her previous birth experience in Nigeria that ignited her interest in exploring the need for culturally competent and culturally congruent maternity care provision for FGNW in London. Although her personal birth experiences in London is not the focus of this study, but as a first-generation Nigerian mother, a British trained midwifery practitioner, an educationalist and researcher in a British higher institution, her understanding of the

physical, mental, emotional and social impact of birth (Etowa 2012) on women has further roused her interest in exploring the traditional (*emic*) measures first-generation Nigerian women in London take to protect themselves from the pressures and potential strains of pregnancy and birth in the diaspora. Moreover, over more than a decade of midwifery practice in London, she is aware that social policy context has developed tension for professionals to remain empathetic to the socio-cultural needs of women but without a specific care model to guide maternity practitioners for delivering this care robustly. Moreover, her awareness that a FGNW's childbearing encounter in London may reflect the cultural beliefs and practices of her society; and reflecting on Jacinto and Buckey's (2013) assertion that pregnancy and childbirth constitute a '*rite of passage*' to womanhood in many cultures, this researcher felt a challenge to explore FGNW's care approaches and to examine midwives understanding of FGNW *emic* care approaches when experiencing birth in London as a *rite of passage*. With this in mind, she pondered to what degree maternity care providers in London understand and accommodate the *emic* care practices of first-generation Nigerian women in their professional care delivery and to what degree FGNW understand *etic* care practices of midwives. Therefore, the focus of this study is exploration of *emic* approaches of FGNW and *etic* care approaches of midwives in relation to culturally competent and culturally congruent care for FGNW.

A plethora of existing literature has highlighted a lack of provision of culturally-competent care (Gil-González *et al* 2015, MBRRACE 2014, Horvat *et al* 2014, CMACE 2011, CEMACH 2007 / 2004 and Seibert *et al* 2002). Moreover, Bonevski *et al* (2014) advocate an urgent need for addressing the health needs of the multi-ethnic populations and MBRRACE (2014) and CMACE 2011 declare that the care needs of marginalized groups are not always met. To address the gaps in meeting care needs on this cohort of BME populations in London, coupled with the apparent gap in knowledge and lack of evaluation of the impact of care, the researcher

sought ethics committee approval to explore the care expectations and needs of FGNW as a sub-group of the BME accessing maternity care in South London. The intention is also to explore the midwives' perception of the needs of these women in regards to the extent to which midwifery care provision meet the *emic* care needs of FGNW as they access maternity care within three Local NHS Trusts in South London. Equally, the views of the midwives might prove useful in gauging how well they are prepared to deal with the barriers they may encounter during care provision to FGNW. Therefore, this study is timely to bridge the gap in knowledge and to make tangible contribution to understanding some of the cultural practices that influence care approaches of midwives and care uptake of FGNW; by examining and contrasting *emic* care practices against *etic* maternity care provision of the study cohorts and suggesting a care model to inform competent and congruent care.

1.3. The Question of "Ethnicity" and "Nigerian"

FGNW has a unique identity as a transnational ethnic group in London. To first-generation Nigerian women, ethnicity may be perceived as both cultural and national identity as both are held in even regard by them. Maalouf (2012) in discussing the increasing complexity of identity asserted that each one of us has two heritages: a vertical one that comes to us from our ancestors, our religious community and our popular traditions, and a horizontal one transmitted to us by our contemporaries and by the age we live in. Therefore various aspects of belief systems and vertical and / or horizontal identity upheld by FGNW in regards to their ethnicity may influence their access of healthcare. Healthcare service responsiveness to such identity, health beliefs and practices, is necessary in order to achieve competence and congruency in health care access and delivery.

Ethnicity is a fluid and multi-faceted notion that is complex and contested but generally refer to the group to which people belong and / or are perceived to belong to due to certain shared characteristics such as: ancestral origins, cultural traditions, geographical location and language (Bhopal, 2014). First-generation Nigerian women cite their ethnic or racial background as an important part of their identity as a racial group with traditions of communal living and extended family linage. Papadopoulos ascent that,

"cultural identity is important for people's sense of self and how they relate to others. A strong cultural identity can contribute to people's overall wellbeing. Identifying with a particular culture gives people feelings of belonging and security. It also provides people with access to social networks which provide support and shared values and aspirations. These can help break down barriers and build a sense of trust between people - a phenomenon sometimes referred to as social capital" (Papadopoulos *et al,* 2008).

Bhopal (2014) assert that ethnicity recognises that people identify themselves with a social grouping on cultural grounds, including food preferences, language, lifestyle, religion and common origins. According to Bhopal (2014) and Cohen (2007), ethnicity also implies shared origins, culture, language, religion and traditions that are distinctive, maintained between generations that lead to a sense of identity and group cohesion; a sense of identity and common language or religion. However, Carter and Fenton (2009) in their critique of the concept of ethnicity have challenged the notion of ethnicity and highlighted the methodological and theoretical difficulties posed by the notion. They state that 'methodologically the difficulty lies in over-stating the concreteness of ethnic groups whilst the theoretical difficulties lie in the definition of the "group", the assumption of group-ness, and the implied explanatory framework. They argue that *ethnicity should be demonstrated through frequent social interaction among its members, a sense of community of people with a materially shared life*

in part prompted by proximity but who may constitute populations "elsewhere" with many of the same characteristics and circumstances (Bhopal, 2014:3). This argument validates first-generation Nigerian women as an ethnic group and appear to reflect the community spirit and kinship apparent amongst the FGNW studied, and the Nigerian communities in London encountered by the researcher during her work as a midwifery practitioner.

First-generation Nigerian women in the context of this study are women born in Nigeria who migrated to the UK and are domiciled in London. Amongst this Nigerian population, there are wide ranges of socio-cultural processes decreed by tribal and religious dictates that inform decisions about pregnancy, birth and maternity care (Nzekwu 2004 and 2004b). These socio-cultural processes associated with pregnancy and birth enhance transformation of the mother's self-concept from one stage of life (coming of age, completing education, marriage and becoming a wife) to another (becoming a mother) (Jacinto and Buckey 2013). The latter assert that a positive transition to the motherhood and close attachment to the infant facilitates a sense of family and self-enhancement. The literature suggests many Nigerian women regard motherhood as a lofty position (Nzekwu 2004) worthy of pursuit and attainment. According to Sered (2007:1), "*individuals may treat history as a smorgasbord from which they select attitudes and behaviours that suit their current needs*". To FGNW, the cultural expectations, rites and rituals may serve as a guide and a means of support during pregnancy and birth experiences which may potentially aid their smooth transition to motherhood. Conversely, unrealistic expectations can be overwhelming and possibly detrimental to their health and wellbeing (Katbamna, 2000). Therefore, there is a need to explore how FGNW's *emic* care practices align with midwives' professional care provision to ensure culturally-competent and congruent care that meets the care needs of this population during birth experiences in South London. Although the current study was open to women from all tribes of Nigeria, this study

recruited women from two dominant ethno-linguistic groups (Igbo's and Yoruba's) who form the majority of FGNW population accessing maternity in South London. This is due to minimal presence of other Nigerian tribes in London. The current study is therefore geared towards understanding their maternity care needs as migrants in South London, and how far maternity care-givers understand and meet their cultural needs during their birth experiences in London.

For this Nigerian cohort, culturally-based beliefs in pregnancy and birth dictate what is presumed acceptable about food, drink, daily activities of living, employment, self-care and access to healthcare (Etowa, 2012). In this way, culturally-based beliefs and values influence first-generation Nigerian women's experiences of childbirth and determine the practices believed appropriate for providing care in pregnancy and childbirth even while living in London. These cultural beliefs play a part in influencing FGNW's decisions about when to register for maternity care, where and from whom to access maternity care and whose advice to adhere to throughout the continuum of pregnancy and birth (Nkwocha, 2007). Cox (1999) emphasized the need for acknowledging '*culturally sanctioned rituals*' that may influence or determine the pathway to care. Therefore, understanding FGNW's expectations of maternity care and gaining midwives perceptions of the cultural needs of FGNW is a step forward in understanding the needs of this population and aligning these with professional care approaches to ensure competency and congruency in maternity care provision.

As previously established, Nigerian mothers in the UK accounted for 7,900 non-UK mothers who had live births in 2011 (ONS, 2012). Of nearly nine million (8,174,100) people living in London, it is estimated that 485,277 (0.8%) are Africans and 93,000 (19%) of the Africans are Nigerians (ONS, 2012). The BME population in Bexley, Bromley and Greenwich in 2009 was estimated at 300,000 (ONS, 2009). Local statistics indicate that the NHS Trusts in South

London selected for this study have a BME population of about 40% of whom 22% are said to be of African origin and a significant proportion of the 22% are Nigerians (Local NHS Foundation Trust Annual Report and Accounts 2009 and 2010). These figures demonstrate a significant number of migrant populations accessing maternity care in the area, and the need for healthcare professionals to ensure that their unique care needs are met within current healthcare resources. As a significant number of the BME population portrayed in these statistics are first-generation Nigerians, the current study is geared towards understanding their maternity care needs as migrants in South London and how far maternity care-givers understand and meet their cultural needs.

Currently, scanty empirical data (Aquino *et al* 2015), exist to affirm competency of midwives in maternity care delivery in the UK but none exist to affirm congruency of such care in meeting cultural needs of first-generation Nigerian women in London. Aquino *et al* (2015) literature is reviewed in chapter two of the thesis. Grey literature: health briefing policy document by MBRRACE-UK 2014, CMACE 2011, CEMACH 2007 and 2004 and Bharj and Salway (2008), highlight shortcomings of maternity care provision to BME populations in UK including FGNW.

Even so, there is a policy imperative driven by the Department of Health to ensure that the healthcare requirements of BME groups in Britain are met (MBRRACE-UK 2014, Department of Health (DH) 2007 and 2004). Health care Trusts are required to have defined sets of policies and structures that enable them to work effectively across cultures; to have capacity to acquire and institutionalise cultural knowledge; adapt to diversity and the cultural contexts of communities they serve; and incorporate these elements into all aspects of policymaking, administration, practice and service delivery (MBRRACE-UK 2014, CMACE 2011, (DH)

2007 and 2004). Despite these requirements, evidence exists to suggest disparity in care provision and poor maternity care experiences of BME women, including first-generation Nigerian women (CMACE 2011, Puthussery *et al* 2010). The notion of marginalisation due to complex identity (migrant status) is not uncommon. According to Maalouf (2000), to claim a complex identity is to be marginalised. Therefore conversely, *identity makes members of BME population* (including first-generation Nigerian women) *'members of a minority' population in Britain; hence marking them deeply, negatively and permanently* (Maalouf 2000:15). This state of affairs therefore requires a critical framework to inform maternity care providers of ways to address and meet *emic* care needs of the BME populations they serve, including first-generation Nigerian women in a competent and congruent manner.

1.4. Overarching Research Aims

The current study is conceived to explore the cultural needs of FGNW in London during maternity care, and to address the gaps in knowledge in the care experiences of this population in relation to cultural competency of midwives and congruency of the maternity care provided to a section of this population (FGNW) in South London.

1.5 Study specific objectives are to:

- explore the cultural (*emic*) care practices of first-generation Nigerian women during their birth experiences in London.
- explore first-generation Nigerian women's retrospective expectations of maternity care in London.
- examine midwives' perception of first-generation Nigerian women's requirements for culturally competent and congruent care in their birth experiences in London.

- consider factors that enhanced midwives ability to give culturally-competent care and some of the barriers they may encounter.

1.6 Research question

1. What cultural practices are important to first-generation Nigerian women in their birth experiences in London?
2. What do first-generation Nigerian women expect from maternity care providers to make care culturally congruent?
3. How well were the cultural needs of first-generation Nigerian women with retrospective experiences of birth in London met as compared to their prior experiences of birth in their home country?
4. What do midwives perceive to be the specific expectations and cultural needs of first-generation Nigerian women and to what degree did they feel they met these needs?

1.7 Study Approach

The study entails an exploratory, contextual and qualitative methodology. According to Sim and Wright (2000), exploratory study is holistic as it desires to fully understand a phenomena and to shed light upon a subject matter in which few or no explanations exist in detail. Exploratory design as a level one research gives basis for development of further research (Fitzpatrick and Kazer, 2011) and hence will create an avenue for further and larger studies on the cultural practices of FGNW in London of whom there is currently no focussed study. Therefore this study fits an exploratory design in forming the basis for subsequent studies of this population.

To explore the phenomena of birth practices of this population, theoretical perspectives drawn on are a configuration of Culture, particularly Helman's (2007) description of '*three levels of culture*', Culture Care Theory by Leininger (2002) and Papadopoulos *et al*'s (2008) four stages of Cultural Competence. It is hoped that these will illuminate *emic* care practices of FGNW in childbirth and highlight how midwives *etic* practices ensure competency and congruency for this population. A three-pronged approach is taken by the researcher to gather data from six first-generation Nigerian women with prior experience of birth(s) in Britain, data is also gathered from four Nigerian and eight non-Nigerian midwives providing maternity care to this population, and a prospective longitudinal approach is taken to explore the birth experiences / practices of six FGNW over a birth continuum; in order to explore what they and midwives consider relevant for meeting their cultural needs during birth in London. The methodological approach consist of a general review of midwifery policy, focus group discussions and semi-structured prospective interviews as illustrated in section 1.7.1 to 1.7.4 of this thesis. Multi-centre Research Ethics Committee (MREC ref: 08/H0810/66) was obtained prior to the commencement of this study.

1.7.1 Focus Group discussion with first-generation Nigerian women with prospective birth experiences in London

Furness *et al* (2011) consider focus group discussions to be more suitable than individual interviews as it allows interviewees to share their experiences in a manner which Aveyard (2014) suggests can broaden the scope of discussion. Aveyard (2014) also assert that focus groups can reduce interviewer bias. Earlier, Kitzinger (1995) expressed that the idea behind the focus group method is that focus group discussions can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview. This method is claimed to be particularly appropriate when the interviewer has a series of open-ended

questions and wishes to encourage research participants to explore the issues of importance to them on the subject matter, to use their own vocabulary, generating their own questions and pursuing their own priorities. Given group dynamics, the participants work alongside the researcher and can take the research in new and often unexpected directions (Kitzinger 1995).

In seeking to explore the retrospective experiences of FGNW with relevant birth experiences in London, a focus group discussion was held with a self-identifying group of first-generation Nigerian women fitting the criteria for this study: the women are Nigerian citizens, domiciled in London for over a year and have had birth(s) in Nigeria and / or in London without adverse outcomes; and consented to participate in the study. In the focus group discussion, participants were required to explore their birth experiences in relation to the cultural practices they adhered during their pregnancies and birth experiences in London, and to highlight the benefits and reasons for the cultural practices adhered to. This group of participants were also required to explore their expectations of maternity care in London, to gauge the degree to which their care cultural needs were met by midwives, and to discuss any conflicts in their care experiences, beliefs and values during birth experiences in London.

1.7.2 Focus group discussion with midwives

Correspondingly, a group of midwives providing care for first-generation Nigerian women within the stated MREC ethics permission locality were also randomly selected and interviewed to explore their understanding of the cultural needs and expectations of first-generation Nigerian women during childbirth and to explore the potential conflicts arising from these in regards to their role as midwives in relation to providing culturally-competent and congruent care for this population.

1.7.3 Prospective longitudinal study of first-generation Nigerian women

Strangor (2014) commend longitudinal study design for enabling follow up and series of assessment of participants in an adequate time difference that permits observation or documentation of changes in behaviour or interest. He highlights the advantages of longitudinal study as granting the researcher the ability to measure current beliefs and behaviours and to evaluate how these change overtime as well as establishing links between earlier and later behaviours.

To gain a prospective in-depth knowledge of first-generation Nigerian women's cultural practices through the birth continuum, a sample of six FGNW were recruited and followed up in a prospective longitudinal manner with discussions held at 24th week gestation, at 6 weeks and 3months postnatal intervals, to gauge whether their birth practices and care expectations change overtime. Data generated from these interviews were recorded with full participant consent and analysed thematically to answer the research questions.

1.7.4 Use of Edinburgh Postnatal Depression tool with prospective samples

Edinburgh Postnatal Depression Scale (EPDS) were administered at each stage of the prospective longitudinal study to screen for psychological health of the prospective sample, so as to assess women for symptoms of psychological distress as part of gauging ongoing psychological health or otherwise through the birth continuum to ensure robustness of information given during interviews.

1.8. Structure of the thesis.

Chapter one

This chapter contextualised this study by examining the researcher's motivation for undertaking this study, appraising empirical evidence and policy documents to justify need for this study and to provide the aims, content, structure, purpose and the theoretical underpinning that inform the thesis, an overview of all other chapters is also given.

Chapter Two

An in-depth literature review is presented of existing evidence on perinatal cultural practices of Nigerian women within and outside of their homeland and to highlight similarities and gaps in knowledge in regards to providing maternity care that is culturally congruent to this population. The literature review also embraced the perceptions of midwives on the care needs of this population as a sub-group of BME women accessing maternity care in The UK. Relevant themes emergent from selected literature in regards to justifying the need for current study is presented, exploring methodologies and findings of other studies and the relevance of some of these to current study.

Chapter Three

This chapter holds the methodology, theoretical framework and epistemological perspectives of this study. The philosophy of Culture Care Midwifery Model (CCMM) is proposed and are explored in relation to how it may enable midwives to achieve culturally competent and congruent care for FGNW.

Chapter Four

In this chapter, the researcher details the methods of this study outlining the research approaches from recruitment of samples, focus group interviews prospective study and ethical considerations, as part of a robust research ethos.

Chapter Five

This chapter hold the finding of this study. In this chapter, the details of focus group interview is explored, detailing demographics of the participants, the explication of categories, codes, and themes arising at all intervals of the study.

Chapter Six

This chapter holds the discussion of findings arising from this study. The themes are critically discussed to derive meanings from the *emic* and *etic* care approaches of first-generation Nigerian women and midwives. Within this interpretative cycle, clarity is gained by accurate reference to focus group and prospective study findings, through the shared experiences of the informants and the triangulation of these with theoretical evidence drawn from literature review and contemporary literature. Core themes explicated from all stages of the study are explored in relation to how the views and perceptions of first-generation Nigerian women and midwives converge and diverge on cultural practices in childbirth and maternity care for this Nigerian population.

Chapter Seven

Chapter seven is the penultimate chapter in which the research question/s, design and key findings are summarised, issues arising from the study are highlighted and critically discussed in relation to informing first-generation Nigerian women, informing midwifery education,

practice and research. CCMM is recommended in order to enhance maternity care that is culturally informed, competent and congruent in meeting the needs of FGNW in London. Furthermore, strategies for dissemination of the findings of this study to midwifery community and allied healthcare will be explored, as well as approaches for replication of this work.

1.8 Chapter one conclusion

In the preceding chapter I have provided the context of this thesis, outlining the origins and motivations for undertaking this work. The uniqueness of the ethnicity of FGNW as part as a sub-group BME population accessing maternity care in London has been established. Existing empirical and policy evidence so far appraised highlight a gap in cultural knowledge and cultural competency of midwives in meeting the cultural care needs of FGNW. The research question, with clear aims and objectives, are also detailed in this chapter. What remains to be addressed is how the cultural expectations and needs FGNW may differ from the general population served by midwives in London and how midwives could competently and congruently meet these needs within existing maternity care provision. This is what this current study aims to address. In the chapter to follow, literature search strategy, emergent themes from existing evidence, the methodologies and findings of other studies are discussed in relation to the relevance to current study. Literature review on existing global knowledge on the birth practices of Nigerian women living in Nigeria and in the diaspora are also appraised in regards to how these inform the current study. The content of subsequent chapters have also been outlined.

Chapter 2 Literature review

2.1 Literature review introduction

The literature review within this chapter examines themes emergent from systematic search in regards to justifying the need for current study, and exploring methodologies and findings of other studies and the relevance they may have to current study. On the whole, 50 empirical and policy documents relevant to the topic area were selected for appraisal.

2.2 Literature search strategy

In an attempt to develop a comprehensive picture of the state of knowledge on the topic, articles were sought utilising Cochrane library, EBSCOhost Research Databases which include: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline; PsycINFO; Psychology and Behavioural Sciences Collection, Academic Search Premier; and SportDISCUS. Furthermore, ProQuest Digital Dissertations: Abstract and Indexing, Social Services Abstracts, Sociological abstracts, Swetswise, Sage Journals Online, Springer link and Science direct search engines. The University library catalogue was regularly accessed for books, electronic literature (eBooks) for relevant chapters to the topic. Hard copy of books and journals were also manually searched.

A Boolean search was carried out in order to produce more focused and relevant results. The search commands and / or, *, #, “ ” were used in combination with search terms since they are useful for focussing searches and obtaining pertinent results. Search terms such as: acculturation, acculturation and Nigerian mothers, culture, culture and childbirth, childbirth celebration and Nigerian mothers, cultural prescriptions in pregnancy, cultural proscriptions in

childbirth, childbirth and cultural rituals, cultural rites in childbirth, culture and expectations in childbirth, culture and satisfaction, ethnicity and rituals, historical practices in childbirth, historical practices in pregnancy, idioms of distress and childbirth, impact of migration, Nigerian women and childbirth, Nigerian women and depression, migration and Nigerian mothers, impact of migration on wellbeing, postpartum depression, postnatal depression, rite of passage, support network in pregnancy, support network in childbirth, transition to motherhood, trans-cultural childbirth, and values and / or of motherhood were applied and repeated using all databases indicated above to obtain and select literature outlined in (figure1 and table 1) below. The use of search terms enabled a thorough, objective and reproducible search of a range of sources to identify as many relevant studies as possible within the topic area. This in order words constitutes a *systematic approach* to literature search and requires the investigator to assess publications in relation to rigorous research criteria (Bowling 2009: 147). The use of Boolean strategy offers more control and refines searches by combining terms to modify key words (Kable *et al*, 2012). The use of quotation marks (“ ”) and truncation (*, #) of search terms / phrases helped to narrow searches and ensured inclusion of mainly relevant articles. To formulate the theoretical framework that informs this study, more literature was sourced within journals of anthropology, biomedicine, sociology, social research methodology, psychology, psychiatry, women’s health and reproductive health.

Inclusion criteria for articles: Having generated hundreds (993 articles) of literature from many sources, it was vital to set inclusion and exclusion criteria to filter the articles. After removal of duplicates, the identified papers were screened to determine eligibility based on predetermined inclusion criteria. Article database papers were included if they were peer-reviewed primary research articles; and were published in English language between 1996 and 2016. However, the nature of some of the evidence informing the topic area originate from

policy documents, warranting the inclusion of grey literature such as: conference proceedings, dissertation and theses, government or organisational reports within the articles selected for review. According to Aveyard (2010), peer reviewing allows a diversity of opinions to be brought to the table, theoretically removing any personal biases and eliminating substandard articles from public access. Nonetheless, grey literature: that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers (Childress and Erik, 2003) has the advantage of adding to the body of knowledge on the topic. The 20-year timeframe is relevant to incorporate all articles within the last two decades that inform the topic area and to ensure broad coverage of literature of the maternity care experience and outcomes, and cultural practices and beliefs of first-generation Nigerian women in their homeland, in the UK and other parts of the diaspora. An initial limit on the country of publication was removed because the initial search yielded no articles when limited only to United Kingdom articles. Latter searches yielded scant UK articles which has been incorporated in the articles appraised. Abstracts of articles were scrutinized for relevancy and quality to make decision on the applicability and value of each article to the research topic as advocated by Aveyard (2010). Features within articles that bear relevance to this literature review, such as beliefs, cultural norms / traditions, rituals or structures and ways of life that may influence health and wellbeing were explored within abstracts and the main article was sought and read if deemed relevant for inclusion in the review. Subsequently, data was extracted from the suitable papers through interrogation with the aid of an improvised assessment form which was adopted from Hawker *et al.*'s (2002) methodology. This enabled specificity about how each of the included papers addressed the research topic.

Furthermore, the suitable papers were critically appraised and scored for methodological rigor by adopting Hawker *et al*.'s (2002) critical appraisal tool which drew on the scoring system of the Critical Appraisal Skills Programme (CASP) (1998) tool. This enabled an assessment of the methodology of each of the accepted papers in order to grade them according to the reliability of the results (Hawker *et al*., 2002). Each of the studies were graded in either 'good', 'fair', 'poor', and 'very poor' based on the said scoring system that indicated methodological rigor. Furthermore, peer review journals were favoured, as they would have undergone rigorous research processes prior to publication (Greenhalgh, 2006). However, some grey literatures, which include policy documents, unpublished theses (for examples, Bharj and Salway 2007 policy paper and Bromley 2007 unpublished thesis on 'obstetricians and midwives views of labour in Nigerian and Caucasian women' which bears some relevance to the current study) proved pertinent to the topic area and hence were consider and used. Literatures with limited distribution were not actively sourced but some of these proved very useful in establishing background knowledge on the topic. Benzies *et al* (2006) affirm this approach as they authenticate the use of grey literature to validate the results of a research-based literature search. The lifespan of articles was set within the last two decades in order to encapsulate broad and comprehensive coverage of existing knowledge.

Exclusion criteria for articles: Exclusion criteria for selection of articles were articles not published in English language, articles outside twenty-year lifespan, articles broad ranging or non-specific to the subject matter, dated and / or generic articles. Below are the search terms used to obtain literature.

Table 1: Search terms used

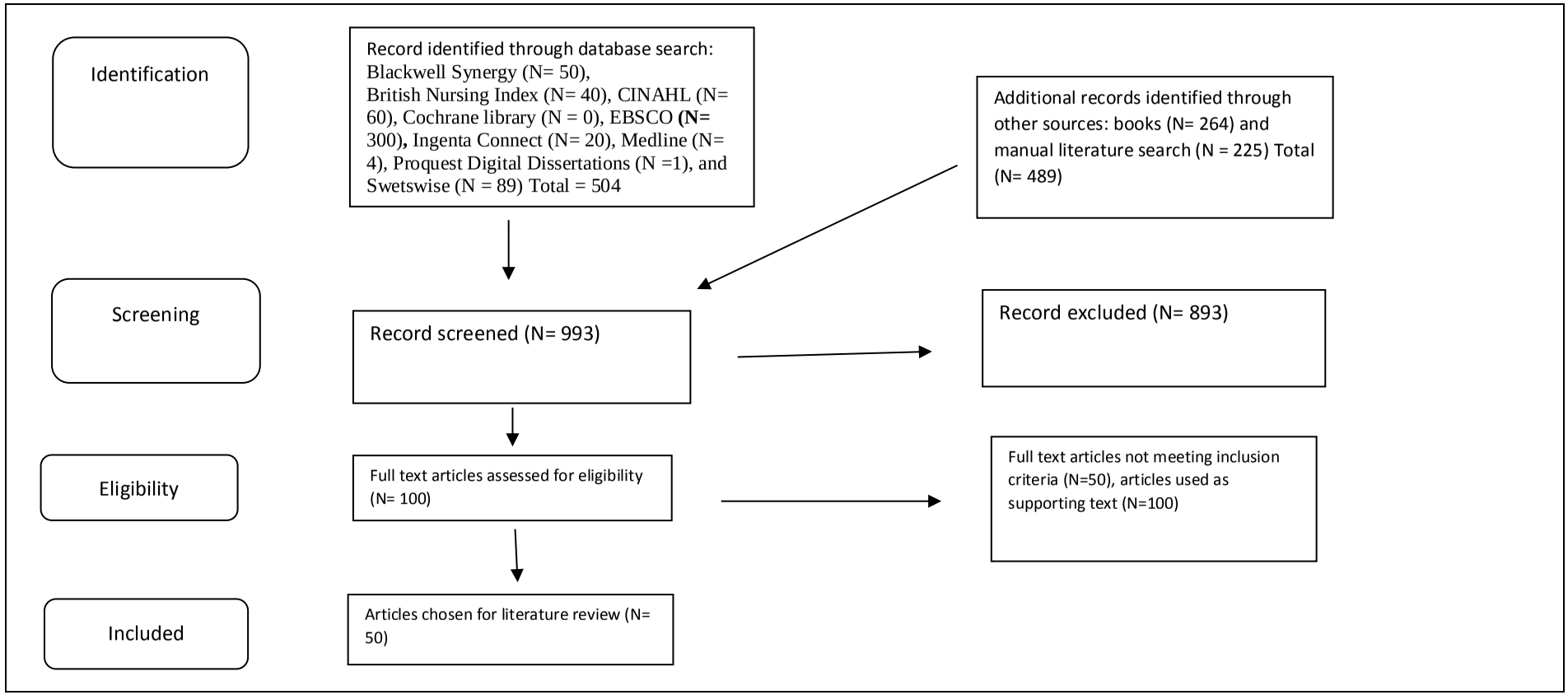
acculturation,	Acculturation and Nigerian mothers,	childbirth and idioms of distress, Nigerian women and depression, postpartum depression, postnatal depression,	culture, Culture and childbirth, childbirth and cultural rituals, culture and expectations in childbirth, culture and satisfaction,
cultural prescriptions in pregnancy, cultural rites in childbirth,	Childbirth celebrations,	Childbirth celebration and Nigerian mother,	cultural proscriptions in childbirth, Nigerian women and childbirth,
ethnicity and rituals, transition to motherhood, trans-cultural childbirth,	historical practices in childbirth,	historical practices in pregnancy, rite of passage,	support network in pregnancy, support network in childbirth,
impact of migration, values and/or of motherhood	migration and Nigerian mothers,	migration and wellbeing,	Immigrant Nigerians, and / or BME populations
Boolean operators were also used to increase return for words that could have alternative endings or similar words spelt differently as follows:			
Culture*	Childbirth*	Well-being	Black minority ethnic groups

Search results

The search strategy yielded 609 papers after abstracts were screened, which identified potentially useful 100 papers after elimination of duplicates. After further screening of the 100 papers that met the eligibility criteria were. The review of titles and abstracts of the 100 papers identified 50 papers which met the predetermined inclusion criteria. Following up on references on the identified papers did not yield any new eligible papers, as the citations located were either duplicates or did not meet the predetermined inclusion criteria. The key findings and overall outcome measures of each of the studies were organised into themes following thematic analysis steps identified by Braun and Clarke (2006). A table (Table 1 above) and flow chart is presented below detailing the number of records gained, assessed and considered relevant for inclusion in the literature review.

A traditional or narrative literature review approach was taken by the researcher with critical appraisal of methodological approaches of researchers in regards to relevance to current study. According to Cronin *et al* (2008), this type of review is useful in gathering volumes of literature in a specific subject area, analysing, summarizing, and synthesizing it and drawing conclusions about the topic in question. Its primary purpose is to provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of new research. It can inspire research ideas by identifying gaps or inconsistencies in a body of knowledge, thus helping the researcher to determine or define research questions or hypotheses (Cronin *et al.,* 2008).

Figure 1: Flow chart of Literature search strategy



Flow chart of Literature search strategy

2.3 Order of literature / use of CASP

'The Funnel method of structuring literature review' (Hofstee, 2006) has been adopted to order literatures found and to discuss relevant works broadly in brief, then concentrating on the aspects most relevant to this work and how these can be utilised within the current study. Some literature are discussed chronologically, while others are compared and contrasted against each other whilst commenting on some of their strengths and weaknesses as they pertain to the topic under study. This is in line with the chosen traditional or narrative literature review approach (Cronin *et al.*, 2008).

Critical Appraisal Skills Programme (CASP) is a systematic process used to identify the strengths and weaknesses of a research article in order to assess the usefulness and validity of research findings (Hawker *et al.* 2002, Harbour and Miller 2001, Young and Solomon 2009, National Collaborating Centre for Methods and Tools 2011). Since the original tool was presented by Gray in 1993 to guide healthcare towards meeting the demands of evidence-based medicine, various forms of the tool has emerged, with varying steps for assessing the quality of clinical and research evidence.

However, Young and Solomon (2009) contend that there is no golden standard tool for assessing usefulness of research but the most important components of a critical appraisal are an evaluation of the appropriateness of the study design for the research question and a careful assessment of the key methodological features of the research design. Young and Solomon (2009) further assert that, the main purpose of CASP is to enhance deeper understanding of a study, rigorously evaluate each article to determine its suitability, reliability and / or validity for use. CASP by Young and Solomon (2009) grants the researcher a simple checklists can be useful to screen out research that is of low quality or of little relevance.

Harbour and Miller (2001) recommend the 'Hierarchy of study types' ranging from systematic reviews to experts opinion to gauge the quality and usefulness of evidence that inform practice and research. Taylor *et al* (2007) assert that hierarchies of evidence are limited in addressing questions on the rigour of qualitative research. Thus suggesting that experiences can be highly subjective as well as feelings of bias, and hence cannot be explained with quantifiable data. For this reason, Harbour and Miller (2001) concur that other types of study design may provide the best evidence outside of the hierarchy. The latter further admonish researchers to weigh the methodological strength of the evidence of the studies they use, as failure to do so increases the risk of bias or confounding and thus reduce the study's reliability.

CASP as presented by Hawker *et al*. (2002) was considered as the most up to date version of CASP that enables a simple scoring system to identify the strengths and weaknesses of a research article by examining and rating sections to gauge its usefulness for informing policy and practice. Hawkers *et al.* (2002) version of the CASP was preferred for its simplicity of grading all forms of evidence using a simple scoring system ranging from 'good', 'fair', 'poor', and 'very poor', which can be easily applied to any form of evidence.

Nonetheless, in exploring the influence of cultural practices in health and wellbeing in childbearing, as in many areas of maternity / medical practice, randomised trials may not be practical or ethical to undertake. For this reason, Hawker *et al.* (2002) tool was used to accept or reject studies related to the phenomena under study in order to ensure that all relevant aspects were considered and that a consistent approach was used in the methodological narrative assessment of the evidence.

The articles selected for literature review bear close reference to the topic area and have been organised in themes reflecting aspects of birth practices of FGNW in Nigerian and the diaspora

already studied. These are in relation to the importance of beliefs and cultural practices around birth, culture / culture of care, migration and acculturation, as well as support network. These themes reflect what anthropologists and researchers consider important in the birth experiences of Nigerian women within their indigenous community and in the Diaspora. Studies addressing approaches to culturally appropriate care tend to be covered under the following terms: tarns-cultural care, cultural diversity, cultural sensitivity and cultural competence but not congruency; as the latter is about the woman's perception of how well her cultural care needs are met while all other terms express what healthcare providers aim to achieve towards providing care that is culturally appropriate. Leininger (2002, 2004, 2006) places emphasis on both competency and congruency as the views and approaches of both the care giver and care receiver need to converge in order to achieve care that is appropriate and meets that expectations of both. The themes have been presented alongside the research articles from which they are drawn on table 2 below.

Table 2: A TABLE OF PAPERS REVIEWED

Themes	**Articles**
2.4 Empirical and policy UK literature on the maternity care experiences and outcomes of BME women including first-generation Nigerian women in the UK.	Aquino *et al* (2015), Henderson et al., (2013), Raine *et al*., (2010), Bharj and Salway (2008).
2.4.1 Beliefs and cultural practices of first-generation Nigerian women.	Makinde (2004), Nkwocha (2007), Nzegwu (2004), Nzegwu (2004b), Ibisomi and Mudege (2014), Donkor and Sandall (2007), Calister and khalaf (2010), Van Hollen's (2003), Adeoye and Kalu (2011), Bromley (2007), (Sered 2003), Ezeobele *et al* (2010), Ugwu and de Kok (2015), Nnaemeka (2003), Para-Mallam and Oluwafunmilayo (2006), Oloruntoba-Oju and Oloruntoba-Oju (2013), Sheridan *et al* (2011), Chalmers (2012),

	Liamputtong *et al* (2005), Walsh (2002), Okafor (2000) and McHugh (2003).
2.4.2 Culture, culture of care, migration and acculturation of first generation Nigerian women.	Helman (2007), Wikberg and Eriksson (2008), Sookhoo (2009), Mcfarland and Eipperle (2008), Papadopoulos *et al* (2008), Posmontier and Horowitz (2007), Gardner *et al* (2013), Okafor's (2000), Dow 2011) Bhugra and Ayorinde (2004) and Coast *et al* (2014).
2.4.3 Support network and first-generation Nigerian women's transition to motherhood.	Segre *et al* (2006), Varma (2008), Morhason-Bello *et al* (2009), Elsenbruch *et al* (2007), Ezeobele *et al* (2010), Martin-McDonald *et al* (2002), Etowa (2012), Nurmi and Almesmaki (2001), Barr (2008), Besser and Priel (2003), Ward and Purdue (2005), Feldman *et al* (2004), Sereika and Olshansky (2005), Gardner *et al* (2013), and Hogan *et al* (2012).

2.4 Empirical and Policy UK literature on the maternity care experiences and outcomes of BME women including first-generation Nigerian women in the UK.

Within this section of the thesis, the original intention of the researcher was to present an overview of the empirical literature on the maternity care experiences and outcomes of first-generation Nigerian women in the UK and to appraise contemporary literature on culture, migration and acculturation in regards to this population. However, due to lack of availability of literature specifically addressing the birth experiences of FGNW, a decision is made by the researcher to examine relevant UK and global literature on maternity care experiences and expectations of FGNW. This approach will be useful to uncover care experiences of this population both in their current domicile, in their home country and in the diaspora, as a plethora of such literatures were located. Therefore, a broadened global literature originating from the UK and detailing birth experiences of FGNW as a sub-group of BME in the UK, and studies exploring the perception of midwives in their care and studies undertaken in their home country and in the diaspora are appraised and hereby presented within the themes of: beliefs and cultural practices, culture/ culture of care, migration / acculturation and support network;

as considered appropriate by sociologists and anthropologists for exploring issues relating to FGNW's birth experiences.

Aquino *et al.* (2015) in their study in Manchester: UK explored the perspectives of self-selecting midwives located within one NHS Trust and studied them over one month period, to explore their views on their experiences of caring for BME women in regards to addressing the complex needs of these women during pregnancy. They recruited 24 midwifery staff of whom 20 participated in a semi-structured interview using topic guide which covered four key areas: information about the midwife, professional experience of providing care for BME women, views of health inequalities, and midwifery training. Three themes were explored which highlighted language barrier as an impediment to delivering competent care. It is reported that use of interpreter at times impeded rather than enhanced communication between midwives and women. They uncovered that lack of engagement with maternity care services was often due to women's lack of understanding of information. Their second theme uncovered divergent expectations between women and midwives which can create tension and / or impede maternity care. The midwifery staff in this study recognised that BME women's expectations of maternity care, especially those new to the UK, could be vastly different to their own, and associated this with a lack of knowledge of the NHS maternity care structure. Moreover, it was found that the depth of the midwives clinical knowledge and experience might make them less sensitive, as their familiarity with NHS system may hinder their perception of the women's lack of knowledge of the NHS maternity care structure. Furthermore, the midwives reported several instances where BME women's cultural and / or religious practices were not supported within NHS maternity care, resulting in women and their families feeling confused and dissatisfied with care. Their final theme highlighted conflicting expectations between midwives and BME women which might adversely affect the woman-midwife relationship, mostly where cultural and / or religious practices cannot be met or are not well understood by the midwife. They

caution that as midwives cultural training is limited, and that cultural factors may become an impediment to care in a Western-orientated practice. However, they do not suggest strategies for meeting BME cultural needs in childbirth in The UK nor did they suggest approaches to make maternity care for BME women culturally-congruent. This creates a gap in which the current study aims to fill through CCMM that will grant midwives strategies for addressing the needs of FGNW.

Henderson *et al*'s (2013) qualitative study of women's experiences of communication in antenatal care examined use of services and perceptions of maternity care by women from seven specific ethnic groups, who had recently given birth. Using structured questionnaire sent to 50,000 women from varied ethnic backgrounds, they explored care access, information, communication and choice regarding antenatal care, as well as delivery mode and neonatal outcomes of 24,319 women who completed the survey. The majority (85%) of the respondents were Caucasian women, only about 9% of women were of BME background (Black African 2.7%, Bangladeshi, 0.7%, Black Caribbean 0.7%, Indian 2.4%, and Pakistani 2.5%). The demographic statistic of their population showed that women from BME were more likely to be younger and single, more likely to be multiparous, lived with other family members and spoke languages other than English compared to their White counterparts. Notwithstanding these differences, BME women through the entire birth continuum, cited a poorer experience of maternity care than their White counterparts: a common trend among other studies across a range of factors (Bharj and Salway 2008, Raine *et al*., 2010; Jomeen and Redshaw 2013). Once more, this study although broad in population and domain, took a survey approach and only had a small sample of BME women and hence it is non-representative of BME population in Manchester. Moreover, the majority (85%) of the respondents were Caucasian women, thereby making the findings of this study more relevant to the White population and less generalizable

to BME populations in Manchester and by extension BME groups in The UK. Furthermore, the views of midwives were not sought or contrasted against the views of women to gauge competency and congruency of the care provided. Furthermore, Henderson and colleagues focussed on antenatal care experiences of a sample comprising mainly of Caucasian women and women from other ethnic groups and hence differs from the current study of FGNW, and thus lends further need for my study which is specifically aimed at exploring both the perceptions of midwives and FGNW on care experiences of FGNW in London, who have not been previously studied specifically by other researchers. Moreover, the approach in the current study differs from Henderson *et al*'s (2013) survey approach as the current study takes an in-depth focus group and longitudinal prospective approach in interviewing a section of the sample through an entire birth continuum, and exploring through face-to face- conversation, their birth experiences and contrasting their perceptions with those of midwives; in order to gain a balanced evaluation of competency and congruency of care given and received.

Raine *et al*. (2010) explored communication experiences of thirty pregnant women from diverse social and ethnic backgrounds accessing maternity care at a large London hospital. Using focus groups and semi-structured interviews, they uncovered through thematic analysis that; 'an empathic conversational style' of communication created reassurance, facilitated effective communication, improved appointment attendance and fostered tolerance in stressful situations for the pregnant women. They recommended training for healthcare providers to enhance empathic interactions that promote constructive provider-user relationships and encourage women to engage effectively and access the maternity care they need. This study only addressed one component of barriers that hinder women from diverse ethnic backgrounds, including BME women from accessing maternity care but did not consider the cultural barriers that hinder care access. Moreover, a mixed cohort of women from varied backgrounds makes

this study non-specific to FGNW or wholly BME category. The current study uses a triangulation of methods: focus group discussions and semi-structured interviews and a longitudinal approach to elicit the views of FGNW and midwives with the aim of gaining in-depth views that can be converged and contrasted to inform midwifery practice of approaches of achieving cohesive maternity care provision that is culturally competent and congruent through the continuum of birth.

Bharj and Salway (2008) health briefing policy document, summarised the evidence available on the maternity experiences of women from BME communities in the UK, and reported that significant ethnic inequalities in maternity outcomes persist in the UK, with some minority ethnic groups experiencing particular disadvantages. They exposed some barriers that hinder BME women from accessing maternity care, asserting that current inadequate service provision contributes importantly to adverse outcomes for minority women. Therefore, managers and commissioners of health are called upon to consult and engage with service users so as to understand and meet the needs of local populations.

Furthermore, although some of the studies appraised are contemporary, the methodological strength of my study include the adoption of prospective cohort design with a longitudinal approach to data collection (from a section of FGNW) which is associated with less confounding and fewer sources of bias (Aveyard 2014), through comparison and contrasting the divergent perspectives of midwives. In this way, my study differs from these other studies and brings a fresh perspective by focusing on cultural competency and congruency in maternity care provision, for FGNW as a sub-group of BME population in the UK who have not been specifically studied in London. The midwives studied by Aquino and colleagues were located in one Trust while my samples of midwives and women are from multiple NHS Trusts (three

large NHS Trusts in London: each delivering over 3,000 women annually). The heterogeneity of my study sample and approach: in-depth focus group discussion with six first-generation Nigerian women and twelve midwives (four of whom are Nigerians), coupled with the longitudinal prospective interviews of Nigerian women at three stages of birth continuum grant breadth and depth to my study in a way that is different from Aquino's *et al* (2015), Henderson *et al*., (2013), Raine *et al*., (2010) and Bharj and Salway, (2008); and advances their works by converging the perspectives of women and midwives together to aid a balanced perspective that has potential to advance cultural competency and congruency in maternity care provision to this population. Therefore, global literature detailing birth experiences in their home country and in the diaspora is presented within three themes to extend existing knowledge on their *emic* care approaches.

2.4.1 Beliefs and cultural practices of first-generation Nigerian women

In Nigeria, as in many other African countries, the concept of motherhood is universally significant probably due to the role of women in childbirth (Nkwocha, 2007). According to a Nigerian Yoruba anthropologist, Makinde (2004), motherhood is the highest value given to a woman because Yoruba people revere motherhood and consider it highly important because of the belief that preservation of humanity is dependent on the role of mothers in society. In Yoruba, as in the lands of the Igbos, the highest value is given to a mother as mothers are revered and wives are valued for the purpose of procreation. Reverence in this context may connote idolatry to outsiders to this culture but Yoruba indigenes consider this adulatory. In line with this reverence, Nzegwu (2004), a Nigerian Igbo anthropologist, asserts that Nigerian society is organised around the principle that 'people are the most valuable resource' and that Nigerian society especially the Igbos are organised around the need to have children, and

mothers are central to this role. Hence, mothers command respect to a degree that appear to denote a sovereignty of motherhood. Furthermore, it is a common adage in Igbo lands that, 'onye nwere madu ka onye nwere ego', meaning that the populous are much wealthier than the financially well off. According to Nzekwu (2004), motherhood is the basis of women's empowerment in many African societies including Nigeria. This Igbo anthropologist further assert that the attainment of motherhood for married African women propelled them out of the subordinate position of "wife" to the lofty category of "mother". This, she claims, is synonymous with acquiring a title: "nne" (mother) at the birth of a first child. At the accomplishment of motherhood, the woman is no longer addressed by her first name but reference is made to her newly merited status of mother. She rises from being described as the wife of X to being addressed as the mother of Y. It is worthy of note that it is the safe delivery of a live baby that earns her this status not conception per se in the sense that, among Nigerians, conception only establishes the potentiality of motherhood that is actualised only upon the birth of the child (Nzekwu, 2004).

Furthermore, Makinde (2004:170) in his narratives of the value of women in Yoruba culture asserts that, "*a woman is a source of life just like water*". Hence in Yoruba culture, women are revered as priestesses, and in some cases, deities (Makinde 2004). Nzegwu (2004b) further reports that since mothers are the pivotal figure in the motherhood schema, they are the epitome of respect as the vehicles for the membership into the family bloodlines. According to her, it is regarded that on a socio-political level, the woman's power and status within the Nigerian community resides in her ability to give birth to children. Hence, motherhood in Nigerian culture constitutes the basis for compelling obedience from everybody who gestated in the womb (Nzegwu, 2004b). The sovereignty of motherhood thus establishes the moral parameters for belongingness and loyalty, in the sense that motherhood gives siblings and lineages a close-

nit sense of loyalty and unity (Nzegwu, 2004b). The challenges of childlessness of Nigerian women unable to reproduce for whatever reason warrant exploration in view of this inherent adulation of motherhood among Nigerians. This was the focus of a study undertaken by Ibisomi and Mudege (2014) amongst three Nigerian tribes: Hausas in Kano, Igbos in Imo and Yorubas in Oyo state. Their study explored societal perception and acceptance of childlessness in Nigeria, and report that childlessness whether voluntary or involuntary contributes to a kind of invisibility and poverty in Nigeria. Thus highlighting an inherent pronatal culture that frown on voluntary childlessness but is somewhat sympathetic to involuntary childlessness.

Donkor and Sandall (2007) have documented traditional belief systems based on the continuity of lineages that place a high premium on fertility in sub-Saharan Africa, hence reiterating that childlessness and reactions to it are mediated by socio-cultural factors, which vary widely across societies. Conversely, childless women endure stigma, open ridicule and isolation from people in such societies with high premium on birth. As fertility is rewarded through inheritance in patriarchal linage, the childless woman may also be subjected to abandonment by her husband, economic deprivation, rejection, physical violence, taunts and threats from her subordinates; with potential detriments to her physical and emotional welfare (Donkor and Sandall, 2007). Feminist perspective uphold the right of control over one's own body and hence would contest the notion of a woman's worth based solely on her ability to reproduce (Nnaemeka, 2003).

Nonetheless, amongst the Igbos of Eastern Nigeria, motherhood is not altogether complementary to womanhood or additional to the unity of the lineage; but it is sometimes the core point of segmentation and departure from the family. In the sense that siblings from one

woman are considered more closely related than siblings of the same father, especially in the polygamous family set up that is common in Nigerian culture; especially among the three dominant tribes. Thus, Nzegwu (2004b) argues for the pre-eminence of mothers over fathers in family formation in Igbo lands. Conversely, if wives were structurally subordinate to husbands as they sometimes are in Igbo lands, then some in Igbo lands would argue that the pre-eminence of the mother lacked social significance. Since under patriarchal family formation intrinsic in both Igbo and Yoruba lands, women's sexual and reproductive capacities are commoditized and controlled by men as husbands; and whatever privileges or powers women may have or derive from giving birth are dependent on their attachment to men as sexual partners and husbands. However, the Igbo moral schema gives husbands the right to the products of a wife's womb and not her personhood as the latter essentially belongs to her parents. This means that marriage does not permanently disassociate the woman from her paternal home, even though she may not have the right of land or property inheritance. This dichotomous, interchangeable, respectable and yet subordinate status of women remains a bone of contention for some FGW (Anugwom, 2007) in London who may share feminist ideologies of equality, independence, and individualism as women and as mothers in their new status as migrants. According a female Nigerian theorist (Nnaemeka 2003:360), these '*nego-feminists*' (the feminism of negotiation; no ego feminist); soft-pedal with both female folks and male folks to gain a more rewarding equal partnering through collaboration, complementarity, conflict management, give-and-take, seeking peace, negotiation and resolution. However, Oloruntoba-Oju and Oloruntoba-Oju (2013: 6) argue against nego-feminism contesting that in regards to gender, *the association of males and females with separate and fixed biological and psychological characteristics leads to a hierarchical social power dynamics within society that is generally unfavourable to the genders, and is particularly oppressive to the female. The*

latter insist that 'the trope of wifehood and / or motherhood as a 'necessary' identification parameter of African womanhood is equally subverted'.

Nonetheless, the apparent 'sovereignty' of motherhood amongst Nigerians makes motherhood and childbirth so politicised and symbolic and not simply a biological function but carries with it deep cultural meanings and connotations (Makinde 2004, Okafor 2000). Callister *et al* (2010) in her study of orthodox Jewish childbearing women found that many women perceived motherhood as the realisation of their gender role and having children to be '*the purpose of life and happiness of the woman*' (Callister *et al.*, 2010: 115). This is in line with Van Hollen's (2003) assertion that reproduction could serve as key to understanding the ways in which cultural groups such as first-generation Nigerian women, conceptualize and re-organise the world in which they live in to form a sense of belonging. To this effect, Nigerian women experiencing birth in London may adhere to cultural prescriptions and proscriptions in a bid to retain the sense of belonging to their home culture and to ensure a health pregnancy and birth. Concomitantly, it is reported that 4% of maternal mortality in Nigeria is attributable to traditional prescriptions and management of pregnancy, labour and delivery (World Health Organization, 1991), as well as postnatal measures geared towards protection of the new mother and baby. Equally, the celebration of fertility where the birth of more than ten children warrants the ceremony of 'Igbu Ewu Ukwu' (celebration of fertility) could pose health problems and contribute to maternal morbidity and mortality through excessive reproduction within this population and warrants competent *emic* care approaches to avert and address these.

Even so, Nigerian women's' preferences of normal vaginal birth and their aversion to caesarean section has been documented. In an observational study of Irish versus Nigerian women's birth

plans, Sheridan *et al* (2011) report that about 91% of Nigerian women selected a vaginal delivery as their delivery mode of choice, with only about 3% preferring a caesarean section. This study comprised 113 Nigerian women and 519 Irish women attending the Unified Maternity Services in Cork. A convenient sample questionnaires survey at antenatal booking clinic generated a 12 months data which was analysed using Fischer's Exact and Chi square tests, using SPSS Version 11. Although a similar demographic of Irish and Nigerian women took part in this study, there were discrepancies in gestational age at booking: Nigerian women booked at a later gestation compared to their Irish counterparts (33.8 weeks vs. 20.8 weeks respectively, $P < 0.001$). With such p value, sampling method, sample size and quality of data should be considered (O'Brien *et al.,* 2015) particularly as the population of Iris were more than four times greater than the Nigerian population (113 Nigerian women and 519 Irish women) which could skew the findings reported. Similarly, Fasubaa *et al.* (2000) document Yoruba women's preference of normal birth and their inherent fear of caesarean section. They report that Caesarean section among the Yoruba of western Nigerian is surrounded by a lot of fears, miseries, aversion, guilt and misconceptions for reasons varying from the desire by women to have a natural vaginal birth, fear of surgery, morbidity and deaths from the operation.

Correspondingly, Ugwu and de Kok's (2015) mixed method study that combined both qualitative and quantitative strategies of enquiry, explored the socio-cultural factors, gender roles and religious ideologies contributing to Caesarean section refusal in Nigeria reporting that 22% of maternity clients refused Caesarean Section and more than 90% of the Caesareans in the focal hospital were emergencies. Their findings highlight need for addressing the prevailing socio-cultural norms and expectations that hinder the acceptance of Caesarean section by Nigerian women and the potential dangers their refusal of warranted caesarean may pose to their and the fetuses wellbeing. Adeoye and Kalu (2011) and Bromley (2007) also

suggest that amongst Nigerian women, there is a strong stigma attached to Caesarean births that extends beyond denigrating the woman to 'a less complete woman' but carries the consequence of preventing her own daughters from acquiring husbands and her sisters from marrying (Adeoye and Kalu 2011, Okafor 2000). The Hausa women of Northern Nigeria are said to prefer births at home and dread delivery in hospital (Adeoye and Kalu 2011), as they are afraid that they may have Caesarean section in hospital, which is considered a failure of womanhood by their traditional standards (Okafor 2000). Comparatively, (Chalmers 2012) report that although Caesarean section rate is high in Britain; these were considerably lower than in the United States and Canada, and birth practices were less medicalized in Britain compared to USA and Canada as the ethos of woman centred care mitigates unwarranted interventions. Chalmers also found striking differences with respect to the partner's presence in labour. Many Hausa husbands object to hospital deliveries because doctors and other health personnel are male, when it is against their religious beliefs for another man to behold their wives, let alone attend to them in childbirth. Therefore, a midwife advocating support from a Hausa husband during labour, for instance, would probably be counter-productive given the strongly held traditional taboos against the husband's presence in labour (Vehviläinen-Julkunen and Emelonye 2014). These cultural practices and adherence to traditional health practices of this form may greatly affect the lives of these women, even in the presence of the most efficient healthcare system (Anugoro *et al*., 2004). Therefore, maternity care providers require knowledge and understanding of reasons behind these *emic* / folk care practices so as to design effective and efficient *etic* / professional care approaches to address these in a competent and congruent manner.

Para-Mallam *et al* (2006) in their fieldwork among Christian and Islamic populations in Nigeria, report religion as a dominant force that converge with indigenous customary values to

create a powerful influence that affect all areas of women's lives. Subscription to a faith can transcend national, regional and social affiliations and may be first-generation Nigerian women's way of proclaiming their own universality. According to Malouf (2000:78), '*belonging to a faith community is the most global and universal kind of particularism*'. Hence, beliefs, customs and rituals are vital in Nigerian women's birth experiences as birth is embedded in traditional expectations and rituals believed to enhance health and wellbeing of both mother and baby (Nzekwu, 2004).

In Nigeria, as in most non-Western cultures of the world, pregnancy and childbirth are regarded as vulnerable states for the woman and her fetus / baby. In this sense, both mothers and their fetuses or babies are regarded as vulnerable entities needing protection by rituals. It is believed that the formation and growth of the fetus depends on the maintenance or violation of some religio-cultural codes and social norms about celebrations, diet, hygiene and other rituals (Anugwom, 2007). As a result, the expectant mother is expected to maintain certain religio-cultural restrictions during pregnancy and the childbirth experience. Therefore, attention to perinatal needs are consistently reflected in rites, rituals, taboos and symbolic structures that inscribe protective meanings that are recognized by the group to which the childbearing woman belongs (Liamputtong *et al.,* 2005).

In regards to religio-cultural restrictions, stipulated periods of rest and recuperation have been found to form part of the protective cultural rites and practices prescribed for parturient amongst First-generation Nigerian women both in Nigeria and in the diaspora (Phillips, 2005, Hundt *et al.*, 2000 and Jones, 2000). In rural or agricultural societies like Nigeria, this serves the purpose of protection for the new mother who would otherwise resume work in the farm

within a short period after giving birth. But the purpose of this practice amongst FGNW in the diaspora has yet to be explored. There appear to be an element of assumption by the subscribers to this view that seclusion equates protection and rest and is therefore synonymous with better health for the new mother and baby (Anugwom 2007, Okafor 2000). However, the lives of babies and mothers can never be guaranteed in childbirth regardless of the cultural measures taken, the kind of care employed and the kind of material resources available, as death is part of life (Van Hollen, 2003). In effect, seclusion and the projected benefits may be dependent on the nature and quality of relationship between the woman and members of her immediate family. Where tension exists in the family relationships, seclusion could turn restrictive and cause distress to the new mother (Mattey *et al.*, 2002). Equally, positive nurturing practices without tension could aid effective transition to motherhood (Wikberg and Eriksson, 2008). It will be useful to discover to what degree these relio-cultural beliefs are upheld by first-generation Nigerian women in London and how useful they find some of these practices in ensuring maternal and child health during their birth experiences in London.

It has become apparent that religion and spirituality hold a significant sway in the birth experiences of first-generation Nigerian women in their homeland and in the diaspora. Spirituality is used to describe a personal feeling of wholeness; sometimes related to the supernatural, but sometimes to a natural sense of connection with other people or with one's own inner core being, while religion relates to constellations of beliefs, practices, and institutions that have to do with the 'ultimate conditions' of existence (Sered, 2003). It has been suggested that all human beings have a spiritual dimension whether they recognise this or not (Wikberg and Eriksson, 2008). African women in general, and more specifically Nigerian women, are known to subscribe to religious and spiritual practices associated with pregnancy and birth (Kirkley, 2000). In Nigerian culture, those who claim to hold spiritual powers are

revered and in some other cultures those who deal with the supernatural are considered to hold unique skills, knowledge, talents, training, powers, responsibilities, or proclivities (Sered, 2003).

The interplay of religion and spirituality in childbirth has fascinated anthropologists and health care researchers for decades. Some uphold religion and spirituality as core components of holistic health which therefore should be catered for in healthcare provision (Callister 2010, Bartocci and Dien 2005, Eckersley 2007, Sered 2007, 1991, Tanyi 2002), while others debate the need to acknowledge it as an essential component of healthcare (Drapper and McSherry 2002). According to Wilding *et al*., (2006), spirituality is a highly individualistic phenomenon that can be experienced as a journey and represents the deepest form of connectedness. Eckersley (2007) affirms that religion is a form of meaning that surpasses personal circumstances, social situations and the material world and therefore sustains people through trouble and strife or mortal existence. According to Tanyi (2002), spirituality enables connection to self-chosen or religious beliefs, values and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being.

Continuing on the notion of spirituality and childbirth, Callister (2010) conducted a qualitative study aimed at generating themes regarding spirituality and religiosity amongst childbearing women espousing Christian, Jewish, and Islamic religious traditions. It is reported that the majority of women in their study regarded childbearing as a spiritual experience. Several women were specific in their articulation that childbirth was a time of powerful connection to their God. Callister (2010) therefore concluded her study by highlighting childbirth and motherhood as an ideal context in which to acknowledge the spiritual dimension of women's

lives. Furthermore, Ezeobele *et al.* (2010) in their phenomenological study examined a purposive sample of 19 Nigerian-born immigrant women's perception of depression in Houston Texas. Religion and spirituality was amongst the six themes explored in their study. Some of the women in this study considered mental illness as a curse or spirit possession. Their findings indicated that spirituality and religion were identified by all 19 women in the study as the main sources of treatment for depression. Prayers and fasting were also mentioned as helping to cure depression. These Nigerian-born immigrant women in the USA sought treatment from clergy rather than healthcare professionals, as they were not able to differentiate depression from other types of mental illnesses. Some earlier studies conducted in Nigeria support these findings. The reader is referred to Adewuya and Makanjuola (2008) and Adebowale and Ogunlesi (1999), where the respective researchers report that Nigerian respondents believed supernatural factors were the cause of depression. To what level the dimensions of belief, religion and spirituality of first-generation Nigerian women is acknowledged and understood by their maternity care providers in London is uncertain and could influence FGNW's perception of cultural congruency in *etic* / professional care practices of midwives.

According to McHugh (2003: 276), *many practitioners in the UK acknowledge birth as a psychophysiological drama that unfolds against the backdrop of technology, medicalisation and taboos*. McHugh asserts that practitioners in Britain have moved from being a society that was dominated by the Church to one that is dominated by medicine as a form of social control; warning that there is little recognition of the spirituality of birth. Furthermore, 'the clash between culture and medicine, means that rites and rituals of obstetric practice overrule cultural, religious and spiritual expression' hence alienating childbearing women and making them vulnerable. Walsh (2002) affirm McHugh's assertion of the lack of acknowledgement of

spirituality within childbirth in Britain. The later documents that 'institutional birth tends to endorse and re-enforce the biomedical model of birth to the exclusion of other models and within this model, clinical marks of birth dominate'. Health care providers have been admonished to be aware of the religious and spiritual activities of their patients, to appreciate the value of religious beliefs as a resource for healthy mental and social functioning; and to recognize when those beliefs are distorted, limiting, and contributing to pathology rather than alleviating pathology (Koenig, 2009).

In summary, in Nigerian culture – as in most African cultures – a woman's childbearing encounter is an experience that reflects the cultural beliefs and practices of her society (Okafor, 2000) and one she may still adhere to outside of her society. As previously stated, first-generation Nigerian women may select aspects of traditional birth practices that they consider relevant and valid during their birth experience in London, based on cultural expectations originating from their country of origin. To FGNW, the culture of care and different approaches to care can be the mitigating factor that compromise their childbirth beliefs and traditions. These (*emic* / folk) belief systems and cultural practices of first-generation Nigerian women in London require further exploration in regards to specific birth practices adhered by them and the reasons for such practices in relation to their expectations on (*etic* / professional) maternity care providers in London.

2.4.2 Culture, culture of care, migration and acculturation of first-generation Nigerian women

Culture has been described as '*an inter-subjective system of abstract symbols and attached meanings* (Petterson (2015:3). Culture is also portrayed as a set of implicit and explicit guidelines or a lens inherited by people as members of a particular society that teaches them how to view the world through their emotions, and how to act towards others, supernatural forces or gods, and the natural environment (Helman, 2007). The American Department of Health and Human Services (DHHS) Office of Minority Health (2000) defines 'culture' as integrated patterns of human behaviour that include language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups, and 'competence' as well as the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities. Culture also informs how people share these guidelines from one generation to another via art, language, rituals and symbols as well as the ways through which people legitimize and organise their society and the way they view their world (Helman, 2007). Helman (2007) also described culture as a learned pattern of behavioural response acquired over time that includes implicit versus explicit attitudes, arts, beliefs, customs, norms, taboos, values and ways of life accepted by a community of individuals. Earlier, Leininger (2002b: 83) described culture as *'patterned life ways, values beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared, and usually transmitted inter-generationally over time*'. Culture as shared by the majority of the group influences their individualized worldview, guides their decision-making, and facilitates self-worth and self-esteem (Giger *et al*, 2007). Culture therefore provides the basis for economic, social and political organisation of groups of people and may influence the expectations and perception of maternity care by first-generation Nigerian women in London.

A number of criticisms are due in regards to the inherent assumptions and presentations of culture by the aforementioned authors and researchers who appear to make the assumption that culture is static and unchanging. Conversely, culture is a 'fluid' concept, adapting and changing because complex societies are not homogenous but rather bi-cultural or multi-cultural at times, especially societies with migrant populations (Helman, 2007). Moreover, even within the same culture, the beliefs, experiences, practices and values of individuals within it may change with changing times and life encounters. Furthermore, there may exist diversity between cultural groups and between generations. Therefore, to view culture as homogenous and constant may induce unwarranted stereotype in expected care needs of BME women and particularly those of FGNW. First-generation Nigerian women living and accessing maternity care in London would have some culturally-orientated expectations of the maternity services. Likewise, healthcare providers may expect some degree of adaptation to the *etic* care approaches of midwives in order to fully benefit from the services offered. Maalouf (2000:35) asserts that *'the more an immigrant feels that their culture is respected, the more open* and accepting s / he (*sic) will be to the culture of the host country'*. Similarly, if the host culture respects and recognises the valuable contributions of the migrant and considers him / her as part of itself, only then does it have the right to reject aspects of the migrant's culture that might be incompatible with its own, the keyword being reciprocity (Maalouf, 2000).

Midwives need enhanced awareness of the levels of culture from which FGNW operate in order to provide high quality individualised and culturally congruent care that meets their maternity care needs. It is noteworthy that recent UK Department of Health reports established culture to be a factor that influences health-seeking behaviour among black Africans (MBRRACE-UK 2014, CMACE 2011). As a result, health care providers need to acquire cultural competence

and cultural congruence in order to understand and meet the differing health care needs of BME populations and to reduce any disparity in health outcomes. A reciprocal balance of understanding is necessary to enhance effective alliance between care providers and the BME populations in London. To avert disparity in care provision, midwives need to avoid, complaisance, condescension and hostility that has become apparent in recent reports (MBRRACE-UK 2014, CMACE 2011, CEMACH 2007 / 2004).

Helman (2007) referring to the American anthropologist Hall (1984), describes three *strata* of culture, which may influence views and values of care providers as well as that of clients. In the *tertiary stratum,* the explicit manifest culture is visible to the outsider such as national cuisines and festivities, traditional attire and rituals. These he describes as 'the public facade presented to the world' but to which are attached hidden assumptions, beliefs and rules that go deeper and constitutes that society's cultural grammar. Helman (2007) presents the *secondary strata* where the hidden rules are known by the members but not shared with outsiders to the culture. This may include rituals and taboos that influence behaviour that individuals within the culture may adhere to. These descriptions of culture are in line with first-generation Nigerian women's cultural background as this plays a pivotal role in many aspects of their childbirth experiences and practices at home and in the diaspora, including their care access, attitudes to care and care outcomes, attitudes to pain and pain-relief, behaviours, beliefs, diets, emotions, family dynamics, religion and spirituality as highlighted by existing evidence thus far reviewed. The current study examines the cultural practices of first-generation Nigerian women at all three levels but focuses more on the *secondary strata* and *primary strata* where some of the hidden rules about *emic* care practices may not be shared with midwives.

The *primary stratum* is described as the deepest level of culture where rules are known to all within that culture, obeyed by all but seldom stated. The latter two levels due to their implicit nature are deemed problematic for health healthcare practitioners from different cultural backgrounds. The researcher as both an insider and outsider in the current study has the advantage of inherent knowledge of some of the cultural practices of FGNW as would some of the first-generation Nigerian midwives who formed part of the focus group discussions. Therefore, there is need for reflexivity (self-examination) on the part of the researcher (within her multiple status) and first-generation Nigerian midwives (as healthcare professionals) to ensure that their personal biases do not hinder effective care delivery to first-generation Nigerian women (Bott, 2010).

Correspondingly, midwives' unfamiliarity with the level of culture from which first-generation Nigerian women are operating in regards to their beliefs, practices and religions may give rise to misunderstanding, stereotyping and insensitivity in the provision of maternity care. As such, Sookhoo (2009) submit that,

"*the challenge of caring for someone whose cultural beliefs and practices are not similar to one's own raises questions about the cultural competence of the healthcare professional particularly that of the midwife". The latter reiterates that misunderstanding of others, their cultural beliefs, values, and practices, often arise because the overt behavioural acts are judged at face value without any analysis of the underlying motives or intent"*

(Sookhoo 2009: 85 and 87).

Moreover, stereotyping reflects misguided or uninformed beliefs of people of different ethnic groups, about their traits, such as attitudes and behaviour, and stems from the erroneous belief that one's belief and culture is superior while the belief, culture and religious practices of others are inferior to one's own (Sookhoo, 2009). As Malouf (2000:37) writes, '*if I study someone else's language but she does not respect mine, to go on speaking her tongue ceases to be a token of amenity and becomes an act of servitude and submission*'. Moreover, Bhopa (2014:19) asserts that *culture and ethnicity are complex and fluid concepts*, suggesting that those who hold an inherent tendency to view their own culture as the standard against which others are judged are portraying ethnocentricity.

According to Weller *et al* (2001), such ethnocentric biases formed on cultural and religious discrimination are prevalent throughout the health services in the UK. Therefore, cultural relativism that entails seeing other cultures as different and unique, not as 'wrong' or uncivilised, is advocated in place of cultural stereotyping as the former strives to uphold the uniqueness of cultures and to protect cultural practices from untoward criticisms and judgements. If the midwife strives to be culturally competent and sensitive, the possibilities of understanding intercultural caring are greater and the woman is more likely to experience effective care that will positively influence her health and wellbeing (Wikberg and Eriksson, 2008).

According to Wikberg and Eriksson (2008) and Leininger (2002), culture provides the overall pattern for caring and a patient's view about their culture should be seen as more relevant than their carer's assumptions about it. The researcher would argue that both views are important and worth due regard in the planning and implementation of maternity care in order to give

care that is culturally sensitive and relevant. Seemingly, a difference in understanding of belief and culture between the expectant woman and those providing maternity care could result in tension in the therapeutic relationships and this should be avoided at all costs (Wikberg and Eriksson, 2008). To gain a balanced perspective, the researcher in the current study took a three-pronged approach by seeking views about cultural practices of first-generation Nigerian women from both first- generation Nigerian women in London and the midwives from Nigerian and non-Nigerian backgrounds providing maternity care for this population of women in London. Awareness of how beliefs, culture, tradition and acculturation may affect individuals is a positive step towards culturally competent and congruent care. Cultural knowledge is therefore the most important construct of cultural competence for maternity care providers. The current study aims to enhance midwives cultural knowledge of first-generation Nigerian women's culture of birth, their steps towards acculturation and the issues that may arise in their transition to motherhood when experiencing birth in London.

To be culturally competent, maternity care providers need to acknowledge women's culture as central to their identity and strive to explore the views of women and any cultural restrictions that influence their pregnancy and birth choices. Ostensibly, McFarland and Eipperle (2008), argue that cultural competence is a process one goes through in order to continuously develop and refine one's capacity to provide effective healthcare, taking into consideration people's cultural beliefs, behaviours and needs. They later cogitate that in order to be culturally competent practitioners, need to develop both culture-specific and culture-generic knowledge and competences. Furthermore, culture-specific competence refers to the knowledge and skills that relate to a particular ethnic group that would enable an understanding of the values and cultural prescriptions operating within that particular culture (McFarland and Eipperle, 2008) that could enhance meeting their care needs. The goal is to enable healthcare providers to

acknowledge and provide care that takes patients' cultural needs into consideration (Gerrish and Papadopoulos, 1999) to ensure congruency. Hereafter Papadopoulos *et al.* (2008) devised a four-stage Model for Developing Cultural Competence in care as follows**:**

1. Cultural awareness: which begins with an examination of our personal value-base and beliefs as necessary planks of a learning platform. Therefore, the midwife becomes more aware that her / his cultural background is a major factor in shaping their values and beliefs, which in turn influences their health beliefs and practices as well as professional practice.
2. Cultural knowledge: which is gained through meaningful contact with people from different ethnic groups and can enhance knowledge around their health beliefs and behaviours as well as raise understanding around the problems they face. Cultural knowledge of first-generation Nigerian women is gained by midwives through participation in maternity care for this population.
3. Achieving cultural sensitivity: which entails appropriate professional care approaches geared towards meeting the trans-cultural needs of FGNW through acceptance, empathy, respect, trust and inter-personal skills. It also entails consideration of the socio-political factors that interplay with maternity care delivery: such as ethno-history of both the midwife and FGNW, the context of care and differences in perspectives between carer and cared for. Unless first-generation Nigerian women are considered as true partners in maternity care, culturally congruent care is not being achieved. Equal partnerships involve trust, acceptance and respect as well as facilitation and negotiation between the Nigerian cohort and their maternity care providers.
4. Cultural competence: which requires the synthesis and application of previously gained awareness, knowledge and sensitivity. Competency in maternity care is also attainable through individualised care, clinical skills, addressing biases and stereotypes and

objectively exploring discrepancies between *emic* and *etic* care approaches. A most important component of this stage of development is the ability to recognise and challenge prejudices whilst promoting the development of skills needed to bring about effective change that serves to enhance congruent care for the client (FGNW). This is then followed with *care actions and decision modes* utilised to *re-organise* care (Leininger 2002, 2004, 2006) through accommodating positive *emic* / *etic* care approaches, preserving health-enhancing care approaches and re-patterning unhelpful or harmful practices to ensure maternity care that is competently delivered by midwives and congruent to meet the cultural and holistic needs of FGNW in London.

These stages of developing cultural competence are necessary for contemporary health care provision as partial knowledge or inadequate understanding can lead to assumptions or adherence to stereotypes which categorise cultural groups without attention to the diversity within them. Maternity care providers neglecting these stages of acquiring cultural competence and attempting to deliver universal maternity care without due regards to the cultural differences (in regards to specific *emic* care practices), will invariably place first-generation Nigerian women in a status of inferiority that cannot be exempt from humiliation (Malouf, 2000) in their maternity care experience in London and may create conflict in the care-giver understanding of the needs of this population. Differences between the cultures of health care services (*etic* / professional care) and service users (*emic* / folk care) have been recognised as a major issue in maternity service delivery (MBRRACE-UK 2014, CMACE 2011, Bharj and Selway 2008).

In seeking to explore effective care interventions available globally for addressing culturally appropriate care, Coast *et al.* (2014) study was located. This study took a systematic mapping

of ten databases from 1990 to 2013 utilising 96 publications in the final map. Their results show that a diverse range of interventions has been implemented in 35 countries to address cultural factors that affect the use of skilled maternity care. The five emergent approaches included: service delivery models; service provider interventions; health education interventions; participatory approaches and mental health interventions. In the first theme, types of culturally-appropriate models of service delivery designed for indigenous communities, ethnic groups and refugees were geared towards directing interventions towards identified population needs in order to accommodate cultural norms. Service provider interventions examined a range of interventions characterised by their focus on people who share cultural characteristics with a target service user group who were employed to bridge the cultural gap between this group and maternity services. In the third theme, a wide range of strategies employed to design culturally-appropriate health education activities included: local trainers who were fluent in the local language and who shared cultural characteristics with the relevant population, and were engaged in specific campaigns carried out in churches targeting relevant populations. This educational strategy proved useful amongst first-generation Nigerian women that formed part of stage one of the current study. The fourth strategy involved credible community leaders, and through identification of culturally-sensitive and locally-acceptable approaches to address transport and referrals and the final category were interventions focusing on perinatal depression, all aiming to overcome treatment barriers by specific cultural groups. Coast *et al.* (2014) concluded their mapping by recommending that these strategies require inter-disciplinary approach and active dialogue with communities in order to understand their cultural systems, health beliefs, health practices and preferences. This study much as it uncovered useful strategies for providing culturally congruent care, the context of care is different as it was non-specific to first-generation Nigerian in the diaspora. However, aspects of service delivery models; service provider interventions; health education

interventions; may prove useful to midwives providing care to first-generation Nigerian women in London. By engaging with first-Nigerian women and midwives in the current study, it is hoped that a broader understanding of their health beliefs and practices could be gained and contrasted with the maternity care approaches of the midwives to develop effective strategies to ensure maternity care that is culturally competent and congruent in meeting maternity care needs of first-generation Nigerian women in London.

In keeping with the notion of culture and care, Posmontier and Horowitz (2007) describe two distinct emerging cultural classifications of care in the West (*techno-centric*) and non-western (*ethno-kinship*) populations. According to their report, *techno-centric* refers to cultures where technology dominates the monitoring of the wellbeing of the new mother and infant in order to avert potential morbidities associated with childbirth. In this type of culture, technological rituals consist of obtaining vital signs, monitoring bodily fluids, bathing and perineal care, separation of mother and baby and early discharge from the hospital to a social system that does not have any formalized norms or traditions to support the new mother. Simply put, technology takes precedence over social support in *techno-centric* cultures of maternity care. Posmontier and Horowitz (2007) claim that *techno-centric* culture occurs primarily in Australia, Canada, UK, US, and Western Europe; stating that new mothers are not fully celebrated in *techno-centric* cultures with the consequence that the women's *rite of passage* to motherhood that emphasizes role change and status are not fully acknowledged (Posmontier and Horowitz 2007). This lack of full acknowledgement of her new status leads to role conflict and decreases in self-esteem among new mothers; and hence exposes them to psychological distress (Posmontier and Horowitz, 2007).

Ethno-kinship culture of childbirth, on the other hand, is referred to as one in which the performance of social support rituals by family networks are the primary focus of the immediate and later postpartum periods (Posmontier and Horowitz, 2007). These social support networks share racial, national tribal, religious, linguistic, and / or cultural practices. Advanced technology may be used to promote safe and optimum postpartum outcomes but family support network retains primary importance. *Ethno-kinship* culture is said to have a recognized social structure in the postpartum period and exist in Africa, Amish, Arabia, China, Hmong, Japan and Mexican cultures (Posmontier and Horowitz, 2007). However, the latter assert that, regardless of geographical location, *ethno-kinship* culture may exist within Western culture and a *techno-centric* culture likewise may exist within a non-Western culture. Moreover, some cultures such as the Japanese contain a mix of both, where technological monitoring of pregnancy and birth is rated on the same hierarchy as social support for the new mother.

Nigerian women and indeed women from other non-Western cultures who migrate from an *ethno-kinship* to *techno-centric* culture of maternity care in the West may find themselves disillusioned by the contrast. Recent study by Gardner *et al.* (2013) exploring postnatal depression in African women in the UK affirms the disillusionment and distress of Ghanaian and Nigerian women in the contrast of care between their home countries and that received in Britain. The participants felt that their experiences in the UK were different to the experience of mothers in Africa and attributed their postnatal distress in the UK to a lack of support, isolation and not having their African family living nearby to assist with postnatal care. Gardner *et al* (2013) findings would appear to indicate that disillusionment with ethno-centric maternity care provision would apply to migrants from other African countries and is not specific to Nigerian or Ghanaian women. Nonetheless, one would wonder what part geography and separation - from home territory, family, culture, etcetera, all play in this narrative; as the expectations of what would happen "back

home" are not realised when one is separated, in the diaspora, then the potential grieving for all the losses caused by geographical dislocation could influence outcomes in their births in London.

Ostensibly, Okafor's (2000) description of traditional Igbo practices surrounding pregnancy and the postpartum period is in line with the *ethno-kinship* cultures already discussed. As narrated by Okafor, elders guide pregnancy in Igbo culture, the new infant is seen as the future for the family lineage, birth is celebrated as a victory, and the new baby and mother are given special attention for a period of about one to three months after birth. As alluded to earlier, such traditional culture is claimed to accord new mothers emotional support and protection against psychological stress associated with childbirth. Nigerian Igbo women who originate from an *ethno-kinship* culture in Nigeria and experience childbirth in London (presumed *techno-centric* culture) may find themselves at a crossroad between the two cultures of maternity care provision and may therefore be bewildered by these divergent cultures of care.

First-generation Nigerian women in London exist within two geographical locations or split worlds as migrants. Bhopal (2014) also highlights the precarious dichotomy of the split world of immigrants, where on the one hand, they may be perceived as a drain on the national resources for their failures and be seen as being at the expense of the local population in their success. According to Bhopal (2014:20), *migration is not a harmless process*. Therefore, there is need to reflect on the inherent dangers it may pose for first-generation Nigerian women in their care experiences in London.

Acculturation as part of the processes of migration has been defined as the dual process of cultural and psychological change that takes place because of contact between two or more

cultural groups and their individual members (Berry, 2005). It involves various forms of mutual accommodation leading to some longer-term psychological and socio-cultural adaptations between both groups. There is also psychological acculturation that refers to a change in an individual who is participant in a culture contact, being influenced both directly by the external culture, and by their internal culture (Berry 2005, Ola-Edo and Dominicus 2014). Various intrinsic factors influence these and extrinsic factors such as age, employment, length of stay, level of education and socialisation, which may positively or negatively influence the acculturation processes as, was apparent in Dow's (2011) study of African immigrant populations in the United States. Dow's study highlighted the stressors immigrants and refugees face upon arrival to their new domicile, such as: acculturation issues, attitudes of the receiving community, difficult family dynamics, discrimination in the labour market, financial and status change, lacking knowledge of the host language, unemployment, scattering and splitting of households, racism and stereotyping. Moreover, immigrants may hold unrealistic expectations of the opportunities available to them and their families in regard to access to health services, employment, finances and housing. However, when confronted with the difficult process of acculturation and adaptation, they may suffer grave disappointments, placing them at risk for developing a number of mental health problems that compound the birth outcomes as Dow (2011) reported.

Immigration does not imply an emotional disconnection from the culture of origin, as links with the culture of origin are assumed to occur exclusively within the physical environment of the immigrants' new host society (Sigad and Eisikovits, 2009). This means that first-generation Nigerian women living in London may form links resembling that formed at home in Nigeria (little Nigerian village in London). Various methods used by immigrants to sustain a connection with their cultures of origin have continued to evolve and may include creation of

large families by excessive reproduction to fulfil some of the roles extended family members fulfilled in their home country. Castells (2010:63) asserts that "*ethnicity does not provide the basis for communal havens in the network society because it is based on primary bonds that lose significance when cut from their historical context"*. Therefore, first-generation Nigerian women in London must navigate and re-negotiate paradoxical family, politico-economic and cultural landscapes wherein they face powerful to have large families to retain links with their original culture to limit their fertility to fit with the economy of their current domicile (Smith 2004). *The ideal number of children amongst the Igbos of Southeast Nigeria living in Nigeria has been reported as 4.5 births per woman* (National Population Commission 2000:36-37). In London, some of the Igbos continues to value large numbers of children even when their economic situation may not be viable. This paradox arises because the Igbos in Nigeria gains access to the resources of the family by inheritance through lineage. Customarily, the male children are expected to inherit extended family assets through a patterned system set up in their parent's original culture in Nigeria. To what degree these measures influence their acculturation to motherhood in London is yet unclear. The full exploration of this notion is outside the focus of the current study.

According to Bhugra and Ayorinde (2004), individuals exposed to another culture may adjust to and reflect the new culture in their values and practices. This is also described by Berry (2005) as cultural *assimilation*; which occurs when the individual does not wish to maintain their cultural identity and seeks daily interaction with their host culture. *Separation* occurs when the individual is in rejection of the new culture and retreats into his or her own culture; or wavers between the two cultures. They may likewise suffer *culture shock* when they encounter feelings of violation of their expectations of the new culture and this can cause them to value their own culture negatively, resulting in culture conflict or culture shock and

marginalization, where they might find themselves not belonging to the majority or the minority cultures. Migration in this way may cause the individual to reconsider, and even change their notions of self, which in effect might cause additional stress. Acculturative stress arises when the events originating from intercultural contact surpass the migrant's coping ability. Positive adaptation results from tenacity as a personal trait of bouncing back from, overcoming, surviving, and / or successfully adapting to a variety of stresses originating from intercultural contact (Pan *et al*., 2007). Bhugra and Ayorinde (2004) report that amongst the first-generation Nigerian population they studied, if personal achievements do not match aspirations during the acculturation process, individuals may be open to low mood, as well as experience a sense of alienation and / or a sense of failure, which can compound morbidity. Seemingly, integration positively enhances social adjustment during migration when the migrant is interested in maintaining equilibrium between their internal and external cultures. Berry (2005) assert that positive acculturation might be enhanced by openness and inclusiveness of migrants by the host society. Therefore, openness between midwives and the Nigerian population can enhance positive acculturation and transition to motherhood.

Inadvertently, maternity healthcare provision in London may not meet the traditional needs of first-generation Nigerian women, especially where the emphasis is on collective values and extended community support as opposed to the individualistic approaches of midwifery care in London. According to Barkow *et al.* (1992), in health care seeking behaviour, the Nigerian psychology differs somewhat from the British psychology in the sense that the Nigerian psychology in relation to health seeking behaviour places emphasis on the value of the collective interest of extended family network of care and support and corporate decision-making about health and wellbeing rather than on promotion of individual or woman-centred care (Barkow *et a.*, 1992). Therefore, while accessing maternity care in London, it may proof

difficult to maintain the traditional practices within the constraints imposed by the biomedical and technologically oriented maternity care environment in London based on individualism. Inadvertently, without having their mothers or other relatives around to help in caring and decision-making, the first-generation Nigerian woman may mourn the loss of collective interest and the inherent social support that comes from that. Conversely, even when support is available for the new mother in the healthcare system in London, ambivalence, dilemma and stresses from within the network of support can mitigate against her access to and the value of available supportive structure of maternity care in London (Besser and Priel, 2003).

In summary, first-generation Nigerian women giving birth outside their country of origin might have to contend with differing cultural approaches to care and may have to forego some of the *ethno-kinship* network of support available within their countries of origin and may need to embrace the new form of biomedical care geared towards maintaining their individualism via woman-centred care. They may have to embrace *techno-centric* or a mixture of *techno-centric* and *ethno-kinship* cultures of care in their new environment in conjunction with or in replacement of *ethno-kinship* system of care. How this interplays with their health and wellbeing would be dependent on the efficacy of the *emic* and *etic* support networks available to them and how well they utilise these to their benefit. Adopting some of the strategies highlighted by Coast *et al.* (2014) Papadopoulos *et al.* (2008) and Leininger (2002) explored within this theme might prove useful in attempting to meet the perinatal cultural care needs of first-generation Nigerian women accessing maternity, seeing that some of these strategies served well in African and Western contexts and may serve this cohort well in their new domicile. However, these studies were mainly on Nigerian women living in elsewhere in the diaspora and experiencing childbirth outside London. Thus giving further credence to the current study aimed at exploring the benefits or otherwise of the bespoke *ethno-kinship* support

network in protecting health and ensuring effective transition when birth is experienced in London.

2.4.3 Support network and first-generation Nigerian women's transition to motherhood in London

This theme of support is central to the experience of first-generation Nigerian women in the diaspora as numerous studies bear relevance to this theme. Different cultures adopt different methods of caring and supporting women during pregnancy and childbirth. Evidence from research studies suggest that the type of social support as well as its degree of significance varies according to women's cultural backgrounds (Bina, 2008). For first-generation Nigerian women in London the presence or lack of support network can greatly influence their care experiences as well as their transition to motherhood as, an extended family-oriented community.

Care and support is recommended for enhancing wellbeing of women in childbirth and to prevent infant and maternal morbidity resulting from psychological distress (CMACE 2011, CEMACH 2007 and 2004). Much earlier, Stern and Kruckman in their cross-cultural study in 1983 went as far as to suggest that new mothers in non-western cultures display fewer symptoms of postpartum depression probably due to the nature of support from relatives in their homeland that serve to protect them against postnatal depression. However, there have been recent studies refuting this claim. For example, Segre *et al.* (2006) examined the extent to which race / ethnicity is a risk factor for postpartum depression. Studying 26,877 postpartum women, they found that African-American women still emerged with significantly increased

risk for postpartum depression with a rate of 15.7% depressed in their study. Varma (2008) later reported a 10% rate of depression respectively in Nigerian women living in Nigeria and those living in London; highlighting the social circumstances (financial strain, racial inequality, isolation) of the women in London as potential factors for depression. To what degree these outcomes could be improved by the presence of adequate financial, social and equitable politico-social circumstance in London warrant further examination outside the remits of current study.

A cross-sectional study by Morhason-Bello (2009) at the University College Hospital, Ibadan, Nigeria sought the attitude and preferences of respondents about social support during childbirth. They found 75% of respondents' desired companionship in labour. Approximately 86% preferred their husband as companion while 7% and 5% respectively wanted their mother and siblings as support person. The authors highlighted the need for Nigerian women to be granted the benefit of social support during childbirth. This study has implications for first generation Nigerian women who for reasons of immigration and visa problems in the UK may not have the benefit of family support during childbirth in London. The current study is therefore timely in seeking to explore what support systems exist for first generation Nigerian women in as they birth in London and to what degree the available professional support meet their need for support.

Correspondingly, Elsenbruch *et al.* (2007) studied the effect of social support during pregnancy on maternal depressive symptoms, quality of life and pregnancy outcomes in Berlin, Germany, and found that pregnant women with low support reported increased depressive symptoms, and reduced quality of life. The researchers concluded that lack of social support constituted an

important risk factor for maternal well-being during pregnancy and had adverse effects on pregnancy outcomes, especially in regards to pregnancy-related health behaviours and life style habits, such as dietary habits and smoking. This finding in some way affirms Segre *et al.* (2006) findings amongst the African-American women they studied. In their study exploring the role of social support in enhancing maternal mental health, a population of 26,877 new mothers comprising of African-American, Hispanic and White Americans took part. They found that African-American women were significantly more likely to report depressed mood compared to White women. This negative outcome was attributed to lack of social support for African-American women in this sample. The findings of this study affirm further the need to explore the support network available to first-generation Nigerian women in London and the effectiveness of such support systems in meeting their *emic* care needs and enhancing their birth outcomes.

Amongst Nigerians, the postpartum period is celebrated as a period of triumph and high accomplishment for the woman (Anugwom 2007), hence the need for family support as part of the celebration of her victory over morbidity and mortality associated with pregnancy and birth. This is one period in the entire pregnancy cycle when the woman is pampered and given much attention. The *Omugwo* (specified rest period of about a month to three months) of the Igbo's of Eastern Nigeria is symbolic and similar to the Chinese ritual of 'doing the month' or "*zuo yuezi*" (Raven *et al.*, 2007:1) where women are relieved of most chores for the specified period in order to recuperate following childbirth. Similar practices exist in Greece and India (Leung, 2011). During this period, women are required to follow certain restrictive prescriptions and proscriptions, such as ritual baths, remaining indoors and following a strict diet. To enforce rest, elder female family members, usually the woman's mother or mother-in-law assume most of the responsibilities for baby care and housework. This practice may serve to protect women

from the risk of postnatal depression, especially if the support offered meets the woman's actual needs (Anugwom, 2007). The findings from these studies would appear to affirm the view that first-generation Nigerian women fare better psychologically in the presence of an effective support network. The lack of the desired social network of support in their perinatal experience in London may implicate their health and wellbeing resulting in poor outcomes. A briefing paper by Bharj and Salway (2008) briefly discussed earlier sought to summarise the evidence available on the maternity experiences of women from BME communities in the UK, drawing on both qualitative and quantitative research, highlighted significant ethnic inequalities in maternity outcomes persist in the UK, with some minority ethnic groups experiencing particular disadvantage such as barriers that undermine timely access to high quality care for many black and minority ethnic women living in the UK. The latter citing existing evidence assert that despite the publication of numerous policies and guidance documents, the UK government continues to fail to meet the maternity needs of its diverse patient populations. This failure reflects a number of factors including: (a) the pattern of service provision and delivery has not kept pace with changing population profiles; (b) maternity provision is, in the main, inflexible and based on the assumption of homogeneity; (c) maternity service providers have not been adequately prepared in terms of attitudes and generic skills, as well as cultural knowledge, to sensitively meet the needs of ethnically diverse populations; (d) innovative initiatives have tended to be small-scale and short-term and their learning has often not been mainstreamed; (e) the necessary data to monitor and address ethnic inequalities in maternity service receipt and outcomes have not been collected and acted on; (f) addressing the needs of diverse communities has not been consistently identified as a priority so that responding to other directives has impeded progress and change. Unless more is done to bridge the gap between policy and practice, women from BME communities will continue to have poorer maternity experiences and outcomes than the white majority. Furthermore, it appears that

maternity care providers fail to implement 'good practice' policy document produced by Commission for Health, Audit and Inspection (2008) which offers a checklist for commissioners and providers of maternity services, to assist in improving maternity services.

As a result, first-generation Nigerian women's transition to motherhood in London may be accompanied by major emotional upheaval and alterations in thinking and behaviour as the women adjust to the inevitable changes, challenges, demands and disruptions that the birth experience brings in a foreign environment. As with all transitions, there will be gains and balances that may make the new mother feel like she is on an 'emotional roller coaster' (Raynor, 2006) with transitory social changes demanding her adaptation. Where there is imbalance in this adjustment, detriments to health and wellbeing may occur leading to morbidity. Ezeobele *et al.* (2010) suggest that migrant Nigerian women may experience psychopathology in their new environment due to loss of traditional support systems and loss of familiar environment. Moreover, the woes of immigration such as ethnic prejudice, unemployment, poverty, poor understanding / poor access to social services, social isolation, and lack of social interpersonal skills, may compound the women's predicament in their new environment whilst experiencing birth in the UK (CMACE, 2011).

The transition to motherhood has often been described using '*rite of passage'* (ROP) (Martin-McDonald *et al.*, 2002). Maushart (1997) and Martin-McDonald *et al.* (2002) used ROP model to depict how women adapt to the new social role of motherhood. There are three phases to this model: *separation*, *transition* or *liminal* phase and *incorporation* or *aggregation* phase. The first phase, s*eparation* is said to occur when a new mother moves away from a previous social position or status in preparation for motherhood. In the second phase described as

transition or liminal phase, the new mother makes changes to accommodate her prospective role as mother. She is somewhat in limbo between her previous status and her new social position or status. This phase is said to be characterized by ambiguity with none of the social attributes from the previous or future social status (Harrison and Khan, 2004). The third phase termed *incorporation* or *aggregation* is when the new mother reaches the social position or status by challenging previous assumptions about herself and her world and replacing these with new altered images and understandings of how she is changing in her daily life (Oakley, 1980). Once this is achieved, her journey through the *rite of passage* is successfully completed and she is better placed to accomplish her new role and relate to her social peers (Barr, 2008). This transition has been described as the most important marker of the entrance into adulthood (Arnett, 2000) and signals that the woman is entering a new phase of the family cycle with inherent major alterations in role requirements. Etowa (2012:31) reports that all women in their study of '*the meaning of childbirth' amongst African-Canadian women indicated that becoming a mother brings a new sense of responsibility*. The sample of Etowa's study included Nigerian women and hence is relevant to the current study.

Various other studies, such as Nurmi and Almesmaki (2001), Barr (2008), Besser and Priel (2003), Ward and Purdue (2005), Feldman *et al* (2004), Sereika and Olshansky (2005) were mainly conducted on non-BME populations (Caucasians). They explored the factors associated with successful transition to parenthood and found that individuals continuously adjust their personal goals to conform to the new demands and challenges of the particular life span in the transition they are facing. The researchers further assert that this goal adjustment has important consequences for individual well-being or lack thereof, as the transition is fraught with various challenges and demands. These studies have limited African participation and therefore have limited scope for generalization to Nigerian women. Nonetheless, inferences could be drawn

from these studies to gauge the link between birth experiences and the development of depression during the transitory phase of childbirth experiences of first-generation Nigerian women. The challenges of life in the Diaspora may bring certain stresses at different phases of this transition for first generation Nigerian women experiencing childbirth in a foreign environment especially without their usual network of support as highlighted by Gardner *et al.,* 2013.

Comparatively, Hogan *et al*'s (2012) systematic review of articles exploring link between social support and healthcare outcomes report that social support vary in definition and conceptualisation. They examined several sub-themes in relation to: support interventions, lack of support versus negative support, matching intervention to need, and determined that it is still unclear whether support interventions are consistently effective modes of treatment for any sort of problem. Moreover, they uncovered that examining why patients lack support may provide important clues as to how their support needs are best met. Regrettably, such a large cohort study failed to uncover actual outcome-related benefits of social support. As Hogan's study was non-specific to first-generation Nigerian women and took a different approach, the in-depth discussion approach within current study may highlight tangible benefits of the usefulness of support to this cohort.

In conclusion, cultures change through the agency of individuals (Karner, 2009), yet ethnic boundaries deemed important by first generation Nigerian women transition to motherhood buffered by network of support may persist and hamper their effective transition to motherhood in London especially in terms of lack of desired adequate social support. As there appear to be lack of specific evidence regarding the nature of support and the influence in the birth

experiences and / or outcomes of first generation Nigerian women in London, this would be explored in the current study to explore to what degree social support influence their transition to motherhood in their birth experiences in London.

2.4.4 Summary of literature review

Knowledge gained from this literature review highlights interesting features of the nature of cultural practices adhered to by Nigerian women in their home country and in the diaspora and the potential influence of these in their birth experiences and highlights potential constrains on their healthcare seeking behaviour in terms of access to maternity care outside their home country. Evidently, a gap in knowledge exist as to what cultural practices they uphold in their birth experiences in London, the nature and influence of beliefs, acculturation and transition to motherhood in London and influence of these on their birth experiences in London. The core findings of this literature review are summarised and would be contrasted and triangulated against the findings of the current study in attempting to understand what first generation Nigerian women in London consider important in relation to their culture in their birth experiences in London. The core highlights of the literature review are as follows:

- Nigerian women's birth experiences both in their home country and in the diaspora are embedded in cultural practices that are believed to optimise their health and wellbeing throughout the birth continuum.

- Beliefs, spirituality and rituals play an important part in Nigerian women's birth experiences both in Nigeria and in the Diaspora.

- Birth and motherhood are cherished, celebrated and supported within an *ethno-kinship* network of support in Nigeria that is believed to enhance maternal and fetal wellbeing.

- Acculturation and migration issues might militate against care access and positive transition to motherhood in their birth experiences in London.

Nonetheless, much as a wealth of information has been uncovered about the culture of birth, beliefs and transition to motherhood of Nigerian women living in Nigeria and in the diaspora, there is a gap in knowledge on the available evidence on childbirth practices, beliefs, acculturation and transition to motherhood of first-generation Nigerian women living in London; and the influence of these on their birth outcomes in London. As most of the available research is mostly from countries other than the UK, and Nigerian populations studied were either experiencing birth in their home country or living in countries other than the UK, this further bolster need for the current study. The purpose of the current study therefore is to bridge this gap in knowledge by researching the *emic* childbirth practices of first-generation Nigerian women in regards to their birth practices, beliefs, expectations and transition to motherhood and gauging *etic* maternity healthcare understanding and provision for these needs in their domicile country.

2.4.5 Chapter two conclusion

As much as it is impractical to learn about all the different cultures accessing maternity care in London, some specific knowledge about aspects of first-generation Nigerian women's belief systems, practices around pregnancy and childbirth, their expectations and influence of these on their transition to motherhood in London is beneficial in enriching the knowledge and understanding of maternity care providers in London.

Improving maternity care provision to first-generation Nigerian women in London must include understanding and deconstructing concepts of acculturation, beliefs, culture, expectation, migration, and religio-spiritual practices that influence their perinatal maternity care in London. Such enhanced understanding is vital to ensure cultural competent care that eliminates stereotyped care and enhances culturally congruent care provision. Findings from the current study will advance knowledge on first-generation Nigerian women's childbirth practices, their expectations of maternity healthcare in London, their carers' understanding of their perinatal care needs and the influence of their ecology, socio-cultural and religio-spiritual status on their birth experiences in London. These will be explored through triangulation of evidence from existing literature, with findings from all angles of current study (focus group discussions and longitudinal prospective) adapting Cultural Competence and Culture Care Theory models to formulate a framework to inform both *emic* and *etic* care practices to bolster culturally competent and congruent care that meets maternity care needs of this population.

In the subsequent chapter, the methodology, theoretical framework and epistemological perspectives of this study are critically discussed. The philosophy and methodology of Cultural Competence and Culture Care Theory will be expounded upon in relation to how it informs the current study.

Chapter Three: Methodology

In this chapter, the methodology, theoretical framework and epistemological perspectives of this study are critically discussed. The philosophy and methodology of Leininger's (2002) Culture Care Theory is considered alongside Papadopoulos *et al*'s (2008) four-stage model for Cultural Competence in relation to how they inform current study.

3.1. Introduction to methodology

Methodology is the philosophical framework adopted by the researcher to clarify the particulars of their research approach or the terrain where actions and philosophy meet (Sprague, 2005), whereas method is the research technique and the procedures for carrying out the research (Caelli, 2001). The elucidation of underlying theoretical (epistemological / ontological) perspectives is fundamental for the conduct of good qualitative research.

The study entails an exploratory, contextual and qualitative methodology. Bowling (2009:141) asserts that, qualitative "*techniques are essential for exploring new topics and obtaining insightful and rich data on complex issues*". Maggs-Rapport (2001) assents that the approach of qualitative research is to explore human behaviour and to search for understanding through people's actions. This entails exploring four levels of understanding, which has been outlined by Porter (1996) as encompassing the following:

- Methodology: examining how understanding of the nature of reality might be gained.
- Methods: exploring how evidence may be collected about reality within research.
- Epistemology: considering what counts as knowledge of the real world in research and

- Ontology: is concerned with the subject matter of the research in terms of what reality means in research.

These research approaches form the foundation of this and the next chapter.

3.2 Research theory and current study

According to Johnson and Onwuegbuzie (2004), theory serves two goals: firstly, theory enables the researcher to make sense of current knowledge (goal function of theory). Furthermore, theory guides the researcher through predictions (tool function of theory). Both angles of theorizing have been embraced to present existing knowledge on Nigerian women's birth practices within and outside the UK through the literature review, through focus group discussions which is to be employed to gain their perspective on retrospective experiences of birth in Britain and semi-structured interviews used to evaluate their prospectively care practices through a birth continuum while domiciled in London. It is anticipated that the integration (triangulation) of what is known (existing evidence) and what is discovered (through focus group discussions and phased in-depth interviews) in this study will inform and enhance understanding of FGNW's birth practices and the significance they attach to these practices. This approach is affirmed by French and Kiger (2005) for providing a complete picture of the phenomenon explored in a qualitative study.

3.3 Theoretical framework and Epistemological perspective

Theoretical framework is a collection of interrelated concepts that guides research and informs the phenomenon investigated. Theoretical framework is said to be the structure that can hold or support a theory of a research study as it introduces and describes the theory that explains why the research problem under study exists. When the professional is operating from an *etic* care perspectives that the client could not comprehend or relate, or the client is operating from *emic* care perspectives alien to the care giver, this can positively or negatively impact client welfare and care and has the potential to tint or thwart the effort of the professional in delivering efficient care, and can lead to discord. Discord between delivery approaches and care-seeking behaviours care can have negative impact both to the care giver and care receiver. Therefore, the need for culturally competent and culturally congruent care that meets the care needs of FGNW during childbirth in London is the driving force that prompted the search for a care model(s) that can enable and inform FGNW and midwives to achieve maternity care that is both culturally competent and congruent. It has previously been established within the earlier chapters of this thesis that a mismatch exists between the *emic* care practices of FGNW in London and the *etic* care approaches of midwives. Chokwe and Wright (2012) assert that cultural sensitivity and awareness is required in order to meet the needs of others through midwifery training and practice. For this reason, there is need for a midwifery model to enhance culturally sensitive care of midwives. To bridge the gap in care approaches, a care model useful to FGNW and midwives is warranted.

Therefore, the interrelated theories guiding this study are those of Helman (2007) which explores three different cultural *strata* (layers) of culture expression, Leininger (2002) Culture Care Theory and Papadopoulos *et al* (2008) Cultural Competent Care model. Leininger's

(2002) theory will guide the exploration of the influence of culture on *emic* care practices first-generation Nigerian women around pregnancy and childbirth both in their home country and in London. Papadopoulos *et al.* (2008) Cultural Competent Care model will guide the exploration of the midwives cultural awareness, cultural knowledge, cultural competence and sensitivity in meeting the cultural needs of FGNW in their care. In this way, both model will be useful in uncovering new knowledge on the influence of these on achieving maternity care that is culturally congruent to meet the maternity care expectations and needs of FGNW as well as unveiling midwives level of cultural competence in meeting the expectations and needs of this population. This is in line with Polit and Beck's (2010) assertion that, a theoretical framework is the theory upon which the study is based and provides a paradigm / model of what the researcher sees as the variables needing exploration within the study. According to Marshall and Rossman (1999:35), *theoretical perspectives discuss 'how the study fits into theoretical traditions in the social sciences or applied fields in ways that will be new, insightful or creative'* and offers suppositions that inform the phenomenon under study (Jones *et al.*, 2006).

Epistemology on the other hand is a way of knowing how we know or ways of thinking about issues that inform the study. They are ways of understanding the world from certain perspectives that then suit various methodologies and methods as the most effective ways to explore what is known. Epistemological perspective therefore influences how the researcher will approach and design the study. As qualitative research aim to enhance understanding of individual *emic* perspective (Bowling 2009: 380), the qualitative paradigm taken in this study will enable the researcher to focus on the meaning FGNW attach to the social world of birth in the diaspora (London) while adhering to culturally-informed or learned emic care practices and

the midwives understanding of this social world of FGNW in comparison or contrast with their professional (*etic*) approaches and perspectives.

"Defined narrowly, epistemology is the study of knowledge and justified belief" (Steup, 2014: 1). If knowledge is *justified true belief (Steup, 2014:2),* midwives need to have cultural knowledge to understand what FGNW believe about their cultural practices and how what they belief influences their care approaches and care expectations. Similarly, FGNW need to comprehend the philosophy of professional (*etic*) care of midwives in order to accept and access it to meet their maternity care needs. This is because knowledge requires truth. Steup (2014) citing William (1989) schema, explores *knowledge of propositions* (Steup, 2014:2) where 'S' stands for the subject who has knowledge and 'P' stands for the proposition that is known. Therefore, to enhance *knowledge* and *justified belief* of the culture and care of FGNW, the question that needs to be answered through epistemology will be: what are the necessary and sufficient conditions for 'S' to know that 'P'? In the context of the current study, FGNW are the subjects who hold knowledge of their cultural beliefs and practices, whilst midwives hold biomedical knowledge that inform professional philosophy of care. The proposition that is known is the lack of culturally competent and culturally congruent care provided to this population in London (MBRRACE-UK 2014, Jomeen and Redshaw 2013, CMACE 2011, Bharj and Salway 2008, CEMACH 2007 and 2004). This knowledge may be partially known and / or shared, as some FGNW may perceive that their cultural beliefs and needs are not fully understood or met by midwives and midwives may observe barriers to care arising from aspects of FGNW's cultural beliefs without fully understanding the reasons for these. According to Steup (2014:2) 'S' and 'P' schema, this amounts to *false propositions* which cannot be known, as midwives cannot fully achieve effective care without *justified true belief* that they are not currently meeting the cultural needs of FGNW. Similarly, FGNW cannot embrace *etic* care

approaches of midwives without *justified true belief* that such care approaches are useful for their continuing health and wellbeing in childbirth. Hence according to Steup (2014:2), *"a proposition 'S' doesn't even believe can't be a proposition that S knows*"; as *knowledge requires truth*. Therefore for knowledge to be justified, there is need to establish what FGNW hold as *justified true belief* of *etic* care approaches and the need for accepting and valuing these from midwives, whilst midwives similarly need *justified true belief* of *emic* care practices of FGNW in order for both to arrive at a level of understanding that '*are individually necessary and jointly sufficient for knowledge*' to be gained (Steup, 2014:2) to enhance culturally competent and congruent maternity care that meets both professional care ethos as well as the cultural needs of FGNW. Striking this balance will booster achievement of the necessary and sufficient conditions for '*S' to know that 'P'* (Steup, 2014:2) and according to evidentialism (what it takes for one to believe justifiably), what makes a belief justified in this sense is the possession of evidence. To satisfy evidentialism, FGNW's evidence of *emic* beliefs and practices will be obtained through literature review of exploring existing evidence on care practices of FGNW and holding in-depth discussions with them about their beliefs about their *emic* care and establishing their perception of midwives *etic* care approaches. Similarly, establishing evidentialism on the part of midwifery practitioners will entail exploring midwives perspectives on FGNW's *emic* care practices and the issues these may raise in providing *etic* care to this population. Establishing *justified true belief* of FGNW and midwives will enhance *the necessary and sufficient conditions for 'S' to know that 'P'*, (Steup, 2014:2) thereby creating new knowledge of enhanced understanding of both FGNW *emic* beliefs and practices and midwives *etic* care perspectives that is culturally relevant to FGNW. This will result in belief that is justified to the degree it fits 'S's (the subjects who has cultural and professional knowledge): both midwives and FGNW's and *for S to know that P (*'P' stands for the

proposition that is known): both FGNW and midwives will gain balanced knowledge of requirements for culturally competent and congruent care.

The integration of Leininger's (2002) Culture Care theory and Papadopoulos *et al*'s (2008) Cultural Competent Care model as a midwifery-specific model will enable a balanced exploration of the degree to which competency and congruency is achieved in the convergence of both worlds of FGNW and midwives through comparing and contrasting *emic* and *etic* care perspectives.

3.4 Consideration of other methodologies

Research methodologies in qualitative research developed in anthropology, sociology and psychology may be applied in researching subjective human experiences and processes (Burck, 2005) and hence may have overlaps in the manner in which they inform one another. For this reason, three qualitative methodologies are compared to demonstrate how each research methodology can highlight different aspects of qualitative research material and address the same research topic from different angles. Furthermore, in comparing alternative qualitative methodologies, the researcher attempts to clarify how these differ from her preferred methodology.

3.4.1 Hermeneutic Phenomenology as possible philosophy and methodology

The attraction to consider hermeneutic phenomenology was based on the understanding of it as an interpretive process through which individuals' understanding of a given 'text' is shaped

by their particular history and socio-cultural identity and its focus on their life world. Phenomenology is concerned with human experiences (life world) as it is lived, focussing on revealing details as well as trivial aspects of experiences that may be taken for granted with the intention of achieving a sense of understanding via the creation of meanings of the experience(s) (Greenwald, 2004). Through interpretation, understandings of the phenomena, as well as the horizons of the participant and researcher are enhanced through a particular philosophical perspective (Laverty, 2003). Hermeneutics is primarily an 'interpretation' of words, language and speech – which then can be applied to a study of human cultural activity (Greenwald 2004). However, there is a degree of discord amongst philosophers in their unresolved deliberation on the way the exploration of lived experience ought to proceed. Therefore, each of the theorists outlined below created a slightly different school of phenomenological thought on the subject but share essential constitutive elements (Crotty, 1998). Dowling (2007) accentuates this view that there are a number of schools of phenomenology, and even though they share common similarities, they have distinct features. In view of these differing philosophical approaches by various scholars, phenomenology has been referred to as a 'philosophical movement' (Lopez and Willis, 2004). Therefore, hermeneutic phenomenology – although considered a potentially suitable philosophical method for this study – was abandoned to avoid being trapped in one of the divergent philosophical approaches that can impinge on the researcher's focus and inadvertently affect her progression. Moreover, the researcher's interest in investigating not just the *emic* care practices of FGNW but also the *etic* care practices of midwives, a hermeneutic approach, much as it would have been useful to understanding the *emic* care practices, would have been cumbersome in exploring the *etic* angle of this enquiry. This is because, midwives due to their professional training often operate within a professional dictate that is somewhat separated or even divorced from their inherent personal *emic* perspective; making it difficult to interpret

their *emic* care practices against their inherent beliefs and values. Mette (2007) highlights the conflict between professionalism and cultural constructions of selfhood, arguing that the complex nature of professionalism and of cross-cultural differences in attitude towards professional role and social identity is often defined by how the institution uses the professional to achieve a universal or near-universal code of professional ethics.

3.4.2 Ethnography and interpretative phenomenology as possible philosophy and methodology

Ethnography is also a qualitative research methodology (Lindsay, 2007) that can enable researchers to make sense of people's actions by observing them in the context of their environment (Varcoe *et al*., 2003). In this regards, ethnography would have enabled an understanding of how first-generation Nigerian women experience their world, their culture and working environment; as the focus of ethnography is on '*individuals, not in isolation, but in relation to their organisations, communities, customs and culture*' (Clark, 2000: 44). In this way, ethnography appears to be well suited to health-care research, whereby the researchers are not just describing behaviour, but are aiming to make sense of it with the potential for making improvements in practice (Holloway and Todres, 2006). Some ethnographic principles are inherent in phenomenological methodology (Kincheloe and McLaren, 2005). Ethnography and interpretative phenomenology are both exploratory, use the researcher as data collection instrument, both use interview, open-ended and structured questioning methods, both seeking meaning in the narratives. Ethnography concentrates on participants' shared views and values of a particular culture and aims to describe the cultural knowledge of the participants while interpretative phenomenology tries to uncover concealed meaning in the phenomena.

However, Maggs-Rapport (2001) highlights the disadvantages in combining both approaches such as: lack of validity due to lack of testing of a combined approach, striking the correct balance between participant dialogue and researcher's interpretation, misplaced focus on theory behind method rather than the method itself, and the danger of searching for meaning within the data that does not exist. As observation of participants in the context of their environment is key to ethnography, it differs from the researcher's chosen method of semi-structured interviews. Firstly, it would not have been possible to observe the retrospective experience of first-generation Nigerian women who formed part of the focus group of this study. Secondly, observing the prospective population over a continuum of pregnancy and observing midwifery practitioners over the same period would have been impractical to implement and resource intensive in regards to time. Moreover, combing two methodologies that lack validity would have been an unsound research approach; therefore both approaches were abandoned due to the practical difficulties and as they did not fit a sound research being yet un-validated.

3.5 Philosophy and methodology chosen for this study

3.5.1 Integration of Culture, Culture Care Theory and Cultural Competence

It has been fully explored as to other models informing cultural congruency in maternity care. It is important to note that midwifery has not developed a pertinent model for providing trans-cultural care in the UK, but upholds the philosophical concept of individualised and holistic care and has relied on generic models for providing trans-cultural healthcare. This generic approach to care is individualistic in the first instance and does not focus on ethnic trans-cultural communities like FGNW who approach healthcare from an extended family orientation rather than individualistic perspective.

Therefore, CCMM have been duly considered and adopted as the philosophies and methodologies of this study and as potential midwifery model of culture care as both feed into all angles of this study and are robust when integrated to enhance both *emic* and *etic* care practices. *Emic* perspective is how people (FGNW) view care while *etic* care is how professionals view care. There is need for convergence of both perspectives for the care needs BME populations and especially those of FGNW to be fully met, hence the conception of the Culture Care Model to ensure a robust approach for meeting the need of trans-cultural populations such as FGNW within maternity care.

This model entails factoring in all components of *emic* care approaches of FGNW such as: their beliefs and the meanings they attach to their *emic* care approaches and ensuring that the midwife is equipped with knowledge of the similarities and differences of anthropological, biological, health beliefs and behaviours, as well as socio-political and psychological factors that interplay with *emic / etic* care approaches and perspectives.

Cultural sensitivity in this model entails appropriate professional care approaches geared towards meeting the trans-cultural needs of FGNW in regards to acceptance, respect, trust and interpersonal skills to navigate the socio-political factors that interplay with maternity care delivery and care access, such as midwives' and FGNW's ethno-history, environment and context of care.

Competency and congruency in care is attainable through addressing components that enhance cultural sensitivity and competency through individualised care, clinical skills, addressing biases and stereotypes, as well as addressing discrepancies between *emic* and *etic* care approaches. This is then ameliorated with *care actions and decision modes* utilised to re-organise care through accommodating positive *emic* / *etic* care approaches, preserving health enhancing *emic* / *etic* care approaches and re-patterning aspects of *emic* and *etic* identified as inappropriate or harmful to ensure maternity care that is competently delivered by midwives and congruency to meet the cultural and holistic needs of FGNW and midwives.

In line with this proposed model, Leininger (2006) asserts that CCT approach is humanistic and naturalistic in aiding fresh insights about care, health, and wellbeing. Adoption of this proposed models will aid insight into the cultural needs of FGNW, about factors that enhance their health and wellbeing in maternity care as migrants in London and provide strategies for meeting their cultural needs in a manner that is both competent and congruent. As a result, healthcare providers are called upon to understand that human beings are innately caring, that diverse cultures were created for a purpose, the goal of healthcare is to care, carers should help and understand diverse individuals, and healthcare contributes to humanity through ethical and moral obligations using culturally appropriate care modalities (Leininger 2006). It is hoped that the evidence from the current study applying this model will be innovative in creating evidence-based knowledge to enhance maternity care as care providers are responsible for discovering cultural phenomena through using evidence-based approaches.

Furthermore, Cultural Competence relies on a strong foundation of knowledge about other cultures as '*culture plays a major role in the way a woman perceives and prepares for her*

birthing experience' (Green 2007:33) and how she evaluates maternity care. Moreover, Ottani (2002:33) assert that, "*each culture has its own attitudes, values, and beliefs surrounding pregnancy and birth and that women from diverse cultures may not have the ability to follow their traditional birth practices because their practices are unknown to those caring for them"*. Therefore, cultural knowledge is core to midwives providing care that is culturally competent and congruent for FGNW.

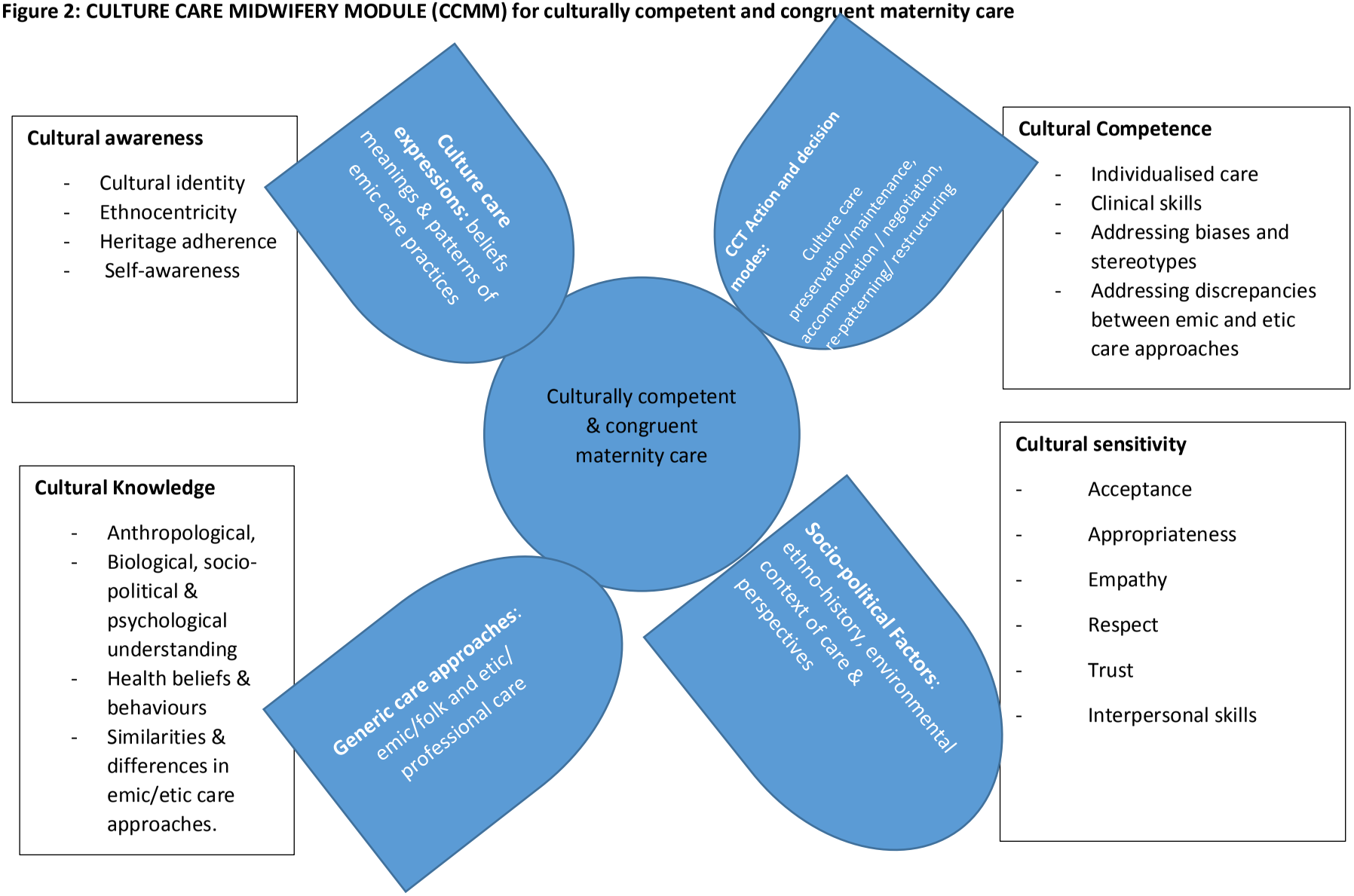
McFarland *et al.* (2012) in their presentation of the CCT for studying culturally competent care propose that the theory could be used with other qualitative methods as long as the philosophical premises and purposes are congruent. Obvious agreement and similarity are apparent in both the CCT and CC integrated to form the Culture Care Maternity Model and so far discussed as the theoretical framework of this study. Furthermore, Leininger (2002, 2006b), advocates that through CCT, knowledge is generated to help healthcare professionals to care for people from diverse and similar (multi-cultural) cultures; further considering that CCT and CC are useful for research that addresses cultural competent care in any discipline in which research findings have implications for human care and health. Similarly, CCMM is useful for structuring maternity care to ensure that the competent skills of the midwife is useful for ensuring cultural congruency in the maternity care expectations of FGNW in London.

Britain is a multi-cultural nation with imperialist background hence, healthcare educators and providers in Britain are challenged to prepare a culturally competent healthcare workforce (Leininger and McFarland 2002). This should necessitate a drive to increase cultural sensitivity and competence amongst healthcare practitioners (Leininger and McFarland 2002). Thus, to ensure culturally competent care and adequate responses to the health needs of the multi-ethnic

populations, midwives in Britain need to embrace trans-cultural healthcare education and practice, to ensure meeting the needs of ethnic groups accessing healthcare within their communities (Mixer 2008). As documented in the literature review section of this study, current evidence points to the lack of congruent health care provision for BME populations in Britain, and an obvious gap exists in providing culturally congruent care that may serve to avert some of the poor care outcomes of BME populations in London. It is hoped that the application of the proposed Culture Care Maternity Module will bridge this gap and enhance care that is culturally congruent, at least for FGNW who are the focus of the current study.

This integration of CCT and CCMM has brought about the conception of **CULTURE CARE MIDWIFERY MODEL** (represented diagrammatically below) as an expression of the integration of aspects of both CCT and CC models that serve to address both cultural competency and congruency for meeting the maternity care needs of FGNW as trans-cultural women.

Figure 2: CULTURE CARE MIDWIFERY MODULE (CCMM) for culturally competent and congruent maternity care



Culture Care Theory (CCT) was developed by Leininger, a United States anthropologist and Nursing theorist to help researchers study trans-cultural human care phenomena and to discover the knowledge 'nurses' need to provide care in an increasingly multi-cultural world. Leininger's model draws on the philosophical concept of caring generally, while midwifery philosophy of compassionate and individualised care is focussed on the application of the concept of caring in a midwifery context (Chokwe and Wright, 2012). Citing (Dickson, 1996), Chokwe and Wright (2012) explored and emphasis the components of caring within midwifery context as: (a) *maintaining belief* which entails *promoting faith and trust to empower someone to pass through an event and face the future with positive meaning*, (b) *Knowing*: *striving to understand an event as it has meaning to the other*, (c) *Being with*: *being emotionally present for the other*; (d) *Doing for: helping an individual to perform a task independently if able to* and (e) *Enabling: making it possible for someone to pass through an unfamiliar life event or transition* (Chokwe and Wright, 2012:2). Themes from their qualitative study categorised caring as: *attending to individuals' needs, being a good role model and showing respect, being positive, being competent and proficient, being compassionate, kind and approachable,* b*eing conscientious and providing individualised attention and care* (Chokwe and Wright, 2012: 3-5). Concluding that *caring is cultural* that *caring is an expression of professionalism* (Chokwe and Wright 2012:5). Therefore, cultural sensitivity and awareness is required in order to meet the needs of others through '*nursing care*' (Leininger 2002, 2004 and 2006a) and midwifery training and practice (Chokwe and Wright, 2012).

It should be noted that 'nurses / nursing' are often used as generic terms that encompass allied healthcare professionals within the nursing-care umbrella, such as Health Visitors, Midwives and Nurses (Crosta, 2015 and Leininger, 2002).

In the formulation of her theory and model, Leininger used the construct of '*Culture*' from anthropology and '*Care*' from nursing, to create the Culture Care Theory in order to advance a global perspective in nursing science and to establish the field of trans-cultural nursing (Leininger 2006a; 2006b). Similarly, Papadopoulos *et al.* (2008) four-stage model for developing Cultural Competence (CC) care describe trans-cultural 'nursing' as *requiring a commitment for the promotion of anti-oppressive, anti-discriminatory practices while emphasising the importance of empowering clients to participate in health care decisions* (Papadopoulos *et al* 2008:2). Care and compassion underpins Papadopoulos *et al*'s model of Cultural Competence as they portray cultural competence as the capacity to provide effective compassionate healthcare, taking into consideration people's cultural beliefs, behaviours and needs. Both Cultural Competence and CCT together with the Sunrise Enabler (Leininger 2006a) depict an integrated holistic view of the influencing dimensions of 'Culture' (*emic* care approaches) and 'Care' (*etic*: professional care practices) of both FGNW and midwives. Both approaches to care are integrated in the Culture Care Model to form the framework for this research as the amalgamation suit the theoretical framework of 'culture' that informs this study. Furthermore, the proposed Culture Care Model centres on the need to provide culturally competent and congruent care from the perspectives of both *emic* (FGNW) trans-cultural background and *etic (midwives)* professional approach.

Equally, Helman's (2007) description of 'three levels of culture' and Papadopoulos *et al*'s (2008) four-stage model for developing Cultural Competence (CC) is about exploring the influence of the woman's cultural context that inform her *emic* care practices and those of the professional midwives' *etic* care approaches that aim to meet the care needs of FGNW in a competent and congruent manner. In the same stream, Leininger (2006c) wanted to explore people's ways of caring from their *emic* (folk) view, and how this contrasted with healthcare

professional's perspective. She presented the theory as a guide for using research findings to design culturally competent and congruent care to promote wellbeing among diverse peoples, communities, groups, and institutions. The goal of the theory and method is to discover folk (*emic*) and professional (*etic*) care practices that promote health and wellbeing among diverse populations, and to explore ways to use both types of care to plan and implement culturally congruent care that is beneficial, meaningful, and satisfying for people to achieve optimal health and to face disabilities or death (Leininger, 1997 and 2006a).

Both CC and CCT provide a holistic means to understand the range of factors that influence trans-cultural care provision. Both methods embrace the importance of discovery of care from the people's (*emic*) folk ways of knowing and caring and gives credence to the professional's (*etic)* professional way of knowing and delivering care (Leininger 2006b, Papadopoulos *et al* 1998). Caring, is seen as a core component of both CC and CCT, as an activity that responds to the uniqueness of individuals in a culturally sensitive and compassionate way through the use of effective therapeutic communication. Leininger (1995) defined life ways as values, beliefs, and life practices that are enculturated within a given group. These life ways influence how life experiences including birth are interpreted. Papadopoulos *et al* (2008:1) define trans-cultural care *as the cultural diversities and similarities of people in the way they define, understand and deal with health and illness and their welfare needs. It is also the study of the societal and organisational structures, which either aid or hinder people's health and welfare*'. Trans-cultural and culture-specific approaches to caring compel health care providers to examine cultural characteristics of patients and caring practices of healthcare providers (Hegyvary, 2006). Thus, trans-cultural approaches stimulate the researcher to focus on care similarities and differences among informants and their care providers (Leininger, 2006) and hence both Leininger (2002) CCT and Papadopoulos *et al* (2008) CC complement each other

as models that could be integrated to guide maternity care providers to deliver care that is culturally competent and congruent.

Caring is the dominant, unifying, focus of the disciplines of midwifery and care influences the health and well-being of people in profound ways within their environmental contexts (Leininger 2006, Papadopoulos 2008). Similarly, trans-cultural care is vital in the UK due to the growing diversity of multi-cultural / multi-ethnic national and global migrant populations accessing maternity care in the UK. With the influx of FGNW escaping the brutality of terrorism (Boko Haram Insurgence), this population living in London is likely to rise rather than decrease and hence the CCMM is timely for ensuring meeting their maternity care needs. Furthermore, the rise in global migration bring with it cultural identities which will engender challenging expectations (from women of child bearing age) on UK maternity care providers to meet, respect and understand the divergent beliefs, ways of life and values in order to achieve culturally congruent care (Leininger 1997).

From an anthropological perspective, Leininger (2006a) found that care is deeply embedded in people's world views, social structures, and values. She perceived that healthcare providers and other professionals need substantive knowledge in their disciplines to guide their care decisions and actions as they move beyond local and national perspectives to a global worldview. Summatively, professional's need knowledge of diverse cultures and their approaches to care (*emic* approaches) to guide their clinical practices (McFarland *et al.* 2012, Papadopoulos *et al* 1998). Furthermore, discovering embedded care phenomena requires an inductive, open-inquiry method that can explicate complex, covert, and largely unknown local people's views about care, health, and wellbeing. This will require understanding of the *stratum*

of culture from which the client is operating (Helman (2007). Engaging with FGNW throughout CCMM will allow discovery of their *emic* care practices and engaging with midwives through exploration of cultural sensitivity and culturally competent care approaches unfolds their *etic* beliefs, socio-political influences that inform *etic* care practices, perceptions and values that inform their care delivery (McFarland *et al,* 2012: 261).

Therefore, the amalgamation of both Leininger's Culture Care Theory and Papadopoulos Cultural Competence model is about enhancing care measures that are in harmony with an individual or group's cultural beliefs, practices, and values as well as their care provider's values. Cultural competent and congruent care is possible when the client and the health care provider together and creatively design a new or different care lifestyle for the health or well-being of the client. In effect, this mode of efficient care delivery requires the use of both generic and professional knowledge and ways to fit such diverse ideas into health care *actions* and *goals* / decisions (Leininger, 2006). To achieve competency and congruency in maternity care delivery, will mean that care knowledge and care approaches may require negotiation and re-patterning for the interest of the client and the care giver (Leininger 2002, 2004, 2006b). Thus, all care modalities require collaboration of the practitioner and the client working together to identify, plan, implement, and evaluate each care mode for cultural competency and congruency. These modes can stimulate practitioners to design *actions* and *decisions* (Leininger, 2006) using new knowledge and culturally-based ways to provide meaningful and satisfying holistic care to individuals, groups or institutions (Leininger, 2002).

Like Papadopoulos and colleagues, Leininger also proposed four major tenets of their Culture Care Theory. The four major tenets of the Culture Care Theory developed by Leininger (2006 a) are presented as follows:

- culture **care expressions**, meanings, patterns, and practices are diverse and similar;
- worldview, multiple **social structure** factors, ethno-history, environmental context, generic care, and professional care are critical influences on culture care and predict health and well-being;
- generic / **folk and professional care** are essential for health and wellbeing and
- three **action and decision modes** guide the provision of culturally congruent care: *culture care preservation* and / or *maintenance*, *culture care accommodation* and / or *negotiation*, *culture care re-patterning* and / or *restructuring* (Leininger, 2006a).

Leininger's assumptions include the idea that care is the dominant, central focus of healthcare. Equally, care is essential for human health and wellbeing and survival; and culture care includes both commonalities and differences of care approaches (Leininger, 2006 a).

Earlier, Leininger (2002) described five concepts adapted from anthropology that are essential for achieving trans-cultural healthcare. These have been described as the five basic interactional phenomena that care providers need to know in order to understand trans-cultural contexts and appear as replicates of aspects of Papadopoulos *et al's* (2008) stages of cultural competence model; as previously presented. These are:

• **culture encounter** which refers to situations in which a person from one culture meets or interacts with a person from another culture. Culture encounter engenders exchange of ideas but not beliefs, values or life ways.

• **enculturation:** that involves the process of how one learns to live by a particular culture with its specific beliefs, practices and values.

• **acculturation** describes as the process by which an individual or group from one culture learn how to take on many (but not all) behaviours, norms, values, and ways of life of the host culture. Within acculturation, an individual may still retain, and use traditional beliefs and values from the old culture that will not interfere with taking on new cultural norms of the host society (Leininger, 2002).

• **socialization** being how an individual or group learn how to function within the culture of the larger society and learns how to interact with others, to work and live in harmony and to survive.

• a**ssimilation** entails the way individuals or groups from one culture selectively choose certain features of another culture without taking on many of the attributes or ways of life that would declare one to be fully acculturated (Leininger, 2002). Aspects of Leininger's tenet would appear to suggest that progressive adaptive acculturation and socialisation would be key to first generation Nigerian women's adaptation and assimilation into the maternity culture of their domicile country. However, for maternity care provision to prove competent and congruent for this population, it is pivotal for aspects of both Leininger (2002) CCT and Papadopoulos *et al* (2008) to be converged to ensure maternity care provision that is both competent on the part of midwives and congruent for FGNW in London.

3.5.2 Culture Care Phenomena presented by Leininger (2006a) encapsulate: (1) what informants know and experience, (2) testing out specific cultural care definitions of the population under investigation, (3) allowing the researcher to access and define culture-specific knowledge based on the expressed experience of the sample, (4) allowing new dimensions of the definitions to emerge as the research process unfolds.

3.5.3 Data gathering phase of Culture Care Theory has five components to guide the researcher and entails: firstly maintaining an open discovery, active listening, and genuine learning attitude in working with informants in the total context in which the study is conducted, hence showing a willingness to learn from the people, demonstrating respect, and avoiding ethnocentric bias. Secondly, actively participating with the informants in reflection about the meaning of what is seen, heard, or experienced (member checking) . The researcher develops sensitivity to the *emic* (folk) view and considers how this affects the *etic* (professional) perspective. The third principle encourages recording whatever is shared by informants to preserve their ideas and meanings. The fourth principle emphasizes using an experienced trans-cultural mentor (supervisor) to guide the research. The fifth principle clarifies the purpose of using CCT in combination with other research methods (Leininger, 2006b) as fully explored earlier in this chapter and demonstrated in the proposed Culture Care Midwifery Model.

Study participants in the CCT method are called informants. Key informants are those people holding the most knowledge about the topic under investigation or major focus of the study. In this instance, the key informants are the six women interviewed prospectively at three intervals in their birth experiences. The general informant category in the current study are the focus

group populations: the cohort of six Nigerian women with prospective birth experiences in London, eight non-Nigerian and four Nigerian midwives practicing in London who were interviewed and formed the focus group of the current study. By this principle, general informants or focus group discussants are presumed not as knowledgeable about the topic, but their general ideas can stimulate the researcher to reflect on similarities and differences in the research data among key informants (Leininger, 2006b). Contrary to this view, the focus group discussants in the current study were knowledgeable about FGNW birth practices, which enriched data gathered on *emic* care practices first generation Nigerian women and data on the *etic* perspectives of midwives providing maternity care for this population and arriving at an enhanced understanding of care expectations of FGNW and appropriateness of maternity care provision. Although the views of the focus groups are not gained in a longitudinal manner like those of prospective sample, the quality of data generated from them are as informed and as valid as that obtained from the prospective sample.

3.5.4 ***Research Enablers*** are important guides that help the researcher tease out the in-depth culture care and general cultural knowledge from informants. Leininger, (2006) in her desire to enable trans-cultural research, devised a diagrammatic model for the exploration of culture care. This she aptly named 'Leininger's *Sunrise-Enabler* to discover Culture'. This figure serves as a cognitive map of the Culture Care Theory (Leininger 2006b) and aspects of it has been integrated with Papadopoulos *et al*'s (2008) model in a complementary manner to produce the CCMM. Leininger's *Sunrise-Enabler* model of cultural care can be viewed as a rising sun and serves as a guide for the researcher to explore multiple influences on care and culture. This multi-faceted viewpoint helps the researcher to enter the informants' world and to remain with them throughout the study (Leininger 2002; 2006b) to obtain culture-rich data.

The cultural and social structural dimensions include educational factors, economic, kinship, legal, philosophic, political, religious, social, technological, ways of life, and value systems which the healthcare provider needs to be sensitive to in order to achieve cultural sensitivity and cultural competence. Each component of these identifies socio-economic factors that influence health and wellbeing. The woman's *emic* (folk) care practices, her environment and language invariably influences the healthcare systems and personnel that deliver her healthcare needs. The *emic* health system includes the cultural beliefs and practices that could enhance and / or hinder her access to health care while the *etic* (professional) health systems are those practices the healthcare provider learned cognitively through formal professional education and training. When cultural competence and congruence is achieved, there is convergence of *emic* and *etic* health approaches to meet the biological, cultural and psychosocial health needs of the client. To achieve these, Leininger (2006) recommend care actions to be planned in one of three modes: *culture care preservation / maintenance*, *culture care accommodation / negotiation*, or *culture care re-patterning / restructuring* (Leininger 2006). Components from both Leininger's and Papadopoulos' models: cultural awareness, knowledge, sensitivity and competence are required of the healthcare to structure their *care actions* in a manner that *preserves* and maintains healthy *emic* care approaches of the client, accommodates and *negotiates* innovative ways of achieving competence and congruency in care. New knowledge gained from engaging with clients and understanding their culture further enhances *etic* care approaches, and informs *re-patterning* or *restructuring* of inappropriate *emic* care practices in ways that are beneficial for the client, guided by professional evidence and knowledge. In this way, congruence is achieved through convergence of folk and professional care approaches in a complementary and robust manner that fosters competent professional practice and congruent care delivery. This is the advantage of incorporating Leiningers's *care modes* within CCMM

to ensure pro-active and progressive actions to enhance maternity care that is culturally congruent.

Purnell (2000) developed a similar model for cultural competence care aimed at meeting the needs of a multi-cultural society that is reflective of aspects of CCMM. Purnell described cultural competence care as the adaptation of care in a manner that is consistent with the culture of the patient. A culturally competent midwife develops an awareness of existence; sensations; thoughts, and the environment without letting these factors have an undue effect on those receiving care. For care to be effective, health care professionals are urged to reflect the unique understanding of attitudes, beliefs, the ways of life, values, and worldview of diverse populations and individual acculturation patterns (Purnell, 2000). Purnell's model was advanced by both Leininger (2002) and Papadopoulos *et al.* (2008). Maputle and Jalil. (2006) also gives some useful guidance on working with diversity, incorporating cultural competence and sensitivity into midwifery practice based on Leininger's four tenets for ensuring culturally congruent care: culture care expressions, folk care, worldview and three action and decision modes about care. All these models share a commonality in reiterating the need for culturally competent and culturally congruent care that meets the care needs of the client and bolsters competent practice for midwives.

Furthermore, Spector's (2002) 'cultural diversity in health and illness' model concerns three concepts of culture care believed to enhance culturally competent care based on three principles that advance Lininger's concepts:

- **heritage consistency** that involves the degree to which one's lifestyle reflects his or her respective traditional culture. An assumption is that a person who holds deeply to more beliefs that are traditional will be more likely to follow more traditional methods of health and illness beliefs and practices. Heritage consistency is typified in the nature of FGNW's *primary stratum* of culture (Helman, 2007) which forms the deepest level of culture where rules are known to all within that culture, obeyed by all but seldom stated; which can serve to hinder cultural knowledge by the midwife who may be alien to some *emic* care practices of FGNW and hence lack the right a*ction* or *decision* in delivering *etic* professional care to them.

- **health traditions** are about the interrelated balance of the body, mind, and spirit that are ethnically informed. These portray what people do from a traditional perspective to maintain health (*culture care expression*), protect health or prevent illness and restore health (Leininger 2002 and 2006. Again, health traditions of FGNW are typified in the *secondary stratum* (Helman, 2007) where the hidden rules and cultural taboos are known by the members but not shared with outsiders to the culture. Hidden rules may influence views and values of care providers as well as those of clients, as professional ethos may not be culturally knowledgeable.

- **cultural phenomena** are described by Spector (2002) as six phenomena that vary among cultural groups and affect health care such as biological variations, communication, environmental control, social organizations, and space and time orientation. The six phenomena serve to illustrate the diversity that exists between cultural groups and are imbedded in Leininger's (2004) *Sunrise Enabler*. Health beliefs and practices can be analysed in terms of ones heritage or at the level at which one has acculturated to the dominant culture. A balance between traditional ethno-cultural

heritage and an individual's acculturated belief system is said to be necessary to enhance health and ensure care that is culturally congruent. As discussed in chapter two, health professionals' unfamiliarity with the level of culture from which FGNW are operating in regards to their beliefs, practices and religions may give rise to misunderstanding, stereotyping and insensitivity in the provision of maternity care. Similarly, lack of knowledge or understanding of the professional culture of care of the midwife may hinder care access and make FGNW less receptive to professional midwifery care.

Through apt knowledge of the cultural *strata* from which FGNW and midwives are operating, guided by robust theoretical understanding of requirement for achieving cultural competence and application of CCMM, the totality of FGNW's ways of life is explored through the convergence of Helman (2007), Papadopoulos et al. (2008) and Leininger (2002, 2004 and 2006) theorem that serve as 'a cognitive guide to tease out culture care phenomena from a holistic perspective of multiple factors that can potentially influence care and the wellbeing of FGNW (Leininger, 2002). McFarland and Eipperle (2008) have contested the assumption that Leininger's (2002) theory only focuses on the culture of the 'other' as inaccurate as it is about the caregiver and receiver. In fact, all the theorem espoused in this methodology chapter, especially CCMM are about converging care approaches of care giver and care receiver to enhance care that is both competent and congruent. Implementing the CCMM in practice will stimulate maternity practitioners and researchers, to reflect upon their own cultural values and beliefs and how they may influence the provision of care for others (Leininger and McFarland, 2002). In this way, trans-cultural care promotes integrative care and practices that enable the client to get the better of the two worlds of knowing and therapies (Leininger, 2002) and

enables the maternity care giver to achieve the level of competence that enhances professional job satisfaction and the level of congruency that reflects positive evaluation of maternity care.

Four **phases of data analysis** are allowed for within Leininger's (2002) Culture Care Theory and transcultural research:

1. In **phase one**, the researcher analyses detailed raw data, including recorded and transcribed interviews, observations, participatory experiences, and field notes.

2. During the **second phase**, data are coded and classified as they relate to the domain of inquiry and research questions.

3. In **phase three**, data are scrutinized to discover ideas and recurrent patterns until saturation is reached (new ideas or meaning cannot be gained from more data). Saturation is favoured in qualitative research as the sample size does not have any significant role, but data saturation during the data collection point of the study determines the sample size used (Kumar, 2011). The researcher engages in discovering the commonalities people share as well as their differences that is essential for knowing peoples' beliefs, practices and values within their environmental context.

4. The **fourth**, and last, phase of data analysis includes interpretation and synthesis of findings. The researcher explicates and confirms major themes, care actions and decisions, and new theoretical formulations with the informants.

Through the stages of the current study, the researcher adhered to the processes outlined within this methodology in regards to data gathering and analysis. For data validation and to reach

new theoretical formulations with the informants, follow-up interviews were undertaken by the researcher to confirm data at intervals by face-to-face meetings, phone calls, or emails that helped to clarify interpretations and meanings as advocated by Leininger (2006b).

Leininger (1991a and 1991b) developed **six qualitative criteria to evaluate qualitative research**: credibility, confirmability, meaning-in context, recurrent patterning, saturation, and transferability. Credibility refers to the truth, accuracy, and believability of findings established mutually by the researcher and informants over time. Believability has been achieved in the current study through validation approaches outlined in the last paragraph. Confirmability refers to establishing verifiable and direct evidence with participants again achieved through data validation. The researcher confirms with informants the accuracy of patterns and themes formulated based on data collected. Data are maintained and systematically documented (through categories and patterns from which themes are drawn and through use of quotes) to ensure findings can be traced to actual data collected. Meaning-in-context focuses on the significance of interpretation and understanding of the actions, events, communications, and other activities of informants within their environmental context. Saturation refers to the notion that data is collected until redundancy occurs; informants share similar content and the researcher notes recurrence of the same information. Transferability denotes reliability and refers to whether the findings of a particular study would have similar meanings in another context with a similar cultural group (Leininger, 1991b; 2006b, Waller *et al.,* 2016: 23). The replication of this work in different context will lend it reliability. Nonetheless, within the constructivist research tradition, it is acknowledged that 'the coding of qualitative data tends to involve some degree of subjective interpretation rather than an adherence to transparent rules' (Waller *et al.,* 2016: 23) because *objective truth is a myth* (Waller *et al.,* 2016: 23) as researchers will have different partial perspectives based on who they are, their life experiences

and world view that could influence their interpretation (Waller *et al.*, 2016). Therefore, reflexivity is warranted to consider and avert unintended potential bias, as follows in the section 3.6 of this thesis.

The resultant outcome of a trans-cultural study should yield three **action and decision modes** (Leininger 2002, 2004 and 2006) for providing culturally congruent and competent care. These encompasses:

(1) *culture care* and *preservation* and / or *maintenance*: assistive, enabling, facilitative, or supporting professional actions and decisions that help cultures to retain, preserve, or maintain beneficial care approaches, beliefs and values or to face handicaps or death (Leininger, 2002). Midwives knowledge of the *strata* of culture (Helman, 2007) that inform FGNW cultural *emic* beliefs and care practices, her understanding of the reasons for such beliefs, converging with her self-awareness of her own cultural influence on her care approaches will enhance her sensitivity and competence in facilitating and supporting health-enhancing care practices of FGNW to a level that will enable them to maintain and preserve appropriate care practices.

(2) *culture care accommodation* and / or *negotiation*: is about assistive, accommodating, facilitative, or enabling creative provider care actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe, and effective care for their health and wellbeing or to deal with illness or dying. The role of the midwife in negotiating appropriate care practices with FGNW in maternity care will avert care practices that maybe unhelpful and /or potentially harmful to health and wellbeing of the women and foster accommodation of appropriate care approaches, and

(3) *culture care re-patterning* and / or *restructuring*: are assistive, enabling, facilitative, or supportive, professional actions and mutual decisions that would help FGNW to change, modify, re-order, or restructure their beliefs, care approaches and health care patterns, practices to improve their care outcomes (Leininger and McFarland, 2006). Collaborative effort of the midwife and FGNW will ensure re-structuring of care to incorporate positive *emic* and *etic* care approaches and re-patterning inappropriate or potentially harmful practices of both midwives and FGNW to achieve care that is culturally competent and congruent to both. In this way, CCMM enhances trans-cultural that assist midwives in discovering, honouring, and enhancing FGNW 's ways of knowing and give credence to the way they want to be cared for (McFarland *et al*., 2012). Similarly, Nigerian women can modify non-health enhancing care practices through re-construction and re-patterning guided by the midwife's professional knowledge and skills to improve care outcomes for herself and her baby. Herein dwells the researcher's choice of integrating the CC and CCT to formulate CCMM framework for this study as it has the potential to enhance culturally competent and congruent care both from an *emic* and *etic* care perspectives for FGNW and midwives.

3.6 Reflexivity: researcher as a first-generation Nigerian woman, midwife and lecturer

Reflexivity in research is about active construction of interpretation of experiences of participants and questioning how the interpretation is arrived at, as well as considering how the researcher's personal interests and perspectives may affect the research process (Bott, 2010, Merriam *et al.,* 2001). England (1994) suggested that reflexivity is self-critical, sympathetic introspection and self-conscious analytical scrutiny of the self as researcher whereby the researcher explicitly acknowledges their reliance on the participants to provide insight into the subtle nuances that shape the experience studied. Reflexivity is useful for situating research

and knowledge production within ethical frameworks for robust research. However, reflexivity is not without critique. It is argued that being reflexive can be self-indulgent in terms of positionality and the interplay of this with the power dynamics of research. Sultana (2007:381) therefore cautions against 'the process and power relations' involved in research. Nonetheless, detachment from involvement at all stages of this study was neither desirable nor possible as my backgrounds: personal and professional, as well as my personal interest in the subject matter could be perceived as strength (Aveyard and Sharp, 2000).

As a researcher from a Nigerian background and a mother who experienced births in Nigeria and in London, and currently working within the midwifery profession (albeit as a lecturer), and as a researcher involved with members of my local church, to some degree, my life and the lives of the women and those of the midwives who participated in this study ran parallel. The parallel lives, which go as far as the point of our origin, attending the same church, having birth experiences in Nigeria / London and working within the same profession, could affect the research process if not effectively managed. Therefore, for this work to remain grounded in research ethos, reflexivity is warranted to enable me to consider and reflect on various roles as Nigerian woman and mother, midwifery lecturer, as well as my position as researcher and to explore this multiple identities with objectivity and sensitivity highlighting potential biases that may arise as a result. This reflection are discussed under the sub-headings of identity, sensitivity and subjectivity to ensure adequate and reasoned reflection.

Identity of researcher is core of reflexivity (Neill, 2006). I as a FGNW, as a mother, midwifery professional, and educator, who studied Mother and Child health at MSc level; these positions and my identity are relevant in my exploration of cultural competency and congruency as a

mother who has been exposed to cultural insensitivity due to lack of cultural knowledge by midwives. Although decades has passed since my birth experiences, I remain curious as to why no specific culture care model exist to inform midwifery practice in delivering culturally competent and congruent care. As a link lecturer who served a local Trust from which my samples were drawn (although I no longer serve within this Trust), my affiliations with the NHS Trust as well as my role within one of the Trusts as part of being an educationalist, require reflexivity. In engaging with FGNW and midwives through this study, this researcher had not anticipated or expected the odd sensation of being so divided between her personal and professional selves. Although the FGNW who formed part of the focus group attended the same Church as the researcher, this was a large multi-ethnic Church and the researcher did not know the women personally. However, reflexivity is key to helping me to reflect on my position within the grids of power, and to consider how that may influence my methods, interpretations and overall knowledge production from the current study. Sultana (2007) ascent with this dilemma of the challenges of multiple roles in conducting research.

However, for robustness of the research endeavour, one's personal self has to be kept under guard in order to accentuate one's professional self throughout contacts with the informants. Due to commonality of ethnicity, gender, language and nationality, some of the participants placed me in certain categories of authority, sameness and subservience at different stages of the research process, albeit subconsciously. Authority entailed respect for my status as senior lecturer and researcher. Sameness in background granted both FGNW and midwives ease of relating to the researcher as a Nigerian, a mother a midwifery practitioner who has some knowledge of some of the *emic / etic* practices under discussion. The researcher felt somewhat subservient to two FGNW informants (lawyer and medical doctor) who at times made their status the focus of discussions. From an insider perspective, it would be naive of me to claim

total detachment or to dismiss prior knowledge of some of the *emic* and *etic* care practices discussed by the participants. What is vital to enhance effective professional relationship with the women and midwives was to ensure professionalism and adequate reflexivity within my multiple status FGNW, midwife and as researcher.

My insider position as a FGNW and midwife was advantageous in bridging the potential power barrier between researcher and researched and enhanced reciprocity, where FGNW felt they could relate to me as a mother and Nigerian and the midwives felt as ease with me as a midwifery practitioner and professional. This reciprocity evolved readily and aided my understanding of common cultural nuances used by FGNW women and midwives in explaining *emic*/ *etic* care approaches. This reciprocity is also useful in retaining participants (full sample retained throughout the period of study) and in my success in obtaining data. Although the connection with FGNW and midwives was meaningful in the moment, my position as a researcher into their live experiences was never forgotten. Maintaining professionalism called for an objective mind-set that enabled me to derive learning from the informants' individual experiences and narratives. According to Smithson (2000), ensuring that the researcher is from a similar background to the participants is a possible strategy to minimize moderator bias during semi-structured interviews. However, Hurd and McIntyre (1996) warn that there is '*seduction in sameness*' between researcher and researched which can hinder a critical reflexive research. Therefore, it was necessary for me to continually negotiate power relations with the informants by explaining my role as a researcher and not a midwifery practitioner or a friend. Although I endeavoured to blend in as much as was possible (being the insider who understood care approaches), I also distanced myself through maintaining a professional stance (being the outsider) to enhance objectivity in the exploration of notions under study. The outsider perspective of no longer serving the Trust from which the samples of midwives were

drawn ensured understanding of my role as a researcher interested in FGNW's birth experiences and midwives *etic* care approaches. This enabled me to 'bracket' myself (Tufford and Newman 2012) and to remain objective in my interactions during interviews; hence ensuring my compliance with research ethos. Tufford and Newman (2012) define bracketing as a method used in qualitative research to enhance rigor by mitigating the potentially deleterious effects of preconceptions that may taint the research process.

The meeting with NHS Trust research directors to seek direct permission to recruit from their local populations and the presence of audio and visual recording systems used for data collection created a power division that placed me in an irreconcilable position of difference (with managers) and power with the participants. Like Bott (2010:165), 'the *power imbalances* implicit in this disparity' generated both personal and professional ethical anxieties in me, as regards the potential exploitative implications of hierarchy in research relations. Maintaining a professional stance and employing non-threatening approaches towards the participants helped in bridging the power imbalance. This is considered important in fieldwork (Sultana 2007).

Sensitivity: Having original experience and insight into the culture of FGNW as one originating from that background and having insight into midwifery practice gives rise to knowledge which is likely to inform my research in various ways and calls for sensitivity on my part as a researcher. Professional experience as educator and a midwifery practitioner can enable me to understand some of the care approaches of midwives and being a FGNW could equally enhance my understanding of the cultural practices discussed by the participants more quickly than one without the advantage of such prior knowledge and / or background. Therefore, there is need to compare my experience and knowledge on the topic against data

generated; basing my analysis and interpretation wholly on what the participants are saying rather than my perception. This factor remained uppermost in my mind through the entire research process. To enhance sensitivity, member checking was used to validate transcribed data and this was confirmed as accurate and a reflection of what was recorded. Data was also validated by the participants as a measure to enhance sensitivity. Member checking grants the informants the opportunity to confirm or disagree with researcher's interpretation but can be controversial if researcher and researched are in discord in regards to: divergent agenda, perspective on data interpretation, if the researched wish to alter, deny or forget their story or struggle with abstract synthesis contained in interpretation of data; or if different members hold different memories/views of the account reported. Moreover, the researched may simply want to please the researcher by concurring with views reported even when this differ from their original perspective given during data collection, therefore, Anjen (2000) contend that member checking relies on the assumption that there is a fixed truth of reality that can be accounted for by a researcher and confirmed by a respondent. It is on this premise that member checking was undertaken to validate data gathered from the informants.

Subjectivity is about my knowledge of the subject matter and setting (Trusts) and care approaches of midwives which can engender queries regarding subjectivity. The notion of insider / outsider in terms of interaction between researcher and researched are the resultant effect of social interaction on focus group discussions and interviews (Lambert *et al.*, 2010). Therefore, to avert introduction of unintentional bias as a qualitative researcher object reflection is vital. As a researcher, being reflexive aids transparency about beliefs, intentions, purposes and values, and eliminates both the '*seduction of sameness*' and the allure of self-justification and / or egocentrism. From a personal perspective, reflexivity entails being conscious of one's own identity as a researcher and considering one's position in relation to

the informants. There is a need for recognition of the influence of personal stance on the informants and the context in which one is studying their *emic* birth practices. Thus, reflexivity demands situating myself in the research and the processes of research in ways that acknowledge and do justice to one's personal stance and to the personal stances of those involved in the research. In this way, there is critical collaboration and the sharing of perspectives, which add value and rigor to the research. However, issues of power (researcher) and voice (researched / informants) need to be balanced through negotiated interpretation of data, as advocated by Leininger (2004). This entails the informants' confirmation of the researcher's interpretation of the views generated during data collection. As discussed earlier, the researcher achieved this by returning to the informants to check the accuracy of her interpretation of their respective views at various stages of data analysis and / or explication.

3.7 Chapter three conclusion

Having detailed the theoretical framework, concepts and suppositions that inform this study, the researcher believes that the epistemological and philosophical grounding employed makes explicit the theoretical framework guiding this study. Culture Care Maternity Model incorporating aspects of Culture Care Theory and Cultural Competence is appropriate and sound for studying the *emic* beliefs and cultural practices of first-generation Nigerian women and discovering how the *etic* care approaches of midwives meet the maternity care needs of this population. The convergence of aspects of *emic* and *etic* care approaches through *accommodation, re-construction* and *re-patterning* could be the key to achieving care that is competent and culturally congruent that meets the care needs of first-generation Nigerian women and achieve professional effectiveness and proficiency for midwives. Reflecting on my multiple status as a FGNW, mother and midwife enhances objectivity in my role as a

professional and researcher and eliminates (as far as possible) the potential inherent biases of being an insider and outsider within conflicting roles. The methods of the current study are discussed in the next chapter with due consideration of how the theoretical framework compliments the method and methodology adopted.

Chapter 4: Methods

4.0 Introduction

In this chapter, the researcher details the methods of this study outlining the research approaches from recruitment of samples, focus group interviews prospective study and ethical considerations, as part of a robust research ethos.

4.1 Defining methods

Methods in research are the steps, procedures and strategies adopted by the researcher in gathering and analysing their data. It is a detailed plan of how the research is conducted, outlining specific tools and techniques adopted by the researcher from which other researchers should be able to replicate the processes. It includes sampling, data collection and data analysis plus other ethical considerations to do with the research such as trustworthiness and rigor (Cluett and Bluff, 2006). Caelli (2001) describes method as the research technique and the procedures for carrying out the research. Lopez and Willis (2004:726) warn that, "implementation of a method without an examination of its philosophical basis can result in research that is ambiguous in its purpose, structure and findings". Therefore, the philosophical basis of research method of the current study is herein discussed in order to enhance robust research ethos.

As established in the last chapter, this study is qualitative in its design. According to Walsh and Downe (2010), qualitative study has the power to explicate complex phenomena. Snape and Spencer (2003) assert that the aim of qualitative research is to provide in-depth understanding of our social world. This is achieved via four core objectives: (a) Contextual:

identifying the form and nature of what exists, (b) Diagnostic: examining the reason for, or cause of what exists, (c) Evaluative: appraising the significance of what exists, and (d) Strategic: identifying new theories, policies, plans or actions (Ritchie and Spencer 2002: 307). This approach focuses on meanings that the informants attach to their experience or their social world. According to Bowling (2009: 380), qualitative research aims to study people in their social settings and to collect naturally occurring data. The intention from an *emic* perspective is to understand the individual's view without placing value judgements during data collection, making sense of data through interpretation and validation of interpretation by informants. Rees (2011) suggest that a manageable sample is favourable in interview data to facilitate a more in-depth understanding of the phenomena. Furthermore, King and Harrock (2015) explain that qualitative research does not need to recruit a statistically representative sample of the population studied, but is more concerned with achieving different forms of transferability related in some way to the phenomena under investigation. Polit and Beck (2012) assent this view by suggesting that what is important in qualitative research is the richness of data gathered since it is the representativeness and trustworthy nature of the data that is most important within qualitative study model.

Furthermore, qualitative methods are concerned with attitudes, experiences and feelings as opposed to precise measurements and statistical analysis (Vishnewsky and Beanlands 2004). In this way, qualitative research humanizes healthcare. Exploring the *emic* birth practices of first-generation Nigerian women and the *etic* care approaches of midwives offer a powerful and rich source of qualitative data. According to Carolan (2006: 66), "greater emphasis needs to be accorded to valuing of women's stories as data". Whereas only quantitative research gained popularity in the past, recently qualitative research has become popular for a more in-

depth study of people's views and experiences, thereby providing a balance in contemporary research (Burns and Grove, 2001).

Research design is used to structure the research, to show how all of the major parts of the research project work together to try to address the central research questions. This study is a qualitative study that explore existing knowledge on emic care practices of FGNW through literature review, and used semi-structured interviews to generate data in order to detailed account of emic care practices, establish associations between emic practices of FGNW within a birth continuum, comparing and contrasting these against etic care provision by midwives to appraise competency and congruency in meeting the maternity care needs of FGNW during birth in London.

The study was planned in two stages. In **stage one**, an exploratory approach was taken through focus group discussions to obtain views about first-generation Nigerian women's emic care practices from three perspectives: the retrospective perspectives of first-generation Nigerian women with valid experiences of birth in London, and the perspective of Nigerian midwives and non-Nigerian midwives providing maternity care. The rationale for stage 1 of this work was firstly to explore their *emic* care practices and what they consider relevant in regards to meeting their cultural needs during birth, and also to use focus group with FGNW with retrospective experience of birth as an exploratory step to help determine the appropriate questions and categories to explore with FGNW in the prospective study. By examining the emic care practices of this cohort and analysing these, insight will be gained into interesting or unexpected findings that may inform the prospective study. Similarly, by examining midwives perspectives on FGNW's *emic* practices and the issues this may raise in their *etic* care

approaches, a broader understanding of their perception of competency and congruency could be ascertained to inform the prospective study.

Stage two of the study entailed obtaining the prospective views of six first-generation Nigerian women through semi-structured interviews at twenty-four weeks gestation, at six weeks postnatal and at three months postnatal. The purpose was to elicit their prospective *emic* care practices around pregnancy and birth in order to identify individual and group patterns as well as identify commonalities of cultural practices over the birth continuum. Moreover, this granted opportunity to provide a detailed narrative understanding of women's experiences, granting an opportunity to understand the wider social context of their birth experiences and to make connection between different areas of their lives as experienced through a continuum of birth. According to Barwell (2009:49), "a narrative has a tripartite structure with a beginning, a middle and an end". In this way, interviewing FGNW at the viability of pregnancy (24 weeks gestation), at the middle of birth experience (6 weeks postnatal) and at 3 months post birth gave a structure for capturing their stories of emic practices at three distinct phases of their childbirth experience. As prospective study is not affected by recall bias (Bowling 2009), changes in belief and practices of the prospective informants could be picked up at different intervals and analysed to reflect reported changes over time. Moreover, accounts of emic practices could be triangulated with either other records or other respondents to highlight changes in beliefs and practices. Such succession in the narration of events if coherent does represent events as an intelligible whole (Barwell, 2009).

Semi-structured interviews are a useful data collection tool in qualitative research, as they allow for participants to expand on their individual experiences. By using open-ended questions

on the topic guide, informants were given the freedom to bring the distinct understanding that narratives supply to the events they are about (their childbirth practices through a continuum). An advantage of this approach is that valuable information can be obtained, providing depth of relevant data (Watson *et al*., 2008). Recruiting a manageable sample is favourable in such interview data collection, to facilitate a more in-depth understanding of the researcher's question and to provide data-rich information (Rees, 2011). There were altogether eighteen prospective interviews and five focus group discussions with the recruited sample of twenty-four informants which provided saturation of categories, patterns and themes that has enriched understanding of how *emic* care practices of first-generation Nigerian women influence their care access, general health and wellbeing and the *etic* maternity care provision of midwives to this population in relation to achieving cultural congruency in their maternity care. Saturation of data means that data was collected until redundancy occurred; informants' shared similar content and the researcher noted recurrence of the same information (Weller *et al* 2016).

Edinburgh Postnatal Depression Scale (EPDS) (see appendix Q) was used at each interval in stage two to assess women for symptoms of psychological distress as part of gauging on-going psychological health or otherwise through the birth continuum. The EPDS provides a timely assessment of a mother's emotional state and has been validated as a good psychometric tool among postnatal Nigerian populations (Uwakwe and Okonkwo, 2003). Perinatal depression as a universal experience with variations across cultures and can affect mental capacity and influence the quality of information obtained from research participants. Therefore, in keeping with research ethos of ensuring mental capacity of participants in this research study, part of my obligation as researcher is to reach a judgement about the ability of participants to give consent, and also to consider the balance of the benefit of participation with an evaluation of

'proportionate risk' (Dobson 2008: 8) in view of the potentiality of perinatal depression with the prospective informants.

4.2 Recruitment of samples

Following National Health Service Multi-Centre Research Ethics Committees (MREC) approval (see appendix A), three NHS Trusts were approached and informed of the researcher's intention to commence recruitment of the study samples. Following this, all Nigerian women of childbearing age, fitting the selection criteria and accessing maternity care at the three NHS trusts and all midwives at the same Trusts were granted equal opportunity to participate in the study by individual invitation letters and information leaflets. Posters sign-posting the study were placed at strategic visible positions within the maternity units with information leaflets for women accessing maternity care at the study centres: Three NHS Trust in South London including community clinics within them (please see appendix B).

Inclusion criteria the target sample were self-identifying first-generation female Nigerians, within childbearing age, with a viable pregnancy and accessing maternity care within three Trusts in South-East London. Midwives were self-identifying Nigerian and non-Nigeria midwifery practitioners interested in the study and working within the three Trusts in South-East London.

Exclusion criteria from the study were non-Nigerian women, second and subsequent generation Nigerian women accessing care at the three NHS Trusts, Nigerian women with non-viable pregnancies, critically-ill Nigerian women and those whose pregnancies and / or births were complicated. Equally, Nigerian women with poor outcomes, for examples, those who miscarried or had intra-uterine death / stillbirth were excluded from the study as a measure to

safeguard their psychological wellbeing. No FGNW fitting this later description were encountered during recruitment or at any stage of this study. Midwives were only excluded by lack of expressed interest in the study.

The researcher through visits to each Trust to place study posters at strategic positions within the Trusts, advertised the study widely in three NHS hospitals and various community midwifery practices where Nigerian women were known to access maternity care. These measures were taken to ensure that all potential informants were reached and recruited to take part in the focus group discussions as well as the prospective study.

Midwives were randomly selected following advertisement of the study across three NHS Trusts. Random sampling enables those interested in the subject matter to volunteer, thereby highlighting their willingness. Baran and Jones (2016) advocate random sampling as a method to attain unbiased sample of participants who are drawn from a population without predictability and with equal chances for inclusion. As a result, random sampling is said to produce highly representative samples of the true population (Baran and Jones 2016).

There was need for purposeful sampling (of FGNW only) for both focus group and prospective cohort to ensure recruitment fitting the inclusion criteria (FGNW) and not Nigerian women of second and subsequent generations in order to access the desired population under investigation. Purposeful sampling is a type of non-probability sampling method in which the researcher selects subjects for the study based on which ones will be most representative of the population under investigation. Purposeful sampling is considered by Welman and Kruger

(1999) as the most important kind of non-probability sampling to identify primary participants, as it helps to identify those who have had experiences relating to the phenomena investigated (Cluett and Bluff 2006). However, Polit and Beck (2010) contest the usefulness of purposeful sampling, by asserting that if the elements in a study population were similar on core critical attributes, any sample will be as good as the other as the vital element of qualitative research is about gaining a sufficient sample to enable valid conclusions about the population. Polit and Beck (2010) however concede that qualitative researchers usually eschew probability samples, as purposeful sampling is not the best method for selecting people who will make good informants. However with more than one generation of Nigerian women accessing maternity care within the Trusts where samples were recruited, there was need for purposeful sampling to ensure recruitment of FGNW only and not second or subsequent generations.

For focus group discussion, the researcher had planned to recruit women accessing parenthood education from the three NHS Trusts in South-East London but this proved futile due to the lack of attendance of FGNW at these sessions. Moreover, parenthood education classes mostly target first-time mothers who would have no valid retrospective childbirth experiences. Therefore, an alternative approach was taken to approach FGNW with retrospective birth experiences in Britain at the researcher's local Church, as advised by her then research supervisor. These FGNW women were not personally known to the researcher but served as a convenient sample. Such sample are regarded to form part of non-probability sampling as subjects are selected because of their convenient accessibility and proximity to the researcher (Bowling 2009). This population were therefore invited to partake in the study through weekly announcements during church services and through weekly newsletter distributed in the church. Three weeks elapsed from briefing of the women to gaining the sample and seeking consent in order to allow a considered and fully informed consent from each woman. Six

women consented and took part in the focus group discussion after the researcher gained their full written consent. In keeping with research ethos, reflectivity is warranted in adopting this measure of studying local women known to the researcher and this has been accounted for within the previous chapter (section 3.6).

To ascertain the *etic* perspectives of midwives, two separate groups of midwives were recruited from two local Trusts (although three NHS Trust were approached) within MREC catchment area (South-East London) to ascertain their perception and views of Nigerian women's emic care practices around childbirth and the issues that may cause in providing etic care to this population. The sample constituted eight non-Nigerian midwives located in one Trust and four Nigerian midwives located in another Trust by mere co-incidence. In this way, a total of twelve midwives consented to take part in the focus group discussion. According to Kumar (2011), in qualitative research the sample size does not have any significant role, and Aveyard (2010) conveyed that a small sample is appropriate in qualitative research to enhance in-depth understanding of phenomena from information-rich informants. Hence, the guiding principle is data saturation (Polit and Beck 2010) which was achieved in this study.

For stage two of this study, 30 first-generation Nigerian women in early stages of pregnancy were approached at booking and invited to take part in the prospective study, which was to take place at twenty-four weeks gestation, six weeks postnatal and three months postnatal. Seven women consented but one withdrew her consent within a day of consenting, for personal reasons not explained to the researcher, leaving six women as the sample population for the prospective study.

To ensure retention of the recruited sample in this phase, the researcher ensured regular contact with participants through interval phone calls to track the progress of their pregnancies and to confirm births. Once notified of birth, cards were posted to participants to acknowledge the birth and to set dates of subsequent semi-structured discussions.

4.3 Stage one: Focus group discussion

4.3.1 Focus group discussion with six first-generation Nigerian women with retrospective birth experiences in UK

Focus group discussions were held with six first-generation Nigerian women with retrospective experience of childbirth in Britain. The focus group interview was orchestrated and facilitated by the researcher in the Church hall following a Church service as was previously agreed and arranged with the women. The discussants consented to audio and / or visual recording of the interview to keep track of individual input to the discussion. The entire discussion lasted an hour and thirty minutes on the whole.

The women considered the following topic areas for discussion:

1. Explore the cultural practices you adhered to during your childbirth experience in Britain and the presumed benefits and / or constraints of these to your health and wellbeing.

2. What do you consider culturally important for Nigerian women during pregnancy and childbirth?

3. In terms of childbirth practices, what do you consider the differences between Nigerian women in Nigeria and FGNW in London?

4. The women were also asked to examine the care they received from midwives in regards to meeting their cultural needs.

5. Topic guide for stage two of the study were also reviewed by this cohort in regards to appropriateness of the tool in addressing pertinent points about pregnancy and childbirth practices of FGNW in the prospective study to follow (See appendix: H.).

These questions were aimed towards obtaining the retrospective views of the women in regards to what they consider important in their birth experiences in regards to meeting their cultural needs. Information generated from the focus group discussion would also be useful to inform the prospective study. This retrospective account is considered useful for gauging matters of relevance to Nigerian women in childbirth. The second and third questions granted the general informants opportunity to highlight, outline, compare, contrast, and draw out the differences in childbirth practices between their home country and their current domicile as some of the sample had experiences of birth in their home country and in London. The fourth question was aimed at gaining the perspectives of FGNW on midwifery care in regards to meeting their cultural needs during birth experiences in London. Finally, the task of reviewing the content of the topic guide was sought from the women to ensure that the questions / topic guide to be used for the prospective study were relevant to first-generation Nigerian women and covered vital aspects of the issues that matter to this population in childbirth. The topic guide was confirmed as containing notions relevant to the focus group sample and hence likely to be relevant to the prospective sample. Therefore, modification of the data collection tool was not necessary, as the view of the focus group mirrored MREC approval of the tool.

4.3.2 Focus group discussion with Midwives

Focus group discussions were also held with two groups of midwives: eight non-Nigerian and four Nigerian midwives who responded and consented to participate in the study. The said focus group discussions aimed at exploring beliefs and practices that might be perceived by first-generation Nigerian women as health enhancing. Midwives were asked to explore cultural practices of FGNW women as observed during maternity care delivery and to evaluate the significance attached to these practices by FGNW; and to highlight any issue that may raise for them in providing etic care to FGNW.

An eleven-point topic guide (see appendix I.) specifically designed by the researcher to elicit information from the midwives and approved by MREC for this study was used for the focus group discussions with midwives. Polit *el al.*, (2001) affirm that topic guides enable discussants to tell their own story in narrative or conversational form. Use of open-ended questions was instrumental in obtaining specific in-depth information (Bowling, 2009) from midwives on their perspectives on FGNW's *emic* practices and the meanings given to these practices by midwives in regards to providing competent *etic* care to FGNW.

These focus group discussions also provided Nigerian midwifery discussants the opportunity to discuss FGNW's beliefs and *emic* care practices in pregnancy and childbirth as well as to explore their understanding of the meanings attached to these practices, as people from similar culture and ethnic identity with prior knowledge and understanding of some of the *emic* practices. Nigerian midwives were also to highlight the issues these may raise for them as midwives providing care to this population. Non-Nigerian midwives provided important views

about cultural practices that may not be questioned by Nigerian midwives due to commonality of ethnicity and the inherent familiarity with such practices.

Although by mere chance, all the Nigerian midwives were recruited from one NHS Trust and were interviewed in one location at different intervals due to the nature of the workload in this particular Trust. All non-Nigerian midwives were also recruited from one NHS Trust by mere chance. The nature of the workload in this Trust was more manageable and enabled two episodes of focus group discussions with six midwives in one sitting and two in a separate sitting. National Maternity Review (2016) highlight the effect of maternity unit culture on collective values of healthcare professionals. An increasing administrative burden and workload cited as a particular difficulty by midwives in the said maternity review, reflect the issues encountered while trying to organise focus group discussion in one particular unit closer to central London. Both groups of midwives explored their observed cultural practices of FGNW during care delivery episodes and the influence of these cultural practices on FGNW and maternity service provision. All focus group sessions were audio recorded and backed up with video recording with prior consent of participants and each session lasted one to two hours. Data generated from all angles of focus group discussions were to inform the prospective study through comparison of emergent characteristics of emic practices of FGNW as perceived by them and by midwives.

4.3.3 Stage two of study: Prospective interviews with six first-generation Nigerian women through a birth continuum

Stage two of the study involved detailed prospective semi-structured interview with six first-generation Nigerian women at twenty-four weeks gestation, at six weeks postnatal and at three months postnatal in their respective homes. The prospective approach is useful for studying trends in behaviour or attitudes as well as other characteristics (Bowling, 2009), and provides data about the same individual at different points in time allowing the researcher to track changes in behaviour (patterns of emic practices) at the individual level over a given period of time. Furthermore, the aim was to elicit their prospective emic care practices around pregnancy and birth through a birth continuum in order to identify individual and group patterns of emic practices as well as to identify modalities of such cultural practices. EPDS tool was also administered at each interview at this stage to ensure mental capacity and accuracy of information obtained from informants, and to screen manifestation of signs of psychological issues over the birth continuum. Data generated through both stages of the study are to be triangulated and compared with evidence from literature review to formulate knowledge about the birth practices of this population and the meaning they attach to these practices in relation to enhancing holistic health and wellbeing during pregnancy and birth and to inform midwifery practice of the expectations of FGNW on maternity care, so as to enhance maternity care that is culturally competent and culturally congruent to meet the care needs of this population.

4.4 Data collection and tools

Data gathering was achieved through use of an eleven-point topic guide (a semi-structured tool appendix H and I) designed by the researcher and approved by MREC for this study. The topic guides were useful to elicit emic care practices of FGNW and to ensure coverage of all relevant

variables. Parahoo (2014) advocate the use of semi-structured tool which comprises elements of both qualitative and quantitative questions to generates richer data and assert that use of pre-determined questions and control of the researcher of the flow of discussion within the interviews provide structure interviews. During the prospective discussions that took place in the women's homes, the emphasis was on gathering narratives understanding of the cultural practices of each participant woman during current pregnancy and childbirth experience in their most convenient environs. Specific open-ended questions were asked pertaining to each woman's experience of cultural practices. Open-ended questions are ideal for qualitative research study as they allow the respondent to answer in their own words, allowing expression of feelings, beliefs and values. However, they can also be burdensome for respondents who have difficulty articulating their responses (Cluett and Bluff, 2000).

Video recording used as an aide memoir allowed integration of audio, visual interaction and environmental material and brought significance to events during data gathering. As communication is both verbal and non-verbal, use of video recording was useful to obtain significant gestures and expressions of some of the informants and for recording the emphasis attached to some of the expressions.

The researcher guarded against equipment failure and other environmental conditions that could threaten the gathering of data using information technology (IT). To ensure anonymity, tapes were labelled with code names to identify each discussant and the researcher adhered strictly to confidentiality by retaining the ascribed codes in the extracts or quotes used during data analysis. The IT support pre-arranged by the researcher was the key to achieving successful recording of discussions. IT assistance was also instrumental in transferring data

from tapes to compact discs for ease of transcription. The data storage therefore included audio tapes, compact discs, hard copy documentation of consent forms, transcripts and videos. Other methods for field notes such as theoretical and methodological notes were helpful in the data gathering exercise. Theoretical notes were also made to enable the researcher to derive meaning when reflecting on data gathering experiences. Equally, methodological notes served as reminders, instructions and critical remarks to oneself on the data gathering process (Greenwald, 2004). As previously discussed, EPDS was used (see appendix: Q) to gather data on psychological health and to ensure mental capacity of informants. The usefulness of the EPDS screening tool is discussed further.

4.5 Use of Edinburgh Postnatal Depression Scale (EPDS) for screening psychological wellbeing of women

Screening women with EPDS has been recommended by various authorities concerned with public wellbeing, such as The National Framework for Young People and Maternity Services (NSF, 2007). The National Institute for Clinical Excellence (NICE, 2007) approved the use of the EPDS as a screening tool for depression during antenatal and postnatal periods as was implemented in the current study. Screening is a public health service in which members of a defined population, who do not necessarily perceive themselves as at risk, or are already affected by a disease or its complications are asked questions or offered tests to identify those individuals more likely to be helped rather than harmed by further tests or treatment. Screening is undertaken in a bid to reduce the risk of disease or its complications (UK National Screening Committee, 2009).

The EPDS, which is a ten-item self-report scale for screening Postnatal Depression (Cox *et al*., 1987), was utilized in the current study and administered at 24 weeks gestation, 6 weeks postnatal and at 3 months postnatal to assess the psychological health of women participating in the prospective study and to gauge mental capacity of informants in this study. The EPDS consists of ten statements with four possible responses related to moods and feelings. Responses to each of the items on the scale are given a score of zero to three points. A score of zero indicates absence of symptoms while a score of one or two points are intermediary statements; and a score of three points represents maximum psychological symptom worthy of further investigation. Respondents are asked to indicate their reaction to each of the items in the self-report scale. A total score of twelve points on the completion of the scale is identified as the point at which healthcare workers should be alerted to the risk of depression being present. According to Cox *et al.* (1987), a score of twelve or more is suggestive of the existence of depressive symptomology, while higher scores are indicative of the existence of postnatal depression. However, it is suggested that the result of the scale must be interpreted in combination with clinical judgement to confirm existence of depression (Torralba, 2007). According to NICE (2007), women screening positive for depression during maternity care should receive standard treatment, such as, self-help strategies, non-directive counselling delivered at home, and brief cognitive behavioural therapy.

Uwakwe and Okonkwo (2003) conducted a study using EPDS to assess the rate of depression in Nigerian women living in Nigeria and found the tool useful and reliable to distinguish between depressed and non-depressed samples of women. The author acknowledged that depression is difficult to detect in African culture, as there is no known language that has an equivalent to the word 'depression'. In similar vein, Onazarawa *et al.* (2003) study amongst non-English speaking women in London found that a greater proportion of women in minority

ethnic groups scored in the depressed range on the EPDS than their white counterparts, hence necessitating need for screening to population of this study as women of minority ethnic groups vulnerable to perinatal depression. However, there was under-representation of BME groups in this study, probably as a result of language difficulties. Their suggestion that women from a non-English speaking background should be regarded as being at a higher risk for postnatal depression is questionable factoring in the lack of proportionate representation in their sample.

Withholding of real affects by women completing the tool is another common difficulty of the EPDS, as reported by Shakespeare *et al.* (2003). In addition, EPDS being devised for postnatal depression screening makes it unsuitable for routine application in the antenatal period, although some researchers have administered it in the antenatal period with varied success. These difficulties give rise to controversies over accurate screening using EPDS amongst African populations. However, Uwakwe and Okonkwo's (2003) study established the usefulness of this tool for screening depression on a Nigerian sample. In the current study, administration of the EPDS was simple due to fluency of the population in English language and the commonality of language of the researcher and researched, as well as exposure of the study population to the EPDS tool within the UK healthcare system. In addition, previous experience of administering the tool by the researcher during her MSc study made for ease of understanding of the items on the EPDS tool.

4.6 Ethical considerations

There is a need for maintenance of basic ethical and moral principles that have relevance for clients' safety within research. According to Cluett and Bluff (2006), ethics in research can be

considered the degree to which the researcher conforms to moral standards in relation to legal, professional and social accountability. As per robust researcher processes, ethics approval was sought from Multi-Centre Research Ethics Committee (MREC) which has a dual duty of protecting the rights, safety, dignity and well-being of research participants; and facilitating and promoting ethical research that is of potential benefit to participants, science and society. In line with this, approval and official recognition of this study (MREC ref: 08/H0810/66) was gained (see appendix: A). Ethical considerations also include confidentiality, informed consent, voluntary participation, and protection of participants against physical or emotional harm. Participants in all angles of this study were recruited through ethical principles of informed consent, respect for anonymity, confidentiality and identity of participants by observing Data Protection Act (1998), un-coerced participation and / or withdrawal, and keeping to ethical principle of beneficence (balancing benefits, costs and risks of research) and non-maleficence (doing no harm) to the participants (Cluett and Bluff 2006). These measures are in line with ethical principles guiding contemporary research studies in health and have been attended to and have been further discussed within relevant sections of this thesis. This also included arranging debriefing services for participants in regards to any potential psychological issues that may arise from partaking in this study. Maternity unit counsellors of the study settings were approached and agreed to provide counselling services for participants for whom reflecting on their childbirth experience might induce adverse emotional reaction(s).

In line with this research ethos of credibility, the researcher was already confirmed credible through the Criminal Records Bureau Check routinely completed as part of her employment requirements. Written consent was sought and gained from all participants in this study. Audio / video recording of each interview was included in the consent sought / obtained. The researcher retains these within the specifications of Data Protection Act (1998) so that

information given by informants is held in strict confidence, anonymised and will be appropriately destroyed at the completion of the project and following the dissemination of findings through publications.

4.7 Illustration of Study design and method

Does culture influence the birth experiences first-generation Nigerian women?

Figure 3: Illustration of Study design and method

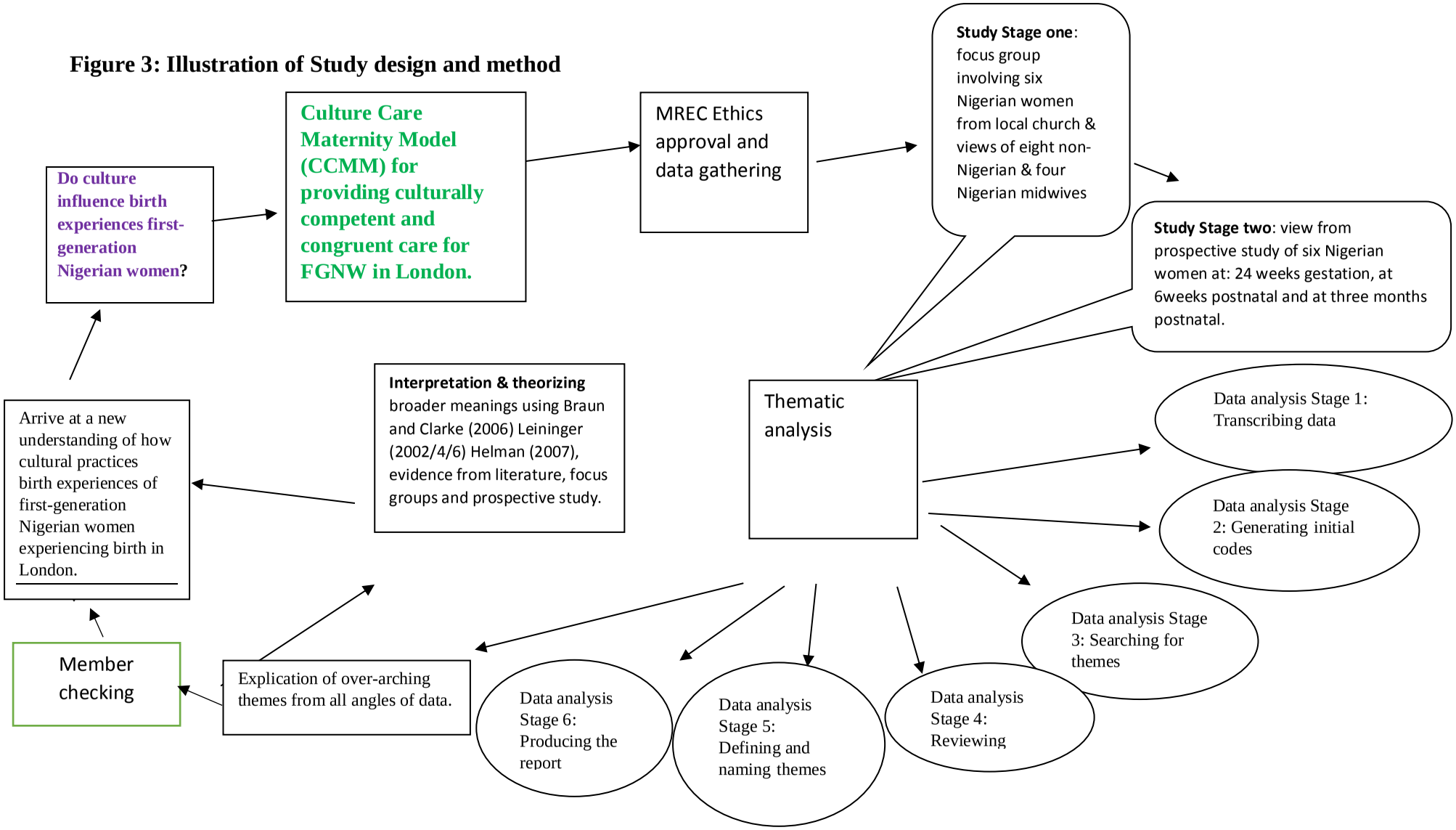


Figure 3: Illustration of study design and method.

The illustration above portrays the cumulative design and method necessary for pursuing and obtaining data for enhancing culturally competent and congruent care for FGNW in London. The reader is guided through the diagram starting from the top far left in which the research expected outcome is stated. The positions of the arrows are intended to point to the processes for achieving culturally competent and congruent care that meets the needs of first-generation Nigerian women. Arrows lead through data gathering stages and analysis, thematic analysis, interpretation and theorizing processes that lead to understanding of how cultural practices influence the birth experiences of FGNW experiencing birth in London and the means through which culturally competent and congruent care can be achieved.

Integrating Leininger's (2002, 2004 and 2006) and Papadopoulos *et al*. (2008) trans-cultural research framework to formulate Culture Care Maternity Model (CCMM) in this regard called for FGNW informants to discuss their emic care practices and for midwives to explore how emic care practices of FGNW influence their etic care provision, the researcher's role was to interpret the narratives to grant it meaning in a manner that generates new knowledge to inform midwifery education and practice. The detailed narratives place the current study firmly within the qualitative approach informed by the philosophy of trans-cultural epistemology of culture and trans-cultural care. The researcher in exploring, interpreting and tracking changes in what FGNW women say they do over the continuum of a pregnancy, birth and postnatal periods, arrived at new understanding of their childbirth emic care practices and the perceived benefits or constrains of these on their perinatal health and wellbeing. Similarly, obtaining detailed perspectives of midwives on FGNW's emic care practices and the influence these may have on etic care provision enables exploration of midwives cultural competence in providing maternity care that is culturally congruent for FGNW. The knowledge derived from literature review, focus group discussions and prospective study would then enhance understanding of the

significance of first-generation Nigerian women's emic beliefs and practices, to inform etic midwifery practice; thereby enhancing culturally competent and congruent care through the application of Culture Care Maternity Model (CCMM) that can inform midwifery practice, guideline and policies in achieving culturally competent and congruent care for this population.

4.8 Data analysis tools: Braun and Clarke (2006), Leininger (2002) and Qualitative framework

Through a thematic analytical approach utilising Braun and Clarke's (2006) model (see tables 3 and 4), informed by Leininger's (2002) phases of data analysis and qualitative framework, concepts have been drawn from transcribed data generated through focus group interviews and prospective interviews to formulate categories through which over-arching themes are devised. The concepts drawn from each interview represent each informant's experience, while the categories are the representation of the dominant features of the entire group of informants' experiences. The collation of these into over-arching themes enhanced the representation of the collective voices of the women and midwives about childbirth practices and maternity care provision of first-generation Nigerian women. Themes are derived from analysis and synthesis of both focus group and prospective study data and then confirmed with informants for accurate representation and meaning (member checking). In the subsequent chapters, themes are critically discussed to derive meanings from the emic and etic perceptions of cultural practices of this population. Within this interpretative cycle, clarity is gained by accurate reference to focus group evidence, the shared experiences of the core informants and the triangulation of these with theoretical evidence drawn from literature review. Nonetheless, much as interpretative approach is about understanding human behaviour, Green and Thorogood (2014) suggest that full interpretation of human behaviour is somewhat inappropriate and

unachievable as humans differ from objects, which makes studying or analysing them difficult. Triangulation is fully explored in chapter five. In this way, the theory that arises from this trans-cultural research is inductively derived and has applicability to the beliefs and practices of first-generation Nigerian women (*emic*) and the etic perspectives of the midwives.

Thematic analysis is an interpretative process in which data is systematically searched for patterns to provide illuminating descriptions of the phenomena, resulting in the development of meaningful themes (Smith and Firth, 2011). A qualitative framework template is used as a data management tool to support data analysis: summarise data, view and interrogate data, search notes and indices so as to order data to facilitate interpretation. Although a qualitative computer programme (Framework-natcen) was useful for managing data (Smith and Firth 2011), manual methods of explication of data from characteristics, patterns and themes was much preferred by the researcher as a way of getting well acquainted with data generated at all stages of data gathering. However, proponents to the use of computer programmes would advocate freeing up researchers' time to permit attention to more important conceptual issues.

Data interpretation involved thematic analysis, systematic classification and explanatory interrogation of data to derive meaning. These approaches are combined with Leininger's (2002) data analysis approaches. The intention is to compare and contrast views from all angles of the study, to arrive at a new knowledge and understanding of the emic and etic perspectives of FGNW's cultural practices and the perceived influence to their health and / or wellbeing and to inform the development of culturally competent and congruent care that meets the maternity care needs of this population. The synergy between responses will be gained by a triangulation of perspectives from focus group interviews, interviews of general informants and semi-

structured in-depth interview of key informants' and appraisal of these with existing knowledge gained through literature review.

Thematic analysis should be seen as a foundational method for qualitative data analysis as it aids the description and interpretation of discussants views. Analysis is achieved via identifying, analysing and reporting patterns and themes within the data. It is considered useful for formulation of concepts from the data generated from in-depth semi-structured interviews as it offers full engagement with data and therefore is an accessible and theoretically flexible approach (Braun and Clarke, 2006). It also permits the researcher to minimally organise and describe data in rich detail and enables the interpretation of various aspects of the research topic (Braun and Clarke 2006). According to the later, "thematic analysis can be a method that works both to reflect reality or to unpick and unravel the surface of reality" (Braun and Clarke, 2006:81). Earlier, Walcott (1994) described three primary categories for organisation and presentation of qualitative data as description, analysis and interpretation. This fits well with Ethno-Nursing approach (Leininger, 2006a) as both entail similar methodological approaches. The descriptive category is about considering 'what is going on' and this is achieved through observations made by the researcher through reading and re-reading data. The explication / analysis phase is about considering 'how things work', by identifying features and systematic descriptions of relationships among data resulting in explication of patterns that form themes. The interpretation phase considers 'what is to be made of it all' by providing a sense of meaning about the data through interpretation of participants' expressed opinions. In this data explication, the researcher plays an active role in identifying patterns / themes drawn from the data, highlighting over-arching themes and reporting on these. As Braun and Clarke (2006) warn, the notion of themes emerging can give an erroneous impression of themes residing in

the data and emerging like ‘Venus on half shell if we but look hard enough’. Hence, the researcher prefers explication of themes to the ‘emergence of themes’.

Thematic analysis has however been criticised by Smith and Firth (2011) as lacking depth and causing fragmentation and loss of meaning when patterns of data are separated from their original source during data interrogation. For these reasons, Smith and Firth (2011) caution that findings from thematic analysis may lack transparency and result in subjectivity. To avert this situation, a common set of principles of self-immersion in the data is undertaken by the researcher to gain detailed insights into the phenomena under investigation. These detailed insights can lead to the development of theory and arrival at new understandings of emic care practices of first-generation Nigerian women and the influence of these on etic care approaches of midwives.

For rigor, the researcher is guided by qualitative research epistemology in utilizing thematic analysis in her interpretation, deduction and theorising of meaning from the data to explore how the phenomena of birth practices can be made known to the researcher. Braun and Clarke’s (2006) model of ‘phases of thematic analysis’ informed by Leininger’s (2002) phased data analysis have been followed and are described further as follows:

Table 3: Braun and Clarke's (2006) model for thematic analysis

Phases	Description of the process
Stage 1: Familiarisation with data	Transcribing data, reading and re-reading the data, noting down ideas.
Stage 2: Generating initial codes	Coding interesting feature of the data in a systematic fashion across the entire data set, collating data relevant to each code.
Stage 3: Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Stage 4: Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis.
Stage 5: Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Stage 6: Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Reproduced from Braun and Clarke (2006): 'Phases of thematic analysis

Explication and analysis of data have been used deliberately as interchangeable terms used by researchers to give account of the processes used to explore research data. Explication is used herein to imply an interrogation of the constituents of the phenomena under investigation, while keeping the context of the whole phenomena (Greenwald, 2004) and is more suitable than is 'analysis' which means breaking into parts; and at times could imply a loss of the whole phenomena.

The themes drawn from data analysis will capture something vital about the generated data in relation to how culture influence the birth experiences of FGNW, and the influence emic and etic care approaches on culturally competent and congruent care. An inductive and semantic approach is adopted in generating themes through coding and identification of patterns between each piece of data generated from the focus groups and prospective discussions in order to provide a rich thematic description of the entire data set to enable the reader to get a sense of the predominant themes.

Inductive analysis approach entails coding data without trying to fit it into a pre-existing coding frame or one's analytic preconception, and hence averts the bias of pre-supposition. Semantic approach enables the researcher to identify themes within the explicit or surface meaning of the data (Braun and Clarke, 2006) without going beyond what the participants have said or what has been written about cultural practices in childbirth. In this regards, Bowling (2014) suggest that verbatim recording and transcription are essential for gathering data to ensure meaning is not distorted or lost.

Having personally obtained the data via interactive means, some immersion with the data occurred during data gathering and transcription to have familiarity with the depth and breadth of the content. One therefore started transcribing with prior knowledge of the data and possibly with some initial analytic interests or deliberation through memos (self-reflection on the data gathering exercise). This entailed recording reflective notes about what one was learning from the data gathered and transcribed as the discussions progressed. This is encouraged by Braun and Clarke (2006) and Leininger (2006) as a measure to ensure engagement with the data.

Transcribing was an excellent way to get to grips with data breakdown as it aided the creation of meanings to the data generated by interviews. Analysis of the various audio recordings (backed with video recording) of the interviews involved detailed scrutiny of particular fragments to illuminate meaning of participant's verbal and non-verbal expressions. In this way, analytical approaches aided the deconstruction of assumptions and fostered understanding of the meaning of these experiences for the informants. The researcher adopted a rigorous orthographic verbatim transcript account of all verbal and relevant non-verbal cues / gestures recorded during data gathering and highlighted interesting categories of the data as she transcribed. Temporary validation of transcription data was accomplished through the appointment of a midwifery tutor colleague who reviewed the interview recordings independently before cross-checking the details with the researcher's transcript. Accuracy of transcript against recording was confirmed. This researcher remains grateful to the colleague for completing this time-consuming task.

The second phase of data analysis involved the production of initial codes from the data. This entailed inclusive extraction and coding of elements of the raw data that can be assessed in a meaningful manner regarding the phenomena under discussion. These were sketched in clusters relative to each code (concepts) on a table (see appendixes: L, M, N and R).

At phase three of data analysis, as potential themes (categories) were explicated, there were candidate themes placed under a 'miscellaneous category' as they did not appear to fit perfectly into obvious themes. According to Dye *et al*. (2000), this is not uncommon as expressed via

their kaleidoscope metaphor (the process of turning things around) to create new patterns and capturing new arrangements. Like the kaleidoscope, it is the duty of the researcher to ensure meaningful coherence of data as well as specific distinctions within themes. This proved laborious task that is not only time consuming but also mentally and physically draining but yet rewarding once undertaken with accuracy.

Phase four of thematic data explication is about reviewing and refining themes, checking for the appearance of coherent patterns and refinement of ill-fitting themes. There was a need to ensure validity of individual themes in relation to the data set (Braun and Clarke 2006) for accurate representation of meaning within the data set. Where a theme fell outside the data set, some re-coding and refining was necessary to arrive at satisfactory themes. This process was repeated until definite themes were identified that portrayed a representative map of the generated data. The refined themes were grouped into overarching themes for explication, discussion and interpretation at a later stage of this study.

At phase five, the essence of what each overarching theme is about appears. Here the analysis of each overarching theme is undertaken, exploring the story that each tells and linking it back to the original enquiry. Sub-themes may be useful in giving structure to complex and overarching themes and for exploring hierarchy of meanings within the data. The content of each overarching theme is made explicit through the concise and punchy subtitling used within themes.

The final phase of thematic analysis is about exploration and analysis of a selection of core themes and writing up of the project using substantive data extracts from the data source. This exploration should be linked to the topic under enquiry as well as to existing literature and current research evidence on the topic in order to arrive at new knowledge and enhance understanding of the concept under investigation.

Interpretation is central to qualitative and trans-cultural research studies (Kincheloe and McLaren 2005, Leininger 2006a). The adoption of an interpretative stance in examining data will render a sense of the lived experiences of first-generation Nigerian women's emic childbirth practices and midwives etic perspectives and the influence of these on birth experiences of FGNW. Discussion and triangulation of study findings with existing knowledge enables interpretation by researcher. Affirmation of interpretation through member checking aids validity and extrapolation of knowledge from these experiences reported.

For rigor in data analysis, Braun and Clarke (2006) emphasize the need to ensure that:

(a) the analysis or explication of data is convincing to someone who has not read the entire data set.

(b) the analysis or explication of data be constructed to persuade the reader of the plausibility of an argument.

(c) the researcher should ensure that their interpretations and analytic points are consistent with the data extracts, hence the need to affirm interpretation with informants.

(d) to avoid mismatch between theory and analytical claims, hence the need for triangulation of methods.

(e) to ensure that the researcher spells out the assumptions and clarify how it was undertaken and for what purpose (Braun and Clarke 2006: 96).

4.9 Ensuring Validity through Trustworthiness, Rigor and Triangulation

4.9.1 Trustworthiness or credibility is core to qualitative studies as a criterion for evaluating integrity and quality of the study and enhancing confidence in the truth of the data (Polit and Beck, 2010) and is used here to denote measures taken to ensure reliability and validity of this study. Reliability as a research term is more applicable in quantitative research; hence, trustworthiness or dependability is favoured in this discourse. Trustworthiness can be used to examine both the process and the product of the research for consistency. Trustworthiness also places emphasis on research findings reflecting the reality of the experience in terms of accuracy and honesty in presentation of data. Trustworthiness was achieved in this study through member checking with academic colleague and FGNW. According to Golafshani (2003), in qualitative paradigms the terms credibility, neutrality or confirmability, consistency or dependability and applicability or transferability are to be the essential criteria for measures of quality and rigor. These are research ethos upheld in this study.

4.9.2 Rigor is used in qualitative research in reference to the discussion about reliability and validity of the data and the reduction of bias (Davies and Dodd 2002, Bowling 2009). Bowling (2009) asserts that validity include essential features of the research process such as rigorous approaches already addressed in the previous and current chapter of this work. These are

inclusive of a systematic approach to the design of the research, awareness of the significance of interpretation rather than assumption, methodical collection, analysis and interpretation of the data, member checking, keeping detailed records of discussions, interviews and observations, and the use of mixed or triangulated methods to keep a check on the validity of findings and explicability of the study. Validation of prospective data has been sought from all informants and a face-to-face affirmation of the focus group (three out of six women), verbal affirmation by midwives (four out of twelve) and affirmation of prospective sample (three out of six women) were gained via text and emails from the key informants. Using focus groups and longitudinal prospective interviews enhances validity (Bowling, 2009). Nonetheless, face validity was confirmed by two experts in the field of midwifery: one was a director working in the professional regulation office of (Royal College) of the researcher's profession, and the other was the researcher's senior colleague with over three decades of midwifery practice and active in research and scholarly activities. Furthermore, the publication of aspects of this work in British Journal of Midwifery (Dike 2013) and African Journal of Midwifery and Women's Health (Dike 2013) adds to face validity of this work, although the latter can be perceived as subjective. Nonetheless, these steps are necessary in qualitative research and are in line with Parahoo (2006) and Leininger's (2006) recommendations for verification of study findings and affirmation of validity of interpretation of data.

4.9.3 Triangulation

According to (Hussein, 2009), researchers use triangulation to increase their in-depth understanding of the phenomenon under investigation by combining multiple methods and theories. Both theoretical and analytical triangulation (Hussein, 2009) has been adopted in this study for validation purposes. Through triangulation, convergence is sought among multiple

and different sources of information from which the theoretical framework was formulated and data generated in the formulation of themes or categories. Firstly, multiple theories of culture, culture care, and trans-cultural care formed the theoretical and methodological approach of this study. According to Bryman (2004), different theories help researchers to see problems at hand using multiple lenses. In theoretical triangulation, both related and / or competing theories may be utilised in formulating hypotheses for providing broader and deeper understanding of research problems. Data analysis triangulation, on the other hand, entails using more than two methods of analysing the same set of data for validation purposes (Bryman 2004, Hussein 2009). Combinations of Culture Care Theory, trans-cultural care approaches of Leininger and Papadopoulos and review of existing knowledge forms the triangulation of theory and methods that validates this study. This approach is taken 'to enrich the research process' (Magnusson *et al*., 2005) by enhancing completeness of views rather than confirming findings (French and Kiger, 2005).

4.10 Chapter four conclusion

Attempts have been made in this chapter to make explicit the links between theoretical frameworks, ethical considerations, the methodological approaches as well as methods and validity processes that underpinned this research effort. In the subsequent chapters, themes explicated from all phases of this study (literature review, focus groups and prospective interviews) will be presented, triangulated, discussed and interpreted to reach an understanding of the influence of emic and etic care practices on the birth experiences and how this interplay with competency and congruency in maternity care provision of first-generation Nigerian women in London.

Chapter Five: Results from both stages of study (focus group and prospective study).

5.1 Introduction

This chapter explores the details of focus group interview, demographics of the participants, the explication of categories, codes, and themes arising at all intervals of the study, utilising a qualitative framework and ethno-nursing research approaches. Some of the core features and gains of a qualitative framework include enabling a summary of transcripts or field notes, cases and themes, ability to search original texts and summaries (Huberman and Miles, 2002). Through a thematic analytical approach utilising Braun and Clarke's (2006) model informed by Leininger's (2002) phases of data analysis already outlined, concepts have been drawn from transcribed data generated through focus group interviews and prospective interviews to formulate categories through which over-arching themes are devised. The concepts drawn from each interview represent each informant's experience, while the categories are the representation of the dominant features of the entire group of informants' experiences. Code is the label that is given to particular pieces of the data that contribute to a theme. The collation of these into over-arching themes enhanced the representation of the collective voices of FGNW women and midwives about childbirth practices, experiences and maternity care provision. Themes are derived from analysis and synthesis of both focus group and prospective study data and then confirmed with informants for accurate representation and meaning.

5.2 Details of focus group interview

The focus group interviews occurred over a total of nine hours in a three-month period and involved eighteen informants, in five separate sessions, using four venues. There were 18 general informants and a total of nine hours of interview. The participants were mostly

interviewed at convenient locations chosen by them such as the researcher's local Church, Trust seminar rooms and offices to minimise potential inconveniences or participant embarrassment, and travelling costs.

Initial descriptive data generated from the focus group interviews were about the length of service of the midwives. These have been manually calculated and indicate that most of the of midwives were highly experienced and had practiced for a range of 4 to 30 years, giving a mean period of service of the midwives as 14 years and two months respectively. These lengths of service indicate that these midwives are experienced and would have encountered first - generation Nigerian women in their many years of midwifery practice. However, it was evident during the focus group discussions that the midwives reporting only four years of practice had limited encounter with first-generation Nigerian women and hence limited knowledge of their *emic* care practices. The experienced midwives serving for 6 to 30 years have worked within hospital and community settings that appear to have enriched and enhanced their encounter and understanding of some of the *emic* care practices reported.

Six FGNW who took part in the first focus were women who had retrospective experience of birth in London and were members of one church and hence preferred to have the interview in the church hall following church service. This focus group discussion was interactive and lasted for two hours. Snacks were provided for this meeting by the researcher for the comfort of the discussants. Table three holds more details of the focus group.

Table 4: Details of focus group interviews (researcher facilitated)

Focus groups	**Venue**	**Date**	**Participants**	**Length of practice**	**Duration**
Non-Nigerian midwives in NHS Trust, Kent	Tambotie Seminar room	6th April 2009	6	4, 6, 17, 22, 25 and 30, years respectively = mean of 17.3 years of midwifery practice.	2 hours
Non-Nigerian midwives at NHS Trust Kent	Sister's office in Antenatal Clinic	22nd June 2009	2	21 and 22 years respectively = mean of 21.5 years of midwifery practice.	1 hour
Self-identifying Nigerian midwives in an NHS Trust Woolwich	Staff office	21st July 2009 23rd July 2009	2 separately 2 separately	4, 4, 6 and 10 years respectively = mean of 6 years of midwifery practice.	2 hours 2 hours

First generation Nigerian women with retrospect childbirth experience in London	Researcher's Local Church meeting room	26th July 2009	6	Not applicable	2 hours
Totals	4 venues	3 months	18 general informants	14.2 average years of midwifery practice.	9 hours

5.3 Demographics of Prospective cohort

Demographics diversity are characteristics, which provide grounds for social grouping as well as self-identification considered objective qualities affiliated with certain groups of interest, values or social organisation (Murdock *et al*., 2015). This falls under the categories of age, area of residence, level of education, sex, job title, marital status and religion, in a manner that influences health outcomes (WHO, 2008). Demographics of FGNW and midwives were obtained with use of questionnaire prior to focus group and at the initial stage of prospective discussions and are presented on Table 5.

Table 5 Interval 1: Interview conducted at 24th gestational weeks

Period of Interviews	Informant: age (years old) and status	Year(s) spent in Nigeria	Interview date and venue	Duration	EPDS scores	Parity	State in Nigeria	Languages spoken
24 weeks gestation	Informant 1 25years old Medical Doctor. Married	24	23rd July 2009 at DVH seminar room by client request.	2 hours	6	0	Edo (West)	Yoruba & English
	Informant 2 35 yrs old PGDip management, Unemployed Married but living alone	34	23rd July 2009 at DVH seminar room by client request.	$1^{1/2}$ hours	3	0	Anambra (East)	Igbo, English & Dutch
	Informant 3 25years old Student (BSc Health) Married	15	29th July 2009	1 hour	3	0	Lagos (West)	Yoruba & English
	Informant 4 29 years old	27+	27th Oct. 2009	1 hour	6	1	Imo (East)	Igbo & English

	National Diploma Married							
	Informant 5 34 years old Bachelor degree Married	32	12th November 2009.	1 1/2 hours	8	2	Lagos (West)	Yoruba & English.
	Informant 6 34 years old (lawyer) Married	30	10th February 2010.	1 1/2 hours	0	2	Enugu (East)	Igbo & English, Husband Yoruba.

Initial interviews at 24 weeks gestation took place at a local NHS Trust for two of the Nigerian women informants and in the antenatal clinic for one informant by their expressed preference. Elwood and Martin (2000) in their research study titled 'Placing interviews: location and scales of power in qualitative research' argue that location influences information that is communicated in research interviews as well as the power dynamics of the interview. They contend that participants given a choice of the location / venue of research interview feel more empowered in their interaction with the researcher.

The demographics of the prospective informants were as diverse as the population studied. The ages of the women ranged from 25 to 34 years with mean age of 30 years. The age range of 25 to 34 years of this population is dissimilar to that reported by Ukwuani and Suchindram (2003) for Nigerian women in Nigeria, where 39.2% of mothers in their study gave birth at younger

ages (<25 years) while about 14% gave birth in older ages (35-49 years). According to World Health Organisation survey in 2003, 4.3% of Nigerian women aged between 15–19 years were pregnant with their first child. The same report indicated that at sub-regional level, a higher proportion of teenage pregnancies were found in women residing in the North East and North West areas of Nigeria (WHO, 2013). The age range in the current study depicts the current reproductive trend for non-UK born women in Britain, were the 25 to 34 age group had the largest percentage of births with proportionally fewer births to non-UK born mothers aged less than 25 years in 2011 (ONS 2009, 2012; Zumpe *et al* 2012). This change in reproductive pattern between first generation Nigerian women in London and their counterparts in Nigerian could indicate acculturation by first-generation Nigerian women in choosing to reproduce in similar age ranges to the women in their domicile country (UK) rather than their Nigerian counterparts living in Nigeria.

The status of the informants ranged from unemployed student to medical doctor and lawyer. They were all educated to Higher Education level (Diploma to Bachelor degree). Interestingly, they were all self-identified married women supported by their respective husbands. WHO (2012) in their study report on the demographics of Nigeria reported that, the proportion of married respondents in North West Nigeria was (94.6%) in the 25 to 34 age group and the proportion of respondents who ever attended school in North West Nigeria was (32.7%). Sadly, the educated figure for Eastern and Southern Nigeria from which the sample of the current study originate were not given in the said WHO report. According to the WHO (2012) report, of those who had ever attended school, more than 60% were engaged in Income Generating Activities, the highest proportion being in the South West of Nigeria (89.1%). This latter figure is more in line with the researcher's knowledge and understanding that South West Nigerian

women are mostly resourceful in terms of academic pursuits and Income Generating Activities, while women from Northern Nigeria are characteristically homemakers. Furthermore, Ayanwuyi and Akintonde's (2011) study examined the income generating activities of rural women in ensuring household food security in Osun State, South West Nigeria and found that, a significant relationship (0.05%) exists between some selected socio-economic variables and income generating activities of the rural women in the study area. Their study samples were (60.0%) literate with different educational backgrounds, while 40.0% of respondents did not have formal education. These reported demographics differ from those of the current study, as most were educated, middle class and Christian.

There tribes were an even mix of Igbos (3 in number) and Yoruba's (3 in number) with parity of 0-2 respectively. Although efforts were made to recruit women representing all Nigerian regions living in London, the population of this study are predominantly South-Eastern and Western Nigerians of Igbo and Yoruba tribes in even proportions (three from each region). This occurred by mere chance and hence could not have been anticipated. Still, the researcher regrets the lack of representation of Northern Nigerian women in the prospective study. This was due to lack of presence and lack of response from first generation Northern Nigerian women living within the NHS catchment of current study. Further obstacle to recruiting women from Northern Nigeria emanate from Nigerian history and migration. Intrinsically, postcolonial conflicts influence the migration patterns in Nigeria. The Nigerian-Biafran war created massive movement of Nigerians across the world. South-eastern professionals, students, job seekers, women and children were among those who left the country due to political instability and insecurity. Nigerian Northerners rarely migrated internationally as they held and still hold the

financial and political power strings of the nation (Cross *et al*., 2006). This resulted in the lack of representation of Northern Nigerian women in this study.

The interviews lasted one to 2 hours each. Their EPDS scores which ranged from 0- 8 were non-indicative of psychological or psychiatric pathology as the cut-off of >10 indicative need for referral and ≥ 13 as sign of depression (Cox *et al.,* 1987).

Table 6 Interval 2: Interview conducted at 6 weeks post birth

Period of interviews	Informants	Interview date & venue	Duration	EPDS scores
6 weeks post birth	1	21st October 2009 at own home	I hour	6
	2	28th January 2010	1 1/2 hours	7
	3	26th October 2009 at own home	1 hour	9
	4	13th April 2010 at own home	1 1/2 hours	4
	5	25th May 2010 at own home	1 1/2 hours	3
	6	16th June 2010 at own home	1 hour	2

At the second interval, the length of interviews was similar to the length of interviews at first interval. The interviews also lasted one to 2 hours each. Similarly, the informants' EPDS scores ranged from 2-9 and were non-indicative of psychological or psychiatric pathology, although the EPDS score for three of the women were slightly higher than earlier scores at 24weeks gestation.

Table 7 Interval 3: Interview conducted at 3 months post birth

Period of interviews	**Cases**	**Interview date & venue**	**Duration**	**EPDS scores**	**Infant(s) gender: Previous/current**
3 months post birth	Case 1	4th December 2009 at own home	1 hour	4	0/ Male
	Case 2	18th March 2010 at own home	2 hours	2	0/ Female
	Case 3	4th December 2009 at own home	1 hour	5	Female/ Female
	Case 4	3rd June 2010 at own home	I hour	7	0/ Female
	Case 5	13th July 2010 at own home	2 hours	1	Male/ Male
	Case 6	3rd August 2010 at own home	$1^{1/2}$ hours	0	Female/ Male

Not all births in the sample were first births. The number of informants' children ranged between zero (primi-parous: three women) to two children (multi-parous: three women) respectively. This means that three women were first-time mothers for whom this birth was their first experience of birth while three had one other child previously. It was useful to gain diverse experiences of this population as the first-time mothers could only relate to their birth experience in London and would not have prior experience of birth to compare with, while

women with previous experience of birth could draw comparisons between their previous and present birth experiences and evaluate these in regards to the cultural practices they upheld as well as the care approaches of the midwives then and now. These divergent views came across during the discussions at second and third intervals.

5.4 Explication of themes from focus group discussions

Below is an example of how themes have been explicated from data generated from discussions with midwives and Nigerian women:

5.4.1 Findings from midwives in stage 1

Table 8: views of midwives

Themes	Codes	Categories	Concepts
Beliefs, customs, family dynamics &	A people of faith	Belief and faith	Strong religious orientation and God's will
			Respect for culture and traditional belief
	Nurture and care of mother	Measures to enhance health and wellbeing	Stipulated diets and use of herbs in cooking
			Stipulated rest period and demands on care givers
			Stipulated hygiene practices
	Family dynamics	Unique/ respected family matters	Expectations, pride and honour: "Being a real woman"
			Good support network
			Family involvement in decision making about care
			Preference for male child

rituals are unique and vital in Nigerian women's birth experiences and are generally perceived as health enhancing.	Physical care of baby believed to enhance health and wellbeing	*Emic* adherent birth rituals	Male baby 'circumcision'
			Cord care rituals and inheritance matters
			Naming ceremony and Christening
Nigerian women are perceived by midwives as amiable and strong in childbirth but with poor understanding of *etic* maternity services.	Amiable and strong people	Traits of Nigerian women	Friendliness, hospitality and appreciation of care
			Flexible and strong coping skills
			Pregnancy perceived as a way of life
			'Getting on with it'
			Nigerian women work hard
			Poor understanding of care system
			Mannerism and interaction abilities

The contents of Tables 7 and 8 represent the convergent and divergent perspectives of midwives and first-generation Nigerian women on the *emic* care practices discussed during focus group meetings. The themes that emerged were: 'beliefs, customs, family dynamics and rituals being unique and vital in first generation Nigerian women's birth experiences which are generally perceived as health enhancing', and the perception by midwives that 'Nigerian women are amiable and strong in childbirth but with poor understanding of *etic* maternity services'. Midwives' perspectives appear to contrast with those of the FGNW for whom childbirth is cherished, nurtured and protected through cultural rituals. These differences in

perspectives may influence *emic* and *etic* care expectations and practices for both, further affirming the need for a workable framework that will bridge the gap in perspectives and enhance care that is congruent and effective for this population. This notion is expanded on within the data analysis section, in chapters six.

5.4.2 Findings from focus groups with women at stage 1 of study.

Table 9: Views of six first-generation Nigerian women about their *emic* birth practices

Themes	Codes	Categories	Concepts
Childbirth is cherished, nurtured and protected through	*Emic* prescriptions and proscriptions to ensure health and wellbeing in pregnancy.	Nurture is vital in birth experience Measures to enhance health and wellbeing of women	Nutrition during childbirth
			Prescribed rest period: *omugwo*
			Good support network
			Pregnancy perceived as a way of life not a kind of disease

cultural rituals.	Birth is cherished	Pregnancy and birth is highly valued	Childbirth perceived as easier in Nigeria than in Britain.
			Being a real woman by giving birth naturally
		Pregnancy raises status of women	
	Childbirth rituals	Physical care of new mother	Special baths: sitting over hot bucket of water or black soap for newborns
			Use of herbs for cooking
		Physical care of baby	Corset use to bind abdomen
			Christening and child dedication
		Birth celebration	Naming ceremony

The contents of Table 9 above were discussed in the last section highlighting the convergent and divergent perspectives of midwives and first-generation Nigerian women on the *emic* care practices discussed during focus group meetings. This creation of themes involves a progression from *description*, where the data have simply been organised to show patterns in semantic content, and coded to draw out themes, which will be *interpreted* (in subsequent chapters) in an attempt to theorise the significance of the themes. The broader meanings in relation to previous literature (Braun and Clark 2006) will be explored in later part of the thesis

and implications for midwifery education, maternity services Nigerian women and further research will be drawn.

5.4.3 Findings from FGNW women in stage 2.

The themes drawn from stage two of study have been organised into concepts, categories, codes and themes that would be compared with themes from focus group data to draw out over-arching themes that will be critically discussed in the next chapter. The colour coding used for stage two data has been deliberating chosen to reflect Force field analysis (to following the next chapter) to be employed in the discussion of the meaning of these findings in relation to how cultural practice might influence the birth experiences of FGNW. Green colour highlights indicate forces within emic practices needing *facilitation and maintenance*, purple colour indicates neutral forces needing *accommodation* and red colour indicate negative forces with potential for negatively influencing health outcomes.

Table 9 Categories and themes from prospective study: Interval 1: 24 week's gestation

Theme(s)	Codes	Categories	Concepts
Religion and spirituality inform and influence pregnancy and birth experiences of Nigerian women in London.	Strong religious orientation and superstitions	Faith, fate and myths superstitions, ritual and taboos of childbirth: avoiding 'evil eyes'/bad spirits.	'Nigerian women are very, very superstitious, they are spiritual and some engage in fetish things… They will say, if you see red pepper or red tomato in your dreams, you will have miscarriage, some believe that when they see a deformed/disabled person…they will have that kind of baby'(C5). Some go into hiding when they are pregnant. Some have a particular deity they believe in and go to oracles who prepare a lot of concussions and give these poor women to eat' (C5). ''Putting all sorts of things into her vagina' (C1). 'what women do when they are pregnant, they can't go out around one o'clock in Nigeria. It's a general believe that during that time some bad spirit walk around and if you have safety pin, you pin it near the pregnancy….. they believe that the metal will drive away bad spirit and even they use smooth pebble stone. They tie it maybe round their wrapper, cos they believe it's a form of protection', I had to hide the pregnancy until it was no more to be hidden (C5). 'Evil force/evil eye & bewitching': 'it is forbidden to tell your due date' or sex of your baby', 'when the baby comes out she will give the name', 'if the baby is breech, there is a taboo associated with that', 'you take the placenta home with you to burn or bury' (C1), 'people do have these superstitious beliefs'(C1).

		Religious beliefs, faith and fate.	The spiritual aspect is deep…some of them they worship river gods, they believe river goddess can give them children, they pray to water and when these children grow up they start behaving funny….the children will be possessed' (C5). 'Amniocentesis and all these congenital disorders are not common' (C1), 'why should she terminate sickle cell baby God has blessed her with?' (C1). '…if feet is swollen, they liken it to the state of the child, something being wrong with the child' (C2), 'mixing cautiously with visitors as witches and wizards may harm you by contact' (C5).
		Respect for cultural beliefs and taboos	'you have to stay away from sex' or the baby will have squint in the eyes, '(C1, C3). They told me not to buy any clothes, cot, & Moses basket for the baby until it's born, not to eat chicken, goat meat or snails' as my baby will salivate excessively'(C3), '…My friends said I should buy Oribe (snake cream) to use when I put to bed to gain a small belly and to start eating garri (sic: powdered cassava) after I put to bed'(C3), 'Avoid uzuza leaves & seed (sic: chilli herbs) especially in early stage of pregnancy as …it can cause miscarriage, pregnant women don't need to do hard job like riding a bike so that they don't miscarry' (C4).
Network of support influences	Expectations of help and support	Family dynamics	'my husband would like a boy but for me, whatever God sends…He gave us a baby girl before' (3).

pregnancy care and transition to motherhood.		Care and nurture by extended family kinship networks	'The Ibo man has great joy in taking care of his wife during pregnancy'(C2), 'My husband goes to the kitchen, prepares me something that I want to eat...(C3), 'In my culture ehm, when a woman have a baby ehm, she has to be in the house up to three months before she can't go out ehm go do, go for shopping, go to church and other things but here it's a different thing' (C4) 'my friends advised me not to breastfeed the baby for more than two months' (C3), 'there are many things I find difficult to do, my husband helps me to do those things (C4).
Discrepancy in expectations may impact pregnancy and birth outcome	Pregnancy and birth is shrouded in high expectations	Expectations on self and others expressed in prescriptions, proscriptions and prohibitions Nutrition to health and wellbeing:	'especially the first year in marriage if you have not conceived in the first four months, infact you are booted out' ' I didn't actually plan this pregnancy (C5), 'I will love to have a girl preferably twin: boy and girl (C5), 'In Nigeria, men are not allowed to be there when their wives are giving birth...to my view it's wrong' (C4). 'Not to be examined by a male doctor' (C1), 'she (mother-in-law) said I should eat fish all the time...her believe is that the baby is going to be very intelligent' but 'I just crave pizza' (C1), I grave Ritz biscuits but my mum told me not to eat it cos it's salty (C3). 'I deliberately do not take soft drink containing sugar' (C4). 'you need to eat heavy food for baby to grow' (C1), 'I desire a boy because I have a girl already (C4), I don't want to be fat'.

			There are certain food pregnant women are not expected to eat' (C3), 'doing exercise makes you stronger and help the baby to come out on the due date' (C4).

Table 10: Categories and themes from prospective study: Interval 2: Six weeks post birth

Theme(s)	Codes	Categories	Concepts
Post birth care and nurture is shrouded in cultural rituals	Rituals inform post birth practices	Ritualistic prescriptions, prohibitions, and proscriptions after birth.	'in Ibo land they will restrict you from eating all types of food when you have a new baby until about two months before you can resume eating all you have been eating before. They will advise you to eat only pepper soup which they call nmiriogwu or agbadakwu' (C4). They will advise you to be eating only that with pounded yam or pounded cassava They say that it can affect baby stooling when you eat some certain food she might have diarrhoea and things like that'(C4), 'Not allowed to go out usually after 41 days (C3), '... take hot pepper in order to clean out the... *to clean out the tummy, relax the womb* (C5), 'Take light food and then drink plenty of water because it helps with the breast feeding flowing. That is just it for me. But for other parts of the country, you don't take salt, you don't take oil', I don't know.... how those ladies will survive with that kind of restrictions'(C5), 'in the old days, they just pamper you. All you do is eat, sleep and then they bring the baby to you when it's time for a feed. To when the baby is three months that you actually really come out. But you can't do that here, not really with an older child. I

		Ritual baths, use of lotions and portions	mean at this time, I really don't go out, and it's only when it's necessary and my husband does the shopping and I do most of my shopping online… friends help me drop her off and pick her (1st child) up (C6)'. From my husband's culture you don't come out for like forty days and ehm, in my culture that's the Igbo culture I know most times you don't really come out that much for the first three months really.... even if you don't wonna rest, you'll be forced to rest'.... It's that granted time that we can recuperate, I still take my pepper.... to clear out the…the body of what was left behind after the delivery and to... to help with your recovery' (C6). ' I had that massage bath, there's a life that came back to me' (C2), ' bathing her (baby), like stretching her, massaging her; she just settles and sleeps easily'(C2), 'they told me to be sitting on hot bucket of water, hot towel massage (C3, C5) that the blood in me can come out easily (C3) ' ''At times they help you with putting hot water on your womb....it's just to help you recover quickly' (C2), 'Vapour rub....you put it in a bucket of water, then you sit on it. I did it like three days consecutively like that and it really worked. *I became relaxed;*

		Baby bath/ Cord care	*you know all this bulgy tummy now everything went down after the blood came out of me* (C5), 'we usually have a sit-bath.... *for the vaginal area to heal*.... hot water pressing on the stomach *to help the uterus shrink back,* you know we've combined ehm... Western.... culture..... 'when I found that if you breastfeed the uterus will still shrink so I was like I'd rather take the easy route than the hard route' ....*I think it's just for the wellbeing of the woman'*(C6) 'they give them a bath with ehm... a loaf of sponge but the Nigerian one. One is brought in..... in the Yoruba they call it Konko but it's a native sponge (C6). ' when they are bathing the baby, they put this special leaves in the village, and use hot water on flannel to massage the fontanel and navels' (C1) 'she makes sure that place is oiled so that the part will close .'They said I should be using an old cloth knotted in a fist size bundle to mop the cord. They say that I should mop it (baby's fontanel) with hot water. Then after mopping it with hot water then I should put rub, baby's rub. *They say the spot will close*. Then if I want to take her out, I should be putting rub round her chest, on her back and then the spinal cord. So that the cold won't go into her (C3). 'Massaging the tummy so that the baby can sleep' and by piercing her ear yourself you save money (C3, C4), 'there are many advantages in those things' (C4), ' the Christian that believe in all these white garment churches they pin it (cloth) just

			anywhere on their clothes. These are just ways to protect the baby' (C5). 'They put palm oil with black soap with sponge and scrub' the baby so that baby won't smell' (C3), 'I don't know how to take her to bath... I just use the towel to mop her' (C3). ''There is a point she will get to and I will start backing her with wrapper...' (C2), 'her grandma she doesn't like seeing us carrying in baby carrier... You have to back the baby with wrapper... the baby will be warn in your back (C3), 'put the baby at your back as she feels comfortable and you also feel comfortable' (C4). 'bathing baby, you have to be careful with the navel, clean it well. Sometimes you can use warm water to press on the navel. 'somebody came in to give him a bath with palm oil... the vernix, so they need to wash that off and with the palm oil.... , just rub it on the baby and scrub the baby and then you can use your regular baby soap' (C6). 'After bathing the baby, you have to put Vaseline (petroleum jelly) on it (cord stump) so that it will heal normal and it will protect her from getting infection through that' (C4), 'They say put miri oku (hot water) on the cord and massage it...(C2), 'After the cord dropped off, they will iron towel and put on baby's cord' (C3),'I can give my mother-in-law or father-in-law the cord, they plant it for the child, that when the child grow they will say this is theirs, this is where they buried the cord' (C4). 'In terms of hygiene, we tend not to allow people carry the baby. So everyone can see the baby in the basket net but for the first six week. If they must, baby is wrapped

			up before or they have to wash their hands and sometimes people get offended if you tell them to wash their hands' (C6). Quickly' 'use of breast milk in the eyes to treat discharge and irritation' (C1), 'they believe in cleanliness' (C1). 'baby care?.... my mum and my husband anytime he's around' (C3), 'my mum and my husband both have been caring for my baby, and friends also, they give me advice, supporting advice on how to do somethings',' if you wish to mould the nose or the head; you use warn water to press the head,' (C4), 'I did it also myself: you take palm oil you rub it all over the baby for few minutes then we wash it off with ehm.. either we can use Oshedudu or dudu Osun (traditional soap, black soap to wash him. *They general belief is it's just to clean out the baby skin*' (C5). 'Physically care, mostly it's done by the mother. Ordinarily, the father will just assist' (C5), 'Though it's been a lot of work but it's something that's expected' (C6). It's very, very important that children are circumcised these days they say after eight days cos they say the *children don't feel the pain*. In the past they used to be circumcised at the age of eleven, it was like a rite of passage for them or he'll be ridiculed. With the adoption of Christianity: reading from the Bible about the Hebrew culture of circumcision so a lot of us circumcise our children. Some women will not want to be with somebody who is not circumcised. Cos, they feel the person is not clean (C6) 'My baby has been circumcised already'. They use engine oil to put in there to make sure the place is lubricated so that the baby doesn't feel pain'. Then she massages like from the end and upwards just to elongate the thing well' (C1). 'in some parts of Igbo land, they normally have female circumcision but they don't do it now ', when

		New-born circumcision Breast feeding	you have a baby girl, I was taught that you have to be using your finger to rub it (clitoris) with Vaseline (petroleum jelly) you use it and press on her vagina for it to have a normal shape... to shape it ' (C4), 'male circumcision: they believe it's biblical, it's good for the man so that he can enjoy sex, it's a proof of his manhood; the Hausa, the Fulani's, they don't do the circumcision immediately. They do it maybe when they are around teenage years which is more painful (C5). We take breast feeding very serious'(C1, , 'I have a friend that is a nurse, she gives me very sound advice and she's very particular about what I eat, taking my rest'(C2), 'my husband is very encouraging, supportive' (C2), 'Breast feeding is important...my husband will be telling me that, it is good for her, that she suck milk from my breast, that her teeth will grow up quickly, it won't come off quickly' (C3), 'they prefer mothers breastfeeding their babies'... they believe children that were fed with bottle their behaviour is always different from those that had breast feeding' (C4).
Birth is cherished and celebrated	Birth celebrations	Celebration of birth: Omugwo,	'It's the culture that when a woman has a baby, if the mother is alive the mother have to go and look after her. In my culture they call it Omugwo, so the mother always

			comes for Omugwo...', ' my mother-in-law as soon as she heard it started singing they call it oro onu' (C4), 'when my mummy was here, she was even doing all the care for the baby. I was just looking. And she was even doing all the cooking and the cleaning of the house' (C5), 'in the culture children are seen as a blessing (C6)' 'Extra help like my mum coming from Nigeria to help...she's been helping me to take care of baby, so right now I'm relaxed. It's a nurture thing that your mum and mother in-law makes sure you eat well. 'You are not allowed to do anything'. You just had a baby so you should rest, you can't go anywhere yet' (C1). 'In my culture..., when a woman have a baby, she has to be in the house up to three months before she can't go out, go for shopping, go to church and other things but here it's a different thing... having enough rest, relaxed mind and not being stressful ... there are many advantages in those things (C4), 'if you have your mother-in-law around or your own mother, they help you mostly with the care of the child but with you, they will just allow you to rest, sleep or they will let you do little things in the home... where you live in urban area, probably you just have the house maid and your mother but very few people coming around to see you and all the rest' (C5). 'There's no harm in it, you know that pampering yes, it's an advantage so you tend to... cos if you are left all

			by yourself: nobody around, nobody helping, you tend to be unhappy: having a baby is a joyous time and it's a time that brings family and friends everyone together' (C6). 'mother in-law comes to stay for first six months for Omugwo ceremony'(C1), 'we started going back to Church after 41 days' (C3), 'now I've had my baby things are better, due to my husband helping me, my mum is here helping me; think those things have made my motherhood to be easy for me' (C4), 'You can't pound yam because they believe you've used a lot of energy to deliver the baby so even if you want to eat pounded yam somebody has to do it for you: maybe your mother, your sister-in-law, even your husband can do that. You have to wait for maybe like forty days for the mother to rest well and (C5), 'they also advocate that you use corset to .... pull the stomach muscles together' (C6).
		Naming ceremony, Christening	'I like the naming. The parents of the child has a name for the child, the parents of the woman has a name, the parents of the man has a name, so the child acquires so many names' (C2), 'naming is like 8 days after the baby is born, so...we did that one in the Church' (C3), 'From my husband's side, he says he's the one responsible for naming the baby but every other person named him (C1), 'what the father gave are the real names so that when you go to register her birth.... you just have to use the

			ones the father gave' (C3), ' my mother-in-law gave her name, other people might also give their own names; we now choose among those names the best we like: Tochi meaning Praise God because the way I had her, so easy, quick, and I prayed for that before I had her that I really want her to come out quick without delaying and God has answered my prayer so we named her Praise God. And the second name Ihunannyachi meaning God's love. We believe that it's just because of the love of God that it was so', 'naming ceremony: they're going to Church and naming the baby and baptize the baby, my baby was taken for dedication after just one month.'(C4), 'I gave him Joseph because of two reasons. You know I didn't plan him and he came during the time there was a lot of good things happening within my mother's family'. 'The second reason was that when I gave birth to him, there was a particular popular prophet around 1913. We call him Apostle Joseph Ayibabalola: he was a very powerful prophet among the Christ Apostolic….' my husband gave him Ayomide, because he said that means joy has come',.... and David Oluwadamilari and oluwatimleyi, but co-incidentally my father gave it. That means God has justified me or vindicated me. (C5) 'when the pastor around for the ceremony commences. He'll first offer prayer, and afterwards they will be praising and thanking God for the journey throughout the pregnancy' (C5), 'His names: 'Titobilolowa', the short form is

			Tobi and it means the Greatness of God and 'ToChukwu' give thanks to God and the names the grand-parents sent in: 'Ayobamidele' That's the grand-father named him 'Ayobamidele' meaning joy met me at home and my mother-in-law named him 'Mofonyifuliwa meaning, I give thanks to God, Chimaobim', that's God knows the desires of my heart (C6) ' we don't joke with our Christening, so family members are coming from nations here and there (C2), 'because we are in a foreign land, the only thing we just do is to tell people and then they come after the eighth day for Christening: the pastor, priest or some whatever you believe will come and name the child, in a traditional setting... they bring out salt, honey, Bible ah they call this one Atari (ginger pepper)... they say ah my child, this is what we eat in the world, please have a taste ...as Christians now, we don't do that anymore, but they did it for us when we were young before my parents (C5). 'prayers are said when those things are brought out: Like honey, your life is gonna be sweet... coal nut is something they use to welcome people..... alligator pepper: your life will be spicy and interesting. For some, they bring in a Bible, read a passage. Those are symbolic things that are used to just say pronouncement and then at the end of that, they say the names.' (C6)

Network of support influences transition to motherhood	Expectations of help and support. .	Family dynamics and the childbirth experience	' assistance of my husband/partner, mother in-law, ' am not doing things I used to do in the house'(C1), 'my husband helps during his leave (C5) 'normally in our culture after the woman come to look after her child that have a baby when she's going back she will expect the in-laws to treat her well, a way of appreciating what she's done (C4)
	Network of support as a source of power and powerlessness	Role of family members	'I am pregnant and they have this way of reaching out to me.....there's this exceptional service'(C2), I have a couple of Nigerian friends...they really help me; they have been consistent in bringing me food so that I don't have to cook'. 'I do some exercise that I've seen my mother do'(C2), 'yea my mum does everything.... during the day when she's around, she will take the baby upstairs so that I'll be resting (C3). 'You have people around you doing a lot of things, even very little thing (C5).
			'They will ask you to eat hot pepper, use hot mentholatum hot water massage, tummy binding...so that the wound would close up & you would look more beautiful, more attractive and not become an old woman'(C5), 'eat well for breast feeding(C1, C5), 'So, in our culture (sic: Ibo) in giving birth, a lot is expected of the woman(C2),

	Migration impacts network of support	Care and nurture by extended family kinship networks	'tummy tie', 'stay home & rest'(C1), 'They say I should eat it so that baby can get a lot of, lots of milk. So I've been taking pap morning, noon and night' (C3), 'When I had my baby, my mum sometimes my husband help me to put hot water on my tummy (C4) mum help me to cook what they call agbadankwu or nmiriogwu in Igbo land. So I've been taking it because they told me that it's helpful to get my body back to its' normal state' (C4). *'These are believed to help you heal quickly. I don't see anything wrong'* (C5), 'I mean with one it was easy, with two there's a bit of an adjustment so'(C6)
		"…. I mean it's all just me!"	'I'm not working anymore, I'm sleeping, I'm always alone all the time, nothing to stimulate you, no people…no body to engage in conversation and ideas. All I could do is watch TV, read magazines, read books…. I mean it's all just me!', when I had my first baby, I was blessed because my mother was around, all I do is breastfeed the baby, sleep and rest. I thank God for my husband, he is very understanding, caring... (C5)

Belief, fate and spirituality inform birth experiences	Culture and beliefs influence birth experience	Culturally and traditional held believes influence choice and decisions in childbirth	In Nigeria, we name children after circumstances: things that happen to you. In the East, sometimes after a market day, ehm, to... in honour of what God have done for you. In the Igbo culture everybody has a 'Chi', that's your own God... our names are usually, chi this, chi that.... the Yoruba culture, its' the Deity they serve in the family.... the culture of re-incarnation, Babatunde' means the father came back, Iyabo', that's the mother came back.' (C6). '...we will give the child an Ibo name that will speak of what the child will be...names has a long way to go with the child's destiny'(C2), children are gifts from God...it is God that gives children because we believe in continuity of lineage..it's like a boy is preferred'(C2), ' ...in Ibo culture they believe that the child's coming speaks a lot about the season of the parents lives, and some children bring blessings into the lives of the parents'(C2), 'We bury the cord, it shouldn't be thrown in the dust been; as we believe that it has a lot to speak about the child (C2)
	Perceived influences of religious beliefs and fate		'When breast feeding they ask me to hold the areola in scissors shape so that the baby doesn't feed too fast and breast does not make the baby's lips droop' (C1), 'if I want to comb her hair, I don't have to comb it forward. I have to comb it (sic: baby's

	on maternal and neonatal wellbeing.	Expectations of self and others expressed in prescriptions, proscriptions and prohibitions	hair) backward'(C3), ''my friends advised me not to breastfeed the baby for more than two months' (C3), ' 'I've started my period even with fully breast feeding; she (mother-in-law) said I have short legs' (local nuances for high fertility) (C1). 'My mum advice hot water bottle on my belly while my mother in-law advice the girdle to regain abdominal firmness; so I just do the sit-ups in my room before I come out' (C1). ' I had a slight episiotomy, they advise that put a bit of salt and Dettol in my bath, but the doctor said I should keep that area dry and clean and warm water baths (C1), 'I was saying mum, you grew up in Nigeria that one doesn't mean that caesarean is bad. Let me just go in there. After some three hours she now says okay you can take her to theatre... seeing me coming out after 5 minutes or 10 minutes, she was like oh, is that all?' (C3), ''my friends advised me not to breastfeed the baby for more than two months' (C3). 'but in Nigeria you know, the men just say it's your business' (C1).

Discrepancy in expectations influence care access and may impact birth outcomes of first Nigerian women	Birth is shrouded in high expectations: 'Why must she have a caesarean section?'	'I must deliver this baby naturally'.	' Why must she have a caesarean section? God has promised us delivery like Hebrew women. It has to be natural...like Hebrew women. So she (mother in-law) was sad when I had forceps delivery' (C1). 'Oh yea, we like natural birth. I want natural birth...I didn't' I never set my mind on cs; it was my last option...' (C2), 'Caesarean... yea it matters a lot, they say maybe is the work of satan' (C3), 'When a woman has Caesarean, they would think that it's not a normal thing' (C4), 'I'm really very happy, because probably I gave birth to him naturally and it was really very a good experience... and it is so nice being in the gathering in ladies & they're telling you how it (labour) will be.... and you cannot profile any because you had Caesarean section'.... they will say lazy woman, You can't even push; (C5), 'I don't have the luxury of jumping around going out to do the shopping now... because this time I have two babies', lot of people pray for natural delivery (C5),' 'So I was shaking in my faith so I said God! God of Apostle Joseph Ayobabalola; I must deliver this baby naturally. I am not going to undergo that C/S anymore. It's not my portion, it's not my whatever it's not gonna happen. So immediately I said Oh God of Joseph Ayobaba, the baby just came out' (C5), 'if you have an assisted birth or something like a caesarean section,

		Gender preferences	you're seen as not being a woman or a strong woman... **caesarean sections a taboo...** Some women still see it as that (C6) 'To be honest, I really desired a baby boy' (C2), 'For the first baby it doesn't matter but in second pregnancy everybody will be saying, it's time for a girl' (C1). 'To be quite honest ... in Igbo land they believe so much in the heir to the family and they believe that females end up going away to another place to start a home, and males stay.. for continuity, prosperity and family lineage' (C2), 'No, it doesn't matter, because this is the first grandchild in my husband's family so they don't mind' (C3), 'we really like or prefer baby boy mostly as male children are the ones that inherit the wealth of their parents I have two daughters... I desired to have a baby boy but ehh! when I found out that it was a baby girl, I was also happy', my husband, he may prefer a baby boy to a baby girl, yea' (C4), 'everyone prays for a male child... if a woman marries and has a boy for first, second and third, she is entitled to a whole goat, they will cook it for her and then she will eat. You know *it's a thing of pride*, generally when you have a boy as a first born ah everybody is happy that the husband has got an heir but women take care of the family nowadays'. 'After having a son, you'll always desire a daughter' (C5), 'we believe in having a male child *who will carry the family name*. In

		Conflicting advice	Nigeria a lot of women have suffered for not having a male child because ehm, pressures from the family...but they believe that if you've not had a male child you haven't really settled in the family as a woman. Until the woman has a male child, she's very insecure.... a lot of people don't understand that things like this is not something you can control '.... so as a girl, you come to the family as a visitor... you were born in the family but you are not part of the family when you marry. So it's the male children that are really... so that's why in the past girls didn't use to get well educated (C6). 'With my mum here and his mum, they keep hammering me that breast feeding is good and drives away diseases and infection; although I want to stop at four months' (C1). 'We do like breast feeding because we talk about the bond that exists between the child and the mother' (C2), 'They will say if you don't breast feed your child, that child will never hear your voice', 'They will say breast feed. That when you get closer, the baby will be healthy. It won't have skin diseases, it won't have eczema... you know. In fact, they even believe that the child will be brainy' (C5). 'Sometimes she says not to eat groundnuts and garri.. because what you eat the baby gets from you...eating specific food and all that' (C1), 'restricting one from eating all

		Sex	kinds of food, sometimes it might not be helpful because someone that just had a baby needs all nutrients' (C4), 'some part of the Ibos or the Ishekiri's they subject their women not to eat palm oil, salt, pepper, they only take cassava (C5). 'I just have to be six weeks abstaining, so we've not had intercourse at all'. '*Think that's to do with involution of the uterus' (C1).* 'Well, I don't see it (sex) as a taboo... I even just got my contraceptive pills today ; it's okay (C2), 'They said we should stop having.... sleeping together, so that I can't have...they want the baby to grow up so that I don't have another pregnancy' (C3), 'you're husband maybe out of ah, I want this woman to recuperate very fast, I will abstain from her, 'Basically they believe that once you are married you are capable of sorting that one yourselves: If you like use condom, if you like use implant , if you like use coil' (C5).

Table 11: Categories and themes from prospective study: Interval 3: three months post birth

Theme(s)	Codes	Categories	Concepts
Network of support influences transition to motherhood	Expectations and transition to motherhood: 'more difficult definitely' 'adapting was a bit stressful' But..... 'culture helps you psychologically'	Family dynamics and transition to motherhood: 'you're all alone by yourself'	'First 3 months post birth: tough because my mum has gone back. It has just made me wake up, but feeling stronger; it's like I just have to be stronger. So, am the only one doing everything thing right now, a bit more difficult definitely'(C1), 'having an older sibling, that has been helpful ... the only time I find a bit difficult and challenging is when he's crying and I notice there's a lot to do and I haven't done it. I tend to stress out. 'The delivery, it's compared to running a marathon; the first three months is usually seen as very rough... I mean you're all alone by yourself, no body to talk to, your first baby, you don't know what to do, nobody to guide you, you read everything from a book.... some women will cry or get depressed because there's no help; culture helps you psychologically cos you need people to reassure you (C6). 'I love this experience, it has been very very rewarding' (C5).
		Care and nurture by extended family kinship networks: 'husband has made motherhood easier'	'We Africans, we're very family-oriented, and because we're very family-oriented, it helps a lot in pregnancy and even after childbirth because you can be overwhelmed by just the activity of your child (C2). 'I'm feeling much better, I'm enjoying it. I had a c/section adapting was a bit stressful for me and then recovery from the pain, the operation; trying to acclimatize to the world'. My husband has made motherhood easier for me He's not just leaving the home things for me', It just gives me joy. The woman resting and not being in a haste to come out is a very good one because it gives you time to recover , so the more you stay indoors you tend to learn and get acclimatized to it and then learn in detail what you have to do outside. Now that she's three months I'm gradually thinking of how I start a weekend regime in the *gym in order to get back on fit* '(C2). 'I believe the gadgets, and the baby swing, yea those things have made life easier (C6). 'I never stopped having my spices' (C5).

Beliefs and faith and fate perceived as positive influences on maternal and neonatal wellbeing.	Belief in God & evil forces: Faith and fate	Spirituality and superstitions influencing birth experience: God, Taboos, witches and wizards and other forces	They say the fish helps with baby's brain development. The baby tends to become more intelligent. God willing I will have the second one (baby) (C1), 'waited seven years for a child... apparently before I got married, I heard this view that when I get married and I start having kids. It's only God that knows each one, the grace and the capacity everybody can. Some of the taboos we have: like when a child is having hiccup, some will say put a thread on the child's head, And they look at a child's palm and say one thing or the other (C2).' We're having her child dedication (ikuwata nwa: take a child to the church and give thanks to God): that day is when I want to thank God and look back from where God has brought us. We believe that children are a gift from God. So we believe that after the woman have rested for about forty days, let's go and thank this God that has seen you through because the process of delivery it's life and death (C2).' I'm praying that God should give me a boy next (C3). ': In Yoruba culture, mixing is somewhat done cautiously as people believe that you and your new-born are in danger of witches and wizards who may harm you by contact'. 'You believe that the child was handed to you to look after and then you bring the child out to the church, dedicate the child to the service of God (C6). 'I don't believe in superstition but I believe in the power of prayer; every person from Africa, has one force or the other manipulating their lives... I can tell you authoritatively that some of them could be natural: difficulty in having children or in giving birth. But I'm telling you in the range of 1-10, seven of them is not natural; and one of the forces is the force of polygamy 'Nigerian women coming to Britain in late pregnancy... believing that they will be safer, It's linked to it (evil forces) hundred percent' (C5).. as Christians we believe in praying over water and it does a lot of healing and then the anointed oil is a form of releasing the power of the Holy Spirit into the oil' (C5).
Discrepancy in expectations influence care access and may influence birth outcomes of first Nigerian women.	Mismatch of expectations: 'Caesarean section: culturally it matters'..... surely there would have been a lot of	Expectations: self & others: 'Natural birth is better'..... and I prayed	'Now that you have a boy... ah! make a sister for him. that's what they expect: a boy and a girl but, then another boy and just have babies as if you came to the world just to have babies. His sex didn't matter as it is my first baby, He (her husband) just tell me to tie it with cloth and use hot water bottle when I sit down, I should have lots of pepper soup and fluid; especially pepper soup. I just try to do like my pelvic floor exercises and some workouts, you just want it to go back into your figure (C1)' different views about immunization, Caesarean section: culturally it matters, cos they tell you oh! Natural birth is better. In my case, they say oh operation, no! natural birth is better. I agree with that but at the same time, but there must be room for flexibility. 'they claim that one is a woman if she

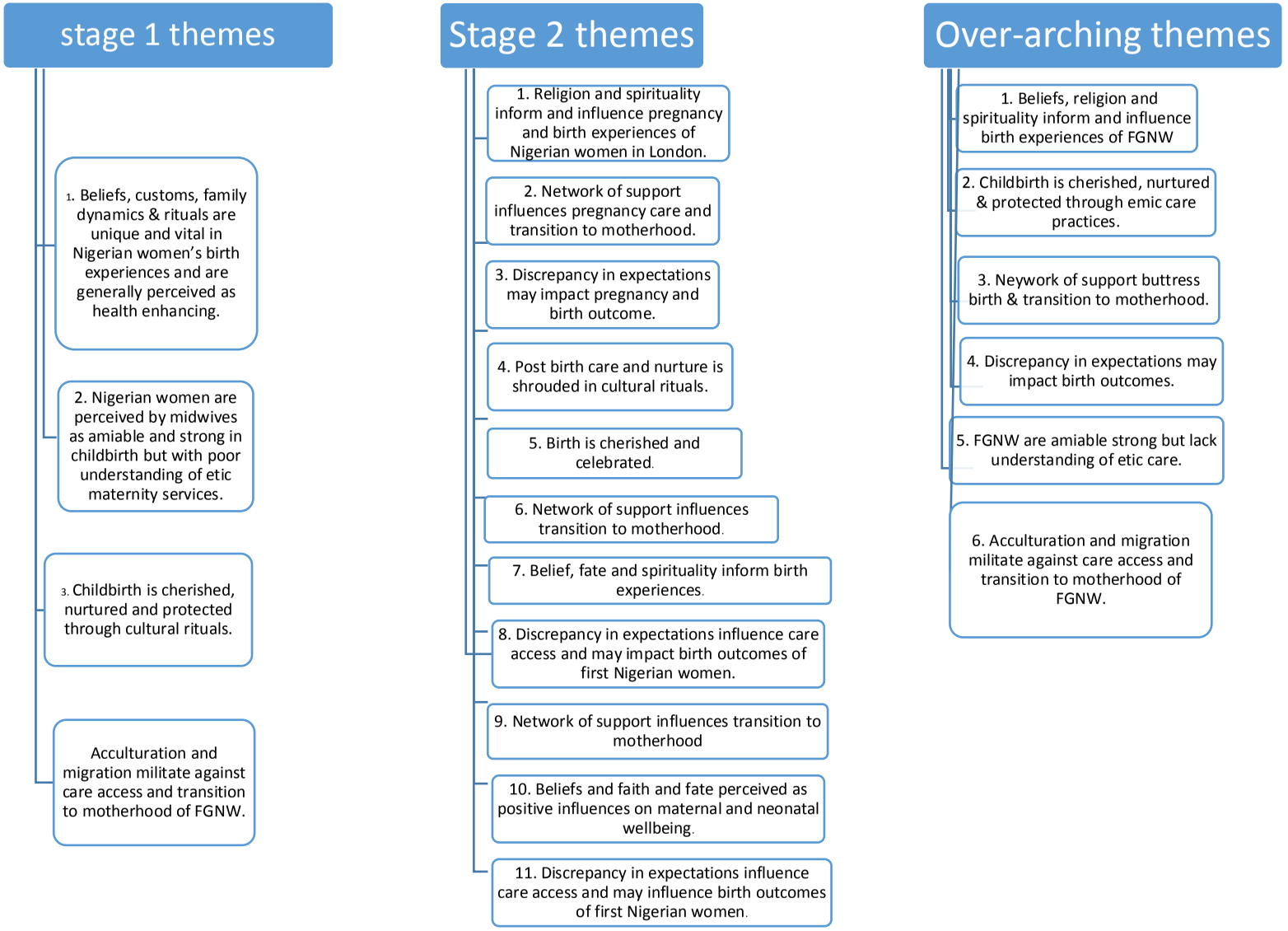
	pressure is on me to have another child; especially trying for a boy'.	for a normal birth this time around'	had a baby vaginally but if you had caesarean section you tend to hide that information from other people because you're seen as weak; so that's pride (C6). 'even me I had caesarean for my first baby and I prayed for a normal birth this time around' (C5). I wanted a boy, I was the person that was more concerned when I discovered that she was a girl, the family was very indifferent (C2). 'My partner is always complaining about my tommy. He want's my tommy to come down. He just said I should buy the hot water bottle, I should just bind it, tie it. At times, he would help me to tie it, and I'll just be screaming like no this is painful'. 'when I was five months pregnant, my husband always told me that he needs a boy, in our culture in Yoruba they believe that boys is the head of the family (3), 'but if I had had another girl, there would be... surely there would have been a lot of pressure is on me to have another child; especially trying for a boy. Because *it is believed that the boys keep the family name and keep the family going*; but girls they get married, change their name, they leave the family (C6). 'Well you know the pressure to try for a daughter, is not as eh.... hard like when you are looking for a son', I think the pressure is more when you are looking for a male child.(C5)
		Sexual activity: 'they would want you to have your baby within two years'..... 'it's advised culturally that you do not engage in	'They don't believe in it (contraception), once you are married you shouldn't have like this contraception because they just believe that after seven months you should be expecting second child. I told my mum about it (contraception), she was like you know there's no need for that it's just best to have your babies within two years. So you just keep taking in (C1). 'won't take anything (contraception) because of I have not taken anything before at all, sexual intercourse, because they would want you to; as you are breast feeding one child to still take in with

		intercourse...yea, we always do that'	another one. Oh they say have the child now, you suffer for it once, you now get yourself done and then face life and then enjoy life' (C2). 'Intercourse, yea, we always do that one, because anytime he asks me that that he needs it, I was like... I don't have any choice than to say okay no problem, because I don't want him to go outside, to look outside (C3). 'It's advised culturally that you do not engage in intercourse... but after the six weeks, it's okay if you are comfortable. Breastfeeding they say then was a form of contraceptive. But it's been proven that it's not a 100%...so I practice contraceptive methods by that I was able to space out the children (C6).' what I believe as a Christian and I don't have to do anything except when the baby is one year (C5) 'They just want me to have all my kids, take care of the home, then when they're grown, you can now go back to into school but you know by then the brain will be just dead' (C1). 'I want to spend time with them, for their formative years to be able to impart certain principles in them because the first teacher of a child is their parents and their first school is the home. So it's sacrifice but at the same time, it's a reward.... in this present economy some will look at me and think what's wrong with you?'(C2). 'in Nigeria at this time you're going back to work after three months... in the UK it's longer' (C5), 'baby could be breastfed for at least two

		Resuming work: 'I want to spend time with them'. '...their husband stop them from going to work'. Baby care/feeding: '...not just one person that brings them or raises up a child'... 'Circumcision is something that is not negotiable'.	years, but because women now go to work, three months and then when you go back to work... expressing' (C6).'I just stay at home, I'm still on maternity leave, so I'll be resuming next year' (C3). 'It depends on you, the family.... going back to work, not going back to work', you can you can work. But some people especially those who have difficulty in getting pregnant. Immediately they conceive, their husbands stop them from going to work. Because they just find out that they go to work today, they come home and miscarry '(C5). I like the way we bath children because that is like straightening the... exercising the muscles and the legs on the kid; it's very important. You know I like the way we also back children at times. *It's a form or relationship* you know (C2). "Africans have stronger bones because they were being carried at the back, than British babies that are being pushed. After bathing, I should always through him up, that will prevent him from being afraid. Then using your thumb to rub the back...the spinal cord, to straighten his spinal cord, rub the edge of his leg, to prevent him from having flat foot. They say I should always put baby oil on it

			(fontanelle) , because the brain is exposed so; with olive oil it should always be moist there'(C1), 'breast feeding: his dad is trying to talk me into like giving him like milk' 'told me to put mentholatum to the cord, the back the spinal cord, the chest and beside; So that *she won't be too cold, so she will feel warm* (C3). 'Circumcision is something that is not negotiable, women who are circumcised are sexually promiscuous than ladies who are not'. (C5) 'Female circumcision: It is illegal in Nigeria. We don't dwell on it. '... children in Africa is that it's not just one person that brings them or raises up a child which is not in the civilized world.... ' the man is very understanding that the woman should spend some time with the children and can allow you to do that while they fend; It's like a pride' (C2). 'Breast feed but because of the way the times have changed, so we tend to express milk (C6).

Figure 4: Themes in diagram



Three themes emerged from stage one focus group discussions and are outlined as follows:

1. Beliefs, customs, family dynamics and rituals are unique and vital in Nigerian women's birth experiences and are generally perceived as health enhancing.
2. Nigerian women are perceived by midwives as amiable and strong in childbirth but with poor understanding of etic maternity services.
3. Childbirth is cherished, nurtured and protected through cultural rituals.

There were eleven themes drawn from stage 2 (prospective study):

1. Religion and spirituality inform and influence pregnancy and birth experiences of Nigerian women in London.
2. Network of support influences pregnancy care and transition to motherhood.
3. Discrepancy in expectations may impact pregnancy and birth outcome.
4. Post birth care and nurture is shrouded in cultural rituals.
5. Birth is cherished and celebrated.
6. Network of support influences transition to motherhood.
7. Belief, fate and spirituality inform birth experiences.
8. Discrepancy in expectations influence care access and may impact birth outcomes of first Nigerian women.
9. Network of support influences transition to motherhood.
10. Beliefs and faith and fate perceived as positive influences on maternal and neonatal wellbeing.
11. Discrepancy in expectations influence care access and may influence birth outcomes of first Nigerian women.

5.4.4 Over-arching themes

The similarity in some of the themes from one stage of the study, **reflect saturation of views** on the *emic* birth practices of FGNW by midwives and themselves. Some of these themes have been merged according to their similarity to arrive at over-arching themes that sum up the perceptions of midwives and FGNW and to answer the research question. Six over-arching themes were drawn as follows:

1. Beliefs, religion and spirituality inform and influence birth experiences of FGNW.
2. Childbirth is cherished, nurtured and protected through emic care practices.
3. Network of support buttress birth and transition to motherhood.
4. Discrepancy in expectations may impact birth outcomes.
5. FGNW are amiable strong but lack understanding of etic care.
6. Acculturation and migration militate against care access and transition to motherhood of FGNW.

These themes will be critically discussed in triangulation with evidence from literature review and all stages of this study and contemporary literature to emerge with new knowledge of how culture may influence the birth experiences of FGNW in London.

5.5 Chapter five conclusion

The demographic statistics, interview data and themes emergent from stages one and two of this study has been detailed in this chapter with six over-arching themes drawn from wealth of information generated from FGNW and midwives. In the discussion chapter that follows, themes will be triangulated with data generated from prospective study of six first generation Nigerian women and will be compared and contrasted with views from the focus group discussions and against the evidence from the literature review to come to a clear understanding of the influence of *emic* cultural practices in birth experiences of first-generation Nigerian

women in London. Finally, the over-arching themes will be explored in greater depth to arrive at a new understanding of how cultural practices influence the birth practices and experiences of first-generation Nigerian women giving birth in London, and to consider the extent to which current maternity services meet their care needs. According to Frith and Gleeson (2004), analysis is only complete when the researcher arrives at a rich description and new, consistent and compelling understanding on the topic.

Chapter six: Discussion of themes

6.0 Chapter six introduction

In this chapter, the themes are critically discussed to derive meanings from the *emic* and *etic* perceptions of cultural practices of this population of Nigerian women. Within this interpretative cycle, clarity is gained by accurate reference to focus group evidence, the shared experiences of the core informants and the triangulation of these with theoretical evidence drawn from literature. Core themes explicated from all stages of the study are explored in relation to how the views and perceptions of first-generation Nigerian women and midwives converge and diverge on cultural practices in childbirth and maternity care for this Nigerian population. Quotes by Nigerian women informants highlight their *emic* care practices and midwife informants affirm some of FGNW *emic* care practices as observed and provide *etic* care perspectives that are critically contrasted and / or evaluated against evidence from literature review, focus group discussions and contemporary evidence. Existing evidence is utilised to discuss emergent themes and to compare and contrast *emic* / *etic* views on cultural practices of this population. In this way, the theory that arises from this transcultural research is inductively derived and has applicability to the *emic* beliefs and birth practices of first-generation Nigerian women and the *etic* perspectives of the midwives. Force field analysis will also be employed to reflect influences of culture on the birth experiences of FGNW and to address the research question: does culture influence the birth experiences of FGNW in London?

6.1 Discussion / explication of core themes

The approach of this data analysis is to 'weave a narrative' that is interpolated with illustrative quotes (Gillham, 2000) to catch not only the nuances of meaning but also the authenticity of expressions and to create link narratives that critically discuss some of the *emic* care practices

of this population in line with available evidence. Narratives are the key to reconstructing the complex meaning shared by the members of a particular culture (Bruner, 1990). Quotes from verbatim transcription from FGNW during focus group and prospective interviews and from midwives provide professional similar and divergent care perspectives that are critically contrasted and / or evaluated against evidence from literature review, focus group discussions and contemporary evidence in a triangulated manner that ensures meaning is not distorted or lost.

Some of the responses received about cultural care practices have been as diverse as the reasons given for them. Some deviant comments have been reported on to create a balanced view of all informants. The colour coding used for within quotes are in line with coding applied in data analysis and has been deliberately chosen to reflect Force Field Analysis to be employed in the discussion of the meaning of these findings in relation to how cultural practice influence the birth experiences of FGNW. Green colour highlights is indicative of forces considered health enhancing within *emic* practices and hence needing *facilitation and maintenance*, purple colour highlights is indicative of forces considered neutral (neither health enhancing nor detrimental to health and wellbeing) and hence needing *accommodation* and red colour highlights is indicative of non-health enhancing or with potential for compromising health and wellbeing. Comments by FGNW informants from focus group are denoted as FGN, wm 1, 2, etcetera and comments by FGNW prospective informants are labelled as cases: C1, C2 etcetera, while midwife informants are identified as mw1, mw2, and etcetera. NHS Trusts of the midwifery informants are denoted numerically as H1 and H2 etcetera to enhance anonymity.

6.1.1 Theme one: 1. Beliefs, religion and spirituality inform and influence birth experiences of FGNW.

Evidence from literature review and all angles of this study affirm that holding religious beliefs, faith and superstition is integral in the life of most Nigerians at home and abroad. Nadeem *et al.* (2008) in their study reported that women from minority ethnic groups in Britain were more likely to endorse faith-based solutions to health problems compared to their counterparts from the United States of America. At times, this can be perceived as having a somewhat dichotomous construct of positive and negative spiritual sides (Mitchell and Baker, 2000). A Nigerian researcher Izugbara *et al.* (2005) assents this later view by asserting that there is also a strong belief in supernatural mystical causes of disease and ill-health amongst some Nigerians. Where, on the one hand, religion and faith aids the acceptance and resolution of certain unpleasant life experiences and aids psychological balance, whilst on the other hand, there seems to be a degree of delusion in respect of faith. The following quotes from midwifery informants go some way to confirm this notion:

'.. the other thing which I've noticed; which is on the increase; a lot of them obviously have a religious background and the partner will sit in the corner praying'. (H1, mw 8)

'And then in labour, again, you know to give them room because the pastor might come in the middle of it all to pray. So you need to allow for that. There's gonna be oh! My pastor is on the way and there's a lot of that, a lot of prayers on the floor, ringing back home, mother's praying, father's praying….'. (H2, mw 1)

'Some of them pray on the baby. Muslims, they pray immediately (sic: after birth) before the baby is bathed'. (H2, mw 4)

It would appear that religious belief in God's will, are constructs that are believed by FGNW to foster wellbeing. This population of Nigerian women in maintaining spiritual beliefs, customs and rituals appear to uphold these traditional measures to ensure healthy pregnancy and birth. These care measures form part of CCMM as they are noteworthy in regards to meeting their cultural needs. Similarly, such care measures were acknowledged in Leininger's (2002) Sunrise Enabler Model as folk (*emic*) care culturally learn to deal with life matters of ensuring wellbeing, countering distress or even dealing with adverse outcomes such as death. Continuing on the matter of faith, one Caucasian and one Nigerian midwife commented:

'I find that they are much more (pause) faith orientated you know, if God is giving you a child that's got this or something wrong with it, then God is giving it to you and it's His will whether that child lives or dies. the one lady that had… the the child that had the hydrocephalus, she really did not want any invasive test. She was against having (emphasized) a foeticide. …It really hurt her to make those decisions. I'm not saying it doesn't hurt anybody else, but, really, you know as far as God was concerned; it troubled her immensely. Ummm….I do find certainly with screening, if I tell parents that they both, they're both em… sickle cell carriers; they will not go for an invasive test. They will say: no, we will take what we are given; umm….and that I think is a marked cultural difference'. (H1, mw 4)

'Unless you're taking it, this is what will happen: this baby will…. (Clicking fingers and gesturing and emphasizing….) Oh! God forbid, I rebuke that… I go don't rebuke it, take the medicine. Don't rebuke it… (More finger clicking with emphasis)…..I reject that, the devil is a liar. Oh! It will unless you take this medication, the devil will be very, very truthful'. (H2, mw 1)

Some of these quotes from midwives highlight and affirm FGNW's adherence to spirituality through belief in God's intervention in their birth experiences and outcomes. There appear to be a strong acceptance of the will of God in accepting "what we are given", and 'rebuking' unwarranted potential outcomes which they consider to be outside the will of God for them.

In the latter quote, the midwife was re-enacting a scenario where a Nigerian mother was non-compliant with anti-hypertensive medications prescribed during her admission in hospital, but rather held the belief that God will miraculously cure her hypertension on the basis of her faith. This expression of belief, faith and / or mythical believe appear to be common amongst FGNW as reflected in the following assertions by a FGNW informant:

'Nigerian women are very, very superstitious, they are spiritual and some engage in fetish things... ."The spiritual aspect is deep...some of them they worship river gods, they believe river goddess can give them children, they pray to water and when these children grow up they start behaving funny....the children will be possessed' (C5). 'People do have these superstitious beliefs'. (C1)

There is evidence in support of this notion from literature review. Moloney (2007) assert that, "cross-culturally and throughout history, pregnancy and childbirth have been perceived as spiritual events because of the miraculous" (Moloney, 2007:1) nature of new life at birth and probably because of the risks and processes involved in childbirth, which were not fully understood by women. In this regards, Tanyi (2006) asserts that one cannot truly assess a childbearing woman without assessing her spirituality. However, although spirituality and religiosity may be related, women may be spiritual without being religious (Calister and Khalaf, 2010). Relying on God to ensure positive maternal / child outcome is a key finding of

Callister and Khalaf's (2010) study of Ecuadorian women's childbirth experiences. They found that a strong reliance on God, and spiritual beliefs were vital for transcending the physical pain and challenges associated with giving birth. Most of the women in the study resonated with the idea that childbirth is a time when spirituality was enhanced.

It would appear that belief and spirituality is perceived by some FGNW and midwives as enhancing wellbeing for this population. The following assertions from focus group and prospective study is evident of their confidence in linking belief to wellbeing:

'I do believe that, it's our culture you know it's tied into the woman's wellbeing. You've got to respect culture and belief. I do feel that if a woman is within her environment, that her culture is respected. It's ....her health outcome is a lot better. She's not worried, she's not anxious, she's secure'. (H2, mw 3)

'Nigerian culture is a very rich culture ..... and looking after your own culture is more difficult'. (H2, mw 4)

Concomitantly, extracts from Nigerian midwives portray a resounding consensus on FGNW's need for respecting culture and upholding certain cultural practices that they perceived as enhancing the health and wellbeing of mother and child. These cultural belief systems tend to resemble the beliefs and spiritual believes of upheld by their counterparts living in Nigeria and experiencing birth there; which go further to affirm the view that *emic* care practices related to childbearing and socialisation are among the most difficult to change (Muscardino *et al.*, 2006).

The comment by a midwife about the difficulty of 'looking after your own' is in line with what Hurd and McIntyre (1996) described as the 'seduction of sameness' where biases may be nurtured by people of the same background because of pre-conceived notions, perceptions and prejudices. Maintenance of professional ethos and reflexivity should guide this Nigerian midwife in avoiding / addressing the 'seduction of sameness' wherever it exists in their practice and should enhance, professional care that is devoid of bias in order to retain the trust of FGNW.

6.1.2 Childbirth is cherished, nurtured and protected through *emic* care practices.

It would appear that amongst FGNW, pregnancy and birth are nurtured through care and attention to healthy nutrition for the pregnant woman and through other emic care approaches geared towards ensuring the wellbeing of both mother and baby. Both midwives and FGMW express that a good deal of attention goes into provision of appropriate nutrition for the pregnant mother and providing restorative nutritious therapy for the new mother to ensure that she regains her vitality and physique as fully and as quickly as possible after the strain and stresses of pregnancy and birth. Concomitantly, there is congruence in first-generation Nigerian women's desire (*emic* practice) for healthy nourishment and the midwives (*etic*) promotion of this. This tradition of nourishing a new mother appear to be upheld with a measure of ritualistic significance orchestrated via the *Omugwo* ceremony (were rest and recuperation is maintained over a given period of about a month to three months with female relatives taking care of the new mother). The following extract from midwives practicing in two different NHS Trusts would seem to confirm FGNW's endeavour to maintain healthy nutrition during pregnancy and childbirth:

"They eat well (H1, mw 7)..... "They don't eat NHS food" .(H1, mw 8) They don't take to hospital food because they believe hospital food is not nourishing enough. "They (family) cook vegetable soup, particularly for her, cos they believe the food will produce a lot of haemoglobin to make you fit and to be able to look after your baby". (H2, mw 4)

On the contrary, one of the Nigerian midwifery informants held a divergent view about the nutritional intake of Nigerian women, highlighting that the diet of Nigerian women may actually be unbalanced and unhealthy; as demonstrated by her comment below:

'*I find that the belief that the Nigerian women have about diet in pregnancy is completely different to what we would advise as a professional. In Nigerian women (repeated), having high carbohydrate diet is the norm' (H2, mw 1).*

'Having high carbohydrate diet' by Nigerian women could be because of food taboos that abound in traditional instructions to pregnant and recently delivered mothers. In parts of Nigeria, cultural food proscriptions discourage pregnant women from eating some fruits, vegetables, rice and other high-calorie foods that enrich and nourish the body and reduce malnourishment and susceptibility to disease. The general belief is that such foods would negatively affect the childbearing process, as well as affect the health and life of the mother and baby. In reality, most of these prescriptions and proscriptions are given in order to sustain the myth surrounding a particular tradition or to emphasise the sacredness of a custom conceived as inviolable (Nkwocha, 2007).

The benefits of the postnatal rest period; common among all Nigerian cultures and described as *Omugwo* by the Igbo's of South-eastern Nigeria was positively endorsed in the literature

review and further endorsed by some of the midwifery informants as portrayed in the following extracts:

'if I have a Nigerian lady there, she will explain to me that her aunt or her mum is flying over from home … she's looking forward to them coming because they're going to do all these things that's going to be great and wonderful'. (H1, mw 2)

'I get the impression as well…that the aunties and mums are coming and that they will help ...and mum just breast feeds…' . (H1, mw 4)

The above extract reiterates the reliance of Nigerian women on their family for care and support during childbirth. This then could lead to dependence on staff to fulfill the role of care-giver in their absence, as well as fulfill their professional duties. Thereby giving rise to a situation described as 'being used to things being done for them', 'waited on' and being 'demanding' by some of the midwives as portrayed in the following extracts:

'They're probably used to things being done for them, and we're encouraging them to be up and mobile and do things'. (H1, mw 8)

'*They want to be you know, sort of be waited on hands and feet, cos that's what we do back home. Oh! You just had a baby, lie down, oh! don't do this, don't do that. But over here you get.... oh! You've got to move, you know, you give all the medical reasons why they've got to move. And they don't understand it'. (H2, mw 3)*

One of the Nigerian midwifery informants recounted her personal experience of observing *Omugwo* and purification bath. Her understanding of the reason for the imposition and the purification process following *omugwo* was given in the following statement:

'I wasn't allowed in the church for forty days. I wasn't allowed anywhere in the church, because I'm considered to be unclean, because I'm still within the four weeks but possibly bleeding here and there and trying to heal from the pregnancy and then on the 40th day of when the baby was born, then I was allowed to bring the baby to the church for blessings, dedication and everything. That's when I was allowed to come into the church premises. Yea, she comes to the church and have a bath, a sanctification bath, we'll be praying into the water and ask the Lord…thank the Lord first of all that she's gone through this journey; and she's come out of it victorious. Some people go into it and sometimes there's mum no baby or there's baby no mum. So if she come out of it, there's baby, there's mum. You know, its big celebration they pray to thank God that she's come back out of this journey. She's well and he's well. And then also they now ask God to cleanse her, cleanse her, and accept her back into the house". (H2, mw 1)

As previously alluded to, this forty day stipulated period of rest dates as far back as early Jewish history and has relevance to Old Testament teaching of orthodox Jews and some modern Old Testament churches as well as Muslims. Amongst Nigerian Muslims, women have to perform '*ghusl*' (purification bath) after their menstrual periods and postpartum bleeding as part of purification. The notion of a 40-day postpartum rest period is common in many non-Western cultures (Lauderdale 1999, Nahas and Amashen 1999). In almost all Nigerian cultures, rest within 40 days after birth is seen as necessary for recuperation. The new mother's activities are strictly limited, and family members attend to her needs. According to Hundt *et al* (2000), the 40-day postpartum period is characterised in the Middle East and elsewhere by an observance of seclusion, congratulatory visiting, the reciprocal exchange of gifts and money and special diets as is common among Nigerians. However, health care providers have to guard against the health hazards of immobility associated with the *omugwo* practice and the potential risk of deep

vein thrombosis, social isolation as well as the potential psychological connotation of 'impurity' associated with this practice.

Some midwifery informants positively evaluated how FGNW are celebrated and nurtured in their birth experiences in London:

'... I think we have a lot to learn from Nigerian women about looking after women that are pregnant and women that 'have delivered…but the idea of actually being looked after which is rather nice'. (H1, mw 4)

'So you don't tend to see a Nigerian woman labouring on her own... It could be a neighbour or a friend that could be there to be with her'. (H2, mw 3)

There's also a wonderful Church community as well that they consider as part of their family as well. So they are supported very much there'. (H1, mw 3)

'In Nigeria, men are not allowed to be there when their wives are giving birth. It's the culture that when a woman has a baby, if her mother is alive the mother have to go and look after her. In my culture they call it Omugwo, so the mother always comes for Omugwo...' . (C4)

'Extra help like my mum coming from Nigeria to help. She's been helping me to take care of baby, so right now I'm relaxed. It's a nurture thing that your mum and mother in-law makes sure you eat well. You are not allowed to do anything. You just had a baby so you should rest, you can't go anywhere yet'. (C1)

'From my husband's culture: you don't come out for like forty days and ehm, in my culture that's the Igbo culture, I know most times you don't really come out that much for the first three months really.... even if you don't wonna rest, you'll be forced to rest. It's that granted time that we can recuperate. I think it's just for the wellbeing of the woman'. (C6)

Although aspects of these assertions confirm Makinde, (2004) notion of the *sovereignty of motherhood* amongst Nigerians, Bharj and Salway (2008) exposed some of aspects of these *emic* care approaches as barriers that may hinder BME women from accessing maternity care. There are explicit childcare practices used by FGNW to promote their health and wellbeing as well as those of their new-born babies, such as good nutrition, special baths, rest, breastfeeding, supplementing feeds, bathing, cord care, circumcision, massage, or use of certain herbs and products are linked to the importance attributed to the child's physical and psychological welfare. Some of these practices may be linked to the environmental conditions of their original country where infant mortality is said to be high as expressed in literature review section of this thesis. Therefore, maternal and infant health is considered by them fundamental factors influencing maternal beliefs and practices related to childrearing. FGNW informants in the focus group discussions expressed their *emic* care practices of physical care and nurture for mother and baby, pride in being 'real women' through fulfilling family expectations by giving birth naturally and much more. They also explored their cultural practices as regards bathing the baby, circumcision, naming the baby etcetera, as portrayed in the following comments to express *emic* care practices for nurture and care of the new-born:

"I like the way we bath children because that is like straightening the... exercising the muscles and the legs on the kid; it's very important. 'Bathing baby, you have to be careful with the navel, clean it well. Sometimes you can use warm water to press on the navel. 'somebody came in to give him a bath with palm oil... the vernix, so they need to wash that off and with the palm oil.... , just rub it on the baby and scrub the baby and then you can use your regular baby soap'. (C6) 'After bathing the baby, you have to put Vaseline (petroleum jelly) on it (cord stump) so that it will heal normal and it will protect her from getting infection through that' (C4), 'They say put miri oku (hot water) on the cord and massage it...(C2), 'After the cord dropped off,

they will iron a towel and put on it the baby's cord' (C3),'I can give my mother-in-law or father-in-law the cord, they plant it for the child, that when the child grow they will say this is theirs, this is where they buried the cord'. (C4)

'In terms of hygiene, we tend not to allow people to carry the baby. If they must, baby is wrapped up before or they have to wash their hands and sometimes people get offended if you tell them to wash their hands'. (C6)

The extracts from FGNW portray the meanings they attach to hygienic practices as part of protection and nurturing for their new-born. It would appear that bathing among this population is considered part of physical and psychological grooming for the new mother and her infant. FGNW of Yoruba tribe appear to belief that the reasons for ritualistic baby baths emanate from a cleanliness perspective, whilst the Igbo's among them appear to practice it in order to prepare the baby for a fearless future, as described by Anugwom (2007) in literature review section of this thesis. According to the latter, "the new-born is routinely exposed to physical exercises like the flexing of the joints, holding the baby upside down, throwing the baby up a couple of times and immersing the baby in water" (Anugwom, 2007:164). These bath rituals are traditionally perceived as generating health and physical strength in the baby as well as giving the baby courage to overcome unnecessary fears. This *emic* care practice warrants scrutiny by maternity care providers to ensure new-born safety in line with safe-guarding policy (Her Majesty's Government (HMG, 2006). However, care should be taken to avoid linking these practices with physical child-abuse, as the intensity of some of the descriptions such as: joint flexing of a new-born could sound barbaric to a non-Nigerian. Seemingly, the actual benefits of this practice to the new-born warrant evaluation in order to aid safe practice. Various other baby nurturing practices were discussed by FGNW:

You know I like the way we also back children (sic: carrying the baby with wrapper on the back) at times. It's a form or relationship you know (C2). "Africans have stronger bones because they were being carried at the back, than British babies that are being pushed. After bathing, I should always through him up, that will prevent him from being afraid. Then using your thumb to rub the back...the spinal cord, to straighten his spinal cord, rub the edge of his leg, to prevent him from having flat foot. They say I should always put baby oil on it (fontanelle), because the brain is exposed so; with olive oil it should always be moist there'. (C1). 'His dad told me to put mentholatum (sic: mentholated ointment) to the cord, the back the spinal cord, the chest and beside; So that she won't be too cold, so she will feel warm'. (C3)

'Female circumcision: It is illegal in Nigeria. We don't dwell on it. '... children in Africa is that it's not just one person that brings them or raises up a child which is not in the civilized world.... ' the man is very understanding that the woman should spend some time with the children and can allow you to do that while they fend; It's like a pride' (C2). 'Breast feed but because of the way the times have changed, so we tend to express milk (C6). " His dad is trying to talk me into like giving him like formula milk'

There are conflicting comments in these quotes in regards to maintaining maternal and neonatal health and wellbeing in these quotes. According to Wellings *et al.* (2000), attitudes are reinforced by beliefs and often attract strong feelings that lead to particular forms of behaviour and the behaviour is manifest in the style of nurturing and care adopted by some of these FGNW for their new-borns. Practices such as carrying the baby on their back for comfort and close 'relationship', breast feeding and massage and exercise during baths are described by them as nurturing and hence health and wellbeing enhancing. However, some expressed practices such as: putting hot water on cord stump, applying mentholated ointment on cord or

new-born fontanel are not supported by current evidence on new-born care and hence in dissonance with recommended *etic* practice of midwives. Moscandino and colleagues (2006) has described these childcare approaches as parenting ethno-theories, which are cultural models of parenting. Leininger (2006) describes these as *emic* care practices worthy of re-negotiation by healthcare providers, to ensure continuing wellbeing of FGNW and their new-borns.

FGNW also discussed male circumcision as part of their child care practices. The following quote expresses this practice and some of their beliefs around this practice:

"My baby has been circumcised already'. They use engine oil to put in there to make sure the place is lubricated so that the baby doesn't feel pain'. Then she massages like from the end and upwards just to elongate the thing well' (C1). 'in some parts of Igbo land, they normally have female circumcision but they don't do it now ', when you have a baby girl, I was taught that you have to be using your finger to rub it (clitoris) with Vaseline (petroleum jelly) you use it and press on her vagina for it to have a normal shape... to shape it ' (C4), 'male circumcision: they believe it's biblical, it's good for the man so that he can enjoy sex, it's a proof of his manhood. (C5)

FGNW (C4) affirmed the practice of Female Genital Mutilation or cutting (FGM / FGC) in Nigeria. Okeke *et al.* (2012) report that FGM is often routinely performed as an integral part of social conformity and in line with community identity in Nigeria. His literature review on the topic uncovered that FGM is widely practiced in Nigeria, and with its large population. According to his report, "Nigeria has the highest absolute number of cases of FGM in the world, accounting for about one-quarter of the estimated 115–130 million circumcised women worldwide. In Nigeria, FGM has the highest prevalence in the south-south (77%) (among adult

women), followed by the south east (68%) and south west (65%), but practiced on a smaller scale in the north" (Okeke *et al.* 2012: 2). Concomitantly, Okeke *et al.* (2012) refute the claim to religion as reason for this practice, asserting that sociocultural determinants have been identified as supporting this avoidable practice, citing literature in support of his assertion: "mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced" (Okeke *et al.* 2012: 6).Nonetheless, as acknowledged in the earlier quote by (C4), Nigerian's ban of has been in place since 1994 (*Okeke et al.* 2012) and the ban of this practice in Britain since 1985 (Dike 2013, Dike and Umoren 2014).

Male child circumcision however, is considered by the informants as part of nurturing in the Southeast and Western Nigeria. Circumcision of the male child appear significant to this section of FGNW who linked these *emic* care practices to their culture, faith and religion. According to them, South-Eastern Christian Nigerians in keeping with the Bible, practice male child circumcision as a Christian ritual. This they tended to link to Abraham being commanded by God to circumcise himself, all male members of his household, his descendants and slaves in an everlasting covenant (Genesis 17: 9-14). It follows therefore that Jewish and Moslem believers ought to uphold this practice. Similarly, in rural South-Western Nigeria, male infant circumcision is one of the indigenous surgical practices performed by Muslims for religious reasons and by non-Muslims as a cultural and / or religious norm. As explored in the literature review and focus group discussions, a great percentage of Nigerians are Christians or Muslims, and male circumcision forms part of normal neonatal care within the two main religious groups represented in this study. It would appear that many Nigerians and other African and Asian cultures perform male infant circumcision as an initiation *rite* or ritual (Mavundla *et al.* 2009).

Although in some parts of Europe, this practice is outlawed, male circumcision is yet not outlawed in Britain. However, the practice has implication for safeguarding children (HMG 2006), especially if performed inexpertly or without consent in the case of a child who is Fraser competent (London Safeguarding Children Board, 2015). Although the evidence on the benefit or otherwise of male child circumcision is currently inconclusive, The British Medical Association (2004) recommend that it should only be performed for therapeutic reasons. Therefore, migrants like FGNW originating from cultures where this practice is upheld continue to uphold the practice.

In Britain, the rate of male circumcision was estimated at 1% in 1985, despite (Darby, 2016) finding no medical benefit from routine male circumcision, maternity care providers continue to encounter male child circumcision. Earlier estimations by Hawker (2009) suggest that a quarter of the world male population is circumcised. Some health benefits of circumcision have been reported by various authors, such as protection against Balanitis (inflammation of the glans), penile cancer (Wiswell, 1985 and Hawker, 2009), Human Immunodeficiency Virus (HIV) (Szabo and Short 2000, Weiss *et al.* 2000)**,** Human papilloma virus (HPV) and urinary tract infection. Male circumcision has also been reported to reduce the rate of cervical cancer for female partners and to confer better hygiene for circumcised males and avoidance of conditions that result from un-cleanliness (Castellsagué *et al. 2002*). It is not known whether the FGNW in this study in view of their education levels are aware of the evidence highlighting some advantages to male circumcision as to their adherence to this practice while in Britain. Nonetheless, controversy remains over the humane aspects of this practice such as the lack of pain-relief for the baby during the procedure and the aftercare. In Anarado and Nduka's (2009) study about the perceptions of pain in neonatal male circumcision among South Eastern Nigerians from Anambra State, mothers' rating of the pain of the procedure was very varied.

Almost 87% of mothers rated the pain between moderate and very severe, while over 9% rated the pain as mild with almost 4% of mothers stating that circumcision is not painful. It beggars belief that such high percentage of women who perceive the procedure as very painful did not seek or advocate anaesthesia or analgesia for their babies during this procedure. The implication for midwifery and healthcare practitioners is to advocate and encourage the use of registered practitioners for the procedure to avert potential harm to male neonates and boys in keeping with Safeguarding policies.

Naming a child is seen by Nigerian informants as a way of celebrating their identity and a way of maintaining practices that endorse their lineage in view of their assertions in regards to the names given to their new-borns as reflected in the following quotes:

"I like the naming..., the parents of the child has a name for the child, the parents of the woman has a name, the parents of the man has a name, so the child acquires so many names' (C2), 'naming is like 8 days after the baby is born, so..., we did that one in the Church. From my husband's side, he says he's the one responsible for naming the baby but every other person named him' (C1), 'What the father gave are the real names so that when you go to register her birth.... you just have to use the ones the father gave' (C3), 'my mother-in-law gave her name, other people might also give their own names; we now choose among those names the best we like'. (C3) "I like Nigerian names: Oluwade, Lade, and… meaningful! Meaningful! All my children, they all have meaningful names and …..'. (FGN, wm 2/3)

Naming has a socio-political concept in regards to identity. Malouf (2000) presents identity as having an individualist and a collective meaning, being unique and comprising of various elements such as: distinctiveness, allegiance to a religion, tradition and / or nationality. This view was upheld by most FGNW informants in this study who delighted in the meaning

inherent in their new-born's names. Some of the names were full of expectations and projections of a positive / prosperous future and life achievement for the child to whom they have been bestowed. For the first-generation Nigerian women, their child's names appear to be a source anticipation and hope that their future is secure.

Some of the Nigerian midwives and women in all phases of this study also highlighted other inherent *emic* practices geared towards nurturing the new-born and its mother in the immediate postnatal period, stressing these as bearing value to FGNW's traditional culture and their origin. Some of these inherent *emic* care practices are expressed in the following comments:

'For us, the Easterner's right, the umbilical cord has to be buried in your village so that the belief is that, that is where it's buried and that is where you will come back to. It's like, they believe that even if you travel to anywhere in the world you will still come back because part of you has been buried there. The umbilical cord is buried in the village, like for my son, we had to take it, we didn't bury it here, not in this country…. (Sic: England). Even back home, living in Lagos, in the West even if you live in the West, we'll still did not bury it in the West, we took it back to the East, we still took it back to the East to bury it there, so that's our culture'. (FGN, wm 5)

The view in the quote above gives meaning to some of the cord care practices highlighted by some of the midwives in this study but were not explored by them in regards to inheritance and the cultural significance that FGNW attached the practice. The burying of the cord stump appear to have great significance to the Igbos of Eastern Nigeria represented in this study who portrays the view that home is where the cord stump is buried. It therefore follows that FGNW of Igbo tribe consider any other domicile a secondary home after their ancestral home. The

practice of burying the cord also appear to be linked to patterns of inheritance, which affirms some of the findings from literature review in this work.

6.1.3 Network of support appear to buttress birth and transition to motherhood.

As established in literature review, amongst this Nigerian childbearing population, the family (nuclear and extended) are expected to provide emotional and material support at every stage of the pregnancy and birth continuum. This quote expresses level of the network of support available to FGNW during birth:

'it's the culture that when a woman has a baby, if the mother is alive the mother have to go and look after her. In my culture they call it Omugwo, so the mother always comes for Omugwo...', ' my mother-in-law as soon as she heard it started singing they call it oro onu' (C4), 'when my mummy was here, she was even doing all the care for the baby. I was just looking. And she was even doing all the cooking and the cleaning of the house' (C5), 'in the culture children are seen as a blessing (C6)'

Oates *et al.* (2004) point to the benefits of such network of support (*omugwo*) as protective and the best cure for some of the emotional and psychological ills of childbirth amongst trans-cultural women. In Morhanson *et al's* (2008) study about the attitudes and preferences of Nigerian antenatal women to social support during labour, it was reported that 80.2% desired emotional support from their partners while about 18% and 7% desired spiritual and physical support respectively. They reiterated the benefits of social support in improving the outcome for both the mother and baby. Social support has also been reported as the 'catalyst for early breastfeeding initiation for first-time Nigerian mothers' Morhanson *et al.* (2009). Similarly, the midwife informants agree with Morhanson by reporting that Nigerian women in their care found breast feeding easy, even for first-time mothers. According to the reports of a randomised

controlled trial of the effect of psychosocial support in labour by Morhanson *et al.* (2009), the median time of breastfeeding initiation was significantly longer in supported women than in their counterparts who had no companion and therefore were un-supported throughout labour and delivery. The network of support available to first-generation Nigerian women during birth experiences in London could influence duration and patterns of their breast-feeding habits, as the Nigerian women from this study who had support expressed intention to want to continue breasting beyond the period of the study. One FGNW spoke of the assistance of her husband as part of the expected or replacement support network while giving birth in London:

'He (husband) did more than I did because in his own case his sisters married on time, everything, my own case, I'm not. I mean, I didn't experience all these things and I don't have any parents too, which is something. So, he did everything. He bathed the baby, he did everything. When here (sic: in Britain) because of the circumstance, you do get more support from them'. (FGN wm 3)

Where reference is made to the husband's absence " because of the circumstance" (FGNwm 3), a replacement network of support in the way of sister-in-law's, friends or church members appear to be arranged to ensure this support, as portrayed in the next quote by a FGNW:

'I am pregnant and they have this way of reaching out to me.....there's this exceptional service '(C2), I have a couple of Nigerian friends...they really help me; they have been consistent in bringing me food so that I don't have to cook'.(C2) 'mother in-law comes to stay for first six months for Omugwo ceremony'(C1),

... where you live in urban area, probably you just have the house maid and your mother but very few people coming around to see you and all the rest' (C5). 'There's no harm in it, you know that pampering yes, it's an advantage so you tend to... cos if you are left all by yourself:

nobody around, nobody helping, you tend to be unhappy: having a baby is a joyous time and it's a time that brings family and friends everyone together' (C6).

This general pattern of accessing social and economic resources through networks of support grounded in ties to kin and community appear characteristic across the Nigerian ethnic spectrum (Smith 2001). A notion previously reported in literature review by Morhason-Bello *et al.* (2008) who reported that most of the women (7 in 10) in their study who were mostly professionals (as per the sample of this study) were willing to pay extra to have a professional source of support, such as a doula. Social support has been defined as access to and use of individuals, groups or organisations in dealing with life's vicissitudes (unexpected changes or shifts often encountered in ones' life) (Pearlin, 1989). Ohaeri (1998) assents that the lack of an organized social welfare system in Nigeria places a burden of care on the extended family, hence perpetuating this cognisance of kinship at home in Nigeria or abroad, especially in times of need; such as during birth.

The *Omugwu* ceremony has also been explored by FGNW as part of the reason for the network of support to ensure rest and recuperation from birth was positively endorsed in the literature review and further endorsed by some of the midwifery informants in the current study as portrayed in the following extracts: *'if I have a Nigerian lady there, she will explain to me that her aunt or her mum is flying over from home … she's looking forward to them coming because they're going to do all these things that's going to be great and wonderful'. (H1, mw 2)*

'I get the impression as well…that the aunties and mums are coming and that they will help …and mum just breast feeds…' . (H1, mw 4)

As previously explored in earlier chapters, this network of support holds the key for recovery and recuperation from childbirth for most (if not all) as believed by Nigerian women at home and in the diaspora. Care and support is often anticipated with great excitement, as women look forward to being pampered by family, extended relatives and friends. Evidence from literature (Oates 2004, Morhanson *et al*, 2008) affirms the benefits of such support networks for Nigerian women. Anugwom (2007) has highlighted the benefits of the Omugwo ceremony in the Eastern parts of Nigeria, where the newly delivered mother receives assistance from her own mother, her elder sisters or her-sisters-in-law who takes care of the household management and of the entire family for a period of six weeks to six months. During the *Omugwo*, mothers follow a special diet in order to restore energy, promote breast milk flow, and facilitate healing from childbirth. The *Omugwo* practice has been elaborately studied and described by Anugwom (2007) in a book by Liamputtong (2007) titled 'Childrearing and infant care issues: a cross-cultural perspective.

At times there seems to be a separation between level of support and total loneliness and isolation for some first-generation Nigerian women who are recently arrived to Britain from and are yet to establish a network of friends or to form this adapted kinship as expressed by C6 in the earlier quote from FGNW. As discussed within literature review, this measure is taken to formulate or replace absent kinship resulting from immigration. However, not all FGNW manage to obtain support from adapted kinship. Some find themselves alone and potentially at risk of loneliness and isolation during birth that may result in 'unhappiness' as portrayed in the following views in which the informants bemoan the lack of such support as follows::

Now, 'I mean it's all just me! When I had my first baby, I was blessed because my mother was around; all I do is breastfeed the baby, sleep and rest'. (C5)

"cos if you are left all by yourself: nobody around, nobody helping, you tend to be unhappy. (C6)

This situation could simply be due to pragmatic social reasons where female relatives supposed to fulfil such duties may not be present in Britain due to immigration / visa restrictions as well as financial constraints in sponsoring the trip to Britain to offer support or it could be seen as acculturative adaptation, where the husbands of first-generation women are adapting to norm of their current domicile. The potential impact of the lack of support therefore warrants further study that is outside the scope of the current study. Co-incidentally, this client (C5) scored highest in this cohort on the EPDS at 24 weeks interval of the prospective study. Although no inferences could be drawn between her EPDS score and her psychological health; especially as her subsequent scores stabilised and were in line with her counterparts, but her trepidation about being alone and unsupported (by her mother) in this pregnancy is apparent. Elsenbruch *et al.* (2007) in their study of 'social support during pregnancy' in a population of 896 women in the first trimester of pregnancy said that pregnant women with low support reported increased depressive symptoms and reduced quality of life. They drew the conclusion that lack of social support constitutes an important risk factor for maternal wellbeing during pregnancy and has adverse effects on pregnancy outcomes. Segre *et al's* (2006) study of African-American 'perinatal depressed mood in late pregnancy and early postnatal period also agree with Elsenbruch *et al*'s (2007) findings by reporting that social support emerges as a potential explanatory variable that is negatively correlated with maternal depression. Their finding that African-American and Native American women reported much more depression than White, Hispanic, and Asian women is further evidence that ethnic and racial factors contribute to

perinatal maternal depression. Such social factors that influence transition to motherhood, like marginalisation, isolation and lack of presence of extended family and significant others in their maternity experience, may interfere with effective transition to motherhood, with grave implications for first-generation Nigerian women's health and those of their new-borns.

6.1.4 Discrepancy in expectations may impact pregnancy and birth outcomes for FGNW

'They're expected to labour with no pain relief during labour; and just have the baby. That makes them a proper woman. They don't believe in pain relief at all. I think it's honour. They don't want ehm… it's honour actually. They want to feel, you know, they are proper women and the family as well, and you know, will be very proud of them if they see they've laboured, blab, blab, blab, that no caesarean section, normal delivery. Yea, from what I've observed, it's em… when they're having babies, they will lecture them, they will tell them not to shout. So, you know, they tell them not to cry, not to scream. You have to bear it that it makes you a woman'. (H2, mw 2)

'They're not used to the culture and they still have great expectation of childbirth, I think'. (H2, mw 3)

'Some people are stressed because not a lot of them like these cultural beliefs. They don't want to do it but because they are forced into doing it, by their, maybe mother, grand parent, may be mother-in-law and everything. So they just have to go with it. And when you go in as a midwife to see them, they're not kind of really happy because they don't have much to say about it'. (H2, midwife 4)

Some of the expressed views on family expectations have great implications both for family dynamics and for demonstrations of power (on the part of FGNW's family) and powerlessness (on the part of FGNW). Nevertheless, in a culture where respect for age, especially of older relatives, is culturally instilled from the cradle and where some degree of subservience forms part of cultural norms, this population can perceive family expectations as cultural norm. In similar vein, in such culture, dignity and honour become highly priced assets that guarantee security and reciprocity of support within the family. Here are some extracts of Nigerian midwifery informants' on the matter of family expectations:

Another Nigerian midwife shared a similar view:

'Most Nigerian women especially that I've met, they don't really have… They don't have a mind of their own really. They are thinking of what people will say, they don't really think of themselves actually'. (H2, mw 2)

The family dynamic intricacies interwoven in decision-making processes of Nigerians form part of their *emic* belief that merits an entire thesis and therefore is better left for such an opportunity. As alluded to earlier, these family dynamic intricacies are linked to demonstration of power, subservience and respect for age and the ultimate reward of being cared for by those one shows respect to. Such intricacies give rise to high expectations of the woman and hence compound her ability to make the right choices in her care. Furthermore, it places the woman in a precarious dichotomy of pleasing her family and / or the health care provider(s) instead of herself. This situation can compound first-generation Nigerian women's autonomy and induce a degree of powerlessness that compounds self-efficacy and can hamper their independence as individuals in their own right.

Moreover, as migrants, there is pressure on first-generation Nigerian women to please the extended family by proving their womanhood through natural birth, giving birth to a male child for the continuation of the family lineage and maintaining inheritance rite. Preferences for male children by this population arise out of the need to raise and maintain patrilineal homesteads headed by men. This was the focus of a study by Gray *et al.* (1983) who reported that a greater preference for male children amongst Nigerians was indicated by the combined sex ratio of 167 males to 100 females for the families of the population of Nigerians they studied. This conjures up ideas of selective conception or even covert infanticide as in India or China. Equally, Obi and Ozumba (2007) in their study of 'factors associated with domestic violence in south-East Nigeria' report that where patrilineal descent is practiced, as it is in almost all Nigerian states and kinship systems, there is always a boy-child preference and that in such an environment, having all female children may promote or perpetuate domestic violence. This situation has care implications for professionals providing maternity care to first-generation Nigerian women in London, in view of enquiring, detecting, and reporting domestic violence linked to the birth of serial female children. A Nigerian midwife in the focus group discussion expressed her view on Nigerian women's security in having male children while a non-Nigerian midwife held a mixed view on the matter as apparent in the following two quotes: *'They do have preferences obviously, 100%. The women … they prefer boys. Because they feel more secure in having male children than female children and em… their husbands as well, they are happier when their wife has boys, because they say they want em… the family name to remain. But women will get married and adopt another name. But the men will still remain in the family. Every Nigerian man will want a male child'. (H2, mw 2)*

'See the ladies I've given care to, they don't appear to have a preference or whether or not they chose not to share that with me, I don't know. The ladies I'm thinking of, I think they possibly would because, I see them every visit umm, but the lady I'm thinking of in particular; she's had a little girl already and there was a lovely relationship. Umm so I wouldn't…, I get the impression if this one is a girl too, I get the impression that this is going to be a problem'. (DH1, mw 2)

The notion of 'being a real woman' by being strong in childbirth appear to form part of the expectation on first- generation Nigerian women by their nuclear and extended family as evident in the following quote:

"Most Nigerian women when they come in and ehm…, especially when there is deviation from the norm: like maybe during labour, there is failure to progress or something and discussing about Caesarean section, they see it as a taboo. They don't really want to hear anything about section. They believe, you know, they shouldn't be sectioned and they don't feel they will be proper women when they have the section. You know they hide it, it's like secret. Nobody must know that I had section or something. They don't really want this…It's actually their last resort, if they have to have section. Their in-laws especially….would think they're not proper women, because they've had section. It's very frustrating, you know, trying to convince them. They wouldn't listen to you. It takes…Like a lady I had about a week ago or two weeks ago. She actually went home. She had two sections before, the 3rd one came, same problem. She was so adamant and said she doesn't want any more section, she wants normal delivery. There was nothing we didn't tell her. She refused to consent for section and went home'. (H2, mw 2)

This view has been substantiated by an unpublished doctoral study by Bromley (2007) in her doctoral study of obstetricians and Nigerian midwives at an NHS Trust in Woolwich by who

reported that "Nigerian women value vaginal birth highly and will persist longer in their attempt to gain a vaginal birth than UK White women" (Bromley 2007:332). Similarly, these views also affirm Fasuba *et al* (2000) report that women of particularly Yoruba of Western Nigeria have an aversion to caesarean section. A midwife from the same trust where Dr Bromley conducted her study assents the notion of FGNW's aversion to caesarean section as evident in the following statement:

'They will, they'll resent it. They hate it. They will do anything not to have Caesarean section. And they would push it, and push it and push it, until they don't have any way out before they will sign on that dotted line. And then she has somebody at the back of the phone saying: "c/s? please! God forbid, I've had 15 generations, no body have had it, are you gonna break that record?" And then she's thinking: "O God! I've failed her". Because the culture sees it as: you're not… you haven't done it yourself, if you've had a Caesarean section. "How can you say in front of your in-laws you had Caesarean section?" Tomorrow they will insult you with it that you couldn't even push the baby out. Because eh… it's like emmm…when the health care professionals actually advise them on the … the decision. It's like they are preventing them from getting what they want to do. I mean, going through normal labour and all that. They don't seem to understand that there's an obstruction somewhere. So it's quite difficult for you to convince them, you know; because they have a lot of things in their mind. What will people say? … that you know…that they couldn't do this, they couldn't do that. They're really anti-Caesarean section'. (H2, mw 1)

These cultural dictates may have grave implications not just for first-generation Nigerian women giving birth in London but for their counterparts in Nigeria and in the diaspora in terms of delay in action in the face of apparent clinical complications that can endanger the life of the mother and / or her baby. Equally, it is an irony for healthcare professionals in London who

have the interest and wellbeing of the mother and baby to uphold, to be confronted with such abject complex culturally imposed resistance against necessary medical intervention. Interestingly, most FGNW informants and some of the midwifery informants of this study perceived pregnancy as a natural process as expressed in the following viewpoints:

'It is natural with Nigerians. You see a lot of Nigerians, as soon as they have the baby whether primip or multip, the next thing is: am I allowed to feed my baby? It's too natural. And we don't really like… compared to other nations, we don't really sit with them and show them how to do it, it's natural with them'. (H2. mw 4)

'What I have noticed is… that certainly in labour, they just get on with it. They don't ask for any pain relief and they're very calm about it. It is a natural phenomenon'. (H1, mw 4)

Furthermore, a Nigerian midwifery informant in the current study reiterated this view:

'And we've been cultured to believe that actually, your mothers had eight, they didn't have house help, so what's your problem? So it's like, that's fine get on with it'. (H2, mw 1)

These views of pregnancy as a natural event amongst this population of Nigerian women and midwives fit well with the sociology of Nigerian society where the average woman gives birth several times in her lifetime and often needs to take care of both the family and extra domestic chores. This when viewed from a dichotomous perspective, could denote the positive and hence naturalistic attributes attached to pregnancy and childbirth by first-generation Nigerian women and their midwives and their desire for non-intervention during birth. Equally, it could warrant an increased level of expectation on the part of the woman who might be expected by her partner / husband to get-on-with-it when some assistance or support may be expected by FGN; even though this may not be verbalised by them. Nkwocha (2007) assert that some Nigerian men do not play supportive roles during pregnancy and postpartum periods that are

significantly different from their normal activities because pregnancy is perceived as a normal condition that does not require special attention. Some of the evidence from the current study is in direct contrast to the notion of lack of support by partner or significant other.

Nigerian women generally are renowned for their high levels of independence and fortitude in the face of adversity. Therefore, it is not surprising that this trait is evident amongst them during their birth experiences in London. This notion was apparent in Ezeobele *et al*'s (2010) study of Nigerian women living in Texas, Houston. Ezeobele and colleagues reported that, Nigerian women are generally seen as strong. A view affirmed in this quote by one of her informants**:** *"A typical Nigerian-born woman is supposed to be strong not just for herself, but also for her family and uh – you just cannot be depressed. Depression is a sign of weakness to a Nigerian-born person. You are supposed to be strong, not only to yourself, but for everybody outside looking onto you and for your whole community".* In Ezeobele's study however, this view was portrayed by an Igbo woman rather than a midwife. The affirmation of this view by FGNW and midwives in the current study, reiterating what appears to be an inherent perception of sovereignty of womanhood by some Igbo women; who through these assertions reinforce their perception as strong women who cope well with natural birth without need for medical intervention. This self-reliant trait is evident in the following extracts from midwifery discussants, and would seem to contradict the notion of continual 'good network of support' portrayed by first-generation Nigerian women in the earlier theme of this analysis. This conflict in expectation is evident in these midwives' view on support for Nigerian women after birth: *'when you go into their houses em, during the postnatal period: first 28 days; you find that the woman tends to do more of the care for the baby more than the man. He kind of sits back; just let her get on with it". (H2, mw 1)*

''No, I've only seen the women in the family. A lot of the time from personal experience, I've gone in postnatally, the father's not been there, maybe at work, shopping, I don't know!'. (H1, mw 7)

Being left to 'get on with it' and seeing only women in the family as portrayed in these extracts could either be an affirmation of the traditionally held belief by Nigerian men that childbirth is a woman's affair, or it could signal the husband's belief that the woman is capable of fulfilling this task without his help or support, and therefore leaves her to get on with it. However, considering that decision-making, including reproductive decisions, is often the remit of the Nigerian men (Hollos and Larsen, 2004), there seems to be a separation between this reproductive decision and the resultant economic burden of raising children if care and nurture is left to the woman and her female relatives.

As reported in literature review, a study by Olayemi *et al.* (2009) exploring the involvement of men in pregnancy and childbirth amongst a group of antenatal Yoruba women at Ibadan Southwest Nigeria, went some way to validate the view of 'childbirth as women's affair' amongst Nigerians. In their study, they found that Yoruba husbands were less likely to accompany their wives, but Yoruba wives with non-Yoruba husbands were 12 times more likely to be accompanied to antenatal care. Women in the rural centre were less likely to receive help with household chores from their husbands during pregnancy, while educated women were more likely to benefit from this. Monogamous unions and increasing level of husbands' education were associated with spousal presence at delivery. Adewuye *et al.* (2007) assent to this notion by reporting that 76% of Nigerian women were not satisfied with their marriage relationship as 54% of these women lacked social support from their spouse and family.

The need to remain healthy through the birth continuum and return to full function and retain the ability to carry out usual chores appear to be an apparent reason for FGNW 's determination and desire for natural birth. A Nigerian midwife in the following comment presents this view:

'Most women will have normal deliveries there [in Nigeria]. You know, you get a lot of sections here [in Britain] a lot of failed inductions here. I do know that ehm…, the fact that they are in a foreign culture, they're not relaxing, you know'. (H2, mw 3)

Nigerian women's preference for a normal birth appear to be necessitated by their need to ensure quick recovery and return to full physical capacity and functioning as soon as possible after giving birth. There is therefore congruency between FGNW's desire for natural birth and midwives promotion and facilitation of normal birth within 'woman centred philosophy of care. The researcher would argue that midwifery in the UK, as opposed to many other European countries, is predominantly driven by the promotion of natural birth, breastfeeding and women's choice which is in line with FGNW's desires. Therefore, the first-generation Nigerian women in London are well placed to receive maternity care that meets their desire for natural birth and there was no evidence in the current study to the contrary. In this respect therefore, congruency between *emic* and *etic* care expectations between FGNW and midwives.

The family dynamic intricacies interwoven in decision-making processes of Nigerians form part of their *emic* belief that merits an entire thesis and therefore is better left for such an opportunity. As alluded to earlier, these family dynamic intricacies are linked to demonstration of power, subservience and respect for age and the ultimate reward of being cared for by those one shows respect to. Such intricacies give rise to high expectations of the woman and hence compound her ability to make the right choices in her care. Furthermore, it places the woman in a precarious dichotomy of pleasing her family and / or the health care provider(s) instead of

herself. This situation can compound first-generation Nigerian women's autonomy and induce a degree of powerlessness that compounds self-efficacy and can hamper their independence as individuals in their own right.

6.1.5 FGNW are amiable strong but lack understanding of *etic* care.

Evidence from this study suggest that FGNW tend to present late for antenatal booking and antenatal care according to the midwife informants, FGNW themselves and evidence from literature review. Adewuya *et al* (2007:20) report that, most African women register for antenatal care quite late in pregnancy, making early detection of fetal problems difficult". This is contrary to National Institute for Health and Care Excellence (NICE 2006) recommendation for pregnant women in Britain book for maternity care within the first ten weeks of their pregnancy.

The following extracts from midwifery informants from the focus group discussions highlight aspects of poor care access demonstrable in late booking, poor attendance and poor compliance by some first generation Nigerian women in London:

'I've actually noticed that which is very common among Nigerian women, is their antenatal care is quite poor. You know their DNA's; they don't take things serious at all. The woman will come in, you know, very obese, high blood pressure, you advise her of diet, advise her to come regularly for blood pressure checks, take medication. They're very adamant about it. They don't…. first of all they don't want to come to antenatal clinic care (a) they like coming late because they believe they have to leave it till late. They don't have to come in… they like coming in from twenty something weeks. That's something to do with their cultural beliefs'. (H2, mw 2)

'Nigerian women book the latest. One was a lady who presented at 28 weeks with a hydrocephalic child, and that child was terminated. But then she needed a Caesarean section because the child, the head was so huge, couldn't get the baby out; she bled and bled and bled and ended up with a hysterectomy. Now that could have been prevented. Umm.. we've had a mother, again that came in very late who again had extremely blood pressure, landed up with a Cesarean section…, and in actual fact, I'm not sure if she wasn't one of our maternal deaths'. (H1, mw 2)

Some of these assertions affirm Aquino *et al*'s (2015) findings that lack of understanding of *etic* care and conflict between women and midwives care approaches and expectations. Similarly, Raine *et al* (2010) upon uncovering that poor interaction between women and midwives had negative impact on care, recommended that a different 'interaction style to improve communication in a manner that may positively influence care.

Late booking could influence birth outcomes for first-generation Nigerian women in London and may result in poor pregnancy and birth outcomes as explored in literature review and confirmed by the midwifery informants. Concomitantly, CMACE (2011) and Bharj and Salway (2008) highlighted poor birth outcomes for migrants in Britain compared to their white counterparts. This may be attributable to poor care access, poor compliance and poor understanding of the healthcare system that appear common amongst this population (Dike 2013). Late booking by FGNW featured heavily in the comments of some midwifery informants:

"A lot of Nigerian women come over here from Nigeria and transfer to us very late in their pregnancy… 36, 37 weeks, straight off the Aeroplane; straight to a hospital". (H1, mw 4)

The midwifery informant did not explain the reason behind FGNW's late booking. However, two FGNW in the prospective study explained the superstition behind their late booking in the following comments:

"Some go into hiding when they are pregnant….". *(C1)* *"I had to hide the pregnancy until it was no more to be hidden (C5). 'Evil force / evil eye & bewitching"*. *(C5)*

From these statements, the reasons for FGNW's late booking appear to be multi-factorial and particularly linked with social factors and spiritual connotations. The interplay of the notion of 'evil eye' with late booking and poor antenatal access warrant further exploration as it has potential for negatively influencing maternity care access. FGNW's social situation in their home country is fraught with poor maternity care provision combined with dreaded high morbidity and mortality compel some pregnant Nigerian women to seek to protect their pregnancy through hiding from forces ('evil eye') believed capable of causing them to lose the child. Some seek maternity care abroad believing this to be safe and more efficient. It is often on the backdrop of late presentation for care and late booking that FGNW have been labelled 'Health Tourists' (CMACE 2011). Even as 'health tourists, they may experience difficulty obtaining international travel visas to travel early to access care. Furthermore, they may have to work late into their pregnancies to raise the funds for this journey as highlighted by the lawyer informant (C5), who spoke about her personal experience in regards to booking late. On the other hand, the reason for late booking may simply be elitist or political, where there is mistrust of the poorly resourced healthcare services in Nigeria by affluent and rich Nigerian population who would fly out to any destination other than Nigeria to seek medical care in a bid to avert risking death in a Nigerian setting. It is the researcher's observation that there is

also the misperception among some Nigerians that childbirth in London and / or America grants the child foreign citizenship that paves the way for a better future not just for the child but also for the entire family and relatives. Even so, in travelling to Britain, some can avert the cost of maternity care in Nigeria. Concomitantly, there are also immigration issues that hamper care access and timely booking such as fear of deportation as highlighted in the following extract by a Nigerian midwife:

"I think majority of them, in this area as well, I've found, they don't access health care because they don't want to: one they don't have papers, there's the fear of deportation, and they don't know how the system works; that we're midwives, we're not immigration officers. You have to constantly remind them of that… listen: "we're just here to make sure you and the baby is fine". In terms of the immigration issue, it's none of my business, it's nothing to do… it's out of my league. I'm not gonna pick up the phone and go: "oh she's here, she doesn't have papers, come and arrest her, but it's none of that. So tell us what we need to know to look after you and this baby. We have women who turn up here, "I'm rhesus negative". You're rhesus positive. I'm new in the country. Your papers…I'm coming to deliver in your name; and our blood group don't match. So the fear of deportation I think ehm…, contributes to why they don't access care. And then, they don't know the services we provide. They don't really know who we are and what we are. And then they let it all go, regarding their immigration problems, they don't know that, and so for that reason, they don't access us'. (H2, mw 1)

The annotated expression by this midwifery informant highlights her concerns over the poor care access to care of first-generation Nigerian women in London. The statement also portrays genuine concerns over the impacts of poor care access on FGNW's pregnancy and birth outcomes. Midwifery staff serving this population should examine the core factors associated

with this apparent poor care access by FGNW. Some of the reasons has been highlighted in the existing literature. A study examining access to maternity care (DH 2005) found that user's ability to access maternity services was heavily influenced by their ability to embrace their pregnancy, their understanding of the role and value of the services and cultural relevance, fear of discrimination, fear of referral to social services or immigration agencies, language difficulties and misconceptions about eligibility for care. CEMACH (2007) emphasises that maternity service providers should ensure that antenatal services are accessible and welcoming so that all women, and can be reached easily and earlier in their pregnancies. An earlier study by Harris (2006) also suggested that locating services at accessible venues might promote and improve access to care. Individualization of care has also been highlighted as improving care through establishment of rapport between the client and the midwife. Moscardino and colleagues (2006) claim that individuals with relatively easy access to healthcare may be more likely to adopt the childrearing beliefs of the host community compared to those with limited access. In this way, easy maternity care access may enhance positive birth outcomes and enhance acculturation of first-generation Nigerian women to maternity services in London.

Nonetheless, when inherent superstitious beliefs like the notion of 'evil eye' (belief that injury or misfortune can be caused witchcraft or sorcery for the person on whom it is directed at, for reasons of dislike or envy), is compounded by social factors such as those expressed in the last quotes; it becomes clearer why some women may present late for antenatal care. Proactive strategies by healthcare professionals are necessary to combat such strongly held mythical beliefs that may hinder care access and impact birth outcomes of FGNW. Equally, maternity care providers may address social factors hindering care access through health promotion and health education measures. More innovative strategies may need to be employed to encourage

FGNW to attend educational sessions such as parenthood education to dispel some of the myths that prevent them from presenting for antenatal care in a timely manner.

Midwifery informants also explored other social factors affecting prompt care access amongst first-generation Nigerian women such as that expressed in the following quote:

"I've sometimes wondered if they're "late booking" and also late for appointments or I'm quite sure, not turning up for appointment. I have to say they haven't got good time management skills…but I wonder if it's cultural'. (H1, mw 7)

The notion of 'African time' was explored during the focus group discussion where it arose, pointing out the habitual and perpetual tardiness of time management of some Nigerians in their home country and even while abroad. The notion is that some Nigerians will deliberately turn up for appointments or events several hours behind schedule and do not perceive this as poor time keeping. The notion of 'African time' was explored by Umez (2010) who framed this idea of lateness as *selective punctuality / commitment* where lateness to appointments and events are culturally accepted amongst Nigerians. This behaviour can be in the least frustrating for health care providers and at worst, ostracise first-generation Nigerian women from their care providers who may be ignorant of or non-accepting of the notion of 'African time'.

Furthermore, discrepancy in communication abilities of first-generation Nigerian women with healthcare professionals may affect care planning, implementation and outcomes. Poor communication with clients has resource implications for the NHS Trusts and may have

negative implications for the planning and delivery of efficient and effective maternity care as highlighted in the following quote:

'It is the newly arrived with language difficulty. You feel you're not getting medical history or proper medical history'. (H1, mw 3) 'I have to say most people from Nigeria speak good English. You do occasionally come across the odd one, especially if they've got quite a thick accent it is quite difficult to understand'. (H1, mw 7)

English is Nigerian's official language. As a result, English language is the language of exchange amongst Nigerians in diaspora as most Nigerians in the diaspora originate from an elite and / or educated percentage of their nation. Those not in command of the English language would prefer professional interpreters. MacFarlen *et al.* (2009) assent that first-generation Nigerian women accessing maternity care in Ireland prefer the use of professional, trained interpreters in general practice consultations. For them, the use of informal interpreters can be inadequate and problematic and can leave them worried, frustrated and with experiences of error and misdiagnosis. This situation may further hamper the provision of efficient maternity care for some FGNW who were reported to have language barriers mostly related to accent. Issues around some of the cultural beliefs and *emic* care practices highlighted herein, as well as unfavourable mannerisms and the approach of some FGNW to their caregivers could strain relations between them and maternity care providers. Both parties should avoid this situation arising as it could affect efficient care delivery and impact birth outcome of FGNW.

6.1.6 Acculturation and migration militate against care access and transition to motherhood of first-generation Nigerian women.

Evidence from this study indicates that acculturation and immigration issues militate against care access and positive transition to motherhood in first-generation Nigerian women's birth experiences in London. Immigration restrictions compounded by high demands of nuclear and extended families may perpetuate first-generation Nigerian women's strivings to autonomy and independence while in Britain. The midwives commented on FGWN tenacity and hardworking ethos as part of their striving towards self-actualization when this may stem from family expectations and the pressure to achieve that is common amongst immigrant populations (Jiménez and Horowitza, 2013). FGNW's drive to self-actualization in the face of apparent obstacles and difficulties imposed by high family expectations and their host environment in Britain seems to mitigate and enhance their adaptation to work ethic of their host nation.

"A lot of them are working, and will work up to quite late into their pregnancy…. (very late)… (H1 mw 2). They work very late…they work almost the last log and they're busy looking after children, and have got a lot of children". (H1, mw 4)

First-generation Nigerian women seem to 'get on with' pregnancy as a normal life event and tend to juggle it with other life demands. This precarious dichotomy between desire to self-actualize and expectations has the potential for compromising the health and wellbeing of first-generation Nigerian women giving birth in London in regards to positive transition to motherhood. Some of the following extracts from the focus group discussion portray this determination of Nigerian women to succeed in Britain:

'The average Nigerian woman, pregnant, she might have two jobs to go to. She might have three, four kids to come home to after doing her two jobs that she's been running around with.

Not only does she have her family here to cater for, she has her family back home in Nigeria to look after. So she's trying to maintain two jobs, keep the house going, and then you have the husband who believes he's the man and the culture doesn't allow him to come back and wash dishes and cook, and you know, she's expected to come back from work still cook, clean, look after these kids and still be a wife and a mother. In the Western world, it's me, my kid, my husband. Whereas, our culture says: you're married to your husband, as well as his family as well as your family. So, you're not only carrying your kids and your husband around with pregnancy and job, you're carrying the rest of the family home and abroad with you. So that's a lot of stress on the woman. She can't afford to rest even though she feels tired. Because she's thinking of that extra money she can bring in and the difference she will make to those who are expecting her, so she carries on. So then, it's not just normal stresses of life, it's the extra expectations dictated by culture'. (H2, mw 1)

It is commendable that midwives recognize and endorse the self-efficacy strategies of first-generation Nigerian women in London. These skills or traits are developed and perpetuated due to their functional state and out of necessity to aid their survival as migrants. According to Hamilton (2013: 174), "rather than perceiving resilience as an attribute which individuals either possess or do not, or being the product of a single cause, resilience is considered to be a disposition derived from a complex series of accumulated experiences". In the case of FGNW, it is the researcher's belief that fortitude and resilience are typical attributes engraved in the core of almost all Nigerian women at home and in the diaspora as a bid for survival. Evidently, almost all Nigerian informants in the current study (midwives and women) held at least a first degree and hence were middle class, a demonstration of their self-actualisation. However, the apparent work pressures and family commitments have implications for the health and wellbeing of the pregnant Nigerian woman in London who may be daunted by multiple

commitments as evident in the quote, that do not allow time for attending antenatal care and other health promotion activities such as parenthood education sessions. Lack of their attendance in parenthood education classes was evident during the recruitment phase of this study, when every effort to recruit FGNW via parenthood classes proved futile due to their lack of attendance. As discussed previously, this situation could compound and perpetuate the reported poor outcome in comparison to their non-Nigerian counterparts in London who promptly attend antenatal care. It is somewhat re-assuring that this hard-working trait is somewhat compensated for through the *omugwo* (rest-period) post birth.

As a measure for acculturation and transition from a poor health provision in Nigeria to a more efficient health care provision in their host nation, FGNW appreciate and value maternity care services in London as apparent in the following comments by two of them:

'I was actually grateful'. (FGN, wm 3)

'I will be too happy because if it is back home I mean you pay for it and, you just go to the midwife... here (sic: in Britain), its, its good'. (FGN, wm 5)

In the absence of an established National Health Service their home country, FGNW expressed gratitude for free maternity care in London. This gratitude stems from the fact that Nigeria operates a 'pay as you go' health service system, with services rendered only to the members of the population who can afford the costs. Moreover, in Nigeria, maternity care services suffer chronic limited infrastructure and poor administration, resulting in high levels of morbidity and mortality associated with childbirth. Poor birth outcome inherent in Nigeria's maternity care provision was highlighted by Ezegwui and Nwogu-Ikojo (2005), who reported that almost 92%

(91.9%) of women developed vaginal fistula following prolonged obstructed labour. This could be linked to the reported 'health tourism' (CMACE 2011) of FGNW, who might wish to escape the ill fate of poor outcome; and travel to London to receive first class effective maternity care. It is therefore understandable that they bear such positive affirmation of maternity services in London. This positive affirmation is in accordance with Reynold's (2006) findings amongst a similar population of Nigerian women domiciled in Texas, Houston. She reported that the search for a robust healthcare service forms part of the reason for the migration of the elite populations of South-East and Eastern Nigerians abroad. There was unanimity amongst the Nigerian informants in the current study of fear of morbidity and mortality in childbirth resulting from historical accounts from their home country.

Therefore, there is positive optimism by a midwifery informant, that women should not lose their lives in a normal life event like childbirth. The reference to death or "not dying from it" is a salient portrayal of the dread of morbidity and mortality associated with giving birth in Nigeria settings, as reported in various official statistics of Nigeria and (World Health organization 2004a and 2004b). The notion of increased morbidity for first-generation Nigerian women experiencing birth in London is reiterated in the following comments from two different midwives working in two separate NHS trusts in London: *'You just have to be careful when you look after Nigerian women. When they come in through the door, they might be fine, next minute, they might… something might go wrong, that is one thing I've learnt. So when I'm, when I'm looking after a Nigerian woman, I'm always… I don't joke with it. Me: So, they seem to have more complications. They have a lot of it than the general population. Particularly PIH, one minute they'll be fine, the next minute they're not". "Blood pressure is…, the rate is quite high among Nigerians'. (H2, mw 2)*

This is in line with findings of WHO (2012) study of health systems in Africa in which it was reported that, respondents in urban areas of Nigeria and other urban areas of West Africa reported hypertension as being common while rural areas in Nigeria reported higher levels of hypertension than the urban areas. Earlier, CEMACH report (2007) highlighted that, black African women suffer maternal mortality rates 5.6 times higher than Caucasians and the rest of the migrant populations in Britain (UNICEF, 2005). This could explain the uneasiness of some Nigerian midwives about caring for first-generation Nigerian women; coupled with the reported poor attitude / animosity of some FGNW to Nigerian midwives as portrayed in the following extract:

'I 'don't really like looking after Nigerians; because they come with a lot of baggage and they have lot of attitude; and they are very difficult to look after in labour. Particularly a lot of them don't like we Nigerians again to care for them, I don't know why. They believe we won't give them the care or may be, they are Nigerian, they've come from abroad; they've come to abroad to be looked after by white people and when they see you, they get kind of "oh I don't want her". They get uneasy with you and they show a lot of attitude'. (H2, mw 4)

FGNW's mistrust of Nigerian midwives' ability to deliver efficient care could stem from experiences of negative birth experiences or outcomes in Nigeria. This could generate anxiety and fear in the woman that could be perceived by the Nigerian midwife as rejection, interpreted by the annotated comment of the Nigerian midwife in the last quote as 'baggage and attitude'. Such mistrust could be perceived as lack of trust in the midwife's ability to deliver competent or congruent care that meets the care needs of FGNW. Nonetheless, the midwife informant in this situation could have explored the woman's reason for expressing preference for a White

midwife. Moreover, the inexperience of this midwife who has only been qualified for four years could engender insecurity, making her more sensitive to rejection implied or otherwise. Bedwell (2012) report that, a significant proportion of midwives referred to lack of confidence as a factor for dissatisfaction and as the main reason for leaving the profession.

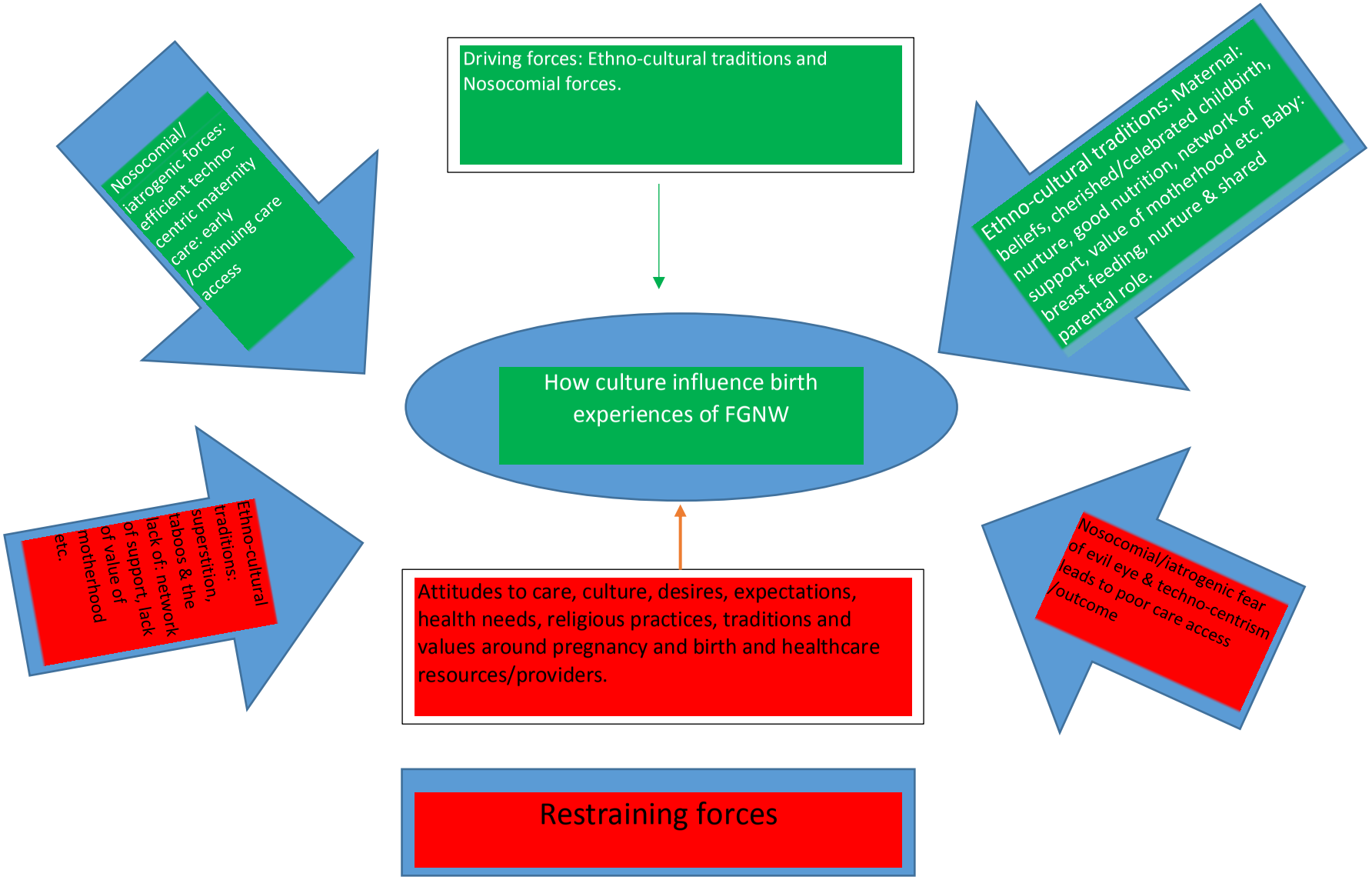
6.1.7 A Force Field Analysis of how culture influence the birth experience of FGNW

Force field analysis as a social sciences tool is useful for analysing the complex matter of how cultural practices might influence morbidity and mortality of first-generation Nigerian women in their birth experiences in London. This tool enables the framing of an issue in terms of restraining and driving forces that drive change in a desired direction, enabling a researcher to identify and recommend factors that must be addressed and monitored to aid positive change in a given situation. In this regards, steps are taken to identify the issues, define the change objective, identify the driving and restraining forces, develop change strategy(ies) aimed at resolving the identified issues. These steps require the researcher to plot the way things are, analyse steps to change the situation and achieve the ideal outcome or objectives (Lewin, 1951).

In regards to first-generation Nigerian women in the study, such factors entails their attitudes to care, culture, desires, expectations, health needs, healthcare resources / providers, religious practices, traditions and values around pregnancy and birth. Force Field Analysis enables this researcher to not only identify these factors but also to identify approaches to ensure the needs are adequately addressed to avert poor birth outcomes associated with restraining forces such as: aversion to caesarean section, poor care access and superstitious beliefs. Equally, some

neutral forces such as aspects of belief, fate and care practices, although not restraining forces can still interplay with FGNW's childbirth experiences and hence may need addressing by midwives to ensure continuing health and wellbeing of FGNW. The driving forces such as: cherishing and celebrating childbirth nurturing both mother and baby, physical care approaches such as bathing, ceremonies, nutrition and network of support may have positive influences on the health and wellbeing of FGNW and hence should be encouraged or facilitated.

Figure 4 Force Field analysis of Findings from study



6.1.8 Chapter six summary

Within this chapter, the themes drawn from all angles of the study had been critically discussed in relation to interplay of cultural practices of FGNW with the perception of midwives and maternity care access and provision. Similarities and incongruences between the expectations of FGNW and midwives have been explored in regards to *emic / etic* care perspectives of both. From the narratives of both, apparent discrepancies exist between the care expectations of midwives of FGNW and vice versa. Based on the dual accounts of both first-generation Nigerian women and midwives, it is apparent that midwives endeavour to work in line with their Professional Code of Practice but do not seem to understand or appreciate the rationale for some *emic* care practices of first-generation Nigerian women. Conflict of interests between *emic* / *etic* care approaches could explain the divergent perspectives of midwives and FGNW in the annotated narratives.

It could be deduced from the analysis in this chapter that effective health promotion measures need to be adopted by midwives to address any incongruence in care approaches of first-generation Nigerian women (*emic* care) and professional care (*etic* care) to ensure improvement in aspects of where incongruences exist. Given some of the highlighted reasons for some of the folk care practices of FGNW, midwives should encourage and affirm positive *emic* care approaches and counter potentially harmful practices such as evil eye, aversion to caesarean section and some of non-health health enhancing child care practices that has safeguarding implications; as a way of affirming competency in maternity care and enhancing congruency in meeting the care needs of FGNW accessing maternity care in London. Force field analysis has been utilised to express health enhancing, neutral and potentially detrimental forces within *emic* approaches that could be addressed through competent and congruent *etic*

care provision to ensure continuing health and wellbeing of FGNW in their birth experiences in London.

In the final chapter that follows, interpretation and synthesis of knowledge espoused from this study is summarized. A framework for Culturally Congruent Care provision based on the theoretical frameworks and philosophies that informed this study is formulated and recommended to effect maternity care that is culturally congruent and competent for this population of Nigerian women and for midwives working with them. The limitations of this study and the recommendations to FGNW, for midwifery education, practice and research, will be highlighted.

Chapter seven: Summarizing issues from this study for FGNW, for midwifery education practice and research

7.1 Introduction

In this final chapter, the research question/s, design and key findings are summarised, issues arising from the study are highlighted and critically discussed in relation to how culture influences the birth experiences of FGNW in London. Recommendations are made to inform first-generation Nigerian women of the influences of *emic* and *etic* care practices on maternal and neonatal health and wellbeing. **Culture Care Midwifery Module** is recommended to guide midwifery education, practice and research in order to enhance maternity care that is culturally informed, competent and congruent in meeting the needs of FGNW in London. Furthermore, approaches for dissemination of the findings of this study and suggestions for replications of this work will be explored.

The current study was conceived to explore the cultural needs of FGNW in London during maternity care, and to address the gaps in knowledge in the care experiences of this population in relation to cultural competency of midwives and congruency of the maternity care provided to a section of this population (FGNW) in South London. A qualitative approach was taken through focus group discussions and prospective interviews with FGNW and midwives providing care for this population. This resulted in generation of a wealth of data about the *emic* care practices of FGNW and their needs in regards to maintaining perinatal health and wellbeing. These data has been appraised and used to device Culture Care Midwifery Model to underpin midwifery practice to achieve culturally competent and congruent care for this population.

The adoption of **Culture Care Midwifery Model** has potential to enhance care for FGNW as it brings to fore pertinent cultural care needs asserted by first-generation Nigerian women as necessary for meeting their care needs for culturally congruent maternity care. It also draws from the perspectives of both British and Nigerian midwives to represent the requirements for meeting the cultural needs of first-generation Nigerian women in childbirth and for averting potential poor perinatal outcomes. Based on data gathered in this study, the cultural needs of FGNW are apparent and distinct from those of their counterparts from other ethnic communities in London and requires specific measures by midwives to ensure that their health and wellbeing is optimised during their birth experiences in London. Concomitantly, the views of midwives in regards to aspects of *emic* care of FGNW that may not serve to optimise their health and wellbeing during birth will be addressed using some of the strategies emergent within Culture Care Midwifery Module to ensure continuing perinatal health of FGNW in London.

This study is unique as the first of its kind to explore first-generation Nigerian women's perspective of their maternity care in London. It is also unique in comparing and contrasting views of *emic* and *etic* care practices of first-generation Nigerian women and midwives adopting a mixed methodology of Culture Care Theory and transcultural research. Through the mix of perspectives from Nigerian and non-Nigerian midwives of two different cultures providing care for a migrant population, trans-cultural care gains its true form as *care that cuts across many cultures with comparative perspectives* (Leininger 1995:26).

7.2 Interpretation and synthesis of findings at stages one and two of study

Interpretation entails an examination of knowledge gained from all phases of this study, from the literature review, focus group discussions and the prospective study of a cohort of six first-generation Nigerian women through a birth continuum. Knowledge gained from the literature

review highlighted that Nigerian women's birth experiences are embedded in *emic* cultural practices that they believe to protect and optimise their health and wellbeing throughout the birth continuum. Existing evidence from the literature review also highlighted that beliefs, religion and transitional rituals play an important part in Nigerian women's birth experiences, both in Nigeria and in the diaspora. Amongst Nigerians, birth and motherhood is cherished, celebrated and supported within an *ethno-kinship* network of support in Nigeria and modified *ethno-kinship* networks established in their new domicile.

Focus group data enriched knowledge and understanding of *emic* cultural care practices adhered to by first-generation Nigerian women and the perspectives of midwives on the said *emic* care practices. From focus group data, it became apparent that beliefs, customs, expectations, family dynamics and rituals are vital in FGNW's birth experiences and are generally perceived by them as health enhancing. The value of motherhood to FGNW is apparent as expressed during focus group discussions and throughout the prospective study in the assertions of these Nigerian women informants and those of the midwives who provide maternity services to them. Data from all tiers of this study highlight that FGNW cherish childbirth and nurture it through celebrations and cultural rituals. Concomitantly, midwives in the study perceived FGNW as amiable and strong in childbirth but lacking in understanding of maternity services in London. FGNW as informants in this study also endorsed some practices warranting further attention by health providers, as a way of advocating and encouraging health enhancing practices and seeking to discourage or redress unhelpful *emic* care practices that may have implications for the continuing health of the mother and child through the birth continuum and beyond.

Data from the prospective study confirmed earlier findings from the review of the literature to focus group findings highlighting that: belief, culture, network of support and religion buttress birth experiences of first-generation Nigerian women in London. Equally, acculturation, family dynamics, aspects of *emic* care practices, poor access / poor attendance of *etic* care provision, lack of networks of support and immigration issues may negatively influence their birth experiences and transition to motherhood while experiencing birth in London.

It is apparent from FGNW's narratives that their maternity care access is influenced by discrepancies in expectations between them, their family and healthcare professionals and this may influence their overall birth outcomes. Conflicts exist between aspects of *emic* care practices of first-generation Nigerian women and *etic* care approaches of midwives. Evidence from the this study highlight and confirm existing evidence around poor care access and poor attendance of *etic* care provision by BME women in London (CEMACH 2007, CMACE 2011, and MBRRACE-UK 2014). Findings also indicates that acculturation and immigration issues militate against care access and may influence FGNW's transition to motherhood in their birth experiences in London. These findings warrant exploration in regards to the influence of these on the reported poor outcomes (CEMACH 2007, CMACE 2011, and MBRRACE-UK 2014) for this population. Therefore, findings from all angles of the study are critically discussed in relation to the amelioration of the enduring health and wellbeing of FGNW and addressing the potential care implications for midwives in relation to improving outcomes for this population.

Furthermore, findings from this study affirm social anthropologists' view that a person's experience as member of a society shapes his or her views of the world (Helman 2007, Nkwocha 2007). For this cohort of immigrant Nigerian women, *emic* care practices are a way of holding on to an attachment to their Home country, and they at times mourn the loss or lack

of understanding of these emic practices by the midwives. These first-generation Nigerian women are unique and different from the UK-born ethnic minority women studied by Puthussery *et al.* (2008) whose childbirth experiences were not influenced by *emic* care practices but who were rather described as 'more like ordinary stroppy British women'. The divergent *emic* care practices and experiences of the two cohorts (focus group and prospective informants) was apparent in the inference and parallels drawn by FGNW in both stages of the study in regards to celebration of births, *omugwo* and networks of support both in their home country and in London compared to their counterparts in London.

In regards to *emic* post-partum rituals, Grigoriadis *et al.* (2009) contend that such ritual practices dictating appropriate and necessary social support may be of some protective value, as the key protective element may be the presence of welcome support rather than the specific form that the support takes. Grigoriadis and colleagues insist that lack of social involvement in childbirth may reflect ambivalence about the value of motherhood, which may exacerbate the role conflict experienced by new mothers and threaten their self-esteem. Ambivalence in terms of lack of societal involvement entails lack of organised social networks and / or resources for new mothers, lack of acknowledgement and lack of celebration of birth. The result of this is that cultures with structured post-partum practices tend to care for the new mother and ease her transition into the maternal role, and this may benefit maternal mental health and reduce the risk of post-partum mood instability, thereby averting psychological morbidity. The finding of nurturing and protective network of support for FGNW during birth experiences in London is a positive signal towards ensuring their positive transition to motherhood whilst experiencing birth in London. Measures should be taken by midwives to ensure that the woman who lack this network of support can access other existing support networks such as more regular midwifery postnatal visits geared at support and surveillance to ensure ongoing health and

adjustment for mothers and their new-born, Sure Start which aims to improve the lives and wellbeing of families and children, Meet-a-mum association (MAMA) that brings mothers together to form networks in order to support each other, Newpin which emphasis on supporting entire family throughout childbirth continuum and Patapata: positive attitude towards antenatal and postnatal adjustment training for mothers and healthcare workers and many more such organisation geared towards supporting new mothers and enhancing their continuing adjustment to motherhood.

First-generation Nigerian women in the current study, are not dissimilar to their counterparts living in Nigeria or other parts of diaspora in expecting support from their extended family in childbirth. As explored in literature review, Morhason-Bello *et al*. (2008) reported that 75% of Nigerian women said they wished to have support during delivery. The proportion was higher among women with post-secondary education than among those with less education (79% vs. 66%), and higher among Christians than among Muslims (79% vs. 63%). Morhason-Bello *et al* (2008) contend that desire for support was greater among professional women than non-professional women (89% vs. 70%). Most of the women (7 in 10) were willing to pay extra to have a professional source of support, such as a doula (a maid in Nigerian terms) (Morhason-Bello *et al* 2008). Such a desire may prove difficult to achieve for FGNW in London, as some of them may not be able to afford the living wage that such a service warrants. Morhason-Bello *et al* (2008), upon further probing of their sample, deduced that 80% of Nigerian women wanted emotional support, 18% chose spiritual support such as assurance that God would protect them, 9% wanted someone who could run errands and 7% desired physical support). Morhason-Bello and colleagues therefore suggested that having a companion of the same cultural background and prior knowledge of the labour process was associated with reduced anxiety and labour pain. Similarly, the women in the current study vocalised their need for

family support during birth experiences in London, and some (two) who did not obtain this support bemoaned its lack. This sort of lack of what is considered both desirable and necessary by first-generation Nigerian women could induce feelings of loss that may have potential for negatively influencing their emotional wellbeing and predisposing them to poor outcomes associated with negative emotions or poor transition to motherhood.

In terms of the influence of migration on first-generation Nigerian women's birth experiences in London, various studies have reported more psychological distress in immigrant women than immigrant men (Munet-Vilaro *et al.* 1999, Ritsner *et al.* 2001, Aorian and Norris 2003, Miller *et al.* 2004). As highlighted in literature review, migrating to a new environment places individuals in situations where they experience stress and anxiety due to the loss of traditional support systems and / or a familiar environment (Bhugra and Ayorinde, 2004). Nevertheless, the Nigerian women in the current study did not manifest symptoms of anxiety, as their EPDS scores were within normal values when assessed at three points of the birth continuum. However, those two women who lacked the support of immediate family member especially post-birth bemoaned this lack. This expressed lack could potentially induce negative emotions that could compromise health and wellbeing and influence birth outcomes negatively.

According to the midwifery cohort of the current study, Nigerian-born immigrant women are unfamiliar with maternity care culture in London (*etic* care) and some of them experienced difficulty adjusting to and accessing it. This poor care access has been suggested to negatively influence birth outcomes for the BME population in London including FGNW (Bharj and Salway 2007, CMACE 2011 and MBRRACE-UK 2014).

Similarly, the socio-economic condition of first-generation Nigerian women in London appear to be affected by their migrant status. For examples, although almost all FGNW in the UK are

well educated with first degrees, difficulties in communication, lack of personal skills and unfamiliarity with the new environment often force them to take low paid menial jobs that are completely unrelated to their former training and level of education (Takougang 2002). This situation prompted Uwah (2002) to question why successful African immigrants, including Nigerians, who uphold the American values of hard work and high standards of education, who have also embraced assimilation into the mainstream culture are still not fully accepted by their host nations; uncommon with many other immigrants from Europe or Asia. These social issues and stressors related to immigration contribute to depression in immigrant women, including first-generation Nigerian women. Some have tended to suggest that ethnic prejudice, social isolation, low access to social mobility, and a lack of linguistic and social skill (Bhugra and Ayorinde 2004) are the factors that further compound the socio-economic situation of BME's in Britain. Other influences on life, aside from place of birth / abode suggested by Bhugra and Ayorinde (2004) to negatively influence health outcomes for BME's in the include individual, educational, environmental & socio-economic factors. According to Helman (2007:5), *discrimination, racism and persecution by the host population, and a general unwillingness to take note of their health beliefs, practices and expectations, further compromise the health of minority groups* including the Nigerian population studied. The issue of covert or overt prejudices and racism has implications for both maternity healthcare providers and migrant populations in London given Britain's history of imperialism, the alleged institutional racism and anti-African legacy, especially in the current political climate where immigration re-currently takes centre stage in political campaigns. This can induce mistrust and hamper effective relationship between midwives and first-generation Nigerian women. As was evident in one of the quotes by a Nigerian midwife making reference to a FGNW, covert racism maybe internalised and become apparent during care encounter; and can hamper care access. In the aforementioned case, a midwife sensed that a FGNW appeared to reject her in preference for a

'White' midwife. In another quote, a midwife narrated how some FGNW will access maternity care using another Nigerian woman's identity to bypass prohibitions on free maternity care by illegal immigrants. The inherent dangers of such practice and the stresses associated with immigration could compound pre-existing anxieties of first-generation Nigerian women and further compound their compromised care outcome.

In the current study, as in Ezeobele's (2010) study, most of the women used the word 'God' when discussing religion and many referred to a Christian philosophy when discussing their perceptions. Some of the women, in their views on childbirth in London, constructed their own realities in the context of belief, spirituality and superstition. Belief may serve as a buffer against emotional distress in this population as in Ezeobele's population in Texas, United States. The Nigerian women and midwifery informants of this study, in some of the earlier quotes, expressed the spiritual dimensions of first-generation Nigerian women's birth experiences. Some of the women explored aspects of their belief and spirituality as a means of ensuring safe pregnancy and birth as well as a means of averting perinatal morbidity and mortality commonly associated with childbirth in their home country. Overall, it would appear that the *emic* care practices of first-generation Nigerian women encompass physical care, emotional support and spiritual dimensions that need to be incorporated into *etic* maternity care provision in order to enhance holistic maternity care practices that is culturally congruent and competent to meet their care needs and avert poor outcomes for this population.

7.3 Recommendations

7.3.1 Recommendations for first-generation Nigerian women in London

- First-generation Nigerian women need to maintain aspects of *emic* care practices that ensure continuing health and wellbeing through the continuum of birth but also will need to re-examine aspects of *emic* care that may negatively influence their birth outcomes.
- FGNW in London need to be open to induction to a different maternity healthcare system from the one they are used to in their home country and to access and embrace *etic* care provision to ensure that their maternity care needs are met by midwives.
- *Ethno-kinship* networks of support in London may need to be re-negotiated to ensure continued efficient network of support during birth in London.
- Expectations of aspects of *emic* care and *etic* care warrant reconsideration to ensure care that is culturally congruent and competent and meets the maternity care needs of FGNW in London.
- Effective communication channels between first-generation Nigerian women and midwives can enhance positive acculturation and transition to motherhood during FGNW's birth experiences in London.
- Assertiveness and self-efficacy measures need to be acquired by FGNW to address self and others' expectations that may induce unwarranted stress and cause conflicts in family dynamics and maternity care provision.

7.3.2 Recommendations for midwifery education, practice and research

- There is an apparent need for the acknowledgement of sound *emic* care practices of first-generation Nigerian women such as self-care and network of support that need

incorporation to *etic* professional maternity care practices. In this regard, midwifery practitioners need to be aware of positive value of Omugwo in terms of the benefits of rest and recuperation for the new mother as well as the positive effect of healthy nutrition associated with this period.

- As cultural education is a dual process, there is need for induction of FGNW to aspects of midwifery care that they tend to default at, such as: late booking for maternity care, poor access to maternity services such as parenthood education classes, not just as a healthcare service culture but also as a culture that focuses on the safety of the woman and baby. In this regard, continuing professional development need to be provided for midwifery care providers to educate them on expectations of first-generation Nigerian women on *etic* care arising from their *emic* care practices. There is also need for midwives to evaluate aspects of FGNW's *emic* care practices that may have a negative influence of their perinatal health such as: late booking resulting from fear of 'evil eye', poor attendance of parenthood education programmes resulting from working through to last trimester of pregnancy, aspects of bath rituals for mother and baby, aspects of child care practices such as using lotions and potions on the cord stump, and unwarranted fear of Caesarean section, etectra.
- In order to foster care that is culturally competent and congruent, midwifery education and practice in London should acknowledge the interwoven nature of culture and care as an intricate matter for FGNW population that needs to be teased out and understood.
- Seeking knowledge / understanding of specific cultural beliefs, ways of life and values of first-generation Nigerian women may uncovers a wealth of new knowledge that will equip maternity education and practice for culturally congruent care for FGNW in London and potentially for other BME populations accessing maternity care in London.

- The example from the six FGNW prospectively studied has shown that care embedded in culture is core to effective and holistic maternity care provision that enhances health and wellbeing for women of this culture within maternity services, and has potential for reducing poor outcomes for this section of the BME population in London.
- Midwives in London need to foster communication channels and effective professional relationships that enable and enhance maternity care access for FGNW population and other BME populations, who for reasons of culture and other reasons may encounter similar difficulties in accessing maternity care in London.
- Maternity care provision for first-generation Nigerian women needs to be *re-conceptualised* or *re-negotiated* in order to demonstrate inter-relationships between care expectations that are explicit on the part of FGNW and culturally competent, beneficial and meaningful in in fulfilling their professional duties and in meeting the care needs of FGNW. Personal and / or professional development is key to promoting positive promoting positive attitudes of midwives towards FGNW and understanding of their cultural studies.

- Midwifery education and maternity services in London should strive to develop curricula and guidelines that will enhance the incorporation of cultural sensitivity into maternity care provision in order to ensure culturally congruent care provision by generations of midwives.
- Guidelines and policies which differ from the cultural preferences of FGNW and other BME women need to be modified in line with evidence, as such measure can influence suitable changes for enhanced experience for midwives and women.
- The British Government should be lobbied by health care providers to address immigration, racial inequities and political issues that compound stresses felt by first-

generation Nigerian women and other BME in their daily lives and in accessing maternity care in London.

- Furthermore, evidence from this study highlight and reiterate the need for midwives to maintain their duty of care in educating FGNW on the importance of accessing maternity care, to promote equality in approaches to care and to change attitudes that foster alienation of FGNW and to encourage their full participation, and to promote attitudes to enhance acceptance of *etic* care.
- Finally, midwifery education and practice could draw from knowledge espoused in the epistemology and ontological framework that informed this study to enhance evidence-based theory to inform their understanding of culture and culture care. Students and researchers in midwifery could extend the evidence generated from this research through replication of this work.

7.4 Contribution to knowledge

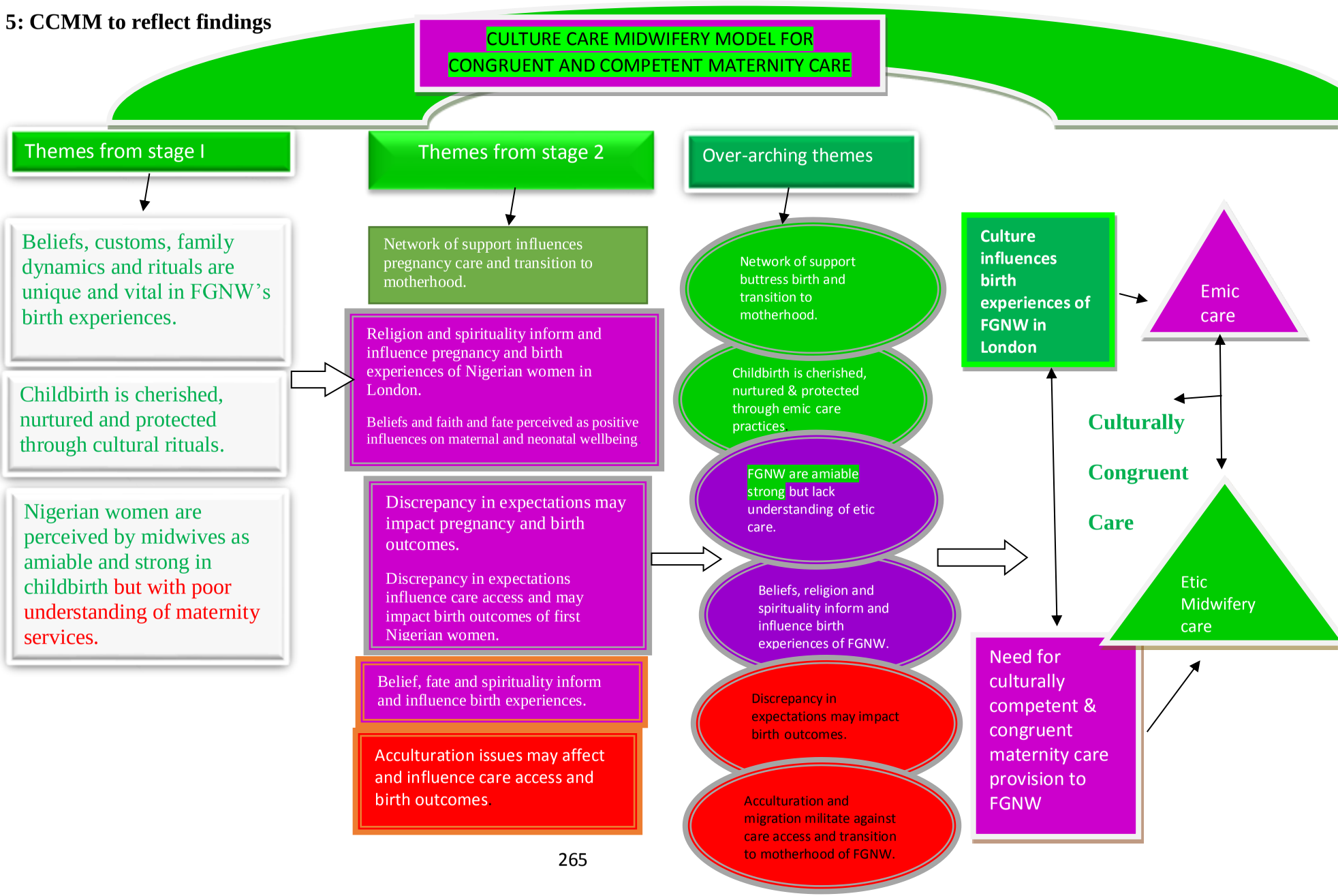
I have developed a conceptual model to underpin midwifery practice in regards to enhancing culturally competent and congruent care for FGNW in London. **Culture Care Midwifery Model** is a bespoke model recommended for Cultural Congruent and competent maternity care that may serve to improve outcomes in the birth experiences of FGNW and potentially other BME populations in London. This model addresses the research question by discovering how culture influences the birth experiences of FGNW. It highlights aspects of health enhancing (positive) *emic* care practices worthy of *preservation and / or maintenance* by FGNW and midwives such as: good nutrition, network of support, nurture of mother and baby. Similarly, aspects of *emic* care which warrants *accommodation and /or negotiation* such as: lack of understanding of *etic* care, some religio-spiritual customary beliefs and practices with no

specific detriment to health and wellbeing has been uncovered. CCMM grants midwives the strategy for *re-patterning and / or re-structuring* aspects of *emic* care practices that may negatively influence maternal and fetal / neonatal wellbeing such as the notion of the 'evil eye' that affect early access to care, discrepancy in expectations and Acculturation and migration issues that militate against care access and transition to motherhood.

'Culture Care Midwifery Model' (see figure 4 below) is proposed for ensuring culturally congruent and competent care for first-generation Nigerian women and other relevant BME populations in London. Leininger (2002)'s 'Sunrise Enabler' has served as a useful guide to the researcher in discovering actual and potential factors that influence trans-cultural care of FGNW during birth in London. Equally, Helman's (2007) 'three *strata* of culture' has proved a useful theoretical framework that informed this study. Papadopoulos's Cultural Competency Module also proved useful in informing the development of Culture Care Midwifery Model suitable for midwifery practice setting to enhance culturally competent and congruent care. Therefore, to ensure effective *etic* maternity care practices that serve to meet the cultural needs of first-generation Nigerian women and potentially other relevant BME populations in London, the adoption of Culture Care Midwifery Model is recommended as the new knowledge emergent from this study, as there has been no specific midwifery module for culture care as far as the researcher is aware, that precedes this module. It is hoped that the application of this model will mean that midwives can understand the expressed needs of FGNW and the factors that influence their birth experiences to enhance cultural knowledge that will serve to achieve culturally congruent care; which in turn could avert and / or reduce poor perinatal outcomes for FGNW. This cultural knowledge can potentially enhance care delivery to other BME populations through accommodating and facilitating health enhancing *emic* and *etic* care practices and re-negotiating non-health enhancing *emic* cultural practices. Moreover, CCMM

could be replicated with other BME populations to enhance full understanding of their cultural care needs in maternity care.

Figure 5: CCMM to reflect findings



The themes in this bespoke 'Culture Care Midwifery Model' (figure 5 above) portrays some of what first-generation Nigerian women regard as important *emic* care practices in their birth experiences in London. In figure 4A, green highlights are intentionally used to express attributes that FGNW described as positive *emic* care practices geared towards promoting and enhancing perinatal wellbeing. These are therefore interpreted as ethno-cultural traditions and nosocomial forces (positive driving forces) in Force Field Terms and would encompass: beliefs, celebration and cherishing childbirth, good nutrition, nurture, network of support, value of motherhood as well as *emic* ethno-cultural childcare practices such as breast feeding, ritual bathing and massaging of new-born, etcetera. These nosocomial forces which are considered health enhancing within *emic* practices by FGNW would require midwives to understand and hence enable FGNW to *maintain* these to ensure continuing health and wellbeing during their birth experiences in London. Purple colour highlights is indicative of forces considered neutral (neither health enhancing nor detrimental to health and wellbeing) and hence needing *accommodation* and review by midwives to ensure that aspects of these do not compromise continuing maternal and neonatal wellbeing. Inclusive in these are some nurturing maternal and neonatal measures such as ritual baths, use of herbs, tying the abdomen post birth, circumcision of male neonates, etcetera. Red colour highlight is deliberately used to indicative of non-health enhancing ethno-cultural traditions of FGNW and to highlight nosocomial and / or iatrogenic (resulting from non-positive the activity of FGNW, a health care provider or institution) forces with potential to negatively influence maternal or neonatal wellbeing such as: poor understanding of healthcare service, leading to poor care access, aversion to caesarean section, fear of evil eye, ethnocentrism, lack of network of support, superstition,

and taboos. These colour coding system run across the themes at stage one and stage two, and follows through the over-arching themes to highlight aspects of *emic* care requiring midwifery intervention to *re-negotiate* or *re-pattern* care with FGNW to ensure optimal maternal and neonatal wellbeing in their birth experiences in London. By adopting Culture Care Midwifery Model, midwives can amalgamate aspects of *emic* care practices of FGNW with *etic* care approaches to work collaboratively with FGNW to ensure continuing perinatal health and to achieve congruency in the cultural care of FGNW in London.

Earlier in chapter five within the themes, the pros and cons of some of the *emic* care practices of FGNW were explored and some suggestions made as to the steps midwives may need to take to achieve culturally congruent care that meets the care needs of this population. The similarity and dissimilarity in *emic* and *etic* care practices of first-generation Nigerian women and midwives hold the key for influencing health and wellbeing of this population and influencing the perinatal outcomes in FGNW's birth experiences in London. Disparity in congruency between *emic* and *etic* care practices between the two need to be addressed through the application of the 'Culture Care Midwifery model in order to enhance care that is culturally congruent and meets the care needs of this FGNW, and also portrays dynamics of competent professional practice by midwives.

Evidently, first-generation Nigerian women and the maternity care providers throughout the stages of this study have expressed that 'culture exerts a significant influence on birth and maternity care experiences of first-generation Nigerian women in London throughout

the birth continuum. Within the first tier of the Culture Care Midwifery Model, an arch that traverses all other aspects of the figure is deliberately used to portray the force that culture has on birth and maternity care of first-generation Nigerian women's birth experiences and the route to achieving culturally congruent care for this population. Themes from stage one and two angles of this study highlight how birth for FGNW is embedded in cultural practices perceived by them as health enhancing, and how belief, spirituality and rituals are core to birth experiences of this population, and how their cultural beliefs and expectations influence their birth experiences. Correspondingly, birth and motherhood is cherished, celebrated and supported through a negotiated or modified network of support in their new domicile, whilst acculturation and migration issues militate against care access and transition to motherhood.

That culture has such influence to this population is the reason their birth experiences are embedded in cultural practices and value systems believed to enhance and maintain the health of the mother and baby dyad. Belief, spirituality and rituals buttress birth experiences as first-generation Nigerian women rely on these innate characteristics for their metaphysical wellbeing. They seem to draw strength from God, as a supreme being with powers greater than their own, to solve and resolve issues beyond their own means of coping, especially with life experiences.

Care meanings for first-generation Nigerian women in the current study are embedded in cultural values and beliefs, economics of the family and other networks of support, their new environment as migrants, their historical / inherent culture of expectations, rituals and

taboos, kinship of support, politics of family dynamics and immigration in their negotiation of maternity care provision in London. These factors are somewhat in concordance with Leininger and McFarland's (2004) 'Cultural and Social Structures' component of their Sunrise Enabler but differ in regards to Nigerian women's historical / inherent culture of expectations, rituals and taboos. These factors influence care expressions, care patterns and care practices and may serve to influence or mitigate health and wellbeing in their experience of childbirth in London and hence may contribute to poor birth outcomes; where aspects of care practices compromise perinatal health and wellbeing.

These cultural norms and value systems are part of first-generation Nigerian women's vertical identity. As previous discussed on page 14 of this thesis. FGNW may operate from a vertical identity that comes from their ancestral or cultural heritage or a horizontal one acquired from their contemporaries in London (Maalouf 2012). It seems to me that the former is the more influential of the two, and that it becomes more apparent in the value system of FGNW through the themes if this study. This vertical identity may influence FGNW's care expression, patterns, and practices that intimately influence their general health and wellbeing when experiencing birth in London.

These care contexts are achieved through trans-cultural care actions and decisions that encompass *culture care preservation and maintenance*, *culture care accommodation and negotiation and culture care re-patterning and restructuring* (Leininger 2002). This entails accepting and upholding the health-enhancing *emic* care practices of this population, *negotiating* and attempting to modify aspects of neutral (non-health enhancing but not

detrimental to health) *emic* care practices through health education and health promotion, and *re-patterning etic* maternity care practices incorporating measures that address deficits in care in order to ensure culturally congruent care for the health and wellbeing of first-generation Nigerian women.

Therefore, the Culture Care Midwifery Model for culturally congruent care is presented as new knowledge arising from this study to aid culturally congruent care for this population of Nigerian women and other relevant first-generation BME populations accessing maternity care in London. This model acknowledges the need for amalgamation of *emic* care practices at the tertiary, secondary and primary strata with *etic* care practices of midwives to ensure care that is culturally congruent. Equally, the beliefs, religion, spirituality and health optimising *emic* care practices of this population are to be evaluated at all stages of maternity care provision to elicit practices potentially detrimental to perinatal health and wellbeing and addressing these through health education and health promotion measures.

The role of FGNW as mothers warrants the merit and value that is accorded to it within their indigenous culture and hence, warrants acknowledgement, *preservation and maintenance* by maternity care providers. The value of motherhood for this population means acknowledging their merit of respect by their carers. Respect may simply be shown though due regard for their individuality and personhood.

Midwives should foster the network of support within which support is propagated for this population during birth processes. Issues pertaining to acculturation and migration that militate against care access and positive transition to motherhood in FGNW's birth experiences in London warrant exploration in conjunction with the women at every care encounter, to seek remedial measures to address shortfalls and to ensure culturally congruent care at all stages of their birth experiences. Equally, active induction of Nigerian women to maternity care in London may enhance a more robust care seeking behaviour. And reverse aspects of *emic* care practices considered non-health enhancing or potentially detrimental to ongoing maternal or neonatal health and wellbeing.

The cultural and social structures of beliefs, education, economics, kinship, ways of life, political factors, religion and spirituality that may serve to militate against FGNW's positive transition to motherhood needs full exploration by midwives and requires understanding in the context of *etic* care, in order to ensure that these are addressed wherever feasible. Diverse care contexts such as self-care practices, folk care from family and friends as well as informed and knowledgeable support from maternity care providers, needs to be amalgamated with *etic* midwifery care practices to ensure effective trans-cultural care actions and decisions that optimise FGNW's health and wellbeing during their birth experiences in London. Such collaboration could serve to enhance early and continued access of maternity services and effective communication channels between first-generation Nigerian women and midwifery professionals through all stages of pregnancy and birth.

Culture at all strata informs and influences first-generation Nigerian women's acculturation in London as their beliefs, celebrations, expectations, practices, values and transition / adaptation to motherhood are culturally influenced. First-generation Nigerian women's social structures influence their birth experience through family dynamics, migration and acculturation or the lack thereof. As previously explored within the philosophy and theoretical framework that informed this study, the tertiary stratum of culture is manifest in their explicit cultural practices visible to their healthcare providers and at the secondary stratum in their hidden assumptions, beliefs, custom, rituals / taboos, religion and superstition that inform and influence their behaviour towards childbirth and maternity care. Their innate socialisation at the primary strata, which forms the covert and deepest level of culture, is implicit and hence entails healthcare professionals engaging with them to gain understanding of these in order achieve culturally congruent care for this population.

The 'midwifery etic care' component of the Culture Care Midwifery Model entails culturally congruent care for the health and wellbeing of first-generation Nigerian women in London and requires care that encompasses culture care *preservation / maintenance*, culture care *accommodation / negotiation* and culture care *re-patterning* and / or *re-structuring*. It also means care by midwives who are culturally competent and have acquired and can apply cultural awareness, cultural knowledge and cultural sensitivity in the care they give to FGNW. These are critically analysed in the context of evidence from all tiers of the current study and the theoretical approaches that informed it.

7.4.1 Culturally informed care and *preservation and / or maintenance* for FGNW throughout birth continuum

Culturally informed care entails *adopting assistive, supportive, facilitative or enabling creative professional actions and decisions* (Leininger 1991:48) that help Nigerian women to retain and / or to preserve relevant emic care values so that they can maintain their wellbeing through the birth continuum. Culture care maintenance also entails determining what mothers expect from the maternity services during pregnancy, labour and puerperium and ensuring that these are incorporated into *etic* maternity care provision within National Health Service available resources.

To be culturally aware / informed, midwives need to understand the factors that influence individual women's behaviour and choices and must be aware of the cultural beliefs and practices that are of importance to a mother. For first-generation Nigerian women in childbirth, these include but are not exclusive to promoting existing networks of support, encouraging healthy nutrition, encouraging breastfeeding and upholding Omugwo ceremonies and practices which they consider vital for health and wellbeing. Where potentially health compromising cultural practices are observed within *emic* care practices, the midwife should aim to *re-pattern and re-negotiate* these through consultation with the mother and family, a culturally-informed significant other, or through health education to enhance modification of behaviour and / or practice. This requires the midwife to have cultural knowledge. Cultural knowledge is the process of seeking and obtaining sound education and knowledge about cultural and ethnic groups. It involves obtaining knowledge of clients' views about health-related beliefs and values. It should be

acknowledged that no individual is a stereotype of one culture of origin, but is a unique combination of life experiences (Buscemi, 2011). Therefore, holistic and individualised care combined with cultural knowledge that informs care is the key to ensuring culturally congruent care that meets the maternity care need of each individual woman within this sub BME community of London.

7.4.2 Culture care *accommodation and negotiation* for FGNW throughout the birth continuum

Culture care *accommodation or negotiation* should guide midwifery actions in accommodating, honouring and meeting culture-specific requirements of the FGN mother by maintaining individualistic approaches to care such as choices, expectations, expressions, language, and personal references. Midwives need to endeavour to accommodate cultural needs within available resources unless these are contradictory to the health model of care. This model of care should be in line with the Midwives Code of Practice stipulated by the Nursing Midwifery Council (2015). It was observed throughout this study that the midwifery informants expressed *etic* care approaches that are in line with their code of practice. Moreover, they also highlighted *emic* care practices of first-generation Nigerian women that were in conflict with *etic* care approaches, such as the FGNW's choice to avoid Caesarean section at any cost and the midwives need to convince them of the need for Caesarean section when warranted. These conflicts of interest between *emic* and *etic* care approaches if unchecked, have the potential for causing a breach of the midwives' code of conduct, for instance swaddling the baby in layers of clothing is seen by some first-generation Nigerian women as part of essential care of new-born aimed at

averting coldness in the baby but has implications for cot death. On the contrary, midwives' advice against this practice links to organisational health and safety recommendations aimed at averting cot death. To counteract this common conflict of interest, the approach of the midwife to the FGNW needs to be respectful to ensure effective communication that enhances modification of behaviour; as midwives uphold child safety as a core part of professional practice. For first-generation Nigerian women, these may include the way they are addressed in relation to status and identity, theirs and their family's expectations, prescriptions and proscriptions within the birth continuum, accommodation of their variant accents, nuances and intonations, and provision of interpreters for those not in full command or eloquent in English language during consultations to ensure effective communication. These differences in *emic* care approaches need to be acknowledged, *accommodated* and aspects *re-negotiated* with first-generation Nigerian women to ensure cultural congruency in care provision. It also means skilled and competent knowledge backed by evidence on the part of the midwife to persuade the FGNW about the need for modification of *emic* care approaches.

Post-structivist theories that see identity as something fluid and constantly changing as opposed to something set in stone would in this context accept that first-generation Nigerian women's identity is not set as one with clearly defined characteristics but is constantly evolving through time and interaction with other cultures in their new domicile. Although this population of Nigerian women retains specific characteristics, rituals and customs through their birth experiences, this does not make them a homogenous group. According to Castells (2010: xxv), "*ethnicity has always been a basic attribute of self-*

identification". This is not simply based on shared historical practice, but because '*the others*' remind people on daily basis of '*their otherness*' through differences in skin colour, language and other differential attributes. These differential attributes form the basis of multi-culturism that compels individuals (FGNW) to find solidarity in the in-group as a refuge against the prejudices of the dominant group (Castells 2010). Nonetheless, there is uniqueness in individuality, so each of these women would have their own unique experience(s) and through a cultural negotiation with *an other* (the other here being other women - Nigerian or not and the midwives they encounter during care episodes) their identity would constantly change and evolve. A Nigerian woman in London who has lived with other Nigerian women and who has recently moved to London may have a different understanding of identity from another Nigerian woman who interacts more with women from other cultures or has spent more time travelling and interacting with other cultures. Equally, the researcher would contend that a Nigerian woman with more exposure to British culture and a British midwife with more exposure to Nigerian culture might find a better way of communicating and negotiating their interactions to effect care that is culturally congruent. Conversely, a Nigerian woman with no experience of British culture and a British midwife with no experience of Nigerian culture may encounter conflicts and / or misunderstanding in negotiating maternity care that is culturally congruent. What is vital in achieving care that is culturally congruent is effective approaches by the care giver (midwife) and receiver (FGNW) to work in collaboration through culture care *accommodation* and *negotiation* strategies to re-pattern care to suit both care approaches in a manner that is competent and congruent.

7.4.3 Culture care *re-patterning and / or restructuring* to enhance health and wellbeing of FGNW in maternity care.

Cultural care *re-patterning and / or restructuring* refers to those assistive, creative, supportive, enabling or facilitative professional actions and decisions that help clients re-order, change or greatly modify their behaviours for a new, different and beneficial health care pattern, while respecting the clients' cultural values (Leininger, 1991:49). For first-generation Nigerian women, this entails co-participation with maternity care providers to assess, plan, implement and evaluate *emic* care strategies that may help the mother maintain wellbeing through the birth continuum. Here, midwives should explore strategies to address poor care access and the reasons for it and work with first-generation Nigerian women to draw out measures for improving care access. Furthermore, effective care *re-patterning* may entail seeking measures to address and reduce unrealistic expectations upon women and families that may serve to compromise their wellbeing. Finally, health promotion strategies should be devised collaboratively to address *emic* care practices that serve to constrain the health of first-generation Nigerian women and their babies and to identify beneficial *etic* care practices for optimisation of wellbeing through the phases of birth. This entails cultural competence, *re-patterning and re-structuring* of care on the part of the midwife to ensure that the care provided is culturally congruent.

7.5 Strength of this study

This study is the first of its kind to explore *emic* care practices of first-generation Nigerian women in London and to explore cultural competency and congruency in the care provided

for this population by midwives in London, as far as the researcher is aware. Therefore, new knowledge generated through this study makes a tangible contributions to midwifery education and practice, as well as allied health and social care practices in regards to highlighting *emic* care approaches adopted by FGNW to ensure perinatal health and wellbeing. Culture Care Midwifery Module is also the first nodule specifically espoused to guide midwives in meeting the cultural needs of first-generation Nigerian women in London, which could also be useful for informing cultural care of other BME population accessing maternity care in London.

Therefore, findings from this study will inform and enhance contemporary midwifery practice and bolster care that is culturally informed and compliments *emic* care practices of first-generation Nigerian women in London and to align these with *etic* midwifery care approaches. Therefore in justifying knowledge of *emic* care practices of FGNW, this study has managed to establish what FGNW hold as *justified true belief* of the need for *emic* care for nurturing pregnancy and birth; and to a degree value *etic* care approaches of midwives. Similarly, midwives through their assertions and the findings of this study would arrive at *justified true belief* of *emic* care practices of FGNW that should enhance a level of understanding that '*are individually necessary and jointly sufficient* (Steup, 2014:2) to enhance culturally competent and congruent maternity care that meets both professional care ethos as well as the cultural needs of FGNW. Cultural knowledge espoused by the findings of this study should therefore enhance cultural awareness and cultural sensitivity and hence contribute to cultural congruency in the care provided by midwives to FGNW. Most importantly, the application of Culture Care Midwifery Model in midwifery care

planning incorporating all components of the model could enhance care that is culturally congruent for both first-generation Nigerian women and could be extrapolated to other first-generation BME populations accessing maternity care in London. This will entail discovery of specific *emic* care practices and / or preferences of the BME population and planning *etic* care to meet these using the components of CCMM.

The researcher plans to extend this work through quantitative study (using a standardised tool) to explore midwives evaluation of their ability to meet the requirements of culturally congruent care. Furthermore, publications already generated from this study and subsequent publications form robust scholarly work that continue to enrich contemporary midwifery practice at local, national and international levels.

Secondly, the researcher continues to utilise knowledge gained from this study to impart knowledge through her lecturing duties, research output and other scholarly roles. So far, the researcher has put out four articles in the period of this study and there are on-going contracts for further publications post this endeavour.

Thirdly, preliminary presentations which forms part of sharing knowledge on research approaches (see appendix: C of presentation slides) of the study which were made to the three Trusts from which the study population were recruited to ensure collaboration and shared understanding of the need for the study. The nature of the presentations varied between formal and informal, depending on management staff preferences within trusts. In two trusts, the researcher was required to present to selected members of the management

team at pre-arranged times and venues. One trust preferred presentation to the potential population of midwives targeted for recruitment to the focus group. These presentations were instrumental for enhancing collaboration in understanding the research proposal, identifying the target population and locations of first-generation Nigerian women as well as gaining local research directorate approval and research ethics approval for the study. These form part research process open for replication of this work by other researchers.

Fourthly, University research day(s) presentations formed part of the preliminary dissemination of findings and aided generation of divergent perspectives and critical peer review of aspects of the study. So far, two research outputs from this study have been published in high-impact peer-review journals (British Journal of Midwifery and African Journal of Midwifery and Women's Health). The said publications opened avenue for other publications with sister high-impact peer review journals (Journal of Health Visiting and Institute of Health Visiting), with more publication contracts ongoing.

Fifthly, as part of contribution to knowledge, the researcher worked with a Clinical Midwife for Special Projects to process an application that won The Mary Seacole Development Award and a Cultural Competency Continuous Professional training for midwives has since been delivered through this sponsorship at one of the study centres. This award goes towards ensuring culturally congruent continuous professional development activities for midwives working with multi-cultural populations in maternity care in London. The researcher also takes the lead in delivering culture-related topics

within department, faculty and disciplines of her higher education institution and has been invited to discuss her findings outside her institution.

Finally, the researcher by undertaking this study at MPhil / PhD level has advanced her research and technical skills and enhanced her research and scholarly output. On successful completion of this endeavour, the research aspires to establish her role as a researcher, a position that has potential for enhancing her role as an academic.

7.6 Limitations of the study

Despite all efforts by the researcher to recruit samples representative of the Nigerian ethnic sub-groups (tribes / regions) in London, only women from South-East and South-west Nigeria formed the samples of the Nigerian populations in this study. The reasons for lack of representation of Northerners (Hausa tribe) have been explored in earlier chapters. Thus the implication of this limitation is that study population only represent views of the Igbo and Yoruba tribes and regions but not the Hausas and other dialects and tribes of Nigeria. This lack of comprehensive representation of samples limits generalisation of findings beyond the represented tribes and regions living in London. However, there are commonalities of *emic* care practices that traverse ethnicity and tribe across Nigerian cultures, hence enabling generalisation of some of the findings of this study beyond Igbo and Yoruba tribes.

Furthermore, the total sample of twelve Nigerian women and twelve midwives may be considered a limited population, as larger numbers could further improve generalisation of

the findings of this research. Nonetheless, there were altogether eighteen prospective interviews and about five focus group discussions with the recruited sample of twenty-four informants which provided saturation of categories, patterns and themes that has enriched understanding of how *emic* care practices of first-generation Nigerian women influence their care access, general health and wellbeing and the *etic* maternity care provision of midwives to this population in relation to achieving cultural congruency in their maternity care experienced in London.

The location limitation of Ethic Committee Catchment of South London means that women and midwives in in South London formed the core informants of this study. However, information generated from six FGNW in the researcher's Church in East London advances generalisation to FGNW beyond South London.

7.7 Recommendations for further study

In view of the aforementioned limitations of this study, the researcher recommends replication of this work incorporating FGNW from the three main tribes / regions of Nigerian living in London to enhance generalisation of findings.

Secondly, it might be useful to explore further the regulatory, legal and human rights aspects of this work and the role these may play in the debate about need for culturally congruent care for BME populations accessing maternity care in London. The Nursing Midwifery Council as the regulatory body for midwives stipulate efficient maternity care provision that meets the holistic needs of women and their family. The midwives in this

study in keeping with their professional ethos and philosophies have advocated care practices that optimise the health and wellbeing of the family dyad and have highlighted *emic* care practices of first-generation Nigerian women that may compromise their general health and wellbeing during their birth experiences in London. It remains the choice of this population of Nigerian women to adapt aspects of *emic* care practices to align with *etic* midwifery care to ensure their continued general health and wellbeing during their birth experiences in London.

For researchers who might wish to replicate this study, it might be worthwhile considering further critical identity theory and women's studies of identity alluded to in this study, and to examine the influence these might have on the birth experiences of this population and other BME populations accessing maternity care in London. The guidance of supervisors from Anthropology with experience in trans-cultural research, especially in Culture Care Theory will be most useful in such an endeavour.

In the case of this study, first-generation Nigerian women appear to have a vertical sense of identity. According to Malouf (2000) 'vertical' sense of identity around historic heritage means that first-generation Nigerian women uphold their cultural identity and hold on to aspects of their *emic* inherited practices during birth, while also experiencing a 'horizontal' (British) sense of identity around their present environment and negotiation with other groups such as midwives and other women giving birth in London in their bid to ensure perinatal health and wellbeing. It would appear that FGNW in this current study seem more attached to their vertical heritage and may find it harder to identify themselves with their

horizontal identity. This was apparent in their poor care access and their delay in accessing maternity care due to inherent vertical sense of identity. This reflects Foucault's (1998) argument that certain groups due to migration and diaspora tend to behave in exactly the same way as they would do in their home country and find it difficult to adapt to a new environment and therefore almost create another new little world within their host country / city (a 'small Nigeria' almost in London). This maintenance of dual identity has been described by some as being 'transnational' or having a foot in two cultures, two societies, two countries, at the same time (International Organisation for Migration (IOM), 2010:1). This warrants active induction by midwives and other maternity care providers for first-generation Nigerian women to a horizontal sense of identity were they embrace the culture of their domicile country alongside their inherited culture to achieve a balanced state of identity. This will serve to enhance their acculturation or adaptation to a somewhat mixed vertical and horizontal identity, which would enable benefits from the dual identities within which they exist in London. This move would enable FGNW to stride across both cultures with balanced footing for continuing health and wellbeing during birth experiences in London.

This study of first-generation Nigerian women's *emic* care practices during childbirth in London is bespoke in its form as the first study of this kind on this population in London. Findings from this study highlight the need for amalgamation of *emic* and *etic* care approaches and the conceptualisation of 'Culture Care Midwifery Model' adds to knowledge and understanding of culture influences childbirth experiences of first-

generation Nigerian women in London and details the strategies for enhancing culturally congruent and competent care for this population in their current domicile.

Conversely, aspects of *emic* and *etic* care approaches warrant *re-patterning, re-constructing and re-negotiation* to avert practices that may hamper culturally congruent care. Re-construction and re-negotiation of maternity care is warranted through the application of 'Culture Care Midwifery Model' to effect competent and congruent maternity care provision that meets the needs this population.

The summative finding of this endeavour is that although birth and motherhood is cherished, celebrated and nurtured by FGNW through *emic* care approaches, acculturation and migration militate against care assess and transition to motherhood for this population. These cultural constructs of first-generation Nigerian women represent their in-depth worldview, the influence on their birth experiences as well as highlighting other *emic* cultural phenomena worthy of further investigation such as the notion of 'evil eye' and the influence of this belief on care access.

In as much as it is not possible to learn about all the specific beliefs, *emic* care practices and rituals of first-generation Nigerian women who access maternity care in London, it is useful to have some understanding of *emic* care practices that inform their maternity care access. While race and ethnicity are of value in clinical care, they can also lead to stereotyping, stigma and racism. The potential value of ethnicity and race in modern multi-cultural societies will be achieved only if understanding and application of these concepts

is advanced such that advantages exceed their weaknesses. Reflecting on both one's own and others' perceptions of one's ethnic and racial group provides a route to understanding the strengths and weaknesses of the concept of ethnicity (Bhopal 2014: 31). A key concept for maternity service providers is to understand what a first-generation Nigerian mother believes to be true, dependent on the cultural and social influences that might influence her health seeking, health promotion activities and health behaviours within perinatal birth experience(s).

Culture care theorists such as Helman (2007), Leininger (2004), Leininger, and McFarland (2002) hold the view that respecting individuals in cultural, holistic and spiritual dimensions during care is essential for efficient and effective care. In regards to FGNW, it is care from the vertical identity, the woman's network of support (*emic* care) together with professional care from culturally-informed maternity care providers (*etic* care) and actions of the professional midwife (caring) based on cultural awareness and knowledge that can enhance health and wellbeing (Leininger and McFarland 2002) and avert poor outcomes for this population. Therefore, midwifery caregivers need to acknowledge that identity based on cultural heritage is a 'fundamental lever of social change' (Castells 2010: xxvii) and hence influences first-generation Nigerian women's approaches to maternity care. *Territorial identity being the anchor of belonging* (Castells 2010: xxviii) is not easily lost in migration from Nigeria to London. The village (*vertical identity*) is not left behind (Castells 2010: xxvii), by first-generation Nigerian women but is transported with its communal ties in London via a recreation of the vertical identity manifest in their modified network of support and other *emic* care practices. Amalgamating these *emic* care practices

with *etic* care approaches will enhance a balanced vertical and horizontal identity that enhances culturally congruent care for this population.

Therefore, this bespoke 'Culture Care Midwifery Model' representing components of *emic* care and highlighting remedial strategies within *etic* care approaches is considered useful for achieving culturally congruent care for first-generation Nigerian women in London. Therefore, the researcher present 'Culture Care Midwifery Model' as a feasible model to be adopted by maternity care givers and FGNW to ensure maternity care that is culturally congruent, efficient and satisfactory for FGNW and healthcare professionals alike.

While avoiding stereotyping and /or unwarranted generalisation, it can be cautiously asserted that this study has wider relevance to other BME populations in London other than just first-generation Nigerian women on whom the study is focussed. The researcher is optimistic that this model is adept and timely in revolutionising maternity care for these populations if incorporated into the formulation of maternity care for first-generation Nigerian women and other related BME populations accessing maternity care in London.

7.8 Post script

This work has been completed through sheer and unwavering determination, enthusiasm, fortitude and tenacity of the researcher despite obstacles along the way. The immeasurable affirmative reinforcement of family and friends and self-belief and trust in God is testament to the completion of this work. For these, I remain eternally grateful.

References

Adebowale, T.O. and Ogunlesi, A.O. (1999) 'Beliefs and knowledge about aetiology of mental illness among Nigerian psychiatric patients and their relative'. *African Journal of Medical Science* 28, 35–41.

Adeoye, S. Kalu, C.A. (2011) 'Pregnant Nigerian women's view of Caesarean section'. *Nigerian Journal of Clinical Practice* 14(3): 276-9.

Adewuya, A.O. and Makanjuola, R.O. (2008) 'Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates'. *Social Psychiatry and Psychiatric Epidemiology* 43, 336–341.

Adewuye, A. O. Ola, B. A. Aloba, O.O. (2007) 'Relevance and correlates of depression in late pregnancy among Nigerian women'. *Depression and Anxiety* 24:15-21.

Anarado, A.N. and Nduka, J. (2009). 'Perspectives of women about pain in neonatal male circumcision in selected rural communities in Anambra State South-eastern Nigeria'. *Newborn and Infant Nursing Review* 9(2): 73-78.

Angen, M.J. (2000) 'Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue.' *Qualitative Health Research.* 10(3):378-395.

Anugoro, P.O. Oyedele, L. and Pacquiao, D. (2004) 'Comparative Study of Meanings, Beliefs, and Practices of Female Circumcision among Three Nigerian Tribes in United States and Nigeria'. *Journal of Trans-cultural Nursing* 15(2): 103-113.*s*

Anugwom, E.E. (2007) 'Starting out: the Omugwo Practice and instilling the rudiments of childrearing in mothers among the Igbo's of South Eastern Nigeria' in Liamputtong P (2007) edition: *Childrearing and infant care issues: a cross-cultural perspective*. Nova Publishers: New York.

Aorian, K. J. and Norris, A.E. (2003) 'Depression trajectories in relatively recent immigrants'. *Comprehensive Psychiatry* 44: 420– 427.

Aquino, M. R. J. V, Edge, D and Smith D. M. (2015) 'Pregnancy as an ideal time for intervention to address the complex needs of black and minority ethnic women: Views of British midwives'. *Midwifery* 31: 373 –379.

Arnett, J.J. (2000) Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist 55:* 469- 480.

Aspinall, P. J. (2012) 'Answer Formats in British Census and Survey Ethnicity Questions: Does Open Response Better Capture 'Super diversity'?' Sociology 46 (2): 354–364.

Aveyard, H. (2014) '*Doing a literature Review in Health and Social Care: a practical Guide*'. 3rd Edition. Barkshire. McGraw-Hill. Open University Press.

Aveyard, H. (2010) '*Doing a literature review in qualitative research in Health and Social Care: A practical guide'* (second edition) Open University Press.

Ayanwuyi, E. and Akintonde, J.O. (2011) 'Income Generating Activities among Rural Women in Ensuring Household Food Security in Ila Local Government, Osun State, Nigeria'. *World Journal of Young Researchers* 1(5):66-70.

Baran, M. L. and Jones J.E (edition) (2016) '*Mixed Methods Research for Improved Scientific Study'. Information Science Reference.* Hershey: USA.

Barkow, J.H. Cosmides, L. and Tooby, J. (1992) '*The Adapted Mind: Evolutionary Psychology and the Generation of Culture'.* New York: Oxford University Press.

Barr, J.A. (2008) 'Postpartum depression, delayed maternal adaptation, and mechanical infant caring: S phenomenological hermeneutic study'. *International Journal of Nursing Studies,* 45 (3):362-369.

Bartocci, G. and Dien, S. (2005) 'Detachment: gateway to the world of spirituality'. *Transcultural* Psychiatry 42(4): 545-69.

Barwell, I. (2009) 'Understanding Narratives and Narrative Understanding'. *The Journal of Aesthetics and Art Criticism* 67(1): 49-59.

Bedwell, C. (2012) 'An analysis of the meaning of confidence in midwives undertaking intrapartum care: A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Medical and Human Sciences'. Accessed online on 23rd March

Begley, C., Declan D., Clarke, M., McCann, C. Hughes, P., Reilly, M, Maguire, R., Higgins, S., and Doyle, M. (2011) 'Comparison of midwife-led and consultant-led care of healthy women at low risk of childbirth complications in the Republic of Ireland: a randomised trial'. Pregnancy and Childbirth. *Bio Medical Central (BMC)* 11:85:1-10. Accessed online on 10th January 2016 at http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-11-85.

Benzies, K.M. Premji, S. Hayden, K.A and Serrett, K. (2006) 'State-of-the-Evidence Reviews: Advantages and Challenges of Including Grey Literature'. *Worldviews on Evidence-Based Nursing* 3(2):55–61.

Berry, J. W. (2005) 'Acculturation: Living Successfully in two cultures'. *International Journal of Cultural Relations* 29(6):697-712.

Besser, A. and Priel, B. (2003) 'The Vulnerability and Coping Strategies in the transition to Motherhood'. *Current Psychology; Development, Learning, Personality, Social.* Spring 2003 22(1): 57-72.

Bharj, K. and Salway, S. (2008) '*Addressing ethnic inequalities in maternity service experiences and outcomes: responding to women's needs and preferences'*, Better Health Briefing 11, Race Equality Foundation Briefing Paper, October 2008.

Bhopal, R. S. (2014) '*Migration, ethnicity, race, and Health in multi-cultural societies'.* Second edition, Oxford Press: UK.

Bhugra, D. and Ayorinde, O. (2004) 'Depression in Migrants and Ethnic Minorities'. *Advances in Psychiatric Treatment* 10(13): 13-17.

Bina, R. (2008) 'The impact of cultural factors upon postpartum depression: a literature review'. H*ealth Care for Women International* 29(6): 568–92.

Blunt, L. (2014) 'Improving Service User Experience in Maternity Services: A Report prepared by The Patient Experience Network'. Accessed online on 13th March 2016 at http://patientexperiencenetwork.org/Resource/ImprovingPatientExperienceinMaternityServicesfinal.pdf.

Bonevski B, Randell M, Paul C, Chapman K, Twyman L, Bryant J, Brozek I and Hughes C (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. Medical Research Methodology 14(42):1-29. Accessed online on 3rd March 2016 at http://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-14-42.

Bott, E. (2010) 'Favourites and others: reflexivity and the shaping of subjectivities and data in qualitative research'. *Qualitative Research. 10(2): 159-173.*

Bowling, A. (2014) '*Research Methods in Health: Investigating Health and Health Services*'. (4th Edition). Open University Press: London.

Bowling, A. (2009) '*Research Methods in Health'* (3rd Ed). Open University Press: London.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology'. *Qualitative Research in Psychology* 3:77-101.

British Medical Association (2004) 'Symposium on Circumcision: The law and ethics of male circumcision: guidance for doctors'. Journal of Medical Ethics; 30:259–263.

Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, McCourt C, et al. (2011) 'Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study'. *British Medical Journal*; 343:1-13.

Bromley, A.K. (2007) '*A comparative analysis of labour events and enquiry into Obstetricians' and midwives' views of labour in Nigerian and Caucasian women'*. Unpublished PhD thesis: The University of Greenwich.

Bryceson, D. and Vuorela U. (eds.) (2002) 'The Transnational Family: New European Frontiers and Global Networks', Oxford and New York: Berg.

Bryman, A. (2004) '*Social Research Methods*'. (Second edition). Oxford: Oxford University Press.

Bruner, J.S. (1990) '*Acts of Meaning*'. Harvard University Press: Cambridge England.

Buck, D. and Maguire, D. (2015) Inequalities in life expectancy: changes over time and implications for policy (Marmot Review). The Kings Fund: Ideas that change Healthcare. Accessed online on 3rd March 2016 at http://www.kingsfund.org.uk/publications/inequalities-life expectancy.

Burck, C. (2005) 'Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis'. *The Association for Family Therapy and Systemic Practice* 237-262. Accessed online on 10 June 2014 at http://staff.neu.edu.tr/~cise.cavusoglu/Documents/Advaced%20Research%20Methods/Qualitative/Burck%20Qualitative%20Research%20Methodologies%20comparison.pdf

Burns, N. and Grove, S.K. (2001) '*Understanding Nursing Research'*. W B Saunders: Philadelphia.

Buscemi, C.P. (2011) 'Acculturation: state of the Science in nursing'. *Journal of Cultural Diversity* 18(2): 39-42.

Caelli, K. (2001) 'Engaging with Phenomenology: Is it more of a challenge than it needs to be?' *Qualitative Health Research* 11:273-281.

Callister, L.C. and Khalaf, I. (2010) 'Spirituality in Childbearing Women'. *The Journal of Perinatal Education.* 19(2): 16–24.

Callister, L.C. (2001) 'Culturally Competent Care of Women and New-borns: Knowledge, Attitudes and Skills'. *Journal of Gynaecology and Neonatal Nursing* (JOGNN) March / April 2001, 30(2): 209-215.

Carolan, M. (2006) 'Women's stories of birth: A suitable form of research evidence?' *Women and Birth; Journal of the Australian College of Midwives, 19,* 65-71.

Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (2013). Accessed online on 19th July 2013 at http://www.casp-uk.net/wp-content/uploads/2011/11/CASP_Qualitative_Appraisal_Checklist_14oct10.pdf

Castells, M. (2010) '*The Power of Identity'*. Wiley-Blackwell Publishing Limited: London.

Castellsagué, X.F., Bosch X., Muñoz, N., Meijer, C.J.L.M.., Shah, K.V. P.H., Silvia de Sanjosé, M.D., Eluf-Neto, José M.D., Ngelangel, C. et al (2002) 'Male Circumcision, Penile Human Papillomavirus Infection, and Cervical Cancer in Female Partners'. *The New England Journal of medicine* 346:1105-1112.

Carter, B. and Fenton, S. (2009) 'Not Thinking Ethnicity: A Critique of the Ethnicity Paradigm in an over-Ethnicised Sociology'. Journal for the Theory of Social Behaviour 40(1): 1-18.

Centre for Maternal and Child Enquires (CMACE) (2011) 'Saving Mothers' Lives: Reviewing Maternal Deaths to make Motherhood Safer: 2006-2008'. *British Journal of Obstetrics and Gynaecology* Press Wiley–Blackwell: London.

Chalmers, B. (2012) 'Childbirth across Cultures: Research and Practice'. *Birth* 39(4): 276-280.

Childress, E. and Erik, J. (2003)'Going Gray: Gray Literature and Metadata'. *Journal of Internet Cataloguing* 6:3: 3–6.

Chokwe, E. and Wright, S. C. D (2012) 'Caring as a core concept in educating midwifery learners: A qualitative study'. Health SA Gesondheid 17(1), Art. #653, 7 pages. Accessed online on 10th January 2016 at: http://www.scielo.org.za/pdf/hsa/v17n1/16.pdf.

Clark, J.C. (2000) 'Beyond Empathy: An Ethnographic Approach to Cross-Cultural Social Work Practice'. Accessed online on 10th May 2012.at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.110.538&rep=rep1&type=pdf.

Cluett, E.R. and Bluff, R. (2006) '*Principles and Practice of Research in Midwifery'*. 2nd edition. Churchill Livingstone: London.

Cluett, E. R. and Bluff, R. (2000) '*Principles and Practice of Research in Midwifery'*. Bailliere Tindall: London.

Coast, E. Jones, E. Portela, A. Lattof, S.R. (2014) 'Maternity Care Services and Culture: A Systematic Global Mapping of Interventions'. *PLoS ONE* 9(9):1-17.

Cohen, R. (2007) 'Creolization', in G. Ritzer (ed.) '*The Blackwell Encyclopedia of Sociology*'. Malden: Blackwell Publishers.

Commission for Healthcare Audit and Inspection (2008) '*Towards Better Births: A review of maternity services in England*'. London: Commission for Healthcare Audit and Inspection.

Confidential Enquiry into Maternal and Child Health (CEMACH) '*Perinatal Mortality (2007): United Kingdom*'. CEMACH: London.

Confidential Enquiries into Maternal and Child Health (CEMACH) (2004) *'Why Mother's Die 2000-2002 – Report on Enquiries into Maternal Deaths in the United Kingdom'*. Royal College of Obstetrics and Gynaecology Press: London.

Cox, J.L. (1999) 'Perinatal mood disorders in a changing culture: a trans-cultural European and African perspective'. *International Review of Psychiatry*, 150:103-110.

Cox, J. L. Holden. J. M. and Sagovsky, R. (1987) 'Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale'. *British Journal of Psychiatry* 150:782-786.

Critical Appraisal Skills Programme (CASP) (2008) 'Making sense of evidence: CASP checklist'. Accessed online on 19th January 2015 at: http://www.casp-uk.net/#!casp-tools-checklists/c18f8

Cronin, P. Ryan, F. and Coughlan, M. (2008) 'Undertaking a literature review: a step-by-step approach'. *British Journal of Nursing* 17(1): 38-43.

Crosta, P.M. (2015) 'What is nursing? What does a nurse do?' Accessed online on 23rd May 2016 at http://www.medicalnewstoday.com/articles/147142.php.

Cross, C. Gelderblom, D. Roux, N. and Mafukidze, J. (2006) '*Views of Migration in Sub-Saharan Africa: Proceedings of an African Alliance Migration Workshop'*. Human Science Research Council and Department of Social Development: South Africa.

Darby, R. (2016) 'Targeting Patients Who Cannot Object? Re-Examining the Case for Non-therapeutic Infant Circumcision'. Sage online publication. Accessed online on 10th May 2016 at http://sgo.sagepub.com/content/spsgo/6/2/2158244016649219.full.pdf.

Data Protection Act (1998) 'UK Statute Law Database'. Accessed online on 29 September 2010 at http://www.legislation.gov.uk/ukpga/1998/29/contents.

Davies, D. and Dodd, J. (2002) 'Qualitative Research and the Question of Rigor'. *Qualitative Health research, 12*(2): 279-289.

Deaton, A. (2008b) 'Income, Health, and Well-Being around the World: Evidence from the Gallup World Poll'. *Journal of Economic Perspectives* 22(2): 53-72.

Department of Environment, Food and Rural affairs (2009) '*Sustainable Development Indicators in your pocket'*. Department of Environment, Food and Rural affairs: London.

Department of Health (2014) 'A framework for personalised care and population health for nurses, midwives, Health Visitors and allied health professionals: caring for populations across the life course'. Accessed online 15th April 2016 at: http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377450/framework_for_personalised_care_and_population_health_for nurses.pdf.

Department of Health (DH) (2010) The Marmot Review Executive Summary. Published by The Marmot Review February 2010. Online www.ucl.ac.uk/marmotreview. Accessed 30th January 2016

Department of Health (2007) '*National Service Framework for Children Young People and Maternity Services'*. The Stationery Office, London.

Department of Health (2007) '*Maternity matters: choice, access and continuity of care in a safe service'*. The Stationery Office, London.

Department of Health (2005-2008) '*Race Equality Scheme'.* Accessed online on 29 September 2010 at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4112159.pdf.

Department of Health (2004) '*Confidential Enquiries Into Maternal and Child Health Why Mothers Die 2000-2002'*. RCOG Press, London

Department of Health and Human Services (DHHS) Office of Minority Health (2001) '*National Standards for Culturally and Linguistically Appropriate Services in Health Care'*. U.S Department of Health and Human Services Office of Minority Health

Dike, P. and Umoren, I (2014) Combating Female Genital Cutting in the UK: The role of the Health Visitor. Journal of Health Visiting 2(5): 260-265.

Dike, P. (2013) 'Birth Practices of Nigerian women: a literature review'. *African Journal of Midwifery and Women's Health*. 7 (1):7-16.

Dike, P. (2013) 'Birth Practices of Nigerian women in the UK'. *British Journal of Midwifery* 21(1): 704-715.

Dobson, C. (2008) 'Conducting research with people not having the capacity to consent to their participation: A practical guide for researchers'. On behalf of Mental Capacity Act Working Party of The British Psychological Society Professional Practice Board. Accessed online on 15th April 2016 at: http://www.psy.ed.ac.uk/psy_research/documents/BPS%20Guidelines%20for%20Conducting%20Research%20with%20People%20not%20having%20Capacity%20to%20Consent.pdf.

Donkor, E. S., and J. Sandall. (2007) 'The Impact of Perceived Stigma and Mediating Social Factors on Infertility-related Stress among Women Seeking Infertility Treatment in Southern Ghana'. *Social Science and Medicine* 65 (8): 1683–1694.

Dow, H.D. (2011) 'The Acculturation Processes: The Strategies and Factors Affecting the Degree of Acculturation'. *Home Health Care Management & Practice* 23 (3): 221-7.

Dow, H. D. (2011) 'An Overview of Stressors Faced by Immigrants and Refugees: A Guide for Mental Health Practitioners'. *Home Health Care Management and Practice* 23(3): 210-217.

Dowling, A. (2009) '*Research Methods in Health: investigating health and health services*'. (Third Edition). Mc Graw Hill: Berkshire, England.

Dowling, M. (2007) 'From Husserl to van Manen: A review of different phenomenological approaches'. *International Journal of Nursing Studies* 44(1):137-142.

Drapper, P. and McSherry, W. (2002) 'A critical review of spirituality and spiritual assessment'. *Journal of Advanced Nursing* 39 (1): 1-2.

Dye, J.F., Schatz I.M., Rosenberg, B. A., and Coleman, S.T. (2007) 'Constant Comparison Method: A Kaleidoscope of Data'. Practicing Qualitative Research: *The Qualitative Report*, Accessed online on 10th September 2010at: http://www.nova.edu/ssss/QR/QR4-1/dye.html.

Eckersley, R. (2007) 'Culture, spirituality, religion and Health: looking at the big picture'. *Medical journal of Australia* 186 (10):854-856.

Elsenbruch, S. Benson, S. Růcker, M. Rose, M. Dudenhausea, J. Pincus-Knackstedt, M. K. Klapp, B.F. and Arck, P.C. (2007) 'Social support during pregnancy: effects on maternal depressive symptoms, smoking and pregnancy outcome'. *Human Reproduction* 22 (3): 869-877.

Elwood, S. A. and Martin, D. G. (2000) 'Placing" interviews: Location and Scales of Power in Qualitative Research'. *Professional Geographer* 52(4): 649-657. Accessed online on 6 November 2013 at http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=ea4de2ab-28f8-4b90-aa2a-e7c860625483%40sessionmgr14&hid=10

England, K. V. L. (1994) 'Getting Personal: Reflexivity, Positionality, and Feminist Research'. *The Professional Geographer* 46(1): 80-89.

Etowa, J.B. (2012) 'Becoming a mother: The meaning of Childbirth for African-Canadian Women'. Contemporary Nurse; 41(1):20-40. Accessed online on 11th May 2013 at https://www.researchgate.net/publication/228059365_Becoming_a_mother_The_meaning_of_childbirth_for_African-Canadian_women.

Evans, J. Heron, J. Francomb, H. Oke S, and Golding, J. (2001) 'Cohort study of depressed mood during pregnancy and after childbirth'. *British Medical Journal* 323:257-260.

Ezegwu, H.U. and Nwogu-Ikojo, E.E. (2005) 'Vesico-vaginal fistula in Eastern Nigeria'. *Journal of Obstetrics and Gynaecology*, 25(6): 589 – 591.

Ezeobele, I. Malecha, A. Landrum, P. and Symes, L. (2010) **'**Depression and Nigerian-born immigrant women in the United States: a phenomenological study'. *Journal of Psychiatric and Mental Health Nursing*, 2010, 17, 193–201.

Fasubaa, O. B., Ogunniyi, S. O., Dare, F. O., Isawumi. A. I., Ezechi, O. C. and Orji, E. O. (2000) Uncomplicated Caesarean section: is prolonged hospital stay necessary? *East African Medical Journal* 77(8):448-51.

Federal Ministry of Information (2011) '*Cultural Policy in Nigeria'*. Accessed online on 9 August 2011 at http://www.wwcd.org/policy/clink/Nigeria.html

Feldman, R. Sussman, A.L. and Zigler, E. (2004) 'Parent leave and work adaptation at the transition to parenthood: Individual, marital, and social correlates'. *Applied Development Psychology* 25: 459- 479.

Fitzpatrick, J. J. and Kazer M. (2011) '*Encyclopedia of Nursing Research, Third Edition*'. (3rd Edition). Springer Publishing Company: New York USA.

Foucault, M (1988) '*The Foucault Reader'*. Random House USA: Incorporative Publication.

French, A. M. and Kiger, A. (2005) 'The use of triangulation for completeness and purpose'. *Nurse Researcher – The Internationa*l *Journal of Research Methodology in Nursing and Health Care* 12(14): 30-39.

Frith, H. and Gleeson K. (2004) 'Pretty in Pink: Young women presenting mature sexual identities' in Harris, A. (2004) '*All about the girl: culture, power and identity'*. Routledge: London.

Furness, P.J., McSeveny, K., Arden,M. A. Garland, C. A., Dearden, M.A and Soltani1, H. (2011) 'Maternal obesity support services: a qualitative study of the perspectives of women and midwives'. Bio Medical Central Pregnancy and Childbirth 11:69. Accessed online on 20th March 2016 at: http://www.biomedcentral.com/1471-2393/11/69.

Gardner, P. L. Bunton, D. P. Edge, D, and Wittkowski, A. (2013) 'The Experience of Postnatal depression in West African Mothers Living in The United Kingdom: A Qualitative Study', *Midwifery*. Accessed online 7 September 2013 at http://dx.doi.org/10.1016/j.midw.2013.08.001on

Gender in Nigeria report (2012) '*Improving the Lives of Girls and Women in Nigeria: Issues, policies and action'* 2nd Edition. UK Aid Department of International Development: British Council.

Gerrish, K. and Papadopoulos, I. (1999) 'Transcultural competence: the challenge for nurse education'. *British Journal of Nursing*, 8(21):1453-1457.

Giger, J. Davidhizar, R. E. Purnell, L. Harden, J. T. Phillips, J. and Strickland, O. (2007) 'American Academy of Nursing Expert Panel report: developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations'. J*ournal of Trans-cultural Nursing*. 18(2):95-102.

Gil-González, D., Carrasco-Portiño, M., Vives-Cases, C., Agudelo-Suárez, A.A., Bolea, R.C. and Ronda-Péreza, E. (2015) 'Is health a right for all? An umbrella review of the barriers to health care access faced by migrants'. *Ethnicity and Health*. 20(5):523-541. Accessed online on 7th September 2015 at: http://dx.doi.org/10.1080/13557858.2014.946473.

Gillham, B (2000) '*The Research Interview*'. Continuum: London.

Golafshani, N. (2003) 'Understanding Reliability and Validity in Qualitative Research'. *The Qualitative Report*, 8(4):597–607. Accessed online on 8 February 2011 at http://www.nova.edu/ssss/QR/QR8-4/**golafshani**.pdf.

Gray, E., Hurt,V. K. and Oyewole, S. O. (1983) 'Desired family size and sex of children in Nigeria'. *Journal of Heredity* 74(91): 204-206.

Green, J. and Thorogood, N. (2014) '*Qualitative Methods for Health Research*'. (3rd Edtion) Sage: London.

Green, M.J. (2007) 'Strategies for Incorporating Cultural Competence into Childbirth Education Curriculum'. *Journal of Perinatal Education*, 16(2), 33–37.

Greenhalgh, T. (2006) '*How to read a paper: the basis of evidence-based medicine'*. 3rd Edition. Oxford: Blackwell Publishing.

Greenwald, T. (2004) 'A Phenomenological Research Design Illustrated'. *International Institute for Qualitative Methodology*. 3 (1): 42-55.

Grigoriadis, S. Robinson, G. E. Fung, K. Chee, C.Y. I. Dennis, M. L. and Romans, S. (2009) 'Traditional Postpartum Practices and Rituals: Clinical Implications'**.** *Canadian Journal of Psychiatry* 54(12):834-40.

Hamilton, P. L. (2013) 'It's not all about academic achievement: supporting the social and emotional needs of migrant worker children'. *Pastoral Care in Education* 31(2): 173–190. Accessed online on 23rd March 2016 at http://dx.doi.org/10.1080/02643944.2012.747555.

Harbour, R. and Miller, J. (2001) 'A new system for grading recommendations in evidence based guidelines'. *British Medical Journal* 323:334-336.

Harper Bulman K., McCourt C., (2002) 'Somali refugee women's experiences of maternity care in west London: a case study'. *Critical Public Health*.12:365–380.

Harrison, T. C. and Khan, D. L. (2004) 'Disability rites: The cultural shift following impairment'. *Family and community Health* 27: 86-93.

Hawker, S. Payne, S., Kerr, C. Hardy, M., and Powell, J. (2002). 'Appraising the Evidence: Reviewing Disparate Data Systematically'. *Qualitative Health Research* 12(9): 1284-1299.

Hawkins, O. (2016) *House of Commons Library Briefing Paper: Migration Statistics*. Accessed online on 23rd March 2016 at http://researchbriefings.file.parliament.uk/documents/SN06077/SN06077.pdf.

Hegyvary, T. (2006) 'Health Disparities Related to Race and Ethnicity'. *Journal of Nursing Scholarship,* Third Quarter: 205.

Helliwell, J. F. and Putnam, R. D. (2004) 'The Social Context of Well-being'. *Philosophical Transactions of the Royal Society of Biological Sciences* 359(1449): 1435–1446.

Helman, C. (2007) '*Culture, health and illness'*. London: Hodder Arnold.

Henderson, J., Gao, H. and Redshaw, M. (2013) 'Experiencing maternity care: the care received and perceptions of women from different ethnic groups'. *Bio Medical Central (BMC) Pregnancy and Childbirth* 13:196.

Herbert, J. Datta, K. Evans, Y. May J, McIlwaine, C. and Wills, J. (2006) '*Multicultural living? The Experiences of New Migrants in London*'. Presented at the Sixth European Urban and Regional Studies Conference Roskilde, Denmark on 21st to 24th September 2006. Accessed online on 13th July 2011 at http://www.geography.dur.ac.uk/conferences/Urban_Conference/Programme/pdf_files/Joanna%20Herbert%20et%20al.pdf.

Her Majesty's Government (HMG) (2006) '*Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children*', London: The Stationery Office.

Hoftee, E (2006) '*Constructing a good dissertation: A practical guide to finishing a Masters, MBA or PhD on schedule*'. Santon EPE.

Hogan, B. E., Linden, W. and Najarian, B. (2012) 'Social support interventions: Do they work?' *Clinical Psychology Review* 22 (2002): 381-440.

Hollos, M., and Larsen, U (2004) 'Which African men promote smaller families and why? Marital relations and fertility in a Pare community in Northern Tanzania'. *Social Science Medicine*, 58(9), 1733-49.

Hollowell, J. Oakley, L. Vigurs, C. Barnett-Page, E. Kavanagh. J. and Oliver, S. (2012) 'Increasing the early initiation of antenatal care by lack and Minority Ethnic women in the UK: a systematic review and mixed method synthesis of women's views and literature on intervention effectiveness'. *Cochrane Database of Systematic Reviews.* Accessed online on 10th May 2016 at http://www.npeu.ox.ac.uk/download/files/infant-mortality/infant-mortality---Diva-fianl-report-Oct2012.pdf.

Holy Bible (1984) '*New International Version*'. International Bible Society: Nairobi Kenya Africa.

Horvat, L., Horey, D., Romios, P., Kis-Rigo, J.(2014) 'Cultural competence education for health professionals'. *Cochrane Database of Systematic Reviews* Issue 5 Art. No.: CD009405. DOI: 10.1002/14651858.CD009405.pub2.

Huberman, M. A. and Miles, M. B. (2002) '*The Qualitative Researcher's Companion*'. Sage Publications: London.

Hundt, G. L. Beckerleg, S. Kassem, F. (2000) 'Women's health custom made: building on the 40 days postpartum for Arab women'. *Health Care for Women International* 21 (6):529-542.

Hurd, T.L. and McIntyre, A. (1996) 'The Seduction of Sameness: Similarity and Representing the Other'. *Feminism and Psychology* February 1996 6: 86-91.

Hussein, A. (2009) 'The use of Triangulation in Social Sciences Research: Can qualitative and quantitative methods be combined?' *Journal of Comparative Social Work* 1:1-12.

Ibisomi, L. and Mudege N.N. (2014) Childlessness in Nigeria: perceptions and acceptability. Culture, *Health and Sexuality* 16(1): 61–75.

Institute of Race Relations (2016) Ethnicity and Religion Statistics. Accessed online on 10th March 2016 at http://www.irr.org.uk/research/statistics/ethnicityand-religion.

International Organisation for Migration (IOM) (2010) 'Migration and Transnationalism: opportunities and challenges was selected by the membership for the first inter-sessional workshop of the IDM in 2010 under the overarching theme "Migration and Social Change. The second inter-sessional workshop held on 19-20 July 2010 on the topic of Societies and Identities: The Multifaceted Impact of Migration. Notwithstanding the importance of the economic dimension, social facets are the primary focus in this paper and the workshop in line with the overarching theme of the IDM 2010. Accessed online on 21 June 2014 at http://www.iom.int/jahia/webdav/shared/shared/mainsite/microsites/IDM/workshops/migration_and_transnationalism_030910/background_paper_en.pdf

Jacinto, G. A. and Buckey, J. W. (2013) 'Birth: a rite of passage'. *International Journal of Childbirth Education* 28(1): 11-14.

Jiménez, T. R. and Horowitza, A. L. (2013) 'When White is just alright: How Immigrants Redefine Achievement and Reconfigure the Ethno-racial Hierarchy'. *American*

Sociological Review XX(X). Accessed online on 18th March 2016 at http://asr.sagepub.com/content/early/2013/08/30/0003122413497012.full.pdf+html.

Johnson, M. and Chang, S. (2014) 'Sampling in Qualitative Research' in (ed) Jirogwong S, Johnson M and Welch A. *Research Methods in Nursing and Midwifery*: Pathways to Evidenc-base. Second Edition. United Kingdom: Oxford University Press.

Johnson, R. B. and Onwuegbuzie, A. J. (2004) 'Mixed methods research: A research paradigm whose time has come'. *Educational Researcher*, 33 (7): 14-26.

Jomeen, J., Redshaw, M. (2013) 'Ethnic minority women's experience of maternity services in England'. *Ethnicity and Health* 18(3):280–296.

Jones, S. R. Torres, V. and Arminio, J. (2006) '*Negotiating the Complexities of Qualitative Research in Higher Education'.* Routledge: New York.

Jones, C. C. (2002) 'Traditional Postpartum Rituals of India, North Africa, and the Middle East: Seclusion, Henna, and 40 Day Homecare'. Accessed online on 24 February 2011 at http://www.lotusfertility.com/Postpartum_Wisdom_Rituals.html.

Kable, A., Pich, J. and Maslin-Prothero, S. (2012) 'A structured approach to documenting a search strategy for publication: A 12 step guideline for authors'. *Nurse Education Today*; 32(8): 878–886.

Karner, S. (2009) 'Identity, Citizenship and Migration Centre: Everyday Globalization, Resistance and Ambivalence: Austrian snapshot'. Working Paper No. 6, University of Nottingham. Accessed online on 9th May 2011 at https://www.nottingham.ac.uk/icemic/documents/karner-icmic-wp-09-06.pdf.

Katbamna, S. (2000) '*Race' and childbirth'*. Open University Press: Buckingham - Philadelphia.

Kertzer, D I. and Arel, D (2002) 'Censuses, identity formation, and the struggle for political power'. In Kertzer, David I.; Arel, Dominique. *Census and Identity: The Politics of Race, Ethnicity, and Language in National Censuses*. Cambridge: Cambridge University Press.

Kincheloe J. L and McLaren P (2005) Rethinking critical theory and qualitative research. In N. K Denzin and Y S Lincoln (Eds.), The Sage handbook of qualitative research (3rd edition). Sage: Publications Thousand Oaks

King, N. and Harrocks, C. (2010) '*Interviews in Qualitative Research'.* Sage: London.

Koenig, H.G. (2009) 'Research on religion, spirituality, and mental health: A review'. *Canadian Journal of Psychiatry*; 54(5): 283–91.

Kirkley, D.L. (2000) 'Is motherhood good for women? A feminist exploration'. *Journal of Gynaecology and Neonatal Nursing* 29(5): 459-64.

Kitzinger, J. (1995) 'Qualitative research: Introducing focus groups'. British Medical Journal. 29; 311(7000):299-302.

Kumar, R. (2011) 'Research Methodology: a step-to-step guide for beginners'. Third Edition. Sage: London.

Leap, N. (2009) 'Woman-centred or women-centred care: does it matter?' *British Journal of Midwifery*, 17(1): 12-16.

Lambert, C., Jomeen, J. and McSherry, W. (2010) 'Reflexivity: a review of the literature in the context of midwifery research. British Journal of Midwifery'. 18(5): 321-326.

Leininger, M. M. (2006a) 'Culture care diversity and universality theory and evolution of the
Ethno-nursing method'. In M. M. Leininger and M. R. McFarland (Edition), *Culture care diversity and universality: A worldwide nursing theory* (2nd edition). Sudbury,
MA: Jones and Bartlett Publishers.

Leininger, M. M. (2006b) 'Ethno-nursing: A research method with enablers to study the theory of culture care' [Revised reprint]. In M. M. Leininger and M. R. McFarland (Eds.), *Culture care diversity and universality: A worldwide theory of nursing* (2nd edition).
Sudbury, MA: Jones and Bartlett Publishers.

Leininger, M. M. (2006c) 'Culture care of the Gadsup Akuna of the Eastern Highlands of New Guinea: First trans-cultural nursing' [Revised reprint]. In M. M. Leininger and M. R. McFarland (Eds.), *Culture care diversity and universality: A worldwide nursing theory* (2nd edition). Sudbury, MA: Jones and Bartlett Publishers.

Leininger, M.M and McFarland, M.R (2006) '*Culture Care Diversity and Universality: A Worldwide Nursing Theory'.* Sudbury, MA: Jones and Bartlett Publishers.

Leininger, M. M. (2004) 'Leininger's Sunrise Enabler Guide'. Accessed online on 6th May 2010 at http://www.madeleine-leininger.com/cc/sunrise.pdf.

Leininger, M. M. (2002) 'The theory of culture care and the ethno-nursing research method'. In M. M. Leininger & M. R. McFarland (Eds.), *Transcultural nursing: Concepts, Theories,*
Research, and Practice (3rd edition). New York, NY: McGraw-Hill.

Leininger, M.M and McFarland, M.R (2002) 'Trans-cultural Nursing, Concepts, theories, Research and Practice (3rd edition). New York, NY: McGraw-Hill.

Leininger, M. M. (1997) 'Overview of the theory of culture care with the ethno-nursing research method'. *Journal of Transcultural Nursing*, *8*(2), 32-52.

Leininger, M. M. (1995) '*Transcultural nursing: Concepts, theories, research, and practice'* (2nd Edition). New York, NY: McGraw-Hill.

Leininger, M. M. (1991a) 'The theory of culture care diversity and universality. In M. M. Leininger (Ed.), *Culture care diversity and universality: A theory of nursing'*. New York, NY: National League for Nursing Press.

Leininger, M. M. (1991b) 'Ethno-nursing: A research method with enablers to study the theory of culture care. In M. M. Leininger (Ed.), *Culture care diversity and universality: A theory of nursing'.* New York, NY: National League for Nursing Press.

Leung, I. S. (2011) '*One Mum's Journey to Motherhood, Infertility, childbirth Complications and Postpartum Depression Oh my!'* Abbort Press: Bloomington.

Liamputtong, P. (Edition) (2007) '*Childbearing and Infant Care Issues: A cross-cultural perspective*'. Nova Science Publishers Incorporation: New York.

Liamputtong, P., Yimyam, S., Parisunyakul, S., Baosoung, C. and Nantapron, S. (2005) 'Traditional beliefs about pregnancy and child birth among women from Chaing Mai, Northern Thailand'. *Midwifery* 21(2): 139-153.

Lindsay, B. (2007) '*Understanding Research and Evidence-Based Practice'*. Reflect Press: Exeter.

Local NHS Annual Report (2009-2010) '*NHS Foundation Trust Quality Accounts'*. Accessed online on 28th June 2011at http://www.nhs.uk/aboutnhschoices/professionals/healthandcareprofessionals/quality-accounts/documents/oxleas-nhs-foundation-trust-quality-account.pdf.

London Safeguarding Children Board, (2015) 'London Child Protection Procedures'. (5th Edition).Accessed online on 18th February 2016 at http://www.londonscb.gov.uk/files/2010/procedures/part_a_london_child_protection_procedures_nov_2015_final.pdf.

London Child Protection (2013) 'Male Circumcision' (5th Edition). (Online) Last accessed 28 October 2014 at http://www.londoncp.co.uk/chapters/male_circum.html#circum_therap

Lopez, K. A. and Willis, D. G. (2004) 'Descriptive versus interpretative phenomenology: Their Contributions to Nursing Knowledge'. *Qualitative Health Research* 14: 726-735.

Maalouf, A. (2012) '*Violence and the Need to Belong: In the Name of Identity'*. Penguin Books: London.

Maalouf, A. (2000) '*On Identity'*. Random House: UK.

McFarland, M. M. and Eipperle, M.K. (2008) 'Culture Care Theory: a proposed practice theory guide for nurse practitioners in primary care settings'. *Contemporary Nurse*. 28(1-2):48-63.

McFarland, M. R., Mixer, S. J., Webhe-Alamah, H. and Burk, R. (2012) 'Ethno-nursing: A Qualitative Research Method for Studying Culturally Competent Care across Disciplines'. *International Journal of Qualitative Methods 2012*, 11(3): 259-279.

MacFarlane, A., Dzebisova, Z., Karapish, D., Kovacevic, B., Ogbebor, F. and Okonkwo, E. (2009) **'**Arranging and negotiating the use of informal interpreters in general practice consultations: Experiences of refugees and asylum seekers in the west of Ireland'. *Social Science and Medicine* 69(2): 210-214.

Maggs –Rapport, F. (2001) `Best research practice': in pursuit of methodological rigour' *Journal of Advanced Nursing* 35(3), 373-383.

Maggs –Rapport, F. (2000) 'Combining methodological approaches: ethnography and interpretative phenomenology'. *Journal of Advanced Nursing* 31(1): 219-225.

Makinde, T. (2004) 'Motherhood as a source of empowerment of women in Yoruba culture'. *Journal of African Studies* 13(2): 164-174.

Maputle, M.S. and Jali, M.N. (2006) 'Dealing with diversity: incorporating cultural sensitivity into midwifery practice in the tertiary hospital of Capricorn District, Limpopo Province'. *Curationis*; 29(4):61-69.

Martin-McDonald, K., Beirnoff, D., Frauman, A. C., Biernoff D (2002) Initiation into a dialysis dependent life: an examination of rites of passage/commentary and response. *Nephrology Nursing Journal* 29: 347-354.

Marshall, C. and Rossman, G. B. (1999) *Designing qualitative research* (3rd Ed.) Thousand Oaks: Sage.

Mattey, S., Panasetis, P. and Barnett, B. (2002) 'Adherence to Cultural Practices following Childbirth in Migrant Chinese Women and Relation to Postpartum Mood'. *Health Care for Women International* 23(6-7); 567-575.

Matthey, S., Panasetisa, P. and Barnett, B. (2002) 'Adherence to cultural practices following childbirth in migrant Chinese women and relation to postpartum mood'. *Health Care for Women International*; 23(6-7): 567-575.

Maushart, S. (1997) '*The Mask of Motherhood'*. Vintage Press: Sydney.

Mavundla, T. R., Netswera, F. G., Bottoman, B. and Toth, F. (2009) Rationalization of Indigenous Male Circumcision as a Sacred Religious Custom. *Journal of Transcultural Nursing* 20(4):395-404.

Mazzucato, V. and Schans, D. (2011) 'Transnational Families and the Well-Being of Children: Conceptual and Methodological Challenges'. *Journal of Marriage and the Family* 73(4): 704-712. Accessed on 17th March 2016 Online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3258421/.

McHugh, N. (2003) 'Midwives of the soul: the Spirituality of Birth'. *Midwifery Matters* 97: 4-5.

Merriam, S. A., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G., and Muhamad, M. (2001) 'Power and positionality: Negotiating insider/outsider status within and across Cultures'. *International Journal of Lifelong Education*, 20(5), 405-416.

Mette, R. (2007) 'Professionalism and ethics in community interpreting: The impact of individualist versus collective group identity'. *Interpreting*, 9(1):47-69. Accessed 22nd March 2016 online at: http://www.ingentaconnect.com/content/jbp/intp/2007/00000009/00000001/art00003.

Mitchell, J. R. and Baker, M. C. (2000) 'Religious commitment and the construct of sources of help for emotional problems'. *British Journal of Medical Psychology* 73: 289-301.

Mixer, S.J. (2008) 'Use of the culture care theory and ethno-nursing method to discover how nursing faculty teach culture care'. *Contemporary Nurse*; 28(1-2): 23-36.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) (2014) *Saving Lives, Improving Mothers Care lessons learned to inform future maternity care from the UK and Ireland. Confidential Inquiries into Maternal Deaths and Morbidity 2009-2012*. National Perinatal Epidemiology.

Morhason-Bello, I.O., Adedukun, B.O., Ojengbede, O.A., Olayemi, O., Oladikun, A. and Fabanwo, A.O (2009) 'Assessment of the effect of psychosocial support during childbirth in Ibadan, south-west Nigeria: A randomised controlled trial'. *Australian and New Zealand Journal of Obstetrics and gynaecology*. 49(2):145–150.

Morharson-Bellor, I. O., Olayemi, O. and Ojengbede O A (2009) Social support during childbirth as a catalyst for early breastfeeding initiation for first time Nigerian mothers. *International Breastfeeding Journal* 4(16): doi: 10.1186/1746-4358-4-16. Accessed online on 14th December 2010 at: http://www.internationalbreastfeedingjournal.com/content.

Morhason-Bello, I.O., Olayemi, O., Ojenbgede, O. A., Adedokun, B. O., Okuyemi, O. O. and Orji, B. (2008) 'Attitude and preferences of Nigerian antenatal women to social support during labour'. *Journal of Biosocial Science* (2008), 40: 553-562.

Moloney, S. (2007) 'Dancing with the wind: A methodological approach to researching women's spirituality around menstruation and birth. *International Journal of Qualitative Methods,* 6(1):1-7. Accessed online on 6th May 2010 at http://www.ualberta.ca/~iiqm/backissues/6_1/moloney.pdf.

Moscardino, U., Nwobu, O. and Axia, G. (2006) 'Cultural beliefs and practices related to infant health and development among Nigerian Immigrant mothers in Italy'. *Journal of Reproductive and Infant Psychology* 24(3): 241-255.

Murdock, H., Kelly, C., Jordan, J., Pecotte, B. and Luedk A (2015) *Demographics: a guide to methods and data services for media and business*. Routledge: London.

Nadeem, R., Lange, J. M. and Miranda, J. (2008) 'Mental Health preferences among low-in-come and minority women'. *Archives of Women's Mental Health* 11:93-102.

Nahas, V. and Amashen, N. (1999) 'Culture care meanings and experiences of postpartum depression among Jordanian Australian women: A trans-cultural study'. *Journal of Transcultural Nursing* 10(1): 37–45.

National Collaborating Centre for Methods and Tools (2011) 'Critical appraisal tools to make sense of evidence'. Accessed online on 11th September 2012 at http://www.nccmt.ca/resources/search/87.

National Health Service (2012) '*Compassion in Practice: Nursing, Midwifery and Care Staff our Vision and Strategy*'. Department of Health: England. Accessed online on 29th January 2016 at https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf.

National Health Service (NHS) *England (2012) Health and high quality care for all, now and for future generations*. Online at https://www.england.nhs.uk/nursingvision/ accessed 29th January 2016.

National Institute for Health and Care Excellence (2007) '*Improving health and social care through evidence-based guidance*'. Department of Health: London.

National Institute for Health and Clinical Excellence (NICE) (2008) *Antenatal Care for the Healthy Pregnant Woman*. Royal College of Obstetrics and Gynaecology (RCOG) Press: London.

National Maternity Review (2016) *Better Births – Improving Outcomes of Maternity Services in England: a five-year forward view of maternity care*. Department of Health: London.

National Service Framework (2007) '*Children's health, our future: a review of progress against the National Service Framework for Children, Young People and Maternity Services 2004*'. Department of Health: England Accessed online on 1st May 2016 at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080379.

Neill, S. (2006) 'Grounded theory sampling: The contribution of reflexivity'. *Journal of Research in Nursing* 11(3): 253–60.

Nkwocha, E. E. (2007) 'Maternal Crises and the Role of African Men: The Case of a Nigerian Community'. *African Population Studies* 22(1):35-56.

Nnaemeka, O. (2003) 'Nego-Feminism: Theorizing, Practicing, and Pruning Africa's Way'. Reprinted in *Journal of Women in Culture and Society*. 29(2):357-78.

Nurmi, J. E. and Almesmaki, K. S. A. (2001) 'Goal Reconstruction and Depressive Symptoms during the Transition to Motherhood: Evidence from Two Cross-Lagged Longitudinal Studies'. *Journal of Personality and Social Psychology* 81(6): 1144-1159.

Nursing Midwifery Council (2015) '*The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives'*. On line at http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf. Accessed on 21st March 2016.

Nzegwu, N. (2004b) 'The Epistemological Challenge of Motherhood to Patriliny'. A *Journal of Culture and African Women Studies*: 5. Accessed online on 30th May 2008 at http://www.jendajournal.com/issue5/nzegwu.htm.

Nzegwu, N. (2004) 'Cultural Epistemology of Motherhood: Refining the Concept 'Mothers'. *Journal of Culture and African Women Studies*: 5. Accessed online on 30th May 2008 at http://www.jendajournal.com/issue5/nzegwu.htm.

Oakley, A. (1980) '*Women Confined: Towards a Sociology of Childbirth*'. Schocken Books, New York.

Oates, M. R., Cox, J. L., Neema, S. (2004) 'Postnatal depression across countries and cultures: a qualitative study'. *British Journal of Psychiatry* 18(4): (supplement 46) S10-S16.

Obi, S.N and Ozumba, B.C (2007) 'Factors associated with domestic violence in south-east Nigeria'. Journal of Obstetrics and Gynaecology; 27(1):75-8.

O'Brien, S. F., Osmond, L. and Yi Q.L. (2015) '*How do I interpret a p value*?' Transfusion 1-5.

Office for National Statistics (2012) '*Population by country of birth and nationality'*. ONS: London.

Office for National Statistics (2009) '*Life expectancy at birth and at age 65 for health areas in the United Kingdom, 2003–05 to 2007–09'.* ONS: London.

Ohaeri, J. U. (1998) 'Perception of the Social Support Role of the Extended Family Network by some Nigerians with Schizophrenia and Affective disorders'. *Social Science and Medicine* 47(10): 1463-1472.

Okafor, C. B. (2000) 'Folklore Linked to Pregnancy and Birth in Nigeria'. *Western Journal of Nursing Research* 22(2):189-202.

Okeke, T.C., Anyaehie, U.S.B and Ezenyeaku, C.C.K (2012) 'An Overview of Female Genital Mutilation in Nigeria'. Okeke T, Anyaehie U, Ezenyeaku C. *Annals of Medical and Health Sciences Research*; 2(1):70-73. Accessed online on 2nd May 2016 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3507121/.

Okonta, P. Okogbenin, S. and Adeoye-Sunday, I. (2004) **'**Pregnant Nigerian woman's view of her prenatal sex determination'. *Journal of Obstetrics and Gynaecology* 24(8): 875-877.

Ola-Edo, Y. O. and Dominicus S (2014) 'The role of acculturative stress factors on mental health and help-seeking behavior of sub-Saharan African immigrants'. *International Journal of Culture and Mental Health*,7:(3): 315-325. Accessed online 10th March 2016 on at: http://www.tandfonline.com/loi/rccm20.

Olayemi, O., Bello,F. A., Aimakhu, C. O., Obajimi, G. O. and Adekunle, A. O. (2009) 'Male participation in pregnancy and delivery in Nigeria: a survey of antenatal attendees'. *Journal of Biosocial Science*., 41, 493–503.

Oloruntoba-Oju, O. and Oloruntoba-Oju, T (2013) 'Models in the construction of female identity in Nigerian postcolonial literature'. African Journals Online Tydskrif Vir Letterkunde 50(2):1-14. Accessed online on 10th March 2016 at http://www.ajol.info/index.php/tvl/article/view/93207/82620.

Onazarawa, K., Kumar, R. C., Adams, D., Dore, C. and Glover, V. (2003) 'High EPDS scores in Women from Ethnic Minorities Living in London'. *Archives of Women's Mental Health* 6 (supplement 2): s52- s55.

Ottani, P. A. (2002) 'When childbirth preparation isn't a cultural norm'. *International Journal of Childbirth Education*, 17(2), 12–16.

Papadopoulos, I. Tilki, M. and Ayling S (2008) 'Cultural competence in action for CAMHS: Development of a cultural competence assessment tool and training programme'. *Contemporary Nurse;* 28(1-2): 129-140.

Papadopoulos, I. Tilki, M. and Taylor, G. (1998) '*Transcultural Care: A guide for Health Care Professionals'*. Quay Books: Wiltshire.

Parahoo, K. (2014) 'Nursing Research: Principles, Process and Issues'. (3rd Edition) Palgrave Macmillan: Basingstoke: Hampshire.

Parahoo, K. (2006) 'Nursing Research: *Principles, Process and Issues*'. Second Edition, Palgrave: McMillan.

Para-Mallam,O.J., Lanre-Abass, B., Adamu, F. and Ajala, A (2006)' The Role of Religion in Women's Movements: The Campaign for Domestication of CEDAW in Nigeria'. Religion and Development Research programme. Working Paper 59. Accessed online on 8th March 2016 at http://www.birmingham.ac.uk/Documents/college-social-sciences/government-society/rad/working-papers/wp-59.pdf.

Pearlin, L. I. (1989) 'The Sociological Study of Stress'. *Journal of Health and Social Behaviour* 30: 241-256.

Petterson, M. (2015) 'Toward a new Materialism in Sociology'. Accessed online on 8th May 2016 at file:///C:/Users/prisca/Downloads/Toward_a_New_Materialism_in_Sociology_Ho.pdf.

Phillips, W. (2005) 'Cravings, marks, and open pores: Acculturation and preservation of pregnancy-related beliefs and practices among mothers of African descent in the United States'. ETHOS *Journal of the Society for Psychological Anthropology* 33(2): 231-255.

Polit, D. K. and Beck, C. T. (2010) '*Nursing Research: appraising evidence for nursing practice*' (7th edition) Lippincott Williams and Wilkins.

Polit, D. F., and Beck, C. T. (2012) '*Nursing research: Principles and methods*'. Philadelphia, PA: Lippincott Williams and Wilkins.

Polit, D. F, Beck C T and Hungler, B. P. (2010) 'Generalization in quantitative and qualitative research: Myths and strategies'. *International Journal of Nursing Studies* 47(11):1451-1458.

Polit, D. F. Beck, C. T. and Hungler, B. P. (2001) 'Essentials of Nursing research – Methods, Appraisal and Utilization', 5th edition. JB Lippincott: Philadelphia.

Posmontier, B. and Horowitz, J. A. (2007) Postpartum Practices and Depression Prevalences: Techno centric and Ethno kinship Cultural Perspectives. Journal of Transcultural Nursing. Accessed online at on 24th September 2007 at http://.tcn.sagepub.com/cgi/content.

Porter, S. (edition) (1996) '*Qualitative research in Cormack D.F.S*'. The Research Process in Nursing. 3rd edition. Blackwell Science: Oxford.

Psoinos, M., Hatzidimitriadou, E., Butler, C., and Barn, R. (2011) 'Ethnic Monitoring in Healthcare Services in the UK as a mechanism to address Health Disparities: A Narrative Review'. Inter-professional Institute of Health and Social Care: Royal Holloway, University of London. Accessed online on 10th February 2016 at http://eprints.kingston.ac.uk/18866/1/Ethnic_Monitoring_Report_FINAL_150411.pdf.

Purnell, L. (2000) 'description of the Purnell model for cultural competence'. Journal of Transcultural Nursing, 13(3):193-196.

Puthussery, S., Twamley, K., Macfarlane, A., Harding, S. and Baron, M. (2010) 'You need that loving tender care': maternity care experiences and expectations of ethnic minority women born in the United Kingdom'. *Journal of Health Services Research & Policy*; 15(3): 156-162.

Puthussery, S. Twamley, K. Harding, S. Mirsky, J, Baron, M. Macfarlane, A. (2008) 'They're more like ordinary stroppy British women: Attitudes and expectations of maternity care professionals to UK-born ethnic minority women'. *Journal of Health Service Research and Policy* 13 (4):195–201.

Raine, R., Cartwright, M., Richens, Y., Mahamed, Z., Smith, D., (2010) 'A qualitative study of women's experiences of communication in antenatal care: identifying areas for action'. *Maternity and Child Health Journal*. 14(4):590-599.

Rees, C. (2011) '*Introduction to Research for Midwives*'. Third Edition. Churchill Livingstone: London.

Reynold, R.R. (2006) 'Professional Nigerian Women, Household Economy, and Immigration Decisions'. *International Journal of Migration* 44(5):167-188.

Rienzo, C. and Vargas-Silva, C. (2015) '*Migrants in the UK: an overview'*. 5th Revision. Accessed online on 10th May 2016 at http://www.migrationobservatory.ox.ac.uk/briefings/migrant-uk-overview.

Rosado, C. (2016) '*The Concept of Cultural Relativism in a Multicultural World*'. Accessed online on 3rd March 2016 at http://www.rosado.net/articles-relativism.html.

Royal College of Midwives (RCM) (2001) '*Woman Centred Care*' (Position Paper No. 4a). London: RCM.

Russel-Roberts, E. (2016) 'Transcultural health care practice: The principles of midwifery care in a transcultural context'. Royal College of Nursing Core Practice Module, Chapter one: Midwifery. Accessed online on 30th February 2016 at https://www2.rcn.org.uk/development/learning/transcultural_health/transcultural/midwifery.

Sandall, J., Benoit, C., Wrede, S., Murray, S.F., van Teijlingen. E.R. and Westfall, R. (2009) 'Social Service Professional or Market Expert? Maternity Care Relations under Neoliberal Healthcare Reform'. *Current Sociology* 57(4): 529-553.

Segre, L. S., Losch, Mary. E. and O'Hara M. W. (2006) 'Race/Ethnicity and Perinatal Depressed Mood'. *Journal of Reproductive and Infant Psychology* 24(2): 99–106.

Seibert, P. S., Stridh-Igo, P. and Zimmerman, C. G. (2002) 'A checklist to facilitate cultural awareness and sensitivity'. *Journal of Medical Ethics* 28:143–146.

Sered, S. S. (2007) 'Religious rituals and secular rituals: interpenetrating models of the childbirth in a modern, Israeli context'. Accessed online on 24th February 2011 at http://findarticles.com/p/articles/mi_m0SOR/is_n1_v54/ai_13976714/

Sereika, S. and Olshansky, E. (2005) 'The Transition from pregnancy to postpartum in Previously Infertile Women: A focus on Depression'. *Archives of Psychiatric Nursing* 19(6):273-280.

Shakespare, J., Blake, F. and Garcia, J., (2003) 'A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale'. British Journal of General Practice; 53(493): 614–619.

Sheridan, C. P., Yekini, I., Oyeye, G. and Higgins, J.R (2011) 'Comparing birth plan preferences among Irish and Nigerian women'. *British Journal of Midwifery* 19(3):172-177.

Sigad, L. I. and Eisikovits, R. A. (2009) 'Migration, Motherhood, Marriage: Cross-Cultural Adaptation of North American Immigrant Mothers in Israel'. *International Migration* 47 (1):63-99.

Sim, J. and Wright, C. (2000) '*Research in Healthcare: concepts, designs and methods*'. Stanley Thorne Limited: Cheltenham.

Smith, J. and Firth, J. (2011) 'Qualitative data analysis: the framework approach'. *Nurse Researcher* 18(2): 52-62.

Smith, D. J. (2004) 'Contradictions in Nigerians Fertility Transition: The Burdens and Benefits of having people'. *Population and Development Review* 30(2): 221-238.

Smithson, J. (2000) 'Using and analysing focus groups: limitations and possibilities'. *Social Research Methodology* 3(2):103-119.

Snape, D. and Spencer, L. (2003) 'The Foundations of Qualitative Research in Ritchie J and Lewis J edition *Qualitative Research Practice'*. Sage Publications: London.

Sokhoo, D. (2009) '*Race, Ethnicity, Culture and Childbirth in Squire C 2nd edition (2009) Social Context of Birth*'. Radcliffe Publishing: Oxford.

Spector, R.E (2002) 'Cultural Diversity in Health and Illness'. *Journal of Transcultural Nursing*, 13(3):197-199.

Sprague, J. (2005) '*Feminist Methodologies for Critical Research: bridging differences'*. Altamira Press: Oxford

Steup, M. (2014) "*Epistemology", The Stanford Encyclopedia of Philosophy* (Spring 2014 Edition), Edward N. Zalta (ed.), accessed 12th April 2016 online at http://plato.stanford.edu/archives/spr2014/entries/epistemology/

Strangor, C. (2014)'Research methods for Behavioural Sciences (5th Edition) Cengage Learning: United Kingdom.

Stern, G. and Kruckman, L. (1983) 'Multi-Disciplinary Perspectives on Postpartum Depression: An Anthropological Critique' *Social Science in Medicine* 17: 1027 - 1041.

Sultana, F. (2007) 'Reflexivity, Positionality and Participatory Ethics: Negotiating Fieldwork Dilemmas in International Research'. *An International E-Journey for Clinical Geographies* 6 (3): 374- 385.

Szabo, R. and Short, R. V. (2000) 'How does male circumcision protect against HIV infection?' *British Medical Journal* 320:1592-1594.

Takougang, J. (2002) 'Contemporary African Immigrants to the United Sates. Accessed online on 1st November 2014 at www.Africanmigration.com/archive_02/j_takougang.htm.

Tanyi, R. (2002) 'Towards clarification of the meaning of spirituality'. *Journal of Advanced Nursing* 39(5):5000-509.

Taralba, C. M. (2007) 'Psychosocial and Psychological Interventions for Preventing Post-partum Depression'. The WHO Reproductive Health Library accessed online on 29th January 2009 at http://www.whoint/rhl/prenancy/care_after_childbirth/mgcguide/en

Taylor, B.J., Dempster, M. and Donnelly, M. (2007) 'Grading gems: appraising the quality of research in social work and social care'. *British Journal of Social Work*; 37:335-354.

Ternström, E., Hildingsson, I., Haines, H. and Rubertsson, C. (2015) 'Higher prevalence of childbirth related fear in foreign-born pregnant women: findings from a community sample in Sweden'. *Midwifery* 31(4):445-450.

The Free Dictionary online (2016) 'Animism'. Accessed online on 19th June 2016 at http://www.thefreedictionary.com/animist.

Tufford L and Newman P (2012) Bracketing in Qualitative Research. Qualitative Social Work. Accessed online on 21st March 2016 at http://qsw.sagepub.com/content/11/1/80.full.pdf+html?hwshib2=authn%3A1458672211%3A20160321%253A5aecb8dd-8ea9

4fec866cc69353018558%3A0%3A0%3A0%3A0x6jgg%2B%2BUuvvl4AHv9Y2Sw%3D%3D.

Ugwu, N. U. and de Kok, B. (2015) 'Socio-cultural factors, gender roles and religious ideologies contributing to Caesarean-section refusal in Nigeria'. *Reproductive Health* 12(1):1-13.

Ukwuani, F. A. and Suchindran, C. M. (2003) 'Implications of women's work for child nutritional status in sub-Saharan Africa: a case study of Nigeria'. *Social Science and Medicine* 56: 2109-2121.

Umez, B. N. (2010) 'Is it "African Time" or "Selective Punctuality" based on Inferiority Complex?' Accessed online on 2nd January 2010 at http://www.umez.com/african-time.html.

UNICEF, (2005) 'At a Glance: Nigeria'. Accessed online on 2nd January 2010 at http://www.unicef.org/infobycountry/nigeria_statistics.html.

Uwah, G.O. (2002) '*Reflections of an African-born immigrant: story of alienation. In: Foreign-born African Americans: Silenced Voices in the Discourse on Race*' (edition Obiakor, E.F. and Grant, A.P.), Nova Science Publishers, New York.

Uwakwe, R. and Okonkwo, J. E. (2003) 'Affective (depressive) morbidity in puerperal Nigerian women: validation of the Edinburgh Postnatal Depression Scale'. *Acta Psychiatrica Scandinavica* 107: 251–259.

UK National Screening Committee (2009) '*Population screening programmes*' UK Government. Accessed online on 9th May 2016 at https://www.gov.uk/topic/population-screening-programmes.

Van Hollen, C. C. (2003) '*Birth on the Threshold: Childbirth and Modernity in South India*'. California Press: London.

Varcoe, C., Rodney, P., McCormick, J. (2003) 'Health Care Relationships in Context: An Analysis of Three Ethnographies'. *Qualitative Health Research* 13: 957-73

Varma, V. K. (2008) 'Transcultural Psychiatry' in Ahuja N and Vyas J N (Ed) (2008) *Textbook of Postgraduate Psychiatry*. Second Edition. Jaypee Brother Medical Publishers Limited: Missouri USA.

Vehviläinen-Julkunen, K. and Emelonye, A.U. (2014) 'Spousal Participation in Labor and Delivery in Nigeria. *Annals of Medical and Health Sciences Research*'. 4(4): 511–515.

Vishnewsky, T. and Beanlands, H. (2004) '*Introduction to Nursing Research*: Incorporating Evidence Based Practice'. Boswell and Barlett Publishers: London.

Walcott, H. F. (1994) '*Transforming Qualitative Data Description, Analysis and Interpretation*'. Thousand Oaks: Sage.

Waller, V., Farquharson, K. and Dempsey, D. (2016) '*Qualitative Social Research: contemporary methods for the digital age'*. Sage: London.

Walsh, D. and Downe, S. (2010) '*Essential Midwifery Practice*: Intra-partum Care'. John Wiley and Sons Limited: West Sussex.

Walsh, D. (2002) 'How's your spiritual life going?' *British Journal of Midwifery*, 10(8):484.

Watson, R., McKenna, H., Cowman, S. and Keady, J. (2008) '*Nursing Research: Designs and Methods, 1st Edition*'. Elsevier Health Science.

Weiss, H. A., Quigley, M. A. and Hayes, R. J. (2000) 'Male circumcision and risk of HIV infection in Sub-Saharan Africa: a systematic review and meta-analysis'. *AIDS* 14(15): 2361-2370.

Weller, K., and Kinder-Kurlanda, K.E. (2016) '*A Manifesto for Data Sharing in Social Media Research*'. In Proceedings of ACM Web Science Conference 2016. DOI: http://dx.doi.org/10.1145/2908131.2908172.

Weller, P., Feldman, A. and Purdam, K. (2001) '*Religious Discrimination in England and Wales*'. Home Office Research Study 220. Home Office: London.

Wellings, K., Branigan, P. and Mitchell, K. (2000) 'Discomfort, discord and discontinuity as data: Using focus groups to research sensitive topics'. *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care;* 2(3): 255-267.

Welman, J. C., and Kruger, S. J. (1999) '*Research methodology for the business and administrative sciences*'. Johannesburg, South Africa: International Thompson.

Wikberg, A. and Eriksson, K. (2008) 'Intercultural Caring – an abductive model'. *Scandinavian Journal of Caring Sciences* 22: 485-496.

Wiswell, T. E., Smith, F. R. and Bass, J.W. (1985) 'Decreased incidence of urinary tract infections in circumcised male infants. *Pediatrics*; 75:901-903.

World Health Organisation (2012) '*Respectful Maternity Care: The Universal Rights of Childbearing Women*'. Accessed online on 6th May 2016 at http://www.who.int/woman_child_accountability/ierg/reports/2012_2015_OIS_Respectful_maternity_care_charter_Theuniversal_Rights_of_childbearing_women.pdf.

World Health organization (2004a) '*Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNIFPA*'. WHO: Geneva.

World Health organization (2004b) '*Commission on Social Determinants of Health: Note by the Secretariat*'. WHO: Geneva.

Young, J.M. and Solomon, M.J. (2009) 'How to critically appraise an article'. Nature Clinical Practice Gastroenterology and Hepatology. 6(2):82-91.

Zumpe, J. Dormon, O. and Jefferies, J. (2012) 'Childbearing Among UK Born and Non-UK Born Women Living in the UK'. Office of National Statistics 1-65. Accessed online 30th March 2014 at http://www.ons.gov.uk/ons/dcp171766_283876.pdf.

Bibliography

Abbort, P. and Wallace, C. (1997) '*An introduction to sociology: Feminist Perspectives'*. London: Rutledge.

Abidoye, R. O. and Akinpelumi, O. B. (1997) 'Implications of Nutritional Beliefs and Taboos - Hausa and Yoruba Pregnant Women in Lagos Nigeria'. *Early Child Development and Care* 138: 71-81.

Adebowale, T.O. and Ogunlesi, A.O. (1999) Beliefs and knowledge about etiology of mental illness among Nigerian psychiatric patients and their relative. *African Journal of Medical Science* 28, 35-41.

Adefuye, A. (1992) '*Culture and foreign policy: The Nigerian Example'*. NII: Lagos Nigeria.

Adeoye, S. Kalu, C.A. (2011) 'Pregnant Nigerian women's view of Caesarean section'. *Nigerian Journal of Clinical Practice* 14(3): 276-279.

Adewuya, A.O, Fatoye, F.O. Ola B A. Ijaodola, O.R. and Ibigbami, S.O. (2005) 'Socio-demographic and Obstetric Risk Factors for Postpartum Depressive Symptoms in Nigerian Women'. *Journal of Psychiatric Practice* 11(5): 353-358.

Adewuya, A.O. and Makanjuola, R.O. (2008) 'Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates'. *Social Psychiatry and Psychiatric Epidemiology* 43, 336–341.

Adewuye, A. O. Ola, B. A. Aloba, O.O. (2007) 'Relevance and correlates of depression in late pregnancy among Nigerian women'. *Depression and Anxiety* 24:15-21.

Adewuye, A. O., Ologun, Y. A. and Ibigbami, O.S. (2005) 'Post-traumatic stress disorder after childbirth in Nigerian women: prevalence and risk factors'. *British Journal of Obstetrics and Gynaecology* accessed online on 10th April 2008 at http://www.blackwellpublishing.com/bjog.

Alabi, E. M. (2013) 'Traditional methods of childbirth in Africa - the Nigerian experience. (Women and Health).' *WIN News. Women's International Network*. 1993. *High Beam Research.* Accessed online on 16 November 2013 at http://www.highbeam.com.

Anarado, A. N. (2009) 'Perceptions of women about pain in neonatal male circumcision in selected rural communities in Anambra State South-eastern Nigeria'. *Pain Column* 9(2):73-78. Accessed online on 14th December 2009 at www.nainr.com.

Annelles, M. (1996) 'Hermeneutic phenomenology: Philosophical perspectives and current use in Nursing research'. *Journal of Advanced Nursing* 23: 705-713.

Anonymous (2009) '*Birth Rituals*'. Accessed online on 24TH September 2009 at http://www.midwiferytoday.com/enews/enews.

Anugoro, P.O. Oyedele, L. and Pacquiao, D. (2004) 'Comparative Study of Meanings, Beliefs, and Practices of Female Circumcision among Three Nigerian Tribes in United States and Nigeria'. *Journal of Trans-cultural Nursing* 15(2): 103-113.*s*

Anugwom, E.E. (2007) 'Starting out: the Omugwo Practice and instilling the rudiments of childrearing in mothers among the Igbo's of South Eastern Nigeria' in Liamputtong P (2007) edition: *Childrearing and infant care issues: a cross-cultural perspective*. Nova Publishers: New York.

Aorian, K. J. and Norris, A.E. (2003) 'Depression trajectories in relatively recent immigrants'. *Comprehensive Psychiatry* 44: 420– 427.

Arnett, J. J. (2000) 'Emerging adulthood: A theory of development from the late teens through the twenties'. *American Psychologist 55:* 469- 480.

Austin, Z. (2007) 'Geographical migration, psychological adjustment, and re-formation of professional identity: the double culture shock experience of international pharmacy graduates in Ontario (Canada)'. *Globalisation, Societies and Education* 5 (2): 239–255.

Aveyard, H. (2010) '*Doing a literature review in qualitative research in Health and Social Care: A practical guide'* (second edition) Open University Press.

Aveyard, H. (2006) 'Doing a literature review in Health and Social Care: A Practical Guide'. (2nd edition) Open University Press.

Ayanwuyi, E. and Akintonde, J.O. (2011) 'Income Generating Activities among Rural Women in Ensuring Household Food Security in Ila Local Government, Osun State, Nigeria'. *World Journal of Young Researchers* 1(5):66-70.

Baker, J., Mancuso, M., Montenego, M. and Lyon, B. (2002) 'Treating Post Partum Depression'. *Physician Assistant* 26: 37-44.

Ballard, C. G., Davis, R., Cullen, P. C. and Mohan, R. N. (1994) 'Prevalence of Postnatal Psychiatric morbidity in mothers and fathers'. *British Journal of Psychiatry,* 164: 782-788.

Bailey, J. (2008) 'First step in qualitative data analysis: transcribing'. *Family Practice* 26(5):127-131.

Barbour, R. (2008) '*Introducing Qualitative Research'.* Sage Publications, London.

Barkow, J. H., Cosmides, L. and Tooby, J. (1992) '*The Adapted Mind: Evolutionary Psychology and the Generation of Culture'.* New York: Oxford University Press.

Barr, J. A. (2008) 'Postpartum depression, delayed maternal adaptation, and mechanical infant caring: S phenomenological hermeneutic study'. *International Journal of Nursing Studies,* 45 (3):362-369.

Barry, B. (2007) '*Culture and Equality'.* Polity Press and Blackwell Publishing Company: UK.

Bartocci, G. and Dien, S. (2005) 'Detachment: gateway to the world of spirituality'. *Transcultural Psychiatry* 42(4): 545-69.

Bashiri, N. and Spielvogel, A. M. (1999) 'Postpartum Depression: a Cross-Cultural Perspective'. *Primary Care Updates for Obstetrics and Gynaecology* 6(3): 82-87.

Baskerville, R. F. (2002) 'Hofstede never studied culture'. *Accounting Organisations and Society* 28: 1-14.

Bear, H. A. (1997) 'The Misconstruction of Critical Medical Anthropology: A Response to a Cultural Construct critique'. *Social Science and medicine* 44 (10): 1565-1573.

Beck, C.T. and Polit, D.F. (2010) '*Essentials of Nursing Research – methods, appraisal and utilisation'* 7th Edition Lippincott, Williams and Wilkins: London.

Bennett, H.A. Einarson, A. Koren, G. Taddio, A. and Einarson, T.R. (2004) 'Prevalence of Depression during Pregnancy: systematic review'. *Obstetrics and Gynaecology* 103:698-709.

Benzies, K. M., Premji, S., Hayden, K. A. and Serrett, K. (2006) 'State-of-the-Evidence Reviews: Advantages and Challenges of Including Grey Literature'. *Worldviews on Evidence-Based Nursing 3(2):55–61.*

Berry, J. W. (2005) 'Acculturation: Living Successfully in two cultures'. *International Journal of Cultural Relations* 29(6):697-712.

Besser, A. and Priel, B. (2003) 'The Vulnerability and Coping Strategies in the transition to Motherhood'. *Current Psychology; Development, Learning, Personality, Social.* Spring 2003 22(1): 57-72.

Bhaba, H. (1994) '*The Location of Culture'*. Routledge: Abington and New York.

Brah, A. (1996) '*Cartographies of Diaspora'*. London: Routledge.

Bhugra, D. and Ayorinde, O. (2004) 'Depression in Migrants and Ethnic Minorities'. *Advances in Psychiatric Treatment* 10(13): 13-17.

Bina, R. (2008) 'The impact of cultural factors upon postpartum depression: a literature review'. H*ealth Care for Women International* 29(6): 568–92.

Bowling, A. (2009) '*Research Methods in Health'.* (3rd Ed) Open University Press: London.

Brah, A. (1996) '*Cartographies of Diaspora*'. London: Routledge.

Bruner, J. (1990) '*Acts of meaning*'. Cambridge: Harvard University Press.

Bryman, A. (2004) '*Social Research Methods*' (2 ed.). Oxford: Oxford University Press.

Buutjens, M. and Liamputtong, S. (2007) 'When giving life starts to take the life out of you: women's experience of depression after childbirth'. *Midwifery* 23(1): 77-91.

Burns, N. and Grove, S. K. (2001) '*Understanding Nursing Research'*. W B Saunders: Philadelphia.

Caelli, K. (2001) 'Engaging with Phenomenology: Is it more of a challenge than it needs to be?' *Qualitative Health Research* 11:273-281.

Callister, L. C. (2010) 'Spirituality in Childbearing Women'. *The Journal of Perinatal Education* 19(2): 16-24.

Callister, L. C. (2001) 'Culturally Competent Care of Women and Newborns: Knowledge, Attitudes and Skills'. *Journal of Gynaecology and Neonatal Nursing* (JOGNN) March/April 30(2): 209-215.

Campinha-Bacote, J. (2002) 'The process of cultural competence in the delivery of healthcare services: A model of care'. *Journal of Trans-cultural Nursing, 13(3),* 181-184.

Carol, R. Ember, M. Skoggard I. (Ed) (2004) '*Encyclopedia of Diasporas: Immigrant and Refugee Cultures Around the World: Volume 2 Diaspora Communities'*. Springer Science and Business media: USA.

Carolan, M. and Cassar, .L. (2010) 'Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia'. *Midwifery*: 189–201.

Carr-Ruffino, N. (1996) '*Managing Diversity'*. Thomas Executive Press, San Francisco.

Chaudron, L. H., Klein, M. H. Remington, P., Palta, M., Allen, C. and Essex, M. J. ((2001) 'Predictors, prodromes and incidence of postpartum depression'. *Journal of Psychosomatic Obstetrics and Gynaecology* 22: 103-112.

Chu, C. M. Y. (2005) 'Postnatal Experience and Health Needs of Chinese migrant Women in Brisbane'. *Ethnicity and Health* 10(1):33-56.

Clark, E. (2000) 'The historical context of research in midwifery'. In: Proctor S, Renfrew M (eds) *Linking Research and Practice in Midwifery'*. Bailliere Tindall, London: 35-54.

Cluett, E.R. and Bluff, R. (2006) '*Principles and Practice of Research in Midwifery'*. 2nd edition. Churchill Livingstone: London.

Cluett, E. R. and Bluff, R. (2000) *Principles and Practice of Research in Midwifery*. Bailliere Tindall: London.

Conn, V. S., Valentine, J. C., Cooper, H. M. and Rantz, M. J. (2003) 'Grey Literature in Meta-Analyses'. *Nursing Research* 52(4):256-261.

Cox, J. L. (1999) 'Perinatal mood disorders in a changing culture: a trans-cultural European and African perspective'. *International Review of Psychiatry*, 150:103-110.

Cronin, P., Ryan, F. and Coughlan, M. (2007) 'Undertaking a literature review: a step-by-step approach'. *British Journal of Nursing,* 17(1): 38-43.

Da Cosat, D., Larouche, J., Dritsa, M. and Brender, W. (2000) 'Psychosocial correlates of prepartum and postpartum depressed mood'. *Journal of Affective disorders* 59; 31-40.

Dailey, D. E., & Stewart, A. L. (2007). Psychometric characteristics of the Spiritual Perspective Scale in pregnant African-American women. *Research in Nursing and Health* 30(1): 61-71.

Daley, A. J., MacArthur, C. and Winter, H. (2007) 'The Role of Exercise in Treating Postpartum Depression: A Review of the Literature'. *Journal of Midwifery and Women's Health* 52(1): 56-62.

David, G. C., Garcia, A. C., Rawls, A. W. and Chand, D. (2009) 'Listening to what is said – transcribing what is heard: the impact of speech recognition technology (SRT) on the practice of medical transcription (MT)'. *Sociology of Health and Illness* 31(6):924- 938.

Davies, D. and Dodd, J. (2002) 'Qualitative Research and the Question of Rigor'. *Qualitative Health research, 12*(2): 279-289.

Department of Health (2007) *Maternity matters: choice, access and continuity of care in a safe service*. The Stationery Office, London.

Department of Health (2005-2008) *Race Equality Scheme.* www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4112159.pdf.

Department of Health (DoH) (1993) *Changing Childbirth: Part 1. Report of the Expert Maternity Group*. HMSO: London.

Denham, S. A. (2003) **'**Relationships between Family Rituals, Family Routines, and Health'
Journal of Family Nursing 9 (3): 305-330.

Ding, Q. J. and Hesketh, T. (2006) 'Family size, fertility preferences, and sex ratio in China in the era of the one child family policy: results from national family planning and reproductive health survey'. British Medical Journal**;** 333: 371-373. Accessed online on 13th July 2011 at http://www.bmj.com/content/333/7564/371.full.pdf

Donovan, P. (2006) 'Ethnography' In: Cluett ER, Bluff R. edition *Principles and Practice of Research in Midwifery*. (2nd edition). Elsevier, Edinburgh: 171–86.
Douglas, M. (1979) *Purity and Danger: an analysis of the concepts of pollution and Taboo,* Rutledge: London.

Dow, H. D. (2011) 'The Acculturation Processes: The Strategies and Factors Affecting the Degree of Acculturation'. *Home Health Care Management and Practice* 23 (3): 221-7

Dowling, M. (2007) 'From Husserl to van Manen. A review of different phenomenological approaches'. *International Journal of Nursing Studies* 44: 131-142.

Drapper, P. and McSherry, W. (2002) 'A critical review of spirituality and spiritual assessment'. *Journal of Advanced Nursing* 39 (1): 1-2.

Draucker, C. B. (1999) 'The Critique of Heideggerian Hermeneutical Nursing Research'. *Journal of Advanced Nursing Research* 30(2): 360-373.

Drauguns, J. G. and Tanaka-Matsunj, J. (2003) 'Assessment of psychopathology across and within cultures: issues and findings'. *Critique of Culture in Research* 41 (7) 755-776.

Dye, J. F., Schatz, I. M., Rosenberg, B. A. and Coleman, S. T. (2000) 'Constant Comparison Method: A Kaleidoscope of Data'. The Qualitative Report (On-line serial), *4*(1/2). Accessed online on 29th January 2010 at http://www.nova.edu/ssss/QR/QR3-4/dye.html

Eckersley, R. (2007) 'Culture, spirituality, religion and Health: looking at the big picture. Medical Journal of Australia 186 (10):854-856.

Eckersley, R. (2006) 'Is modern Western culture a health hazard?' *International Journal of Epidemiology* 35: 252-258.

Edge, D., Baker, D. and Roger, A. (2004) 'Perinatal Depression among 'Black Caribbean Women'. *Health and Social Care in the Community* 12(5): 430- 438.

Elliot, S. A., Leverton, T. J., Sanjack, M., Turner, H., Cowmeadow, P., Hopkins, J. and Bushnell, D. (2002) 'Promoting Mental Health after childbirth: a controlled trial of primary prevention of postnatal depression'. *British Journal of Clinical Psychology* 39:223-241.

Elsenbruch, S., Benson, S., Růcker, M., Rose, M., Dudenhausea, J., Pincus-Knackstedt, M. K., Klapp, B. F. and Arck, P. C. (2007) 'Social support during pregnancy: effects on maternal depressive symptoms, smoking and pregnancy outcome'. *Human Reproduction* 22 (3): 869-877.

Etowa, J. B. (2012) 'Becoming a mother: the meaning of childbirth for African–Canadian women'. *Contemporary Nurse* (2012) 41(1): 28–40.

Evans, J., Heron, J., Francomb, H., Oke, S., and Golding, J. (2001) 'Cohort study of depressed mood during pregnancy and after childbirth'. *British Medical Journal* 323:257-260.

Ezeobele, I., Malecha, A., Landrum, P. and Symes, L. (2010) **'**Depression and Nigerian-born immigrant women in the United States: a phenomenological study'. *Journal of Psychiatric and Mental Health Nursing*, 2010, 17, 193–201.

Fang, T. (2003) 'A critique of Hofstede's Fifth National Culture Dimension'. *International Journal of Cross Cultural management* 3(3): 347-368.

Finn, J. and Lee, M. (1996) 'Transcultural Nurses Reflection on Discoveries in China Using Leininger's Sunrise Model'. *Journal of Trans-cultural Nursing* 7 (2): 21-27.

Finn, J. (1995) 'Leininger's Model for Discoveries at The Farm and Midwifery Services to The Amish'. *Journal of Trans-cultural Nursing* 7(1): 28-35.

Freshwater, D. and Rolfe, G. (2003) 'Critical Reflexivity: A Politically and Ethically Engaged Research for Nursing'. *Nursing Times Research* 6: 526-537.

Fuggle, P., Glover, L., Khan, F. and Haydon, K. (2002) 'Screening for postnatal depression in Bengali women: preliminary observations from using a translated version of the Edinburgh Postnatal Depression scale (EPDS)'. *Journal of Reproductive and Infant Psychology* 20(2): 71-82.

Gibb, S. and Hundley, V. (2006) 'What psychosocial well-being in the postnatal period means to midwives'. Accessed online on 1 February 2008 at http://www.elsevier.com/locate/midwifery.

Glover, V. and O'Connor, T. G. (2002) 'Effects of antenatal stress and anxiety: implications for development and psychiatry'. *The British Journal of Psychiatry* 2002; 180: 389-391.

Gough, I. (2005) 'Theories of Wellbeing'. Accessed online on 29 December 2010 at http://www.welldev.org.uk/spa-presentations/theories-of-wellbeing-text.pdf.

Grice, L. E. (2007) '*Indigenous Birthing Rituals*'. Accessed at online on 24 September 2007 at: http://www.chatham.edu/pti

Hallberg, L. R-M. (2010) 'Some thoughts about the literature review in grounded theory studies'. *International Journal of Qualitative Studies in Health and Well-being.* Accessed online on 23rd August 2013 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2915820/pdf/QHW-5-5387.pdf

Hamlon, C., Whittley, R., Wendimagegn, D. and Alem, A. (2009) 'Postnatal Mental Distress in Relation to Socio-cultural Practices of Childbirth: An exploratory qualitative study from Ethopia'. *Social Science and Medicine* 68(8): 1211-1219.

Haper-Bulman, K. and McCourt, C. (2002) 'Somali refugee women's experiences of maternity care in west London: A case study'. *Critical Public Health* 12(4): 365–80.

Harris, M. (2006) 'Promoting Inclusive Service'. *The Practising Midwife* 9(2): 4-5.

Harrison, K. M. and Dean, H. D. (2011) 'Use of data systems to address Social determinants of health: A need to do more'. *Public Health Reports*; Supplement 3(126):1-4.

Hardin, C. D. and Higgins, E. T. (1996) 'Shared Reality: how social verification makes the subjective objective. *In handbook of motivation and Cognition: Foundations of Social Behaviour'*, Sorrentino RM, Higgins ET ed. Chichester: Wiley.

Hawker, D. (2009) '*The Benefits of Male Circumcision*'. Access online on 14th December 2009 at http

://www.circinfo.com/benefits/bmc.html

Haynes, K. (2007) 'Transforming identities: Accounting professionals and the transition to motherhood'. *Critical Perspectives Account* (2007), doi:10.1016/j.cpa.2006.10.003. Accessed online on 10th April 2008 at http://www.blackwellpublishing.com/bjog.

Heath, C. and Hindmarsh, J. (2002) '*Qualitative Research in Practice'*. London: Sage.

Heidegger, M. (1962) '*Being and Time'*. Blackwell: Oxford

Heidegger, M. (1967) 'Being and Time'. Blackwell: Oxford

Helliwell, J. F. and Putnam, R. D. (2004) 'The Social Context of Well-being'. *Philosophical Transactions of the Royal Society of Biological Sciences* 359(1449): 1435–1446.

Holloway, I. and Todres, L. (2006) 'Ethnography' In: Gerrish K, Lacey A. eds *The Research Process In Nursing*. 5th edition. Blackwell Publishing, Oxford: 208–22

Holloway, I. and Wheeler, S. (2002) '*Qualitative Research in Nursing'*. 2nd edn. Blackwell Publishing, Oxford.

Hollos M. and Larsen, U. (2004) 'Which Africa men promote smaller families and why? Marital relationships and fertility in a Prae community in Northern Tanzania'. *Social Science and Medicine* 58: 1733-1749.

Huberman, M. A. and Miles M B (2002) '*The Qualitative Researcher's Companion*'. Sage Publications: London.

Hundt, G.L., Beckerleg, S., Kassem, F., Abu-Jafar A.M., Belmaker, I., Abu-Saad, K.and Shoham-Vardi, I. (2000) 'Women's health custom made: building on the 40 days postpartum for Arab women'. *Health Care for Women International* 21 (6):529-542.

Hutchison, E. D. and Charlesworth, L.W. (2011) 'Theoretical Perspectives on Human Behavior' In Hutchinson, E. D. (2011) *Dimensions of Human Behavior*. 4th Edition. SAGE Publications.

Hycner, R. H. (1999) 'Some Guidelines for the Phenomenological Analysis of Interview Data'. In Bryman A and Burgess R G (Eds.) *Qualitative Research* 3: 143-164. Sage: London.

Izugbara, C. O., Etukudo, I. W. and Brown, A. S. (2005) 'Trans-ethnic itineraries for ethno-medical therapies in Nigeria'. Accessed online on 14th December 2009 at http://ww.sciencedirect.com/science.

Jassen, P. (1997) 'Race, Culture, and the Colonization of Childbirth in Northern Canada'. *The Society for the Social History of Medicine* 10(3): 383-400.

Jarvis, G.E., Kirmaver, L. J., Weinfeld, M. and Lasry, J. (2005) 'Religious practice and psychological distress: the importance of gender, ethnicity and immigrant status'. *Transcultural Psychiatry* 42(4): 657-75.

Jegede, R. O. (1979) 'Depression in Africans revisited'. *African Journal of Medicine* 8: 125-132.

Jones, S. R., Torres, V. and Arminio, J. (2006) '*Negotiating the Complexities of Qualitative Research in Higher Education'.* Routledge: New York.

Jones, C. C. (2002) '*Traditional Postpartum Rituals of India, North Africa, and the Middle East: Seclusion, Henna, and 40 Day Homecare'*. Accessed online on 24th February 2011 at http://www.lotusfertility.com/Postpartum_Wisdom_Rituals.html

Kale, R. (2006) 'Chinese women want small families and male children'. Accessed online on 13 July 2011 at http://www.bmj.com/content/333/7564/0.1.full

Kane, C. M. (2000) 'African American Family Dynamics as perceived by Family Members'. *Journal of Black Studies* 30(5): 691-702. Accessed online on 3rd March 2010 at http://www.jstor.org/stable/2645877.

Karner, C. (2007) '*Ethnicity and Everyday Life'*. Routledge: London.

Kelly, P. (edition) (2005) '*Multiculturalism Reconsidered*'. Polity Publications in association with Blackwell Publishers Limited: UK.

Kleinman, A., Eisenberg, L. and Good, B. (2006) 'Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross- Cultural Research'. *The Journal of Lifelong Learning in Psychiatry* IV (1): 140-149.

Knight, A. and McNaught, A. (Ed) (2011) '*Understanding Wellbeing'*. Lantern Publications Limited: Banbury.

Koniak-Griffin, D., Logsdon, C., Hines-Martin, V. and Turner, C. C. (2006) 'Contemporary Mothering in Diverse Society'. *Journal of Gynaecological Nursing (JOGNN)* 35(5):671-678.

Kuper, A. (1999) '*Culture – the anthropologists' account'*. London: Harvard University Press.

Kuper, A., Reeves, S. and Levinson, W. (2008) 'An introduction to reading and appraising qualitative research'. *British Medical Journal* 337:a288.

Laumann, E. O. (2013) 'The Circumcision Dilemma'. Accessed online on 18 December 2013 at http://web.ebscohost.com/ehost/detail?vid=7&sid=00b1b821-78aa-4428-a783d7f34a88df18%40sessionmgr110&hid=128&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=aph&AN=20935716

Lindsay, B. (2007) '*Understanding Research and Evidence-Based Practice'*. Reflect Press, Exeter.

Lewis, G. (2007) *Confidential Enquiries into Maternal and Child Health Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer 2003-2005 (midwifery summary).* CEMACH: London (online) Last accessed 28th October 2009 at http://www.cemach.org.uk/getattachment/7654804a-9442-4a3o-8857-4c20c4391ae/saving-mothers'-lives 2003-2005_midwifumm.aspx.

Leowenthal, K. (1995) '*Mental Health and Religion'.* Chapman and Hall: London.

Lewin, K. (1951) *'Field Theory in Social Science'*, Harper and Row, New York.

Littlewood, R. and Lipsedge, M. (1989) '*Aliens and Alienists: Ethnic Minorities and Psychiatry'*. 2nd Edition. Unwin Hayman: London.

Lovenduski, J. and Randall, V. (1993) '*Contemporary Feminist Politics: women and Power in Britain'*. Oxford University Press: Oxford.

Lowry, F. (2009) Herbal Product Use in Pregnancy, May Pose Risk to Fetus. Accessed online on 2nd January 2010 at http://www.medscape.com/viewarticle/714461?src=mp&spon=16&uac=75102MK

Mackey, S. (2004) 'Phenomenological nursing research: methodological insights derived from Heidegger's interpretative phenomenology'. *Nursing Studies* 42: 179-186.

MacLachlan, M. (2006) '*Culture and Health: a critical perspective towards global health'*. Second Edition. John Wiley and Sons Limited: England.

Mallinson, S. and Popay, J. (2007) 'Describing depression: ethnicity and the use of somatic imagery in accounts of mental distress'. *Sociology of health and Illness* 29(6): 857-871.

Marcus, S. M., Flynn, H. A., Blow, F. C. and Barry, K. L. (2003) 'Depressive symptoms among pregnant women screened in Obstetric setting'. *Journal of Women's Health* 12(4): 373-380.

Melike, S., Aysen, G. and Zehra, U. (2007) 'First time mother's anxiety and depressive symptoms across the transition to motherhood: associations with maternal and environmental characteristics'. *Women's and Health* 44(3):61-77.

Miller, T. (2003) Shifting perceptions of expert knowledge: transition to motherhood. *Human Fertility* 6(3)142-146.

Moustakas, C. (1994) '*Phenomenological research methods'*. Sage: Thousand Oaks.

Murphy, M. (2007) 'Choosing Caesarean Birth: An alternative to today's Crisis in Natural Childbirth'. Accessed online on 24th September 2007 at http://www.obgyn.net/displayarticle.asp

Musgrave, C. F., Allen, C. E. and Allen, C. J. (2002) 'Spirituality and Health for Women of Color'. *American Journal of Public Health* 92(4): 557–560. Accessed online on 18th July 2011 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447116/

National Population Commission (2000) *Nigerian Demographic and health Survey 1999*. National Population Commission: Abuja Nigeria.

Nigeria Demographic and Health Survey (1999) Results from the Demographic and Health Survey. *Studies in Family Planning* 32(4): 361-365 National Population Commission Abuja, Nigeria.

National Population Commission (2000) *Nigerian Demographic and health Survey 1999*. National Population Commission: Abuja Nigeria.

Oates, M. (2003) 'Suicide: the leading cause of maternal death'. *British Journal of Psychiatry* 183:279-281.

O' Donnell, E. (2004) 'Birthing in prehistory'. *Journal of Anthropological Archaeology* 23(2): 163-171.

Office for National Statistics (2010) 'Current Estimates - Population Estimates by Ethnic Group Mid-2007 (experimental)'. ONS: London.

Omeri, A. (1997) 'Culture Care of Iranian Immigrants in New South Wales, Australia: Sharing Transcultural Nursing Knowledge'. *Journal of Trans-cultural Nursing* 8(2): 5-16.

Onuorah C E and Ayo J A (2003) Food taboos and their nutritional implications on developing nations like Nigeria: a review. Accessed online on 14th December 2009 at http://www.emraldinsight.com/Insight/ViewContentServlet?contentType.

Pan, J. Y., Wong, D. F. K., Joubert, L. and Chan, W. C. L. (2007) 'Acculturative stressor and meaning of life as predictors of negative affect in acculturation: a cross-cultural comparative study between Chinese international students in Australia and Hong Kong'. *Australian and New Zealand Journal of Psychiatry* 2007; 41:740-750.

Papadopoulos, I. and Lees, S. (2002) 'Developing Culturally Competent Researchers'. *Journal of Advanced Nursing* 37(3): 258–264.

Polit, D. F. Hungler, B. P. (1999) '*Nursing Research Principles and Methods'*. Lippincott, Philadelphia.

Petrous, S., Cooper, P. and Davison, L. L. (2002) 'Economic costs of postnatal depression in a higher-risk cohort'. *British Journal of Psychiatry* 181: 505-512.

Phillips, E. M. and Pugh, D. S. (2010) '*How to Get a PhD'*. 5th Edition. Open University Press: UK.

Race Relations Amendment Act (2000) accessed online on 3rd March 2012 at http://www.equalityhumanrights.com

Ramsden, I. M. (2002) '*Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu* Doctoral Thesis'. Wellington: Department of Nursing. Victoria University of Wellington.

Raven, J. H. Chen, Q. Tolhurst, R. J. Garner, P. (2007) 'Traditional beliefs and practices in the postpartum period in Fujian Province, China: a qualitative study'. *Biomed Central Pregnancy Childbirth* 7(8): 1-1.

Raynor, M. (2006) 'Pregnancy and the puerperium: social and psychological context'. *Psychiatry* 5(1): 1-4.

Records, K. and Rice, M. (2007) 'Psychosocial correlates of depression symptoms during the third trimester of pregnancy'. *Journal of Obstetrics and Neonatal Nursing* 36:231-242.

Rhodes, H. A. (2010) 'The African-American Family in Crisis'. Access online on 3rd March 2010 at http://www.yle.edu/ynhti/curriculum/units/1990/4/490.04.06.x.html.

Richards, H. and Emslie, C. (2000) 'The 'doctor' or the 'girl from the University?' Considering the influence of professional roles on qualitative interviewing. *Family Practice* 17(1): 71-75.

Ritchie, J. and Spencer, L. (2002) 'Qualitative Data Analysis for Applied Policy Research' in Huberman M A and Miles M B (2002) *The Qualitative Researcher's Companion*. Sage Publications: London.

Ritsner, M. Ponizovsky, A. Nechamki Y. and Modai, I. (2001) 'Gender differences in psychosocial risk factors for psychological distress among immigrants'. *Comprehensive Psychiatry* 42: 151–160.

Roberts, T. (2009) 'Understanding ethnography 'from a midwifery perspective' *British Journal of Midwifery;* 17(5): 291-294.

Robson, C. (2007) '*How to do a research project: a guide for undergraduate students'*. Blackwell Publishing Limited: UK.

Royal College of Psychiatrists (RCOP) (2001) '*Perinatal Mental Health Services, recommendations for provision of services for Childbearing Women'.* London: Royal College of Psychiatrists.

Sadala, M. L. and Adorno, R. C. (2001) 'Phenomenology as a method to investigate the experiences lived: A perspective from Husserl and Merleau-Ponty's thought'. *Journal of Advanced Nursing* 37(3): 282-293.

Sayer, J. F. A. (2012) '*The Bible and Culture'*. Wiley-Blackwell: John-Wiley and Sons Limited: UK.

Sered, S. (2003) 'Afterword: Lexicons of the supernatural'. *Anthropological Forum* 13(2):213-218.

Sered, S. S. (1991) 'Childbirth as a religious Experience? Voices from an Israeli Hospital'. *Journal of Feminist Studies in Religion* 7(2): 7-18.

Shandy, D. J. and Power, D. (2008) 'The Birth of the African-Irish Diaspora: Pregnancy and Post-Natal Experiences of African Immigrant Women in Ireland'. *International Migration* 46 (5): 119–142.

Shaw, S. and Bailey, J. (2009) 'Discourse analysis: what is it and why is it relevant to family practice?' *Family Practice* 26(5): 413-419.

Shaw, E., Levitt, C., Wong, S., and kaczorowski, J. (2006) 'Systematic Review of the literature on Postpartum Care: Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health'. *Birth* 33(3): 210-220.

Sigad, L. I. and Eisikovits, R. A. (2009) 'Migration, Motherhood, Marriage: Cross-Cultural Adaptation of North American Immigrant Mothers in Israel'. *International Migration* 47 (1):63-99.

Smith, D. J. (2001) 'Kinship and Corruption in Contemporary Nigeria'. *Ethnos* 66(3):344-364.

St Clair, R. N. and Koo, J. H. (1991) 'Rites of passage across cultures'. *Intercultural Communication Studies* 1(1): 131-146.

Streubett, H. J. and Carpenter, D. R. (1999) '*Qualitative Research in Nursing: advancing the humanistic imperative',* 2nd Edition. Lippincott: Philadelphia.

Takougang, J. (2002) 'Contemporary African immigrants to the United States'. *A Journal of African Migration* 2: 1–7.

Takougang, J. (2003) 'Recent African immigrants to the United States: a historical perspective'. *The Western Journal of Black Studies* 19: 1–8.

Thomas, J. and Harden, A. (2008) 'Methods for the thematic synthesis of qualitative research in systematic reviews'. *Biomed Central Medical Research Methodology* 8(45):1-10.

Tiran, D. (2003) 'The use of herbs by pregnant and childbearing women: a risk-benefit assessment'. *Complimentary Therapies in Nursing and Midwifery* 9(4):176-181.

Todorova, I. R. G. Falcon, L. M. Lincoln, A. K. and Price, L. L. (2010) 'Perceived Discrimination, Psychological Distress and Health'. *Sociology of Health and Illness* 32(6): 843- 861.

Togunde, D. and Newman, S. (2005) 'Value of Children, Child Labor, and Fertility Preferences in Urban Nigeria'. *West African Review* 7: West Africa Review, 7:2005, 1525-4488.

Truong, M., Paradies, Y. and Priest, N. (2014) 'Interventions to improve cultural competency in healthcare: a systematic review of reviews'. *Bio-Med Central Health Services Research 14(99):1-16.*

Varisco, D. M. (2004) 'Reading against Culture in Edward Said's Culture and Imperialism. Culture, Theory and Critique' 45(2): 93-112.

Vocabulary.com (2016) Diaspora. Online at https://www.vocabulary.com/dictionary/diaspora. 6th February 2016.

Walker, D. and Myrick, F. (2006) 'Grounded Theory: an exploration of process and procedure'. *Qualitative Health Research* 16(4): 547-559.

Walker, C. (1995) 'Conceptualising motherhood in twentieth century South Africa'. *Journal of Southern African Studies* 21(3): 417-428.

Ward, J. P. and Purdue, U. (2005) 'Identifying factors associated with successful transition to Parenthood'. *Dissertation Abstracts International Section A: Humanities and Social Sciences* 65(10A): 4009.

Weeks, J.R. (2012) *'An Introduction to Population: International Edition* (11th Edition) Thomson Wadsworth Incorporation: USA.

White, S. C. (2008) 'But what is wellbeing? A Framework for analysis in social and development policy and practice'. Accessed online on 29th December 2010 at http://staff.bath.ac.uk/ecsscw/But_what_is_Wellbeing.pdf

White, J. (2007) 'Wellbeing and Education: Issues of Culture and Authority. *Journal of Philosophy of Education* 41(1):17-28.

Wilding, C., Muir-Cochrane, E., and May, E. (2006) 'Treading lightly: Spirituality issues in mental health nursing'. *International Journal of Mental Health Nursing* 15(2): 144–52.

Williamson, D. (2010) '*Human Relations: Forward from a Critique of Hofstede's Model of national Culture*'. Accessed online on 7th December 2010 at http://hum.sagepub.com/content/55/11/1373.

Williamson, M. J. (2008) '*Dealing with diversity: incorporating cultural sensitivity in professional midwifery practice'*. Accessed 15th March 2016 Online at http://ro.uow.edu.au/cgi/viewcontent.cgi?article=3068&context=theses

World Health Organization (2010) *World Health Statistics 2010*. WHO, Geneva.

World Health organization (2007) '*Depression*'. Accessed online on 22nd February 2011 at

http://www.who.int/mental_health/management/depression/definition/en/

World Health Organisation (1991) *National Mortality*: A Global Fact. Geneva: Switzerland.

WHO / UNICEF (1989) '*Protecting, Promoting and Supporting Breast-feeding: the Special Role of Maternity Services*'. A Joint WHO/UNICEF Statement. Geneva: World Health Organization.

Yearwood, E.L. Brown, D. L. and Karlik, E. C. (2002) 'Cultural diversity: Student's perspectives', *Journal of Transcultural Nursing* 13: 237–240.

Zwart, J. J., Jonkers, M. D., Richters, A.; Öry, F., Bloemenkamp, K. W., Duvekot, J. J. and Roosmalen, J.V. (2011) 'Ethnic disparity in severe acute maternal morbidity: a nationwide cohort study in the Netherlands'. *European Journal of Public Health*; 21 (2):229-234.

Appendixes

Appendixes

A. MREC approval ethics approval

Lewisham Local Research Ethics Committee
South London REC Office (4)
University Hospital Lewisham
1st Floor Owen Centre
Lewisham High Street
London
SE13 6LH

Telephone: 020 8333 3135
Facsimile: 020 8314 0626

01 December 2008

Mrs Priscilla Dike
Senior Lecturer in Midwifery
The University of Greenwich
Avery Hill Campus, Southwood Site
Avery Hill Road, Eltham
London
SE9 2UG

Dear Mrs Dike

Full title of study:	**Adherence to cultural practices by Nigerian women in London and the relationship to their health and well being during child bearing.**
REC reference number:	**08/H0810/66**

Thank you for your letter of 26 November 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by Dr Colm Lanigan.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

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

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

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Letters from Julie Boyer,Seshadri Sriprasad, Pauline Essen & Anna Sasha re project		
Prof Corney & Elizabeth West CV		
Participant Information Sheet: PIS		
1	08 October 2008	
Advertisement		
1	08 October 2008	
Questionnaire: Stage 2/3		
1	08 October 2008	

Questionnaire: Stage 1		
1	08 October 2008	
Questionnaire: Staff Focus Group Questions		
1	08 October 2008	
Compensation Arrangements		
AON	01 August 2008	
Peer Review		
Covering Letter		
	08 October 2008	
Protocol		
1	08 October 2008	
Investigator CV		
Application		
1.1	08 October 2008	
Post study de-briefing form		
Edinburgh Postnatal Depression Scale		
Participant Consent Form: Consent		
1	08 October 2008	
Response to Request for Further Information		

	26 November 2008	
Participant Consent Form: Consent for Focus Group		
1	26 November 2008	
Interview Schedules/Topic Guides		
1	26 November 2008	
Covering Letter		
	26 November 2008	
Participant Consent Form: Consent		
2	26 November 2008	
Participant Information Sheet: PIL for Focus Group of Nigerian Women		
1	26 November 2008	
Participant Information Sheet: PIL for Staff Focus Group		
2	26 November 2008	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0810/66	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Mehool Patel
Vice Chair

Email: pat.martin@uhl.nhs.uk

Enclosures: "After ethical review – guidance for researchers" *SL- AR2*

Copy to: *Mrs Linda Cording - R&D office for University of Greenwich*
Professor Roslyn Corney – University of Greenwich

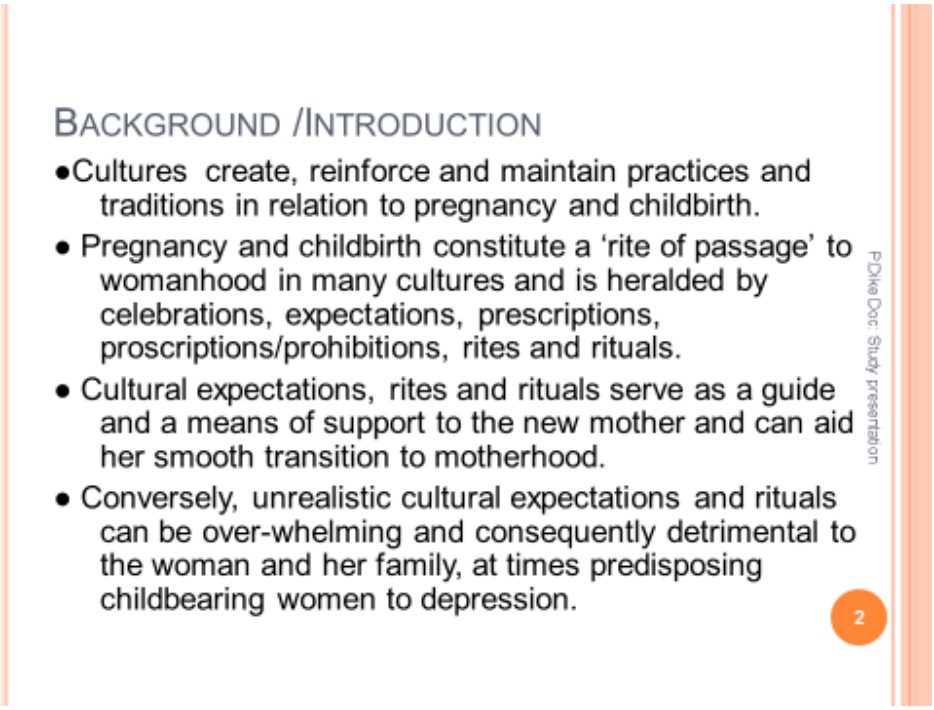
B. Study Flyer
08/H0810/66

Are you a first-generation Nigerian and pregnant?
We are interested in your experiences /cultural practices regarding pregnancy and childbirth.
Please speak to the midwife attending to you or contact Priscilla Dike on:
020 8331 9294 or Email:P.Dike@gre.ac.uk or
Prof. Ros Corney on: 020 8331 8926 or email:
R.H.Corney@gre.ac.uk.

the UNIVERSITY of GREENWICH

C. Presentation of study to NHS Trust staff

08/H0810/66



STUDY AIMS AND OBJECTIVES

This study is conceived to explore the cultural needs of FGNW in London during maternity care, and to address the gaps in knowledge in the care experiences of this population in relation to cultural competency of midwives and congruency of the maternity care provided to a section of this population (FGNW) in South London.

Study specific objectives are to:

- explore the cultural (emic) care practices of first-generation Nigerian women during their birth experiences in London.
- explore first-generation Nigerian women's retrospective expectations of maternity care in London.
- examine midwives' perception of first-generation Nigerian women's requirements for culturally competent and congruent care in their birth experiences in London.
- consider factors that enhanced midwives ability to give culturally-competent care and some of the barriers they may encounter.

PDike Doc: Study presentation

3

THEMES FROM LITERATURE REVIEW

1. Culture and childbirth practices/rituals,
2. Care and network of support in childbirth(Bina 2008),
3. Impact of anxiety and depression on childbirth experience(Chaudron *et al* 1998, Da Costa et al 2000 and Elliot et al 2000),
4. Childbirth culture and adaptation to and transition to motherhood,
5. Value of motherhood in Nigerian culture,
6. Migration, acculturation and Childbearing Nigerian women.

PDike Doc: Study presentation

4

RESEARCH DESIGN AND METHODOLOGY

- There are **2 phases**: focus group with FGNW and midwives and prospective study of FGNW at 3 intervals of birth continuum.

Stage one:

- **Focus Group 1**: with 6 FGNW with prospective birth experience(s) in London, using a topic guide.
- **Focus group 2:** discussion with midwives from 3 NHS trusts in South London, using a topic guide.

Stage two:

- **Longitudinal prospective study of FGNW at 3 intervals of birth continuum:** using a topic guide and EPDS at 24 weeks gestation, at 6 weeks and at 3 months postnatal.

PDAw Doc Study presentation

5

ETHICS, CONFIDENTIALITY, EQUAL OPPORTUNITY AND HEALTH AND SAFETY

- NRES/IRAS ethics approval gained October 2008: South London REC Office (4).
- Management permission or approval sought with individual NHS Trusts.
- Information leaflet/written consent of participants.
- Obstetric counsellors available for participants.
- Participation will be voluntary and participants will be able to withdraw at any stage of the study.
- Data protection act 1998 upheld by researcher.

PDAw Doc Study presentation

6

BENEFITS OF THE STUDY

- This study may highlight intra-group similarities and/or variability that may aid the development of culturally appropriate maternity care that enhances health, improves satisfaction with healthcare provision.
- A tool may be devised to enhance cultural congruency in maternity care provision to FGNW in London.
- Publication and dissemination of findings.
- Access to counsellor psychiatrists.
- Implications for midwifery education, practice and research will be drawn and recommendations made to enhance contemporary midwifery practice.
- Boosts research activity within the 3 Trusts and the university.
- Forms part of MPil/PhD study.

PDMe Doc Study presentation

7

ONGOING

- Prospective study at 3 stages of birth continuum.
- EPDS screening of prospective cohort.
- Transcribing of interviews
- Thematic analysis of data
- Write up of thesis
- Dissemination of findings

PDMe Doc Study presentation

THANK YOU: ANY QUESTIONS

D. Information leaflet

08/H0810/66

CONFIDENTIAL

RESEARCH STUDY INFORMATION LEAFLET FOR FIRST GENERATION NIGERIAN WOMEN

Does culture influence child birth experiences of first-generation Nigerian women in London?

I am writing to ask for your help with a study which I am carrying out within your local hospital. This study forms part of project for a doctorate (PhD) which I am studying for at the University of Greenwich.

The study will provide information that may help improve understanding of cultural practices related to childbirth. I am asking first-generation Nigerian women to consent for interviews to discuss their cultural practices around pregnancy and childbirth, in order to assess the impact of these on their health and wellbeing. The interview is expected to take about half an hour and will be tape or video recorded at any venue of your choice.

Participation is voluntary and information that you give will be treated in strict confidence and your identity will not be revealed to anyone not connected with the study.

Withdrawal from the study will not affect the maternity care you receive in any way.

I realise that you may be busy at the moment but I would value your participation in my study. I have enclosed a consent form which I would like you to sign and return to me today or in the next few days. If you have any further questions about the study, please contact me on the address and / or phone numbers provided.

Thank you.

Yours sincerely

Priscilla Dike: Senior lecturer (midwifery)

The University Of Greenwich

Avery Hill campus, Avery hill Road

London SE9 2PU

Phone: 0208 331 9294

Email: P.Dike@gre.ac.uk.

Professor of Psychology
The University of Greenwich
Avery Hill campus
Avery hill Road
London SE9 2PU.
Phone: 0208 331 8926
Email: R.H.Corney@gre.ac.u

Professor Ros Corney

E. Consent form for women

08/H0810/66

South Wood Site
Avery Hill Road
London SE9 2UG

PARTICIPANT CONSENT FORM
Study Centre:
Study Number:
Patient Identification Number:

Title of Research: Does culture influence the birth experiences of first-generation Nigerian women in London?		
Investigator's name: Priscilla Dike		
To be completed by the participant		
1.	Have you read the information sheet about this study?	YES/NO
2.	Have you had an opportunity to ask questions and discuss this study?	YES/NO
3.	Have you received satisfactory answers to all your questions?	YES/NO
4.	Have you received enough information about this study?	YES/NO
5.	Which researcher / investigator have you spoken to about this study?	……
6.	Do you understand that you are free to withdraw from this study:	
	• at any time?	YES/NO
	• without giving a reason for withdrawing?	YES/NO
	• without affecting your future with the University/studies/medical or midwifery care?	YES/NO
	• information obtained from you will not be used if you withdraw or lose your capacity to consent.	YES/NO YES/NO
	• Do you consent to be taped and/or video recorded during focus group discussion?	
7.	I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals conducting this study and give permission for these individuals to have access to my records.	YES/NO
8.	Do you agree to take part in this study?	YES/NO
Signed		Date
Name in block letters		
Signature of investigator		Date

F. Information leaflet for midwives

08/H0810/66

CONFIDENTIAL

RESEARCH STUDY INFORMATION LEAFLET FOR MIDWIVES

Title of Research: Does culture influence the birth experiences of first-generation Nigerian women in London?

I am writing to ask for your help with a study which I am carrying out within your local hospital. This study forms part of project for a doctorate (PhD) which I am studying for at the University of Greenwich.

The study will provide information that may help improve understanding of cultural practices related to childbirth. I am asking Nigerian women to consent for interviews to discuss their cultural practices around pregnancy and childbirth, in order to assess the impact of these on their health and wellbeing. The interview is expected to take about half an hour and will be tape or video recorded at any venue of your choice.

Participation is voluntary and information that you give will be treated in strict confidence and your identity will not be revealed to anyone not connected with the study.

Withdrawal from the study will not affect the maternity care you receive in any way.

I realise that you may be busy at the moment but I would value your participation in my study. I have enclosed a consent form which I would like you to sign and return to me today or in the next few days. A prepaid, self-addressed envelope is enclosed for your reply. If you have any further questions about the study, please contact me on the address and/or phone numbers provided.

Thank you.

Yours sincerely

Priscilla Dike: Senior lecturer (midwifery)

The University Of Greenwich

Avery Hill campus, Avery hill Road

London SE9 2PU

Phone: 020 8331 9294

Email: P.Dike@gre.ac.uk

Professor Ros Corney

Professor of Psychology

The University of Greenwich

Avery Hill campus, Avery hill Road

London SE9 2PU.

Phone: 0208 331 8926

Email: R.H.Corney@gre.ac.uk

G. Consent form for midwives

08/H0810/66

the UNIVERSITY of GREENWICH
South Wood Site
Avery Hill Road
London SE9 2UG

PARTICIPANT CONSENT FORM: FOCUS GROUP

Study Centre:

Study Number:

Title of Research: Does culture influence the birth experiences of first- generation Nigerian women in London?		
Investigator's name: Priscilla Dike		
To be completed by the participant: please delete **"yes"** or **"no"** as appropriate		
9.	Have you read the information sheet about this study?	YES/NO
10.	Have you had an opportunity to ask questions and discuss this study?	YES/NO
11.	Have you received satisfactory answers to all your questions?	YES/NO
12.	Have you received enough information about this study?	YES/NO
13.	Which researcher/investigator have you spoken to about this study?	……
14.	Do you understand that you are free to withdraw from this study:	…
	• at any time?	YES/NO
	• without giving a reason for withdrawing?	YES/NO
	• without affecting your future with the University/studies/medical or midwifery care?	YES/NO
	• information obtained from you will not be used if you withdraw or lose your capacity to consent.	YES/NO
	• Do you consent to be tape and/or video recorded during focus group discussion?	YES/NO
		YES/NO
15.	Do you agree to take part in this study?	YES/NO
Signed		Date
Name in block letters		
Signature of investigator		Date

H. Topic guide for interview with six Nigerian women with retrospective experiences of birth in Britain.

08/H0810/66

FOCUS GROUP DISCUSSION WITH NIGERIAN WOMEN

Thank you for consenting to participate in this focus group discussion. Please take a moment to consider your responses to the following questions:

1. Explore the cultural practices you adhered to during your childbirth experience in Britain and the presumed benefits and / or constraints of these to your health and wellbeing.

2. What do you consider culturally important for Nigerian women during pregnancy and childbirth?

3. In terms of childbirth practices, what do you consider the differences between Nigerian women in Nigeria and yourself as a first-generation Nigerian woman living in London?

4. Please examine the care you received from midwives in regards to meeting your cultural needs during your birth experiences.

5. Please take a moment to review and comment on this document to be used later in this study, in regards to appropriateness or usefulness of the tool in covering pertinent points about pregnancy and childbirth practices of first-generation Nigerian women.

Thank you.

Yours sincerely

Priscilla Dike: Senior lecturer (midwifery)

The University Of Greenwich

Avery Hill campus, Avery hill Road

London SE9 2PU

Phone: 020 8331 9294

Email: P.Dike@gre.ac.uk

Professor Ros Corney

Professor of Psychology

The University of Greenwich

Avery Hill campus, Avery hill Road

London SE9 2PU.

Phone: 0208 331 8926

Email: R.H.Corney@gre.ac.uk

I. Topic guide for focus group discussion with midwives

08/H0810/66

CONFIDENTIAL

Title of Research: Does culture influence the birth experiences of first- generation Nigerian women in London?

Thank you for participating in this study. These topics have been compiled in order to elicit your perspectives on some of the cultural practices of first-generation Nigerian women under your care. The information you provide will enable the researcher to gather factual information about aspects of first-generation Nigerian women's cultural practice, the influence of these on the women's birth experiences and on your care delivery to this population.

1. How long have you been as a midwife?

2. Please share with me, your experiences of providing maternity care to first-generation Nigerian women.

3. What have you enjoyed most about caring for first-generation Nigerian women?

4. Are there specific cultural practices you have observed whilst providing care to first-Nigerian women during pregnancy, labour or during the postnatal period?

5. Could you describe these and highlight any presumed importance to the women and the issues arising from these in relation maternity care?

6. What is your belief about these cultural practices?

7. Please share with me the benefits of these cultural practices to the health and wellbeing of the first-generation Nigerian women you cared for?

8. Have any of the Nigerian women you've looked after had problems as a result of observing cultural practices?

9. If yes, please expand on the problem(s) and the issues this may have caused in care delivery?

10. Have you experienced any difficulties with first-generation Nigerian women in your care, or encountered any general problems".

Are there any other comments you want to make in relation to childbirth practices of first-generation Nigerian women that you have cared for?

Thank you once more for participating in this study. The responses you've provided will be kept in strict confidence and only be used for the purpose of this study.

J. Topic guide for prospective interview with six first-generation Nigerian women

08/H0810/66

CONFIDENTIAL

Topic guide for stage one interview at 24 weeks gestation

Title of Research: Does culture influence the birth experiences of first- generation Nigerian women in London?

Thank you for participating in this study. These topics have been formulated as a guide to help you to express your views on your cultural practices during pregnancy. There is no right or wrong answer to these questions. The information you provide will enable the researcher to gather information about the influence of culture on first-generation Nigerian pregnancy and birth experiences in London.

Section 1: Demographic data

Please state:

1. **Your age**:
2. **Your educational level**:
3. **Your employment status**
4. **Years spent in Nigeria**
5. **Years spent in Britain**
6. **Which Part of Nigeria are you or your parents from?**

Section 2: Questions to ascertain general wellbeing

7. How are you feeling in yourself?
8. Has this changed over the pregnancy?
9. What might have caused these changes?
10. Has anything made it easier for you?
11. Has anything made it difficult for you?

Section 3: Questions about expectations, preference and support

12. What type of relationship are you in?

13. Do you have other children either in Britain or in Nigeria and what are their sexes?

14. Was this pregnancy something you planned and wanted?

15. Do you desire a boy or girl in this pregnancy?

16. Has anyone been of help to you in this pregnancy?

17. If yes, who and what sort of help was given? What about the father of the baby, your family, your in-laws, your friends or acquaintances?

18. Has anyone been unhelpful to you?

Section 4: Ascertaining cultural practices and the influence on general wellbeing in antenatal period

19. Please share with me specific cultural practices you uphold in pregnancy that relate to your Nigerian culture?

20. What is your belief about these cultural practices?

21. How has the cultural practices influenced your health and wellbeing in this pregnancy?

22. Do you have specific expectations of midwives in relation to meeting your cultural needs?

23. Please tell us about any other childbirth practices in your culture not discussed already?

Thank you once more for participating in this study. The responses you've provided will be kept in strict confidence and only be used for the purpose of this study.

K. Topic guide for prospective interview with six first-generation Nigerian women

08/H0810/66

CONFIDENTIAL

Topic guide for stages two and three interviews at 6 weeks and 3 months postnatal

Title of Research: Does culture influence the birth experiences of first- generation Nigerian women in London?

Thank you for participating in this study. These questions have been formulated as a guide to help you to express your views on your birth experience(s). There is no right or wrong answer to these questions. The information you provide will enable the researcher to gather information about aspects of your cultural practices in relation to birth and your expectations of family and midwives in regards to meeting your care needs.

Section 1: Ascertaining general wellbeing following childbirth

1. How are you feeling since the birth of your baby?
2. Has this changed since giving birth?
3. What might have caused these change(s)?
4. Has anything made it easier for you?
5. Has anything made it more difficult for you?

Section 2: Questions to assess the impact of culture on wellbeing in postnatal period

6. Have you carried out any practices that relate to your Nigerian culture since the birth of your baby?
7. What is your belief about these cultural practices?
8. Have there been any advantages or disadvantages in your health and wellbeing from observing any of these practices?
9. Have you had any health problems as a result of observing these practices?
10. How has the cultural practices influenced your health and wellbeing since giving birth?
11. Do you have specific expectations of midwives in relation to meeting your cultural needs?
12. Who gives you help and support in looking after yourself and your baby?

13. How would you rate this support?

Section 3: Questions to ascertain child care practices

14. Does it matter where and how your baby was born?

15. Does it matter that you had a baby boy or girl?

16. Who in the family names your baby and why is this relevant?

17. Who provides physical care for the baby?

18. Are there cultural requirements about breast feeding or not breast feeding your baby?

19. Are their cultural requirements on circumcising your child?

20. Please tell us about any other childbirth practices in your culture not discussed already?

Thank you once more for participating in this study. The responses you've provided will be kept in strict confidence and only be used for the purpose of this study.

L. Views of first-generation Nigerian women about their cultural practices around pregnancy and childbirth.

Cultural practices requiring preservation and or maintenance, accommodation and or negotiation.	**Cultural Practices requiring accommodation and or negotiation, re-patterning and or re-structuring**
• Different diets (5) • pregnancy is a way of life not a kind of disease • "Childbirth easier at home than here " FG mw 5 • Naming ceremony, christening / birth celebrations (4) • Rest and recuperation • Good support network (2) • Supportive husband (3) **Care issues (Positive attitudes to care systems)** • Appreciative of care systems (2) • Friendly and hospitable	• Increased morbidity/mortality: "back home many people some die through pregnancy". • Myth and misconceptions (4) • Taboos (2) • Work hard: "even to the last minute, they still go…still go about their daily activities". FG wm 3 • Ritual child care practices: "bath, stretch & shake the baby upside down "FG wm 2 (2) • Corset's use instead of doing exercises (2) • Cord care practices & inheritance (4) • Stipulated rest period s(2) • Expected to cope with labour (3) **Care issues (Negative attitude to care systems)** • Poor understanding of care system (2)

M. Views of Nigerian midwives about cultural practices of Nigerian women in pregnancy and childbirth.

Cultural practices requiring preservation and or maintenance, accommodation and or negotiation.	**Cultural practices requiring accommodation and or negotiation, re-patterning and or re-structuring.**
• Faith is important to Nigeria women • Vocal in labour (2) • brilliant attitude to breast feeding: 90% of them will breast feed .(3) • sacred time to recuperate. • "99.9% of Nigerian women will circumcise their boy" QEH mw 1. • Childbirth easier in Nigerian than in Britain "Most women will have normal deliveries there, you get a lot of sections here, a lot of failed inductions here" QEH mw 3 Q4). (1) • Excellent adaptation to motherhood (3) • naming ceremony/birth celebrations and Christening (4) • Fate: "whatever it is, they accept it" QEH mw 2 (2) • Good nutrition (5) • Rest and recuperation periods (3) • Good network of support (3) • Respect for culture and belief QEH mw 3 (2) **Care issues (Positive attitudes to care systems)** • Receptive to screening: majority will not terminate for sickle cell. • Rewarding to look after them postnatally (2)	• Having high carbohydrate diets (2) • Work hard: might have two jobs, working till late into pregnancy (3) and looking after too many children/family (• Unhelpful partner/husband (3) • extra expectations dictated by culture (4) • Stipulated rest periods (3) • Stipulated diets (3) • Purification and sanctification baths (9) • They're really anti-caesarean section (2). • Corset's use instead of doing exercises QEH mw 3 (2) • Administration of substances : water, honey , glucose, etc to neonates (5) • Use of lotions and potions on baby's fontanel (3) • Unsafe cord care practices: "hot ironed cloth, powder etc" QEH mw 4 • Taboos • Family pride/honour (4) • Use of herbs (QEH mw 2) (3) • they're expected to labour with no pain relief (3) • Childbirth a woman's affair (2) • … more secured in having male children QEH mw 2 (3) • Myth and misconceptions: baby body odour, care abroad as private care QEH mw 3 (6) **Care issues (Negative attitude to care systems)** • Poor care access (4) • Poor compliance: "she won't take her medications" QEH mw 1, "we advice them and they do differently QEH mw 4" (6). • Increase morbidity/mortality (2) • Bible references: "Oh! God forbid, I rebuke that,)…..I reject that, the devil is a liar" QEH mw1 • Family interference in decision making about care (3). • they're very argumentative • being extremely demanding QEH mw 4 • "Preference of white mw" QEH mw 4 • extra stress resulting from ecological migration problems (QEH mw 3) (3) • Immigration issues: fear of deportation. (1)

N. Composite list of categories arising from focus group study

Cultural practices requiring preservation and or maintenance, accommodation and or negotiation.	**Cultural Practices requiring accommodation and or negotiation, re-patterning and or re-structuring.**
• have a religious background (3) • brilliant attitude to breast feeding • Good nutrition (5)/ Different diets (5) • male baby 'circumcision' • Childbirth easier in Nigerian than in Britain "Most women will have normal deliveries there, you get a lot of sections here, a lot of failed inductions here" QEH mw 3 Q4). (1) • naming ceremony/birth celebrations and Christening (4) • Fate: "whatever it is, they accept it" QEH mw 2 (2) • Rest and recuperation periods (3) • Good network of support (3) • Respect for culture and belief QEH mw 3 (2) • pregnancy is a way of life not a kind of disease • Good support network (2) **Care issues (Positive attitudes to care systems)** Appreciative of care systems (2) Friendly and hospitable	• Preference of male child: … more secured in having male children QEH mw 2 (3) • Work hard: (3) • Unhelpful partner/husband (3) • Stipulated rest periods (3) • Stipulated diets (13) • Purification and sanctification baths (9) • They're really anti-caesarean section (5). • Corset's use instead of doing exercises QEH mw 3 (2) • Unsafe cord care practices: "hot ironed cloth, powder etc" QEH mw 4 Taboos /Myth and misconceptions: • Ritual baby bath due to baby body odour, • care abroad as private care QEH mw 3 (6) • Family pride/honour (4) • Use of herbs (QEH mw 2) (3) • family expectations (4):they're expected to labour with no pain relief (3) • Childbirth a woman's affair (2) • Cord care practices & inheritance (4) • Family involvement in decision making about care (5) **Care issues (Negative attitude to care systems)** • demanding (3)/used to things being done for them (4) • Poor understanding of care system (2) /Poor care access (4)/Poor compliance resulting from/in: late booking (5), late for appointments (2), not turning up for appointments (4), late transfer of care (4) language difficulty (4), not getting medical history or proper medical history (1), Poor time management skills, Poor care outcome (2), other medical problems: diabetes (2) fibroids, high blood pressure (3). • Family interference in decision making about care (3). • extra stress resulting from ecological migration problems (QEH mw 3) (3) • fear of deportation

O. Research grant application to recruit from Northern Nigeria

THE FLORENCE NIGHTINGALE FOUNDATION

2010 is the Florence Nightingale Centenary Year

APPLICATION FOR A FLORENCE NIGHTINGALE FOUNDATION TRAVEL SCHOLARSHIP 2011

Please type the following information and submit a hard copy or email copy to the Foundation. Hand written forms will not be accepted.

It should contain:

Surname	**Dike**
First name	Priscilla
Title (e.g. Mr/Mrs/Ms/Miss/Other)	Mrs
Date of birth	[redacted]
NMC Pin number	
Expiry date (month and year as shown on your registration card)	November 2010

It is essential that all the above details be correctly given to enable us to check your registration with the NMC

Place of birth	[redacted]
Nationality	British
Home address	[redacted]
Home telephone number	

Mobile telephone number	[redacted]
Home email address	
Present appointment	Senior Lecturer (midwifery)
Work address	The University of Greenwich Southwood site Avery Hill Road London SE9 2UG
Work telephone number	[redacted]
Work email address	
Nursing and/or midwifery education (Starting with most recent. Please include names of colleges and dates of registration.)	• M.Sc in Mother and Child Health (2001): University College London. • B.Sc (Hons) in Midwifery (1998): City University London. • Diploma in Tropical Nursing (1998): London School of Hygiene and Tropical Medicine (UCL). • Registered Midwife (1993) City University London. • Registered General Nurse (1991) Roding College of Health Care Studies, Leytonstone, London.
Other professional qualifications	• Specialist Practitioner and Carrier Counsellor for Haemoglobinopathies (March 2007). • PGDip(HE) (2004) The University of Greenwich.
Summary of relevant health care experience *(Maximum of 150 words)*	[redacted]

Please complete the following about your referees, one of whom should be your current employer and another who is aware of your proposed project:

Reference 1 (Current Employer)**:**	**Reference 2** (Mentor/Advisor)**:**
Name and title Karen Cleaver: Head of Department	Name and title Prof. Ros Corney
Address (including post code) The University of Greenwich Southwood site Avery Hill Road London SE9 2UG	Address (including post code) The University of Greenwich Southwood site Avery Hill Road London SE9 2UG
Email address K.P.Cleaver@gre.ac.uk	[redacted]
Telephone number	Telephone number
Mobile telephone number: none	Mobile telephone number: none

The following information setting out your study proposals under these headings is important as it contains the criteria on which your application will be judged:

Title of Study	**Does culture influence the birth experiences of first-generation Nigerian women?**
Aims/Terms of Reference of the professional study *(maximum 150 words)*	This study aims to explore connections between cultural practices and the wellbeing of Nigerian childbearing migrants in London. The submerged cultural practices, rites, rituals and expectations as practiced by this cultural group in London are studied in order to assess the influence of these on maternal physical and psychological wellbeing throughout the childbirth continuum. This study forms part of MPhil/PhD study.
Anticipated benefits of the study to patients/clients within your area of	This study has the following potential benefits for the participants and the study centres: • Firstly, women who screen positive on depression scales used in this study will be referred to psychiatrists for review and/or treatment,

responsibility *(maximum 300 words)*	• All participants will have access to a counsellor to discuss any issues which may arise as a result of exploring their childbirth experiences. • Opportunities to evaluate maternity care provision in relation to receiving culturally sensitive care. • Opportunity to evaluate the value and/or impact of cultural expectations, rites and rituals on women's health and wellbeing. • Opportunity to compare and contrast cultural childbirth practices in Nigeria and Britain. • Evaluation of effects of acculturation on cultural expectations and practices on childbirth experience. • The potential contribution of their experiences on maternity care provision on the whole. • Possibility of having their expressed views published. • This study may highlight intra−group similarities and/or variability that may aid the development of culturally appropriate maternity care that enhances health, improves satisfaction with healthcare provision and reduces the prevalence of depression among Nigerian childbearing women within the study settings and beyond. • Dissemination will be aimed at Nigerian women, midwifery practitioners, policy makers, psychiatrists, obstetricians, health visitors, global media, and publications will be submitted within these circle. • Equally, anonymised, feedback provided for organizations involved in the project. • A report of the findings will also be submitted to the institute of psychiatry as well as to the centre from where the participants were recruited and any relevant organization involved in the project and a copy of the thesis will be displayed in the library of the researcher's institution. The researcher believes that improving healthcare provision to multi-cultural populations during pregnancy and childbirth must include understanding and deconstruction of concepts of culture, rites, rituals and practices that influence their health and wellbeing.
Country or countries and/or centres to be visited	Nigeria
Rationale for places chosen	Country of origin of original research sample
Expected length of visits	A month to two months

Proposals to disseminate the knowledge and experience acquired	Implications for practice will be drawn and recommendations made to enhance contemporary practice. Dissemination will be aimed at midwifery practitioners, policy makers, psychiatrists, obstetricians, health visitors, global media, and publications will be submitted within these circle. A report of the findings will also be submitted to the institute of psychiatry as well as to the centre from where the participants were recruited and any relevant organization involved in the project.
Any other relevant information *(maximum 150 words)*	The study is in three parts encompassing: literature review, semi-structured focus group interviews of Nigerian women, focus group interviews of focus group interviews of Nigerian midwives, non-Nigerian midwives and a longitudinal study of six Nigerian parturient women at: 24−28 weeks of pregnancy,6 weeks after giving birth and at 3 months postnatal using a semi−structured questionnaire. Edinburgh Postnatal Depression scale (EPDS) will be completed by each woman at each stage of the study. Data from the three parts will be compared and contrasted for similarities and differences of views pertaining cultural practices of Nigerian women. This sponsorship is sort to enable the researcher to travel to Nigeria to recruit women from Northern Nigeria: a population so far unrepresented due to lack of their presence in London. So far the population recruited for this study has constituted mainly two tribes: Ibo's and Yoruba's, while the Hausa tribe of Northern Nigeria remain unrepresented. The inclusion of this population group is vital to boost robustness of the study by enhancing inclusiveness/representation of the three main tribes of Nigeria; thereby making the findings more applicable and relevant to the three dominant tribes.

Please do not send copies of previously written articles in lieu of this paper.

If you are shortlisted to attend for interview, you will then be asked to provide an estimate of the amount of money you would require to undertake this project. If you are applying for or have obtained funding from elsewhere, please inform us at this stage. Please note that we cannot pay for secretarial assistance, computers, stationery, and replacement staff costs or for unpaid study leave while the Scholar is undertaking the study.

The quality, not quantity, of this information and its presentation will be an important part of the selection process.

If you are awarded a scholarship we can put you in touch with past scholars who are willing to advice and act as mentors if required. Former scholars can also help with overseas contacts.

A hard copy of this information or an email copy should be returned no later than ***Friday 20 August 2010 to***:
Professor Elizabeth Robb

Chief Executive

The Florence Nightingale Foundation

Email: admin@florence-nightingale-foundation.org.uk

Applications will not be acknowledged until after ***Monday 20 September 2010.***

CANDIDATES WHO ARE SHORTLISTED WILL BE INTERVIEWED IN LONDON ON THE FOLLOWING DATES: 28, 29 OCTOBER and 1, 2 NOVEMBER 2010. ANY CANDIDATE WHO IS UNABLE TO ATTEND FOR INTERVIEW AT THIS TIME CANNOT BE CONSIDERED.

Travel expenses to attend for interview will be reimbursed from home or place of work.

The Foundation complies with the provisions of the Data Protection Act 1998.

P. Grant presentation invitation email.

From: Priscilla Dike
Sent: 21 October 2010 18:14
To: 'admin@florence-nightingalefoundation.org.uk'
Cc: Roslyn Corney
Subject: The Florence Nightingale Travel Scholarship 2011

Dear Professor Robb.
Thank you for the positive consideration of my application for the above award and especially for the invitation to the 28th October interview. I am truly honoured by your invitation. I had mapped out a period for this travel but regrettably, this time has not been granted to me due to internal commitments of my employer. I therefore write to make a plea for the postponement of my interview and/or transfer of my current application to 2012 awards (where possible). Thank you once more as I eagerly await your response to my plea. My MPhil/PhD supervisor is copied in for information.
Kind Regards
Priscilla Dike
Senior Lecturer (midwifery)
Family Care and Mental Health department
School of Health and Social Care
Avery Hill Road
London SE9 2UG
Phone: 020 8331 9294

RE: The Florence Nightingale Travel Scholarship 2011

Florence Nightingale Foundation [Admin@florence-nightingale-foundation.org.uk]

Sent: 25 October 2010 14:05

To: Priscilla Dike

Dear Priscilla

Many thanks for your email informing us that you are unable to attend for interview. Professor Robb is disappointed at the late notice given as this slot could have been given to another applicant. There is no possibility to transfer your application to the following year and given your late application this would be taken into account in any further application.
Kind regards
Stephanie Dawes
Administror.

Q. Edinburgh Postnatal Depression Scale: Taken from the British Journal of Psychiatry June, 1987, Vol. 150 by J.L. Cox, J.M. Holden, R. Sagovsky.

Instructions for users:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women.

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Question numbered 3,5,6,7,8,9,10 are reverse cored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The EPDS was developed at health centers in Livingston and Edinburgh. The validation study showed that mothers who scored above threshold 92.3% were likely to be suffering from a depressive illness of varying severity. The scale indicates how the mother has felt during the previous week and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorder.

Name: _____
Address: _____
Baby's Age: _____
As you have recently had a baby, we would like to know how you are feeling. Please mark the answer which comes closest to how your have felt **in the past 7 days**, not just how you feel today.
Here is an example, already completed:
I have felt happy:
__ Yes, all the time
_**X**_ Yes, most of the time
__No, not very often
__No, not at all
Since the second choice is checked, this would mean, "I have felt happy most of the time during the past week". Please complete the following questions in the same way.

1. I have been able to laugh and see the funny side of things.

___ As much as I always could

___ Not quite so much now

___ Definitely not so much now

___ Not at all

2. I have looked forward with enjoyment to things.

___ As much as I ever did

___ Rather less than I used to

___ Definitely less than I used to

___ Hardly at all

3. I have blamed myself unnecessarily when things went wrong.

___ Yes, most of the time

___ Yes, some of the time

___ Not very often

___ No, never

4. I have been anxious or worried for no good reason.

___ No, not at all

___ Hardly ever

___ Yes, sometimes

___ Yes, very often

5. I have felt scared or panicky for not very good reason.

___ Yes, quite a lot

___ Yes, sometimes

___ No, not much

___ No, not at all

6. Things have been getting on top of me.

___ Yes, most of the time I haven't been able to cope at all

___ Yes, sometimes I haven't been coping as well as usual

___ No, most of the time I have coped quite well

___ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.

___ Yes, most of the time

___ Yes, sometimes

___ Not very often

___ No, not at all

8. I have felt sad or miserable.

___ Yes, most of the time

___ Yes, quite often

___ Not very often

___ No, not at all

9. I have been so unhappy that I have been crying.

___ Yes, most of the time

___ Yes, quite often

___ Only occasionally

___ No, never

10. The thought of harming myself has occurred to me.

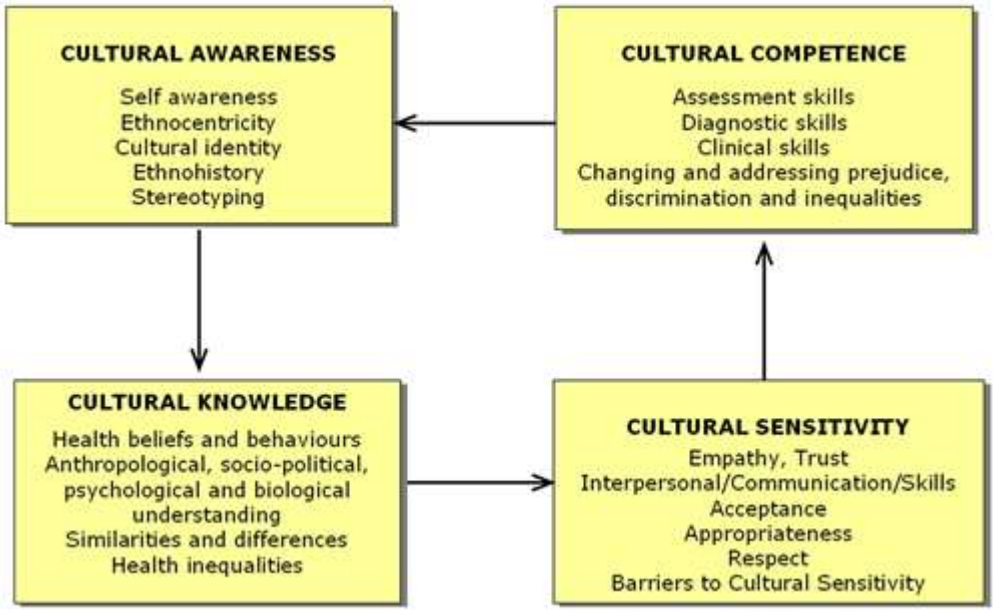
___ Yes, quite often

___ Sometimes

___ Hardly ever

___ Never

S: Papadopoulos et al (2008) Cultural Competence Model



T: Leininger's Culture Care Theory (CCT) (2002)