

**Access to and use of healthcare services by
Palestinian women in the UK.**
Focusing on Maternal and Child Healthcare Services

Eman Alshawish

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List of Abbreviation

A&E departments	Accident and Emergency Departments
ASSIA	Applied Social Science Index and Abstracts
ANOVA	Analysis Of Variance
AMUs	Alongside Midwifery Units
AWHONN	American Association of Women's Health, Obstetrics and Neonatal Nursing
BCG vaccine	Bacillus of Calmette and Guerin vaccine
BME	Black and Minority Ethnic group
BNI	British Nursing Index
CARE	Cooperative for Assistance and Relief Everywhere
CMACE	Centre for Maternal and Child Enquiries
CINAHL - EBSCO	Cumulative Index and Abstracts for Nursing and Allied Health Literature
DV	Dependent Variable
DOH	Department of Health
EPDS	Edinburgh Depression Scale
FMUs	Free-standing Midwifery Units
JNC	Journal of Clinical Nursing
EBM	Evidence-based Medicine
GP	General Practitioner
GUBS	General union of Palestine students
HCC	Healthcare Commission
HCP	Healthcare Programme
IV	Independent Variable
MCH	Maternal and Child Healthcare
MOH	Ministry of Health

MEDLINE	Medical literature on-line
MIDIRS	Maternity and Infant Care
N	Number
NA	Not Available
NHS CRD	National Health system - Centre for Reviews and Dissemination
NGOs	Non-governmental Organisations
NICE	National Institute of Clinical Excellence
NPEU	National Perinatal Epidemiology Unit
PLO	Palestinian Liberation Organisation
PhD	Doctor of Philosophy
(RR(A)A)	Race Relations (Amendment) Act
SPSS	Statistical Package for the Social Sciences
PBCS	Palestinian Central Bureau of Statistics
UK	United Kingdom
USA	United States
UNRWA	United Nations Relief and Work Agency
UKOSS	United Kingdom Obstetric Surveillance System
WHO	World Health Organisation

Abstract

The UK has a relatively large and increasing Black and Minority Ethnic (BME) population. It is acknowledged that this group has, until now, experienced poorer health, and that there have been barriers for them accessing certain services. There are an increasing number of women from Palestine currently living in the UK. Their access to, and use of, maternal and child healthcare (MCH) services have not been investigated before. From an initial review of the literature there does not appear to be any research which has examined Palestinian women's access to and use of MCH services. This study will address these gaps and explore the access and use of MCH services by Palestinian women in the UK.

The overall aim of the study is to investigate the access to, and use of, MCH in the UK by Palestinian women. The specific objectives are: to explore facilitators and barriers to care for Palestinian women in the UK; to determine what provisions exist which are intended to facilitate access to healthcare services; to explore factors that may demonstrate effective and positive change to health services and to make recommendations for improving the health service provision for Palestinian women in the UK.

The study was designed to use a sequential, exploratory, mixed-method, pragmatic approach. In phase one - twenty-two, in-depth, face-to-face, semi-structured interviews were conducted. In phase two - survey questionnaires were distributed through the Palestinian organisations to generalise the qualitative findings and 243 questionnaires were returned from responders.

Four themes emerged from the findings of the qualitative interview, which were: 'cultural variations'; 'knowledge of the NHS and the UK healthcare system'; 'healthcare services and their utilisation, focusing on maternal and child healthcare services,' and 'communication, information provision and needs'. The quantitative findings focused on issues specific to Palestinian women, although they might resonate with other BME groups. These include: cultural variations, such as the use of herbal medicine; self-prescribed medication (antibiotics); termination of pregnancy (fatalism); circumcision for male babies; breastfeeding practice and preference for a female GP and caregiver; knowledge of the UK health system; confidence in using the English language; interpreter services; late booking of pregnancy; not attending antenatal classes; duration of visit time and information needs.

This study strives to reduce inequalities in MCH among Palestinian women in the UK by highlighting the issue surrounding Palestinian women's access to, and use of, MCH services. It is important to have a culturally sensitive MCH service that is flexible, adequate and accessible. The study concludes with the following recommendations:

- Having cultural competence care and adaptive services for Palestinian and all minority ethnic groups are crucial to have equitable services.
- Culturally appropriate care could be satisfactorily achieved through effective and continuous training programmes based on culture, ethnicity and religion for all health professionals, in order to understand patient needs.
- Interpretation services should be provided to Palestinian women who have the need. Midwives or nurses should provide oral explanations as well as leaflets to allow patients a full choice when making a decision.
- An important implication for midwifery-nursing practice is that, when developing education interventions for this population, it may not be appropriate to implement a "One Size Fits All" programme.
- Another practical suggestion is to have a videotape/podcast provided explaining all the required information in English and Arabic languages. This could increase the patients' knowledge about using and accessing healthcare services

The Author

The author completed her Bachelor's degree in Nursing from Quds University - Jerusalem in 1996 then worked as a staff nurse and supervisor for seven years in Augusta Victoria Hospital in different departments but mainly in Paediatric and Maternity wards. This raised her interest to enrol in a Master's programme of Maternal and Childhood care "MCH", which was the first such programme established for nurses in Palestine. By 2003, she gained her Master's degree in MCH. The author's research interests are related to women's health in general and MCH in particular, therefore her Master's thesis title was "Osteoporosis among Palestinian Women, Evaluation of Risk Factors", at that time this was the first study in Palestine that revealed this silent disease among Palestinian women. The study revealed that 25% of the sample had osteoporosis or osteopenia that needed more attention.

In September 2009 the author commenced her doctoral studies. The interest increased regarding the health of women in exile once she started to integrate with a new society in the UK, therefore she decided to investigate how the Palestinian women as one of the minority ethnic groups are accessing and using the healthcare services in the UK, particularly MCH services. In the first semester of her PhD study, the author became pregnant and underwent major surgery several weeks after giving birth. Therefore, she used the NHS services regularly for her and her baby later on. This experience stimulated her to compare the healthcare system in her home country and the UK. Thinking of other Palestinian women living in exile who suffer from different types of challenge was exciting. Therefore, sequential, mixed-method research starting with an exploratory qualitative study was begun to explore the problem, followed by a survey of a larger number of Palestinian women.

The author's background in Palestine was as a staff nurse in Augusta Victoria Hospital - Jerusalem; nursing director in a private hospital mainly offering maternity services; as a teacher and instructor in the nursing and midwifery college at An Najah University and Ibin Sina College; and working with different USA projects (CARE international organisation - field manager) to improve the maternity and child health in the West Bank. She also has unique experience in using the NHS in the UK. Additionally, the researcher worked as a reviewer for the Journal of Clinical Nursing (JCN). All this personal and professional experience has influenced and contributed to her ability to produce this work. In parts of this thesis, she has written about her own experience, especially the absence of adequate supportive literature in some places.

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Publication & Conference papers arising from the thesis

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Alshawish (2013). Access to, and use of, maternal and child healthcare (MCH) services in the UK by Palestinian women, *Research Institute for Health and Social Change 9th Annual Conference, Manchester, UK, 4-5 July*

Alshawish (2013). Methodological challenges in conducting Sequential Exploratory Mixed Methods research. *Research Institute for Health and Social Change 9th Annual Conference, Manchester, UK, 4-5 July*

Please see Appendix 1.1 for conference papers & Appendix 9.1 for publication article.

Foreword: Thesis organisation

The thesis is organised into ten chapters. It starts with the introduction chapter pertaining to the study's background. Chapter Two covers the Maternal and Child healthcare services in the UK. Chapter Three presents overviews of the related literature covering the access to, and use of, MCH services by minority ethnic groups, followed by a discussion of the overall research design in Chapter Four. There were two phases of investigation, with qualitative interviews being the first phase and a questionnaire survey the second. Every phase of research has its own data collection, analysis and discussion. The next four chapters (Chapters Five, Six, Seven and Eight) discuss the research methods and findings from each phase respectively. Chapter Six includes qualitative findings and discussion. Chapter Nine discusses the quantitative phase findings in relation to existing literature and NHS policy documents. Finally, Chapter Ten concludes the thesis by discussing the originality and implications of the study findings and the refocused aims of this study. In addition, the significance of the findings for nursing practice and the policy agenda and the study's recommendations are also discussed in this chapter.

CHAPTER ONE

Introduction

Chapter One – Introduction

1.1 Background

The United Kingdom (UK) has a relatively large and increasing Black and Minority Ethnic (BME) population (Szczepura, 2005). It is acknowledged that this group has until now experienced poorer health, and that there have been barriers to them accessing certain services (Szczepura, 2005). A major challenge for clinicians, managers, and policy makers in the coming decades in the UK is to ensure equitable access to healthcare services for all groups, including BME groups. This challenge was emphasised following the implementation of the Race Relations (Amendment) Act (2000), which requires the National Health system (NHS) to examine and adapt services in order to ensure equitable access for local BME populations (Szczepura, 2005).

In 1996, the NHS recommended the following steps to improve the health services for BME groups: awareness, understanding, people involvement and active group commitment (National Health Services, 1996). Importantly, the client was considered to be central to the process. Also, it is important for community health workers to have a good understanding of the demographic and social characteristics of particular ethnic groups so as to improve their practice (Chan, 2000). Sheikh recently found that it was difficult to measure progress in this area due to insufficient national data on access to services by various groups (Sheikh, 2009). Data about differences in health status among ethnic groups in the UK are limited and patchy, and in some cases data on certain ethnic groups is extremely limited, for example Irish and Chinese groups (Smith *et al.*, 2000). The concept of equity of access to healthcare is an important founding principle of the UK National Health Service (Goddard & Smith, 2001). Therefore, the priority of the Department of Health (DOH) is to reduce health inequality (Department of Health, 2009a; Department of Health, 2009b). In order to reduce these inequalities that are related to ethnicity, Acheson (1998) has recommended considering the needs of BME groups in health inequalities policies; having sensitive services that meet their needs; and then considering this group's needs in planning and resource allocation.

Globally, half of the migrant population are women; they represent 80% of the total migrant population in some countries. The maternal mortality rate is higher among asylum seekers and minority ethnic groups than among native women (Jentsch *et al.*, 2007). In the UK, 53% of foreign nationals are women (Research Development and Statistics Directorate, 2001) and Maternal and Child Healthcare (MCH) is thus an important issue to explore and improve.

MCH services must be delivered for a diverse range of needs and in a culturally sensitive manner. Therefore, the current study aims to investigate the access to, and use of, MCH services by Palestinian women. In order to introduce this topic, Chapter 1 consists of two parts. In part one, the ethnic diversity of the UK population will be examined followed by a discussion of the Palestinian Diaspora and a description of Palestinian culture and healthcare services in Palestine. Part two considers ethnicity, culture, race, socio-economic status and racial discrimination, institutional racism and evidence of inequity and poverty will be explored in order to consider why minority ethnic groups may have problems in the access and use of healthcare services.

1.2 UK Population Diversity

The UK population consists of multi-ethnic groups; the 2001 UK Census classified ethnicity into several groups: White, Black, Asian, Mixed, Chinese and Other. The minority ethnic groups in 2001 represents almost 7.9 % (4.6 million) of the total population (Office for National Statistics, 2001). In the 2011 Census this figure increased to 14.1% of the overall total population (Office for National Statistics, 2011).

From the 2001 Census, there were 392,819 people in Greater Manchester. BME groups made up 19% (74,806) of the population, an increase from 12.6 % in 1991 (Manchester City Council, 2001). In London, there were 7,172,091 people and BME groups made up 28.8% (2,065,536) of London's population (Office for National Statistics, 2001). The Palestinian population is categorised under 'other Asian group' in previous censuses. The 'other Asian group' accounts for 0.8% of the total population in Manchester (Manchester City Council, 2001), and 1.9 % of the total population in London (Office for National Statistics, 2001).

In the 2011 Census, the question simply asked about 'your ethnic group or background' and there were categories added for White Gypsy or Irish Traveller and Arab. This latest Census provides for the first time a picture of the Arab population in the UK, which includes the

Palestinian people. They account for 240,000 usual residents, 0.4 per cent of the population (Office for National Statistics, 2011). This group is more youthful in age structure than other segments of the population, which means that minority ethnic population growth will remain rapid over the coming years (Manchester City Council, 2001).

The information about certain minority ethnic groups, such as asylum seekers, is poorly recorded and difficult to find in sources such as the Census and other national datasets, such as the Labour Force Survey for migrant workers (Szczepura, 2005). It was estimated in 2006 that 190 million people were living outside their countries of origin and, in 2005, the UK hosted 270,000 refugees. Worldwide, women constitute approximately 70-80% of the total migrant population (Birgit *et al.*, 2007). It is known that the maternal mortality in the UK is higher among these groups than among white native women (Birgit *et al.*, 2007). According to the UK Home Office website, there were 30,675 applications for asylum in 2009. In 2010, the number of applications during the first and second quarters (January-July, 2010) was 17,540 (Home Office, 2010). Asylum seekers have great health needs, possibly as a consequence of their status (Arora *et al.*, 2000). Moreover, they may be unaware of their rights to receive healthcare and a lack of knowledge about how to access health services (Arora *et al.*, 2000). These facts suggest that tailored maternity care provision is essential for BME groups and for asylum seekers.

The predominant religion among Palestinian people is Islam. In the UK, the total number of Muslims is approximately 1.6 million and they comprise over half the UK's non-Christian population (Laird *et al.*, 2007). This figure is expected to increase as the Muslim groups have a much younger age profile than the rest of the population (Donald & Rattansi, 1992). Their communities in the UK are ethnically, historically, culturally and linguistically diverse, including immigrants and the native born (Laird *et al.*, 2007).

In order to contextualise the study, the following section provides information about the Palestinian Diaspora to understand why Palestinian people move to the UK. This is followed by an insight into Palestinian culture with its rich array of beliefs, expectations, preferences and behavioural make up.

1.3 Palestinian Diaspora

Palestine is one of the Arabic countries in the Middle East. The population of Palestine in 2009 was estimated at 3,935,249, which increased to 4,048,403 in 2010 (West Bank and East Jerusalem). In addition, the population of the Gaza Strip in 2009 and 2010 was 1,486,816 and 1,535,120 respectively (Palestinian Central Bureau Statistics, 2010). The Palestinian population in 1947 was 1,303,585 and thirty-four years later, the Palestinian population totalled 4.5 million, 60% of whom were living outside the territory of the former mandate (Smith, 1986). The Palestinian community constitutes more than half the population in Jordan. Others are resident in Lebanon, Syria, Kuwait, Saudi Arabia, the Gulf States, Egypt, Libya, Iraq and Cyprus (Smith, 1986). In 1967, Israel occupied the Palestinian territories of the West Bank, including East Jerusalem, and the Gaza Strip. The occupation and wars in 1948 and 1967 caused a forced migration of the Palestinian people. As a result, the Palestinian refugee population is considered to be one of the largest in the world. Nur states that 70% of Palestinians are refugees (Nur, 2008). They have been excluded from the international protection regime, including the 1951 Convention on the Status of Refugees (Shiblak, 2005). This Convention, held in Geneva, regulates the legal status of refugees. The aim of the Convention is to define certain basic human rights of refugees, for example, non-refoulement. The Convention contains a 'conceptual' definition of the term 'refugee' as "a person who, as a result of events occurring before 1 January 1951, is outside his or her former home country because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion" (Jackson, 1991: 405). One item had added to this Convention: this law does not apply to persons who receive support and assistance currently from organs or agencies of the United Nations. Therefore, Palestinian refugees who are assisted by UNRWA are not included in the 1951 Convention relating to the Status of Refugees (El-Abed, 2005).

The term 'Diaspora' is derived from the Greek verb *spero* (to sow) and the preposition *dia* (over). Cohen pointed out that for some communities, such as Palestinian or Jewish people, Diaspora is signified as 'a collective trauma, a banishment, where one dreamed of home but lived in exile' (Cohen, 1996: 507).

There are three ideal classifications of Palestinian status abroad which express their present situation. The first type is "Diasporised people"; their identities refer to both host-land and homeland. The second is "population in transit"; which means this population has a

precarious juridical status in their host country. The third classification refers to the “assimilated people”, which means “the dilution of an individual into the host country’s identity” (Lei & Weingrod, 2005: 107). Another classification of Palestinians abroad is linked to homeland. The first category refers to Palestinians who migrated before 1948 to escape from Ottoman military service. The second category concerns the 1948 exodus from Palestine after which they lost their right to return. The third category is voluntary migration, the Palestinians who emigrated for economic reasons to the Gulf States, the United States and other countries (Lei & Weingrod, 2005). Although Shiblak (2005) describes the presence of large numbers of Palestinians in Europe as a recent phenomenon and these numbers are on the increase, the author argues that there is a Palestinian Diaspora in ever more complex formation. A victim’s Diaspora is a special dimension that has occurred following the establishment of the State of Israel in 1948.

1.4 Palestinian culture

Palestinian culture is not homogenous. However, the main features highlight the key elements that might influence women’s access to, and use of, MCH services, such as family, daily life, etiquette, religion, gender, traditions of birth and circumcision, herbal medicine in Palestine and self-medication practice.

1.4.1 Family

As highlighted in section 1.2, Palestine is one of the Arabic countries and the Arabic Islamic culture is the main influence on people’s values, beliefs and rituals. The majority of Palestinian society is traditional, hierarchical and centred on the family (Multicultural America, 2006). There is a dominant value in every culture. The central value of the Arab family is honour, loyalty, obligations, responsibility and unity (Patai, 2002). The family structure is extended, consisting largely of grandparents, aunts, uncles, nieces and nephews. Children are taught to respect their elders, as age is considered to bring wisdom and experience (Hammad *et al.*, 1999). Individuals are considered to be part of the family structure and not separate units, and this leads to a patriarchal hierarchy (Nasir & Nasir, 2006). The family forms the primary source of support for its members, whether their needs are emotional, physical or financial. During illness or crises, the expectation is to have constant support from family, friends and neighbours rather than to cope alone (Multicultural America, 2006). When a Palestinian family moves to another country, they consider this migration as a big challenge, because they must cope alone without the support of family and

friends. Hattar-Pollara and Meleis (1995) state that immigrant women of Arab origin should adapt to a new culture by learning the new language and incorporate a variety of added roles without relinquishing their previous roles. It is required from them in western society to maintain cultural continuity whilst establishing a balanced family life.

1.4.2 Daily life and etiquette

It is generally socially expected that people greet each other as they pass in the street, even if they do not know each other. Men shake hands on meeting, and women kiss one another on the cheeks. Palestinians are friendly and hospitable, it is common to invite each other for lunch or dinner. It is considered polite to initially turn down a dinner invitation to avoid imposing, but the host will continue to insist on the guest's company at which point the guest should accept (Multicultural America, 2006). Palestinian society is very conservative by Western standards, where the traditions, culture and Islamic beliefs govern the communication between people. Men and women are forbidden to have sexual relations before marriage (Ahmad, 2004).

1.4.3 Religions

The vast majority of the Palestinian population is Muslim, most of whom are followers of the Sunni branch of Islam. Palestinian Christians represent a significant minority, followed by much smaller religious communities, including Druze and Samaritans. The Palestinian population of the West Bank and Gaza Strip is 97% Muslim and 3% Christian (The Palestinian Academic Society for the Study of International Affairs, 2009). Both Christians and Muslims are living peacefully and have holy sites in Palestine that are visited by pilgrims from around the world. It is common to hear the church bell every Sunday and the call for prayer in public. Muslims pray 5 times a day, usually women pray at home and men either in the Masjid or at home. All prayers are said facing Mecca. Each Muslim is expected to make a pilgrimage (*hajj*) to Mecca at least once in his or her lifetime (Multicultural America, 2006).

1.4.4 Gender issues

Men are at the centre of Palestinian life as in other Arab cultures. A man is a spokesperson and a decision maker for a family, while the women are the chief caregivers for children. Women are expected to fulfil the traditional role of homemaker. The traditional view of women in Arab society that they should be primarily committed to the house is inconsistent with the current push in the United Arab Emirates and other Arab countries, where there is an

increasing number of females in the labour market (Whiteoak *et al.*, 2006). Gharaibeh and Abu-Saad (2002) state that decision making is negotiated within the family in Jordan. However, there is an assumption that decisions should not be taken in the absence of the head of the family. This assumption is somewhat present in Palestinian society and the older male family member can play this role and become the head of family. In specific situations, especially during Intifada, the woman takes the full responsibility until her male son becomes old enough to fill this position.

For a woman to expose her body is not accepted, therefore women usually wear the traditional Muslim dress *jilbab*, a long jacket-like dress with a scarf to cover their hair. The majority of Palestinian men prefer their women to work at home or in local cottage industries. Despite the men's views and traditional influence, women are beginning to break out of these roles. The main reason is that under Israeli occupation, the military government arrested many men for political activities; therefore, women were forced to fill in for men held in prison. Women thus assumed jobs and became heads of households and filled male roles inside and outside the home. Having attained prominent social and professional roles, many women now insist on equality of the sexes. However, in healthcare settings, women and men prefer to be treated by a healthcare professional of the same gender. If this is not possible, women treated by male healthcare workers must be chaperoned in Palestine.

1.4.5 Circumcision and birth tradition

Childbirth is considered an important aspect of marriage. The Islamic religion favours having children, and, in addition, Palestinians feel that reproduction is an important national (patriotic) duty. Moreover, the number of male children plays a big role in helping the mother's stability in life, because, not having a male child is a big issue and forces a husband to consider taking another wife.

Traditionally in Palestine, women receive more care during pregnancy and post-delivery if they are carrying a baby boy but are ignored if carrying a girl. It is normal for Palestinian women to have multiple pregnancies until a boy is born. A boy child is viewed as a source of help for their parents in the future, having females as a source of suffering. A male has freedom of action and it will be culturally accepted but this does not follow for a female. Post-delivery, all the attention and care is focused on baby care, feeding, protection and not

on the mother's health. It is common to see a boy baby wearing a blue pendant in the first few months, because this practice is believed to protect the baby from "the evil eye".

Male children are circumcised and the family holds a great feast to celebrate the occasion (Fernea, 1995). A male circumcision is the surgical removal of some or the entire foreskin from the penis. This practice is greatly influenced by cultural and religious traditions. Nothing is mentioned in the Qur'an regarding circumcision, but it is reported in Hadeth that the prophet Mohammed mentioned that: "Five practices are characteristics of the Fitra: circumcision, shaving the pubic region, cutting the moustaches short, clipping the nails, and depilating the hair of the armpits". (Siddiqi, 1982; Khan, 1997). The word Fitra is related to instinct and the natural way of cleanliness. Circumcision is performed at an early age, usually on the 7th day after birth, or up to 40 days after birth or any time before the age of 7 years, depending upon the infant or child's health. Traditional and religious practice in Palestine prohibits female circumcision.

The British Medical Association's position is that circumcision should be done for medical reasons only and not as routine for a male boy (Williams & Kapila, 1993; British Medical Association, 2004). Courts in the UK have described non-therapeutic circumcision as an irreversible decision (Law Commission, 1995). The 1996 guideline on circumcision was replaced by a new statement in 2003 and revised 3 years later stressing the lawfulness of non-therapeutic circumcision in the UK (British Medical Association, 2006).

Male circumcision has been the subject of debate, on the one hand, many studies have supported this practice as a routine procedure for a newborn male in preventing certain diseases such as urinary tract infections (Chin, 1992; Wiswell & Roscelli, 1986), whilst on the other, some studies have stated that evidence does not justify a routine circumcision for a newborn male (Hirji *et al.*, 2005; Van Howe, 2004).

1.4.6 Breastfeeding

Breastfeeding is a common practice among Palestinian women. It is desirable traditionally and religiously for mothers to suckle their children. The Holy Quran underscores the right of infants to be breastfed and encourages the mother to suckle her offspring for 2 years if possible (Ali, 2011). From Al-Baqarah verse 233 "The mothers shall suckle their offspring for two whole years, (that is) for those (parents) who desire to complete the term of suckling"

(The Holy Quran). In Palestine, evidence has shown that breastfeeding continues for the first eight months without gender differentials. However, mothers breastfeed male infants more than females after ninth months (Palestinian Central Bureau Statistics, 2005).

1.4.7 Prenatal diagnosis and termination of pregnancy

Culture and religion have a big impact on health decisions. A factor contributing to an increase in the rate of genetic disorders in Palestine and Arabic countries is marriage between relatives. Approximately 25%-60% of all marriages are consanguineous and the rate of first cousin marriage is high among the Palestinian population (Amayreh, 2012). Consanguinity can be defined as a union or marriage between couples who are related as second cousins or closer (Al-Salem & Rawashdeh, 1993; Amayreh, 2012). The main ways of preventing genetic disorders are prenatal testing and abortion (Zlotogora & Reshef, 1998). Within Palestinian culture, abortion is illegal and Islam's approach allows women to prevent pregnancy but forbids them from terminating it. It is mentioned clearly in the Quran that a child should not be killed. A favoured text to support this is from Surah, Al-An'am, 6:151 : "Do not kill your children for fear of poverty for it is We who shall provide sustenance for you as well as for them." (The Holy Quran). Abortion is permitted in Islam if the mother's health is endangered, the text from Surah Al-Baqara, 2:233 mentions, "A mother should not be made to suffer because of her child" (The Holy Quran). Moreover, Fatwa allows termination of pregnancy in the first 120 days after conception if the foetus is shown beyond doubt to be affected with severe malformation that is not amenable to treatment (Al-Gazali *et al.*, 2006). Arabs believe that health and illness are the will of God. This indicates that humans have no control over their health or illness (Zahr & Hattar-Pollara, 1998). Many studies have shown that a significant number of Arab women choose not to terminate their pregnancy, even when the foetus is affected, if the diagnosis is late in pregnancy (Sheiner *et al.*, 1998; Zlotogora & Reshef, 1998), because they perceive that as a test of their faith in God and their patience (Hammoud *et al.*, 2005).

1.4.8 Herbal Medicine in Palestine

Traditional remedies, such as herbal medicine are part of the cultural and religious life of Palestinian people. This is due to popular belief that using plant medicine is safer than manufactured drugs. However, there is no published data regarding self-therapy using herbal

products in the Middle East and Palestine (Sawalha, 2008a). Palestine is famous for its wealth of plant species and its unique diversity of geographical characteristics. More than 2,600 plant species exist in the mountains of Palestine and about 700 are noted for their use as medicinal herbs or as botanical pesticides (Silva & Abraham, 1981). More than 184 different plant species are currently in use for treating different diseases and illnesses (Jaradat, 2005).

The well-known plants commonly used are White Sage, Anise, Cinnamon and Caraway (Shtayeh, 2010). Based on Palestinian belief, Cinnamon increases uterine contraction, therefore it is not recommended to pregnant women, but for women post-delivery. Caraway is a popular drink for women after delivery; the belief is it helps to increase their haemoglobin level, while White Sage and Anise are claimed to relieve abdominal pain. A recent study revealed that a large percentage of pregnant women have used herbal medications in Palestine to treat pregnancy-related or pregnancy-unrelated problems (Sawalha, 2007). This is because the pregnant women may consider herbal medication safer during pregnancy than pharmaceutical products (Hollyer *et al.*, 2002). It is clear that herbal medicine plays a pivotal and indispensable role in the current public healthcare of Palestinian people, especially the pregnant women. The relative lack of evidence of either efficacy or harm of these herbal medications increases the problem. Therefore, it is crucial for healthcare providers to ask about and document the use and safety of herbal drugs in pregnancy (Sawalha, 2007).

1.4.9 Self-medication practice

This practice is common in Palestine; people can obtain medication such as antibiotics or some type of sedatives without a prescription. Therefore, the utilisation of a prescription and/or non-prescription medication without prior medical consultation has occurred frequently among Palestinian people (Sawalha, 2008b). Many studies have highlighted self-medication practice among Palestinians, the misuse of antibiotics is especially common and inappropriate (Sawalha, 2008b; Sweileh, 2004). A survey among 1093 government teachers in Palestine regarding their attitude and practice toward antibiotics has revealed their misuse (Sawalha, 2008a). Just over 42.2% of participants administered antibiotics to their children without medical consultation and 52.3% stored antibiotic leftovers for further use (Sawalha, 2008a). Similar studies in Jordan (Albsoul-Younes *et al.*, 2010) (Sawair *et al.*, 2009) and Dubai (Abasaheed *et al.*, 2009) found antibiotic self-medication to be a frequent practice. A study in Egypt found that being younger than 30, illiteracy, being a housewife, primigravida

and a history of abortion are factors associated with poor knowledge of drug use during pregnancy (Rizk *et al.*, 1993).

In order to overcome this entrenched practice, health policy makers should take action to control it by increasing public awareness and strengthening pharmaceutical law in Palestine (Sawalha, 2008b).

Finally, the culture and religion of Arabs in general and Palestinians in particular can greatly influence their perspectives about healthcare and, as a consequence, their access and use of healthcare resources. Understanding their beliefs and background can help to deliver the services in more culturally-sensitive ways.

1.5 The healthcare system in Palestine

If we are to understand Palestinian women's use of the NHS, it may be necessary to have some awareness of the system with which women who have moved from Palestine to the UK are themselves familiar. This section presents a brief history and description of the current healthcare system in Palestine, and focuses on the health status and maternity services in Palestine.

1.5.1 A brief history of the healthcare system in Palestine

The Declaration of Principles was signed by the Palestinian Liberation Organisation (PLO) and the Israeli Government on limited self-rule on the Gaza Strip and areas in the West Bank in 1993. By 1994, following the Oslo Peace Accord, the responsibility for the health sector in the Gaza Strip and the West Bank had been taken over by the Palestinian Authority (Hamdan & Defever, 2003). The four systems that offered health services were the United Nations Relief and Work Agency (UNRWA), the Israeli Civil Administration, Non-governmental Organisations (NGOs) or private, not-for-profit organisations and private clinics. These four systems have developed independently without any overall plan, coordination or regulation. The result has been a costly health service, inefficient resource allocation with overlapping services in some places while other areas are under-covered, great variation in the quality of care, lack of standards and regulatory mechanisms and an unclear division of responsibility between the public and private providers (Giacaman *et al.*, 2009).

1.5.2 Brief description of the current overall structure

Currently, there are four major health service providers in Palestine: The Ministry of Health (MOH), the United Nations Relief and Work Agency (UNRWA), Non-governmental Organisations (NGOs) and private, for-profit providers. The Ministry of Health is considered the main health service provider. It provides primary, secondary and some tertiary health services and purchases some tertiary services from private providers, both domestically and abroad. The Ministry of Health is the key provider of immunisation schemes and public health activities and the licensing and registration of private clinics and non-public health institutions. The government health insurance scheme covers only the civil service employees and voluntary individuals and groups in addition to the poor and vulnerable groups who are covered financially by the Ministry of Social Welfare. There are some private insurance services but with a low percentage of population coverage (3%) (Regional Health Observatory, 2006).

1.5.3 Health status and maternity services in Palestinian

As highlighted in section 1.3, the Palestinian population in 2010 is estimated to be around 4,048,403 (Palestinian Central Bureau of Statistics, 2010). The Palestinian community is considered to be a younger community with about 46% of the population younger than 15 years of age, an indication of the high fertility rate (approximately 5.6 per 1000 population) and the falling infant mortality rate; infant mortality stalled at around 27 per 1000 live births during 2000 - 2006 (Giacaman *et al.*, 2009). A study shows that only one-third of women in Palestine obtain postpartum care. The main reason was that women did not feel sick (85%) followed by the reason that no one told them to come back for post-natal care (15%) (Dhaher *et al.*, 2008). In another study by Giacaman *et al.* (2006), about Palestinian women's childbirth location, dissatisfaction with the place of birth and determinants, it was shown that 3.5% of women delivered at home and 20.5% of women delivered in a place that was not the preferred place for childbirth delivery. The main reason was the closures on West Bank and the Israeli siege of Gaza Strip.

Thus, the healthcare system to which Palestinian women are accustomed from their homeland is very different to that which they are likely to encounter in the UK. Key differences include the presence of four systems to deliver the health services, which creates competition between them; some people pay for healthcare services, while others have health insurance

(Giacaman *et al.*, 2009). Usually, the poor people seek healthcare from the government or UNRWA sources and the more affluent people use the private health services. Of interest is that the same nurses and doctors can be found working in both private and government hospitals, but offering different standards of care. For example, a midwife might work at a government hospital by day and at a private hospital at night. The performance of this midwife is high in the private hospital. Double employment is considered a big problem among Palestinian nurses, which affects the quality of the service. However, in the UK the NHS service is free for all, but referral procedures may take a long time with the patient waiting several months to undergo a procedure. The NHS aims to provide high quality care with a high standard that is safe, effective and focused on the patient experience (Department of Health, 2010b).

In the UK, the majority of the population would use the NHS with only a relatively small percentage using the private sector. However, in Palestine, conditions are different; the use of healthcare services could be by any one of three routes based on healthcare providers and the financial status of people. First, the majority of people using MOH belong to the government authority and usually they must have government health insurance for which they pay annually. There is an exception for children under 5 and those with social problems, where the health services are free. Second, UNRWA health services (free services) are provided only to refugee people who hold the UNRWA card and live in camps. Finally, the private sector provides services for people who can pay for high-standard health services and for people having private health insurance from their organisation. Generally, the majority of people use MOH services with only a small percentage using the private sector. For MCH services, whether a woman uses the MCH clinic that belongs to MOH, UNRWA or private clinics is based on her financial status and whether she is living in a city, village or camp. At the time of giving birth, the woman's doctor refers her to the hospital where he is working based on her financial circumstances.

1.6 Access to Healthcare and Ethnicity in the UK

1.6.1 Access to healthcare

Equitable access has been defined as “care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic status”

(Millman, 1993: 32). The equitable provision of care is a core principle of the NHS. The NHS has identified the three dimensions of equitable access for ethnic minorities: having equal access via appropriate information; having access to services that are relevant, timely, and sensitive to the person's needs; being able to use the health service with ease and having confidence that you will be treated with respect (Szczepura, 2005). Goddard and Smith in 2001 highlighted four potential reasons for variations in accessing health services. These are: certain healthcare services may not be available to certain groups; the quality of certain services; the creation and maintenance of healthcare services may impose financial costs and the system fails to ensure that the availability of information about certain services is known equally by all population groups (Goddard & Smith, 2001). Additionally, quality of services is also important. Maxwell identified four important components to ensure quality services. These are accessibility, social acceptability, availability and appropriateness (Maxwell, 1984).

Quality has been a significant focus in recent years and is usually broken down into three elements: structure, process and outcome. Variation in any one of these elements will affect the patient and lead to a sub-optimal health service. In addition, the lack of information for minority ethnic groups about available resources could affect their autonomy and decision-making, hence reducing their empowerment (Birgit *et al.*, 2007).

In 2006, WHO published a report on 'Quality of care: a process for making strategic choices in health systems', which suggests that a health system should seek to make improvements in six areas of quality. These dimensions require that health care be: effective, efficient, accessible, acceptable/patient-centred, equitable and safe.

In the UK, three principles have guided the development of the NHS over more than 60 years, these are: it meets the needs of everyone; it is free at the point of delivery; and it is based on clinical need, not ability to pay. Recently, in 2011, these have been updated to include the following seven key principles that guide the NHS (Department of Health, 2011b):

- 1- "The NHS provides a comprehensive service available to all"
- 2- "Access to NHS services is based on clinical need, not an individual's ability to pay"
- 3- "The NHS aspires to the highest standards of excellence and professionalism"
- 4- "The NHS aspires to put patients at the heart of everything it does"

- 5- “The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population”
- 6- “The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources”
- 7- “The NHS is accountable to the public, communities and patients that it serves”

Quality of healthcare can be measured by the quality of the services they provide by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided (Department of Health, 2013).

This study examines a number of these core principles of the NHS in relation to Palestinian women. It considers their access to and experience of the NHS and therefore, the principles of comprehensiveness and universal availability, along with standards of care and accountability.

1.6.2 Ethnicity, culture and race

People may understand the meaning of the terms *race*, *culture* and *ethnicity* in different ways. It is important to know the difference between these concepts in order to understand the multicultural diversity of UK society in which they are playing a significant role by shaping health services in the UK. The following discussion will explore these terms.

Ethnicity refers to the relationship between groups whose members consider themselves distinctive and may be hierarchically ranked within a society (Eriksen, 2002). The term ethnicity comes from the Greek word “ethnos”, which means “nation” or “people”. There are three ways to establish ethnicity: Parental or preferably grandparental origin, self-identity and appearance (Oldroyd *et al.*, 2005).

Ethnicity is a relatively new term in research. It is a socially-constructed phenomenon that varies within time and place according to the political and social context (Chauhan *et al.*, 2008). The concept of ethnicity is that “human beings identify themselves as belonging to a social grouping because they differ culturally in fundamental ways; language, food, lifecycle,

religion, beliefs and values, historical and geographical origins” (Arora *et al.*, 2000: 5). An ethnic group is “a social group” that may share some of these features (Arora *et al.*, 2000: 5).

Ethnicity and *race* are overlapping but not synonymous social categories (Taylor & Field, 2007). The categorisation based on biological criteria is misleading and inaccurate in indicating health because the genetic variation between racial groups is small. Arora *et al.* (2000) argue that all human beings belong to the same species. Actually, the genetic, intra-racial variation is greater than genetic inter-racial variation. However, race is used more in the medical literature. Race can be defined as a biological concept that describes a group of people. These people have a common inheritance and distinguishing physical characteristics such as skin colour. The main characteristic of race is the visible physical appearance that is determined by genetic ancestry, while the main characteristics of ethnicity are the shared history, language and culture determined by group identity and social pressures (Chauhan *et al.*, 2008). For public health purposes, the term ethnicity should be considered in sociological rather than biological or anthropological terms (De Cock & Low, 1997). Although ethnicity may be used to measure socio-economic status, Chaturvedi (2001) mentioned that there is a difficulty in defining ethnicity and different definitions have been used in different studies, although the author argued that, scientifically, ethnicity is preferable to race. Most social scientists prefer to use ethnicity and culture rather than race (Turney *et al* 2002).

The simple definition for *culture* is how we view things in our group - “it is a shared set of values, assumptions, perceptions and conventions, based on a shared history and language, which enable members of a group or community to function together” (Schott & Henley, 1999: 2). Culture is a difficult term to define, as it is a dynamic entity (Arora *et al.*, 2000). It is the way people see the world and shape their behaviours, thoughts and responses to it. It covers a shared set of values, perceptions and assumptions based on shared history, language or experiences. Culture is a social construct, characterised by the behaviour and attitudes of a social group (Campbell *et al.*, 2000). Culture is difficult to measure and it is constantly changeable and not homogenous (McKenzie & Crowcroft, 1994; Arora *et al.*, 2000). The main characteristics of culture are the ideas, beliefs, values, knowledge, behaviour, attitudes and traditions shared by a group, which are determined by social experiences and education through upbringing and choice (Chauhan *et al.*, 2008). Brah used the term *diasporic space* which explains how the dynamic movement and negotiation of culture is reconfiguring the

meaning of ethnicity (Brah, 1996). This author (1996: 209) used England as an example and said:

“African-Caribbean, Irish, Asian, Jewish and other diasporas intersect among themselves as well as with the entity constructed as “Englishness”, thoroughly re-inscribing it in the process..... in the post-war period this Englishness is continually reconstituted via a multitude of border crossings.... These border crossings are territorial, political, economic, cultural and psychological”.

The term “Racial” began to be used at the end of the nineteenth century. The term “racism” was first recorded in English in the 1930s. The racial differentiation began to be limited to physical characteristics after the end of World War I. The popular anthropological method for determining race was by using the measurement of the anatomical features of skulls and other bodily features (Barkan, 1993).

Race is often used interchangeably with ethnicity or culture. The race is considered to be biologically determined, while ethnicity and culture are socially derived. McKenzie and Crowcroft highlight the common mistake of using ethnicity with biological or genetic explanations (McKenzie & Crowcroft, 1994). On the other hand, “Race” when written between brackets is not a scientific category, rather it is a political and social construct; “it is the organising discursive category around which has been constructed a system of a socio-economic power, exploitation and exclusion e.g. racism” (Gunaratnam, 2003: 4). Gunaratnam claimed that the major conceptual differences between them are that race evokes a biological and genetic reference, but ethnicity refers to cultural and religious differences. Therefore, the author argues that multiculturalism and the contemporary diasporic way of life are playing a big role in disrupting the cultural and biological meanings of “race” and ethnicity (Gunaratnam, 2003).

1.6.3 Socio-economic status, ethnicity and health

The Fourth National Survey of Ethnic Minorities reported that socio-economic factors account for differences in morbidity and health-related behaviours according to ethnic group membership (Smith *et al.*, 2000), whereas Cooper’s study shows that socio-economic inequality can account for the health disadvantage experienced by minority ethnic men and women (Cooper, 2002). Nazroo’s review (2003) emphasised this point and stated that the

fundamental cause of ethnic inequalities is the social and economic inequalities that underpin racism (Nazroo, 2003).

In the Marmot Review (2010), the author mentions that economic and social inequalities are determinants of health, simply stated, the lower a person's social position, the worse his or her health. Although the author points to the factors that are influenced by social position and shaped by the education, occupation, income, gender, ethnicity and race. The examples of these factors are material circumstances, social environment, psychosocial factors, behaviours and biological factors (Marmot, 2010). In addition, the complex interaction between society, the individual and the healthcare system is responsible for the poor health in minority ethnic groups. The direct factors, such as socio-economic disadvantage, and socio-cultural factors, such as life style and genetics, have the responsibility to explain the differences in health among minority ethnic groups. The accessibility and quality of healthcare is another determinant of health. Medical care has been estimated to play a role in only 10% of the variation of health outcomes, whilst genetic and behavioural factors have been estimated at 30% and 40% respectively (McGinnis *et al.*, 2002).

Smith *et al.* (2000) summarise the effect of racism and discrimination on health in three ways. First, as an indirect effect on health because of consequent socio-economic disadvantage; second, minority ethnic people will have a clear recognition of the relative disadvantage they face as a result of the obvious inequalities, discrimination and racism that they experience in virtually all spheres of their lives; third, a direct detrimental effect on health related to the experience of racial discrimination and harassment (Smith *et al.*, 2000). Marmot (2010) emphasises this point claiming that income and wealth have a direct effect on health inequalities.

1.6.4 Racial discrimination and inequality in health

Discrimination, defined as “to treat one group of people less favourably than others on the basis of their ‘race’, nationality, ethnic or national origin or religion, can be either direct or indirect. Direct discrimination takes place when ‘race’, religion or nationality is used as explicit reasons for discriminating. Indirect discrimination applies when regulations and procedures (though not set up to discriminate) have the effect of discriminating against

certain groups” (The Institute of Race Relations, 2012). In other words, direct discrimination includes racial abuse and harassment. While indirect discrimination may occur when a condition or requirement is applied equally to all racial groups, but a particular racial group is unable to comply with it (Arora *et al.*, 2000; Schott & Henley, 1999).

There are a number of pieces of legislation, which outlaw discrimination. The Government in the UK has amended acts and/or brought new ones into being for public sector organisations. For example, in Great Britain, the Equality Act, 2010 replaced the previous different discrimination laws. It protects people from discrimination because of race, sex, religion or belief, sexual orientation, disability, being transsexual, being pregnant, being married, having caring responsibility and, in certain situations, age.

The Race Relations (Amendment) Act (RR(A)A) (2000) replaced the original Race Relations Act (1976). Under section 20 of the Race Relations Act 1976, it is illegal to discriminate directly or indirectly in delivering any services to the public: by refusing or deliberately omitting to provide a service; by offering services of a lesser quality and by offering services in different ways or on different terms (Schott & Henley, 1999).

The RR(A)A (2000) makes it unlawful to treat a person less favourably than another on racial grounds. These cover grounds of race, colour, nationality (including citizenship) and national or ethnic origin. It extended the RRA (1976) coverage to the functions of public authorities and outlawed discrimination (direct and indirect) and victimisation in two major ways: first by outlawing any discrimination (direct and indirect), by eliminating unlawful discrimination and promoting race equality. Another important point that the RR(A)A report pointed out, is that positive discrimination or affirmative action is illegal in the UK. There is a common misperception between (illegal) positive discrimination and (legal) positive action.

Karlsen and Nazroo (2002) suggested that 3 aspects of the structural context of ethnicity in relation to health is unaccounted for in current research; first, the effect of the accumulation of disadvantage over the life course; second, the role of ecological effects produced by the concentration of minority ethnic groups in deprived residential areas and, finally, the effects of living in a racist society (Karlsen & Nazroo, 2002).

From this context, it is difficult to ignore the effects of racism on the explanation for inequalities in health. The discrimination can occur in all aspects of life, although it can vary in form, depending on how it is expressed by whom and against whom (Chauhan *et al.*, 2008). Karlsen and Nazroo (2002) divide racism into two types:

1. Interpersonal discrimination: this refers to discriminatory interaction between individuals and is usually perceived directly, although it can be associated with health problems such as increased blood pressure, depression, psychological distress and stress.
2. Institutional discrimination: which is more visible than interpersonal discrimination, it refers to discriminatory policies or practices embedded in organisational structures.

1.6.5 Institutional racism in healthcare

This phrase was first coined in 1967 in the USA by Stokely Carmichael. He defined the term as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin” (Carmichael, 1967). It represents the systematic and covert forms of racism perpetuated by institutions, dominant groups and social systems (Arora *et al.*, 2000). However, it was used before this in the UK. It was not until its use in the Macpherson Inquiry into the death of black teenager Stephen Lawrence that it came to prominence. Known as either the ‘Stephen Lawrence Inquiry’ or ‘The Macpherson Report’, this report defined institutional racism as:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin, it can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people (Macpherson, Great Britain, 1999).

Although the Stephen Lawrence Inquiry focused on the police service, it was noted that institutional racism "is in fact pervasive throughout the culture and institutions of the whole of British society, and is in no way specific to the police service" (Macpherson, Great Britain, 1999).

The previous definition of institutional racism highlighted three key points; first, racism can be unintended or unconscious; second, it is focused on behaviour and effects; finally, it is

focused on groups' or organisations' performance rather than on the individual. Institutional racism is known as 'structural racism', 'state racism' or 'systemic racism' (Williams, 1985). Institutional racism and social racism have been argued to contribute to black and minority ethnic groups being over-represented among low income groups, the unemployed and those living in poor housing (King, 1996). These factors are all associated with poorer health. The healthcare system is vulnerable to institutional racism (King, 1996). There is growing evidence that institutional racism has contributed to ethnic inequalities in health (Nazroo, 2003).

Therefore, it is important to investigate racism in institutions. The three aspects of addressing institutional racism are: the processes and auditing systems of an organisation; changing to a more inclusive organisational culture and challenging individual behaviour and attitudes (King, 1996).

1.7 Conclusion

The increasing number of minority ethnic groups and migrants from a variety of cultural and linguistic backgrounds coming to the UK draws attention to the need to investigate their access to, and use of, healthcare services in a culturally sensitive manner. The current numbers of Palestinian women in the UK is small, but increasing. Their use of, and access to, healthcare services have not been investigated before. Many Palestinian women living in the UK appear to be of childbearing age. Thus, studying this group suggests a need to focus on maternal and child health rather than other services, such as geriatric services.

From an initial review of the literature, there does not appear to be any research that has explored this issue. In overview, no previous study has focused on this specific group, and their needs may well both overlap and differ from those of other minority groups. The next chapter will discuss the MCH services in the UK, followed by Chapter 3 that discusses relevant studies.

CHAPTER TWO

Maternal and Child Healthcare Services in the UK

Chapter 2: Maternal and Child Healthcare Services in the UK

2.1 Introduction

In order to understand access to, and use of, healthcare services by Palestinian women in the UK, it is important to understand how the Maternal and Child Healthcare Services are run in the UK and how they meet the needs of Palestinian women as a Minority Ethnic Group. The first section gives an overview of the guidelines and the routine healthcare provided to all women during pregnancy, the aims of antenatal care, the pathway of antenatal care, care during labour and postnatal care. The role of the healthcare visitor will also be covered. The second section will discuss; “Healthy Child Programme - pregnancy and the first five years of life”, the role of the health visitor and the Sure Start Programme in the UK.

In this section, the aims of antenatal care, the services provided to pregnant women during labour, both antenatal and postnatal, and after discharge from hospital will be discussed in detail. The Department of Health has published several policies and a set of standards aimed at improving the quality of, and access to, maternity care for all women. These include the NICE guidelines (NICE, 2003; 2008), the National Service Framework, Maternity Matters (Department of Health, 2007a), the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004), and Choice in Maternity Services (House of Commons Health Committee, 2003). The discussion on antenatal care is based on these publications, especially the NICE guidelines on Antenatal Care: Routine Care for the Healthy Pregnant Woman (NICE, 2003) which was replaced with a new version in (2008). These help to improve access to maternity services and increase the survival rates and life chances of children from disadvantaged backgrounds. A White paper published in 2010 reflects on this, stating: “Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage” (Department of Health, 2010a: 17).

Five principles of maternity care were identified from the literature review carried out by Fraser *et al.*, (2009). These are choice, communication, control, continuity of care, quality of care and safety. Choice is a key element of the DoH’s policy on maternity services; therefore

Maternity Matters (Department of Health, 2007a) mentions four national choice guarantees for all women:

- Choice of how to access maternity care: women can choose to be referred to local midwifery services or to access this service via their GP
- Choice of type of antenatal care: means early contact with midwives or the obstetrician before the 12th week of pregnancy.
- Choice of place of birth: women can choose to deliver their baby at home or in hospital.
- Choice of place of postnatal care: women can choose to receive post-natal care either at home or in community settings, at convenient times.

Maternity Matters also states that women can choose to access maternity services outside their area. Midwives will provide them with care and support during pregnancy and childbirth (Department of Health, 2007a). The free translation services from the NHS will help and support BME in their decision and choice.

Despite the fact that choice has been high on the maternity agenda as illustrated previously, many scholars and reports have criticised the choice agenda in NHS. Well before ‘Maternity Matters’ (Department of Health, 2007a) in 2003, a House of Commons health committee report described the maternity choice as illusion and asked the DOH to address this issue as a matter of urgency (House of Commons Health Committee, 2003). However, informed choice whether it is desirable or possible in maternity services remains central to current debates (Kirkham, 2004). Hollins-Martin (2007), Jomeen (2007) and Kightley (2007) believe that barriers to informed choice are still in place, although Jomeen (2012) feels that small changes, have taken place more recently.

Additionally, Edwards *et al.* (2011) highlights that although the NHS rhetoric promises the policy of choice, in reality there is little choice outside consultant-led units. Moreover, Jomeen (2008) describes the women’s own experiences of choice as relatively silent in the debate. She suggests that there is a lack of evidence that women do have choice in maternity services and concludes that choice in maternity services may not involve merely a desire but a gamble. It is clear that women are not homogenous and the choice concept is not an equitable concept, where some women may have a more choice than another (Jomeen, 2007). The ‘Maternity Matters’ report (2007) states that, choice is dependent on circumstances and

for some women a consultant team will be the safest option. In this model, for the ‘high risk’ women, the option of choice is constrained.

It seems clear, as mentioned previously, that choice in maternity services in reality is not applied and real choice remains elusive. Maternity health professionals should be aware of their role and facilitating women’s choice based on their individual need.

2.2 Antenatal care

The aims of antenatal care are the following:

- To build open communication and good relationships between women and professionals;
- To provide women with available choices, information about the care and respect for their decisions;
- To support women during pregnancy and promote all aspects of their care such as psychological, emotional and social wellbeing;
- To provide women with health education and improvement of health during pregnancy;
- To monitor a pregnant woman’s condition and monitor foetal condition regularly;
- To prepare women for labour and safe delivery;
- To prepare the women for infant feeding, either breast feeding or bottle feeding;
- To prepare women for family planning advice after delivery (Henderson & Macdonald, 2004).

2.2.1 The pathway of care during antenatal care will include the following:

2.2.1.1 Access and booking

Women and their partners can choose to access antenatal care by self-referral to the local midwifery service or via their GP. In the first visit, the initial assessment or ‘booking’ appointment is normally carried out by a midwife. It includes a detailed assessment of all aspects of the woman’s situation, physically and socially. Then the planning for the rest of the antenatal period will be done and potential problems will be identified early. This appointment must be made without delay. The NICE antenatal care guidelines (NICE, 2008), recommend that booking with the maternity services should take place before 12 weeks.

During pregnancy, the number of appointments is 10 for nulliparous women and 7 appointments for parous women (Department of Health, 2007a). This is the prescribed pathway, but it does rely on women knowing how to access the service and this can be problematic in those without a good knowledge of NHS processes (see chapter 6).

2.2.1.2 Content of booking appointments and pregnancy book

The midwives will provide pregnant women with information about healthy pregnancy and explain the scheduled screening tests for her. The midwives will allow the women to ask questions and express concerns. The midwives will use a checklist to ensure that all necessary information is discussed at booking or first visit to midwife. All pregnant women should be given a copy of the pregnancy book (Department of Health, 2009b) and up-to-date information, so that they can make informed choices in pregnancy. The antenatal classes are part of a high quality service and midwives should emphasise the importance of booking into these classes. Additionally, women can choose the place of antenatal care (Healthcare Commission (HCC), 2008).

2.2.1.3 Care for women with high-risk pregnancies

All pregnant women need a midwife, but if women have been identified as high risk or have a problem during pregnancy, obstetricians and specialist teams should be involved.

2.2.1.4 Tests, screening and ultrasound

NICE (2008) recommends that all women should have at least two ultrasound scans during pregnancy. The first one is a dating scan in early pregnancy and the second is for any foetal abnormalities and to monitor the baby's health at 18-20 weeks of pregnancy. There are varieties of screening tests, such as Down's syndrome screening, which involve both ultrasound scanning and blood tests. These screening tests provide the parents with information about the baby's condition. The potential risks and benefits of these procedures should be explained to women as this helps them to make informed choices. While the NICE guidelines are evidence based, they may not take into account women's individual circumstances or needs for information and this is further discussed later in thesis (chapter 6 and 9).

2.3 Care during labour and birth

This can be provided in four settings: Obstetric units, where obstetricians and midwives work together for all-risk births; Alongside Midwifery Units (AMUs), integrated with the obstetric unit; free-standing midwifery units (FMUs), in a separate building from the obstetric unit and at home, where the midwives take care of low-risk births. The results of surveys show that the majority of births, about 93%, occur in obstetric units, while 3% occur in AMUs, 2% in FMUs and 2% at home (Healthcare Commission (HCC), 2008).

For women who decide to give birth at home, the midwives should assure them that if any complications happen they will be transferred to hospital. Pain relief such as birthing pools and gas should be available at all midwife-led services and epidurals should be available 24 hours a day in every obstetric unit. Evidence shows that water relieves pain without evidence of harm to the baby and also reduces the number of women having an epidural (Healthcare Commission (HCC), 2008).

The Healthcare Commission (2008) recommended the following points for implementation to provide high-quality care during labour and birth:

- All women should have the pain relief they request in all settings safely.
- Women should not be left alone during or just after labour, but if this becomes necessary a clear explanation and agreement are needed.
- Women should be encouraged to move during labour and choose the most comfortable position.
- The baby's heart rate (cardiotocography) should be monitored continuously.
- Vaginal birth after caesarean and external cephalic version to correct the breech position should be reviewed.

2.4 Postnatal care

After the birth, most mothers stay in hospital from 1-4 days depending on the type of delivery. Women's physical and emotional health should be assessed before discharge from hospital and six to eight weeks after birth. However, the National Childbirth Trust (2010) states that research shows repeatedly more negative comments from service users about postnatal services in the hospital than any other aspect of maternity care. The trust believes that all parents should be able to access good quality and support in the postnatal period.

The postnatal period is defined as “a period of not less than ten and not more than 28 days after the end of labour, during which time the continued attendance of a midwife on the mother and baby is requisite” (Henderson & Macdonald, 2004: 725). Therefore, a community midwife should visit the mother at home for 10 days then hand over the responsibility to the health visiting service on the 11th day (Healthcare Commission (HCC), 2008). Women should receive support and help in this period. NICE (2003) states that, regardless of the location of care, breastfeeding support should be available. The health visitor role covers health promotion, diagnostic health screening, health surveillance and working to the NICE guidelines (2007) on ante and postnatal mental health. Routinely the Edinburgh Depression Scale for postnatal women (EPDS) is done by the health visitor (Henderson & Macdonald, 2004).

2.5 Child Health Programmes

The aim of the Healthy Child Programme (HCP) is to improve the health and wellbeing of children. The HCP provides every family and child with their health service needs such as the programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting. In this section the HCP for the first five years of life and the Sure Start Programme will be discussed.

2.5.1 Healthy Child Programme

Pregnancy and the first five years of life and the health visitor role

Pregnancy and the first years of life are one of the most important stages in the life cycle. The Marmot Review (2010) stresses the importance of having the best start in life for every child. Recently, the “Birth to Five” book has been revised and is given free to all parents in England through the health visitor team. This book includes all issues that relate to a mother and her child, such as feeding, immunisation, the growth and development of the child, benefits for both parents and baby, rights in the workplace and so on (Department of Health, 2009c).

The routine screening test schedule for the HCP includes the following;

- Antenatal: the foetus is assessed at 12 weeks of pregnancy then regularly according to NICE guidelines.

- Newborn hearing test at 4 weeks in the hospital-based programme or 5 weeks in the community.
- After birth, all babies should be examined within 72 hours – clinical examination for eyes, testes (boy), cardiac and dysplasia of the hips. If there is abnormality of the hip, an ultrasound examination should be done.
- At five to eight days (ideally five days), bloodspot screening; biochemistry - hypothyroidism, phenylketonuria, cystic fibrosis, medium chain acyl-coA dehydrogenase deficiency, and haematology - haemoglobinopathies.
- At six to eight weeks – complete physical examination.
- By five years - pre-school hearing and visual screening must be completed.
- Immunisations – (Red book - the personal child health record should be provided for every baby, which contains information about the immunisation schedule, growth and development of the baby and other related issues).

The health-visiting workforce is central to the delivery of the HCP. Health visitors have different roles and guide multi-skilled teams across the NHS. The two core roles for health visitors are firstly, to deliver the HCP to deprived or denied populations and, secondly, to deliver preventive programmes intensively to at-risk families with young children (Department of Health, 2009c). Other roles for the health visitor may include delivering the Child Health Promotion Programme in pregnancy and the early years through Children's Centres. They also deliver evidence-based intensive programmes at risk children as well as dealing with obesity-prevention for children. Finally, they help to decrease inequalities by focusing on disadvantaged families and communities. (Department of Health, 2007b; Department of Health, 2011a)

2.5.2 Sure Start Programme

In 2010, the government accomplished its goal of having 3,500 Sure Start Children's Centres throughout the country. The Sure Start programme is one key element in the Every Child Matters agenda and it is central to the objective of choice for parents and the best start for children (Marmot, 2010). The aims of the Sure Start programme are to enhance the children's health and emotional development, to increase the availability of healthcare for all children and to provide supportive services for the parents (Department of Health, 2007c; Garbers *et al.*, 2006).

The Sure Start Children's Centres are "situated in easily accessible areas, often a pram's push away from home, and bring together a range of integrated services for children and their families through pregnancy and then from birth to five years of age. Services include child and family health, education and support e.g. for parents of children with special needs" (Department of Health, 2007a: 48).

The Sure Start principles include the following points. First, working with parents and children, Sure Start Children's Centres should help the parents to have easy access to their services and receive appropriate benefits. Sure Start Services are for everyone and they should provide services based on parents' needs. The services must be flexible at the point of delivery and they must start very early with the first visit to the midwife. Services must also be respectful and transparent, community-driven and professionally coordinated. Finally, services are outcome-driven, which means the services must have a better outcome for both parents and children (Department for Education and Skills, 2005).

Sure Start has many benefits; children who live in Sure Start areas show better social development, and greater independence, than those in areas without such services (The Lancet, 2011). However, cuts to local authority funding may affect Sure Start, either through direct cuts or changes such as transfer of services to voluntary or private care providers. A survey by children's charities has suggested that 250 Sure Start centres will close, 2000 centres will reduce services, 3100 centres will have reduced budgets, and another 1000 centres will lose staff (The Lancet, 2011).

CHAPTER THREE

Literature Review

Chapter Three: Literature review

3.1 Introduction

In this chapter, studies related to the access and use of healthcare services, particularly maternal and child healthcare, by minority ethnic groups in the UK will be discussed. Initially, the literature search strategy and the systematic approach to the literature review will be outlined and results set out. Then, the different factors influencing the access to, and use of, healthcare services by minority ethnic groups will be discussed in terms of themes and sub-themes based on the findings of the empirical studies. Gaps found in the literature will be reviewed. The final section will give an overview of the revised literature review.

3.2 Literature search strategy

The search strategy of this narrative review was started with a wide literature review on the UK healthcare services for minority ethnic groups in general, then focusing on maternal and child health. The search strategy was devised using the search of electronic databases, hand searching of the relevant journals and searching the reference lists of relevant studies and published reviews. Moreover, each section of the literature required slightly different search terms to identify the relevant literature, with library books, theses, papers, journals and on-line resources being used.

The following electronic databases were searched for relevant literature:

- Medical literature on-line (MEDLINE),
- Maternity and Infant Care (MIDIRS),
- Cumulative Index and Abstracts for Nursing and Allied Health Literature (CINAHL - EBSCO),
- Applied Social Science Index and Abstracts (ASSIA),
- Evidence-based Medicine (EBM) Cochrane Central Register of Controlled Trials 1st Quarter 2011; EBM Reviews - Cochrane Database of Systematic Reviews 2005 to March 2011; and Cochrane pregnancy and childbirth group,
- British Nursing Index (BNI).

3.2.1 Systematic approach to the literature review

A systematic approach to searching the literature was conducted using guidance from National Health system - Centre for Reviews and Dissemination (NHS CRD), 2010 and the principles set out were used to extract and review the literature systematically. This initial search was undertaken in March, 2011. The articles identified from the databases were published between 2001 and 2011. The reason for restricting the search to the last 10 years is that NHS policies have changed appreciably during that period (Department of Health, 2009a).

The strategies of the searching process were first to combine two terms, then, if the result of two combinations of terms were large, a third term was used to achieve a manageable number of studies. For example, numbers one and two combined from the next table; if the numbers of studies were large then number three was added.

Table 3. 1: Search terms used in the Literature Review search strategy

	Terms	Combined with
1.	‘Access* or use* and healthcare or health provision’ OR ‘Access* or use* and health services or health provision’	} AND
2.	‘Matern* services or care’ OR ‘Child* health services or care’	
3.	‘Ethnic minorit*’ OR ‘UK or England and migra*’	

A number of relevant Internet websites were also searched for relevant information as noted in Appendix 3.1. Reference lists of articles were also searched to identify additional relevant articles/reports. As prominent authors in the field became apparent, author searches were undertaken. Manual or hand searches of the electronic library catalogue of the University of Manchester and Manchester Metropolitan University have been made. All articles were imported into the End Note reference-management software package. Strategies were developed, for example, using citation alerts to keep up to date with the new and emerging literature that would be relevant to the topic area.

3.2.2 Inclusion and exclusion criteria for the studies

The inclusion criteria for studies were those which focussed on the aim of this research (see section 5.2 & 7.1) and met the following criteria:

- Access to healthcare,
- Maternal healthcare services and/or child healthcare services,
- Minority ethnic groups,
- Studies undertaken in the UK,
- Studies which used a qualitative, quantitative or mixed methods approach, because they are considered as high quality studies (NHS CRD, 2010).

Articles were excluded for the following reasons:

- They did not meet the above inclusion criteria,
- The study took place in countries with a different healthcare system, such as the USA and Canada,

Only empirical articles were included in this initial review, as stated in inclusion criteria high quality studies have been considered. If the article met the inclusion criteria, but was not an empirical article such as a descriptive or opinion article, report, audit, systematic review or narrative review article, then it was excluded from the critical appraisal process, however the researcher considered them if they were appropriate in the final discussion of findings and literature review.

First, the titles and abstracts were reviewed and then an assessment of how the articles met the selection criteria was carried out. The abstracts that did not meet the inclusion criteria were then excluded. Figure 3.1 summarises the search strategy and shows in detail the number of articles included and excluded.

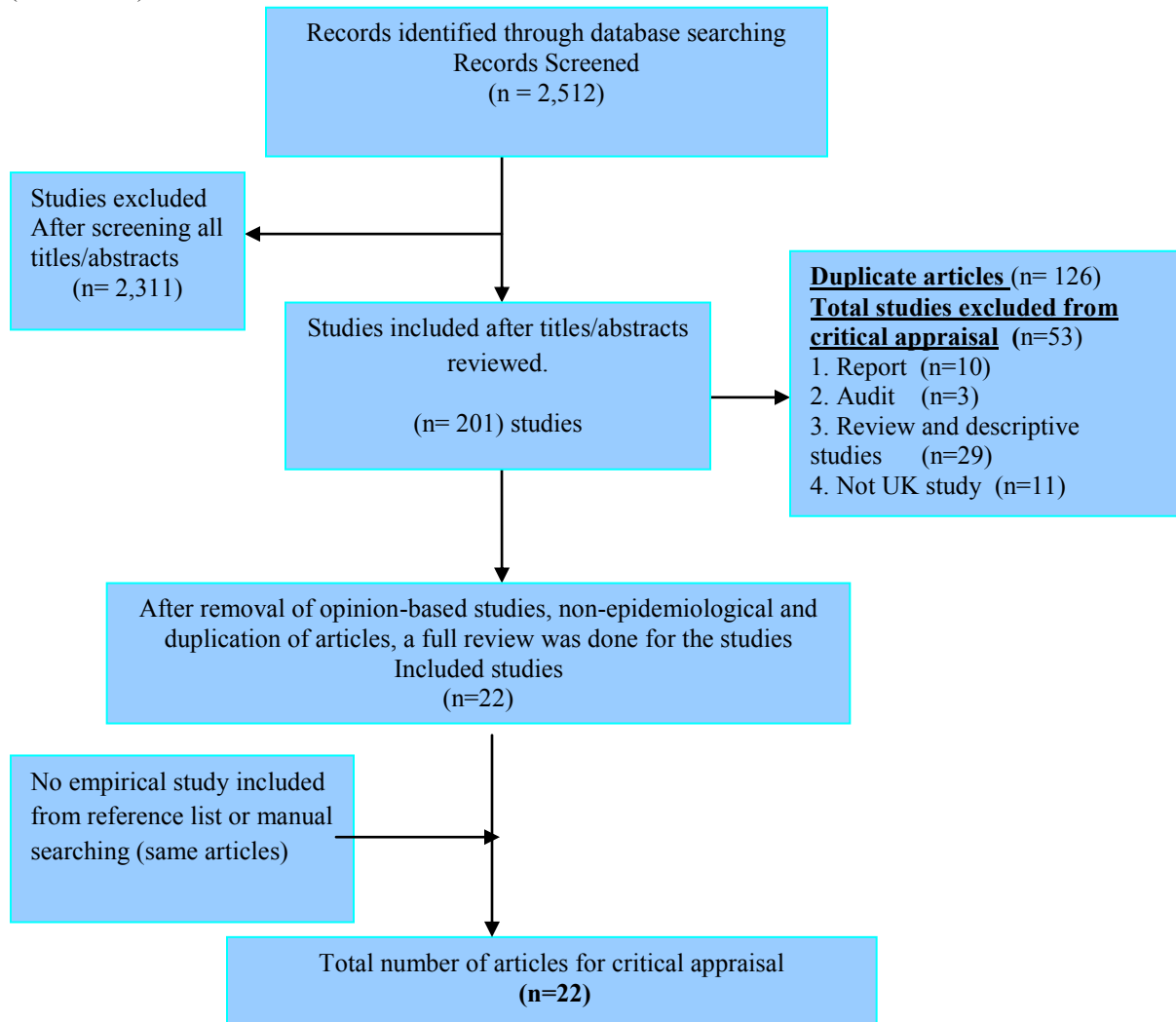
3.2.3 Results of the systematic approach

Using the search strategies mentioned in the previous section, 2,512 records were identified through the database searching process. After reviewing the articles and applying the selection criteria, 201 studies were included and 2,311 were excluded by title because they failed to meet the inclusion criteria. For the remaining 201 studies, a detailed abstract review was done to evaluate the articles and remove duplication, opinion-based studies, reports, non-epidemiological studies and review studies. Following this process, a further 53 articles were excluded. The numbers of excluded review, audit and report articles were 29, 3 and 10 respectively; while another 11 articles were excluded because the studies were conducted in the USA, Canada or Australia.

A full text review and evaluation was undertaken for the remaining studies. Twenty-two studies met the inclusion criteria as shown in Table 3.2, Appendix 3.2 and Figure 3.1. No further original articles were discovered from the reference list of the papers reviewed. These articles, which discuss important issues related to access to healthcare services by minority ethnic groups, were chosen to be critiqued and discussed, as shown in Table 2.2. None of these articles were about Palestinians as a minority ethnic group in the UK and only one study (Ahmad *et al.*, 2010) discussed the Arabic population. Moreover, one thesis was identified during hand searching that investigated maternity needs of Muslim Arab women and have been included in the review.

Figure 3.1: Flow diagram summary of the search strategy

(n = number)



3.2.4 Data Extraction

A data extraction sheet was used to make comparisons between studies, see Appendix 2.6. Appropriate information was transferred to a table to facilitate the process of comparison between studies. The factors that were major facilitators and barriers to access and use of MCH services were highlighted in these twenty-two studies. They were then categorised into themes and sub-themes. These themes were considered as the cornerstone for the literature review. The major limitation for this method is that it does not account for the effect of the researchers, their prejudices and pre-conceived ideas. To

reduce this researcher bias in extracting the themes, discussion took place with peers who are familiar with the literature. The extracted data are reported in Table 3.2.

3.2.5 Critical Appraisal Tool

There are many tools which have been developed to assess, evaluate and critique qualitative and quantitative research studies. The tool developed by Hawker *et al.* (2002) for appraising evidence was used to assess the qualities of the research studies by scoring nine items, each item can be rated from one to four as good, fair, poor or very poor. These parts included: abstract and title; introduction and aims; method and data; sampling; data analysis; ethics and bias; findings/results; transferability; implications and usefulness. This tool is not effective for theoretical papers, but it is effective for research studies. The researcher used this tool because it can be used for qualitative and quantitative studies. In addition, giving the score may provide the reader with an overall estimation of paper quality. Each article was assigned a score out of a maximum score of 36. There is no cut-off point in the score that distinguishes good quality from low quality articles; therefore, the higher the total score, the better the quality. Quality issues were considered for each single paper and were indicated within the text. An adapted version of this tool was used as shown in Appendix 3.3.

3.2.6 Quality of included studies

Overall, the literature scored well using Hawker *et al.*'s (2002) tool, the scores ranged between 27 and 34, with an average score of 31. Generally, the literature had a high score with the tool, but with some limitations. All qualitative studies (n=11) included a clear research aim, introduction and appropriate research design. However, there were some weaknesses such as the absence of the sample type (Chan, 2000; Almond & Lathlean 2011); no response validation for example, (Jayaweera *et al.*, 2005; Puthussery *et al.*, 2010) and some failures to explain how they reduced bias, for example the use of an interpreter during an interview, may affect the quality of interview (O'Donnell *et al.*,

2007). Moreover, the majority of the studies are specific to a group of women from a specific ethnic group, which limits the generalisability of the results.

The quality of mixed method studies (n=2) was reasonable. The use of mixed method triangulation increased the credibility of the study, for example, where the in-depth interview followed by the quantitative data analysis to validate the findings (Aung *et al.*, 2010). However, some other studies had a selection bias with all participants having a medical background or all coming from one university (Ahmad *et al.*, 2010).

Nine quantitative studies were included, some, for example, the millennium cohort studies (Jayaweera & Quigley, 2010), have provided good evidence. Overall, the research question, design, data collection and analysis were appropriate. Some of the surveys had a low response rate, for example, 57% for Rowe *et al.* (2008). Responses from minority ethnic groups were low (Puthussery *et al.*, 2010) and one study did not mention how the researcher assessed the reliability and validity of the questionnaire (Singh *et al.*, 2002).

In this literature review, the researcher is interested in empirical evidence that meets the inclusion criterion of including only UK studies. Therefore, the review focuses on the discussion of only 22 studies supplemented with NHS evidence and reports.

Later in the research process, the literature review was updated and literature was integrated into the whole thesis. The first phase of the research highlighted the need for further literature search using specific terms such as: preference for the use of antibiotics, circumcision for male baby, examining the newborn, first bathing of newborn and the effect of acculturation on the use of MCH services. A number of the studies found have been used to contextualise or illuminate findings and are included in the discussion. International studies have been integrated into these discussion chapters to highlight the relationship between this evidence and the study findings as well as the UK studies presented in the literature review.

A wider picture of the discussion of related NHS policy and documentary evidence is presented in the discussion chapters concerning the qualitative and quantitative findings as well as in the conclusion chapter. This helps to demonstrate and relate the study findings to these important NHS sources of evidence.

In order to identify further and more up-to-date literature or evidence related to this research, a new search was carried out covering the period between March 2011 and June 2013. In order to keep consistency in searching, the researcher carried the search out following a similar search process to that discussed in sections 3.2.1 and 3.2.2 using the same terms and following the same strategy. None of these studies was an empirical study that met the inclusion criteria. Furthermore, the email alert features of the databases were utilised (an example is using Google Scholar alert), which enabled the researcher to be up-to-date with newly published studies.

3.2.7 Conclusion

A literature review regarding the access to, and use of, maternal and child health services by minority ethnic groups was conducted to provide the background for this study, especially as no previous study has mentioned or covered the health issues that relate to Palestinian women as a minority ethnic group in the UK. The preliminary empirical research (phase one of data collection), which included twenty-two in-depth interviews about access to, and use of, healthcare services by Palestinian women, raised awareness about the potential gap in the literature.

A literature review revealed no studies about Palestinians as a minority ethnic group in the UK, but it included research literature about women from other minority ethnic groups such as Pakistani; Bangladeshi; Somali; Chinese and Ethiopian women. Palestinian women share minority ethnic status with these minority ethnic women, however, the needs of Palestinian women may differ from their needs in term of access to, and use of, healthcare services, particularly maternal and child health services, in the UK.

Based on the hierarchy of evidence for quantitative studies, a systematic review and meta-analysis are considered to be the highest quality literature, followed by randomised controlled trials, cohort studies, case-control studies, cross sectional surveys and case reports (NHS Centre for Reviews and Dissemination, 2010). Therefore, systematic review, reviews and included empirical studies were used in section 3.2 to provide a robust background for the study. Moreover, important reports were included to provide a wider picture and to meet the research aims. A wider discussion of related NHS policy and documentary evidence is presented in the discussion chapters to illuminate the study findings.

The different factors influencing the access to, and use of, healthcare services by minority ethnic groups will be discussed in terms of themes and sub-themes based on the findings of the empirical studies. The following data extraction and critical appraisal table will guide the discussion in section 3.2.

Table 3. 2: Data extraction table & critical appraisal of the studies

(Qualitative studies 1-11, Quantitative 12-20 and mixed method studies 21-22)

Data extraction - Qualitative studies 1-11

Biographic details	Score	Design		Finding	Comments
Author/Date Aim of the study		Methodology Data Collection Sample/ Setting	Number/Attrition Characteristics of participants		
1. (Puthussery <i>et al.</i> , 2010) /UK To explore the maternity care experiences and expectations of UK-born minority ethnic women.	31	Grounded theory approach. In-depth interviews. Purposeful sample. Nine (NHS) maternity units in England.	34 UK-born mothers. Black Caribbean, Black African, Indian, Pakistani, Bangladeshi and Irish.	UK-born women's familiarity with the system and the absence of language barriers were felt to be influential in getting the same treatment as white women. They stressed the need for professionals to be 'sensitive' and 'delicate' in their interactions and wanted 'continuity of care'. They also expressed the need for better physical environments in maternity units.	<ul style="list-style-type: none"> Useful study that focuses on UK-born minority ethnic women's maternity experiences. Response rate from BME was low. No respondent validation. Recruitment process limited to Indian and black Caribbean and less from other ethnic groups, which limits generalisability.
2. (Straus <i>et al.</i> , 2009) /UK To conduct a qualitative study of perceptions of experiences of childbirth from Somali health workers in the UK.	32	Ethnographic approach. In-depth narrative interviews. Snowball sampling. Community centres and places of work in London.	Eight women aged 23-57 years. Somali women.	Issues concerning female circumcision, verbal communication, and cultural aspects of care and pressures that were a consequence of migration play a part in the experience of childbirth in the UK for Somali women.	<ul style="list-style-type: none"> Language bias; interviews in English, this may create cultural and communication difficulties (plus the problem of culture translation). Female circumcision is not related to Palestinian women, because the Somali culture is totally different.
3. (Chan, 2000) /UK To examine the views of both users and providers of primary healthcare services for the Chinese minority in Manchester.	30	Qualitative study. Structured and unstructured interviews. NA sample type (Not reported in paper).	38 GPs. 26 health visitors. 30 Chinese mothers. Chinese women.	Language and inability to use health information mean that communication between Chinese mothers and primary health workers is a major problem. Chinese traditions still have a strong influence on healthcare. Problems associated with health service provision are exacerbated by the unpopularity of health services in	<ul style="list-style-type: none"> Bias is presented in sample selection of mothers (what about other women who are not mothers?). Interviewing the health visitors in pairs may affect reliability of study.

		Manchester.		Chinatown and the stereotyped perception of Chinese health. Views of the health needs of Chinese people differ among health workers, and between health workers and users.	
4. (Reid & Taylor, 2007) /UK To explore Traveller women's experiences of maternity care so that their needs might be identified and perceptions of helpful responses elicited.	31	Feminist research methodology. Unstructured non-directive interviews. Snowball sampling. The Republic of Ireland.	13 Traveller women aged 19–42 years. Traveller women each had experienced between two and eight pregnancies.	Political and structural factors, such as the direct discriminatory barriers created by general practitioner services. Indirect discrimination arising from dysfunctional communication and control of information, poor housing and lack of public transport were the basic causes of inequity of access to care.	<ul style="list-style-type: none"> Using snowball-sampling technique may predispose the sample to bias with women referring to others with similar opinions.
5. (Jayaweera <i>et al.</i> , 2005) /UK To examine the circumstances, experiences and needs of a local sample of low income, childbearing women of Bangladeshi origin in the UK.	30	Qualitative interviews. A semi-structured questionnaire. Purposeful sample. Leeds in the North of England.	Nine women of Bangladeshi origin who were pregnant or had a baby less than 1 year of age.	The women's constrained material circumstances limit their access to resources, services and good health. This is related to their limited education, qualifications and English fluency.	<ul style="list-style-type: none"> Bias in recruitment process; the women who are isolated from organisational help and support are not recruited. No response validation.
6. (Twamley <i>et al.</i> , 2010) /UK To explore the factors that impact on UK-born minority ethnic women's experiences of, and decisions around, feeding their infant.	31	Grounded theory approach. In-depth semi-structured interviews. Purposeful sample. Hospitals in London and Birmingham.	34 UK-born BME groups. 30 healthcare professionals. Women of Black African, Black Caribbean, Pakistani, Bangladeshi, Indian and Irish parentage.	The main barriers to breast feeding were the perceived difficulties of breast feeding, a family preference for formula feed and embarrassment about breast feeding in front of others.	<ul style="list-style-type: none"> The sample size was small for some ethnic groups. The socio-economic bias in the make-up of the groups; the black Caribbean and Irish women were broadly from a lower socio-economic group, and the Indian women were primarily from a higher socio-economic group. The interviews were done from 3-9 months after giving birth, which may have affected some women's ability to recall decisions around breast feeding.

7. (Edge, 2008) /UK To explore the factors that might account for low levels of consultation for perinatal depression among Black Caribbean women and their absence from perinatal research in the UK.	31	Qualitative study. In-depth interviews. Purposeful sample selected from a larger mixed-method study. Antenatal clinics in the Northwest of England.	12 women. Black Caribbean women.	The absence of Black Caribbean women with perinatal depression from clinical practice and research may be because social, structural and personal barriers prevent these women from accessing the care and support they need. The need to train the health professionals to deal with depression.	<ul style="list-style-type: none"> • Purposeful sample was selected from a previous study. • The researcher investigates the problem using one method (interview). It is helpful to use more than one method (triangulation).
8. (Almond & Lathlean, 2011) /UK To investigate equity in the provision of a public health nursing postnatal depression service.	32	In-depth qualitative case study. Observation, interviews and document analysis. NA sample type. PCT in the south of England.	20 health visitors, 6 managers, 3 Bangladeshi & 12 English women. Respondents included health visitors, manager, Bangladeshi and English women.	While a policy was in place, equity in care was not achieved. An analysis of women's needs is recommended prior to policy development and policy implementation should be planned. To achieve equity, training should include knowledge and skills for cultural competency.	<ul style="list-style-type: none"> • Study focused on one ethnic group: Bangladeshi women. • It took a long time to process the data analysis. • This case-study approach might lack generalisability, because it is limited to the particular case, which is an organisation in the NHS.
9. (Davies & Bath, 2001) /UK To explore the maternity information concerns of a group of Somali women in a Northern English city and to investigate the relationships of these women with maternity health professionals.	27	Qualitative/ theme analysis. Focus group and semi-structured interviews (<i>using interpreter</i>). Convenience and purposeful sample from a Northern English city.	13 women age between 21 and 40. English-speaking and non-English-speaking Somali.	Poor communication between the non-English speaking Somali women and health workers was perceived as an underlying problem in seeking information. Fears about misinterpretation and confidentiality limit the usefulness of interpreters.	<ul style="list-style-type: none"> • Using convenience or purposeful sampling may not represent the whole population. • The researcher has a different background to the participants and cannot speak the Somali language. • The length of time that participants had spent in the UK was not considered.
10. (O'Donnell <i>et al.</i> , 2007) /UK To understand the barriers facing asylum seekers and the facilitators that help them access healthcare.	30	Two qualitative methods: Focus groups and interviews. Purposeful sample. Scotland.	31 female, 21 male aged between 20 and 57 who had been in the UK over 3 yrs. Asylum seekers. Study conducted through an interpreter.	Most asylum seekers were registered with a GP. Many of them have difficulty getting timely appointments with their doctor. They were surprised at the length of waiting times both for hospital appointments and when attending (ER) departments.	<ul style="list-style-type: none"> • Use of interpreter during interview may affect the quality of interview. Researcher did not mention the effects on data collection. • The provision of interpreters in primary care was generally good, but in the hospital was inadequate.
11. (Cross-Sudworth & <i>et al.</i> , 2011) /UK	31	A retrospective Q methodology study.	15 women interviewed.	Six factors were identified: (1) confidence of women	<ul style="list-style-type: none"> • Result cannot generalise to rest of population. This

To explore first- and second-generation Pakistani women's experiences of maternity services and the inter-generational differences/comparisons.		Semi-structured interview with Q grid sorting Purposeful sample. Two Children's Centres in an inner city in the West Midlands.	16 women tested. Pakistani women following childbirth.	who had attended higher education, (2) isolation of some women from both family and maternity services, (3) women who had poor experiences of maternity services but good family support, (4) women with positive experiences of maternity care and who were influenced by traditional cultural practices, (5) importance of information and support from healthcare professionals and (6) importance of midwifery care to women. Cultural competency awareness training is crucial to improve practice.	<p>method is limited to limited perception.</p> <ul style="list-style-type: none"> Bias in data collection presented in two points: The principal researcher had been a community midwife for two participants which may have influenced their responses. Researcher did not share the same background as participants. Using two languages in interviews may introduce a bias.
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Data extraction - Quantitative studies 12-20

Biographic details	Score	Design		Finding	Comments
Author/Date Aim of the study		Methodology Data Collection Sample/ setting	Number/Attrition Characteristics of participants		
12. (Jayaweera & Quigley, 2010) /UK This study examines indicators of health status, behaviour and healthcare use among mothers of infants in the Millennium Cohort Study according to whether born in the UK or abroad, individual ethnic grouping, and length of residence.	34	Millennium cohort study (MCS). Longitudinal birth cohort. Survey. UK.	18,818 selected from child benefit records. Mothers of an infant under one year.	There are both positive and negative health indicators associated with ethnicity, birth abroad and length of residence and presenting results on a single factor in isolation could lead to a misinterpretation of associations. Mother's ethnicity has an important relationship with most health indicators independent of country of birth, length of residence and socio-demographic circumstances.	This study provides good evidence and is based on the largest survey. Limitations of the study included: <ul style="list-style-type: none"> Response rate is low in Black and Minority Ethnic BME subset. Categorising the participants into 4 groups and neglecting the minorities of BME. Migrant mothers are not a homogenous group.
13. (Raleigh <i>et al.</i> , 2010) /UK To examine ethnic and social inequalities in women's experience of maternity care in England.	32	Multiple logistic regression analysis. Survey with sample drawn from records. NHS + PCTs providing maternity care in England.	Sample of records 149 NHS+2 PCTs. Women over 16 yrs with maternity experience.	Minority ethnic women were more likely than white British women to access services late, not have a scan by 20 weeks and experience complications during pregnancy and birth.	<ul style="list-style-type: none"> Response rate slightly low at 59%. Response from some BME groups was low. The analysis based on the largest survey and questionnaire based on previous national survey conducted by National Perinatal Epidemiology Unit (NPEU).
14. (Rowe <i>et al.</i> , 2008) /UK	32	Cross-sectional logistic regression.	836 participants.	This study provides recent, good-quality evidence that women born	<ul style="list-style-type: none"> Response rate was not high at 57%.

To identify any social or ethnic differences in accessing antenatal care, and to quantify the effect of any such differences using data collected in a survey of women's experiences of antenatal screening.		A postal questionnaire. A stratified, clustered, random, UK hospital with more than 15% women of BME.	Pregnant women over 16 yrs.	outside the UK and those living without a husband/partner may be at particular risk of late attendance for antenatal care.	<ul style="list-style-type: none"> Response bias affects reliability of study; non-responders were younger and from BME more than responders.
15. (Hawkins <i>et al.</i> , 2008) /UK To compare health behaviours during pregnancy (smoking and alcohol consumption) and after birth (initiation and duration of breast feeding) between British / Irish white mothers and mothers from BME; and, in mothers from BME, to examine whether indicators of acculturation (generational status, language spoken at home, length of residency in the UK) were associated with these health behaviours.	32	Prospective nationally-representative cohort study. Survey. Stratified cluster sampling. England.	Participants: 6,478 British/Irish white mothers and 2,110 mothers from BME. Comparison between British/Irish white mothers and mothers from BME.	After immigration, maternal health behaviours worsen with length of residency in the UK.	<ul style="list-style-type: none"> This study did not explain the influence of acculturation on the access to healthcare services. Small number of BME in cohort study which limited the generalisability to mothers from BME. The cohort study not designed to assess acculturation but used indicators such as language spoken at home and length of residency. This might affect the reliability of the study.
16. (Hawkins <i>et al.</i> , 2010) /UK The study aims to examine the contributions of conventional lifecourse factors and women's domestic trajectories to smoking behaviour before pregnancy and postpartum among women from minority ethnic groups.	34	Study based on Millennium Cohort Study/Survey. A stratified clustered sampling. UK.	2,140 mothers from Millennium Cohort Study. Minority ethnic groups.	Among women from minority ethnic groups, those on more disadvantaged social and domestic lifecourse trajectories were more likely to smoke before pregnancy and postpartum.	<ul style="list-style-type: none"> The study was constrained by using only data available in the MCS.

17. (Howell <i>et al.</i> , 2001) /UK The aim of the study was to compare the uptake of a folic acid health message in two different ethnic groups.	29	Survey. Univariate analysis Questionnaire. Tower Hamlets, in East London.	Women attending for a booking between October 1997 and July 1998. White and Bangladeshi women.	Univariate analysis showed that white women were 5.7 [95% confidence interval (CI) 2.5, 13.2] times more likely to have taken folic acid supplements before conception than Bangladeshi women.	The limitations for the study which affect the generalisability: <ul style="list-style-type: none"> Recruitment process not explained. Language of questionnaire not mentioned. The study done in one place (Tower Hamlets). The duration of the study is limited 9 months only.
18 (Knight <i>et al.</i> , 2009) /UK To describe on a national basis ethnic differences in severe maternal morbidity in the United Kingdom.	33	National cohort study using the UK Obstetric Surveillance System (UKOSS). The UKOSS methodology. All hospitals with consultant-led maternity units in the UK.	686 women. Women with severe maternal morbidity.	Severe maternal morbidity is significantly more common among non-white women than among white women in the UK. These differences may be due to the presence of pre-existing maternal medical factors or to factors related to care during pregnancy, labour and birth; they are unlikely to be due to differences in age, socio-economic or smoking status, body mass index, or parity.	<ul style="list-style-type: none"> The study provides good evidence about the problem of access to healthcare by Black and minority ethnic groups (BME). The duration of study was limited to one year.
19. (Singh <i>et al.</i> , 2002) /UK To focus on the information needs of first-time mothers during pregnancy.	27	Survey. A self-completed questionnaire. Random sample. Scotland, Wales and North Ireland.	702 women. Pregnant women including BME.	Over two thirds of the 702 first-time mothers surveyed said that they wanted to know 'a great deal' about pregnancy and birth and all had some unmet information needs. Young mothers, ethnic minorities, and women from lower socioeconomic groups showed the greatest desire for more information. Pregnancy book was the most useful source of information.	<ul style="list-style-type: none"> Randomised sample from largest database of pregnant women. Response rate at 61% not high. Teenagers and BME groups were less likely to use written material and antenatal class. Nothing mentioned in the study about the reason for that. How the researcher assesses the reliability and validity of the questionnaire was not mentioned.
20. (Redshaw & Heikkila, 2011) /UK To describe the worries experienced by pregnant Black and Minority Ethnic (BME) women about labour and birth and compare their experience to that of white women.	31	Survey. Questionnaires were mailed at three months postpartum. Random sample. England.	4,800 women selected from birth registration records. Post-partum women.	Study concluded that, compared with White women, twice as many minority ethnic women worried about pain and discomfort, not knowing how long labour would take and about embarrassment during labour and birth.	<ul style="list-style-type: none"> Response rate 63% (2960/4800). Compare respondents and non-respondents using aggregate statistics. Women from minority ethnic groups were probably under-represented among the survey respondents.

Data extraction - mixed method studies 21-22

Biographic details Author/Date Aim of the study	Score	Design		Finding	Comments
		Methodology Data Collection Sample/ Setting	Number/Attrition Characteristics of participants		
21. (Aung <i>et al.</i> , 2010) /UK To explore access to and utilisation of General Practice (GP) services by Burmese migrants residing in London.	31	Cross-sectional study. Mixed-method approach: In-depth interviews, Questionnaire. Snowball sampling. London.	11 participants for interview. 137 Questionnaires. Burmese migrants use GP services. 70% of them are female.	The GP registration rate was relatively high, GP service utilisation during the last episode of illness, at 56.8%, was low. The statistical analysis showed that age being younger than 35 years, lacking prior overseas experience, having an unstable immigration status, having a shorter duration of stay and resorting to self-medication were the main barriers hindering Burmese migrants from accessing primary healthcare services.	<ul style="list-style-type: none"> The use of mixed-method triangulation increases the credibility of the study. In-depth interview followed quantitative data to validate the finding. The use of qualitative and quantitative methods means the research question can be fully addressed because the qualitative research may help to inform the findings of the quantitative intervention.
22. (Ahmed <i>et al.</i> , 2010) /UK To provide an overview of the perceptions and experiences of Arabic speakers in one university community about primary care services in Scotland.	30	Exploratory descriptive design. In-depth interviews. Convenience sample. Questionnaire. One university in Scotland.	20 participants. Arab students.	The majority were satisfied with the availability of a healthcare professional of their preferred gender, and their communication with and attitudes of healthcare professionals, as well as the health information provided.	<ul style="list-style-type: none"> Selection bias, all participants have medical background and from one university. Nothing mentioned about data saturation or reflexivity of the researcher. The study highlighted the importance of having information in an appropriate language for BME and the practitioner needed relevant cultural information.

3.3 The Literature Review

The focus of this narrative review is on the access to, and use of, healthcare services, particularly maternal and child healthcare services, by minority ethnic groups in the UK. Therefore, the included studies (see table 3), reviews and key reports are used in this section to provide evidence and a robust background for the study.

From the literature, there is evidence of inequities in healthcare for minority ethnic groups (Knight *et al.*, 2009). To understand the inequity in maternal health among minority ethnic groups, the maternal morbidity as well as the maternal mortality should be investigated in detail. Waterstone *et al.* (2001) stated that maternal morbidity is 100 times higher than maternal mortality in the UK. However, it is known that the traditional measurement of maternal health is the maternal mortality ratio (Pollock & King, 2009). Another potential reason to look at maternal morbidity might be the presence of similarities between the causes of maternal mortality and maternal morbidity (Pollock & King, 2009). For these reasons, it can be argued that focusing on maternal morbidity will help to overcome the inequalities in maternal health.

Gross inequalities exist in the maternal mortality ratio between minority ethnic groups and white women (Pollock & King, 2009). Evidence is well documented about the inequity in health for black and minority ethnic groups (Marmot, 2010), but inequities among migrants are usually isolated from evidence and policy concerns (Jayaweera & Quigley, 2010).

Two studies discussed the maternal inequity among minority ethnic groups. Knight *et al.* (2009) used the United Kingdom Obstetric Surveillance System (UKOSS) and underscored the above assumptions, emphasizing the significant relationship between severe maternal morbidity among non-white women, particularly black African and Caribbean ethnic groups. They also considered ethnicity as an indicator of poor maternal outcomes and, as a consequence, of an increased probability of maternal death. The important issue that arises is whether ethnicity directly results in poor maternal outcomes, or if it is associated with other factors, such as low levels of education. Nevertheless, it is evident that there is a significant relationship between poor maternal condition or outcome and minority ethnic groups (Bhopal, 2006). However, for UK-born mothers of black Caribbean, black African, Indian, Pakistani, Bangladeshi and Irish descent, Puthussery *et al.* (2010) found that the UK-born

women did not face inequalities compared to white women in terms of the maternal care they received. They did not face any cultural barriers in communicating with health professionals regardless of their cultural background. However, they insist that healthcare professionals need to be sensitive to the particular needs of these groups. The main limitation for this study is the recruitment process which enrolled mothers of mainly Indian and black Caribbean descent and only small numbers from other ethnic groups, which limits generalisability.

From the literature review, four overarching factors emerged which influenced the access to, and use of, healthcare services, particularly those addressing maternal and child health, by minority ethnic groups in the UK. The literature suggests that each of these factors interacts with each other and affects the access to, and use of, maternal and child healthcare among minority ethnic groups in the UK. Some of these factors can be considered as both barriers and facilitators in accessing healthcare services. These factors will be discussed thematically based on empirical findings in sections 3.3.1, 3.3.2, 3.3.3 and 3.3.4. The emergent themes from the synthesis of the studies reviewed were categorised into four themes:

- The lack of knowledge of the NHS and the UK healthcare system.
- Healthcare services and their utilisation.
- Communication and information provision and needs.
- Cultural variations.

3.3.1 The lack of knowledge of the NHS and the UK healthcare system

Lack of knowledge of available healthcare services and how to use them is one of the key factors identified that makes the minority ethnic groups less likely to consume healthcare services (Netto *et al.*, 2001; Gulliford & Morgan, 2003; Davies & *et al.*, 2000). This theme is considered the keystone for utilising healthcare services. Many studies from the literature have discussed the lack of knowledge of the healthcare system in the UK (Ahmad *et al.* 2010; Puthussery *et al.*, 2010).

Szczepura (2005) stated that newness or user-ignorance explains the pattern of poor access to health services of new groups due to their lack of knowledge of available services and unfamiliarity with the NHS system. Ahmad *et al.* (2010) adopted an exploratory methodology designed to reflect the limited knowledge related to the perception and experience of Arabic-speaking individuals in using GPs. One quarter of participants lacked information about

access to primary care. Interestingly, the authors stated that, although all participants were studying health-related programmes, the problem of a lack of knowledge existed. However, the major limitation was selection bias, where all the participants were studying health programmes and the study took place in one location, which affected the generalisability of the findings (Bowling, 2002). The other study, based on Grounded Theory, emphasized the importance of knowledge in having the ability to access the services. Puthussery *et al.* (2010) argued that the familiarity of women from minority ethnic groups with the healthcare service improves their access and utilisation of these services. In this study, the participants were UK-born mothers who did not suffer from a language barrier. The major limitation is the recruitment process as outlined above.

The Longitudinal Birth Cohort study based on the largest survey follows a sample of children born in the UK at the beginning of the new millennium and provides good evidence. It highlighted that migrant women, Pakistani and black Caribbean, are more likely not to receive immunization for their infants. However, the study did not investigate deeply the actual reasons why the response rate was low in the Black and Minority Ethnic group (Jayaweera & Quigley, 2010). In this study, a lack of knowledge could be the main reason for not receiving immunisation.

Moreover, Aspinall & Jacobsen (2004) found that minority ethnic groups are less likely to use dental services. A lack of information, language barriers and costs are the main reasons identified for that. This might suggest that lack of knowledge might play an integral role in the access to, and use of, different health services. A lack of knowledge and information about services by minority ethnic groups means that they might lose many of the benefits from accessing and utilising healthcare services (Shah & Priestley, 2001). Moreover, unfamiliarity and insufficient knowledge about their rights to use healthcare services by people from specific minority ethnic groups are also considered as main barriers (Burns *et al.*, 2007).

It is crucial for minority ethnic women to be familiar with, and have sufficient knowledge about, health services in order to maximize their benefits and decrease inequity in health.

3.3.2 Healthcare services and their utilisation

The healthcare system and services in the UK might be different from those in the country of origin of women from minority ethnic groups. Therefore, familiarity and knowledge of available healthcare services might affect utilisation of those services. Eleven studies were identified which discussed the utilisation of healthcare by minority ethnic groups, migrants or asylum seekers. Four sub-themes were identified: general practitioner (GP) services; antenatal care, screening and late booking; care during labour and birth and postnatal care.

O'Donnell *et al.* (2007) argued that the absence of a primary care system in asylum seekers' home countries would impact on their views of healthcare in the UK. Consequently, seeking medical help might be reduced. Some participants from the "Arabic speaking students' primary care experiences in Scotland study" mentioned that they felt unable to trust the healthcare system in the UK and they preferred to postpone their treatment until returning to their countries. However, two thirds of participants viewed the healthcare professionals as competent and helpful (Ahmad *et al.*, 2010). This study did not investigate the actual reasons for the mistrust of the UK care system; despite it being well known in Arabic countries that the British healthcare system delivers a high standard of care. This suggests that a future in-depth study is required.

3.3.2.1 GP services

Primary care services are provided by general practitioners in the UK. The GP is the first point of contact for most medical services. The care is provided by the GP either directly to the patients or by referral to other health services based on patients' needs. An example is sending pregnant women for follow-up at midwifery services. Therefore, access and use of GP services is considered to be a crucial matter. Three studies discussed the barriers to accessing a GP (Aung *et al.*, 2010; Ahmed *et al.*, 2010; O'Donnell *et al.*, 2007).

O'Donnell *et al.* (2007) conducted a qualitative study with fifty-two asylum seekers, 16 of them participated in one-to-one or group interviews using an interpreter and the remainder participated in focus groups. O'Donnell does not account for the use of the interpreter and how this affects data collection. This study found that most participants were registered with a GP, but they had a problem in getting appointments and complained of long waiting times both for hospital appointments and when attending accident and emergency departments. Most participants in this study came from countries with a different healthcare system to the UK's, which might have influenced their understanding of the UK healthcare system and

therefore affected their use of the healthcare services. Moreover, the participants identified that the cost of over-the-counter medication, knowledge of out-of-hours medical care and access to specialists in secondary care were some of the main barriers which had influenced their access to, and utilisation of, healthcare services. However, despite the fact that this study does not only consider maternal and child health services, it does include female participants and discusses child healthcare.

However, a mixed approach was used in the Ahmed *et al.* and Aung *et al.* studies (2010). The Burmese migrants in Aung *et al.*'s study were educated and had a good knowledge of the healthcare system in the UK. Their registration rate with GPs was high but their utilisation of GP services was low during their most recent illness. The main barriers included a lack of previous experience abroad, their uncertain, short-stay, immigration status and their use of self-medication. The study revealed that medicine brought from Burma as an antibiotic was one of the most significant barriers. This is consistent with Ahmed *et al.*'s (2010) study where the majority of Arabic students (17/20) brought medication from their home country. The use of qualitative and quantitative methods in these two studies means that the research question can be fully addressed because the qualitative research may help to inform the findings of the quantitative investigation. However, nothing was mentioned about the reflexivity of researchers and data saturation in either study. Other problems highlighted in these studies are a lack of continuity of care and difficulty in getting timely appointments (Ahmed *et al.*, 2010; O'Donnell *et al.*, 2007). These studies highlight the most important barriers to accessing GP services. The main problems are lack of previous experience abroad, immigration status, self-medication, language barriers, long waiting time, problem in getting appointments and mistrust of healthcare professionals.

3.3.2.2 Antenatal care, screening and late booking

It is known that antenatal care is important to health outcomes for the women and their babies (Rowe & Garcia, 2003). The time of entry into maternity care has a relationship with the health outcome for women (Buller *et al.*, 2007). However, booking late appointments is an increasing problem among minority ethnic women. Evidence has shown an association between ethnicity and late or poor attendance for antenatal care (Rowe & Garcia, 2003), and National surveys of maternity care have emphasised ethnicity as an indicator of poorer experience (Redshaw *et al.*, 2007; Raleigh *et al.*, 2010).

In 2007, the Centre for Maternal and Child Enquiries (CMACE) published a report called “Saving Mothers’ Lives”. This report highlighted the problems in booking, such as late booking. It pinpointed that missing four routine antenatal visits is the cause of 20% of maternal deaths. According to this report, minority ethnic groups' access to antenatal care is either late, after 22 weeks' of pregnancy, or not at all (The Confidential Enquiry into Maternal and Child Health (CEMACH), 2007). A more recent report published by CMACE showed that different ethnic groups account for 75% of deliveries for the financial year 2008/09 in the UK (Centre for Maternal and Child Enquiries (CMACE), 2011). Moreover, this report showed that about 26% of the mothers who died from causes directly and indirectly linked to their pregnancy had poor attendance, or even no attendance, at antenatal care (Centre for Maternal and Child Enquiries (CMACE), 2011). Hence, according to this report, more attention should be paid to late attendance at maternity services by women from minority ethnic groups.

Many studies deal with this theme from the literature, but they do not account for reasons for late booking or why the utilisation of antenatal services is low among minority ethnic women (Raleigh *et al.*, 2010; Rowe *et al.*, 2008; Jayaweera and Quigley, 2010). Moreover, Rowe *et al.* (2008) argued that evidence about late booking in antenatal care among minority ethnic groups is of poor quality because of its failure to investigate factors such as socio-economic status.

Rowe *et al.*'s (2004) systematic review showed that women from minority ethnic groups are less likely to receive screening for certain conditions and they are also less likely to be offered screening. It suggests a relationship between early booking for prenatal services by women from minority ethnic groups and the services offered to them. This systematic review showed evidence that women from Asian backgrounds have lower utilisation of screening for Down's syndrome and neural tube defects compared to white women. Asian women were less likely to be offered such screening tests. Moreover, the review showed a strong relationship between ethnicity and the offer of screening tests for Haemoglobin disorders (Rowe *et al.*, 2004). It is not clear from the study why the Asian women were less likely to be offered the test, hence more investigation is needed. However, Permallo's view (2006) is that offering screening tests in the first trimester would increase the take-up of this test by BME groups.

Two recent survey studies (Rowe *et al.*, 2008; Raleigh *et al.*, 2010) showed that minority ethnic women tend to access services late, not having a scan by 20 weeks, which is consistent with the previous literature. In addition to ethnicity, Raleigh *et al.* (2010) mentioned other factors which played a role in late booking such as being a single mother and those with an earlier age for completing education; the major limitation is the low response rate from some BME groups. However, the analysis and questionnaire were based on a previous national survey conducted by the National Perinatal Epidemiology Unit (NPEU).

Jayaweera and Quigley (2010) indicated that neither country of birth nor ethnic group is associated with utilisation of antenatal care. However, the strongest predictors were young age, level of education, unemployment, occupational class and living in an area populated by ethnic minorities. This study showed no connection between the length of residency in the UK and antenatal care. However, Rowe *et al.* (2008) concluded that the probability of late initiation of antenatal care was more than four times higher for women born outside the UK compared with women born in the UK. Late bookings were six times higher for black women compared with white women. The limitation of this study was the response bias, which affected its reliability; non-responders were more likely to be younger and from the BME groups.

This evidence draws attention to the size of the problem among minority ethnic women, especially those born outside the UK. Late booking for antenatal care means that many benefits, such as screening tests, will be lost, which may affect the health of women and their babies.

The reason behind not attending antenatal care classes may be due to not offering this services to the women (Ali *et al.*, 2004), or the presence of both sexes in the classes, for example, as trainer or a participant's partner as illustrated in many studies (Ali *et al.*, 2004; Bawadi, 2009). The presence of males in the ante-natal class may make the class culturally inappropriate (Kensington, Chelsea & Westminster BME Health Forum, 2004). Ellis (2004) commented on antenatal classes in the UK and argued that maternity services are in fact scheduled for white, middle-class women. This was supported by discussing how antenatal classes designed for couples might exclude Muslim women just because they include men in the classes (Kensington Chelsea & Westminster BME Health Forum, 2004).

3.3.2.3 Care during labour and childbirth

Childbirth is considered to be a painful experience which varies among women. In order to facilitate the childbirth process, healthcare services must be accessible, adequate and meet women's needs during labour and childbirth.

Two survey studies are presented under this sub-theme (Redshaw & Heikkila, 2011; Knight *et al.*, 2009). Knight *et al.*'s study showed that severe maternal morbidity is more common among non-white women than white women in the UK. This study suggests that women from minority ethnic groups have a problem in accessing healthcare services during pregnancy, labour and birth. According to Knight *et al.* (2009), this problem of access is not related to factors such as smoking, body mass index, age, socio-economic status or parity, but is related to inequity in maternal medical factors or care during pregnancy and birth. This study highlights an important message to clinicians and policy-makers aiming to decrease the inequities in healthcare as they affect the maternal health issues of women from minority ethnic groups: there is a need to improve their access to such services. This study provides good evidence regarding the inequity in healthcare during pregnancy, labour and birth, which explained the high rate of mortality and morbidity among minority ethnic women.

Redshaw and Heikkila (2011) carried out a survey in England using postal questionnaires. They were mailed 3 months postpartum to a random sample of 4,800 women, with a 63% (2,960) response rate. This study showed a difference between women from black and minority ethnic groups compared to white women in terms of pain and discomfort, not knowing how long labour would take and about embarrassment during labour and birth. According to this study, women from minority ethnic groups were more likely to be hospitalised for at least one night during pregnancy and had depression more than white women. This could be correlated with the presence of worries among BME women involving a lack of knowledge about the childbirth process and labour. The main limitation of this study was the under-representation of minority ethnic groups. More recently, Jomeen and Redshaw (2013) carried out a secondary analysis of this survey for text responses of the BME participants (n = 219). The findings highlighted enduring concerns affecting the quality of maternity care for BME women, and that these issues such as staff attitudes and postnatal care are coherent with other international studies.

The previous literature demonstrates that the needs of women from minority ethnic groups are different from those of white women. They provide evidence about the inequity in

healthcare during labour and birth. Therefore, healthcare services must be aware of these problems and be more sensitive to women's needs.

3.3.2.4 Postnatal care

Midwives and health visitors provide follow-up and care in the postnatal period for both the mother and baby. This care must be comprehensive and cover the potential problems such as postpartum depression. Unskilled health visitors and midwives may be one of the barriers to efficient postnatal care.

Two qualitative studies about postnatal depression services are presented under this sub-theme (Edge, 2008; Almond & Lathlean, 2011). Almond and Lathlean used a case study with different data collection methods: observation, interviews and document analysis. Respondents mainly included health visitors, managers and Bangladeshi and English women. Despite the presence of a policy in the organisation that aimed to create equitable postnatal depression services, this study showed that health visitors were unclear about its implementation. Moreover, health visitors were not trained to assess and treat the needs of women from minority ethnic groups. This study showed that, consistent with other studies, there is an inequity that exists in the provision of postnatal care between white women and women from minority ethnic groups. This case-study approach might lack generalisability, because it is limited to the particular case, which is an organisation in the NHS. Moreover, in this particular study, data were collected in 2003 but only analysed in 2008. Therefore, it can be argued that the long gap might affect the quality of data analysis and, moreover, the data itself might have become out-of-date. Another study, about the exploration of the absence of black Caribbean women from clinical and epidemiological data on perinatal depression in the UK (Edge, 2008) identified ethnicity and personal barriers as important factors that affect black women's access to healthcare.

Both studies suggested a failure of some health professionals to diagnose perinatal depression in women from minority ethnic backgrounds. Therefore, the study recommended training for health professionals to deal with and manage the depression of women from minority ethnic groups.

3.3.3 Communication and information provision and needs

Kreps (2006) argued that racial disparities in health outcomes are related to communication problems within the healthcare system, which can lead to unequal access to health information and inadequate participation in healthcare decision-making. Effective and adequate communication are important in providing good maternity care (Premkumar, 2008). In this section, language barriers, interpreter services and the need for information will be discussed.

3.3.3.1 Language Barriers

Language and communication are determinants of the quality of care, especially for minority ethnic groups who typically do not share the primary languages of the healthcare system (Cross-Sudworth, 2007). Many studies have highlighted the language barrier as a significant obstacle to accessing maternity services (Chan, 2000; Davies & Bath, 2001; Jayaweera *et al.*, 2005; Straus *et al.*, 2009) and linked it to a decrease in women's satisfaction with their childbirth journey. Others have stated that communication and language are a central basis for the quality of healthcare (Cross-Sudworth, 2007; D'Souza & Garcia, 2004), and others stressed that BME groups are likely to experience many difficulties in their contact with the health services in the UK (Ali *et al.*, 2004; Bulman & McCourt, 2002; Katbamna, 2000).

The National Service Framework for Children, Young People and Maternity Services recognised that women who do not use the services are often from disadvantaged groups: those who do not understand English and those who are unfamiliar with the NHS (Department of Health, 2004; Birgit & *et al.*, 2007). The consequences of language difficulties might be very serious. The 'Why Mothers Die' report found that the risk increased for mothers with language difficulties due to inappropriate communication and poor medical history being taken by the health professionals (Confidential Enquiry into Maternal and Child Health, 2004). A further report about Muslim's services use of health services (Kensington Chelsea & Westminster BME Health Forum, 2004) noted that many participants missed their hospital appointments because they could not read the letter

In three key qualitative studies (Chan, 2000; Jayaweera *et al.*, 2005; Straus *et al.*, 2009) in the UK, using in-depth interviews, the association between language and quality of care has been shown to exist. The eight Somali health professionals felt they were removed from the decision about the delivery process due to their inability to communicate effectively because of language problems, such as using medical terminology (Straus *et al.*, 2009). However,

Bangladeshi women who spoke English fluently believed that they had a high quality of antenatal and postnatal care (Jayaweera *et al.*, 2005). This study was limited by its small sample size that impedes its generalisability to women from other minority ethnic groups (see Bowling, 2002). In addition, there was a bias identified in the recruitment process of participants. The major limitation of the Somali study was language bias; the interviews were conducted in English, which may create cultural, and communication difficulties (plus the problem of cultural translation).

Chinese mothers emphasised that communication was a major problem, especially the language barrier between them and the health professionals. Inability to speak English was responsible for late booking. Half of health visitors had great difficulty in communicating with Chinese mothers and they used non-verbal communication and non-professional interpreters. In addition, 95% of GPs had to use both verbal and non-verbal communication. One-third of the mothers had problems making appointments by telephone although they had been in the UK for at least 7 years, whereas two-thirds could partially communicate with GPs (Chan, 2000). The triangulation made possible by the use of multiple methods increased the credibility of the study (Creswell, 2007).

Literature revealed that language barriers are the basic element that face by the minority ethnic groups in their access to, and use of, healthcare services. The presence of this barrier will affect the benefit and use of information provided during the childbirth journey.

3.3.3.2 Information provision and needs

As mentioned earlier, language competency is a crucial element in effective communication. This will enhance gaining adequate information and influence the mother's and her baby's health condition.

Four studies discussed this sub-theme. Two survey studies (Howell *et al.*, 2001; Singh *et al.*, 2002) discussed the information provision and emphasized that minority ethnic groups have difficulty in gaining information. Howell *et al.*'s (2001) study about the use of pre-conception folic acid among white and Bangladeshi women in London showed that white women were 5.7 times more likely to have taken folic acid supplements before conception than Bangladeshi women, which might indicate a problem in accessing health information sources. In Singh *et al.*'s (2002) study, 70% of first-time mothers, including those from ethnic

minorities, expressed their great need for information about pregnancy and birth. Women from minority ethnic backgrounds were less likely to attend antenatal classes or use written material. Generally, the pregnancy book was considered the main source of information. This study did not investigate the most-preferred method of delivering the information for women. In a qualitative study of Bangladeshi women, they claimed that their ability to access information related to benefits and other resources was limited due to language barriers and the absence of written information in their language (Jayaweera, 2005). The major limitations to the generalisability of Howell *et al.*'s (2001) study were that the language of the questionnaire was not mentioned and that the study took place only in Tower Hamlets.

In two further qualitative studies (Jayaweera, 2005; Davies & Bath, 2001), the sample size ranged between 9 and 13 women. The Bangladeshi and non-English-speaking Somali women claimed that their ability to access or seek information was limited due to poor communication and language barriers. According to the Bangladeshi women's perspective, the absence of a script in their language was a barrier to accessing resources. Davies & Bath's study (2001) underscored that fears and embarrassment limited the Somali women's use of interpreter services to seek information. The main limitations included: the researcher had a different background to that of the participant and could not speak the Somali language. The length of time that participants had spent in the UK was not considered. Moreover, because of the use of a convenience sampling, the findings may be difficult to generalise. In Jayaweera's study, bias in the recruitment process was present since the women who are isolated from organisational help and support were not recruited.

These studies indicate the problems in accessing health information sources. Most of these elements are considered as personal barriers. These were poor communication; language barriers; absence of a script in the women's own language; additionally, women's fears and embarrassment limited the use of interpreter services.

3.3.3.3 Interpreter services

The area of culture, language and health needs is a major concern for minority ethnic groups and healthcare providers (El Ansari *et al.*, 2009). Recent surveys showed that over 300 languages are used in London (Szczepura, 2005) and about 150 languages are used in Manchester (Manchester City Council, 2010). NICE guidelines on 'Antenatal Care: Routine care for the healthy pregnant woman' (2008) considered the presence of appropriate

interpreter services as a good practice to overcome the language barriers. However, Rowe and Garcia (2003) argued that, in practice, the use of interpreter services is usually very poor. Bulman and McCourt (2002) in west London have found that inadequate provision of interpreting services, stereotyping and racism from health service staff are the main barriers preventing Somali refugees gaining equal access to maternity services.

In 2003, a qualitative study conducted in Muslim parents' experiences of maternity services in England. It stressed that a shortage of interpreters for those who did not speak English resulted in poor communication between healthcare providers and Muslim parents (Ali *et al.*, 2004).

In a recent study of Somali women's experience of maternity services, participants stated that the presence of an unsuitable interpreter was limiting their ability to communicate (Straus *et al.*, 2009). However, in Davies & Bath's study (2001) Somali women mentioned that fears and embarrassment about sharing intimate experiences with a stranger prevented them using this service.

Lack of appropriate interpreters is one of the key factors in the failure to break down communication barriers and the consequent lack of access to healthcare services. It is inappropriate to use a family member as a translator, especially children. Many researchers highlighted the inadequate interpreter services in primary care and the full dependence upon a family member to interpret (Gerrish *et al.*, 2004; Bhakta *et al.*, 2000). Szczepura *et al.* (2005) considered the use of informal interpreters as a serious problem in healthcare settings. Therefore, it is suggested that professional and independent interpreter services should be available for women in both primary and secondary care (Centre for Maternal and Child Enquiries (CMACE), 2011). In addition, to overcome the language barrier, it is suggested by some that there is a necessity to develop bilingual advocacy, which has two functions - interpretation and advocacy (El Ansari *et al.*, 2009).

The literature has revealed that communication is an essential part of the process of care. Effective communication is a key element in increasing the quality of healthcare, especially for minority ethnic and migrant women, taking into consideration their specific needs such as language and cultural issues. Moreover, it helps those women to be familiar with NHS services and to use healthcare services effectively and participate in decisions regarding healthcare for themselves and their children. Therefore, women should be provided with

sufficient information for them and their baby during pregnancy, at childbirth and after delivery.

3.3.4 Cultural variations

Many studies have highlighted the influence of culture in utilising the healthcare services (Aung *et al.*, 2010; Ahmed *et al.*, 2010; Chan, 2000; Cross-Sudworth & *et al.*, 2011; Hawkins *et al.*, 2010; Hawkins *et al.*, 2008; Twamley *et al.*, 2010). It is clear from the literature that acceptance of cultural and religious diversity is important for successful healthcare delivery, especially for women from minority ethnic backgrounds who have different beliefs and concepts that might be barriers or facilitators to their utilisation of maternal and child health services. Moreover, the literature underscores the influence of cultural practices and traditions during childbirth (Wiklund *et al.*, 2000). It is known that the use of traditional practices and herbal medication as self-therapy is part of the Arab tradition (Ahmad *et al.*, 2010).

Ahmad *et al.*'s (2010) study underscored the importance of the healthcare profession in Scotland being familiar with Arab culture and norms, such as showing warmth and respect during communication. Most of the females preferred to see female doctors. There may be a lack of cultural awareness and stereotypical views present, which create barriers to access to health services (Szczepura, 2005). Therefore, healthcare professionals should be sensitive to culture in terms of privacy and gender (Ahmed *et al.*, 2010).

Several previous studies underlined the needs of the female patients from BME groups to see female doctors (Kensington Chelsea & Westminster BME Health Forum, 2002; Ahmed *et al.*, 2010; Ali *et al.*, 2004; Bawadi, 2009). The unavailability of female doctors was the reason for Bangladeshi women not receiving full antenatal care (Katbamna, 2000), whereas in the Ali *et al.*, study (2004) most participants felt intensely embarrassed and uncomfortable when treated by male healthcare providers.

Four qualitative studies have discussed the influence of culture when utilising healthcare services. Chan (2000) mentioned that Chinese people tend to rely more on Chinese traditional medicine, which influences their access to healthcare services. On the other hand, Straus *et al.* (2009) claimed that Somali participants used oral tradition terms to differentiate between UK and Somali culture. Therefore, they preferred to receive a verbal explanation of the information rather than using a pamphlet, even if translated. Moreover, this study highlighted other barriers factors such as stereotyping and the negative attitudes of health professionals.

Twamley *et al.*'s (2010) study identified the factors and barriers to breastfeeding among women from minority ethnic groups, the main barriers identified were the perceived difficulties of breastfeeding, a family preference, the lack of privacy and, as a consequence, embarrassment about breastfeeding in front of others. Moreover, Cross-Sudworth *et al.* (2011) suggested that cultural and social factors might influence women's access to healthcare regardless of age and education level. For example, Pakistani women with positive maternity experiences were still influenced by traditional cultural practices. The main limitations for these studies are a small sample size and the absence of response validation (see Creswell, 2007). In the Twamley *et al.* study, there is socio-economic bias in the make-up of the groups: the black Caribbean and Irish women were from a lower socio-economic group, and the Indian women were from a higher socio-economic group (Twamley *et al.*, 2010).

In fact, there might be similarities between people from Pakistan and Palestine in terms of religion and conservative culture, but evidence still need to be provided to support this supposition. Two studies (Hawkins *et al.*, 2008; 2010) have examined the health behaviour of minority ethnic women. Hawkins *et al.* (2008) have highlighted the fact that the maternal health behaviours of minority ethnic groups are worsening when compared with length of residency in the UK. This behaviour, which is an indicator of acculturation, includes smoking during pregnancy and breastfeeding. On the other hand, the study concludes that pregnant, British/Irish, white women smoke and drink alcohol more than pregnant women from minority ethnic groups. However, this cohort study was not designed to assess acculturation, and there was no respondent validation (Hawkins *et al.*, 2008). Moreover, this study did not explain the influence of acculturation on the access to healthcare services. However, Lara *et al.* (2005) indicated that the more acculturated have fewer barriers to care, although there is an association between the use of preventive services, such as 'pap smears', and acculturation. It can be concluded that there is a strong relationship between acculturation and the health of migrant women from minority ethnic groups, such as Palestinians.

The previous studies showed that the enculturation of minority ethnic groups affects their utilisation of healthcare services; this means how their home culture affects them. However, other studies have indicated that it is acculturation that influences the health behaviour of minority ethnic and migrant women. Acculturation in this context means the acquisition of new health behaviours from the new country or culture, and the abandonment of original

behaviours. Hence, health professionals cannot rely on ethnicity in their estimation of risky health behaviour among migrant women. Moreover, the effect of western culture on migrant women's health and behaviour is unknown (Hawkins *et al.*, 2008). It might be concluded that the health needs of minority ethnic groups might be different to those of the native population.

3.3.4.1 Linguistic and cultural competence

Linguistic and cultural competence in healthcare organisations is one of the factors that need to be developed in order to facilitate access for people from different languages and backgrounds. Extensive evidence is emerging of the need for cultural competence, as well as linguistic competence, in healthcare organisations. This need increases in countries and regions that have experience of population diversity, such as the UK. Linguistic competence describes “the capacity of an organisation and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, and those who have low literacy skills or [who] are not literate” (Szczepura, 2005 p,143). However, cultural dimensions might also include: patients' health, healing and wellness beliefs; how illness, disease and their causes are perceived; the behaviour of patients/consumers seeking healthcare and their attitudes toward healthcare providers, as well as the views and values of those delivering healthcare (Szczepura, 2005).

Bawadi's study (2009) used an interpretive ontological-phenomenological perspective to explore “Migrant Arab Muslim Women's experiences of Childbirth in the UK”. She concluded that maternity caregivers should provide culturally competent care, as well as, avoid cultural stereotyping by maintaining an emphasis on individualised care. This study focused on migrant Arab Muslim women experiences of childbirth in the UK and included women from different Arab Muslim countries, however; none of the participants were from Palestine. Consequently, the needs of Palestinian women may be different from those participating in Bawadi's (2009) study.

3.4 Conclusion

From the literature, there is evidence of inequities in healthcare for minority ethnic groups (Knight *et al.*, 2009). Many studies concluded that minority ethnic groups have limited access to healthcare resources and welfare services, which results in health disparities (Hesselink *et al.*, 2009). This literature review has revealed four themes under which the relevant studies about the access and use of MCH by BME groups in the UK have been discussed. These are: the lack of knowledge of the NHS and the UK healthcare system; healthcare services and their utilisation; communication and information provision and needs and cultural variations. These themes are interacting with each other and affect the access to, and use of, maternal and child healthcare among minority ethnic groups in the UK.

CHAPTER FOUR

Overall Research Design

Sequential, exploratory, mixed- methods design

*“Words are but images of matters, to fall in love
with them is to fall in love with a picture”*

Frances Bacon (1561-1626 cited in Lavender et al. 2005)

Chapter Four: Overall Research Design

4.1 Introduction

This chapter explores assumptions relating to the ontology, epistemology and methodology of research paradigms in general. This is followed by justifying the use of a pragmatic approach and discussing the overall research design: sequential, exploratory, mixed-method, including the reasoning for choosing this approach. Finally, a detailed explanation of the two phases of the study with the rationale for their use within this mixed-method design will be given.

As highlighted in the previous chapter, there is no previous research that has investigated the access to maternal and child health services in relation to Palestinian women in the UK. A lack of literature to support the study topic makes quantitative methods alone an unsuitable approach for this research. Qualitative techniques are suited to explore the conceptualization of need and useful in exploring areas where little or no research has been done before (Bowling, 2002). Moreover, they can produce rich data and thorough understanding of the phenomenon under investigation. The quantitative approach is useful when we need to measure the effects of intervention or if we need to quantify people's attitudes, beliefs or opinions toward the topic of interest (Bowling, 2002). Therefore, a sequential, exploratory, mixed-method has been used. The qualitative method was chosen to explore the problem in the first phase of the study followed by the survey method in the second phase to enable confirmation of the findings and generalisability of them to a larger population. The combination of both approaches enables the full range of study questions to be explored and answered. Additionally, using this approach enables findings from one phase of the work to power the other and generate a comprehensive or holistic investigation into the area of concern (Creswell, 2003). The qualitative and quantitative methods can be complementary to each other, therefore, using both of them in one study allows for a more robust result, taking advantage of the strengths of each (Creswell, 2003).

4.2 Research paradigms of this study

Paradigms can be viewed as a way to summarise the researcher's beliefs (Morgan, 2007) and are based on ontology, epistemology and methodological assumptions. There are three questions related to these assumptions. First, the ontological question includes 'what is the

form and nature of reality? ‘What is there that can be known about it?’ Then, the epistemological question: ‘What is the nature of the relationship between the knower, or would-be knower, and what can be known?’ Finally, the methodological question is ‘How can the inquirer go about finding out whatever he or she believes can be known?’ (Guba & Lincoln, 1994: 108). The answer for the epistemological question is constrained by the answer to the ontological question. The answer for the methodological question is also constrained by the answers already given to both the ontological and epistemological questions. The methodological assumption is concerned with the methods used to gain knowledge. However, ontology and epistemology are concerned with the fundamental beliefs of the researcher (Guba & Lincoln, 1994).

Based on these assumptions, three research paradigms are presented: positivism, constructivism and post-positivism. According to their ontological and epistemological assumptions, positivism and constructivism sit at two extremes, while post-positivism sits in between and closer to the positivist end of the spectrum (Guba *et al.*, 2000). Post-positivism shares some beliefs held by positivists and constructivists (Guba & Lincoln, 1998). Qualitative purists or constructivists argue for the superiority of constructivism and reject positivism. They emphasise that multiple-constructed realities abound and argue for the superiority of constructivism. Qualitative purists prefer detailed, rich descriptions, written in a direct way and informally (Johnson *et al.*, 2007). However, quantitative purists or positivists believe that social observations should be treated as entities and that the observer is separate from the entities (Johnson *et al.*, 2007). They maintain that social science inquiry should be objective. The researcher should eliminate their biases, be isolated from the study and emotionally detached. Both of the qualitative and quantitative purists view their paradigms as the ideal one (Johnson *et al.*, 2007).

The basic principle of this debate, sometimes referred to as the “paradigm wars” (Erzberger & Kelle: 457), is whether qualitative and quantitative approaches are compatible or not (Johnson *et al.*, 2007). The incompatibility thesis states that the qualitative and quantitative research paradigms should remain completely separate. They are incompatible due to their different epistemologies, which are strongly linked to particular methods (Sale *et al.*, 2002). However, the compatibility thesis believes that it is possible to carry out mixed-method research, but the researcher should carefully review the assumptions of each paradigm.

Neither qualitative nor quantitative methods under this stance will be the driving force behind a study and dictate the epistemological stance used (Morse, 2003).

In order to address the paradigm 'war', the pragmatist approach was enlisted (Howe, 1988). This allows the use of both quantitative and qualitative methods in the study (Tashakkori & Teddlie, 1998). The paradigmatic stance argues that methods and epistemology are not linked in real-world research and research should continue independently from the paradigm debates (Bryman, 2007). The next section discusses this approach.

4.2.1 The pragmatic approach

Classical pragmatism originated in the late 19th/ early 20th century. The father of pragmatism is Charles Sanders Peirce (1877). The word 'pragmatic' is derived from the Latin word *pragmaticus* that means 'skilled in business or law'. It is highlighting the realistic function of knowledge as an instrument to adapt and control the reality. This approach agrees with empiricism, which stresses the priority of experience rather than reasoning (Peirce & Turrisi, 1997).

The pragmatic approach has been defined as a:

“Deconstructive paradigm that debunks concepts such as truth and reality and focuses instead on what works as the truth regarding the research questions under investigation. Pragmatism rejects the either/or choices associated with the paradigm wars, advocates [the] use of mixed methods in research, and acknowledges that the values of the researcher play a large role in the interpretation of results” (Tashakkori & Teddlie, 2003: 713).

The pragmatic framework is considered by many authors as the most appropriate paradigm for mitigating the use of mixed-methods research (Howe, 1988; Tashakkori & Teddlie, 2003; Tashakkori & Teddlie, 1998). Tashakkori and Teddlie (1998: 22-30) summarise the connection between mixed methods and pragmatism as follows: first, pragmatism encourages the use of qualitative and quantitative methods in the same study and between phases in a research programme. Second, the pragmatic researcher considers the research questions to be more important than the method and the paradigm that underlies the method. Third, the

pragmatic researcher keeps away from using metaphysical concepts such as ‘truth’ and ‘reality’. Fourth, they refuse the obligatory choice between post-positivism and constructivism with regard to epistemology, logic and so on. Moreover, pragmatism avoids the use of metaphysical concepts (e.g. “truth,” “reality”) that have caused much endless discussion and debate. Finally, the application of the pragmatic philosophy is considered as being very practical (Tashakkori & Teddlie, 1998).

After reviewing the research paradigms, the pragmatic approach was selected as the most suitable one for this study and fitted with the researcher. It meets the study aim to investigate access to, and the use of, healthcare services, particularly maternal and child healthcare, by Palestinian women in the UK.

4.3 Overall Research Design - Sequential, exploratory, mixed-methods design

Researchers have been using mixed-method approaches for decades (Tashakkori & Teddlie, 1998; Teddlie & Johnson, 2009). However, recently, this method has developed rapidly and emerged as a research movement (Onwuegbuzie *et al.*, 2010). Mixed-method research is also called mixed research. Johnson *et al.* (2007) have analysed the 19 definitions of mixed-method research and, in order to overcome potential gaps in definition, produced a new definition:

“Mixed-methods research is an intellectual and practical synthesis based on qualitative and quantitative research; it is the third methodological or research paradigm (along with qualitative and quantitative research)” (2007: 129).

Therefore, the inclusion of both quantitative and qualitative approaches within a study is the traditional basis for mixed methods.

The development of this approach began in the 1980s; the researchers at that time began expressing concerns about the mixing of quantitative and qualitative data without providing defensible reasons (Greene *et al.*, 1989). Subsequently, many scholars began identifying a number of rationales for combining the data-collection methods and research questions particular to different mixed-method research designs (Greene *et al.*, 1989).

Reasons or justifications for using mixed methods may differ, depending on an author's aims, beliefs and values. Greene *et al.* (1989) present an influential summary of five different purposes of mixed-method research. First, Initiation - to look for contradictions or new perspectives on results or questions by using different methods. Second, Expansion - to extend the range of inquiry by using different methods in a study. Third, Development - to develop one method using the results from another method. Fourth, Complementarity - to clarify results from one method by using another method's results. Finally, Triangulation - to have corroboration by using different methods. Later on, Bryman (2006) reviewed published mixed-method studies and identified 18 reasons for using mixed methods. He concluded that complementarity, as defined earlier by Greene *et al.*, (1989), was the most common. Bryman (2006) warns researchers of the outcomes of their research and the rationale behind using mixed methods. The mixed-methods studies may not always be predictable as studies progress (Bryman, 2006).

On the other hand, Collins *et al.*, (2006) have suggested a framework for optimising a mixed-method design that includes four rationales for doing mixed research. Participant enrichment to optimise or increase the sample size; instrument fidelity to increase the appropriateness of the instrument/tool; treatment integrity to assess the fidelity of the intervention or programme and significant enhancement to maximise the researcher's interpretations of data.

In addition, three factors should be considered when determining the mixed-method design. The first factor is the timing of the qualitative and quantitative parts. According to Tashakkori & Teddlie (2010) the key design component in implementing mixed-method research is to decide whether it should be parallel or sequential. Parallel refers to the research phases occurring simultaneously or with the same time lapse, while sequential refers to the research phases occurring consecutively, with one phase following the other. The second factor is the study weighting that involves deciding whether one method should play a greater role or if one method is more important or both methods are of equal standing in addressing the study questions (Morse, 1991). Lastly, (Creswell & Plano Clark, 2007) stated that the mixing of quantitative and qualitative methods can include the merging, embedding or connecting of methods.

Creswell & Plano Clark (2007: 86) explained the sequential, exploratory, mixed-method design as:

“If one phase is followed by another phase, the first phase is qualitative, the two phases are connected by the development of an instrument based on the results of the first phase, and the intent is to develop and implement an instrument on the topic of interest, then the choice of design is the Exploratory Design-Instrument Development model”.

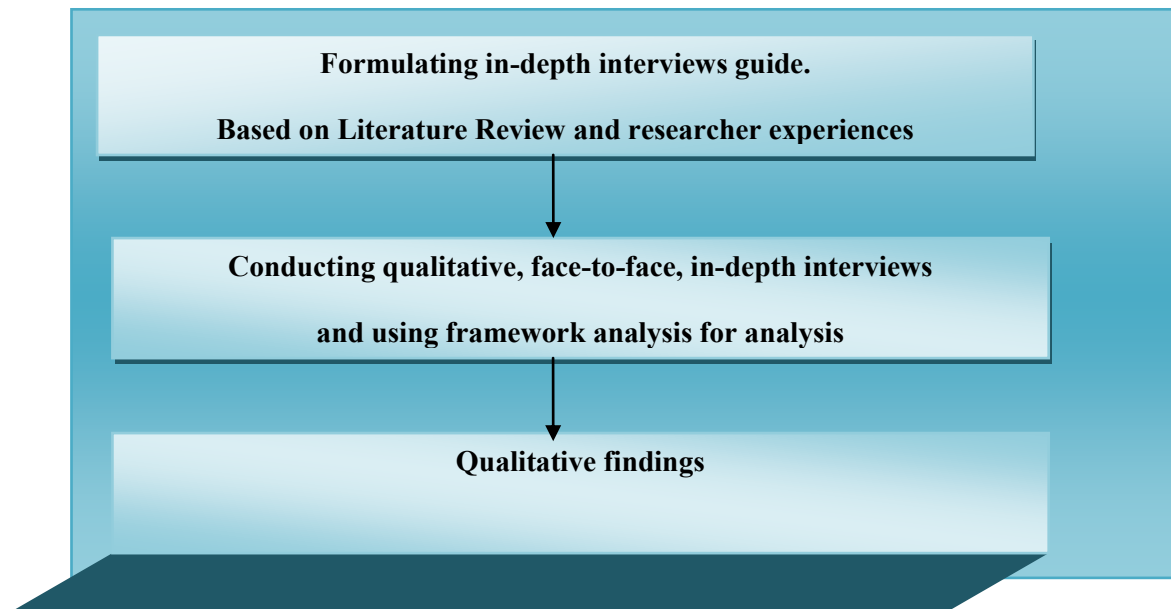
Creswell & Plano Clark (2007) had mentioned that in using this approach the emphasis and priority will be on the second phase of study (quantitative phase), while the qualitative phase plays a secondary role. Tashakkori & Teddlie (1998:151) separate the terms *stage* and *phase* in a sequential mixed model study. While the stage refers to a component of a study, for example, the framing of the research question, or data collection, or data analysis, the phase refers to a complete research effort consisting of a number of stages.

In this study, this model was adopted using both qualitative and quantitative research methods, starting with qualitative in-depth interviews, with the findings from this phase used to develop a quantitative questionnaire survey to investigate the research question and to examine how Palestinian women access and use MCH services in the UK. Both phases of the study are complementary to each other. Every phase of research has its own data collection, analysis and discussion. Figure 4.1, below, presents the overall research design of the study.

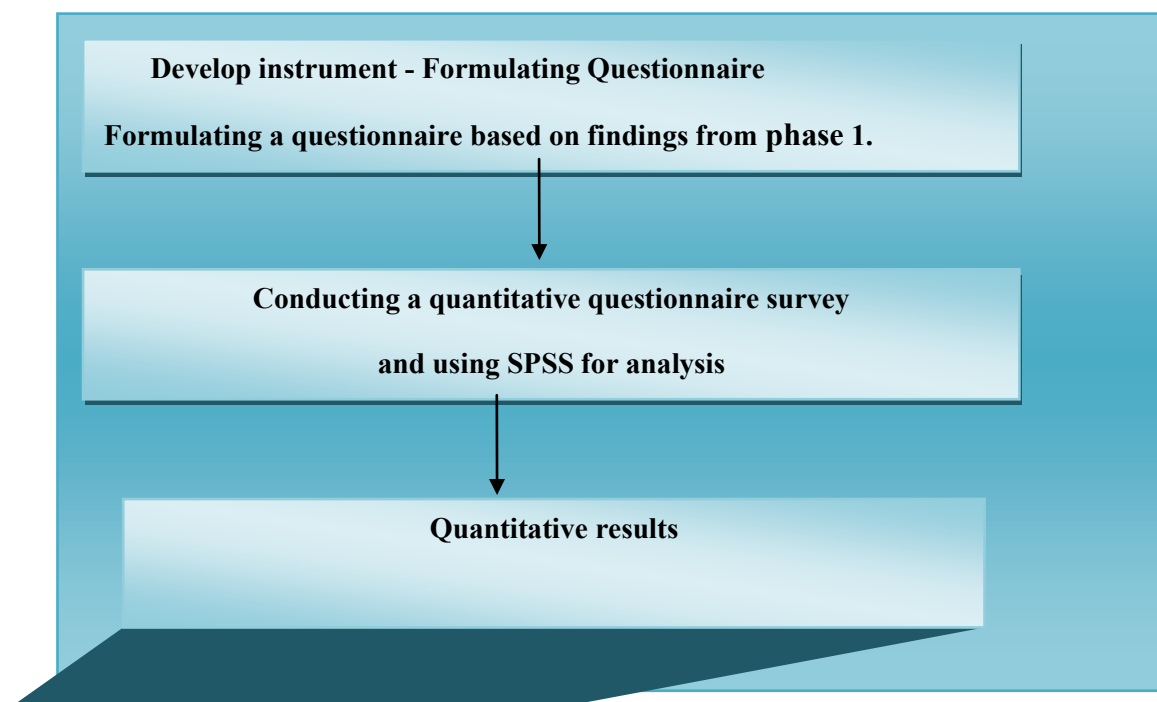
Mixed methods research has become increasingly popular in healthcare where there can be complex social problems, such as that highlighted in this research. Mixed methods research, which uses both qualitative and quantitative research methods, can overcome the limitations of each approach, and as such, better address these complex social problems (Tashakkori & Teddlie, 2008; Creswell, 2009). The research that results from mixed method design will guide healthcare professionals to improve healthcare quality and patient outcomes. The qualitative and quantitative phases are complementary to each other and that helps to increase the research validity (Creswell, 2003).

Figure 4.1: Overall Research Design – Sequential, exploratory, mixed-methods

Phase One; Qualitative in-depth interviews



Phase Two; Quantitative questionnaire survey



4.3.1 Research method used in phase one

A literature review (Chapter 3) was conducted by the researcher which revealed that no studies regarding the use of MCH by Palestinians as a minority ethnic group in the UK were known, but it did include research literature about women from other minority ethnic groups. Therefore, qualitative, in-depth interviews were initially used to explore the issues relating to MCH in the first phase of this study. Moreover, they provide rich data about access to, and the use of, maternal and child health services by Palestinian women in the UK.

The first phase of study was designed as a qualitative study using a pragmatic approach for the exploration and description of how Palestinian women, as one of the BME groups in the UK, use and access MCH services. Qualitative research has become more widely accepted in health services research. It can be assessed based upon two criteria: validity and relevance (Mays & Pope, 2000). The central strength of this approach is that it provides both philosophical and methodological support by trying to capture the meaning of significant human experiences in a rigorous manner. This gives an insight into what an experience or lived situation is like (Gerrish, 2001). To ensure rigour, and thus quality, in qualitative research, the basic strategy is a systematic, self-conscious, research design as discussed in Section 5.7 (Mays & Pope, 2000).

4.3.2 Research method used in phase two

Qualitative in-depth interviews provide rich information in the first phase of this study. Phase two of the study is designed as a survey using a questionnaire developed from the findings of the qualitative interviews. This instrument (questionnaire) will be used subsequently in order to explain the findings using a larger population. Another aim is to further examine the research topic among a large group of Palestinian women in the UK and therefore, potentially generalise the results.

Surveys are “systems for collecting information to describe, compare and predict attitudes, opinions, values, knowledge and behaviour” (Fink, 1995:21). There are two basic types of surveys: cross-sectional surveys and longitudinal surveys. The descriptive survey is also

referred to as a cross-sectional survey, as data is collected at the same time from potential participants (Bowling, 2002). The prospective, longitudinal surveys are analytic, because they analyse events from many different points of time. The three main types of longitudinal surveys are: panel studies that follow-up the same population; trend studies - different samples at each data collection; and cohort studies - the sample followed up in the future has the same characteristics (Bowling & Ebrahim, 2005).

A cross-sectional design was used for the questionnaire survey in this study. This is due to the nature of the research question and the study aims. Moreover, there is no intention to follow up the participants. There are three methods of gathering information in the survey. These are questionnaires, interviews and observation (Bowling, 2002). A questionnaire method via post and email was used in this study. The major advantages of an email survey are low cost and the speed of data collection, while the main disadvantages are low response rate (which can lead to response bias) and limited access of certain people to the internet (Czaja & Blair, 2005).

In this study, the qualitative interview was used in the first phase and the quantitative research survey in the second phase. Both of these methods have their own methods of data collection, data analysis, evaluation of the research quality and discussion.

4.4 Summary

The pragmatic approach has been used in this study because it is a suitable paradigm that meets the study and researcher aims. A sequential, exploratory, mixed-method design that includes the qualitative interviews and the quantitative questionnaire survey was preferred. The integration or connections of these two phases was achieved by the development of an instrument tool based on the findings from the first phase of study. This helped to increase the validity of the study findings and generalise the results. Chapters 5 and 7 will discuss these methods in detail.

CHAPTER FIVE

Phase one of the study method

“The method consists in an attempt to build a bridge between the world of sense and the world of science”

Bertrand Russell, 1872-1970

Chapter Five: Phase 1- Methods

5.1 Introduction

This chapter introduces the methods used for the first phase qualitative research. The aim of the study is presented first, followed by a discussion on the sampling method; ethical considerations; data collection, which includes the in-depth interviews with participants recruited via three Arabic schools and a mosque, and data analysis. Framework analysis and the NVivo software programme were used to analyse the study data and produce the findings.

5.2 Aim

The overall aim of the study is to investigate and explore the access to, and use of, health services, particularly maternal and child healthcare (MCH), in the UK by Palestinian women. Based on the findings from this exploratory, qualitative phase, a questionnaire was developed in phase two, to examine these findings in relation to a larger population of Palestinian women in the UK.

5.3 Population and sample selection

The research population of this phase of study was Palestinian women living in Manchester, UK. In this study, Palestinian women were defined as those who considered their ethnicity to be Palestinian. They were included if they were aged 18 years and above, if they had experienced maternal and child care services in the UK. They were excluded if they had not met these criteria.

The logic of qualitative sampling originates from the importance of gaining a detailed understanding of an area of interest (Patton, 2002), and usually requires a flexible, pragmatic approach (Marshall, 1996). The research populations of this study were Palestinian women. They were selected through different approaches in a pragmatic way. Two approaches to sampling were used (Marshall, 1996). Firstly, a sample of women who met the inclusion criteria and who had children in one of three Arabic schools in Manchester was selected. Women attending the Mosque (Masjid) were sampled to identify other Palestinian women, especially those not having children in the three schools. Purposive or judgmental sampling is the most common sampling technique in qualitative research, whereby the researcher actively selects the most productive sample to answer the research question (Pope & Mays, 1995). Judgmental sampling is based on the belief that the researcher handpicks the sample members

based on his/her knowledge about the population (Polit & Beck, 2004). To an extent this could be done between an opportunistic or convenience sample initially as the researcher was based in Manchester, where a large proportion of Palestinian diaspora lives. Through contacts at the relevant schools and the Arabic Mosque, snowball technique was used to identify other Palestinian women living in Manchester. Snowball sampling arises from opportunistic sampling; “When a researcher identifies one respondent, he or she asks whether the respondent knows any other people who might fit the sampling requirement” (Clifford & Foundation, 1997: 23).

An important step in the research process is to choose the study sample. The selection of an appropriate method depends upon the aim of the study (Marshall, 1996). However, the lack of clear guidelines on the principles for selection of a sample has resulted in much confusion in qualitative research (Imelda, 1997). Probability sampling is rarely used in qualitative research partly because qualitative research is to understand unique cases ideographically, rather than to permit generalisation to the broader public. Many qualitative researchers use non-probability sampling for practical rather than principled reasons (Murphy *et al.*, 1998), and qualitative research is conducted in real-life, day-to-day situations, so the use of small and select sample groups can prove advantageous (Clifford & Foundation, 1997). The rationale for using small samples can be summarised in four points:

- First, if data are analysed properly, a point will be reached whereat little new information or evidence is obtained from each fieldwork unit.
- Second, there is no concern about incidence or prevalence in qualitative research.
- Third, in qualitative studies, the type of information is rich in detail.
- Finally, this type of research is highly intensive in its use of research resources. It may take a researcher several years to conduct and analyse hundreds of interviews (Ritchie & Lewis, 2003).

There are a number of issues that must be taken into consideration in determining the size of a sample. These include the heterogeneity of the population, the number of selection criteria, the extent to which nesting of criteria is needed, multiple samples within one study, groups of special interest that require intensive study, types of data collection method and the budget and resources available (Ritchie & Lewis, 2003). The Palestinian population numbers are small compared with other BME groups in the UK and Palestinian women are considered as

a hard-to-reach group. Therefore, the researcher decided to include all participants who met the inclusion criteria and consented to participate in this study for interview. Manchester was chosen for conducting the qualitative phase of the study for two reasons. Firstly, most of the UK Palestinian populations are concentrated in this city. Secondly, the researcher is living in Manchester and it is accessible for her to conduct this study, therefore it is the most effective source of participants. The next section will describe the recruitment process.

5.4 Recruitment

There are three main Arabic schools in Manchester for the Palestinian population and the Mosque provides different services for Palestinian people. These services included a Palestinian forum that meets monthly, weekly religious classes and other activities. Therefore, this study was conducted in these locations within Manchester. There are around 200-220 students in each school, around 10% of whom are Palestinian (according to head of teacher). The three schools are Almanar and Noor Arabic Schools located in Burnage, and Alhijra School located in Whalley Range. These are the only Arabic schools in Manchester. All of these schools were happy to participate in this research and wished to be identified in this study. Therefore, their names have not been anonymised. The interviewees included the teachers and the mothers of the children. The second source of participants was Didsbury Mosque, located in Didsbury, where female participants were recruited. The researcher interviewed twenty-two women in these settings. The recruitment process used three pragmatic approaches to recruit different sub-samples of Palestinian women.

5.4.1 First approach

Potential participants were invited by letter. These letters were sent by the head teachers to the mothers of children in the three Arabic schools in Manchester. These three schools are the only schools in Manchester for Arabic children to learn the Islamic religion and Arabic language. These places were a practical place to identify the sample required for the study. The invitation letter, information sheet for the in-depth interview and a return slip were written in Arabic and English languages (Appendix 5.3-5.6) and explained the purpose of the study. The mothers were asked to return an acceptance slip presented in both languages by post using a prepaid envelope indicating their willingness to be interviewed for the study. The head teacher informed the researcher that the parent must bring their children to school each Saturday and Sunday themselves, so it was easy to access potential participants on these days. Ethical issues (as in section 5.4) were considered throughout the study, for example, the issue

of confidentiality and the right to withdraw at any time were explained in the information sheet. The permission to distribute the letters of invitation was obtained from the head teacher and trustees of the three schools (Appendix 5.17-19).

5.4.2 Second approach

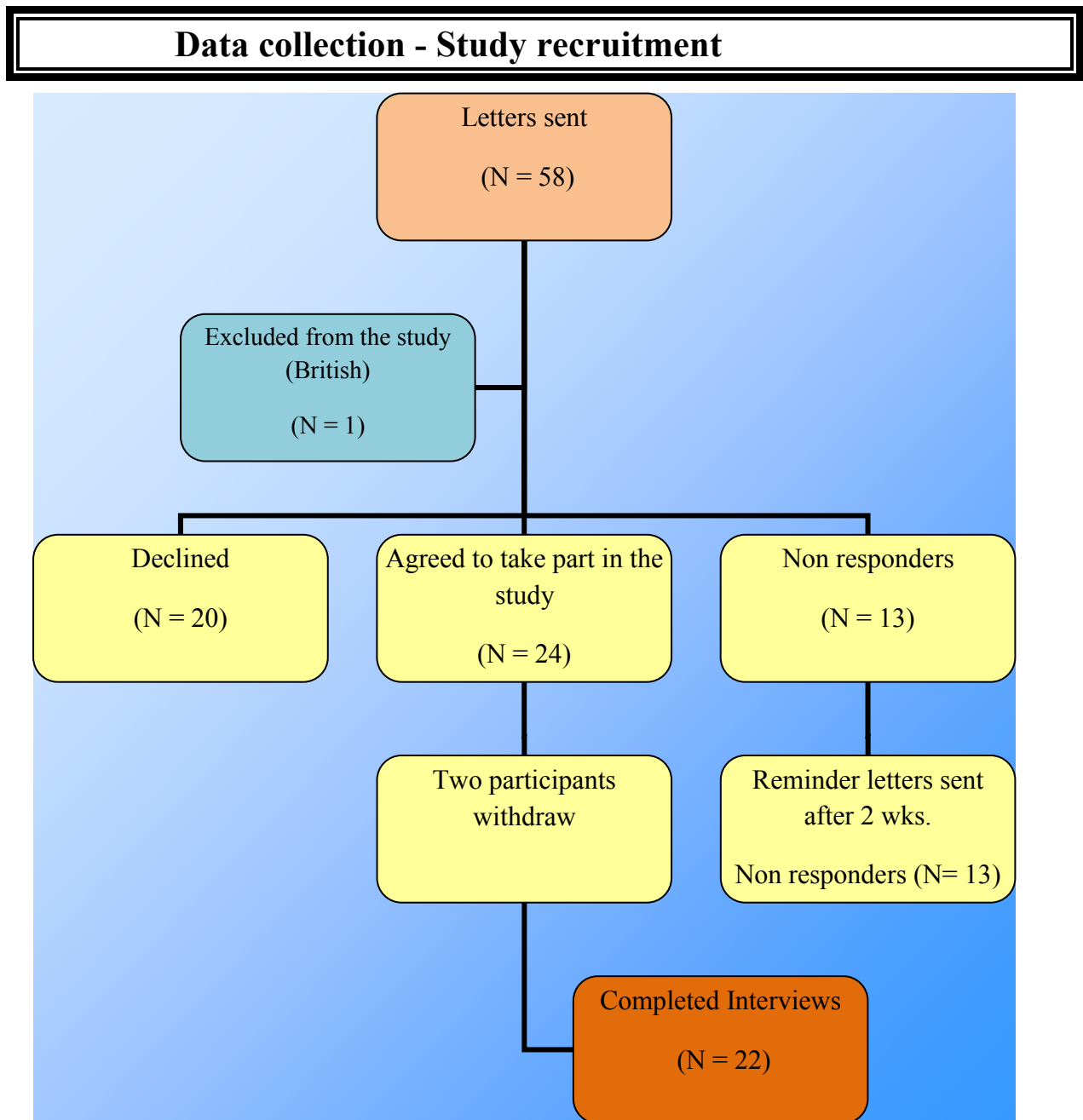
When a visit to these schools was made, Palestinian teachers were invited to participate in the study. Also, other female Palestinian teachers were recruited by using the snowball technique. The teachers who participated in the study were asked to identify other teachers from Palestine. This technique ensured that all Palestinian teachers in these schools had the opportunity to be included in the sample. Permission was obtained from the head teacher and the trustees.

5.4.3 Third approach

The Didsbury Mosque is considered a central place for the Palestinian forum and community. This site was included as a place to recruit other Palestinian women, in particular, those who did not have school-age children. This ensured a more representative sample of Palestinian women living in Manchester. The permission to conduct the study was obtained from the Imam (Appendix 5.20). Then, the women were invited by letter to participate in the study. As in the first approach, the letter distributed by the trustees of the mosque was in English and Arabic. Again, women were asked to return a slip to the researcher by post to indicate their willingness to participate in the research. Once consent was obtained, the women were interviewed at a convenient location and time. The participants who were recruited via this approach were religious Muslim. Their attendance at the Didsbury Mosque activities mainly originates from their Islamic faith. They are not like other participants recruited via Arabic schools that were simply helping their children to learn the Arabic language and to interact with other Arabic children.

Using these approaches fifty-eight women were invited to take part in the study, one of these was excluded because she is British and her husband Palestinian, twenty women declined to participate. Of the twenty-four that agreed to participate, two of them withdrew and there were thirteen no responders. The researcher followed the protocol of the study and another letter was sent to each of them. Details of the number of women who were invited to take part in the study, withdrew or were excluded are summarised in Figure 5.1.

Figure 5.1: Flow chart shows the recruitment process and results



5.4 Ethical considerations

During the qualitative interviews, the researcher is not only interested in finding out the knowledge they are looking for, but should consider whether the situation of the participants improved and whether they may be exposed to any potential harm (Kvale, 1996). Manning (2004) stated that researchers in qualitative research have ethical responsibilities to conduct

methodologically sound research. These responsibilities include gaining informed consent, to protect participants from harm, protecting their confidentiality, maintaining anonymity and disseminating the findings of research honestly. Therefore, ethical approval for conducting the research has to be considered during the whole research process. Ethical approval for the study was obtained from the Ethics Committee of the University of Manchester prior to commencing work. Appendices 5.1 - 5.20 present the ethical approval, the protocols for the study and other documents that have been used for qualitative interviews, as explained earlier.

The researcher explained to the participants before conducting the interviews that they had the right to withdraw, that information would be kept confidential and any information provided would not be attributable to a specific interviewee. Moreover, the distress policy was followed during the qualitative interviews and a point of contact that helps stressed women in both Arabic and English languages identified (Appendix 5.14 – 5.16). However, this proved to be unnecessary.

The participants of this study were healthy Palestinian women with experiences of using the healthcare services, particularly MCH services, in the UK. Three main ethical issues were considered: informed consent, confidentiality and potential harms.

5.4.1 Informed consent

Traditionally, ethical concerns have centred around informed consent (Denzin & Lincoln, 2000). There are three components of informed consent: information sharing, promoting participant understanding and assurance on the voluntary nature of participation. The participant information leaflet should clearly explain the proposed study, the rationale for doing the study and what participation would involve (Bowling, 2002). In order to promote genuine informed consent by participants, the researcher made sure that all information related to this study was presented in an information sheet (Appendix 5.7 - 5.8). In addition to this, information sheets, informed consent forms and other documents were presented in both languages in order to provide readily understandable and easily readable information. Silverman (2000) commented on the consent form that consent may not be enough, particularly when using a recording. In such cases, the researcher must obtain further consent regarding the ways in which data will be used (Silverman, 2000). Moreover, in the information leaflet for participants, the study protocol should explain how data will be

obtained (such as using audio recording during an interview). This point was included in the study's consent form (Appendix 5.9 - 5.10). The information sheet emphasised the right to withdraw from the study at any time, even after signing the consent form, without the need to provide a reason.

5.4.2 Confidentiality

Confidentiality was ensured in this study. The issues on confidentiality were discussed with potential participants before interviews were carried out. The researcher had used a series of methods for maintaining confidentiality during data collection and the data analysis process. The researcher must explain, for example, measures to protect participant identity, the storage methods for notes and recordings and the methods of their disposal upon completion of the study. All data from interviews was kept securely locked away and data were anonymised before being subject to analysis. Participants were given a number and the researcher kept their identification numbers securely. Apart from the researcher, no one was able to link individuals to their numbers. Kvale and Brinkmann (2008) commented that anonymity in an interview on the one hand can serve as an alibi for researchers and on the other can protect the participant, but can also deny the participant credit. In some cases, participants who spend a long time providing valuable information may wish to be acknowledged for their contribution to the research.

5.4.3 Potential harm

There is no specific potential harm for participants. However, the researcher had assessed the participant's level of distress or discomfort during the interviews, as explained in the distress policy (Appendix 5.16). If the researcher feels that the participant is becoming distressed or experiences discomfort the interview will be stopped and support will be provided. The researcher will encourage the women to contact their GP, specialist nurse, hospital consultant, other appropriate individual or through the NHS Direct telephone number (Appendix 5.14 - 5.15). However, all participants were happy during interviews in sharing their experience with the researcher. There is also no specific potential harm for the researcher, but the researcher has followed the risk assessment for lone workers as illustrated in Appendix 5.21.

5.5 Data collection

This section begins by justifying the use of in-depth interviews to collect data in this study and the main advantages and disadvantages of this method. It is followed by a description of the data collection process.

Interviews were conducted using a semi-structured approach (Bowling & Ebrahim, 2005). The interview is considered the gold standard of qualitative research (Silverman, 2000). From the philosophical and epistemological perspective, the interview in qualitative research is suitable for researchers who seek to access participants' experiences and understanding of the world (Holloway, 2005). There are four approaches to qualitative data collection: observation, interviews, documents and audio-visual materials. Interviews have many advantages and weaknesses. These limitations include: the interviewers provide indirect, filtered information; information is provided outside the natural field-setting; the researcher's presence may prompt some interviewees to reconsider their participation and some relevant people may be excluded (Creswell, 2009). Holloway mentioned other limitations of interviews: firstly, interviews are time-consuming, especially in transcription and analysis; secondly, the format of an interview varies between participants; thirdly, achieving an open and reflexive interview is a complex art; fourthly, an interview can capture the reconstruction of events, but not how people might actually behave (Holloway, 2005). On the other hand, the advantages of this approach include that: participants can provide historical information; it provides the closest engagement possible when participants cannot be directly observed and it allows the researcher to control the line of questioning (Holloway, 2005). Kvale (1996) proposed two positions for the in-depth interview. The first position is dubbed the "miner metaphor", which falls within the modern, social science, research model and sees knowledge "as given". The second position is the "traveller metaphor", which falls under the constructive research model that describes knowledge as creative and negotiated, but not given (Ritchie & Lewis, 2003; Kvale & Brinkmann, 2008). Holstein *et al.*, stressed that the researcher is not a "pipeline" through which knowledge is transmitted (Holstein *et al.*, 1997). Ritchie and Lewis described the researcher as an active player in developing data (Ritchie & Lewis, 2003). Although novice qualitative researchers may see interviews as an easy option, this is considered as problematic by several writers. Kvale (1996) stated that interview research may neglect both social interaction and action, both of which need observational studies (Holloway, 2005).

After considering the advantages and disadvantages of interviews, it was felt that these would be a suitable method to address the research question in the first phase of the study. Data were collected using face-to-face interviews with twenty-two Palestinian women. Face-to-face interviews involve interviewing people in a place convenient to the participant such as in the participant's or the researcher's own home or in schools or the Mosque. In this study, the semi-structured interviews used an interview schedule and open-ended questions (see Appendix 5.11) that lasted between 60 and 90 minutes. Demographic data were collected using a standard demographic protocol presented in both languages (see Appendix 5.12 - 5.13). The interviews provide an in-depth understanding of the interviewees' personal opinions and expectations (Morgan, 1997).

Malterud (2001) claimed that researchers, who use the inductive approach without applying any theory for analysis, fail to realise that their stance is unavoidably affected by theory. Thus, making explicit the standpoints of the researcher should enhance inter subjectivity in qualitative study. The researcher was an 'insider' in relation to aspects of this research, as she shared with participants their cultural and social background, as well as their understanding and experience of using MCH services in both countries Palestine and the UK. This helped to promote positive inter subjectivity in the current study. The researcher followed specific strategies and explained the reflexive process through her journey in data collection and analysis in this section and next one.

Once potential participants had been identified and had indicated their willingness to be contacted, the researcher contacted them to arrange a suitable time and place (home or school) for the interview. A semi-structured topic guide which provided the structure for the interview was developed from the literature review and based on the researcher's experiences of living and experiencing in using the MCH services in the UK. This assisted with gathering the information in detail and kept the researcher within the context of the study. The interviews did not strictly follow the guide, Rubin and Rubin (1995) pointed out that an inelastic interview may miss important insights about the topic being examined. The interviews were digitally recorded, with the permission of the women, and took approximately between 60 and 90 minutes. The researcher gained permission from the head teacher and trustees to conduct the interviews in the schools. Before the interview, a full explanation of the study and an explanation of the consent form were provided in Arabic and English (Appendix 5.9 - 5.10). The Arabic language was used throughout the interview to obtain in-depth information by the researcher.

During the data collection, the researcher attempted to understand herself including her feelings, preconceptions, values and cultural, medical and social background. This helped in acknowledging her influence on data generation, and in setting them apart, particularly as the researcher shared a similar cultural and social background with participants. The researcher had been a nurse for 15 years and knows the healthcare system in Palestine, particularly MCH services, well. Moreover, the researcher had used the MCH services in the UK before and during the data collection phase. As the researcher shared a similar cultural and social background with participants, it was easy for her to understand participants' words and feelings, which can help decrease the risk of misinterpretation. Ashworth (1986) pointed out that rich prior understandings quickly helped to capture a relevant idea and then to conduct incisive qualitative work. However, Ashworth (1986) also pointed to disadvantages. These included being so familiar with participants' cultural and social background that the researcher may fail to see other viewpoints other than the ones to which she was accustomed. To overcome this weakness the researcher ensured she maintained an open mind during data collection by gaining in-depth information. Using the "why question" was valuable and helped the researcher to understand deeply the participants' views during data generation. The researcher tried to see the situation from the participants' viewpoint by focusing on their ideas only. Discussion with other PhD students and supervisors, who have different backgrounds and qualitative research experience, was helpful. These differences allow the researcher to be more alert to specific points in interviews to which the investigator may not have been sensitive. Regular meetings with the supervisor were an important issue for the process of reflexivity during data collection. For example, analysis of the first two interviews revealed that in some places during the interviews closed questions were used. In subsequent interviews the researcher focused more in using open questions instead of closed questions, such as "can you explain it to me..." and "can you give me more detail..." in order to gain more in-depth information regarding how the participants were accessing and using the MCH services.

To ensure the rigour of the research and avoid bias during translation, the researcher translated all documents herself and asked the opinion and feedback of independent colleagues in Palestine and the UK. These colleagues are bilingual and read and speak both English and Arabic fluently and have experience in research. The researcher also participated in informal group meetings at the Manchester Metropolitan University to improve her skills

of translation and overcome the difficulty of the translation process, especially with regard to cultural issues (cultural knowledge).

Memo writing played an important role in identifying and building the framework themes in this study. Memos are the food for our thoughts. They encourage the researcher to think carefully about the data, to write down any ideas emerging from the analytical and coding process. Usually, the researcher used typed memos and dated them after each interview and during data analysis. Documenting any idea that came into the researcher's mind was helpful, particularly in comparing MCH services in the UK and Palestine. After interviewing one of the participants (number 21), the researcher wrote down the following memo:

“This participant could not speak any words in English and she said every time she booked an appointment, the interpreter is unavailable. Their kids helped her to book an appointment with [the] interpreter. She preferred her kids to go to their school and not miss a day to accompany her. So she went alone to the GP, who explained to her that [the] interpreter was unavailable. And in any emergency situation what would she do if her husband and their children were away from home” (2nd February, 2011).

The memo encouraged the researcher to think deeply about the data and directed her to further data collection. In the following interviews, the researcher paid attention to detailed information, especially for women who have language problems. To ask them how they know the specific information, who translated it for them and usually what they would do in an emergency situation.

5.6 Data analysis

5.6.1 Excel™ computer programme

The researcher used the Excel™ computer programme to analyse the demographic characteristics of the participants. The horizontal rows represented the 22 participants using coding numbers and the vertical columns related to their demographic characteristics. This demographic information included age, marital status, country of birth, number of years living in the UK, number of years living in Manchester, reason for residing in the UK, if they have a parent in the UK, level of education, current work, spoken and written English language, the number of children they have and how many children had been born in the UK. The percentage of children born in the UK was also calculated. The findings are presented in Chapter 6.2.

5.6.2 Framework Analysis & NVivo computer programme

As a pragmatist, the researcher is able to choose, to an extent, what method she should use in order to answer the question she is asking. Prior to this research, the researcher had exclusively used quantitative methods. Therefore, it was felt that framework analysis, which leans towards the positivistic spectrum for the analysis of qualitative data (Gale *et al.* 2013), not only suited her theoretical perspective and the data she collected, but was congruent with the next phase of the research, which was to collect quantitative data. This method allowed a seamless transition to the quantitative phase of the work.

Framework analysis was used to analyse the data. It is a structured data analysis method that was first used in applied policy research and then in applied health services research (Swallow *et al.*, 2003; Ritchie & Lewis, 2003; Pope *et al.*, 2000). Framework analysis is suitable and useful in health services research (Thorne, 2000). It involves organising data into a series of thematic matrices then analysing it in a systematic way. Data was transcribed *ad verbatim* and analysed using this approach. The data was coded and labelled during and after data collection (Spencer *et al.*, 2003). The interviews were transcribed for data analysis. The researcher used framework analysis because this method is suitable for systematically and comprehensively applying an analytical framework to a large quantity of qualitative data (Yardley *et al.*, 2006; Ritchie & Lewis, 2003). Often this data is collected by multiple researchers in a short time scale to be analysed in an effective way, but recently it has been used in smaller-scale studies (Furber *et al.*, 2009). The advantage of this method is that it is based on a methodical procedure. This is an attractive feature to a new researchers and audiences who are not familiar with qualitative data analysis (Ritchie & Lewis, 2003). The data analysis requires three forms of activity: data management, descriptive accounts and explanatory accounts (Thorne, 2000).

Qualitative research generates a vast quantity of data which the computer programme NVivo 9 (QRS, 2010) was used to organise for analysis. The research is novel; therefore, a manual method was used initially beside the NVivo 9 programme. The researcher decided to use the manual method to build and improve her qualitative analysis skills and after that to use NVivo 9. With practice, the researcher found that this increased the precision when using the computer programme and increased the validity of data analysis by adopting a systematic approach which meant that it was unlikely to miss any code. However, the framework requires the analyst to interpret meaning and to think logically to identify patterns. Using the

NVivo 9 programme facilitated the process of categorising the similarities and differences of all the data and was used then to analyse it.

Listening to the transcript or recording helped the researcher to live with the participants' story. This programme was particularly useful in gathering all data that related to the same topic and made it easy to make comparisons between data, as mentioned earlier. However, the greatest disadvantage of coding and cutting was that cutting the data could result in the quotation becoming ambiguous and not linking to the original data. Therefore, it was helpful to re-read the manual coding of the transcript intensively and listen again to the tape after developing the themes and subthemes. This helped to capture the real meaning and connect the relationships between the four themes.

The researcher conducted and analysed the data using one language (Arabic), this helps the researcher to become immersed into the data and decreases any translation problems. However, the researcher faced a lot of technical problems in using the NVivo 9 programme; for example, it is not designed for the Arabic language, which, unlike English, is usually written from right to left. Therefore, the coding process using NVivo 9 had to be done using audiotapes instead of transcripts. This was helpful; the researcher heard the verbal and touched on the nonverbal from the tone of the voice during the interview. The researcher followed the five stages of data analysis in the framework approach; familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation (Ritchie & Spencer, 1994).

5.6.2.1 Familiarisation

Familiarisation is the process of becoming familiar with the data before the process of sifting it. Familiarisation and immersion in the raw data involves listening to tapes, reading transcripts, looking at the demographic characteristics of participants and studying notes in order to list key ideas and themes. Factors that affect this phase include the number of researchers collecting the data; the range of methods being used; the diversity of the individuals and environments studied; the time of conducting the interview and the extent to which the research agenda evolved or was modified over time. The interviews were collected by one researcher over a four-month period. It was easy for the researcher to immerse herself in the data, especially as the researcher conducted the interviews, listened to the audiotapes and transcribed all the interviews.

5.6.2.2 Identifying a thematic framework

This is the process of developing a coding system. It is done by identifying all the key issues, concepts and themes by which the data can be examined and referenced. Initially, the topic guide questions form the categories that help to form an index and develop a thematic framework. The thematic framework provides a mechanism for the abstraction and conceptualisation of data. At this stage, it is possible to add validity to the process by discussing the credibility and trustworthiness of interpretation and analysis in regular meetings with supervisors (Mays and Pope, 1995). Therefore, researcher had a regular meeting with her supervisors and discussed these issues.

5.6.2.3 Indexing

Indexing is done by applying the thematic framework or systematically indexing or coding all the data in textual form by annotating the transcripts with numerical codes from the index. This is usually supported by short text descriptors to elaborate the index heading. Interview records were indexed or coded line-by-line in NVivo 9. Indexes or codes are referred to as nodes and baby nodes, which are equivalent to themes and subthemes.

5.6.2.4 Charting

Charting is rearranging the data according to the appropriate part of the thematic framework to which they relate and forming charts (for example, there is likely to be a chart for each key subject area or theme with entries for several respondents). The NVivo programme was used for coding and organising the data (Appendix 6.2). It facilitated the process of indexing and charting, which made it visible and accessible for others to see for themselves how the data was being sifted and organised. Every participant was allocated a row and each column denoted a subtopic. This allows the use of the constant comparison method to compare participants' views regarding specific subtopics or subthemes. This helps the researcher in the analysis phase and writing up the results of interviews.

5.6.2.5 Mapping and interpretation

This involves using the charts to define concepts, map the range, create typologies and find associations between themes with a view to providing explanations for the findings. The process of mapping and interpretation is influenced by the original research objectives as well as by the themes that have emerged from the data (Mays & Pope, 2000; Pope *et al.*, 2000; Ritchie *et al.*, 2003; Ritchie & Lewis, 2003; Spencer *et al.*, 2003). The researcher used practical steps to assist this process. First, during the previous phases of the analysis process, associations and emergent categories within themes were documented. Second, the researcher

reviewed these notes, memos and demographic data charts and used colour to highlight and link the information. After the preliminary analysis of the data using this approach, four main themes were developed and will be discussed in detail in Chapter 6.

5.7 Rigour in qualitative research

Qualitative methods are now widely used in health research, but quality in qualitative research is a mystery to some health services researchers (Mays & Pope, 2000). There are arguments about the difference between qualitative and quantitative research and it is argued that it is not possible to judge qualitative research by using conventional criteria such as reliability, validity and generalisability (Mays & Pope, 2000). Morse *et al.* (2002) mention that, in the 1980s, the rejection of reliability and validity in qualitative inquiry resulted in an interesting shift towards ensuring rigor. However, quality in qualitative research can be assessed with the same broad concepts of validity and relevance used for quantitative research, but these need to be operationalised differently to take into account the distinctive goals of qualitative research (Pope *et al.*, 2000).

Some authors consider qualitative research to be a soft option lacking in scientific rigour due to the possibility of researcher bias (Whitehead, 2004). Rigour is considered as the key for research success and the researcher's responsibility is for ensuring it (Rolfe, 2006). Rigour provides evidence of validity and reliability within qualitative research. Tobin and Begley (2004) mention that reliability, validity and generalisation may not be the most appropriate tools for demonstrating robustness in naturalistic inquiry. Also, they discuss the concepts of triangulation, state of mind and goodness as ways of ensuring the quality of naturalistic research (Tobin & Begley, 2004). Additionally, Cohen and Crabtree (2008) propose seven criteria to evaluate qualitative research. Although they emphasise that the researcher and reviewer have to be aware of these criteria, it is not suitable to use all of them to the same standard for all qualitative studies. The seven criteria are: carrying out ethical research; the importance of the research; the clarity and coherence of the research report; the use of appropriate and rigorous methods; the importance of reflexivity or attending to researcher bias; the importance of establishing validity or credibility and the importance of verification or reliability. However, others argue that, rather than use the seven steps above, trustworthiness is more important. The researcher must be aware of the criteria that make qualitative research trustworthy and how to implement these criteria (Decrop, 1999).

Lincoln and Guba (1985) have argued that trustworthiness criteria are more appropriate for the evaluation of qualitative research than the traditional criteria of reliability and validity. Trustworthiness includes credibility, transferability, dependability and confirmability.

- Credibility - comparable with internal validity. How truthful a particular finding is. There are many strategies, such as audit trails and member checks, to demonstrate credibility (Lincoln, 1995).
- Transferability - comparable with external validity. How the research findings are applicable to another group (Decrop, 1999). Transferability refers to the generalisability of an inquiry.
- Dependability - comparable with reliability. Are the results consistent and reproducible? This can be achieved by auditing and demonstrated through audit trails (Tobin & Begley, 2004).
- Confirmability - comparable with objectivity or neutrality. “How neutral are the findings in terms of whether they reflect the informants and the inquiry, and not a product of the researcher's biases and prejudices?” (Decrop, 1999: 158).

The critique for these criteria by Tobin & Begley and others is that they focus on the evaluation of a study at its end (*post hoc* strategy) and avoid focusing on verification during its conduct (Tobin & Begley, 2004; Sparkes, 2001; Silverman, 2000).

Therefore, the issue on which criteria were appropriate for this study depends upon the philosophical basis of this study as a whole. As discussed in the previous chapter, pragmatism appeared to be the most appropriate paradigm for this research. The framework analysis was used to analyse the qualitative data, but, as mentioned earlier, the researcher found the reliability and validity criteria described by Ritchie & Lewis (2003) to be inappropriate.

In order to establish and demonstrate the validity of the qualitative study, the researcher chose and applied the Creswell (2007) standards to ensure the trustworthiness and quality of the research. This guides the researcher throughout the process of these qualitative interviews. Firstly, the research question directs the data generation and analysis rather than the opposite. The data collection methods and data analysis process were clearly presented in structuring the report. The reflexivity process was involved in data collection and analysis (see sections 5.4 & 5.6), taking into consideration that the researcher shares the participants’

social and cultural background. Finally, the ethical issues were followed in this research as mentioned in section 5.4.

As a method used for establishing the validity of the qualitative findings, respondent validation was not applied in this study. This was because many researchers have criticised respondent validation, Bloor (1997) was of the opinion that participants' responses given during qualitative interviews may not be consistent across time. Moreover, disagreement may exist between the replies arising in the discussions for respondent checking and the draft of the analysis (Bloor, 1997). Emerson and Pollner (1988) highlighted another point: respondent validation could not guarantee that during the checking process the participant would pay enough attention to the draft of the analysis and focus on the point that the researcher was concerned with. In this case, the quality of the checking would be affected.

5.7.2 Reflexivity

Reflexivity is a key aspect in evaluating the rigour of qualitative research. There are many definitions of reflexivity. "Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter' while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999: 228). Hardy *et al.* (2001) state that reflexivity includes reflection on the method of study and the understanding of the research process. "Reflexivity is not simply a change in research plan as a reaction to poor test results or ambiguous findings; rather, it involves a reflective self-examination of our own ideas and an open discussion and comparison of our research experiences" (Davies & Dodd, 2002: 285). There are two types of reflexivity: "personal" reflexivity refers to the researcher's own identity, while "functional" reflexivity refers to the research function (Wilkinson, 1988). The researcher must be aware of empathy and transference in reflexivity. Transference means the transfer of feelings between participant and researcher (Davies & Dodd, 2002), whereas empathy means the ability of an interviewer to perceive the feelings and meanings of another person (Kalisch, 1973). Therefore the researcher must distinguish between interviews in qualitative research and therapeutic interviews (Davies & Dodd, 2002). Finally, the researcher must recognise and acknowledge how they affect the data (Davies & Dodd, 2002). This helps to ensure research that is more rigorous. The reflexive process was involved in data collection and analysis,

which have been discussed in data collection and analysis. Moreover, the regular meetings with the researcher's supervisors helped the researcher to maintain an awareness of reflexivity during the study.

5.8 Summary

The literature review (Chapter 3) revealed that no studies about Palestinians as a minority ethnic group in the UK had been conducted, but it included research literature about women from other minority ethnic groups.

The aim of the first phase of the study was to investigate the access to, and use of, health services, particularly maternal and child healthcare, in the UK by Palestinian women. Based on the findings from the qualitative phase, an instrument was developed to examine this result with a larger population of Palestinian women in the UK.

Twenty-two, in-depth, face-to-face interviews were conducted in the first phase of this study using an interview schedule, a pragmatic approach and following a study protocol. Interviews were conducted in participants' homes, the researcher's home and in schools. Data was transcribed *ad verbatim* and analysed using framework analysis. The next chapter will discuss the qualitative findings of the study.

CHAPTER SIX

Findings & Discussion of Phase One of the Study.

Qualitative Interviews

“What matters more...is not being disadvantaged by poverty, race or disabilities, but by the attitudes and reactions of those involved in care”

Hunt (2003 cited in Lavender et al. 2005)

Chapter Six: Phase 1- Findings & discussion

6.1 Introduction

This section discusses the findings of the qualitative study starting from the description of the participants' demographic data and followed by a discussion of the main themes that emerged from the data analysis illuminated by excerpts from the interviews. Important points will be discussed along with the relevant literature. From these qualitative interview findings, a questionnaire was developed to conduct the survey in the second phase of the study. The two phases of the study are separated, each with its own data, analysis and discussion (as discussed in Chapter 4).

6.1.1 Demographic Data

Fifty-eight Palestinian women were invited to take part in the study through qualitative interviews (see Chapter 5). Twenty-two interviews were conducted. Participants lived in different geographic areas in Manchester, but they were concentrated in the south of the city. Three Arabic schools and the main Mosque for Palestinian children are to be found in the south; no schools are present in the north because the majority of the Palestinian population live in the south. A few families lived in the north and they were recruited via the schools to take part in the study.

The participants were aged between 25 and 50 years with an average age of 34 years. Thirteen participants had lived in the UK for more than 10 years, one had lived in the UK for 7 years and eight had been in the UK for less than 5 years. However, ten participants had lived in Manchester for more than 10 years, four had lived in Manchester between 5-10 years and eight had been in Manchester for less than five years. Six participants had lived for more than three years in other UK cities such as Birmingham before they settled down in Manchester. Some Palestinians had lived in Scotland. The main reason for these participants moving to Manchester was to find a job for their husband or themselves.

Sixteen participants mentioned that their family was the reason for residing in the UK. However, only four participants had parents in the UK and eighteen had no relatives in the UK. Three women gave education as the reason. One participant said that family and education together were the reason, whereas one participant said that employment was the cause.

Ten participants were born in Palestine, eight of them in the West Bank and two in Gaza. The majority of participants stated that their country of birth was not Palestine; three participants mentioned Jordan; three Saudi Arabia; four Kuwait and two Qatar. None of the participants were born in the UK, but two of them came to the UK at the age of 10 days.

All the participants were educated and the sample was educationally qualified (Guba & Lincoln, 1998). Eighteen had a college or university qualification and four had A level or Level 3 qualifications. Nine participants worked as teachers, nine were housewives, three were students and one worked as a consultant paediatrician. Seven of the husbands of participants were specialist doctors in NHS hospitals, two husbands were PhD students and others had their own businesses. Eighteen had between 1 and 5 children, two were pregnant and two were single. All the mothers except one had experience of delivery in the UK. Fifteen women had more than 50% of their children born in the UK and two had less than 33%. Seven participants had experience of delivery in the UK and outside the UK.

Sixteen women described their spoken and written English as being from good to very good. However, five described their language as average and one as very poor (see Appendix 6.1 for detailed information on the demographic characteristics of the participants).

6.1.2 Framework analysis

Framework analysis was used to analyse the data. It involves organising data into a series of thematic matrices then analysing it in a systematic way (as discussed in Chapter 5). After preliminary analysis of the data using this approach, four main themes developed, which were: cultural variations; knowledge of the NHS and UK healthcare system; healthcare services and their utilisation, focusing on MCH services; and communication, information provision and needs. This chapter focuses on presenting the main findings of the qualitative interviews, with a section dedicated to each of these themes.

6.2 Cultural variations

There are differences in the culture and healthcare systems, particularly MCH services, between the UK and Palestine (see Chapter 1). Therefore, knowledge regarding the systems and the expectations is diverse. As a consequence, access to, and use of, these services in the UK are affected. The subthemes derived from the first theme are differences in culture, MCH systems and cultural expectations.

6.2.1 Differences in culture

Through the interviews, the participants made a comparison between their country of birth and the UK regarding the maternity and child healthcare services. The key points that presented under this subtheme are the use of herbal remedies; a preference for antibiotics; a preference for privacy; refusal to terminate pregnancy; belief in destiny and fate (fatalism) and acculturation.

It is known that the use of traditional practices and herbal medication as self-therapy is part of the Arab tradition (Ahmad *et al.*, 2010). It is noticeable in Palestine that herbal medicine plays a pivotal and indispensable role in the current public healthcare of Palestinian people (Sawalha, 2007). This study confirmed this idea and shows that participants relied on herbal remedies for their minor illnesses. Twenty-one participants relied on herbal medication such as cinnamon, anise and sage, usually bought from Palestine or from Arabic shops in the UK, for minor illnesses.

“I trust in the traditional herbal medicine for me and for my children because it is natural, no S.E. (side effect). There is a line between being clever and not being. I tried the herbal method twice and then I used my good sense” (Participant No 2).

If these did not help, then they used medication or visited their GP. Only one participant no longer used such herbal remedies for either herself or her children because they were raised in the UK and they depend on medication only. A previous qualitative study (Chan, 2000) of health services for the Chinese minority in Manchester pointed in the same direction, namely that Chinese traditional medicine has a strong influence on British Chinese families, even though they may have been in the UK for a long time.

Another important point that the interviews revealed was that the majority of participants got their medication, such as antibiotics, from their home country; they considered that doctors in the UK did not prescribe antibiotics for them in spite of the presence of infection. The participants believed that without an antibiotic they will not be cured.

“We usually have used antibiotic for any infection. I have antibiotic at my home; we brought it from our country for ourselves. My children were born here in the UK, they do not need it, their immunity is good, but we need it. All Palestinian and Arabic friends here that we know do the same” (Participant No 7).

This study's findings confirm two previous studies. In Ahmed *et al.* (2010), the participants expected that antibiotics should be prescribed routinely and, as a result, they brought them from their home country. The other study (Aung *et al.*, 2010) showed that medicines, that require prescription in the UK, were brought from the participants' country of birth. It might be valuable here to point out that in both studies, as well as in the current study, the participants' expectation of health services and dissatisfaction were possibly the main reasons for bringing medications from their home countries.

Some participants perceived that healthcare professionals respected their culture and religion. All participants emphasised their wish to have privacy during their hospitalisation. Despite there being differences in culture between the UK and Palestine, the participants were satisfied because the health professionals and the midwife accepted and respected their decision and request regarding privacy based on their cultural and religious beliefs.

"My husband was angry because one male entered without knocking on the door. So we asked the midwife to keep the door closed because I want to stay free without head cover. She was very nice and respected that" (Participant No 8).

One participant had a problem with her pregnancy and she respected the midwife because she respected the cultural variation and her wish to continue pregnancy in spite of there being a problem with the foetus. This woman refused to have the lumbar puncture test for the foetus or undergo other screening tests, as she believed the result of this screening would not affect her decision. Therefore, there was no need to do these tests and she was happy with her decision.

"[The] scan shows a lot of fluid around the baby and the possibility of having an abnormal baby is high, at that time I was 25 weeks pregnant and I decided not to have an abortion, because of religious issues, we believe in destiny and fate. The midwife was very nice and respected our decision" (Participant No 5).

This finding was consistent with two previous studies (Bawadi, 2009; Rassin *et al.*, 2009). Rassin *et al.*'s study reported that Arab women have lower frequencies of genetic examination and this study involved Jewish and Arab women in Israel. Bawadi's study revealed the refusal of Arabic women to go for screening tests for Down's syndrome.

Fatalism or belief in destiny and fate appeared as an important factor in women's decisions. Participants believed in God and they affirmed this many times during the interview.

Participants perceived depending or relying on God and their belief in destiny and fate to be important factors in their lives, especially since most of them gave birth in UK hospitals without family support. One participant talked about her fears and experience of delivery in the UK, saying;

“I went to [the] labour department to give birth and my husband stayed with our children at home. They (doctors and midwives in hospital) have their own medical equipment which might [be] better than the medical equipment in Palestinian hospitals. However, they are still human beings and the possibility of error and mistake are present. My faith in God and my belief in my destiny helped me a lot”
(Participant No 6).

Some participants perceived themselves as being well-integrated into British society. One participant highlighted that Palestinian people integrated well with British society unlike other minority ethnic groups which live together and appear as a unit, but Palestinian people are very different. She highlighted the Palestinian mentality in using the child health services and their wish to see the specialist as soon as possible, especially as there are differences in the health systems between the two countries.

“Palestinian people integrated well with British society, other ethnic groups [such] as Pakistani people lived as [an] extended family with no need for them to know the English language. They used their own shop using their own language and their Pakistani GP. Based on my work as a doctor, some Palestinian people do not agree to follow the treatment plan, for example, they need the specialist to see their child before the actual appointment (as soon as possible). They feel there is something hidden, that I can prescribe or relate that to conspiracy theory [sic.] (Participant No 18).

Moreover, some participants’ breastfeed their babies and they related that to the Quranic injunction to feed the baby for two years. Other participants expressed their wishes to breastfeed their baby, but they faced many problems with feeding techniques. Consequently, they decided to use bottle-feeding.

“This is the first baby and I cannot breast feed him. He could not feed well and I do not know [how] to help him, the midwife showed me once and later I feel fed up. Bottle-feeding is easier for him and me” (Participant No 9).

“Usually I breast feed my baby [for] 2 years as in [the] Quran” (Participant No 6).

6.2.2 Differences in MCH systems and expectations

Throughout the interview, participants compared the systems in the UK and Palestine regarding the MCH services. A few participants cannot compare their country of birth with the UK because they did not have any experience in Palestine. Studies by Ahmad *et al.* (2010) and O'Donnell *et al.* (2007) found the expectations of Arabic speakers of UK health services may be one of disappointment because they are based on their culture and traditions and were influenced by the healthcare system in their home country. This is confirmed by this current study, where the majority of participants considered the healthcare system in the UK to be slow in delivering its services. Moreover, they considered the access to, and use of, MCH services in Palestine to be easier and faster. Antenatal care is reported as excellent in Palestine by a few participants because they routinely provide women with Iron during pregnancy, unlike in the UK. Usually the women registered at the beginning of her pregnancy with a specialist doctor who follows her throughout (see quote of Participant No 7&16, page 120).

An ultrasound scan is a routine part of pregnancy. Some participants in this study were concerned about the number of scans during pregnancy and knowing the baby's sex. They considered the number of scans, (at 12th and 20th week) according to NICE guideline (2003), was not enough. The scan is done only twice in the UK during normal pregnancy. However, in Palestine, an ultrasound scan is done more frequently and repeated at each visit to the doctor during pregnancy. The reason for doing a scan is that it usually reassures women about the baby's condition, and in some cases for business reasons (in Palestine, patients are required to pay for each scan). Knowing the baby's sex is an important matter, as mentioned in Chapter 1, and some participants in the qualitative interviews were really concerned to have this information.

“In our country, they do the US in each visit to check the baby condition, not like here in the UK. They do it just twice at beginning of the pregnancy and at 5 months, which is not enough” (Participant No 7).

Regarding the quality of services, half considered the quality of maternity care in the UK to be excellent during labour, even better than the private sector in Palestine. The majority of

participants have experience in using the private health sector in their home country, not the government or United Nations Relief and Works Agency (UNRWA) healthcare services. Therefore, they compared the private sector with the NHS. The participants were happy that they could see their specialist directly any time they wanted (easy and flexible booking by phone) in their home country.

“Once I know I am pregnant in Palestine, a specialist doctor follows my case from the beginning of pregnancy and after my giving birth; this is more comfortable for me. I do the pregnancy test and know the result and see the specialist on the same day. However, here I need one week to know the result of the urine test [and] if the sample was lost, so I need another few days. Then I need another few weeks to see my midwife. Then, every visit I saw a different midwife and she may or may not [have] read my entire file” (Participant No 7).

“I am 7 months pregnant and my blood is just 11 and the midwife refused to get me Iron. However, in our country they prescribe multivitamins and Iron for every pregnant woman” (Participant No 16).

One participant only had experience of delivery in a government hospital in Gaza. She highlighted an important point that the midwife in the UK had encouraged a natural delivery. However, in Palestine the decision is based on the specialist’s free time and not on protocol.

“I gave birth here in the UK, the midwife is perfect, smiling and explaining everything for me. I feel there is equity in health here and they encourage the delivery to be normal, no episiotomy. In my country, if you use a private doctor, you will receive a high quality of care, but they don’t follow the steps in the delivery process like here. This [is] based on the doctor’s decision and time. I gave birth in a separate room in the UK hospital, but in a government hospital in our country 7 delivery beds are present in one room” (Participant No 12).

Another participant was surprised that in the UK, the midwife dealt with pregnant women all the time during pregnancy and she never saw the specialist. She was afraid in case she had any hidden problems and whether the midwife would be able to identify and deal with them.

“During my pregnancy and after that, different midwives dealt with me. I am afraid in case I have hidden problems [and wonder] how the midwife will discover that. I think the specialist doctor must see me at least once every trimester” (Participant No 8).

In comparing the emergency services between both countries, all the participants complained about the long waiting time in A&E departments in the UK since people are usually treated straightforwardly and directly in an A&E department in Palestine. However, the quality of care provided in the UK emergency department was considered to be better by more than half of the participants.

“In our country they deal with emergency cases directly without any waiting a long time” (Participant No 7).

Another problem highlighted by participants is the prescription of antibiotics by A&E doctors and GPs. Many participants complained about the doctor in the UK not prescribing any type of antibiotic to them, in spite of the presence of an infection. As a result, the participants got their medication, such as antibiotics, from their home country as mentioned earlier. Some of them considered GPs' medication as simple and they can buy it from a pharmacy without prescription. However, in their home country they can take it any time from any pharmacy or by asking any doctor to write them the appropriate antibiotic prescription.

“I have infection in my hand due to trauma and it is red and painful, I went to the GP and he refused to prescribe any antibiotic, then I went to ER but they prescribe a painkiller for me not an antibiotic. They don't like to prescribe antibiotics here and medication that is prescribed from my GPs; I can take it by myself” (Participant No 11).

One participant was unhappy about the limited sessions of physiotherapy for her child. Therefore, for three months every year during summer she pays for him to have physiotherapy in the private sector in Jordan.

“The Physiotherapy department can do limited sessions for my child, but he needs more. I go every year in summer just to do extra sessions for him. After that, when he returned back to his school, his teacher noticed the difference and the improvement in his condition. The problem is that our work and home are in the UK and we cannot stay more than three months there [sic.]. NHS refused to increase the number of sessions for my child. There is no private physiotherapy service in the UK, so nothing to do [sic.]” (Participant No 5).

Moreover, the interviews revealed that some women who faced problems with using and accessing MCH services prefer not to make any complaints. They thought that nothing would

change and they preferred to keep silent. On the other hand, a few do decide to complain about the services with their husband's support and they were happy to do that.

"I found it is useless to make any complaint and nothing will be changed, therefore I decide to give birth this time in my country (Participant No 12).

6.3 The knowledge of the NHS and the UK healthcare system

The second theme is the knowledge of the NHS and the UK healthcare system. All participants knew that the NHS is free to all at the point of use. Being free of charge is considered as an important advantage of the NHS. They were aware that maternity and child healthcare services are free as are the prescriptions and dental care during pregnancy and one year after delivery.

"The healthcare services to pregnant women and one year after delivery including the medication and dental care are free. In fact this helps me to feel comfortable during my pregnancy" (Participant No 4).

Palestinian women consider the NHS being free of charge to be an important factor in assisting their access to, and use of, the maternity services. In Palestine, as mentioned in Chapter 1, the MCH services are not free at all; even the small groups of women who hold UN cards and receive free antenatal care must contribute to their cost of childbirth. Therefore, being free of charge has been considered in this study as important and a positive characteristic of NHS services despite some participants who commented that they paid taxes in the UK but in Palestine they paid directly to have health services. Preventing NHS privatisation was a major concern of participants.

"I have [a] positive attitude toward [the] British system, no countries like the UK deliver free healthcare services [to a] high standard level for all people. Actually they cut taxes directly from our salary, but they are free services and we must keep the NHS [free from] privatisation" (Participant No 2).

Some participants reported their lack of knowledge regarding MCH services, such as maternity benefits for the first baby. Most participants believed before their arrival to the UK that healthcare services in the UK are delivered to a high standard using up-to-date medical equipment. However, some participants' views were changed by their experience in the UK. They emphasised that no one explained their rights to them and they discovered them later on. The lack of knowledge regarding the healthcare services, especially maternal and child

health services, of Palestinian women that have recently settled in the UK is particularly noticeable when women recount their experience of having their first baby in the UK. Interviews revealed that most participants who have lived in the UK for more than 10 years emphasise the importance of knowing their rights and asking about them if no one provides them with this information. If not, they will suffer and miss a lot of maternal and child health service benefits in the UK.

“You must be aware of your rights; you must stand for your rights. If you do not, you will be easily ignored. No one works as a volunteer to help you. So, I missed a lot of maternity benefits” (Participant No 3).

“Before I came to the UK, I thought the healthcare services were ideal, but my view changed. They think that foreigners are not trouble makers; therefore they did not deliver the health services to a high level as they do with British women. They know well our problem, which is lack of knowledge regarding the healthcare services, the language barrier and we do not like to shout like British women. When we found something wrong in the services, we rely on God at every step. They (healthcare providers) keep silent, not advising you but if you read the papers well and ask about your rights, they will provide them with a plastic smile. They prefer to summarise in everything, even the information, because they do not want to work. After a time I found myself like them” (Participant No 3).

“I don’t know anything about the maternity benefits, no one told me. My friend gave birth two months after me. When I visited her, she told me the benefits for her baby, I was surprised because no one told me. At that time, I reviewed all the papers from hospital and midwife and I asked about this benefit. I got the lesson to read every piece of paper because no one explains any information for me” (Participant No 3).

The interviews revealed the lack of prior experience with a GP system in their home country. All participants were aware of the different healthcare services in the UK and their home country. GPs are considered as a key element when using the healthcare services in the UK, and then the GP refers the patient to other healthcare services such as midwifery, hospital and other services. Moreover, some participants’ knowledge is up-to-date regarding the new NHS policies and the effect of the new government.

“The old NHS policy was pushing the specialist to see the patient within 3 months. However, this policy changed after the new government, which became an open appointment” (Participant No 15).

One participant mentioned the problem caused by closing the nearest maternity hospital to her home and the effect this had on her access to another hospital i.e. the distance became longer.

“The plan after the new government is to close some maternity hospitals and develop others; this will affect the services because if we have an emergency gynaecology problem it will take a long time to reach the hospital” (Participant No 18).

Three participants stressed that the knowledge of NHS services is the key factor for using MCH services, the more you know, the less you face the problem. One participant who lost two pregnancies, one of them due to misdiagnosis, said:

“The NHS system is tricky, if you don’t know what you want from the system or how the system is working, you will be lost easily. For example, if you know your health problem and know the system, you will go to the GP and he will refer you to the right specialist. However, if you do not know your diagnosis you will easily become lost and it happened with me” (Participant No 18).

6.4 Healthcare services focusing on maternal and child healthcare services

The third theme related well with the first and second themes. This theme included four subthemes: GP services, hospital services, walk-in centres and Sure Start services.

6.4.1 GP services

All participants registered with GPs and they reported that the registration process was easy and not complex. Most of the women mentioned that their husband came to the UK before them and registered with the GP, so they followed them. Moreover, the majority of participants selected the GP surgery because it was near their home and convenient for them. However, other women selected their GP in spite of it not being near their home and others changed their GP because they preferred a female doctor. Other participants highlighted the problem of there being no female doctors at emergency appointments or when the female doctor was on leave.

“I am interested in having a female doctor therefore; I change the GP many times. I spend a lot of time searching for a female doctor. Previously I had a Jewish female doctor, but now with an Indian one, I feel comfortable with my doctor” (Participant No 2).

“In my GPs, there are two female doctors. Usually they cover just two days per week and when they are on leave no one covers them. In this case, when I have a gynaecology problem I prefer not to contact the male GP and leave my illness to recover by itself” (Participant No 17).

“I registered with the nearest surgery to my home. My husband came before me to the UK and knows everything here. He told me about GP services and the process was so easy” (Participant No 1).

Most participants believed that booking an appointment with their GP is often inflexible; especially since the phone line is busy all the time. They complained of long waiting times to see their GP, even though they attended the clinic at the exact booking time. However, some women were not happy regarding the phone assessment when booking an appointment.

“The problem with that is the only way you can make an appointment for that day is if you call 8:30 [in the] morning. Usually, when you make a call, the line is always busy. It’s very difficult to get through. When you do get through they always tell you they are fully booked and don’t have any appointments left and you can’t make an appointment for next day or day after or next week and you have to do the appointment on the same day. In practice it’s impossible to make an appointment; it was a very bad GP clinic. The new GP has flexibility in booking an appointment and I am happy with their services (Participant No 9).

“Long waiting time to see a GP is really a problem and he does nothing inside his room, no patients” (Participant No 6).

“Another problem is when calling the surgery to book an appointment, the problem with their assessment by phone. I explained to the receptionist my baby is tired and feverish but she said don’t come to surgery we have swine flu, so what [can I] do?” (Participant No 7).

One participant's husband found the GP line busy all the time and he could not book an appointment for her. He decided to go personally to the clinic, then he tried to call them using his mobile and he found the line still busy, meanwhile the receptionists were sitting and chatting. He did the booking personally and decided not to complain, because he believed that nothing could be changed, but they decided to change their GP.

On the other hand, a few participants were happy with their GP's services, the flexibility to make an appointment, phone services for emergency cases, the booking of emergency appointments on the same day as calling the GP and the system of repeat prescriptions by internet or by phone.

"I am happy with my GP. Nowadays, I make an appointment easily, but previously I needed at least one week to see the doctor. Now I can see him [on the] same day of calling the clinic in an emergency case. I am happy with the repeat prescription service, where I can pick up my prescription the next day" (Participant No 15).

Another point about GP registration is the cancelling of the files of families who had not used the GP service. One participant was angry because the GP had closed her family file.

"My child has a fever and I tried to book emergency appointment but I was shocked because the GP closed our file and they can't see my baby. They reward my family by cancellation of our record because we didn't have anyone sick for one year!" (Participant No 13).

Some participants note a difference between GPs' qualifications and the quality of services according to geographic location. They believed that GP services in more affluent areas are better than in deprived areas. Others pointed to differences in services between GPs. Some GPs have good and comprehensive services. For example, the GP may have maternal and child services such as immunisation and family planning but others did not provide these services.

"Based on my long experience in the UK, qualifications & services of GPs are different according to geographic location. For example, in a specific area where the number of immigrants is high, GP's qualifications are different than in other areas. Generally, GPs service in rich area is better than in others" (Participant No 4).

“My GP is two minutes from my home but the problem is that there is no immunisation for my baby or family planning services. I ask my GP about the coil device and she referred me to hospital, but I found myself lethargic to do that [sic.]. Then I use [the] pill but it does not protect me” (Participant No 1).

Three participants mentioned that some GPs' qualifications are inadequate. The majority are in the later stages of their careers. They focus more on their computer and books rather than the patient. Moreover, there was an expectation that patients would receive a physical examination automatically. The omission of this meant that to them a diagnosis had not been made. They thought that this led to misdiagnosis.

“To be honest I am not happy with the GP services. My GP relies on chatting history rather than examining me. I have a urinary infection and hydronephrosis. I am seven months pregnant. He prescribed an antibiotic for me without repeating the urine analysis. I asked him to do that and finally he agreed to do the test. I [brought to] his attention that previously two urine samples were lost. I described for him the pain and I told him according to my work as a physiotherapist I think the pain [is coming] from the kidney but he focus on the computer and did not examine me” (Participant No 8).

“The GP did not measure my vital signs such as pulse and blood pressure; he just read in the book and took a history” (Participant No 7).

“I feel the GP qualification is not good, my GP spent all the time reading the book to prescribe one medicine” (Participant No 6).

“That majority of GPs are old in age and they need training in order to meet the community need. The problem [is that] they considered their work as a business” (Participant 20).

Many participants mentioned the problem of following up urine tests and blood tests, the results of these tests when done by GPs took a long time and some participants mentioned the problem of lost urine samples, as presented previously by Participant 8. Additionally, GPs do not know the results of tests done in the hospital.

“The result of my pregnancy test took [a] long time [to reach] the GP, around 12 days. I called him every day to know the result, but in our country you can know the result within one hour” (Participant No 5).

The participants perceived that the healthcare services in the UK are slow and take a long time. Participants assumed the slow services resulted in more suffering and deterioration in the patient's condition. One mother was angry because her baby had an eye deviation and referring the baby to hospital took a long time - 2 months - to refer to hospital and waiting for the operation took another 6 months. Unfortunately, after that, the operation was cancelled twice because the anaesthetist was absent. Furthermore, it was postponed a third time because the baby had flu. Hence, the operation was done one year after discovering the problem.

“At the beginning, the eye deviation was simple, as the result of the delay in the surgery the deviation increased. I'm blaming the health system because it is very slow and how to deal with emergency situations is a really big problem” (Participant No 1).

Most participants mentioned the problem of long waiting times for referral to hospital. Some women were waiting more than 6 months and this period is long compared to those in their home country.

“My last referral to an orthopaedic specialist at the hospital took about 6 months. During this period I forgot my illness and the problem resolved by itself” (Participant No 22).

“In the UK, the most annoying thing is the long waiting time to be referred to hospital. I need to wait at least six months to be referred to hospital. However, in my country, if I have problem I can see the specialist doctor on the same day” (Participant No 8).

All mothers reported that their children received all immunisations using the 'red book' which refers to the baby's Personal Child Health Record and is used to document immunisations and baby growth. Two mothers faced the problem of immunisation for their children when they entered the UK and GPs refused to get their baby the red book. The immunisation schedule is different to that in their home country and it took a long time to overcome the problem.

“When I came to the UK, my youngest baby was one month old and my GP refused to get me the red book. It was not comfortable for me to record by myself the date for every vaccine to remember the next one. I am surprised that [whenever I] visit the

clinic the previous record of immunisation is missing so it is difficult for [the] nurse to do her job. I can't tolerate the situation, because I am suffering and no one responds to my concerns. I insist not to leave the clinic without the red book, because it is their mistake. They refused to get me the red book and they lost the record. Finally I got it after several months" (Participant No 13).

The main barrier to accessing GP services in this study confirms other previous studies (Ahmed *et al.*, 2010; Aung *et al.*, 2010; O'Donnell *et al.*, 2007). These can be summarised as the lack of previous experience abroad, self-medication, language barriers, long waiting and referral times and problems in getting appointments. This study adds new knowledge that has not been highlighted in previous studies and draws attention to other points as perceived by participants and mentioned earlier. First, the participants changed their GP based on their preference for a female GP. Second, participants underscored the inflexible appointments due to the GP's phone being frequently busy. The third point concerned the differences between the services offered by surgeries according to geographical location and not all GPs having the same MCH services. Finally, women felt that the majority of GPs were in the final stages of their career and more focussed on computer work rather than their patients. Some of the comments presented by Ahmed *et al.* (2010) revealed that participants reported not having had a physical examination automatically, meaning that a diagnosis had not been made. The possible explanation for this view in the current study is the cultural expectation of a physical examination.

6.4.2 Hospital Services

6.4.2.1 Antenatal care, screening and booking

All participants made bookings using a GP's clinic and GPs referred them to midwives. No women contacted the midwife directly. The key comment is "the system is very slow" and this comment was repeated many times throughout the interviews. At the beginning, when a woman wanted to confirm her pregnancy the result of the pregnancy test took at least 3-7 days. Then, to refer women from the GP to the community or hospital midwife takes another few weeks. This visibly contributes to lengthening the process of booking. Most of them contact their midwife around 12-16 weeks and not before 12 weeks. According to participants' perception, this is a big concern for women who have special health problems or risks. One woman said:

“The system is very slow, I need at least one week to know the result of my test from the GP, that confirmed my pregnancy, then I need another 2 months to contact the midwife, the most critical period is the first 3 months which finished without any care. For normal women that’s fine, but for me because I have thalassemia it is a big problem” (Participant No 21).

These women followed the protocol of antenatal visits: screening, scanning (at 12 and 20 weeks), regular check-ups, antenatal classes and using the green book (pregnancy book). They were happy about these services. Only one participant did not use antenatal care and the first time she visited the midwife was one week before her delivery. The reason was that she had been moving from one city to another in the UK.

“The first time I saw my midwife in my first pregnancy was one week before my delivery. However, in my next pregnancies, I contact the midwife immediately around 8-9 weeks of my pregnancy, but in my first pregnancy, I moved from Scotland to Manchester. I did not register with any GP and I was busy at that time. When the midwife saw me at that time, she was not surprised, really I was surprised by her reaction, maybe because this area is full of foreigners” (Participant No 3).

Late bookings are of potential concern in terms of antenatal care, especially for women with special health needs. NICE antenatal care guidelines (2003) endorsed that ‘booking’ with the maternity services should be made before 12 weeks of pregnancy.

Some participants did not use antenatal or exercise classes due to the presence of both sexes and the need to arrange childcare for older children, so they sacrificed themselves. Similar findings were reported in previous studies (Ali *et al.*, 2004; Bawadi, 2009; Rassin *et al.*, 2009).

“I never attended the antenatal class, because no one takes care of [my] other two kids. Where [can I leave] them?” (Participant No 10).

Continuity of care emerged as a key element; most of the women would have preferred to have been cared for by the same midwife through antenatal care and, if possible, during birth and post-partum. This helps the women to feel comfortable; her midwife knows her case well and follows up her condition. On the other hand, some women considered themselves as lucky because they had the same midwife throughout their pregnancy and in all pregnancies. Many studies have demonstrated that familiarity with the midwife makes a difference to

women during childbirth and decreases the need for continuity of caregiver during pregnancy (Waldenström *et al.*, 2000; Biró *et al.*, 2000).

“I don’t have family in the UK, but the presence of the same midwife in my pregnancy and in all other pregnancies helped me a lot” (Participant No 2).

Half the women received a choice about places of delivery: in hospital, in a maternity unit or at home. They preferred to give birth in hospital. The reason was their concern about the safety and facilities to cope with an emergency. One woman who was surprised about these choices said:

“Really, I was surprised when my midwife asked me where I would like to give birth, at hospital or at home. I answered her; surely at hospital in case I faced any problems it is better to be at hospital” (Participant No 13).

6.4.2.2 Care during labour and birth

All the women gave birth in a hospital maternity unit. Some of them faced problems during their delivery such as prolonged labour, lack of awareness about the labour process and insufficient painkillers. They considered the presence of these problems to be mainly due to system issues or organisational problems such as lack of staff, workload, locum doctors and shortages of midwives, especially on the night shift, Christmas and at weekends.

“I asked her many times to examine me but she refused to do that. She just looked at the monitor and left. She left me alone for a long period of time and finally I could not tolerate the pain. I asked my husband to call her or any doctor. Just 3 minutes and I gave birth. The midwife was so lovely but she ignored my concerns. She did not believe me when I asked her to examine me again because I felt the baby was coming down. I know the problem is the shortage of staff in hospital not with the midwife herself. The NHS must increase the number of midwives. Previously, I noticed that there were two midwives for each woman in the delivery department. In my last delivery, there was just one midwife for each woman” (Participant No 10).

“The painkiller was not enough during my labour. I can’t tolerate the pain. The midwife told me that the anaesthetist was in the operating theatre and cannot come now to put the epidural line in for me, this is not the first time; they repeated this story

for all women. My friend faced the same problem. I decided not to be pregnant again, because I had a very bad experience in my delivery” (Participant No 16).

On the other hand, some women were satisfied with the care during birth and delivery. Two participants emphasised that the midwife helped them to take a shower after giving birth.

“After my delivery, I never forgot that feeling. The midwife helped me to take a shower then she brought for me a cup of tea and toast. I felt like a princess. Really it was the most delicious drink in my life” (Participant No 2).

Three participants called attention to the problem of contacting the midwife by using the ‘phone, where the midwife directed them not to attend the maternity unit until they felt a contraction every three minutes. Consequently, one participant gave birth before she arrived at the delivery department.

“The midwife advised me not to come to the maternity unit until I feel the contraction every 3 minutes. I called her and I explained my condition that the contractions were every 5 minutes and I can’t tolerate the pain, but she insists not to go there until I feel the contraction every 3 minutes. I decided not to follow her advice and I went there. When I arrived at the department, the midwife put me in a normal room and I am shouting and told her that baby go down [sic.]. She did not believe me and continued her work, then she decided to measure my blood pressure and I am shouting from the pain. Finally, when I touch my baby head and I told her please help me. At that moment, she believes me and called another one to bring the equipment. There was nothing in the room except my bed. After that she apologised because she did not believe me and she explained to me that her shift is finished and another midwife will come to do the stitches for me. She put my baby on my chest then I waited one and a half hours for the next midwife. I felt that I will die from the pain; my friend who came with me tried many times to remind the staff about me and inform them about my pain. They told me that your name still not on computer, so they can’t bring any analgesia. As I told you, the midwife came after one and half hours and she did the stitches for me, I can’t look at myself and I covered my face. She apologised that my name was not in the computer and she can’t bring analgesia for me, my friend decided to bring [an analgesic] for me from her car, no one cared for me after that or brought any medication. I thanks God that my friend was with me helping me with

translation and she supported me. I decide to give birth this time in my country, the maternity care is better than here” (Participant No 21).

Bathing baby with dirty water emerged as a key element. All the participants complained about the way of bathing the baby after delivery. They reported that the midwife put only a little shampoo in the water and then she did not change the water to rinse out the dirty water or blood. The participants considered that the bathing was not done in a proper way. In the UK the guidelines, 'Routine postnatal care for women and their babies', recommend that cleansing agents should not to be used to bathe a baby in the early postnatal period (National Institute of Clinical Excellence, 2006). However, this guideline is not applied in Palestine and cleaning agents are used to clean a newborn baby.

“I am surprised about the way of bathing my baby. The midwife was bathing my baby in a miserable way. The midwife did not change the water and using the same water during the bath. It became red in colour after cleaning the baby’s head. She used it again to clean her body. When I look at the white clothes of my baby, the colours become red from the dirty water” (Participant No 1).

The participants were surprised that it was midwives who examined their babies 24 hours after delivery and not the paediatrician; they considered this as completely different from their home country.

“The next day after my delivery in the hospital the midwife examined my baby. Here it is different than our country; the midwife does that, not the paediatrician” (Participant No 12).

6.4.2.3 Postnatal Care

This subtheme is divided into two parts, the care provided to women immediately after delivery at hospital and that provided in the community by the midwife and health visitors. The interviews revealed the deficiency of care provided to women in the postnatal department and one participant stated ‘they neglect us completely after delivery’. This sentiment was echoed by most of the participants. However, they were satisfied by the 10-days post-delivery visit by the midwife and then by the health visitors.

6.4.2.3.1 Postnatal Care in Hospital

All participants who had experience of delivery in the UK perceived the problem of the postnatal neglect of woman at the hospital. No participant was happy with the postnatal care

in hospital. Generally, the postnatal care of women was evaluated negatively compared with that provided during birth and labour. The women, after the exertions of delivery, need to take a rest and, as proposed by participants, need help with the baby or to send the baby for a few hours to a nursery. Most of them had a normal delivery and were discharged from the maternity department 24 hours after delivery. The majority reported that they had adequate pain relief. However, a few participants felt that the midwife did not welcome them after delivery and wanted them to leave the department as soon as possible.

“After my first delivery, my husband left me alone because he was on call. He is a cardiologist. At that time my language was very poor and I was so young, only 18 years old. The nurses and midwives never gave me any attention and they left me alone. I did not know the system to get the food in the postnatal ward and I kept waiting for the nurses to bring me breakfast or dinner. I stayed without food until my husband came in the evening. Now I learned a lesson from my experience in healthcare services: to know my rights and ask about them, because no one cares for you. If you don’t ask about your rights, they think you don’t need them” (Participant No 3).

“The more time you stay in the post-delivery department the more neglect you receive from them” (Participant No 1).

This resonates with previous studies such as “Migrant Arab Muslim Women’s Experiences of Childbirth in the UK” where the women were unhappy with the post-partum wards in the hospital (Bawadi, 2009). Another similar qualitative study assessing maternity care of Pakistani and white British women conducted in a northern UK NHS region demonstrated the same negative comments about postnatal periods at hospital (Hirst & Hewison, 2001). However, in the same study, groups of both Pakistani and white British women provided positive comments on postnatal community care (Hirst & Hewison, 2001), that are similar to the study findings in this research. The main reasons for dissatisfaction in Bawadi’s (2009) study were that Arab Muslim women felt uncomfortable with shared rooms, toilets and food. However, in this study they perceived a total neglect of women and babies, the main reasons for their frustration with postnatal care at hospital included leaving them alone for a long time so that they felt a lack of emotional support and also of food services. Proctor and Wright’s (1998) study about women’s response to maternity services recognised that the main key

element for women's satisfaction was staff attitudes, especially the support and help from the midwife.

Moreover, a recent survey by the National Childbirth Trust (2010) on 1260 first-time mothers' experiences of postnatal care in the UK came to similar conclusions about post natal care, with the women's feedback indicating widely varying standards of postnatal care. Around 50% of first-time mothers showed they had received high quality care. However, one in eight were highly critical, reporting: insensitivity, inconsistent advice, inadequate assessments and care, and lack of emotional support in postnatal period.

The majority of participants breastfed their baby and they refused bottle-feeding. Some participants reported their concern about breastfeeding their baby in the first days after delivery. Some midwives help the women with breastfeeding and thought them how to do that but others did not. One participant said:

“The midwife was very cooperative and helped me with feeding my baby, but the next day another midwife refused to help me and told me you can do that yourself. I think this is related to the midwife's attitude” (Participant No 12).

6.4.2.3.2 Postnatal Care in the Community

The participants considered the visit by the midwife and then by the health visitor during the 10 days after delivery to be a good thing which contributed to their care and allowed their needs to become known. They were satisfied with this care and happy with the follow up and explanation, a service which is new to them and not available in their home country. Indeed, in Palestine, only one third of women received postnatal care. The women were happy with the amount of time and support during post-natal visits.

The participants said that the midwife and health visitor provided women with explanations regarding the immunisation, 6-week check-up of the baby and the family planning methods available to them. Multigravida women highlighted the problem of the information being summarised because they already have previous experience.

“The midwife visited me 10 days after delivery. The midwife and then the health visitor were helpful and nice. They advised me what to do for my baby, especially when he had constipation” (Participant No 13).

“I have four children, so they tried to summarise during their visit because they think that I know everything” (Participant No 14).

One participant had itching around the stitches after delivery. She told the midwife about her problem and she felt that the midwife during her visit did not examine her well.

“I have itching and think I got [an] infection around [my] stitches. I explained [to] her [the midwife] my concern but she ignored that, then I asked her to check the stitches site, I feel she did not like to do that. She looked at them quickly without using a torch and said that’s fine. My room was dark and the light is not enough, I think she should have her equipment such as a torch to do the proper examination” (Participant No 8).

6.4.2.4 Food services

Some participants commented about the food provided at hospital not being suitable for women after delivery since it caused them constipation. Moreover, the women mentioned that the meaning of Halal food is not spicy food. One participant commented on food type and said:

“If Pakistani women like the spicy food that does not mean that Halal must be spicy. I am angry about the food in hospital, because every time I asked about Halal they bring for me spicy rice and I could not eat it, I hate spicy food” (Participant No 2).

Another comment from participants is that there are no food services for women post-delivery and women must serve themselves. The stitches that presented post-delivery prevent women from walking normally and collecting their food. Moreover, no midwife assured that all the women received their food.

“The midwife shouting on the corridor for all women to take their lunch, sometimes I did not hear her and stayed without food. Although, post-delivery, I can’t walk normally and I walk slowly to bring the dinner. The food provided at hospital is not good, no soup or fruits” (Participant No 1).

6.4.2.5 Dental services

Dental services appeared as a big problem for some participants, especially at weekends. Some participants postponed dental care until returning to their home countries due to the high cost in the UK. The dental hospital deals with a specific number of patients every day

until 12 mid-day, usually the people go there from 7a.m. since the policy is to accept the first 50 patients only.

“The use of dental services is not easy, it is so expensive and there is a big pressure on the dental hospital. I went to the dental hospital at 7a.m. to stay in a queue outdoors, it was very cold and I stayed there for more than 2 hours. The hospital is open at 9a.m. and people came early to book an appointment” (Participant No 19).

Many studies have indicated that lower attendance at dental care and poorer dental health were both more common among women from disadvantaged backgrounds, such as women from BME groups, than for middle class women (Lieff *et al.*, 2004; Taani *et al.*, 2003). Interviews revealed the problem in accessing dental services by some participants, especially at weekends. Other participants, for example students, reported postponing dental care until returning to their countries due to the high cost in the UK. This is consistent with two previous studies, (Aspinall & Jacobsen, 2004; Ahmed *et al.*, 2010) where minority ethnic groups are less likely to use dental services because they are expensive. Consequently, where possible, they postpone accessing dental care until returning to their home country. According to the NHS, pregnant women or women who have had a baby in the last 12 months are entitled to free dental treatment by using a maternity exemption certificate (Department of Health, 2004). However, it seems that this problem is exacerbated for students or women without an exemption certificate. For availability of weekend dental services, more information is needed to increase awareness regarding these services such as the fixed schedule for on-call clinics.

6.4.2.6 Accident and Emergency Department (A&E)

Most participants complained about the long waiting time in A&E, this ranged between 4 and 8 hours. This long waiting time annoyed the participants and they suggested the importance of having an assessment unit to distinguish between the cases. However, the presence of an emergency department for children was considered to be a very good idea, but the long waiting time was perceived to be a big problem.

“Long waiting time in A&E is a big problem for me. I went to the A&E last month because my temperature was 40°C and I could not stand or sit at that time. As usual I waited about 5 hours until the doctor came to see me and prescribed some antibiotic” (Participant No 1).

“I have allergy all over my body, I took antihistamine then I went to A&E. I waited 5 hours but no one came to see me. I felt better then I returned to my home. I think [there should be a] screening room or person that assesses the condition of patients in A&E” (Participant No 16).

The participants were satisfied with the quality of management in A&E, but unhappy with the long waiting times. They believe that the A&E process is very slow due to system problems such as shortages of staff and the pressure on this department. A previous study about asylum seeker participants embraced the same view. They were happy with the quality of services, nonetheless they complained of long waiting times both for hospital appointments and when attending A&E departments (O'Donnell *et al.*, 2007). According to NHS guidelines, people should not wait more than four hours in accident and emergency. Recently, the King's Fund report in May 2012 showed that more than 4% of patients (226,000 people) had waited more than four hours in A&E in the previous 90 days, an increase of nearly 18% on the previous quarter (Appleby *et al.*, 2012).

6.4.3 Walk-in centre

Interviews revealed that participants did not use the walk-in centre due to the long waiting time there. However, three participants did not know anything about it.

“I never went to a walk-in centre; my thinking or what I know [is] that I must wait for a long time to see the doctor” (Participant No 8).

6.4.4 Sure start services

Most of the participants knew and used the sure start services for their children and to learn different skills, such as improving their English language and learning sewing. Some of them commented on the poor hygiene of children's toys but they considered it to be a good idea to see other people and for their children to play with others.

6.5 Communication and information provision and needs

It is well-known that the fundamental aspect of health practice is effective and satisfying communication between healthcare professionals and patients (Berry, 2006). This theme is divided into three subthemes: the language barrier; interpreter services and information provision and needs.

Interviews revealed that the majority of participants mentioned that all the midwives have good communication skills and they deal with patients in a nice manner, especially during

delivery and antenatal. However, other participants complained of poor communication from the medical staff in hospitals and GP receptionists.

“I don’t have family in the UK, but the presence of the same midwife in all my pregnancies helped me a lot. She is a human being, lovely and kind. After my delivery, I never forgot that feeling. The midwife helped me to take a shower then she brought for me a cup of tea and toast. I felt like a princess. Really it was the most delicious drink in my life” (Participant No 2).

One participant did have a scan for her first pregnancy. She believed the female doctor who performed the ultrasound scan at 20 weeks talked to her in a tough and aggressive way. The participant felt that the doctor was labelling her. This participant decided not to complain because she believed that nothing would change.

‘When I asked my doctor after doing U/S for my baby’s sex, she refused. They make an assumption that because I’m covering my head and I am Muslim I’m from Pakistan or Somalia. So she dealt in a very tough way with me. I couldn’t stop my tears at that moment because I was feeling as a second class being. She was not sure about the sex of my baby and thought it was a girl, but because she also thought that I was from those countries, she thought that I would want an abortion if it were a girl. So she wouldn’t tell me” (Participant No 1).

Another woman admitted to the maternity unit complained of poor communication from her midwife.

“I asked the midwife to bring me [a] cup of tea with breakfast, she was shouting and said I can’t go twice for you, [and] then I did complain about her” (Participant No 8).

Some participants complained about the way in which GP receptionists communicated.

“The receptionist at my GP is so tough on the phone and uncooperative; she doesn’t like to get me an appointment” (Participant No 3).

Some participants felt that they experienced racism in their communication with healthcare professionals. Participant No 10 has two children complaining of vitamin D deficiency.

“Most of the doctors in the surgery are Jewish not British. I never experience any racism from the British, they are professional. My son [has suffered from] rickets since birth. The health visitor puts pressure on me. I am the reason for the disease of my son. She told me Arabs are stupid because you breastfeed your baby for two years (Participant No 10).

In another visit to an orthopaedic specialist, this woman said:

My daughter has a problem in her hip and the specialist prescribed medication for her. He told my daughter that “body created not to be covered”. He is an excellent doctor but he does not have the right to talk with my children like that. I considered that as a type of racism. She told me that when we reached our home. She said to me “Mama he humiliated me” he asked me why you cover your head [since] the body [was] created not to be covered. I told her he is an excellent doctor; he is the only specialist for children in [the] hospital. Although, he follows her cases, on the next visit, I felt that he was not comfortable when he saw us. He told me about the research result. “Do you know something; we do research in an Islamic school [in the UK]. They suffer from Vitamin D deficiency because they cover themselves” but I think the research makes no sense.

6.5.1 Language Barrier

All interview participants' first language is Arabic. Five participants evaluated their English language skill as average and one as very poor. These participants perceive the language as the main barrier to the effective use of MCH services. Some of them have a language problem that negatively affected their health during pregnancy, as in participant number 21's story (see below). Others highlighted the problem of language, accent and medical terms. Some participants reported that they missed their appointment at hospital or with the midwife because they could not understand the exact time by phone.

“Sometimes I wait 4-5 days to have an appointment with the GP, because I want an Arabic doctor to see me. My English language is poor and I feel more comfortable when I deal with an Arabic doctor. He can understand me” (Participant No 2).

“I can't speak or understand any phrase in English; my husband usually makes the booking for me with the GP. ... we asked about an interpreter but unfortunately I didn't see her during my pregnancy 9 months [sic.]. My midwife is very nice, she

tried to simplify the words, I can understand her body language and what she draws but I can't understand her speech. I faced difficulty in language and I needed care during pregnancy. I am thalassaemic and my HB was level 7 at that time, my midwife prescribed iron for me, I tried to explain that I can't take it but she insisted. I tried to explain for her [that] I feel drowsy and unwell but she could not understand me. Then I called my friend because I am not well. After 10 minutes, I met her near ASDA then she called an ambulance. I can't remember what happened but she told me that I became unconscious" (Participant No 21).

The other sixteen participants evaluated their language as good or very good and two of them considered themselves to be bilingual. These bilingual women came to the UK at the age of 10 days. The participants considered the use of medical terms and speaking quickly to be the major problems during the conversation with the midwife or the GPs.

"I am usually able to understand, [but] if I found my midwife and GP speaking very quickly or that something was unclear I ask them to repeat and always they are happy to do so" (Participant No 9).

In a similar previous qualitative study, Chinese mothers emphasised that communication was a major problem, especially the language barrier between them and the health professionals (Chan, 2001). Inability to speak English contributed to late booking in this Chinese study. The consequences of language difficulties might be very serious. The 'Why Mothers Die' report found that the risk increased for mothers with language difficulties due to inappropriate communication (Confidential Enquiry into Maternal and Child Health, 2004). Bharj and Salway (2008) stated that women from the BME group who are most in need of health information are most likely to receive the least, which agrees with this study. One participant (No 21), who has thalassemia and could not understand English, reported the story of her last pregnancy that reflected her lack of knowledge regarding the health system and the resulting poor antenatal care and inefficient use of maternity services.

6.5.2 Interpreter services

An interpreter is one solution to the language barrier according to those participants who have difficulty with the English language. The need to find an interpreter can lead to acquaintances and family members being used. The participants stated that their children, friends and husband can help them to book appointments and translate their concerns during their visit to

GPs, midwives and emergency departments. The use of professional interpreters is an important step in overcoming the inequality in the healthcare that should be available and accessible even in an emergency.

“My children speak and understand English well, like native people. Usually my children are explaining the problem and my concern to the GP and in the emergency department” (Participant No 21).

“We asked about an interpreter but unfortunately I didn’t see her during my pregnancy 9 months” (Participant No 21).

Moreover, all the participants know about the interpreter services in the NHS and GPs, but they underscored the difficulty of accessing these services. The interviews revealed that most of the participants have not been asked about this service, therefore they used their family. Only one participant mentioned that before her discharge from hospital her midwife asked the interpreter to assess the participant’s knowledge regarding the discharge plan.

“I know about the interpreter services, but I don’t need it. Before I leave the maternity unit, my midwife brought the interpreter to explain the care plan for my baby and when I have to take him to the GP for a check-up. I am surprised for this action, because I told her I understood the plan. Really, I feel happy because she was concerned that we got the right message” (Participant No 12).

Another problem is the absence of an interpreter in an emergency appointment, as the participant indicated in this current study. To make a booking for an interpreter takes around one week, therefore the participant preferred to see their GP using a family member or friend as interpreter. In case their husbands or friends are not available, they try to communicate with the GP using their limited words and body language to describe the health problem.

“My husband is a PhD student and he cannot be absent from his university to come with me to my GP. Therefore, I asked him just to make an appointment because I cannot do that, if we need an interpreter usually they postpone us for at least one week. When I go to my GP, I try to use simple words or body language or ask her to write [information] down on paper to show my husband” (Participant No 22).

6.5.3 Information provision and needs

All participants mentioned that they only received information in the English language. Some of them agreed to have the pamphlets in English to improve their fluency in English. However, others preferred to receive the information in Arabic to understand the information well. Some prefer the information to be provided by explanation only, but the majority prefer to have the information by both an initial explanation from the midwife then confirmation by a pamphlet, which allows them to read the material again at home. They reported that the GP doctor printed the information for them from the internet without giving any explanation and they were unhappy to receive information without an explanation.

“The midwife notices that I struggle with the language. She got me the pamphlet in English, I look at them and when I reach my home I put them in the rubbish bin. If the midwife herself cannot help me, then I don’t think the pamphlet will do” (Participant No 21).

“The midwife provides me with all material - pamphlets - about my pregnancy and baby. I read the pamphlets, they are useful. If I faced any difficulty in reading, I use the dictionary” (Participant No 12).

On the other hand, other participants prefer to use the internet as a source of information.

“If I need any information I read the NHS web site or Google or Wikipedia. Sometimes I ask my doctor, but I feel I got a full picture from the internet” (Participant No 4).

It is noticeable that those participants who have difficulty with languages and cannot read the English pamphlets relied on their friends or family to gain the required information. However, these participants recommended receiving not only a leaflet but also hospital letters in Arabic to enable them to understand the information correctly.

“Usually, if I need any information I ask my friend or my family here in the UK, or I call my mother in my country. For example, I had a prolonged labour and the nurse was not concerned about me, because of the lack of staff at weekends. I asked my mother what to do and she advised me to walk and drink Cinnamon with sugar” (Participant No 1).

During an ante-natal visit and ante-natal class the participants were satisfied with the information. They sounded positive about the adequacy of information given by the midwife

during the ante-natal appointments, such as the nutrition, development of the baby and screening tests. However, women with certain health problems were not satisfied with the quality of information and the visit time for the midwife did not allow them to have their concerns answered. One woman who felt strongly about the inadequacy of the information that she received said:

“I have a lot of questions regarding my problem during pregnancy - hydronephrosis; I felt that the visiting time for the midwife was not long enough to answer my question. Fifteen minutes is not enough to examine me and to answer my questions. She told me that the time had run out so she could not answer any more questions. I need to know which position is good for my foetus and me; which position helps to relieve the pain. She did not advise me what to do regarding my problem” (Participant No 8).

Some women believed that no information offered to them dealt with the psychological or emotional changes during and after delivery. Other participants reported that some essential information for their babies was not routinely offered to them. One participant reported the problem with vaccination and she did not know the schedule in the UK and the nurse did not offer her the BCG vaccine.

“No one told me about BCG vaccine for my baby; I [found out] accidentally from my friend and my baby missed this vaccine” (Participant No 22).

Moreover, one participant stated that the paediatrician was unable to answer all the questions about the health problem of a child with a certain syndrome.

“My baby had a syndrome since birth. My paediatrician did not know anything about this syndrome. I have a lot of questions but every visit he did not answer our concerns. However, when we went to Jordan and visited the paediatrician, this doctor opened the book and explained everything for us. Why did my doctor in the UK not do that?” (Participant No 5).

6.6 Summary of qualitative findings

The aim of these qualitative interviews was to explore and to investigate the access to, and use of, Maternal and Child Healthcare Services in the UK by Palestinian women. Four themes emerged: cultural variations; knowledge of the NHS and the UK healthcare system;

healthcare services and their utilisation, focusing on MCH services; communication, information-provision and needs.

There are differences in the culture and healthcare systems, particularly MCH services, between the UK and Palestine. The knowledge regarding the system and expectations is varied. Therefore, access to, and use of, these services in the UK is affected. The key points that presented are the use of herbal remedies; preference for antibiotics; preference for privacy; refusal to terminate a pregnancy; fatalism (belief in destiny and fate) and acculturation. The participants pointed out that MCH in Palestine is easier and faster (they could see their specialist directly any time they want with easy and flexible booking by phone) with the specialist scanning the women every visit, Iron is prescribed routinely for pregnant women and there is the presence of a support system. However, most participants underscored that the quality of MCH in the UK is higher than the private system in their country and the UK system encourages the natural process but this pushes women to experience more pain.

Findings revealed a lack of knowledge regarding the MCH services for the first baby and for new participants that have recently settled in the UK. Knowledge and experience was considered as a key to using the services. Being free of charge at the point of delivery was considered as an important advantage of the NHS. Interestingly, the interviews had shown the lack of prior experience with a GP system in the participants' home country. The interviews indicated the variations in services between GPs and the preference for having a female doctor. Long waiting times to see a GP and referral problems; inflexibility in making an appointment and busy GP phone lines emerged as barriers to the use of GP services. Moreover, long waiting times in emergency departments were considered to be a big problem. The key comment "the system is very slow" was responsible for late booking from the participants' viewpoint. Also, from the participants' perspective there are issues during the birth process, including the problem of inadequate pain control; basic nursing care, such as in bathing the baby, and neglect of the postnatal physical and emotional care of new mothers. Continuity of care emerged as an important issue. On the other hand, the postnatal visits by the midwife and health visitor were valuable.

Most participants perceived language to be a major barrier, especially medical terminology and talking quickly. This led to acquaintances and family members being used as interpreters. There was a positive reaction to the adequacy of information given during the ante-natal

appointments, but the women with certain health problems were not satisfied with the quality of information. Some participants expressed their wish to receive information in the Arabic language, but the majority preferred to receive an oral explanation then to read the pamphlet or search the internet at home.

Based on the findings from these qualitative interviews, a questionnaire was developed. A questionnaire survey was conducted subsequently in the second phase of this study to examine this result with a larger population of Palestinian women in the UK. The methods and findings of the second phase of this study will be presented in the next two chapters.

CHAPTER SEVEN

Phase 2-Methods

Quantitative survey

Chapter Seven: Phase 2-Methods

7.1 Introduction & Aims

The first phase of this study utilised a qualitative methodology to explore access to, and use of, healthcare services, particularly maternal and child health services, by Palestinian women in the UK. It provided a clear picture of the potential barriers to, and facilitators of, healthcare services of Palestinian women from Manchester. However, in order to generalise these findings and to further examine the research topic with a larger population of Palestinian women in the UK a questionnaire survey was undertaken in phase two of the study.

From a primary analysis of the first phase - a qualitative, in-depth interview for twenty-two participants - four themes, which discussed the potential barriers to, and facilitators of, healthcare services, emerged. These were: Cultural variation; Knowledge of the NHS & the UK healthcare system; Healthcare services and their utilisation; and Communication & information provision & needs. The questionnaire survey had the following aims in order to examine these findings in a larger population:

- To examine the facilitators of, and barriers to, the health care of Palestinian women and their children in the UK.
- To determine the existing provisions which are intended to facilitate access to healthcare services (i.e. to map the resources available and to identify those which are used by Palestinian women).
- To investigate Palestinian women's views about the maternal and child healthcare services in the UK.
- To make recommendations for improving health service provision for Palestinian women in the UK.

7.2 Sampling & population

Producing a sample for a research project involves “techniques used to obtain a subset of a population without the expense of conducting a census – gathering information from all members of a population” (Bowling, 2002 p.436). The main goals of sampling are to decrease time, increase the amount of data, increase the accuracy of the data and decrease the cost. Therefore, the researcher must define the target population and the inclusion and exclusion criteria clearly (Lunsford, 1995; Bowling, 2002). There are two types of sampling

in a quantitative study: probability and non-probability sampling. A probability sample means that each person has an equal chance of being selected and it is representative of the whole population. However, non-probability sampling means that some people have more chance of being selected than others, which may create sampling bias. The greatest advantages of non-probability sampling are its cheapness and its usability when a sample frame is not available and in exploratory studies (Fink, 1995; Blaxter *et al.*, 2010).

7.2.1 Population & consecutive sample

The target population in this survey is Palestinian women aged 18 years and above living in the UK and this is consistent with the target population in the first phase of the study. In the absence of a suitable sampling frame covering the whole community, a consecutive sample was preferred (Bowling, 2009). In other words, it is impossible to identify all eligible Palestinian women in the UK. Therefore, a pragmatic approach to sample selection was followed and a consecutive sample favoured.

Consecutive sampling is considered to be the best of all non-probability sampling techniques. It is a strict version of convenience sampling. It means that all available subjects over a specific time period are included, which makes the sample a better representation of the entire population (Bowling, 2009).

7.2.2 Setting

The study was conducted in the UK, through the Palestinian organisations in London, and Manchester. This is mainly because larger Palestinian populations are concentrated in these cities and Palestinian organisations presented there, but there are no statistics about the exact number of Palestinians in the UK population. The recruitment process is similar to that which had been used in the first phase of the study in Manchester (recruiting women through the Mosque and Arabic schools). In addition to that, the Palestinian organisation were involved in London, more detail is presented in section 7.5.

7.2.3 Sample size

An essential part of a quantitative survey design is determining the sample size and dealing with non-response bias (Kotrlík & Higgins, 2001). The sample size in a survey should be sufficient (Fowler, 2009); for major subgroups 100 cases and for minor subgroups 20-50 cases is fair (Oppenheim, 2000). The risk of sampling errors decreases when larger sample

sizes are used (Grove, 1997). The exact size of the UK Palestinian population is not recorded. Anecdotal evidence suggested it is around 20,000-22,000. Taking into consideration that around half of this population is women and not all of them of child bearing age, approximately 1,000 questionnaires were sent out to participants. This represents approximately 10% of the target population. Additionally, as many women were invited by email to complete the survey, there is no idea how many women have received the email or forwarded it on to others. Therefore, the final sample size in relation to returned questionnaires 200-250 from the 1000 sent out seems appropriate for this study.

7.3 Instrument development

Questionnaires are an important tool for generating data, so development of the questionnaire for this survey from the qualitative study involved many considerations, particularly choosing the questionnaire design and the development of an item pool. There are many types of attitude scales such as Thurstone scales, Likert scales and others. Foddy (1994, p.180) claimed that Likert scales or summated scales “have been used more often than any other rating device for measuring attitude”. Therefore, this scale was used in the survey to examine Palestinian women’s views regarding their access to, and use of, healthcare services, particularly maternal and child health services, in the UK.

7.3.1. The Likert or Summated Scale

This scale was developed in 1932 by Rensis Likert. It is considered as the most common and usable scale to assess participants’ opinion. This scale provides more specific information than the yes/no dichotomous type of scale. It describes the complexity of opinion or attitude by asking the participants to make a decision on a five-point scale related to a statement. These are (1) strongly agree, (2) agree, (3) uncertain, (4) disagree and (5) strongly disagree with the statement (Oppenheim, 1998; Foddy, 1994). It is sometimes called a summated scale because a participant’s score can be calculated by summing the number of responses (Foddy, 1994). A Thurstone scale is another scale that can provide information about the level of agreement or disagreement, but it is difficult to use (Oppenheim, 1998). The following table summarises the advantages and disadvantages of both scales.

Table 7. 1: A summary of the advantages and disadvantages of the Likert & Thurstone scales.

	Scale	Advantages	Disadvantages
1.	Likert Scale	<ul style="list-style-type: none"> ➤ Simple to construct, ➤ Easy to read and complete, ➤ Good reliability, ➤ Each item of equal value so the participants are scored rather than items. 	<p>Most criticisms relate to</p> <ul style="list-style-type: none"> ➤ Lack of reproducibility, ➤ Absence of metric or interval measures and the lack of a neutral point.
2.	Thurstone scale	<ul style="list-style-type: none"> ➤ Items are valued rather than subjects. ➤ More reliable than the Likert scale. 	<ul style="list-style-type: none"> ➤ More difficult to construct than a Likert scale, ➤ Measures only agreement or disagreement,

Tittle and Hill (1967) mentioned that the Likert scale is easier to construct and more reliable than other scales with the same number of items. For this reason it is the most widely used in the social sciences (Oppenheim, 1998), therefore it was decided to apply a Likert scale to this study. However, this scale has some disadvantages as illustrated in Table 7.1. To overcome these disadvantages, the researcher in the analysis phase must be alert to the lack of reproducibility, which means that the same total score on the scale could be achieved in more than one way. Therefore, the pattern of responses to the items as well as the total score must be taken into consideration.

7.3.2 Item pool

After deciding on the type of attitude scale, an item pool was then developed. Oppenheim (1998, p.179) mentioned that 'item pool' means “the collection statements from which the scale will be built”. These statements should be interesting, meaningful and exciting to the participants. Streiner and Norman (1995) stated that, in social science, the item pool for a scale is usually derived from four sources: theory, research findings, clinical observation and input from patients. In this study, the item pool was developed from the findings from the first phase of the research (the analysis of twenty-two in-depth interviews from which four

themes emerged), and then questions were developed from the participants' statements. All statements were translated from Arabic to English and, to ensure validity, expert people in research and translators were involved in this process, taking the ethical issues into consideration such as protecting anonymity of data. The next step was modifying these items by removing or modifying some words, for example, removing leading or ambiguous words/statements and identifying those with double meanings (Oppenheim, 1998). After a discussion with her PhD supervisors regarding the design and items, the researcher decided to keep the statements in positive or negative form as the original participants' opinions. Moreover, some important questions were added based on the literature review. When translating the questionnaire and participants' statements, the researcher used the back translation technique: the statements were translated into English then the English version into Arabic and the same meaning and content maintained. Linguistic specialists were consulted to check the Arabic and English versions of the questionnaires. A few changes were made which related to inappropriate translation (semantic issues).

The last section of the questionnaire elicits the demographic characteristics of the participants and the remaining statements were categorised into four sections that reflect the four themes. The questionnaires were available in both Arabic and English languages. The next section will explain the pilot testing for this instrument.

7.4 Pilot study

Pilot testing is an important and critical step in developing a new survey instrument; it reflects how the survey instrument really behaves in the field. Moreover, it allows the researcher the opportunity to correct errors and redesign any difficult parts of the instrument before the real use of the questionnaire (Litwin, 1995). Suchman and Jordan (1992) described the technique as a 'think-aloud' test, where people are asked to describe how they interpret a question and what they are thinking when they read it. The researcher must follow the pilot study procedure to improve the questionnaire's validity. This includes: administering the questionnaire in the same way as in the real study, recording the time taken to complete the questionnaire, asking for participant feedback, removing ambiguous and difficult questions and re-scaling or re-writing the questions that were not answered exactly (Peat & *et al*, 2002).

A pilot study of this questionnaire was conducted with twelve Palestinian women in February 2012 to check if the questions were generally well planned, well structured, clear and easy to follow and fill in (Appendix 7.1). Thirteen women were invited to participate in the pilot study, of which five agreed to take part. However, following a second reminder after two weeks, another five women agreed to participate. Three participants did not respond to both invitations. After modification of the questionnaire a re-pilot test was undertaken with two new participants and no suggestion was added to the final version of the questionnaire.

The questionnaire was initially piloted using face-to-face interviews with five participants in their own homes. The researcher asked the participant to read the information sheet, invitation letter and fill out the questionnaire survey. After that, they completed the checklist for the pilot test and discussed their comments. The researcher then sent e-mails to a further eight women asking them to take part in the pilot and complete the survey. Three of them did not respond, but the others filled in the questionnaires and provided their feedback. Pilot testing revealed that some participants did not have the computer skills to fill in the survey. One participant requested help because she did not know how to tick the answer using the PC. Therefore, an explanatory sentence was added to the beginning of the questionnaire that explained how to tick the correct box. "If you want to answer this survey using your computer, you can click on the right side of the mouse inside the selected box and choose bullets to click your answer". Another statement was added to last section "To answer this part using your computer, please click the mouse inside the box and type your answer".

The time taken for completing the survey and reading the information sheet and invitation letter ranged between 18 and 35 minutes. The researcher had spent about 10-25 minutes after the participants completed the survey to fill in the checklist for the pilot test and gain more explanation about their opinions. Participants in the pilot study were aged between 20 and 45 years; all of them have an experience of using MCH services in the UK.

Generally, participants believed that the invitation letter, information sheet and instructions on how to complete the questionnaire were easy to understand in both English and Arabic. The survey questionnaires were well structured, organised and clear. They did not think the survey was too long or too detailed or the style of the items too monotonous. Participants suggested several possible modifications to the questionnaire. For the women who were born in the UK, they felt that the statement. "I found out about the NHS service before I came to

the UK”; “I had adequate knowledge about the NHS when I arrived in the UK”; “I feel the NHS - Maternal and Child Healthcare services in the UK are better than the private or government sector in Palestine”, were not applicable to them. It would not be right for them to choose “not sure”, therefore the style of this statement was changed and the choice of ‘not applicable’ was added. Two participants who have experience with misdiagnosis by GP phone assessment suggested the statement “I am not happy with the GP system for assessment by phone when I book an appointment” should be included. One of them perceived that her GP refused to see her baby despite the baby having a chest infection. However, the emergency department doctor prescribed antibiotics for her baby on the same day. One participant suggested adding two questions regarding the regularity of attending antenatal visits and antenatal classes.

With regard to the issues about answering, the pilot study showed that the majority of women found it easy to select one answer among the five options (Likert scale). It was found that some participants answered “not sure” because they hesitated between “agree” and “disagree” and they felt that more explanation was needed. As a result, the statement “I am able to book an appointment with my GP when I want” was changed into two sentences “I am able to book an emergency appointment with my GP on the same day” and “I am able to book a regular appointment with my GP within 3 days”. The pilot revealed that the statement “The national healthcare services (NHS) in the UK are free for all people in the UK” was understood wrongly so ‘all people’ was replaced by ‘all residents’ as suggested by participants. Moreover, some terms were vague for participants. For example, the term “anonymised” was not clear for them. Therefore, it was replaced by “kept without name”, and “boy” replaced the term “male”. The statement “my baby received all his/her immunisation” was changed to “my baby is up-to-date with all his/her injections” to remove the ambiguity.

The final draft of the survey (see Appendix 7.1) was developed after making the modifications based on the pilot test results. Bowling (2002) mentioned that face-to-face pilot testing should be continued with a new sample until no further changes were required. Therefore, additional feedback was sought after modifying the questionnaires from a further two Palestinian women who had not been involved in the first pilot test. They were happy to complete the survey and no changes were required. The survey questionnaire included four sections with 65 statements in total aiming to examine the access and use of MCH services in

the UK by Palestinian women. In the fifth section, participants' demographic data were collected using 12 questions. Pilot data was not used in the main findings of the study as changes in protocol as a result of pilot testing, risk adding additional sources of variation and thus may affect the validity of the study (Leon *et al.*, 2011).

7.4.1 Section A: Your Knowledge about the Maternal and Child Healthcare services in the UK.

In this section knowledge about the healthcare services was examined by nine items. "The national healthcare services (NHS) in the UK are free for all residents in the UK", "You must be aware of your rights, otherwise you may miss out on some MCH services", "The delivery of maternal and child health services is better for British women than Palestinian women", "I feel it is good to have all the healthcare services, including dentistry, free for pregnant women and one year post-delivery" and "Maternal and child healthcare services in the UK are fulfilling my needs". Two items were developed to examine the knowledge of participants before and when they arrived in the UK. "I found out about the NHS service before I came to the UK" and "I had adequate knowledge about the NHS when I arrived to the UK". A filter question "Are you aware of the government plans to close some maternity hospitals and develop others" was used before the final item, then the last item examined their opinion regarding this new policy "In which way will this affect the services do you think".

7.4.2 Section B: Information about accessing and using the general practitioner (GP) and MCH services

In this section, accessing and using the MCH services, as examined by 28 items from three aspects arising from the qualitative interviews. These are GP services, the use of MCH services in the community and MCH services in the hospital.

For the GP services, ten items were included: "The GP's registration process is easy", "I am able to book an emergency appointment with my GP on the same day", "I am able to book a regular appointment with my GP within 3 days", "My general practice has all the services that I need in one place such as child care, immunisation and a midwife", "The waiting time to see my GP is too long", "I would prefer a female GP to examine me at the GP surgery", "My GP relies on a verbal history rather than physically examining me", "I have to wait a long time for my test results" "I am not happy with the GP system for assessment by phone

when I book an appointment” and “The time between my GP referral and hospital appointment is too long”.

The nine items for MCH services in the community were: “I had the same midwife throughout my pregnancy”, “It is important to me to have the same midwife throughout my pregnancy”, “I had contact with my midwife or GP before the 12th week of my pregnancy”, “I had contact with my midwife before the 12th week of my pregnancy”, “Given a choice regarding the location of delivery, I would prefer to give birth at hospital rather than at home”, “My baby is up-to-date with all his/her injections”, “I can easily access the dental services in the UK”, “The waiting time in the (A&E) emergency department is too long” and “The waiting time in the paediatric emergency department is too long”.

The MCH services in the hospital involved nine items “My pain relief was adequate during my labour”, “I received adequate support from the midwife to breastfeed my baby post-delivery”, “My baby was bathed in an unsatisfactory way in the hospital”, “I prefer to use only water to bath the baby in the first week after delivery”, “I received adequate care post-delivery in the hospital”, “I receive adequate pain relief post-delivery in the hospital”, “I did not received adequate attention post-delivery in the hospital” and “I like the food provided at the hospital”. A filter question “did you deliver your baby at hospital?” was used before this sub-section to distinguish between participants who have experience of hospital delivery.

7.4.3 Section C: Information about language problems, interpreter services and information provision in MCH services.

This section examined communication problems, particularly the language barrier that Palestinian women experienced when accessing MCH services and their experiences with interpretation services, information provided and their need. A total of fifteen items were developed: “The receptionists at my GP are helpful”, “The midwife provided me with information and leaflets”, “I had adequate information in a language that I could understand”, “There was not enough time during my visit for the midwife or doctor to answer my questions”, “I would prefer having the leaflets about my pregnancy in addition to the midwife’s explanation”, “I would prefer to read the leaflets about my pregnancy in the Arabic language”, “If I have health problems, I prefer to deal with a doctor or nurse who speaks Arabic”, “I can understand written English well”, “Language problems make it hard to understand what the midwife, doctor and nurse are saying to me”, “Language problems make

it hard to explain my concerns to the midwife or doctor”, “I find it difficult to book an appointment with my doctor because of language problems”.

Three questions investigated experiences with interpretation services: “Interpreters are usually not available when I request them”, “I prefer a family member or my friend to act as an interpreter”, “My family member or friend who helps me with interpretation usually has difficulty in finding time to do it”. A filter question was used before the interpretation services questions, asking them if they needed an interpreter or not.

7.4.4 Section D: Information about the Culture

This part examined the effect of culture on accessing and using the MCH services and made comparisons between MCH services in the UK and Palestine. Fourteen items were developed. “I prefer to use a traditional herbal medicine”, “I prefer to use antibiotics for a viral infection”, “I brought my medication from my country – Palestine”, “The system in the UK encourages the birth process to be natural”, “I would prefer to be cared for by a midwife throughout my pregnancy”, “I would prefer to be cared for by a specialist doctor throughout my pregnancy”, “I would prefer not to have screening tests for Down’s Syndrome during my pregnancy”, “If the test or scan shows the possibility of abnormality, I would not terminate the pregnancy”, “I would prefer not to have scanning tests for Down’s Syndrome during my pregnancy”, “I prefer to breastfeed my baby rather than to use bottle feeding”, “I prefer a midwife to examine my baby post-delivery”, “I prefer a paediatrician to examine my baby post-delivery”, “I would prefer the circumcision service to be available on the NHS for male babies”. Two items asked about the participant to compare between the two countries “I feel the NHS - Maternal and Child Healthcare services in the UK are better than those in the government sector in Palestine” and “ I feel the NHS Maternal and Child Healthcare services in the UK are better than the private sector in Palestine.

7.4.5 Section E: Demographic Data – about the participants

This section examined participants’ characteristics using 12 questions: age, religion, marital status, education, occupation, number of children and how many of them have been born in the UK, country of birth, length of time living in the UK, the city in which they live in the UK, the main reason for residing in the UK and if their parents are present in the UK. Open-ended questions were used to elicit the participants’ response. For specific questions, such as

education, reason for residence in the UK and your parents' residence in the UK, multiple choices were given to facilitate the process of answering the question.

7.5 Data collection

Surveys are commonly used to collect data in healthcare research (Rubin and Babbie, 2009). There are different types of surveys, including self-administered questionnaires, mail surveys, interview surveys and telephone and online surveys (Rubin and Babbie, 2009). In this study, a self-administered questionnaire and an e-mail questionnaire were used. A detailed explanation follows of the data collection, recruitment process and key advantages and disadvantages of the questionnaire collection method used in this study.

Data collection started in March 2012 and lasted two months. Respondents were recruited in the UK via Palestinian organisations mainly from Manchester and London. Due to the limited numbers of Palestinian organisations, all of them were involved in the study. These organisations include;

1. Arabic schools in Manchester – Al- Manar and Anoor. However, the third school (Alhijra) did not participate in this phase of study. The researcher contacted 16 Arabic schools in London and centres that teach the children the Arabic language and Islam. It found that four schools have Palestinian children and teachers; these are the Palestinian school, Ahleyeh, Academeyeh and Anajah School. All of those schools were happy to participate in this research and wished to be identified in this study. Therefore, their names have not been anonymised.
2. In Manchester, a Mosque, where Palestinian activities and the Palestinian forum meeting occurred was used and recruited the majority of participants. From discussion with the head of the Palestinian forum in London, it seems that Palestinian women in London do not go to the Mosque and prefer to pray at home. Therefore, for this population a Mosque was not used as a recruitment location, instead a fitness gym for women where Palestinian activities and the Palestinian forum meeting occurred regularly was used.
3. In London – the Palestinian delegation and the general union of Palestine students (GUBS).
4. In London and Manchester – the Palestinian conflict society.

Women who were not on the databases of the organisations above were less likely to become part of the study. Therefore, a snowball technique was also used whereby women recruited to the study via the above methods were asked to forward the survey to other Palestinian women. Detailed information about the research setting is presented in Table 7.2.

Table 7. 2: A summary of the data collection routes in the UK
(Mainly in two big cities-Manchester and London).

Mode of data collection	Manchester	London
⇒ Questionnaire sent via e-mail to	<ul style="list-style-type: none"> • Palestinian Conflict Society 	<ul style="list-style-type: none"> • Palestinian Conflict Society • Palestinian Delegation • Palestinian Forum • GUBS
⇒ Questionnaire sent by Post to	<ul style="list-style-type: none"> • Arabic schools (Anoor and Manar) • Mosque/Palestinian Forum 	<ul style="list-style-type: none"> • Arabic schools (Anajah, Palestinian, Ahleyeh and Academeyeh) • Palestinian Forum/ fitness gym building

Permission to conduct the studies in these locations was obtained from the head teacher, the trustees, the Imam and the head manager of the other Palestinian organisations. In order to ensure women with a wide range of characteristics were recruited in this survey, a series of strategies was evolved.

Strategy 1- approaching organisations which belong to different political waves. An example was recruiting religious women via the Palestinian forum and liberal women via the Palestinian delegation and the Palestinian conflict society. Using the Arabic schools involved all political waves.

Strategy 2- approaching participants that belonged to different religions. (The researcher recruited Christian woman through using a key person in the Christian Palestinian community in the UK. A key person has sent the survey through her email list and mobile phone contact list to all her Palestinian contacts in the UK).

Strategy 3- approaching organisations located in different geographic areas in London and Manchester. An example is the location of schools in east and west London. Therefore, the data collection involved both the e-mail and postal questionnaire.

The advantages and disadvantages of e-mail and postal questionnaires are overlapping. Discussion of each method is presented below separately as existing in the text book.

7.5.1 E-mail questionnaire

First, the questionnaire, cover letter and information sheet about the study were sent to participants via e-mail through the Palestinian Conflict Society, the Palestinian forum, the Palestinian delegation and GUBS. Their e-mail lists include a few hundred Palestinian people and the administrators in these organisations sent reminder e-mails after two to three weeks. To ensure a representative sample and avoid sampling bias, the researcher asked participants to forward the survey to other Palestinian women. Most of the Palestinian women used their own e-mail list and mobile phone contact list to distribute the survey. The researcher twice received the invitation to fill in the survey by her personal e-mail during the data collection period, which provided an unexpected but welcome check that the process was operating effectively.

The e-mail method was selected taking convenience, time and budgetary constraints into consideration. Other possible advantages include the ability of an e-mail survey to reach a broader population than is possible through other channels. Additionally, thousands of participants can be reached in a short period of time (Nie *et al.*, 2002). Although e-mail surveys offer many advantages over traditional surveys, there are, however, disadvantages that the researcher must consider, such as sampling issues, and that little is known about the characteristics of the people in the communities (Wright, 2005). Some researchers have found that the response rate in e-mail surveys is better than, or the same as, other traditional mailed surveys (Thompson *et al.*, 2003). However, in this study, the response rate was low using this approach, only 24 questionnaires were completed. This may be due to the fact that the majority of women used their mobile phone to check their emails and it is difficult to fill in the survey by mobile phone. Therefore, most of the participants preferred to complete the survey by post. The researcher has discovered this fact during her regular visits to the research setting during data collection. Extra copies of questionnaire were sent to the Palestinian Forum and Palestinian delegation in London.

7.5.2 Postal questionnaire

Second, the questionnaire, cover letter and information sheet about the study were distributed to participants through the Arabic schools, the Palestinian Forum meeting, the Mosque and the fitness gym for women only. An introductory cover letter explained the aims of the study, gave notification of ethical approval, the time required for completion and clear instructions on how to complete and return the questionnaire. The respondents were assured of the confidentiality and anonymity of their responses. Two weeks after sending the questionnaires and covering letter, a reminder was sent to those who had not replied to the initial questionnaires.

Postal questionnaires are a common method of covering a large population. They are quicker and more economical than interviews. They eliminate bias in interviews and are useful when questions are simple and direct, however, they are not appropriate for complex issues (Bowling, 2002). However, the main disadvantages are the absence of control over who actually completes the questionnaire and the influence of other family members in completing the questionnaire (Williams, 2003). Additionally, the response rate may be low due to the non-return of questionnaires (non-response bias) (Bowling, 2002). Some of the key advantages and disadvantages of the modes of questionnaire collection used in this study are presented in Table 7.3.

Table 7. 3: A summary of the advantages and disadvantages of using e-mail and postal questionnaires in data collection

	Data collection	Advantaged	Disadvantages
1.	E-mail Questionnaire	<ul style="list-style-type: none">• Convenience, time and money saving,• Thousands of participants can be reached in a short period of time.	<ul style="list-style-type: none">• Little known about the characteristics of people in the communities.
2.	Postal Questionnaire	<ul style="list-style-type: none">• Covering a large population so a large sample can be obtained,• Quicker and more economical than interviews,	<ul style="list-style-type: none">• Not appropriate for complex issues,• Response rate may be low due to non-return of questionnaire,• No control over who actually

		<ul style="list-style-type: none"> • No bias from the interviewer, • Useful for simple and direct questions. 	<ul style="list-style-type: none"> • completes the questionnaire, • Influence of other family members in completing the questionnaire.
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To overcome data collection disadvantages and increase the response rate, Bowling (2002) stated that the nature of the study topic, sponsorship and the length of the questionnaire are major factors affecting the response rate in a survey. Therefore, several techniques have been followed. For example, the content of the cover letter included the aim of the study. Moreover, the researcher visited the research setting and explained the aim of the study, emphasised that participation in this study was quite unrelated to any political issues and gave participants the opportunity to ask questions about their concerns.

In a study that compared the length of a questionnaire and the response rate, it was found that the response rates for a one-page and a three-page questionnaire were 90% and 73% respectively (Cartwright, 1988). In this survey, the length of the questionnaire was 7 pages in the Arabic version and 8 pages in English.

7.6 Data management and analysis

7.6.1 Preparing the data for analysis

SPSS Version 19.0 for windows was used to analyse and manage the data. Various steps were taken to prepare the data for analysis, including data checking, coding, transforming and entry.

7.6.1.1 Data checking

Several strategies were followed to handle the data. For example, when the e-mail responses were received from participants, a specific number or coding was given after saving the questionnaire on a password protected computer.

In addition, a specific number was assigned to a postal response so that it could be referred to again. The completed questionnaires were checked for missed answers, mistakenly filled in sections, incorrectly followed "skip" instructions and unclear answers. An example is the participant who selected two boxes for the same question and left the next question empty. In

this case, the variable should be treated as "missing" and the questions with two answers excluded from the analysis.

7.6.1.2 Data coding and data transformation

Sixty-five statements were coded from one to five, 1 means “strongly disagree”, 2 means “disagree”, 3 “not sure”, 4 “agree”, 5 “strongly agree”. In four questions (n= 6, 7, 67 and 68) from sixty-five statements, “not sure” was replaced by “not applicable”, this was because some of the Palestinian women were born in the UK or they have never lived in or visited Palestine. Three ‘skip questions’ were coded as 1 meaning “yes” and 2 meaning “no”. Demographic data were categorised and coded as follows:

The four continuous variables are date of birth, total number of children, number of children born in the UK and date of arrival in the UK. These needed to be converted into different formats and recorded as new variables.

Date of birth - age was calculated by subtracting the date of birth reported by the participant from the current year [2012]. Age group was classified into four categories from 20-30, 31-40, 41-50 and over 50 years. Experience of giving birth in the UK; this was done by dividing the numbers of children born in the UK by the total number of children and multiplying by 100 to give a percentage. This was then sorted into three codes: 1 refers to the mothers that have no experience of giving birth in the UK (0%), 2 means mothers with mixed experience (<100%) and 3 refers to mothers with 100% UK experience. Another new row was added to calculate the length of time living in the UK by subtracting the actual year they arrived to the UK from the current year [2012]. Then number of years were categorised into four groups and coded from 1-4. These groups are less than 5 years, from 6-10, from 11-20 and more than 20 years spent living in the UK.

The categorical variables were coded in the same way that the responses were listed in the questionnaires, with the first as 1, second as 2 and so on. “Your parents reside in the UK” had two categories “yes” coded as 1 and “no” as 2. In “Reason for residing in the UK”, where more than one choice was available, family coded as 1; employment as 2; education as 3; family and employment as 4; family and education as 5; employment and education as 6; and if the participant ticked the three boxes it was coded as 7. “Level of education” had five

categories; coded ordinally from lower to higher level as follows: 1 for high school (others), 2 for Diploma, 3 for BSc, 4 for Master's, and 5 for PhD.

After reviewing the first 20 questionnaires, the researcher had categorised and coded these variables. First, "Work" was categorised into three variables: Housewife (not working) coded as 1, working as 2 and student as 3. Second, the "Religion" variable was coded into 1 for Muslim, 2 for Christian and 3 for Atheist. Third, "Marital status" was categorised into married, single, divorced and widow, and was coded from 1-4 respectively. Finally, "Country of birth" was given 1 for Arabic countries (that included Palestine and other Arabic countries) and 2 for the UK.

7.6.1.3 Data entry

There are two approaches to entering data. First, two people enter data and then compare the results. The second approach is entering the data only once, but a number of checks are needed. In this study, the researcher entered all the data as soon as possible after receipt into a pre-prepared SPSS data file by herself. A line-by-line double-check against the original questionnaires was done. Moreover, a random check technique for 25% of questionnaires was applied and a few mistakes found that were subsequently corrected, for example, entering the wrong number due to pressing more than one key or missing some values. The researcher also checked all variables; computed frequency and range; and corrected unreasonable values. The data was then ready for analysis

7.6.2 Descriptive statistics and inferential statistics

Two types of analysis - descriptive and inferential – are used in this study. The descriptive statistics used were means and standard deviations for continuous variables. The categorical variables were presented using frequencies and percentages. Inferential statistics were used to investigate differences between and among groups (Field, 2009). Consistent with Pallant (2010), nonparametric techniques were used when study data are measured on nominal (categorical) and ordinal (ranked) scales. In this research, a Likert scale questionnaire was used to examine Palestinian women's view on access to, and use of, MCH services in the UK. Likert scales generate ordinal level data, as such, non-parametric techniques were used to analyse this data to test the significance of the results (Jamieson, 2004).

The first analysis of the demographic data involved calculating frequencies, percentages and mean and standard deviations for continuous variables and frequencies and percentages for categorical variables. Two main approaches used to analyse the statements were: first, describing the responses for each statement using a frequency and percentage for each item. Second, using bivariate analysis that correlates between dependent (demographic and clinical characteristics) and independent variables (65 statements), three types of tests were used to describe this correlation or effect based on dependent variables and to answer the research questions. These are the Mann-Whitney, Spearman's rho and Kruskal Wallis tests. The detailed explanation about why these tests and procedures were appropriate to answer the research questions is discussed below and the findings presented in the next chapter.

7.6.2.1 Bivariate analysis “Spearman's rho”, the Mann-Whitney and Kruskal Wallis Tests

The next step after describing the frequency and percentage of 65 statements was examining the relationship between, or measuring the effect of, the demographic characteristics and survey statements or items. If there is a significant difference, then there is a significant effect (Field, 2009). In order to investigate these effects or relationships between two variables at one time, bivariate analysis was applied. Bivariate analysis includes the test of the differences between two groups (Pallant, 2010). In this study, 65 items were developed to examine Palestinian women's view on access to, and use of, MCH services in the UK. The Likert Scale questionnaire items were considered to provide the independent variable (IV), while the dependent variable (DV) was one item of the demographic or clinical characteristics.

Three research questions were addressed by bivariate analysis:

- 1- Is there any association between the Likert Scale questionnaire item's score and ordinal or higher-level demographic and clinical data?
- 2- Is there a difference in the Likert Scale questionnaire item's score between two groups of independent variables with demographic and clinical data that has two categories?
- 3- Is there a difference in Likert Scale questionnaire item's score between three or more groups of independent variables with demographic and clinical data that has three or more categories?

In order to answer these research questions, the three tests of non-parametric data that were suitable were the Spearman's rho, Mann-Whitney U and Kruskal Wallis tests. These tests do not assume that the data fits the normal distribution (Field, 2009).

For Research Question 1- Spearman's rho correlation coefficient: This is a standardised measure of the strength of the relationship between two variables that does not rely on the assumptions of a parametric test. The researcher looked at the correlation coefficient value (r), whose value ranges between -1, negative correlated, through zero, where there is no relation, and +1, positively correlated (Field, 2009). Cohen (1988) suggested these guidelines: small $r = 0.10$ to 0.29 , medium $r = 0.30$ to 0.49 , and large $r = 0.50$ to 1.0 . A $p < 0.05$ is considered a significant correlation. This was used to assess the correlation between independent variables (65 items) and continuous dependent variables in this study. These variables include ratio-level variables (“age” and “length of time living in the UK” and “experience of giving birth in the UK”) and an ordinal level variable “education”.

For Research Question 2 - Mann-Whitney U test: This is a non-parametric test that looks for differences between two independent samples. It is used to examine if there were differences between the two groups of the two variables with regard to the median score of items (Field, 2009). The DV was one of the questionnaire items and IV was “country of birth” and “having a family in the UK”. According to responders’ replies, the country of birth includes the UK (sample size $n = 25$) and one of the Arabic countries ($n = 209$). “Having a family in the UK” statement has two answers yes and no with sample size (43 & 192) respectively.

For Research Question 3- Kruskal Wallis Test: This is the non-parametric version of the one-way independent ANOVA, to test whether more than two independent groups differ (Field, 2009). The DV was one of the questionnaire items and the IV was one of the following four variables: “religion”, “marital status”, “occupation”, and “reason for residing in the UK”. According to the replies, the Occupation variable was categorised into working ($n = 142$), housekeeper (77) and students (15) with acceptable sample size. Reason for residing in the UK had 7 categories. The three main categories used were family ($n = 168$), education ($n = 18$) and employment ($n = 40$). However, other categories that mixed between these main categories were excluded due to the small sample sizes ranging from 1-3.

The religion variable had three categories Muslim, Christian and Atheist, most of the responders were Muslim (n=234). Christian and Atheist groups have a very small size (4 and 1 respectively). For “marital status”, most of the women were married (n=236). However, divorced or separated, the widowed and single groups had also very small sample sizes (6, 3 and 1 respectively). Therefore, for these two variables (religion and marital status) the researcher has dealt with them as one group due to small size of their groups.

7.6.2.1 Post hoc comparisons

The Kruskal Wallis test used to identify differences in a DV among three or more groups does not show the differences between these groups. For that reason, *post hoc* comparisons were used to find the significant differences between groups (Pett, 1997). Dunn’s multiple comparison procedure was used following the Kruskal Wallis test (Pett, 1997). However, this procedure is not available in SPSS. Alternatively, the Kruskal Wallis test was followed up with the Mann-Whitney U test between two pairs of groups. In order to avoid inflating type-one error, the Bonferroni adjustment to the alpha values should apply, this adjustment involves dividing the alpha level of 0.05 by the number of tests that you intend to use (Pallant, 2010; Pett, 1997). It is used as a criterion to determine the significance level, for example, if three tests were used ($0.05/3 = 0.017$), then the stricter alpha level will be 0.017 (Pallant, 2010; Pett, 1997).

7.7 Summary

The aim of the second phase of the study was to examine the findings of the first phase of the study and then to make feasible generalisations of the results. A Likert Scale questionnaire survey was developed based on the in-depth interview results from the first phase. A pilot study of 12 Palestinian women was conducted to evaluate these questionnaires. It showed the questionnaires were clear, well-structured and easy to follow. Modifications were made to some statements based on recommendations from participants and to ensure the research aim was addressed. A cross-sectional survey was conducted using e-mail and postal questionnaires to potential respondents in the UK focused on two large cities: London and Manchester in order to examine participants’ views regarding their access to, and use of, MCH services in the UK. In the absence of a suitable sample frame covering this minor community, all Palestinian organisations in both cities were involved to recruit Palestinian women living in the UK to be involved in this study. SPSS version 19 software was used to

analyse the data. The main approaches of analysis included descriptive and inferential statistics. The Mann-Whitney, Spearman's rho and Kruskal Wallis tests were used to measure the correlation or effect between the DV and IV. The next chapter will discuss these finding and summarise the main barriers and facilitators in accessing MCH services in the UK by Palestinian women.

CHAPTER EIGHT

Phase 2-Results

Quantitative survey study

Chapter Eight: Phase 2-Results

8.1 Introduction

A questionnaire survey, which aimed to examine the findings of the first phase of the study, was conducted in the UK mainly through Palestinian organisations in two large cities: London and Manchester. This chapter presents the findings of this questionnaire survey, question by question without significant discussion. The discussion for these results, with existing literature and policy agenda of healthcare system in the UK, will be presented in the next chapter.

The characteristics of the sample are introduced first. Then, describing the responses for each statement and the findings of bivariate analysis, the correlations between the dependent variables (demographic and clinical characteristics) and the independent variables (statements) are presented. Three types of tests used to describe this correlation or effect that answered the research questions have been discussed previously (Chapter 7). These are the Mann-Whitney U, Spearman's rho and Kruskal Wallis tests.

8.2 Characteristics of the sample

A total of 243 questionnaires were returned by post and e-mail from the responders in the UK between March and June 2012. Six questionnaires were excluded because they were not completed and 237 returned questionnaires used for the analysis.

Age- 222 responders reported their date of birth. The mean age of the sample was 36.55 with an age range between 20 and 59, (40.9% being in the age range 31-40). Approximately 97% (n=232) described themselves as Muslim, 1.7% (n=4) Christian and 0.4% (n=1) atheist. 94.5% (n= 224) reported they were married, 2.5% (n=6) divorced, 0.4% (n=1) single and 1.3% (n= 3) widowed. Most of responders are well-educated, 44.5% (n=105) have a Bachelor's Degree, 13% (n=31) have a Master's Degree, 4.7% (n=11) have a PhD and only 11.4% (n=27) have a high school qualification. In terms of employment, 60.7% (n= 142) were not working (housewife), 32.9 % (n=77) working and 6.4% (n=15) students.

The mean number of total children was 3.2 with SD=1.4. Most of mothers 61.2% (145) having 100% experience of giving birth in the UK, and 31.6% (n=75) of mothers reported they have <100% experience of giving birth in the UK (they have mixed experience in the UK and their home country). However, 3.8% (9) of Mothers have no experience of giving birth in the UK and their experience of giving birth in their home country only. Regarding the country of birth 10.6% (n=25) reported the UK and 88.9% (n=209) Arabic countries. Interestingly, only 25% (n=59) of responders were born in Palestine. The mean length of time living in the UK was 13.3 years with lengths of residence ranging between 1 and 40 years, 42.5% (n= 88) have been living in the UK for 11-20 years. Most participants 71.5% (n=168) mentioned their family as the main reason for residing in the UK, 18% (n=7.7) employment, 40% (n=17) education and 9% for a mixture of reasons. About 18.3% (n=43) have a parent in the UK, while 81.7% (n=192) do not have their parents in the UK. A demographic profile of the 237 respondents is presented in Table 8.1.

Table 8. 1: Demographic and clinical characteristics of the sample

Variable (N)	N (%)
Age (222)	
Mean (SD)	36.55 (SD=8.6)
Median	36
Age group	
20-30	55 (32.2)
31- 40	97 (40.9)
41-50	54 (22.8)
>50	16 (6.8)
Religion (237)	
Muslim	232 (97)
Christian	4 (1.7)
Atheist	1 (0.4)
Marital Status (234)	
Married	224 (94.5)
Single	1 (0.4)
Divorced or separated	6 (2.5)
Widowed	3 (1.3)
Educational qualification(236)	
Diploma	62 (26.3)

BSc	105 (44.5)
Master's degree	31 (13)
PhD	11 (4.7)
High school	27 (11.4)
Occupation (234)	
Housewife – not working	142 (60.7)
Working	77 (32.9)
Student	15 (6.4)
Number of Children (229)	
Mean (SD)	3.2 (1.4)
Mothers have no experience of giving birth in the UK	9 (3.8)
Mothers having <100% experience of giving birth in the UK (mixed experience)	75 (31.6)
Mothers having 100% experience of giving birth in the UK	145 (61.2)
Country of birth (235)	
UK	25 (10.6)
Arabic country	209 (88.9)
Palestine	59 (25)
Other Arabic country	151 (64.3)
Length of time living in the UK (207)	
Mean (SD)	13.3 (SD=7.8)
Less than 5 years	31 (15)
6-10 years	50 (24.2)
11-20 years	88 (42.5)
More than 20	38 (18.4)
Reason for residing in the UK (235)	
Family	168 (71.5)
Employment	18 (7.7)
Education	40 (17)
Family+ Employment	3 (1.3)
Family+ Education	4 (1.7)
Education+ Employment	1 (0.4)
Family+ Employment + Education	1 (0.4)
Having a family in the UK (235)	
Yes	43 (18.3)
No	192 (81.7)

8.3 Descriptive and inferential analysis

This section presents the following findings in two parts. The first part represents participants' responses to related statements for each statement as illustrated in Appendix 8.1. The second part tests the relationship between the main independent variables and the dependent variables (continuous variables), with only significantly correlated results (using Spearman's rho) being reported ($P < 0.05$). Other independent variables (categorical variables) will be measured for impact on the dependent variables using tests such as the Mann-Whitney U and Kruskal-Wallis tests, again only significant results are reported ($P < 0.05$). Tables 8.2-8.5 show the results of these tests. Moreover, the significant Kruskal Wallis test results were followed up with the Mann-Whitney U test between two pairs of groups (*post hoc* comparisons) as reported in Appendix 8.2.

The dependent variables (65 statements) are listed under five main categories these include culture; knowledge; GP services and maternity and child health services; hospital delivery; and communication and information provision. The dependent variables (10 demographic and clinical variables) are age, religion, marital status, education, occupation, experience of giving birth in the UK, country of birth, length of time living in the UK, reason for residing in the UK and having a family in the UK.

8.3.1 Cultural variation

Culture has a large influence on utilising the healthcare services and knowledge. Fifteen items (part -d of the questionnaire) examined this theme as presented below from statements 54- 69. Responses to these statements are presented in Appendix (8.2) and the impact or the associations between these statements and associated demographic and clinical variables that were significant with $P < 0.05$ are presented in Table 8.2.

Statement 54: a majority of participants (15.2% strongly agreed and 38.4% agreed) with the use of a traditional herbal medicine in their illness. The Kruskal-Wallis test revealed that the 'work' variable was significant to this statement ($\chi^2=8.731$, $P < .013$). There was a significant difference between the housewife and the worker groups (Mann-Whitney z

= -2.582, $P < .010$ with the mean ranks of 117.82 and 95.57 respectively). No differences between the student and housewife groups (Mann-Whitney $z = -1.884$, $P < .06$), or between the student and worker groups (Mann-Whitney $z = -.523$, $P < .601$) were found. The result indicates that housewife responders preferred the use of traditional herbal remedies more than those who are a worker or student.

Statements 55-57: Most women preferred to take antibiotics when feeling unwell (18.6% strongly agreed and 37.6% agreed), age was negatively correlated (Spearman's $\rho = -.207^*$, $P < .002$), younger women preferred to take antibiotics when they feel unwell more than older women. One quarter of participants (24.9%) brought their medication from their Arabic home country or from Palestine. This independent variable negatively associated with two variables: age (Spearman's $\rho = -.143^*$, $P < .034$), and length of time living in the UK (Spearman's $\rho = -.160^*$, $P < .021$) indicating that younger responders and those who had lived in the UK for a shorter length of time brought their medication from outside the UK. Additionally, the vast majority (40.1% strongly agree and 42.6% agree) believed the system in the UK encourages the birth process to be natural.

Table 8. 2: Culturally related items and associated demographic and clinical variables

Dependent variable (DV)	Independent variable (IV)	P-value	
1. Culture			
S54-I prefer to use a traditional herbal medicine	Work	.013	Chi-Square 8.731 df 2
S55-I like to take antibiotics when I feel unwell	Age	.002	Spearman's $\rho = -.207^{**}$
S56-I brought my medication from my country – Palestine	Age	.034	Spearman's $\rho = -.143^*$
	Length of time living in the UK	.021	Spearman's $\rho = -.160^*$
S59-I would prefer to be cared for by a midwife throughout my pregnancy	Age	.008	Spearman's $\rho = -.178^{**}$
	Educational qualification	.045	Spearman's $\rho = -.131^*$
S61-I would prefer not to have scanning tests during my pregnancy	Educational qualification	.035	Spearman's $\rho = -.138^*$
S62- If the test or scan showed the possibility of abnormality, I would not terminate the pregnancy	Reason for residing in the UK	.010	Chi-Square 16.909 df 6
S64-I would prefer a midwife to examine my baby post delivery	Age	.038	Spearman's $\rho = -.140^*$
	Educational qualification	.048	Spearman's $\rho = -.129^*$

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2-tailed) $S = \text{statement}$

Statements 58-59: The vast majority of responders (33.8% strongly agreed and 45.6% agreed) preferred to be cared for by a midwife throughout their pregnancy. This independent variable had a significant association with two dependent variables: age

(Spearman's $\rho = -.178^{**}$, $P < .008$), and education level (Spearman's $\rho = -.131^*$, $P < .045$). Younger responders with lower educational qualifications preferred to be cared for by a midwife throughout their pregnancy more than do those from other groups. However, the majority of responders (35.5% strongly agreed and 41.8% agreed) also wished to be cared for by a specialist doctor throughout their pregnancy.

Statements 60- 61: An important part of antenatal care is the screening tests carried out during pregnancy. In relation to screening for “Down’s Syndrome”, half the participants (23.2% strongly agreed and 24.5% agreed) wished not to have this screening during their pregnancy.

More than half the women (27% strongly agreed and 24.5% agreed) did not wish to have scanning tests during their pregnancy. This independent variable has an association with age (Spearman's $\rho = -.138^*$, $P < .045$), indicating that younger responders were more likely not to have scanning tests during their pregnancy.

Statement 62: Half the participants desired to terminate the pregnancy if the test or scan shows the possibility of abnormality. While one-third (29.95%) preferred to keep the pregnancy. ‘Reason for residing in the UK’ was the dependent variable that associated with this statement (Kruskal-Wallis $\chi^2 = 16.909$, $P < .010$). *Post hoc* investigation revealed there was no difference between family and employment groups (Mann-Whitney $z = -1.123$, $P < .262$). However, the educated group shows a significant difference with the employment group (Mann-Whitney $z = -2.524$, $P < .012$), and with the family group (Mann-Whitney $z = -3.339$, $P < .001$). The mean rank was higher for the educated group (33.17) compared with employment (21.33); also, it is higher for the educated group (131.66) compared with the family group (97.37). The responders who gave education as the main reason for residing in the UK desired “to terminate the pregnancy, in case the test or scan shows the possibility of abnormality”.

Statement 63: Most of the responders (57% strongly agreed and 31.2% agreed) wished to breastfeed their baby rather than to use bottle-feeding.

Statements 64-66: In the UK, midwives could routinely examine the healthy new born after delivery, unlike in Arabic countries or Palestine. Half the women preferred a midwife to examine their baby post-delivery (22.8% strongly agreed and 30.4% agreed). This independent variable negatively associated with two variables: age (Spearman's $\rho = -.140^*$, $P < .038$), and education (Spearman's $\rho = -.129^*$, $P < .048$), indicating that responders who were younger and had fewer educational qualifications were more likely to prefer a midwife to examine their baby post-delivery than responders who are older and had higher qualifications. However, the vast majority prefer a paediatrician to examine their baby (65.8% strongly agreed and 28.3% agreed). Almost all participants preferred the circumcision service to be available on the NHS for male babies (65.8% strongly agreed and 28.3% agreed).

Statements 67-68: Most of the participants felt (46.4% strongly agreed and 34.2% agreed) that the NHS - Maternal and Child Healthcare services in the UK are better than in the government sector in Palestine. Moreover, responders felt that Maternal and Child Healthcare services in the UK are better than in the private sector in Palestine (34.2% strongly agreed and 34.6% agreed).

8.3.2 Knowledge about the MCH services and healthcare system in the UK

Responders' knowledge regarding their access to, and use of, "MCH" services includes eight statements and one skip question. Responses to these statements are presented in Appendix (8.2) and the impact or the associations between these statements and associated demographic and clinical variables that were significant with $P < 0.05$ are presented in Table 8.3.

Statement 1: Most participants strongly agreed (47.3%) and agreed (33.3%) that the NHS in the UK is free for all residents in the UK. Using Spearman's ρ correlation coefficient, it was found that this item was positively correlated with the period of living in the UK (Spearman's $\rho = 0.163$, $P < 0.019$) and with education (Spearman's $\rho = .144^*$, $P < 0.027$). These relationships are considered small but significant since they

indicate that the longer participants live in the UK and the more educated they are, the more likely they are to be knowledgeable about the NHS.

Statement 2: Two thirds of participants, 27.4%, strongly agreed and 44.3% agreed that they must be aware of their rights otherwise they may miss out on some “MCH services”. ‘Reason for residing in the UK’ had a significant effect on awareness of rights, this was significant at Kruskal-Wallis $\chi^2 = 12.981$, $P < 0.043$, the mean rank was the highest for the group residing for employment reasons (142.97), then education (114.19) and family (113.69). This indicated that responders whose main reason for residing in the UK was employment agreed with this statement more than the others. However, *post hoc* comparison showed that there is no significant difference between groups. Mann-Whitney U was $z = -0.80$, $P < .936$ for ‘family’ and ‘education’, $z = -1.831$, $P < .067$ for ‘family’ and ‘employment’ and $z = -1.758$, $P < .079$ for ‘employment’ and ‘education’. The sample size for family, employment and education were 168, 18 and 39 respectively.

Statement 3: Most of the participants (33.8%) strongly disagreed and (21.1%) disagreed that the delivery of maternal and child health services is better for British women than Palestinian women, while 15.3% agreed/strongly agreed to this statement.

Statement 4: Most of the women felt that it was good to have healthcare services, including dentistry, free for pregnant women and one year post-delivery (64.1% strongly agreed and 30.4% agreed). This was affected by the work variable (Kruskal-Wallis $\chi^2 = 9.435$, $P < .015$). *Post hoc* the Mann Whitney U test revealed a significant difference between worker and housewife groups ($z = -3.050$, $P < .002$), but no significant difference between the ‘housewife’ and ‘student’ groups ($z = -.003$, $P < .997$) or between worker and student ($z = -1.565$, $P < .118$). The mean rank for the worker group (123.16) was higher than for the housewife group (100.54). The sample sizes for housewife, worker and student groups were 140, 76 and 15, respectively. Working responders have more agreement with this statement than housewives.

Statement 5: More than two thirds of women, (30.4%, strongly agreed and 42.4% agreed) felt that MCH services in the UK are fulfilling their needs, this correlated

negatively with educational qualification (Spearman's rho = -0.149*, $P < 0.023$). Women with higher qualifications were in less agreement that MCH services were fulfilling their needs.

Table 8. 3: Knowledge items and associated demographic and clinical variables

S= statement

Independent variable (IV) 2. Knowledge	Dependent variable (DV)	P-value	
S1-The National healthcare services (NHS) in the UK are free for all residents in the UK	Length of time living in the UK Educational qualification	.019 .027	Spearman's rho .163* Spearman's rho .144*
S2-You must be aware of your rights otherwise you may miss out on some "MCH" services	Reason for residing in the UK	.043	Chi-Square 12.981 Df 6
S4-I feel it's good to have all the healthcare services, including dentistry, free for pregnant women and one year post-delivery	Work	.019	Chi-Square 9.435 Df 2
S5-Maternal and child healthcare services in the UK are fulfilling my needs	Educational qualification	.023	Spearman's rho -0.149*
S6-I found out about the NHS service before I came to the UK	Length of time living in the UK Having a parent in the UK	.039 .004	Spearman's rho .144* Mann-Whitney U 2910.000 Wilcoxon W 21246.000 Z -2.865- Mean rank yes (143.21), no (111.24)
S9-In which way will this affect the services do you think?	Age Having a parent in the UK	.021 .029	Spearman's rho -.157* Mann-Whitney U 3215.000 Wilcoxon W 20606.000 Z -2.178- Mean rank yes (133), no (230)

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2-tailed)

Statement 6: 24.9% strongly disagreed and 18.1% disagreed that they “found out about the NHS service before they came to the UK”, this was correlated with the “Length of time living in the UK” (Spearman's rho = .144*, $P < .039$) and with having a parent in the UK (Mann-Whitney $z = -2.865$, $P < .004$). Women who had parents in the UK had a higher mean value (143.21) than those who did not (111.24). Responders who have lived in the UK for longer and have a parent in the UK were not searching for information about the NHS service before they came to the UK.

Statement 7: One third of women had adequate knowledge about the NHS when they arrived in the UK (7.6% strongly agreed and 28.3% agreed). However, 11% strongly disagreed and 27.4% disagreed to this statement.

Question 8 & Statement 9: Two thirds of participants (67.9%) were not aware of the government plans to close some maternity hospitals and develop others, in spite of 48.5% thinking the effect will be negative, 24.9% positive and 24.1% no difference. There is a significant negative relationship between this statement and age (Spearman's $\rho = -.157^*$, $P < .021$). Having a parent in the UK had a significant effect on awareness of government plans, this was significant at Mann-Whitney $z = -2.178$, $P < .029$. The mean rank for participants who have parents in the UK (133.23) was higher than for those who did not have parents in the UK (110.78). This suggests that participants who have parents in the UK and are younger show more awareness about government plans to close some maternity hospitals and develop others

8.3.3 MCH and GP services

8.3.3.1 GP services

Ten statements (10-19) examined the access to, and use of, GP services, which is considered as crucial matter in using UK healthcare services as presented in Table 8.3 and Appendix 8.2. It is the main key to enter the healthcare services. In general, responders indicated a positive view of GP services. The detailed explanations for responders' statements are discussed below.

Statement 10: 38.4% of women strongly agreed and 49.4% agreed that the GP registration process is easy. This was affected by country of birth (Mann-Whitney $z = -0.057$, $P < .040$) and having a parent in the UK (Mann-Whitney $z = -2.030$, $P < .042$). Responders who had been born in the UK and had a parent in the UK found the process easier (mean = 142 & 135.26) than those who had been born in an Arabic country and did not have a parent in the UK (mean = 115.14 & 114.14).

Statements 11-13: More than half the participants were able to book an emergency appointment with their GP on the same day (18.6 % strongly agreed and 42.2% agreed), while one quarter (24.9%) could not. Although more than half were able to book regular appointments with their GP within 3 days (19.4% strongly agreed and 40.5% agreed),

15.8% reported that they could not do so. Most women felt (43.9 % strongly agreed and 28.3% agreed) that their GP clinic has all the services they needed and 9.6% did not. This item was correlated negatively with the education variable (Spearman's rho= $-.200^{**}$, $P < .002$), the higher the educational qualification, the less the agreement that their GP clinic has all the services they need.

Table 8. 4: GP services items and associated demographic and clinical variables

Independent variable (IV) 3. A. GP services-	Dependent variable (DV)	P-value	
S10-The GPs registration process is easy	Country of birth	.040	Mann-Whitney U 2025.000, Wilcoxon W 24180.000 Z=-2.057- Mean rank UK (142), Arabic country(115.14)
	Having a parent in the UK	.042	Mann-Whitney U 3386.000 Wilcoxon W 21914.000 Z=-2.030- Mean rank yes (135.26), no (114.14)
S13-My general practice has all the services that I need in one place such as child care, immunisation and a midwife	Educational qualification	.002	Spearman's rho $-.200^{**}$
	Religion		Chi-Square 7.235 Df 2
S16-I would prefer a female GP to examine me at the GP surgery	Country of birth	.026	Mann-Whitney U 1962.500 Wilcoxon W 23698.500 Z=-2.226- mean rank UK(142.5), Arabic country(113.94)
S17-My GP relies on a verbal history rather than physically examining me	Length of time living in the UK	.004	Spearman's rho $-.202^{**}$
S18-I have to wait a long time for my test results	Age Length of time living in the UK Religion Marital status	.006 .001 .005 .003	Spearman's rho $.179^{**}$ Spearman's rho $-.231^{**}$ Chi-Square 10.512 Df 2 Chi-Square 13.717 Df 3

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2-tailed) S= statement

Statement 14: More than half the responders (18.1% strongly agree and 35% agree) were not happy with the GP system for assessment by phone when they book an appointment.

Statements 15-16: Half the participants (16.9% strongly agree and 33.3% agree) reported that the waiting time to see the GP is too long but a quarter (29.9%) of them are

happy with GP waiting times. Most responders (54%, strongly agreed and 31.2% agreed) wished to have a female GP for their examination. Only 4.3% of responders preferred not to have a female GP. This was affected by country of birth (Mann-Whitney $z = -2.226$, $P < 0.026$). The mean rank for responders who were born in an Arabic country was (113.94) and in the UK (142.5). Women born in the UK preferred to have a female GP than did any other group.

Statement 17: Half of women have reported that their GP doctor focused on taking a verbal history rather than a physical examination (17.3% strongly agree and 32.9% agree). Using Spearman's rho correlation coefficient (Spearman's $\rho = -.202^{**}$, $P < .004$), it was found that this item was negatively correlated with length of time living in the UK. The responders who had lived for longer in the UK were less in agreement that their GP focused on a verbal history rather than a physical examination.

Statement 18: 21.5% of the responders strongly agreed and 30% agreed that they have to wait a long time for their test results. The Spearman's rho correlation coefficient correlated positively with age (Spearman's $\rho = .179^{**}$, $P < .006$) and negatively with length of time living in the UK (Spearman's $\rho = -.231^{**}$, $P < .001$). The responders who were older and had lived in the UK for a shorter length of time were not satisfied with the waiting time for their test results.

Statement 19: 31.2% of responders strongly agreed and 41.8 % agreed that the time between GP referral and hospital appointment is too long. However, 11% of responders disagreed to this statement and the referral time to hospital appointments is acceptable for them.

8.3.3.2 Maternity and child health services

Ten statements (20-29) examined the access to, and use of, MCH services and another eight items (31-38) focused on responders' views regarding hospital delivery as presented in Table 8.4 and Appendix 8.2. One skip question (number 30) was used to filter responders with experience of hospital delivery. 93.7% of responders have had a hospital delivery whilst 4.2% have had a home delivery.

Statement 20: One third of women have experienced care from different midwives throughout their pregnancy (5.5% strongly disagree and 28.7% disagree). On the other hand, 19% strongly agreed and 28.7% agreed that they had the same midwife throughout their pregnancy.

Statement 21: However, two thirds of women (27% strongly agree and 50.2% agree) reported that it is important for them to have the same midwife throughout their pregnancy, this was negatively significant with age (Spearman's rho= $-.200^{**}$, $P<.045$), hence a younger mother felt it is important for them to have the same midwife throughout their pregnancy.

Table 8. 5: MCH services items and associated demographic and clinical variables

Independent variable (IV) B. Maternity and child health services	Dependent variable (DV)	P-value	
S21-It is important to me to have the same midwife throughout my pregnancy	Age	.045	Spearman's rho $-.136^*$
S22-I contacted a healthcare professional before the 12 th week of my pregnancy	Age	.002	Spearman's rho $-.210^{**}$
S24-I attended the antenatal class during my pregnancy	Country of birth	.017	Mann-Whitney U 1793.000 Wilcoxon W 21893.000 Z -2.377- Mean rank - UK (141.28) Arabic country (109.47) Chi 9.782 Df 2
	Work	.008	Spearman's rho $-.196^{**}$
	Age	.004	Mann-Whitney U 2842.000 Wilcoxon W 19862.000 Z -2.545- Mean rank yes (135.65), no(107.95)
	Having a parent in the UK	.011	
S25-Given a choice regarding the location of delivery, I would prefer to give birth in hospital rather than at home	Age	.037	Spearman's rho $.137^*$
	Length of time living in the UK	.026	Spearman's rho $-.156^*$
	Having a parent in the UK	.037	Mann-Whitney U 3318.500 Wilcoxon W 4264.500 Z -2.083- Mean rank yes (119.840), no (99.17)
S28-The waiting time in the emergency department is too long	Work	.004	Chi-Square 10.871 Df 2
S29-The waiting time in the paediatric emergency department is too long	Age	.012	Spearman's rho $-.170^*$
	Length of time living in the UK	.028	Spearman's rho $-.154^*$
C. Hospital Delivery			
S32-I received adequate support from the midwife to breastfeed my baby post-delivery	Length of time living in the UK	.000	Spearman's rho $.291^{**}$
S35-I received adequate care post-delivery in the hospital	Length of time living in the UK	.001	Spearman's rho $.227^{**}$
	Educational qualification	.016	Spearman's rho $-.164^*$

S36-I received adequate pain relief post-delivery in the hospital	Length of time living in the UK	.000	Spearman's rho .261**
	Educational qualification	.004	Spearman's rho -.196**
	Religion	.011	Chi-Square 8.971 Df 2
S37-I did not receive adequate attention post-delivery in the hospital	Age	.019	Spearman's rho -.160*
	Having a parent in the UK	.003	Mann-Whitney U 2500.500 Wilcoxon W 18076.500 Z -3.023- Mean rank yes (133.99), no (102.71)
S38-I like the food provided at the hospital	Length of time living in the UK	.001	Spearman's rho .224**

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2-tailed) S= statement

Statements 22-23: Two thirds of women contacted a health professional before the 12th week of pregnancy (27.4% strongly agreed and 41.8% agreed) and a fifth of women (18.2%) had a late booking. A lower percentage of responders contact the midwife directly before the 12th week of pregnancy (19.4% strongly agree and 38.4% agree and 22.8% did not). Age has a significant relation, younger women contacted a healthcare professional before the 12th week of their pregnancy (Spearman's rho= -.210^{**}, P<.002), which is more than older women.

Statement 24: Antenatal education classes can be an important source of information and support. Only 13.9% strongly agreed and 27.4% agreed that they attended the antenatal class during their pregnancy, where one third never participated in this activity. Four variables have significant correlation with antenatal class attendance: age (Spearman's rho= -.196^{*}, P<.004), work (Kruskal-Wallis $\chi^2 = 9.782$, P< .008), country of birth (Mann-Whitney z = -2.377, P< .017) and having a parent in the UK (Mann-Whitney z = -2.545, P< .011). The mean rank for women born in the UK was higher than those born in an Arabic country (141.28 & 109.47). The mean rank for having a parent in the UK was more than other groups (135.65 & 107.95). *Post hoc* testing for work (DV) showed the significant difference between the housewife group and students (Mann-Whitney z = -3.043, P< .002), the student group's mean rank (108.89) was higher than that of the housewife group (72.64). However, there was no significant difference between “worker” and “housewife” (Mann-Whitney z = -1.391, P< .164) and “worker” and “student” groups (Mann-Whitney z = -2.110, P< .035).

Younger responders, non-workers or the housewife group, who had been born in the UK and had a parent in the UK, participated in antenatal classes more than other groups.

Statement 25: As part of the choice commitment, it is important that women can choose where to give birth. A vast majority (57.4% strongly agree and 31.2% agree) reported their preference for giving birth in hospital rather than at home with age (Spearman's $\rho = -.137^*$, $P < .037$), length of time living in the UK (Spearman's $\rho = -.156^*$, $P < .026$) and having a parent in the UK (Mann-Whitney $z = -2.083$, $P < .037$) being significant. The mean rank for not having a parent in the UK group was (119.84), higher than the group having a parent (99.17). Younger responders, who had lived for a shorter length of time in the UK and not have a parent in the UK, preferred hospital delivery.

Statement 26: Regarding the immunisation, the vast majority in this study felt (57.8% strongly agreed and 32.9% agreed) that their baby was up to date with all his/her injections. On the other hand, (3.8%) of responders disagreed that their baby was up to date with all his/her injections.

Statement 27: Almost half of the responders cannot access dental services (30% strongly disagreed and 16% disagreed) that they can access the dental services in the UK easily.

Statement 28: A vast majority considered the waiting time in emergency to be a barrier to accessing the health services. 45.6% strongly agreed and 34.6% agreed, "Waiting time in the emergency department is too long". The work variable has correlated with the statement that waiting time in the emergency department is too long (Kruskal-Wallis $\chi^2 = 10.871$, $P < .004$). Using the post hoc test, the significance was noticeable between housewife and student groups (Mann-Whitney $z = -3.065$, $P < .002$) with the mean rank higher for the student group (110.10) compared with the 'housewife' one (75.14). However, no significant problems presented between the worker and housewife groups (Mann-Whitney $z = -1.683$, $P < .092$) and between worker and student groups (Mann-Whitney $z = -2.218$, $P < .027$). Taking into consideration the Bonferroni adjustment for alpha level (because of the three tests the significant criteria here is 0.017). The student

group considered the waiting time in emergency as a barrier to access the health services more than the housewife groups.

Statement 29: Two thirds of responders considered the waiting time in the paediatric emergency department to be too long (30.8% strongly agree and 37.1% agree). Age (Spearman's $\rho = -.170^*$, $P < .012$) and length of time living in the UK (Spearman's $\rho = -.154^*$, $P < .028$) were negatively correlated, younger mothers and those who have lived for a shorter length of time in the UK viewed the waiting time in paediatric emergency to be too long.

8.3.3.3 Hospital Delivery

Question 30 & Statement 31: 93.7% ($n=222$) of responders are mothers with experience of hospital delivery and only 4.2% ($n= 10$) do not have this experience. For those who have had a hospital delivery, most women were satisfied with pain relief during labour (24.3% strongly agreed and 45.9% agreed). However, one fifth of women felt that they did not get sufficient pain relief during their labour.

Statement 32: Mothers considered the support from the midwife to breastfeed their baby post-delivery was adequate (28.4% strongly agreed and 51.4% agreed). Length of time living in the UK was significant (Spearman's $\rho = .291^*$, $P < .000$), women who had lived for a greater length of time in the UK were more in agreement that the midwife supported them to breastfeed their babies.

Statements 33-34: Approximately one quarter (25.7%) of women considered that their baby was bathed in an unsatisfactory way in the hospital, while half of responders disagreed (32% strongly disagreed and 17.6% disagreed). However, given the above the majority of mothers rejected the idea of using only water to bath the baby in the first week after delivery (40.1% strongly disagreed and 15.3% disagreed).

Statements 35-38: Three statements focused on postnatal care in this study. Responders thought that they received adequate care post-delivery in the hospital (31.1% strongly agreed and 41.4% agreed), while 14.4% felt they had not received adequate care.

Education was negatively significant (Spearman's $\rho = -.164^*$, $P < .016$) and length of time living in the UK was positively correlated (Spearman's $\rho = .227^*$, $P < 0.001$), the responders with more time in the UK and a lower level of education felt they had received adequate postnatal care in the hospital.

Statement 36: Most of the women reported that pain relief post-delivery in the hospital was adequate (25.7% strongly agreed and 51.8% agreed), while 7.2% of women did not feel they got the pain relief they needed. Three items correlated with pain relief post-delivery. Education was negatively significant (Spearman's $\rho = -.196^*$, $P < .004$) and length of time living in the UK was positively correlated (Spearman's $\rho = .261^*$, $P < .000$). This finding indicated that younger women who had lived for a greater length of time in the UK had more agreement that the pain relief post-delivery in the hospital was adequate.

Statement 37: Women felt they received adequate attention post-delivery, 44.6% strongly disagreed and 15.3% disagreed that “I did not receive attention post-delivery”. However, 23.9% felt ignorance relating to the post-delivery period. Two items correlated with this statement. Age has a negative correlation (Spearman's $\rho = -.160^*$, $P < .019$), as was having a parent in the UK (Mann-Whitney $z = -3.023$, $P < .003$). The mean rank for those who had a parent in the UK was higher (133.99) than for those who had no parents in the UK (102.71). Younger women responders who had a parent in the UK had more agreement with this statement since they felt they did not receive attention post-delivery.

Statement 38: The majority of responders do not like hospital food (20.7% strongly disagreed and 21.6% disagreed), while 28.8% of women like it. Length of time living in the UK was positively correlated (Spearman's $\rho = .244^{**}$, $P < .001$), the responders who lived for a greater length of time in the UK liked the hospital food more than the group who had lived in the UK for a shorter length of time.

8.3.4 Communication & information provision (237)

Communication is an essential part of the process of care. Effective communication is a key element in increasing the quality of healthcare. Women can obtain information about

pregnancy and childbirth from a range of sources and by different methods such as written material and formal and informal interactions with health professionals. Different sources may suit different women and several questions were asked about what was available and how useful they found the different information sources. Eleven items presented under this group as presented in Table 8.5 and Appendix 8.2.

Statements 39-41: the majority of women do not have a communication problem with GP receptionists, 27.4% strongly agreed and 51.5% agreed that receptionists at GP surgeries are helpful.

A vast majority (26.6% strongly agreed and 62% agreed) felt that the midwife provided them with information and leaflets and only 3% disagreed. 21.9% strongly agreed and 44.7% agreed that they had adequate information in a language that they could understand and 15.6% disagreed. Having a parent in the UK was significant for those three statements Mann-Whitney ($z = -2.707$, $P < .007$) ($z = -2.137$, $P < .033$) and ($z = -2.001$, $P < .045$). Responders who had a parent in the UK had a higher mean rank in these three statements (139.99, 135.15 and 134.17) compared with responders not having a parent in the UK (111.70, 114.15 and 112.59). They were satisfied with GP receptionist services; in greater agreement that the midwife provided them with information and leaflets and had adequate information in a language that they could understand.

Statement 42: More than half of participants found that the length of the appointment with the GP was enough to answer their inquiries, 39.7% strongly disagreed and 13.1% disagreed that “There was not enough time during my visit for the midwife or doctor to answer my questions”. For this statement, three demographic variables were significant: education level was negatively correlated (Spearman's $\rho = -.144^*$, $P < .033$). The Kruskal-Wallis test revealed that work and reason for residing in the UK were significant ($\chi^2 = 8.423$, 12.569 and $P < .015$, $.005$) respectively. *Post hoc* testing revealed differences between the housewife and the worker groups (Mann-Whitney $z = -2.855$, $P < .004$), the mean ranks were 116.98 and 92.55 respectively. However, no differences between the housewife and student groups (Mann-Whitney $z = -.998$, $P < .318$), and between the

student and worker groups (Mann-Whitney $z = -.541$, $P < .588$) were found. For the 'reason for residing' variable, the test showed a difference between the family and employment groups (Mann-Whitney $z = -2.083$, $P < .037$). The mean rank was (116.96) for the employment group and (90.01) for the family group. However, no differences between the family and education groups (Mann-Whitney $z = -1.633$, $P < .102$) and between employment and education (Mann-Whitney $z = -.853$, $P < .394$) were found. These test results might lead us to conclude that younger women, housewives, and women for whom the main reason for residing in the UK was employment have more agreement that there was not enough time during their visit for the midwife or doctor to answer their questions.

Table 8. 6: Communication & information provision items & associated demographic & clinical variables

Dependent variable (DV)	Independent variable (IV)	P-value	
3. Communication			
S39-The receptionist at my GP is helpful	Having a parent in the UK	.007	Mann-Whitney U 3096.500 Wilcoxon W 21241.500 Z -2.707- Mean rank yes (139.99), no (11.700)
S40-The midwife provides me with information and leaflets	Having a parent in the UK	.033	Mann-Whitney U 3389.000 Wilcoxon W 21917.000 Z -2.137- Mean rank yes (135.15), no (114.15)
S41-I have adequate information in a language that I could understand	Having a parent in the UK	.045	Mann-Whitney U 3248.000 Wilcoxon W 21393.000 Z -2.001- Mean rank yes (134.17), no (112.59)
S42-There was not enough time during my visit for the midwife or doctor to answer my questions	Educational qualification	.033	Spearman's rho -.140*
	Work	.015	Chi-Square 8.423 df 2
	Reason for residing in the UK	.05	Chi-Square 12.569 df 6
S44-I would prefer to read the leaflets about my pregnancy in the Arabic language	Work	.017	Chi-Square 8.121 df 2
	Educational qualification	.002	Spearman's rho -.201**
S45-If I have health problems I prefer to deal with a doctor or nurse who speaks Arabic	Educational qualification	.001	Spearman's rho .218**
S46-I can understand written English well	Work	.000	Chi-Square 20.636 df 2
	Educational qualification	.001	Spearman's rho .209**
	Experience of giving birth in the UK	.002	Spearman's rho .200**
	Having a parent in the UK	.028	Mann-Whitney U 3260.000 Wilcoxon W 21405.000 Z -2.193- Mean rank yes (136.19), no (112.66)
S47-Language problems make it hard to understand what the midwife, doctor and nurse are saying to me	Work	.011	Chi-Square 9.005 df 2
	Educational qualification	.000	Spearman's rho -.248**
	Experience of giving birth in	.009	Spearman's rho -.176*

	the UK		
S48-Language problems make it hard to explain my concerns to the midwife or doctor	Work Educational qualification Experience of giving birth in the UK	.007 .000 .014	Chi-Square 10.027 df 2 Spearman's rho -.281** Spearman's rho -.164*
S49-I find it difficult to book an appointment with my doctor because of language problems	Marital status Educational qualification Work Reason for residing in the UK	.012 .003 .001 .036	Chi-Square 10.898 df 3 Spearman's rho -.142* Chi-Square 13.855 df 2 Chi-Square 13.515 df 6
S51-Interpreters are usually not available when I request them	Age Length of time living in the UK Having a parent in the UK	.020 .015 .018	Spearman's rho -.286* Spearman's rho .307* Mann-Whitney U 212.000 Wilcoxon W 2103.000 Z -2.370- Mean rank yes (949.83), no= 34.48

* Correlation is significant at the 0.05 level (2 tailed)

** Correlation is significant at the 0.01 level (2-tailed) *S= statement*

Statement 43: The majority of responders preferred to “have the leaflets about the pregnancy in addition to the midwife’s explanation” (28.3% strongly agreed and 48.9% agreed) with 8.7% disagreeing.

Statements 44-45: Many of the responders who have language barriers preferred to communicate in Arabic languages either through written information such as leaflets or the spoken word as when dealing with a nurse, midwife or doctor who speaks Arabic. Most of them (22.8% strongly agreed and 34.6% agreed) preferred to “read the leaflets about pregnancy in the Arabic language” and 16% preferred English leaflets. Two dependent variables were significant for this item is education and work. Education was negatively correlated (Spearman's rho= -.201**, $P<.002$) and the Kruskal-Wallis test for work was ($\chi^2=8.121$, $P= .007$). Using a *Post hoc* test a difference existed between the housewife and worker groups (Mann-Whitney $z = -2.847$, $P< .004$), the means were 116.98 and 92.55 respectively, there was no significant difference between the student and the housewife groups (Mann-Whitney $z = -.856$, $P< .392$), or between the worker and the student groups (Mann-Whitney $z = -.367$, $P< .714$). The results have shown that women with lower educational qualifications and housewives preferred to read the leaflets about pregnancy in the Arabic language.

Half of the responders (25.7% strongly agreed and 27.4% agreed) preferred to deal with a doctor or nurse who speaks Arabic if they have a health problem, while 21.1% disagreed.

Education level has a positive correlation (Spearman's $\rho = .218^{**}$, $P < .001$) with better-educated women preferring to deal with a doctor or nurse who speaks Arabic.

Statements 46-49: Four statements have examined the language barrier, the results of which can be presented as three points. First, most participants can understand written English well (33.3% strongly agreed and 41.4% agreed). This independent variable has a correlation with education (Spearman's $\rho = .209^{**}$, $P < .001$), experience of giving birth in the UK (Spearman's $\rho = .200^{**}$, $P < .002$) and work (Kruskal-Wallis $\chi^2 = 20.636$, $P < .000$); and having a parent in the UK (Mann-Whitney $z = -2.193$, $P < .028$). The mean rank (136.19) was higher for the group who have a parent in the UK than the other group who have not got a parent in the UK (112.66). Using *post hoc* testing, there was a difference between the housewife and the worker groups (Mann-Whitney $z = -4.581$, $P < .000$), the mean values were 95.38 and 133.7 respectively. There was no significant difference between students and housewives (Mann-Whitney $z = -.829$, $P < .407$), or between workers and students (Mann-Whitney $z = -1.261$, $P < .207$). Test results indicated that women having higher educational qualifications, having a parent in the UK, being a woman who worked and a woman with more experience of giving birth in the UK were more linguistically confident and felt that they understood English well.

Second, despite claiming to understand English well as in a previous statement, responders still felt that they had a language barrier. 13.9% strongly agreed and 27% agreed that "Language problems make it hard to understand what the midwife, doctor and nurse are saying to me". Half the participants felt (16% strongly agree and 29.1% agree) that language problems make it hard to explain their concerns to the midwife or doctor. For these two statements, the significant dependent variables were education (Spearman's $\rho = -.248^{**}$, $-.281^{**}$, $P < .000$, $.000$), experience of giving birth in the UK (Spearman's $\rho = -.176^{*}$, $-.164^{*}$, $P < .009$, $.014$), and work (Kruskal-Wallis $\chi^2 = 10.027$, $P < .011$, $.007$). Using a *post hoc* investigation for "Language problems make it hard to understand what the midwife, doctor and nurse are saying to me" has shown the differences between the housewife and the worker groups (Mann-Whitney $z = -3.041$, $P < .002$) with the housewife group having a higher mean rank (115.12) than the worker group (89.11).

However, there were no differences either between the housewife and student groups (Mann-Whitney $z = -.375$, $P < .708$) or between the worker and the student groups (Mann-Whitney $z = -.869$, $P < .385$).

Using *post hoc* testing of “Language problems make it hard to explain their concerns to the midwife or doctor”, has shown the differences between the housewife and worker groups (Mann-Whitney $z = -3.180$, $P < .001$), the housewife group has a higher mean rank (118.09) than the worker group (90.47) does. Nevertheless, no differences either between housewife and student (Mann-Whitney $z = -.653$, $P < .514$) or between the worker and student groups (Mann-Whitney $z = -.812$, $P < .417$) were found.

The result indicates that women with lower educational qualifications, housewives and those with less experience of giving birth in the UK have a language barrier. This problem makes it hard for this group to understand what the midwife, doctor and nurse are saying to them and for them to explain their concerns to the medical staff.

Third, two thirds of women make a booking with their GP without experiencing a language barrier, 34.2% strongly disagreed, 30.4% disagreed that “they find it difficult to book an appointment with their doctor because of language problems”. On the other hand, 22.4% of women agreed that language problems make it difficult to book an appointment. The significant dependent variables were education (Spearman's $\rho = -.142^*$, $P < .003$), work and reason for residing in the UK (Kruskal-Wallis $\chi^2 = 13.855$, 13.515 , $P < .001$, $.036$ respectively).

Using *post hoc* investigations, the ‘work’ variable has shown a difference between the housewife and the working groups (Mann-Whitney $z = -3.696$, $P < .000$), the housewife mean rank (120.23) was higher than that of the worker group (88.58). However, no differences were evident between the worker and the student groups (Mann-Whitney $z = -1.669$, $P < .095$), or between the housewife and the student groups (Mann-Whitney $z = -.157$, $P < .875$). For the ‘reason for residing in the UK’ variable, a *post hoc* test revealed differences between the family and the education groups (Mann-Whitney $z = -2.320$, $P < .002$) with the mean rank of the education group (122.39) being higher than that of the family group (98.95). However, there were no differences between family and

employment (Mann-Whitney $z = -.998$, $P < .318$), or between employment and education (Mann-Whitney $z = -.467$, $P < .640$). The results indicate that being younger, a housewife and seeking education as the main reasons for women residing in the UK were finding it difficult to book an appointment with their doctor because of language problems.

8.3.4.1 Interpreter services

Question 50 & Statements 51-53: Two thirds of women were not using an interpreter 68.6% ($n=132$). Yet 31.4% (64) needed to use an interpreter when they saw a doctor who only spoke English. More than half the women (20.5% strongly agreed and 32.5% agreed) believed that “Interpreters are usually not available upon request”. Three demographic variables showed significant association: age (Spearman's $\rho = -.286^*$, $P < .020$), length of time living in the UK (Spearman's $\rho = .307^*$, $P < .015$), and having a parent in the UK (Mann-Whitney $z = -2.370$, $P < .018$). Responders who have a parent in the UK had a significantly higher mean value than others (49.83 vs 34.48). Responders who were younger, had lived longer in the UK and had a parent in the UK reported that interpreters are usually not available upon request.

Two thirds of participants had preferred a family member to act as interpreter (19.2% strongly agreed and 52.1% agreed) and 13.7% disagreed. However, 20.5% strongly agreed and 50.5% agreed that a family member or friend who helps them as an interpreter usually had time constraints preventing them doing so. Only 8.2% agreed that a family member or friend is available to act as their interpreter.

8.4 Summary & Conclusion

This chapter presented the findings of the questionnaire survey by describing the responses for each statement in the questionnaire. Then, the findings were presented with bivariate analyses that correlate between dependent and independent variables. Three types of tests were used to describe this correlation or effect: Mann-Whitney U, Spearman's ρ and the Kruskal Wallis Test. The main summary from these tests is divided into four groups as follows:

1- Cultural variation - Responders who are housewives, other than students and worker women, preferred to use traditional herbal medicines. Younger women more than older women preferred to take antibiotics when they feel unwell. Younger responders and those who have lived for a shorter period of time in the UK brought their medication from their home country.

Responders who are younger and have less educational qualifications preferred to be cared for by a midwife throughout their pregnancy. Younger responders were more likely not to have scanning tests during their pregnancy. The responders who gave education as the main reason for residing in the UK desired to terminate the pregnancy if the test or scan showed the possibility of abnormality. Responders who were younger and had less educational qualifications were more likely to prefer a midwife to examine their baby post-delivery than responders who are older and had higher qualifications.

2- Knowledge about the MCH services and healthcare system in the UK- In summary the contributory factors that most affect responders' knowledge regarding the MCH services in the UK included: longer length of time living in the UK, more educational qualifications, having a parent in the UK and being younger and a worker.

3.1- GP services - Generally, responders were satisfied with GP services. Responders who had been born in the UK and had a parent in the UK found the process of access and use of GP services easier. Responders who had lived for a greater length of time in the UK were less in agreement and felt that GP doctors focused on taking a verbal history rather than physical examination. However, better-educated women reported that their GP clinic did not include all the services they needed. Responders who had lived in the UK for a shorter length of time and were older in age were not satisfied regarding the waiting time for their test results. Interestingly, more women born in the UK preferred to have a female GP compared to those born in an Arabic country.

3.2- Maternity and child health services – A younger mother felt it is important for them to have the same midwife throughout their pregnancy, and they had contacted a

healthcare professional before the 12th week of their pregnancy. Younger responders, non-workers or housewives who were born in the UK and had a parent in the UK were more likely to participate in antenatal classes than other groups. Younger responders, who had lived for a shorter length of time in the UK and did not have a parent in the UK, preferred hospital delivery. Students considered the waiting time in emergency as a barrier to accessing the health services more than housewives. On the other hand, younger mothers, who have lived a shorter length of time in the UK, viewed the waiting time in paediatric emergency as too long.

3.3-Hospital delivery- Women who had lived for a greater length of time in the UK have more agreement that midwives support them in breastfeeding their babies. The majority of mothers rejected the idea of using only water to bath the baby in the first week after delivery. Responders who had lived for a longer period of time in the UK and had a lower level of education reported that the postnatal care provided for them at hospital was adequate. Responders who have lived for a longer period of time in the UK and were younger have more agreement that the post-delivery pain relief in the hospital was adequate. Responders who had a parent in the UK, were younger and had no experience of giving birth in the UK reported that they did not receive attention post-delivery. Responders who had lived for a longer period of time in the UK, like the hospital food more than the group who had lived in the UK for a shorter length of time.

4- Communication and Information provision- Responders who had a parent in the UK were satisfied with GP receptionist services, were more in agreement that the midwife provided them with information and leaflets and had adequate information in a language that they could understand. Younger women, housewives and women for whom the main reason for residing in the UK was employment reported that there was not enough time during their visit for the midwife or doctor to answer their questions. Women with lower educational qualifications and housewives preferred to read the leaflets about pregnancy in the Arabic language, and women with higher qualifications preferred to deal with a doctor or nurse who speaks Arabic.

According to the 'understand English well' variable, higher educational qualifications, having a parent in the UK, being a woman who worked and women who have experience of giving birth in the UK were associated with greater confidence with languages. However, women with lower educational qualifications, who were housewives and had less experience of giving birth in the UK, reported experiencing a language barrier. This problem makes it hard to understand what the midwife, doctor and nurse are saying to them and to explain their concerns to the midwife or doctor. Additionally, women who are younger, a housewife and had education as the main reason for residing in the UK, find it difficult to book an appointment with their doctor because of language problems. Responders (who used and need an interpreter) who were younger, had lived longer in the UK and had a parent in the UK reported that interpreters are usually not available upon request.

The next chapter will discuss the above findings, make comparisons with the findings in the qualitative chapter, and relate them to previous studies.

CHAPTER NINE

Phase 2

Integrated discussion of the Quantitative and qualitative findings

Chapter Nine: Phase 2- Integrated discussion of the quantitative findings

9.1 Introduction

The aim of this discussion is to emphasise the major issues in relation to the research question and discuss it with regard to the current literature and NHS policies (chapter 2 & 3). These issues belong or are strongly connected to Palestinian women, rather than common problems which might face white British women as well and, as such, are worthy of particular attention. However, some issues are relevant across the child bearing population in the UK. These major issues that connected to Palestinian women, such as a preference for having an NHS male circumcision service, are generalizable to other Palestinian female populations and specific groups for whom male circumcision is a religious or social requirement. However, the views of those for whom this is not the case will be mentioned below.

Despite Palestinian women sharing some characteristics with other BME groups, such as in terms of ethnicity and living in a different country to their home country, they have their own characteristics and needs. Palestinian women differ in values, customs, symbols, way of life and even language, the totality of these constituents comprises the concept of culture (Schott & Henley, 1999). Palestinian women share the same religion (Islam) with some BME groups such as Pakistani or Somali women. However, not all the Palestinian women are Muslim and even the interpretation and the impact of religion is slightly different. For example, the practice of female circumcision is common among Somali women and based only on their culture, however, this is uncommon in Palestinian culture. Therefore, it can be concluded that culture has a greater influence than religion on health behaviour; the influence of culture on using health services is complex, as discussed in detail in Chapter 1.

On the other hand, some of the problems that are reported in this study by Palestinian women in using health services, particularly MCH services, are also faced by native white British women. These included the inequity of GP distribution, the referral system to hospital, limited physiotherapy sessions, inadequate information about certain syndromes, dental services and long waiting times in A&E departments. However, other issues were specific to Palestinian women although they might resonate with other BME groups. These include: cultural variation such as herbal medicine; self-prescribed medication (antibiotics), termination of pregnancy (fatalism), circumcision for male babies, breastfeeding practice and preference for a female GP and caregiver; knowledge of the UK health system; confidence in

English language; interpreter services; late booking of pregnancy; not attending antenatal class; duration of visit time and information needs.

In addition, dissatisfaction with the bathing of a newborn baby and examining the newborn by the midwife are issues raised in this research. Whilst these issues could be reported by white British women in the UK, the main reason behind these reports by Palestinian women is the different MCH system in the UK and their home countries which results in different expectations of care. However, it is the health service's responsibility to meet the legitimate patient expectations (Mead & Roland, 2009). To illuminate this in more detail the points that are specific to Palestinian women will be discussed below.

9.1.1 Cultural variation

The culture and healthcare systems in the UK and Palestine are different. Therefore, an individual's knowledge, expectation and use of services are varied. This study, like many before it (e.g., Aung *et al.*, 2010; Ahmed *et al.*, 2010; Chan, 2000; Cross-Sudworth *et al.*, 2011; Hawkins *et al.*, 2010; Hawkins *et al.*, 2008; Twamley *et al.*, 2010), has highlighted the influence of culture in utilising the healthcare services by BME groups. Studies by Ahmad *et al.* (2010), O'Donnell *et al.* (2007) and the first phase of this study revealed that the expectation of Arabic speakers of UK health services may be one of disappointment because it is based on their culture and traditions and influenced by the healthcare system in their home country.

This section includes discussion about herbal medicine, self-prescribed medication (antibiotics), fatalism, termination of pregnancy, circumcision for male babies, breastfeeding practice and preference for a female GP and caregiver.

9.1.1.1 Herbal medicine

As illustrated in Chapter 1, the culture and healthcare systems in the UK and Palestine are different. Therefore, an individual's knowledge, expectation and use of services are varied. As mentioned earlier (Chapter 6), the use of traditional practices and herbal medication as self-therapy is part of the Arab tradition (Ahmad *et al.*, 2010), and herbal medicine plays an essential role in the current public healthcare of people in Palestine (Sawalha, 2007). This study confirmed this idea, a majority of participants (15.2% strongly agreed and 38.4% agreed) with the use of a traditional herbal medicine in their illness. The survey results showed a significant relationship between using herbal remedies and the participant's occupation. The responders who are housewives, other than students and working women,

preferred to use traditional herbal medicines. There is a general assumption that older people are more likely to hold traditional views than younger people, but an examination of the association between age and use of herbal remedies revealed no significant correlation.

The possible explanation for using herbal remedies by housewives more than other groups, is that working women and students might have more regular contact with the British community in comparison to housewives, which might lead them to becoming acculturated more than the housewives group. It has been argued that more-acculturated women would be more effectively using the healthcare services (Bermúdez-Parsai *et al.*, 2012). However, some evidence shows that less-acculturated women have better health (McDonald *et al.*, 2008). Acculturation is a complex phenomenon. It can be classified into five levels based on Barry's model (1980). These levels are assimilation, being bicultural, alienation and separation, with another level added by Coatsworth *et al.* (2005) which is moderation. The current study is not designed to measure the effect of acculturation on Palestinian health behaviours, but the effect of the existence of acculturation. Bermúdez-Parsai *et al.* (2012) had emphasised the importance of assessing the acculturation level to develop culturally sensitive interventions. Furthermore, the relative lack of evidence of either efficacy or harm of these herbal medicines has increased the problem. Therefore, it is crucial for the midwife and nurse practitioner to ask about and document the use and safety of herbal drugs.

Acculturation might be proposed as a model here and indeed, there are some clear indicators that acculturation may have had an effect – it seemed that the longer the women had been in the UK, the easier they found it to access and navigate the NHS. Furthermore, speaking English was an indicator of a better experience of maternal and child health services. However, acculturation is usually related to situations where a number of generations have had experience of the culture (Bermúdez-Parsai *et al.*, 2012), yet in the case of the Palestinian diaspora, this has taken place only over a 50 year period, as such, this theory may not prove to be wholly appropriate in this case.

The participants reported that if their symptoms were not relieved by using herbal medicine, the next step is to use a self-prescribed medication. Most women in this study preferred to take antibiotics when feeling unwell (18.6% strongly agreed and 37.6% agreed). Many studies have highlighted self-medication practices among the Palestinians and the misuse of antibiotics is especially common and inappropriate (Sawalha, 2008b; Sweileh, 2004). A survey among 1093 government teachers in Palestine regarding their attitude and practice toward antibiotics has shown that they are misused (Sawalha, 2008a). Approximately 42.2%

of participants administered antibiotics to their children without medical consultation and 52.3% stored antibiotic leftovers for further use (Sawalha, 2008a). Similar problems are underlined in previous studies in Jordan (Albsoul-Younes *et al.*, 2010; Sawair *et al.*, 2009) and Dubai (Abasaheed *et al.*, 2009).

In relation to the analysis of the findings in this survey, age was a significant variable, with younger women more than older women preferring to take antibiotics when they feel unwell. A study in Egypt found the same association, being younger than 30 was associated with poor knowledge of drug use during pregnancy (Rizk *et al.*, 1993). This study found that Palestinian women preferred to take antibiotics during illness, therefore they obtained antibiotics from their home country without prescription; unlike in the UK where a prescription is needed. Coffman *et al.*'s study supported this finding and described self-medication as a "cultural artefact" and that loose regulation in countries of origin is responsible for this situation (2008:209). Participants in the current study considered that doctors in the UK did not prescribe antibiotics for them in spite of the presence of infection. The participants perceive that without an antibiotic they will not be cured. Therefore, the majority of participants got their medication, such as antibiotics, from their home country. This study's findings confirm two previous studies. In Ahmed *et al.* (2010), the participants considered that antibiotics should be prescribed routinely and, as a result, brought them from their home country. The other study (Aung *et al.*, 2010) showed that medicines, that require prescription in the UK, were brought from the participants' country of birth. It might be valuable here to point out that in both studies, as well as in the current study, the participants' expectation of health services and dissatisfaction were the possible main reasons for bringing medications from their home countries. The same finding was reported in the US where Mexican migrant participants faced significant barriers to accessing healthcare, therefore they purchased their medication from Mexico (Coffman *et al.*, 2008). However, another recent US study, which investigated Reasons for Self-Medication and Perceptions of Risk Among Mexican Migrant Farm Workers, concluded that the main reason for self-prescribed antibiotics was due to job security rather than to cultural preference (Horton & Stewart, 2012).

The study findings regarding the preference of antibiotics (see Section 9.1.1.2) highlighted the need to develop educational interventions and to disseminate information about the potential risk of the improper use of antibiotics among the Palestinian population, especially the new settlers in the UK. Davies (2004), in his article about whether the increased use of

antibiotics results in increased antibiotic resistance, concluded that the misuse of antibiotics rather than their proper use is the main reason for bacterial resistance. The author emphasised the importance of educating physicians about patient satisfaction parameters, as well as educating patients about the dangers of misuse of antibiotics. Many intervention studies demonstrated that simple and inexpensive education is effective in improving patients' knowledge regarding antibiotics (Maor *et al.*, 2011; Taylor *et al.*, 2003). Moreover, the safety concerns that arise related to the dangers of self-prescribed antibiotic practice are crucial and should be recognised by healthcare professionals such as GPs, nurses and midwives. Recently, the leftover antibiotic has attracted public attention (Kardas *et al.*, 2007); for example, a survey of 6,983 UK households carried out in the UK reported standby antimicrobial medication in 10% of cases (McNulty *et al.*, 2006). This has drawn attention to leftover medication as another possible source of the improper use of antibiotics. However, this is not investigated in this study.

Findings from the survey study have shown that the longer a woman has lived in the UK the more unlikely they are to bring their medication from their home countries. The impression here is that acculturation has a positive effect on the health behaviour of participants. Therefore, it is recommended that further future research needs to be undertaken to examine the effect of acculturation on the health beliefs, attitudes and practices of Palestinian women. The differences in the Palestinian subgroup in relation to the acculturation of women, have an important implication for midwifery-nursing practice when developing educational interventions for this population. It may not be appropriate to implement a "One Size Fits All" programme.

9.1.1.3 Termination of pregnancy (fatalism)

Generally, Arabs believe that health and illness are the will of God. This indicates that humans have no control over their health or illness (Zahr & Hattar-Pollara, 1998). This study confirmed this view and revealed that the Palestinian women held a fatalistic view regarding use of MCH services, especially during pregnancy and in the labour stage. This fatalist view appeared in many studies, where women show a strong religious viewpoint, in which God is believed to be the final determinant of illness. These studies have shown that a significant number of Arab women choose not to terminate their pregnancy, even when the foetus is affected, when the diagnosis is given in late pregnancy (Zahr & Hattar-Pollara, 1998; Sheiner *et al.*, 1998), because they perceive it as a test of their faith in God and their patience (Hammoud *et al.*, 2005).

In this study, fatalism appeared as a significant factor that affects women's access to, and use of, MCH services. Palestinian women held a fatalistic view that most likely affects their decisions. Half the participants desired to terminate the pregnancy if the test or scan shows the possibility of abnormality, while one-third (29.95%) preferred to keep the pregnancy. Approximately, half the participants wished not to have the screening test (e.g. Down's syndrome test) during their pregnancy (23.2% strongly agreed and 24.5% agreed). The reason for refusal for the lumbar puncture test for foetus abnormalities and other screening tests is the belief that an abnormal result would not affect their decision not to terminate their pregnancy. One-third preferred to keep the pregnancy, even if the test or scan shows the possibility of abnormality. Fatalism or belief in destiny and fate appeared to be an important factor in influencing women's decisions.

This finding was consistent with two previous studies. Rassin *et al.*'s (2009) study reported that Arab women have lower frequencies of genetic examination and this study involved Jewish and Arab women in Israel. Bawadi's (2009) study revealed the refusal of Arabic women to go for screening tests for Down's syndrome. The current study concludes that the times of performing the test and knowing the results were responsible for their decision. The overall timeline for pregnancy chromosomal screening is from 10 weeks to 20 weeks. Usually the combined screening is offered from 10 weeks and the quadruple test window starts from 14 weeks + 2 days to 20 weeks + 0 days of pregnancy (UK National Screening Committee, 2008). A period of at least 10 days following the tests is required before the results are known. A Fatwa allows the termination of pregnancy in the first 120 days (approximately 16 weeks) after conception if the foetus is shown to be affected beyond doubt with a severe malformation (Al-Gazali *et al.*, 2006). Therefore, the screening test should be offered to Palestinian women as early as possible before the 16th week of gestation to help them to make the right decision based on their own belief. However, many abnormalities are not detected until after the 20-week scan.

The main ways of preventing genetic disorders are prenatal testing and abortion (Zlotogora & Reshef, 1998). Within Palestinian culture abortion is illegal and Islam's approach allows women to prevent pregnancy but forbids them from terminating it, except in cases where there is a severe malformation. Since 2000, a Palestinian national strategy for the systematic prevention control of B-thalassemia was applied. It is obligatory to undergo pre-marital testing and genetic counselling. If both of a couple were found to be carriers of B-

thalassemia, they are given the results and receive genetic and social advice regarding the cancellation of marriage. In case they decided not to cancel their marriage, they would have to take full responsibility for their decision and sign a declaration (Tarazi *et al.*, 2007). However, this strategy is not applied in the UK for their population or those at-risk groups, but the NHS Sickle Cell & Thalassaemia Screening Programme has recommended offering this screening as part of early antenatal care to all women by 10 weeks and performing it by 12 weeks of pregnancy (NHS Sickle Cell & Thalassaemia Screening Programme, 2011). Therefore motivating Palestinian women to make an early booking for antenatal screening is a crucial matter. An early booking and screening would enable them to have a termination within an acceptable timeframe if genetic disorders were revealed.

9.1.1.4 Circumcision for male babies

The need for circumcision to be provided on the NHS was underscored in this study. All Muslim participants preferred the circumcision service to be available on the NHS for their male babies. The four participants in the study sample who were non-Muslims disagreed with having this procedure on the NHS. Therefore, the need of this service to be available within the NHS is generalisable to Muslim Palestinian women. Moreover, American, Australian, Canadian and American paediatricians and the British Medical Association are against routine circumcision of newborn infants (Hirji *et al.*, 2005; British Medical Association, 2004). Male circumcision has been the subject of debate, on the one hand, many studies have supported this practice as a routine procedure for a newborn male in preventing certain diseases such as urinary tract infections (Chin, 1992; Wiswell & Roscelli, 1986), and on the other hand, some studies have stated that evidence does not justify a routine circumcision for a newborn male (Hirji *et al.*, 2005; Van Howe, 2004). Circumcision was characterised as a sign of social inclusion in Kavakli *et al.*'s study (2000). This study examined the psychological and social implications of this procedure in Jews and Muslims and concluded that circumcision is a compulsory procedure based on parents' views (Kavakli *et al.*, 2000). This procedure is not provided by the NHS to Muslims and Jews for religious reasons in England (Department of Health, 2012), but it is done in Scotland for religious reasons. That decision was made for the safety of patients and in the interest of quality of care (The Scottish Government, 2008). Consequently, in England, unregulated services, where the control of infection is not implemented, are used to circumcise the baby (Paranthaman *et al.*, 2011).

On the one hand, it is impossible to stop people carrying out this practice. On the other hand, it is crucial to protect children from malpractice and prevent them from physical and psychological harm, so it is argued here that the NHS should provide these services to provide high quality care. Lord Darzi has made it clear that every PCT should meet the needs of its local population (Darzi, 2008). However, the need for circumcision to be provided on the NHS was underscored in this study. This has been highlighted previously as an “expressed need” of Muslim groups (Paranthaman *et al.*, 2011).

9.1.1.5 Breastfeeding practice

Breastfeeding is encouraged on religious and cultural grounds in Arab countries and Palestine, as mentioned in Chapter 1. However, women from some cultures considered the milk colostrum ‘bad’ milk and discarded it (Liamputtong, 2004; Kaewsarn *et al.*, 2003). Almost all the participants wished to breastfeed their babies rather than using bottle-feeding (57% strongly agreed and 31.2% agreed) based on the Holy Quran recommendation as mentioned in Chapter 1.

The breastfeeding rates in the UK are below the international average (Dyson *et al.*, 2005); the UK is still considered to have a lower uptake of breastfeeding than other European countries (Lavender *et al.*, 2005). In England, 78% of mothers initiate breastfeeding, 70% in Scotland, 67% in Wales and 63% in Northern Ireland (Bolling *et al.*, 2007). However, in this study the picture of breastfeeding is different to that of the general British population.

This result was echoed in many studies. In one comparative study between Palestinian and Jewish women’s attitude regarding childbirth, every one of the Palestinian women decided to breastfeed their babies, while 71% of Jewish women expressed their interest (Rassin *et al.*, 2009). Another study, comparing English, Arabic and Chinese women regarding the initial infant feeding and duration, found that Arab women breastfed more and for longer, in comparison with the other two groups (Homer *et al.*, 2002). The author’s experience that Arabic or Palestinian women grow up learning that the main function of the new mother is to breastfeed their baby successfully for up to two years based on the Quran has already been mentioned. A new mother receives significant support from their family during and after childbirth that might contribute to the success of breastfeeding. Rassin *et al.* (2009) have

pointed to the same idea and considered that the main reason behind more and longer breastfeeding by Palestinian women in their study was that women were raised in a society where breastfeeding is the norm.

9.1.1.6 Preference for a female GP and caregiver

The study has shown that most responders wished to have a female GP and caregiver for their examination (54%, strongly agreed and 31.2% agreed). Only 4.3% of responders preferred not to have a female GP. More women born in the UK preferred to have a female GP than in any other group, the suggested explanation here is that Palestinian women born in the UK might hold to their tradition more than other groups. Some participants selected their GP in spite of them not being near their home and others changed their GP because they preferred a female doctor. Other participants highlighted the problem of there being no female doctors at emergency appointments or when the female doctor was on leave.

The gender issue highlighted in this study - preference for a female caregiver - was the need of Palestinian women to discuss female issues with another female and for a physical medical examination. Several previous studies underlined the needs of the female patients from BME groups to see female doctors (Kensington Chelsea & Westminster BME Health Forum, 2002; Ahmed *et al.*, 2010; Ali *et al.*, 2004; Bawadi, 2009). The problem with the presence of a male caregiver was reported in previous studies in the UK. The unavailability of female doctors was the reason for Bangladeshi women not receiving full antenatal care (Katbamna, 2000), whereas in the Ali *et al.* study (2004) most participants felt intensely embarrassed and uncomfortable when treated by male healthcare providers. The ignorance of the participants' request to have female caregivers made the participants feel disempowered. Similar impressions were found among BME groups in Australia, where the unavailability of female doctors led women to refuse prenatal testing (Tsianakas & Liamputtong, 2002). A study in Lebanon, that investigated Lebanese women's responses to the medical management of their pregnancy and delivery, found that women reported their feelings of wariness and discomfort when male doctors treated them (Kabakian-Khasholian *et al.*, 2000). Such beliefs may be shared with Palestinian women, most participants in the current study endeavoured to be seen by a female doctor, but they would agree to see a male if no female was available. The reason behind their preference arose from their culture where 'Hiya' or, in other words, 'shame' is required which is part of their culture. It is important here to highlight that the preference for a female caregiver is a personal issue, not a religious requirement. There is overlap between cultural and religious issues in Arabic culture, including Palestinian culture. It has been

argued that social values and norms of Arabs are more dominant than the religious issues (Khater, 2001). The women's preference for female doctors and refusal of male doctors is culturally determined rather than due to religion. In Islam, the saving of life is paramount, and there is no religious prohibition on a male doctor or caregiver examining women.

Some participants perceived that healthcare professionals respected their culture and religion. All participants emphasised their wishes to have privacy during their hospitalisation and a female caregiver. This confirmed the findings of Ahmad *et al.* (2010) in their qualitative study of Arabic-speaking students' primary care experiences in Scotland where most female participants preferred to be seen by female doctors and most of them found healthcare professionals to be sensitive in terms of privacy and gender preference.

Another point revealed by the qualitative interviews that is worth highlighting in this section is that participants and healthcare professionals, such as a GP doctor, should share similar cultural beliefs. This important factor helps women in accessing the GP services and having a positive view of care. The survey showed that more than half of the participants prefer to deal with a doctor or nurse who speaks Arabic if she has a health problem. Another possible explanation for preferring to have an Arabic doctor is confidence in the language, as explained later in Section 9.4.4.1.

Despite the differences in culture and systems between the UK and Palestine, the current study has highlighted the positive view of the trustworthiness of MCH services in the UK and access to services that are free of charge. The vast majority of participants found Maternal and Child Healthcare services in the UK to be better than the government sector in Palestine or even better than the private sector. This study did not investigate the actual reasons for patients' views of the UK care system; although there is a belief in Arabic countries that the British healthcare system delivers a high standard of care. This suggests that a future in-depth study is required to explore perceptions on how and why it is considered better.

9.1.2 Knowledge of the UK healthcare system

The different health systems of the UK and Palestine may be responsible for the lack of knowledge about UK health services, particularly by people newly-settled in the UK. This study highlighted the lack of knowledge regarding the healthcare services, especially MCH services (an example is the maternity benefits), of Palestinian women that have recently settled in the UK. This is noticeable when women recount their experience of having their

first baby in the UK. As a consequence, many health service benefits may be lost (Shah & Priestley, 2001). Most of the women (64.1% strongly agreed and 30.4% agreed) felt that it was good to have healthcare services, including dentistry, free for pregnant women and one year post-delivery and two-thirds of participants agreed that they must be aware of their rights otherwise they may miss out on some “MCH services”.

This study’s findings are similar to those of previous studies (Ahmed *et al.*, 2010; Davies *et al.*, 2000) in reporting some lack of information on available healthcare services and how to use them. Lack of knowledge is the key factor that makes minority ethnic groups less likely to consume healthcare services (Netto *et al.*, 2001; Gulliford & Morgan, 2003; Davies *et al.*, 2000). It has been recognised by government that a lack of knowledge of the services available is a form of inequality in accessing maternity services (House of Commons Health Committee, 2003).

The study by Ahmad *et al.* (2010) which investigated the perception and experience of Arabic-speaking individuals in using GPs, found that one quarter of participants lacked information about access to primary care. On the other hand, Puthussery *et al.* (2010) argued that the familiarity of women from minority ethnic groups with the healthcare services improves their access and utilisation of these services. The participants in Puthussery *et al.* (2010) were UK-born mothers who did not suffer from a language barrier. In this current study, the problem is likely to be increased because not all participants were born in the UK. Therefore, the language barrier might play a significant role in these Palestinian patients’ lack of knowledge and familiarity with the UK health system.

Palestinian women consider the NHS being free of charge to be an important factor in assisting their access to, and use of, the maternity services. A study done in Finland considered access to prenatal care as an important factor and reported that 99.8% of pregnant women attend antenatal care since the service is free of charge (Raatikainen *et al.*, 2007). In Palestine, as mentioned in Chapter 1, the MCH services are not free at all; even the small groups of women who hold UN cards and thus receive free antenatal care must contribute to their cost of childbirth. Therefore, being free of charge has been considered in this study as an important and positive characteristic of NHS services, despite some participants who commented that they paid taxes in the UK but in Palestine they paid directly to have health services. Preventing NHS privatisation was a major concern of participants.

The analysis in the current study indicated that specific factors are associated with increases in participants' knowledge. These items are the longer length of time living in the UK, having more educational qualifications, having a parent in the UK and being younger and a worker. These sets of items that contribute to increased knowledge are considered as facilitating factors that empower Palestinian women and maximise their access to the benefits available from the NHS. Some of these demographic variables were highlighted by Jayaweera and Quigley's study (2010). They found that the strongest predictors of using antenatal care by minority ethnic groups were young age, level of education, unemployment, occupational class and living in an area populated by minority ethnic groups. However, the study showed no connection between the length of residency in the UK and antenatal care as found in the current study.

9.1.3 MCH services

The previous sections pointed to the participants' knowledge about the availability of health services and their own culture. This section includes a discussion about late antenatal booking, not attending antenatal classes, dissatisfaction with the bathing of the newborn baby and the midwife's examining of the newborn.

9.1.3.1 Late antenatal booking

It is known that antenatal care is important to health outcomes for the women and their babies (Rowe & Garcia, 2003). The time of entry into maternity care has a relationship with the health outcome for women (Buller *et al.*, 2007). The first health professional most women contacted about their pregnancy care was their GP or family doctor. They used a GP as a pathway to contact the midwife; this indicates the lack of awareness regarding the MCH system, especially by first-time mothers, where pregnant women could go straight to a midwife rather than a GP. This visibly contributes to lengthening the process of booking. The survey revealed that two thirds of women contacted a health professional before the 12th week of pregnancy (27.4% strongly agreed and 41.8% agreed) and a fifth of women (18.2%) had a late booking. A lower percentage of responders contacted the midwife directly. However, the qualitative interviews revealed that most of them contact their midwife around 12-16 weeks and not before 12 weeks. Only one participant did not use antenatal care and the first time she visited the midwife was one week before her delivery. The reason was that she had been moving from one city to another in the UK. Late bookings are of potential concern in terms of antenatal care, especially for women with special healthcare needs. NICE antenatal care guidelines (2003), endorsed that 'booking' with the maternity services should

be made before 12 weeks of pregnancy. Additionally, two important reports in the UK (Confidential Enquiries into Maternal Deaths, *Why mother's die 2000-2002* (CEMACH 2004) and *Saving mothers' lives: reviewing maternal deaths to make motherhood safer 2003-2005*), acknowledged late booking as one of the risk factors for maternal deaths (Lewis, 2007). According to NHS policy, The National Service Framework (Department of Health, 2004: 12) specifies that, "*Maternity services are proactive in engaging all women, particularly women from disadvantaged groups and communities early in their pregnancy*". On the other hand, The Maternity Matters document to enable earlier access to maternity services gives a choice to pregnant women either to go straight to a midwife if they wish or to their GP (Department of Health, 2007a).

As mentioned earlier (in Section 9.1.3.1), late booking and the slowness of systems are responsible for knowing the result of screening tests as late as the 16th – 20th gestational week of pregnancy. By this stage, it is too late to make the decision to terminate the baby based on their tradition and Islamic belief. From this point of view, half the participants did not wish to have this screening during their pregnancy, where knowing the test result after the 16th week of gestation will not affect their decision, as the Fatwa does not allow a termination beyond this time.

Late antenatal booking was an important matter that appeared in this study and needs attention since it caused some women to miss some screening tests. This study revealed that participants used the GP as a pathway to contact the midwife as mentioned earlier, which indicates their lack of awareness regarding the MCH system. The current study had highlighted their lack of confidence with the English language, which might be another reason for late bookings. In a similar previous study, Chinese mothers emphasised that communication was a major problem, especially the language barrier between them and the health professionals. Inability to speak English was responsible for late booking. This finding helped to illuminate the conclusion of Rowe and Garcia's systematic review (2003), which found that all the studies involved in their review indicated that women of Asian origin tended to book later for antenatal care compared to white British women. Moreover, other studies do not account for reasons for late booking or why the utilisation of antenatal services is low among minority ethnic women (Raleigh *et al.*, 2010; Rowe *et al.*, 2008; Jayaweera & Quigley, 2010). This current study underscored Permallo's view (2006) that offering screening tests in the first trimester would increase the take-up of this test by BME groups.

Raleigh *et al.* (2010) highlighted different factors which played a role in late booking. These included being a single mother and those with an earlier age for completing education. However, the major limitation for their study was the low response rate from some BME groups. These significant variables were not present in this current study in relation to late booking, but age was significant, with more younger women contacting a healthcare professional before the 12th week of their pregnancy compared to older women. This could be explained by older women possibly having more experience in pregnancy than younger women.

As women reached the midwife in this study, they had antenatal checks, which are a key part of care, including screening and scanning. However, they expressed their preference regarding the continuity of care and their wish to be cared for by the same midwife at each visit. A Swedish study has shown that women appreciated the continuity of midwife caregiver during pregnancy, the vast majority of participants (70%) reported it as ‘very’ or ‘rather’ important to meet the same midwife during pregnancy (Hildingsson *et al.*, 2008). However, Green *et al.* (2000) argued that the importance of seeing the same midwife at birth may have been overstated, but evidence showed that familiarity with the midwife made a difference to women during childbirth and decreased the continuity of care given during pregnancy (Waldenström *et al.*, 2000; Biró *et al.*, 2000).

An ultrasound scan is a routine part of pregnancy. According to NICE guidelines a scan is normally done twice during pregnancy; at 12 weeks and then at 20 weeks in the UK (National Institute for Health and Clinical Excellence (NICE), 2003). During their interviews, some participants in this study were concerned about the number of scans during pregnancy and also about knowing the baby’s sex. In Palestine, an ultrasound scan is done more frequently and repeated at each visit to the doctor during pregnancy. Taking into consideration that women have to pay for a scan, doing a scan usually reassures women about the baby’s condition. Knowing the baby’s sex is an important matter, as mentioned in Chapter 1, and some participants in qualitative interviews were really concerned to have this information.

9.1.3.2 Antenatal classes

Minority ethnic women were less likely to attend NHS antenatal classes than British women (Raleigh *et al.*, 2010), which is confirmed in this study. Only 13.9% strongly agreed and 27.4% agreed that they attended the antenatal class. One third never participated in this activity.

Interestingly, in this study, the significant predictors of antenatal class attendance were younger responders, non-workers or housewives who were born in the UK and had a parent in the UK. However, a previous study that investigated factors influencing attendance at antenatal class among immigrants in Canada had found the significant predictors to be education, knowing English, age and length of residency (Edwards, 1994).

This study highlighted the crucial factors for the non-attendance at antenatal classes that include: the presence of both sexes at classes, the childcare for older children and confidence in language. A recent study comparing Palestinian and Jewish women in Israel which explained cultural differences in child delivery showed that Jewish women participated in antenatal classes more than Arabic Palestinian women, 71.42% and 20% respectively, and none of the Arabic women attended the delivery room tour (Rassin *et al.*, 2009). The reason behind not attending these activities may be due to not offering this services to the women (Ali *et al.*, 2004), or the presence of both sexes in the classes, for example, as trainer or a participant's partner (Ali *et al.*, 2004; Bawadi, 2009; Rassin *et al.*, 2009). The presence of males in the ante-natal class made the class culturally inappropriate (Kensington, Chelsea & Westminster BME Health Forum, 2004), because Arabic women feel shame or discomfort in the presence of men (Hammad *et al.*, 1999). Ellis (2004) commented on antenatal classes in the UK and argued that maternity services are in fact scheduled for white, middle-class women. This was supported by discussing how antenatal classes designed for couples might exclude Muslim women just because they include men in the classes (Kensington Chelsea & Westminster BME Health Forum, 2004).

Another reason mentioned in the qualitative interview of this study was that some women may have other children and no one to take care of them so they sacrificed their antenatal class. It is known in Arabic countries that women sacrifice themselves for their children. This view is supported in two previous studies: Bawadi's study (2009) where Arabic Muslim mothers went to hospital a short time before delivery in order to spend a longer time with

their children; and in Liamuttong's study (2006) where participants suggested that a good mother has to fulfil her obligations to the best of her ability and sacrifice herself for her children. It can also be concluded that other factors are likely to prevent women from participating in these classes. A language problem might be another hidden reason for not attending an antenatal course; this fact agrees with Rassin *et al.* (2009) whose study reveals that a lack of proficiency in the Hebrew language was another barrier to using antenatal classes.

9.1.3.3 Dissatisfaction with bathing baby

This study revealed that mothers were unhappy regarding the first baby bath at hospital (25.7% agree/strongly agree) and preferred not to use only water to bath their baby in the first week after delivery (40.1% strongly disagreed and 15.3% disagreed). There is a debate in the literature regarding the bathing of the newborn in the first few weeks after birth. The guidelines, 'Routine postnatal care for women and their babies', in the UK recommended that cleansing agents should not to be used to bathe a baby in the early postnatal period (National Institute of Clinical Excellence, 2006). In contrast, The American Association of Women's Health, Obstetrics and Neonatal Nursing (AWHONN) guidelines encouraged the addition of mild cleansers that have a pH of 5.5-7.0 with warm water to bathe the baby (Lund *et al.*, 2006). A resolution of this debate requires further in-depth study.

In Palestine, the nurse or midwife would usually do the bathing for the baby on the first day of the mother giving birth and they use a baby-product shampoo to clean the newborn. The mothers have their babies completely cleaned before they are discharged from the hospital. Therefore, participants in this study were dissatisfied regarding the first baby bath at hospital; their expectation was to have their babies completely cleaned before their discharge from hospital. The old Palestinian tradition of salting newborn babies is not common nowadays in Palestine, but remains common in other Arabic countries. The newborn was cleaned with water and soap followed by a daily rubbing of the baby's skin with a little salt and oil. They thought this would prevent any infection of the newborn, improve the immunity, and strengthen muscles and bones. The term 'pickling' has been used to describe this practice, which leads to high mortality among the newborn by increasing the sodium level in the blood. There is no published work regarding the complications of this practice and further research on caring for the newborn baby is needed.

An exploratory study in Jordan aimed to determine the beliefs among Jordanian women regarding 10 selected postpartum behaviours. It reported that 65% of the participants felt that salt should be applied to the body of the newborn to strengthen muscles and bones (Jarrah & Bond, 2007). However, Palestinian women in the qualitative interviews in this study confirmed that none of the participants carried out this practice and considered it to be a harmful practice for the newborn. Further details of the Palestinian tradition concerning the newborn baby are discussed in Chapter 1.

9.1.3.4 Examination of the newborn by the midwife

Arising from this study, a new issue for participants was that midwives rather than the paediatrician examined their babies 24 hours after delivery. The majority of participants in this survey prefer a paediatrician to examine their baby (65.8% strongly agreed and 28.3% agreed) and fewer preferred a midwife (22.8% strongly agreed and 30.4% agreed). Participants found this completely different to Palestinian health service practice, where it is the paediatrician who must assess the newborn's condition. The Cochrane Review highlighted four models of care (Hatem *et al.*, 2008), these include the midwife-led model used in the UK, obstetrician-provided care as is common in North America, family-doctor-provided care and shared models. In the UK, the midwife-led model is followed; therefore, the midwife is responsible for examining the newborn. Townsend *et al.* (2004) carried out research in the UK regarding newborn examination by the midwife that is usually carried out by junior doctors. Their study had influenced the way of providing care for all healthy newborns. It concluded that there was an increase in maternal satisfaction when midwives perform the newborn examination. The midwives were more likely to provide advice about caring for the newborn in addition to the examination. Furthermore, other studies (Bloomfield *et al.*, 2003; Rogers *et al.*, 2003) found that the participants were happy with the midwife's examination for their newborn baby because they were not waiting for a doctor's review before their discharge from hospital. Recently, Macdonald (2013) was concerned in her literature review about the examination of the newborn, about whether transferring this responsibility to midwives is just cost-saving or to allow midwives to reclaim the agenda of normality. The King's Fund report (2011) mentioned that the NHS aims to save by the end of 2013/2014 between £15-£20 million by using midwives to examine the newborn.

Although, the policy of a 10-day post-delivery visit by the midwife and then by the health visitor was appreciated by participants, there were some concerns as presented in the findings chapter. However, this service is not available in Palestine, where only one third of women received postnatal care (Dhafer *et al.*, 2008). The women were happy with the amount of time and support during post-natal visits in the UK.

9.1.4 Communication and information need

The central aspect of health practice is the effective and satisfying communication between healthcare professionals and patients (Berry, 2006). This study revealed that the majority of participants mentioned that all the midwives have good communication skills and they deal with them in a nice manner. However, some participants complained of poor communication from the medical staff in hospitals and GP receptionists.

Many studies have highlighted the language barrier as a significant obstacle to accessing maternity services (Chan, 2000; Davies & Bath, 2001; Jayaweera *et al.*, 2005; Straus *et al.*, 2009). Others have stated that communication and language are a central basis for the quality of healthcare (Cross-Sudworth, 2007; D'Souza & Garcia, 2004), and others stressed that BME groups are likely to experience many difficulties in their contact with the health services in the UK (Ali *et al.*, 2004; Bulman & McCourt, 2002; Katbamna, 2000). Moreover, the Bangladeshi and non-English-speaking Somali women claimed that their ability to access or seek information was limited due to poor communication and language barriers (Jayaweera, 2005; Davies & Bath, 2001). A review of 47 published articles examined the relationship between language barriers and health disparities among BME groups. The review showed that language problems resulted in a lack of awareness of the benefits of healthcare, dissatisfaction with services and ineffective use of health services (Yeo, 2004).

The following section discusses the confidence in language of participants; consultation or visit time; interpreter services and information provision.

9.1.4.1 Confidence in English language

In this study, confidence in language was apparent as an important factor in using health services. Most participants could understand written English well (33.3% strongly agreed and 41.4% agreed). Despite claiming to understand English well, responders still felt that they had a language barrier. Language problems make it hard to understand what the midwife, doctor and nurse were saying. Half the participants felt that language problems make it hard

to explain their concerns to the midwife or doctor. Therefore, half of the responders preferred to deal with a doctor or nurse who speaks Arabic if they have a health problem.

Those participants who evaluated their language knowledge as average or below perceived the language as the main barrier to the effective use of MCH services and some of them reported that it had negatively affected their health during pregnancy. Even participants, who evaluated their language as good or very good, considered the use of medical terms and speaking quickly to be the major problems during the conversations with the midwife or the GPs. In a similar qualitative study, Chinese mothers emphasised that communication was a major problem, especially the language barrier between them and the health professionals (Chan, 2000). Moreover, the Bangladeshi and non-English-speaking Somali women claimed that their ability to access or seek information was limited due to poor communication and language barriers (Davies & Bath, 2001; Jayaweera *et al.*, 2005).

In a previous qualitative study, Chinese mothers emphasised that communication was a major problem, especially the language barrier between them and the health professionals. Inability to speak English was responsible for late booking for pregnancy care. The consequences of language difficulties might be very serious. The 'Why Mothers Die' report found that the risk increased for mothers with language difficulties, due to inappropriate communication (Confidential Enquiry into Maternal and Child Health, 2004). Bharj and Salway (2008) stated that women from the BME group who are most in need of health information are most likely to receive the least, which agrees with this study. One participant in the qualitative interviews (No 12), who has thalassemia and could not understand English, reported the story of her last pregnancy that reflected the degree of lack of knowledge regarding the health system and the resulting poor antenatal care and inefficient use of maternity services.

The National Service Framework Maternity Standard (Department of Health, 2006: 5) specifies: *"All women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth"*. In order to achieve this standard, the Maternity Services Code of Practice states that *"The fact that some women do not speak English well, or that they have different values and ways of doing things, must never be a barrier to the benefits offered by advances in obstetrics, or to the greater flexibility of care now available to women. If all women are to exercise their right to choose the kind of maternity care they want, they must*

have full information about all the options; they should be fully aware of what they are choosing or refusing” (Commission for Racial Equality, 2005).

In order to overcome the language problem and achieve equality in accessing health services by all BME groups, CEMACH (2004:252) recommended having “systems and protocols for accessing appropriate independent interpreters” after the findings of the 2000-2002 enquiries into maternal deaths. Hence, by 2003 the UK government promised free interpreter services for all NHS trusts (Department of Health, 2000), but availability of this service remains patchy (Aspinall & Jacobsen, 2004), see Section 9.4.4.3. The idea of using bilingual health professionals and information was proposed as a solution to the communication barrier. Baxter’s study (1997) concluded that using a bilingual health advocacy scheme is a good investment, as it can reduce interventions and increase the satisfaction of the patient. Moreover, many authors stated that the use of bilingual health information in everyday language could eliminate unnecessary suffering by eliminating language barriers and reducing the costs of healthcare (Robinson, 2002; Mir & Din, 2003; Katbamna *et al.*, 2000). Using simple English in bilingual materials with pictures and diagrams can also improve the access to health services by BME patients (Aspinall & Jacobsen, 2004; Robinson, 2002).

This study adds to the knowledge that having higher educational qualifications, having a parent in the UK, being a working woman and a woman who has experience of giving birth in the UK were associated with greater confidence with languages. This can be explained by these factors leading to more exposure to western culture and the UK health system. A study carried out in the US found that new immigrants were most likely to have language barriers and fewer visits to the doctor than immigrants who had lived in the US for a longer time (Cunningham & Artiga, 2009).

9.1.4.2 Consultation or visit time

Language barriers not only result in difficulty of communication, but also affect women’s perceptions. Participants express their need to have more time during their visit to talk about their concerns. More than half of the participants in this study found that the length of the appointment with the GP was enough to answer their inquiries, 39.7% strongly disagreed and 13.1% disagreed that ‘there was not enough time during my visit for the midwife or doctor to answer my questions’. A national survey in the US showed that additional time was needed by patients who had limited English proficiency during visits ranging between 5-15 minutes (American College of Physicians, 2007). Therefore, this study stressed the need for GPs,

nurses and midwives to provide support to those women suffering from poor English proficiency by giving additional consultation time.

9.1.4.3 Interpreter services

The use of professional interpreters is an important step in overcoming the inequity in healthcare. This current study underscored that interpreter services should be available and accessible even in an emergency. Almost one third of women were using an interpreter, 31.4% of participants needed an interpreter when they saw a doctor who only spoke English. More than half of them (20.5% strongly agreed and 32.5% agreed) believed that interpreters are usually not available upon request, this lead to acquaintances and family members being used as interpreters.

Similar findings have been echoed in previous studies. In 2004, a qualitative study was conducted into Muslim parents' experiences of maternity services in England. It stressed that a shortage of interpreters for those who did not speak English resulted in poor communication between healthcare providers and Muslim parents (Ali *et al.*, 2004), and Somali women stated that the presence of an unsuitable interpreter was limiting their ability to communicate (Straus *et al.*, 2009). Furthermore, Davies & Bath (2001) studied the fears and embarrassment when having to talk about their health problems, which limited the Somali women's use of interpreter services to seek information. However, in the current study, the unavailability of an interpreter was the main problem.

The NHS and GPs provide interpreter services and the NHS has 24-hour telephone services. However, interviews revealed that participants know about the interpreter services in the NHS and GP practices, but they underscored the difficulty of accessing these services, especially in an emergency appointment. To make a booking for an interpreter takes around one week, therefore they preferred to use their husband, children or acquaintances as their interpreter in order to access their GPs immediately. Many have previously highlighted the inadequate interpreter services in primary care and the full dependence upon a family member to interpret (Gerrish *et al.*, 2004; Bhakta *et al.*, 2000). Szczepura *et al.* (2005) considered the use of informal interpreters to be a serious problem in healthcare settings. Therefore, it is suggested that professional and independent interpreter services should be available for women in both primary and secondary care (Centre for Maternal and Child Enquiries, 2011). Using an unsuitable interpreter has many disadvantages. In a study of Somali women's experience of maternity services, participants stated that the presence of an

unsuitable interpreter was limiting their ability to communicate (Straus *et al.*, 2009). In another study conducted in London, the participants used family members, such as their children, rather than friends for interpreting, because of the issue of confidentiality (Kensington Chelsea & Westminster BME Health Forum, 2002).

A high level of satisfaction was observed when women used interpreters in their maternity care (Bulman & McCourt, 2002). The patient should not postpone their appointment based on the availability of this service or use their family members or friends as revealed in this current study. Therefore, interpreter services should deliver a high standard and be sensitive to patient need. This current study underlined that interpreter services are inadequate and need more attention and evaluation. Moreover, many authors emphasised the importance of an interpreter being a patient-centred advocate rather than acting as a literal conduit. On the other hand, Greenhalgh *et al.* (2006) stated that interpreter professionalism tied them to accurate translation and limited their involvement in the consultation.

Additionally, cuts in the NHS and limited resources are currently a major challenge. Therefore, interpreter access by telephone might be a feasible way to solve this problem and could be more cost-effective than using the traditional attendance in person method (Hornberger *et al.*, 1996). This has been introduced into the NHS over the last 15 years (Leman, 1997), but until now has not been available in every GP surgery and most participants in this study were not aware of it.

However, the views of scholars and many professional interpreters is that telephone interpreting may involve a considerable loss of quality, and argue that nothing can replace non-verbal cues in communication (Gracia-García, 2002). Patients might feel uncomfortable using this method to communicate about sensitive issues with the GP or a midwife. Moreover, if we considered the cost effectiveness issues, not providing a good quality of care will cost the NHS more money than that which is saved from not using a personal interpreter. On other hand, many emergencies might happen at night, and decisions regards the life-saving might be needed, therefore telephone decisions should be considered in this case.

9.1.4.4 Information provision

In two previous studies (Howell *et al.*, 2001; Singh *et al.*, 2002), the authors discussed the information provision and emphasised that minority ethnic groups have difficulty in gaining

information. Other authors underlined the desire of women from BME groups to have accurate and easily understood information about childbirth at the same level as British women (Bharj & Salway, 2008). In the current study, a positive reaction to the adequacy of information given during the antenatal appointments presented, but the women with certain health problems were not satisfied with the quality of information. Most participants expressed their wish to receive information in the Arabic language, to “read the leaflets about pregnancy in the Arabic language” (22.8% strongly agreed and 34.6% agreed) and 16% preferred English leaflets. Nevertheless, the majority preferred to receive an oral explanation in addition to the midwife’s explanation, (28.3% strongly agreed and 48.9% agreed) with 8.7% disagreeing.

This result was echoed in many previous studies; a study of Bangladeshi women's perspective on childbearing in the UK highlighted that the absence of a script and written information in their language was a barrier to accessing resources (Jayaweera *et al.*, 2005), and Straus *et al.* (2009) pointed out that Somali women preferred to receive a verbal explanation of the information rather than using a pamphlet, even if translated. However, the analysis of the survey in this study has found the association between the preference of using the mother language and work and education. The women with lower educational qualifications and housewives preferred to read the leaflets about pregnancy in the Arabic language. This indicated that, among Palestinian women, confidence in language plays an important part in seeking information.

Moreover, O’Donnell *et al.* (2007) revealed that written materials given to asylum seekers upon arrival were not used as a source of information later on. Therefore, the authors recommended the development of different methods of delivering health information. During interviews, some Palestinian participants recommended receiving not only a leaflet but also hospital letters in Arabic to enable them to understand the information correctly. This request was recommended in a previous report about “Task Group Experiences of Muslim Women Using Health Services”. This report mentioned that many participants missed their hospital appointments because they could not read the letter (Kensington Chelsea & Westminster BME Health Forum, 2004).

From the author’s experience as a resident in the UK, the system when requesting a police certificate is practical and convenient, where all documents are presented in many languages, which enables people to use the most convenient one. It may well be worth adopting this

system in healthcare services. Another practical suggestion is to have a videotape/podcast, which explains all the required information in English and Arabic languages. This could increase the patients' knowledge about using and accessing healthcare services.

Generally, the variation in quality of MCH services for BME groups is presented. The gaps between policy documents and practice are noticeable. The evidence for this is shown either in this current study or previous studies, as discussed earlier. An example is the interpreter policy and the inefficient use of this service. The participants in this study know about the interpreter services in the NHS and GPs, but they emphasised the difficulty of accessing these services, especially in an emergency appointment. Inadequate interpreter services in primary care and full dependence on a family member to interpret have been highlighted in the current and previous studies (Gerrish *et al.*, 2004; Bhakta *et al.*, 2000).

Therefore, the author's view is that policy and guidelines relating to BME groups should be compared with the evidence presented, with periodic monitoring and evaluation whether these documents have been supplied or not. A report that criticises the white paper 'Equity and Excellence: Liberating the NHS', recommends having an effective and logical process to gather, analyse and compare feedback information in order to achieve the improvement (British Association for Community Child Health, 2010).

The Race Relations (Amendment) Act, 2000 places a responsibility on service providers to ensure the absence of discrimination. Discrimination is defined as "to treat one group of people less favourably than others on the basis of their 'race', nationality, ethnic or national origin or religion" (The Institute of Race Relations, 2012). The NHS is committed on paper to reducing inequalities in health, as in the Marmot Review (2010), but this report does not address the impact of ethnic diversity and racial discrimination on health outcomes sufficiently (Salway *et al.*, 2010). Notwithstanding these prolific publications, policies and guidance, it has been argued that the maternity needs of BME groups still need to be improved. The criticism regarding the maternity provision for any particular group by Bharj & Salway (2008) includes the following points. It is inflexible and based on the assumption of homogeneity; inadequate in terms of attitudes and generic skills such as cultural knowledge or sensitivity; patterns of service are not changing with changing population profiles; data that discusses the ethnic inequalities in maternity services is neither collected nor acted on and the needs of minority ethnic groups are not recognised as a priority.

The current study provides evidence that supports this claim by highlighting the issues surrounding Palestinian women's access to, and use of, MCH services in the UK. It is hoped that highlighting these issues as barriers in using maternity services can help to improve the maternity services and practice, thereby reducing inequalities in MCH among BME groups in the UK. The use of a sequential, mixed-method approach and the synthesis of data provide a clear and comprehensive picture. This leads us to look comprehensively at Palestinian women's needs, as one of the BME groups in the UK, especially their need to have a culturally sensitive MCH service that is flexible, adequate and accessible. Finally, this study draws attention to the importance of healthcare professionals, including GPs, midwives and nurses, considering the women's beliefs and providing individualised care to meet their needs. The implications for practice and recommendations for healthcare professionals, midwives and nurses are discussed in detail in the next chapter.

9.2 Summary

This chapter discussed the qualitative findings focusing on issues that belong or are strongly connected to Palestinian women, rather than common problems, which might face white British women as well and, as such, are worthy of particular attention. These include cultural variation such as the use of herbal medicine; self-prescribed medication (antibiotics); attitudes towards the termination of pregnancy (fatalism); circumcision for male babies; breastfeeding practice; the preference for female GPs and caregivers; knowledge of the UK health system; confidence in communicating using the English language; interpreter services; late booking of pregnancy; not attending antenatal class; duration of visit time and information needs. In addition, dissatisfaction with practices for bathing the newborn baby and examining the newborn by the midwife were covered. The next chapter will provide the study's recommendations and their implications for nurses, midwives and policy.

CHAPTER TEN

Conclusion Chapter

“What we call the beginning is often the end.

And to make an end is to make a beginning.

The end is where we start from.”

T.S. Eliot

Chapter 10 - Conclusions

10.1 Introduction

The first section of this chapter presents the overview and the contribution of the study, followed by a discussion about its key findings that highlight the important points and implications for research and clinical practice. The next section will present the recommendations for nurses, midwives and policy. Finally, a reflection on the strengths and limitations of the research; along with a plan for the dissemination of the conclusions are presented.

10.2 Overview of the study

An exploratory, sequential, mixed-method, research design (Tashakkori & Teddlie, 2008; Creswell, 2009) was employed in this study. This started with in-depth interviews, from which, the instrument tool was developed based on their analysis. A quantitative questionnaire survey and its analysis followed, the final phase integrated the results from both study stages. This approach produced more complete knowledge for practice as predicted by Johnson & Onwuegbuzie (2004).

In the first phase, in-depth interviews with 22 Palestinian women were conducted between October 2010 and June 2011 in Manchester to explore their access to, and use of, healthcare services, particularly maternal and child health services in the UK. It provides a clear picture of the potential barriers and facilitators when using MCH services in the UK.

In the second phase, a questionnaire survey was conducted between March and June 2012 aiming to examine the access to, and use of, healthcare services, particularly maternal and child health services in the UK, by a larger sample of Palestinian women, as the aim of the quantitative research is to generalise the data (Pope *et al.*, 2007). A total of 243 questionnaires were returned by post and e-mail from the responders in the UK. Six questionnaires were excluded because they were not completed and 237 returned questionnaires used for the analysis. Overall, the methods were considered appropriate in meeting the aims of the study.

10.3 Contribution of the study

This study is the first of its kind, since the literature review revealed that no research has been undertaken about Palestinians as a minority ethnic group in the UK. Furthermore, it adds to the body of knowledge concerning BME groups in relation to MCH provision. The findings from this study will help healthcare professionals, especially nurses and midwives providing MCH services, to design culturally-sensitive healthcare services and educational interventions to promote Palestinian women's health or access to MCH as one of the BME groups in the UK.

This study makes an important contribution to our understanding about how Palestinian women access and use MCH services in the UK. It also provides an insight into the potential barriers and facilitators that arise when using this service. The use of a mixed method design where both phases were complementary to each other, provided strong evidence for conclusions to be made (Cronholm & Hjalmarsson, 2011). Identification of potential barriers and facilitators has helped to promote strategies, as presented in section 10.6.2. From this, culturally competent strategies will be explored in this chapter, which meet the needs of the service user. Detailed explanations regarding potential barriers and facilitators, and how they improve the MCH services for this group, will be illustrated in the next section.

10.4 The main findings of the study

The aim of the research findings were to generalise the major issues that belong or are strongly connected to Palestinian women, rather than common problems which might face large groups of British women as well; as such, they are worthy of particular attention for this study. These key issues could be generalised to other Palestinian women and include: cultural variation such as herbal medicine; self-prescribed medication (antibiotics), termination of pregnancy (fatalism), circumcision for male babies, breastfeeding practice and preference for a female GP and caregiver; knowledge of the UK health system; late booking of pregnancy; not attending antenatal class; duration of visit time; confidence in using the English language; interpreter services and information needs. In addition, dissatisfaction with the bathing of a newborn baby and the examination of the newborn being carried out by the midwife rather than a doctor are issues raised in this research. Whilst these issues could be reported by other women in the UK, the main reason behind these reports by Palestinian women is the different MCH system in the UK and their home countries which results in different expectations of care.

10.4.1 Cultural variation

The culture and healthcare systems in the UK and Palestine are different. Therefore, an individual's knowledge, expectation and use of services are varied.

10.4.1.1 Herbal medicine: From the traditional Palestinian view, the use of herbal medicine is a common practice. This current study confirmed this idea and showed that a majority of participants use a traditional herbal medicine in their illness. Responders who are housewives, other than students and working women, preferred to use traditional herbal medicines. The relative lack of evidence of either efficacy or harm from these herbal medicines has increased the problem.

- **Implication for practice:** It is crucial for midwifery and nursing practices to understand the significance of herbal medicines and their effects. To ask and document the reported use and explore the potential safety of herbal drugs, especially for those who do not have exposure to wider aspects of British culture such as those who class themselves as housewives, as well as to provide education regarding their side effects.
- **Implication for research:** More research is needed regarding the safety of herbal medicine use during pregnancy.

10.4.1.2 Self-medication practices: This study highlighted self-medication practices among Palestinian women; the participants expected that antibiotics would be prescribed routinely. When this proved not to be the case, they brought antibiotics from their home country.

- **Implication for practice:** It is crucial for both midwife and nurses practices to recognise this belief and that women may access antibiotics in ways other than through UK sources. Furthermore, both midwife and nurse should provide education regarding the proper usage of medication.
- **Implication for research:** Leftover medication is another possible source of the improper use of antibiotics that is not investigated in this study.

10.4.1.3 Acculturation: The findings of this study suggest that acculturation has a positive effect on the health behaviour of participants. The longer a woman has lived in the UK, the more unlikely they are to bring their medication from their home countries.

- **Implication for practice:** The differences in the Palestinian subgroup in relation to the acculturation of women have an important implication for midwifery and nursing practice when developing educational interventions for this population. It may not be appropriate to implement a “One Size Fits All” programme. It is important to know how long women have been in the UK and what their experience of MCH services in the UK has been.
- **Implication for research:** It is recommended that further research needs to be undertaken to examine the effect of acculturation on the health beliefs, attitudes and practices of Palestinian women.

10.4.1.4 Fatalism: Palestinian women held a fatalistic view that most likely affects their decisions. One-third preferred to keep the pregnancy, even if the test or scan shows the possibility of abnormality. The responders who gave education as the main reason for residing in the UK desired to terminate the pregnancy if the test or scan showed the possibility of abnormality. An early booking and screening would enable them to have a termination within an acceptable timeframe if genetic disorders were revealed.

- **Implications for practice:** Motivating Palestinian women to make an early booking for antenatal screening is a crucial matter in this study. Midwives should be oriented to the role of culture and religion in women’s decisions to undertake tests and take actions based on them.

10.4.1.5 A preference to have a female caregiver: The study showed that Palestinian women preferred to have a female GP and caregiver for their examination. This may be the same for British women but there are cultural factors to take into consideration.

- **Implication for practice:** It is crucial for GPs, midwives and nurses to understand the significance of having a female caregiver in a GP clinic to meet the specific group’s needs.

10.4.1.6 Need for circumcision services: The need for circumcision to be provided on the NHS was underscored by the Muslim group in this study.

- **Implication for practice:** More thought should be given by policy makers to the need for circumcision to be available from the NHS or at least via the NHS for groups with a specific religious need, such as Muslim and Jewish people.

10.4.1.7: MCH services in the UK: The vast majority of participants found MCH services in the UK to be better than the government sector in Palestine or even better than the private sector.

- **Implication for research:** This study did not investigate the actual reasons for patients' views of the UK care system. This suggests that a future in-depth study is required.

10.4.2 Knowledge of MCH services in the UK

Knowledge was a significant factor in using and accessing MCH services. This study highlights the lack of knowledge regarding the healthcare services, especially MCH services, of Palestinian women that have recently settled in the UK. The contributory factors that most affect responders' knowledge regarding the MCH services in the UK include a longer length of time living in the UK, more educational qualifications, having a parent in the UK and being younger and a worker. These items are considered as facilitating factors that empower Palestinian women and maximise their access to the benefits available from the NHS.

- **Implication for practice:** The knowledge and understanding of women's experience, history and demographic data will help nurses and midwives to have better ideas of culture and UK population and to implement MCH services effectively.

10.4.3 MCH services

10.4.3.1 Late antenatal booking: This was an important issue in the study and a reason to miss some screening tests. This study revealed that participants used the GP as a pathway to contact the midwife rather than contact the midwife directly, which indicates their lack of awareness regarding the MCH system. Their lack of confidence with the English language might add to the problem of late bookings.

- **Implication for practice:** To provide new immigrants with detailed information about the UK health system, particularly the pathway to a GP, midwife or other services which may be self-referral. Furthermore, this information should be provided in appropriate languages.

10.4.3.2 Non-attendance at antenatal classes: The crucial factors for the non-attendance at antenatal classes highlighted in this study were: the presence of both sexes at classes, the childcare for older children and confidence in language. On the other hand, the significant predictors of antenatal class attendance were younger responders, non-workers or housewives who were born in the UK and who had a parent in the UK.

- **Implications for practice:** Demographic data should help nurses and midwives to identify and target hard-to-reach groups. The barriers of non- attending antenatal class, such as not having a female-only session, should be taken into consideration and acted on in order to facilitate attendance.

10.4.3.3 Newborn bathing: The mothers were unhappy regarding the baby bath at hospital and preferred not to use only water to bathe their baby in the first week after delivery.

- **Implications for practice:** To provide explanations and information about bathing a newborn and using water alone. Evidence suggests that plain water is better for a newborn baby but evidence-based practice needs to be used in conjunction with education.

10.4.3.4 Examining the newborn by midwives: Arising from this study, a new issue for participants was that midwives rather than the paediatrician examined their babies 24 hours after delivery. Participants found this completely different to Palestinian health service practice, where it is the paediatrician who must assess the newborn's condition not the midwife.

- **Implication for practice:** Education and communication about the skills of midwives and their post-natal role should be explained to Palestinian women and new migrants to the UK so that they understand the different roles and responsibilities and the competencies of the professionals they interact with.

10.4.4 Communication and Information provision

10.4.4.1 Confidence in language: In this study, confidence in language was apparent as an important factor in using health services. Most participants could understand written English well. Despite claiming to understand English well, responders still felt that they had a language barrier. Language problems make it hard to understand what the midwife, doctor and nurse were saying or explain their concern. Therefore, half of the responders preferred to

deal with a doctor or nurse who spoken Arabic if they had a health problem. This study adds to the knowledge that having higher educational qualifications, having a parent in the UK, being a working woman and a woman who has experience of giving birth in the UK were associated with greater confidence with languages

- **Implications for practice:** Information should be provided in languages understandable by the recipient. Health care professionals need to recognise that even if women appear to have good English language skills, better understanding may be facilitated by an interpreter. Obtaining positive evidence of understanding is vital in order to achieve good, two- way communication.

10.4.4.2 Interpreter services: In spite of the fact that the UK government promised free interpreter services for all NHS trusts by 2003 (Department of Health, 2000), this study revealed the problem of the unavailability of interpreter services, especially in an emergency appointment. This inhibits communication and informed decision making and is discriminatory (see chapter 9). Consequently, women preferred to use their husband, children or acquaintances as interpreter which is counter to NHS policy.

- **Implication for practice:** Interpreter services should be available upon request and in emergency and normal appointments for those in need.

10.4.4.3 Consultation visit time: Participants expressed their need to have more time during their visit to talk about their concerns. Therefore, this study stressed the need for GPs, nurses and midwives to provide support to those women suffering from poor English proficiency by giving additional consultation time and providing interpreter services.

- **Implication for practice:** Appointment times for GP services and the midwife should be longer for women whose first language is not English.

10.4.4.3 Information provision: A positive reaction to the adequacy of information given during the antenatal appointments. Most participants expressed their wish to receive information in the Arabic language, but the majority preferred to receive an oral explanation in addition to the leaflets.

The study revealed the problem in communication, such as receiving leaflets and hospital letters in English. As mentioned earlier in Chapter 9, from the author's experience as a resident in the UK, the system when requesting a police certificate is practical and

convenient, where all documents are presented in many languages, which enables people to use the most convenient one.

- **Implications for practice:** It is vital to adopt this system and use multilanguage information in healthcare, where all documents are presented in many languages; in order to have culturally competent services.
- Another practical suggestion is to have a videotape/podcast, which explains all the required information in English and Arabic languages. This could increase the patients' knowledge about using and accessing healthcare services.
- Midwives and nurses should provide an oral explanation in addition to the leaflets.

The gaps between policy documents and practice are noticeable. The evidence for this is shown either in this current study or in previous studies, as discussed earlier in Chapter 9. The Race Relations (Amendment) Act, 2000 places a responsibility on service providers to ensure the absence of discrimination. The findings of this study provide evidence of discriminatory practices, such as the lack of available interpretation leading to a lack of information and less than fully informed consent and highlights issues surrounding Palestinian women's access to, and use of, MCH services in the UK.

It is hoped that highlighting these issues as barriers in using maternity services can help to improve the maternity services and practice, thereby reducing inequalities in MCH among BME groups in the UK. The use of a sequential, mixed method and the synthesis of data provide a clear and comprehensive picture of Palestinian women's needs. As one of the BME groups in the UK they need to have a culturally sensitive MCH service that is flexible, adequate and accessible. Finally, this study draws attention to the importance of healthcare professionals, including GPs, midwives and nurses, considering the women's beliefs and providing individualised care to meet their needs.

10.5 Recommendations

In this part, recommendations are underlined for future research for nursing-midwifery practice and at the institution level.

10.5.1 Recommendations for future research

The non-probability sampling methods with the snowballing technique were employed to examine to whom Palestinian women had access and their use of MCH services in the UK; most of the participants were recruited through Palestinian organisations. With some attention, these current research findings might be generalised to other research settings. Therefore, the recommendation here is to conduct further research using different sampling methods. Moreover, the findings highlighted the major barriers that help or prevent Palestinian women from using and accessing the MCH services effectively such as language barriers and cultural issues, among others. This might also be influenced by their behaviour in using and seeking the MCH services. The current study is not designed to focus on the health-seeking behaviours of participants. Acculturation has a positive effect on Palestinian women, as mentioned previously, but again the study aim does not include an examination of the effect of acculturation. Therefore, further research is required to investigate the effect of acculturation and the health-seeking behaviours of Palestinian women.

The questionnaire developed and used in the second phase of this study can be used in future research, not only for Palestinian women but also with Arabic-speaking women from different countries. This will help to test the questionnaire validity and reliability as a tool to examine the access to, and use of, healthcare services, particularly MCH services, in the UK. As employed in this study, using a bilingual researcher is recommended in future research that deals with BME groups where English is not their first language. Such an approach can provide many benefits such as accurately understanding interviewees and capturing the real meaning of data. In this study, the researcher had to deal with participants as a homogenous group regardless of their religion, or whether they are first or second generation Palestinians in the UK. It may be worth comparing groups in future research to examine whether any differences exist among these groups.

10.5.2 Recommendations for Nursing-midwifery Practice and NHS services

Recommendation 1:

- Interpretation services should be provided to Palestinian women who have the need and need should be directed by women not by the perceptions of professionals. Relatives and friends should not act as interpreters.

- Information leaflets on interpretation services should be available in GP surgeries, pharmacies and Palestinian organisations. Hospital and GP letters should be presented in both Arabic and English languages.
- Midwives and nurses should provide oral explanations beside leaflets to allow patients a full choice when making a decision and check for understanding.
- Appointment times for GP services and the midwife should be longer for women whose first language is not English.
- Another practical suggestion is to have a videotape/podcast provided explaining all the required information in English and Arabic languages. This could increase the patients' knowledge about using and accessing healthcare services.

Recommendation 2:

- Detailed information on the demographic characteristics of Palestinian patients should be collected when they register with a GP service and midwife, such as length of time living in the UK, country of birth and first language. This will assist health professionals in better understanding their healthcare needs and providing more tailored health services.

Recommendation 3:

- Particular attention should be paid to new Palestinian immigrants in order to rapidly provide them with detailed information about the UK health system, particularly the pathway to the GP and midwife. This may be started at the airport or after police registration that occurs in the first week after arrival.

Recommendation 4:

- Having cultural competence care and adaptive services for Palestinian and all minority ethnic groups are crucial to have equitable services.
- Consideration should be given to provide initial and on-going education about cultural competence.
- Culturally appropriate care could be satisfactorily achieved through effective and continuous training programmes based on culture, ethnicity and religion for all health

professionals, especially GPs, receptionists and midwives, in order to understand client needs.

- Service users should be offered a choice of gender, for example, a female GP or midwife, and female, single-sex, antenatal class sessions.
- Policy makers should review policy around circumcision procedures within the NHS.

Recommendation 5:

- Maternity services should be flexible, accessible and meet the women's needs. A health manager should ensure that healthcare professionals are prepared adequately to deal with BME groups.
- Maternity services should explain to Palestinian women the evidence behind procedures such as for bathing a newborn and the reason for using only water.
- Explanations about of the skills and scope of practice of midwives should be given to new mothers at their first appointment.
- To maintain the continuity of caregiver; women should expect to have the same midwife throughout pregnancy.

Recommendation 6:

- Education intervention – the important implication for midwifery and nursing practice when developing education interventions for this population is that it may not be appropriate to implement “One Size Fits for All” programmes.

10.6 Strengths and limitations of this study

The section focuses on the strengths and limitations of this study. The following discussion will help develop a critical understanding of the findings in this study. The first part presents the strengths followed by the study limitations in part two of this section.

10.6.1 Strengths

Method: This study employed a pragmatic approach using a sequential, exploratory, mixed-method design. The advantages for using this approach were that the qualitative data and their subsequent analysis provide a general understanding of the research problem and

explore views in more depth. However, the quantitative data provided statistical results for large numbers of participants. The main objective of using this approach in this study was to explore the access of Palestinian women to MCH in the UK and the use they make of these services. Obtaining a more comprehensive understanding about the topic and increasing the validity of the research results, particularly since the qualitative and quantitative phases are complementary to each other, was valuable.

In this study, qualitative, in-depth interviews were used first to provide an initial and in-depth understanding about this topic. This approach is particularly useful in discovering the main barriers and facilitators in using the healthcare services and generating the traditional cultural influences on Palestinian women using MCH services, which have not been identified in previous research. Moreover, it helped to identify the dynamic connection between the themes identified and to understand the interrelationships between the factors identified in the quantitative survey. Using a quantitative survey in the second phase, the associations between demographic data of participants and survey scale items were identified, which helped to further the understanding of the main factors that affect Palestinian women in using healthcare services.

Comprehensive and adequate sample size: Participants were recruited from Palestinian organisations in different research locations in the UK. In the first phase of the study, several approaches were used to recruit Palestinian women from Arabic schools and Mosques using purposeful and snowball sampling and this was appropriate in this study. Twenty two Palestinian women having various demographic characteristics participated in these qualitative interviews.

In the second phase of study, consecutive and snowball sampling were used and this was deemed suitable in this phase. Respondents were recruited in the UK via Palestinian organisations mainly from Manchester and London. Due to the limited numbers of Palestinian organisations, all of them were involved in the study. All of these organisations took part in this survey except for only one school in Manchester. The researcher dealt with participants as a homogenous group regardless of their religion. The number of Christian participants was four and one considered herself an atheist.

Moreover, during data collection the researcher visited the research settings regularly in order to keep in touch with participants and address any concerns by doing short presentations about the study, which it was felt helped to increase the response rate. The Palestinian diaspora was mentioned in the introduction chapter and the political situation is the main reason for immigration to the UK from their home country. Therefore, the researcher emphasised that participation in this study was quite unrelated to any political issues and gave participants the opportunity to ask questions. Potentially this motivated participants to complete and return the questionnaire. Additionally, regular attendance at the research settings enabled the researcher discover other methods to recruit the participants. For example, during a visit to a Mosque in London the researcher discovered that Palestinian women preferred to pray at home, therefore, a gym building and a forum were the most likely places to recruit participants, in contrast to the Manchester Mosque, where the researcher recruited many participants through the Mosque. As mentioned in chapter one, the religion in Palestine includes Muslim and Christian. In order to have a representative sample the sample should include participants from both religions. Therefore, snowball sampling was used to recruit the participation of non-Muslim women; the researcher knew one Palestinian Christian woman in the UK and asked her to send the invitation letter and questionnaire by email to all other Palestinian Christian women. In future, research could seek to use a booster sample of Christian women. The aim of this type of sample is to increase the number of participants for a particular subgroup in order to obtain more information on this population than would be available from the main sample (Clark & Leven, 2002).

Finally, various methods were offered to complete the questionnaire, such as handing it to the head of the school or forum, sending it back by prepaid envelope or filling in the questionnaire on line and send it back by email. This was felt to help increase response rate.

The sample size of earlier qualitative studies, which examined the use of MCH in the UK among women from BME groups, ranged between 8 (Straus *et al.*, 2009) and 34 participants (Straus *et al.*, 2009; Puthussery *et al.*, 2010). Therefore, the sample size for the qualitative phase of this research fits well with previous studies. However, a comparison of the sample size for the quantitative phase of this research to the existing quantitative literature, may suggest that the current study has a low sample size. On the other hand, previous mixed-methods studies of BME groups use of NHS services were 11 and 20 in the qualitative phase; and 147 and 20 for the quantitative survey (Ahmed *et al.*, 2010; Aung *et al.*, 2010).

Therefore, in the current study, having 22 participants in the qualitative phase and 237 participants in the quantitative phase is acceptable, considering that the target population was difficult to reach. A variety of strategies were employed to ensure a high response rate, which has been discussed (see section 7.5). In order to ensure women with a wide range of characteristics were recruited in this survey, a series of strategies had been evolved, as discussed in Chapter 7.

Researcher experience: The researcher had personal experience of using MCH services in the UK before and during the data collection phase. This gave insight for her to understand participants' words and feelings, which contributed to decreasing the risk of any misinterpretation. Ashworth (1986) emphasised that rich previous understanding will help to quickly apprehend a relevant idea. Using both Arabic and English languages in the interview had a positive effect. This helped to obtain in-depth information and established a good relationship that helped the women to talk freely. Silverman (1993) pointed out that building a rapport helps women to feel comfortable and able to talk. The researcher felt that it was beneficial being an insider of this group, in terms of having experience of MCH services in the UK, the ability to use Arabic and being empathetic as a woman from the same culture. All this helped to facilitate a deeper understanding of the dialogues and gain an insight into the experiences which motivated them. However, it is acknowledged that being an insider can have limitations, such as assumptions being made during data analysis about meanings and interpretation. This was minimised through reflexivity (see section 5.7.2) and by discussing the findings with the researcher's supervisory team and other researchers.

10.6.2 Limitations

Selection bias: As mentioned earlier, no sampling frame was available from which to select Palestinian women of reproductive age. Therefore, non-probability sampling and consecutive sampling were used in the second phase of this study. The sample was selected from Palestinian organisations in the UK. By using this approach, selection biases may exist and the sample may not be representative of all Palestinian women in the UK. Nevertheless, snowballing sampling was used to help overcome this bias. Moreover, the vast majority of responders were from London and Manchester compared with responders from other UK regions. This is simply explained since most Palestinian people in the UK are concentrated in these two big cities. This is gleaned from anecdotal evidence.

Translation: All documents were presented in English and Arabic languages in the first phase of the study (that includes the information sheet, consent form, interview schedule, demographic information sheet and point of contact for women who may have felt distress following the interview) and the survey questionnaire in the second phase of the study. To ensure the rigor of the research and avoid bias, the researcher translated all documents herself and asked opinion and feedback from independent colleagues in Palestine and the UK. These colleagues are bilingual and read and speak both English and Arabic fluently. Moreover, they have experience in research. The researcher also participated in informal group meetings at Manchester Metropolitan University to improve her skills of translation and overcome the difficulty of the translation process, especially the cultural issues (cultural knowledge).

NVivo programme: The researcher faced numerous technical problems in using the NVivo 9 computer programme; for example, it is not designed for the Arabic language. Therefore, the coding process was done using audiotapes instead of transcripts. This was helpful; the researcher heard the verbal and could infer the nonverbal information from the tone of the voice during the interview.

Building instrument tool: The researcher needed to decide which data to use from the qualitative phase to build the quantitative instrument and how to use these data to generate quantitative measures. The researcher found all the qualitative items interesting and important but it was challenge to develop a questionnaire which included all this information whilst remaining a meaningful size. Therefore, the researcher used her own experience either as a member of the health profession or as a client in using healthcare services in both countries. In addition, critical discussions with her supervisors helped with this issue.

10.7 Plan for Dissemination of Findings

The findings of this study will be accessible to Palestinian organisations and people linked to the study. This will be achieved by distributing flyers, newsletters and posters in places which have a large concentration of Palestinian population, such as Arabic schools and forums. Furthermore, writing academic journal articles is another way of disseminating this research to other researchers and health professionals. The researcher has presented two papers at the Research Institute for Health and Social Change 9th Annual Conference, Manchester (see Appendix 1.1) and an article has been published in the British Midwifery Journal (see

Appendix 9.1). The researcher plans to participate in a mixed method conference in June/2014 in USA, as well as to publish an article in a Mixed Methods Research journal.

10.8 Summary

A pragmatic approach has been used in this study to investigate the access to, and use of, healthcare services, particularly maternal and child healthcare, in the UK by Palestinian women. An exploratory, sequential, mixed-method research design was employed in this study, which combined qualitative interviews with a quantitative questionnaire survey.

The exploratory, sequential, mixed-method design helped to obtain a comprehensive understanding of the research topic. Both phases in this study were complementary to each other and provide stronger evidence for a conclusion. Most of the findings from the first phase of the study were confirmed in the second phase but a few differences in findings existed and that helped to understand specific research issues more deeply and make it feasible to conduct a synthesis of the main findings from the two phases.

This study is the first of its kind, especially since the literature review revealed that no studies about Palestinians as a minority ethnic group in the UK were known. Palestinian women shared some characteristics with other BME groups, but their needs are different. This study increased knowledge and understanding about how Palestinian women access and use maternal and child healthcare services in the UK. This study provides an insight into the potential barriers and facilitating factors that contribute to using this service.

This study has achieved the original aims of this research. The overall aim of this research was to investigate and explore the access to, and use of, health services, particularly maternal and child healthcare (MCH), in the UK by Palestinian women (see section 5.3). Based on the findings from this exploratory, qualitative phase, a questionnaire was developed in phase two, to examine these findings in relation to a larger population of Palestinian women in the UK.

The following specific aims were achieved for phase two (see section 7.1):

- 1- Investigate the access to, and use of, health services particularly maternal and child healthcare, in the UK by Palestinian women
- 2- Examine the facilitators of, and barriers to, the health care of Palestinian women and their children in the UK.

- 3- Determine the existing provisions which are intended to facilitate access to healthcare services.
- 4- Make recommendations for improving health service provision for Palestinian women in the UK.

There are differences in the culture and healthcare system services between the UK and Palestine. Therefore, the knowledge regarding the system and the expectations are diverse. The study findings confirmed that Palestinian culture has a significant effect on how Palestinian women access and use MCH services. This includes using herbal medicine; using self-prescribed medication; preference for a female caregiver; refusing to terminate pregnancy and a belief in destiny and fate (fatalism). On the other hand, the findings underlined other variables such as the knowledge of the UK health system and communication skills as signs of confidence in English language skills. The findings underscored that screening tests should be offered to Palestinian women as early as possible before the 16th week of gestation to help her make a right decision based on their own belief about termination.

The MCH services should be flexible and culturally competent, not based on the assumption of homogeneity. The gap between theory and practice for NHS protocols should be addressed, such as access to interpreter services and further research should be carried out relating to overcoming barriers to the provision of such a services. Finally, it is crucial for healthcare professionals to apply certain strategies to tackle potential barriers and the fostering of facilitating factors that contribute to increasing the effective use of MCH services and decreasing the inequity in healthcare services.

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Appendices

Appendix 1: Conference papers - Research Institute for Health and Social Change 9th Annual Conference

Seminar Session 2.1

Methodological challenges in conducting Sequential Exploratory Mixed Methods research

Eman Alshawish

Nursing

Manchester Metropolitan University

eman.alshawish@stu.mmu.ac.uk

Abstract

This paper will explore the challenges that one researcher faced when undertaking a mixed methods research project as part of her PhD. From reviewing the literature, there is ambiguity in using and applying a sequential exploratory mixed method design, with a paucity of exemplars available. This lead to many challenges for the researcher in relation to applying this methodology to research practice. Therefore, the purpose of this presentation is to discuss and clarify the design, procedures, rationale, strengths and challenges of using this approach; in so doing a specific example of the application of this model for other researchers will be provided.

The development of the mixed methods approach began in the 1980s; the researchers at that time began expressing concerns about the mixing of quantitative and qualitative data without providing defensible reasons (Greene et al., 1989). Subsequently, many scholars began identifying a number of rationales for combining the data-collection methods and research questions (these being for initiation, expansion, development, triangulation and complementary) particular to different mixed-method research designs (Greene et al., 1989). According to Tashakkori & Teddlie (2010) one key design issue in developing and implementing mixed-methods research is whether data collection is to be parallel or sequential. The major categories of sequential design are either explanatory, exploratory or transformative (Johnson et al., 2007).

Creswell & Plano Clark (2007a: 86) explained the sequential, exploratory, mixed-method design as: *“one phase is followed by another phase, the first phase is qualitative, the two phases are connected by the development of an instrument based on the results of the first phase, and the intent is to develop and implement an instrument on the topic of interest, then the choice of design is the Exploratory Design–instrument development model”*.

The key issue in what Creswell & Plano Clark (2007b) mention in using this approach is the emphasis and priority on the second phase of study (quantitative phase), while the qualitative phase plays a secondary role. The main challenges are (i) resources (ii) teamwork (iii) sampling issues (iv) analytic and interpretive issues (v) page and word limitation.

The aim of my study was to examine how Palestinian women access and use MCH services in the UK. The study used both qualitative and quantitative research methods; it started with qualitative in-depth interviews, with the findings from this stage being used to develop a quantitative questionnaire survey to investigate the research question. Both phases of the study were complementary to each other. Every stage of research has its own data collection, analysis and discussion.

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Seminar Session 2.2

Access to, and use of, maternal and child healthcare (MCH) services in the UK by Palestinian women

Eman Alshawish

Nursing

Manchester Metropolitan University

Abstract

Introduction: The UK has a relatively large and increasing Black and Minority Ethnic (BME) population. It is acknowledged that this group have until now experienced poorer health, and that there have been barriers for them accessing certain services. There are an increasing number of women from Palestine currently living in the UK. Their use and access to MCH services has not been investigated before. From an initial review of the literature there does not appear to be any research which has examined this issue. This study would address these gaps and explore the access and use of MCH services by Palestinian women in the UK. The purpose of this presentation is to present the qualitative findings of my PhD research and the key implications for practice.

Aim: The overall aim of the study is to investigate the access to and use of MCH in the UK by Palestinian women. The specific objectives will be: to explore facilitators and barriers to care for Palestinian women in Manchester; To determine what provision exists which are intended to facilitate access to healthcare services; To explore factors that may demonstrate effective and positive change to health services and to make recommendations for improving the health service provision for Palestinian women in the UK.

Methodology: The study was designed as a sequential exploratory mixed method design using a pragmatic approach.

First phase - twenty-two, in-depth, face-to-face interviews were conducted using semi-structured interviews. **Second phase**- survey questionnaires were distributed through the Palestinian organisations to generalise the qualitative findings and 243 questionnaires were returned from responders.

Findings: Four themes emerged from the findings of the qualitative interview, which were: 'cultural variations'; 'knowledge of the NHS and the UK healthcare system'; 'healthcare services and their utilization, focusing on maternal and child healthcare services (MCH),' and 'communication, information provision and needs'. The quantitative findings focused on issues specific to Palestinian women, although they might resonate with other BME groups. These include: cultural variation such as herbal medicine; self-prescribed medication (antibiotics), termination of pregnancy (fatalism), circumcision for male babies, breastfeeding practice and preference for a female GP and caregiver; knowledge of the UK health system; confidence in English language; interpreter services; late booking of pregnancy; not attending antenatal classes; duration of visit time and information needs. Examining of new born by midwife and bathing a newborn. In addition, dissatisfaction with the bathing of a newborn baby and examining the newborn by the midwife are issues raised in this research.

Conclusion: This study strives to reduce inequalities in MCH among BME groups in the UK by highlighting the issue surrounding Palestinian women's access to, and use of, MCH services. It is important to have a culturally sensitive MCH service that is flexible, adequate and accessible. The study concluded with the following recommendations:

- Interpretation services should be provided to Palestinian women who have the need. Midwives or nurses should provide oral explanations as well as leaflets to allow patients a full choice when making a decision.
- Culturally appropriate care could be satisfactorily achieved through effective and continuous training programmes based on culture, ethnicity and religion for all health professionals, in order to understand patient needs.

An important implication for midwifery-nursing practice is that when developing education interventions for this population it may not be appropriate to implement a "One Size Fits All" programme.

Appendix 3. 1: Web sites

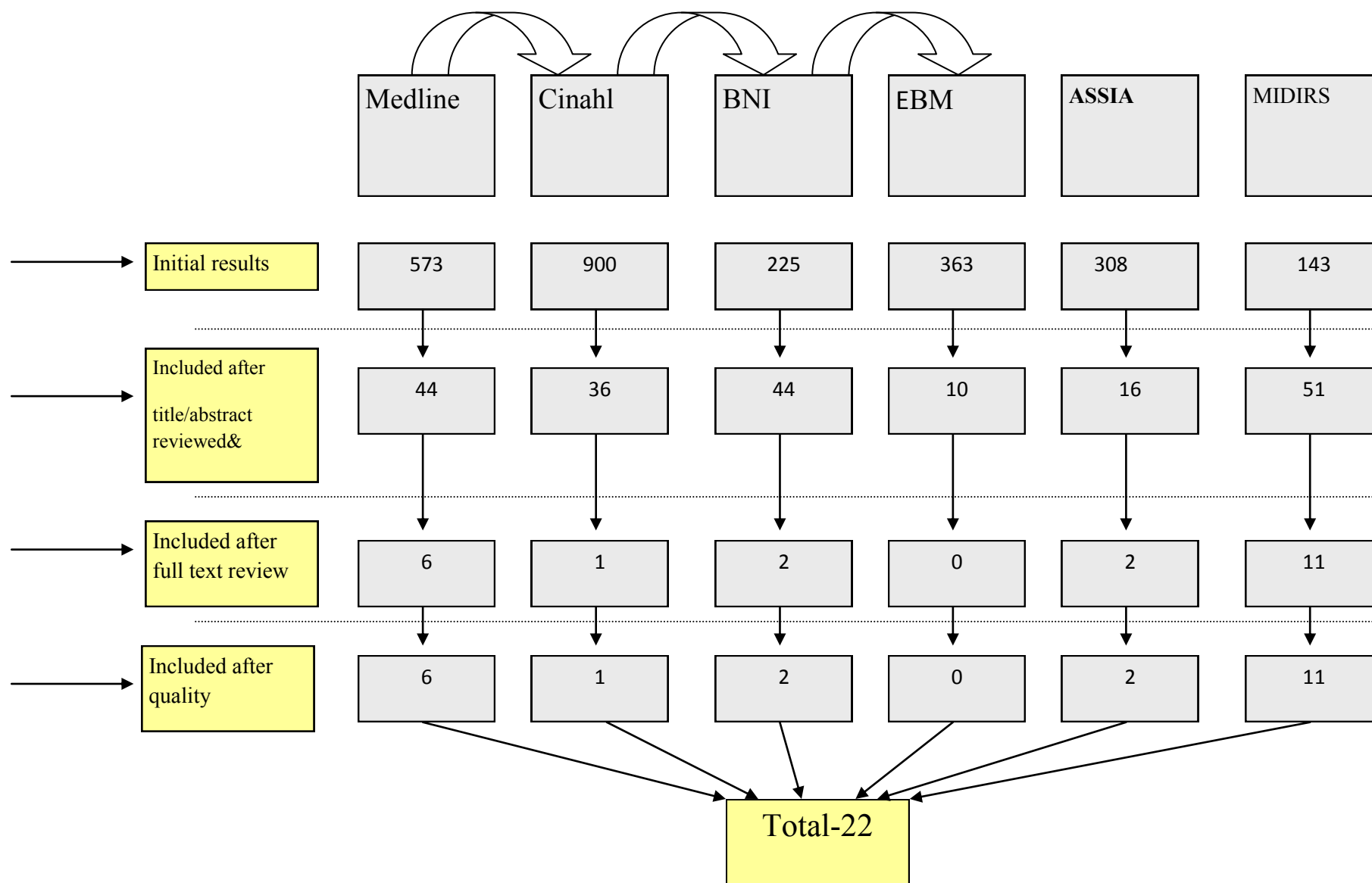
- Sure Start www.surestart.gov.uk
- <http://www.better-health.org.uk/>
- <http://www.ic.nhs.uk/pubs/hse04ethnic>
- Cochrane Library www.nelh.nhs.uk/cochrane.asp
- Birthchoice UK www.birthchoiceuk.com
- National Screening Committee www.nsc.nhs.uk Provides guidance and recommendations on antenatal screening

- Healthcare Commission www.healthcarecommission.org.uk Statutory organisation inspecting health bodies and recommending improvements,
 - including investigations into maternity care at North West London Hospitals,
 - Wolverhampton Hospitals and Ashford and S Peter's Hospital.

- National Institute for Health and Clinical Excellence (NICE) www.nice.org.uk
 - Publication of evidence-based guidance on elements of maternity care and
 - Intervention

- CEMACH – Confidential enquiry into maternal and child health www.cemach.org.uk Report and research published annually providing pointers to systems failings in maternity care, together with positive initiatives
- Department of Health www.dh.gov.uk
- Birthchoice UK www.birthchoiceuk.com Helping women to choose where to have their baby through information, links and statistics
- MIDIRS Informed choice leaflets www.infochoice.org/ Evidence-based leaflets produced in collaboration with the NHS Centre for Reviews and Dissemination. (2003)
- Royal College of Obstetricians and Gynaecologists www.rcog.org.uk Various guidance including “Towards safer childbirth: minimum standards for the organisation of labour wards”, “National Caesarean Section Audit”
- National Childbirth Trust www.nctpregnancyandbabycare.com/nct-online Various publications and support materials for user reps and health professionals including Modernising maternity care -a commissioning toolkit for primary care trusts in England. Better Birth Environment – Survey and toolkit
- Cochrane Library www.nelh.nhs.uk/cochrane.asp
- <https://www.npeu.ox.ac.uk/files/downloads/reports/Maternity-Survey-Report>

Appendix 3. 2: Literature Review flow chart



Appendix 3. 3: Hawker’s assessment tool- Critical Appraisal of Key Articles

Hawker *et al*’s tool- Assessment Form 1: Reject/Accept

Author(s): Date of Publication:

Abbreviated Title:

Relevance to Research Questions

- ☐ Does it address access to healthcare?
- ☐ Does it address maternal and/or child health services?
- ☐ Does it address ethnic minority groups?

Source of Data

- ☐ Professionals
- ☐ Patients
- ☐ Carers
- ☐ Researcher (observational)

Study Type: - (ring)

- [1] Empirical study—Peer reviewed
- [2] Theoretical paper—Peer reviewed
- [3] Research paper—Non-peer reviewed
- [4] Theoretical paper—Non-peer reviewed
- [5] Professional document
- [6] Case study
- [7] Service Evaluations
- [8] Other

Comment:

Author and title: _____

Date: _____

	Good	Fair	Poor	Very Poor	Comment
1. Abstract and title					
2. Introduction and aims					
3. Method and data					
4. Sampling					
5. Data analysis					
6. Ethics and bias					
7. Findings/results					
8. Transferability/generalisability					
9. Implications and usefulness					

Total: _____

Criteria for table

1. Abstract and title: Did they provide a clear description of the study?

Good: Structured abstract with full information and clear title.

Fair: Abstract with most of the information.

Poor: Inadequate abstract.

Very Poor No abstract.

2. Introduction and aims: Was there a good background and clear statement of the aims of the research?

Good: Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions.

Fair: Some background and literature review. Research questions outlined.

Poor: Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background.

Very Poor: No mention of aims/objectives. No background or literature review.

3. Method and data: Is the method appropriate and clearly explained?

Good: Method is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording.

Fair: Method appropriate, description could be better. Data described.

Poor: Questionable whether method is appropriate. Method described inadequately. Little description of data.

Very Poor : No mention of method, AND/OR Method inappropriate, AND/OR No details of data.

4. Sampling: Was the sampling strategy appropriate to address the aims?

Good: Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained.

Fair: Sample size justified. Most information given, but some missing.

Poor: Sampling mentioned but few descriptive details.

Very Poor: No details of sample.

5. Data analysis: Was the description of the data analysis sufficiently rigorous?

Good: Clear description of how analysis was done. Qualitative studies: Description of how themes derived/respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.

Fair: Qualitative: Descriptive discussion of analysis. Quantitative.

Poor: Minimal details about analysis.

Very Poor: No discussion of analysis.

6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

Good: Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed.

Bias: Researcher was reflexive and/or aware of own bias.

Fair: Lip service was paid to above (i.e., these issues were acknowledged).

Poor: Brief mention of issues.

Very Poor: No mention of issues.

7. Results: Is there a clear statement of the findings?

Good: Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.

Fair: Findings mentioned but more explanation could be given. Data presented relate directly to results.

Poor: Findings presented haphazardly, not explained, and do not progress logically from results.

Very Poor: Findings not mentioned or do not relate to aims.

8. Transferability or generalizability: Are the findings of this study transferable (generalizable) to a wider population?

Good: Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).

Fair: Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.

Poor: Minimal description of context/setting.

Very Poor: No description of context/setting.

9. Implications and usefulness: How important are these findings to policy and practice?

Good: Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.

Fair: Two of the above (state what is missing in comments).

Poor: Only one of the above.

Very Poor: None of the above.

Appendix 3. 4: Data extraction sheet

Reference number							
Appriaisal tool score:							
Title:							
Author:							
Database:							
Year:		Vol:		Issue:		Pages:	
Design							
Paradigm							
Methodology							
Data collection methods							
<u>Sample</u>							
Method							

Number/Attrition	
Setting	
Inclusion/exclusion criteria	
Characteristics of sample	
<u>Statistics</u>	
Which statistical tests were used?	
Details:	

Summary	
Author conclusions	
My conclusions	
Endnote summary	
Implications for practice	

Appendix 5. 1: Ethical Approval Reports

MANCHESTER METROPOLITAN UNIVERSITY
FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

M E M O R A N D U M

FACULTY ACADEMIC ETHICS COMMITTEE



To: Mrs Eman Alshawish (MMU ID 11501575)

From: Prof Carol Haigh (Chair, Ethics Committee) cc Emma Reilly

Date: 01 February 2012

Subject: Ethics Application 1137

Title: Access to and use of healthcare services by Palestinian women in the UK. Focusing on Maternal and Child Healthcare Services

Thank you for your application for ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your ethics application.

We wish you every success with your project.

A handwritten signature in blue ink, appearing to read "Prof Carol Haigh and Prof Jois Stansfield".

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

School of Nursing, Midwifery and Social Work
The University of Manchester
Jean McFarlane Building
Oxford Road
Manchester
M13 9PL

tel: +44 (0)161 306 0260
fax: +44 (0)161 306 7707
www.manchester.ac.uk

Our Ref: HS/MH

Mrs E Alshawish
PhD Student
School of Nursing, Midwifery & Social Work
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL

26 May 2010

By email and internal post.

Re: Access and use of healthcare services by Palestinian women in Manchester

Proposal Number: 10/1041/NMSW

Dear Mrs Alshawish,

Thank you for the clarifications and amendments to the above study as requested by the Research Ethics Committee.

I am of the opinion that no major concerns or objections are evident of an ethical nature. Therefore on behalf of the Committee and taking Chair's Action, I am happy to grant full ethical approval.

During the progress of the study please inform the Committee of any changes or amendments that may be necessary.

On completion of the study would you please provide the Committee with a "Completion of Study Report".

Direct Contact: Jean McFarlane Building, University Place

Howard Shilton
Tel: +44 (0)161 306 7642 Fax: 0161 306 7707
Email: Howard.Shilton@manchester.ac.uk

Appendix 5. 2: Study Protocol

Access to and use of healthcare services by Palestinian women in the UK

“Focusing on Maternal and child health services”.

I. Summary

The UK has a relatively large and increasing Black and Minor Ethnic (BME) population. It is acknowledged that this group have until now experienced poorer health, and that there have been barriers for them accessing certain services (Szczepura, 2005). There are an increasing number of women from Palestine currently living in the UK. Their use and access to MCH services has not been investigated before. From an initial scoping of the literature there does not appear to be any research which has been examined this issue. The proposed research would address these gaps and explore the access to and use of MCH services by Palestinian women in the UK

II. Aim

The aim of the study is to investigate access to and use of health services by Palestinian women in the UK focusing on Maternal and Child healthcare services,

The specific objectives are:

- ☐ To examine the facilitators and barriers to the care of Palestinian women and their children in the UK.
- ☐ To determine the existing provisions which are intended to facilitate access to healthcare services (i.e. to map the resources available and to identify those which are used by Palestinian women).
- ☐ To examine factors that may demonstrate effective and positive change to health services.
- ☐ To make recommendations for improving health service provision for Palestinian women in the UK.
- ☐ To investigate Palestinian women’s views about the maternal and child healthcare services in the UK.

III. Background

The UK has a relatively large and increasing Black and Minor Ethnic (BME) population. It is acknowledged that this group have until now experienced poorer health, and that there have been barriers for them accessing certain services (Szczepura, 2005). A major challenge for clinicians, managers, and policy makers in the coming decades in the UK is to ensure equitable access to health care services for all groups, including BMEs. This challenge was emphasised following the implementation of the Race Relations Amendment Act (2000), which requires the NHS to examine and adapt services in order to ensure equitable access for local ethnic minority populations (Szczepura, 2005). This agenda addresses the causes of ill-health, including inequalities and social exclusion. The concept of social exclusion includes economic and psychological isolation (Department of Health, 1998).

Maxwell identified four important components to ensure quality services. These are accessibility, social acceptability, availability and appropriateness (Maxwell, 1984). In 1996 the NHS guide recommended the following steps to improve the health services for ethnic minorities: awareness, understanding, people involvement and active group commitment (National Health Services, 1996). Importantly, the client was considered to be central to the process. Also, it is important for community health workers to have a good understanding of the demographic and social characteristics of particular ethnic groups so as to improve their practice (Chan, 2000). Sheikh recently found that it was difficult to measure progress in this area due to insufficient national data on access to services by various groups (Sheikh, 2009). Data about differences in health status among ethnic groups in the UK are limited and patchy, and in some cases data on certain ethnic groups is extremely limited, for example Irish and Chinese groups (Smith, 2000). Since 1984 the concept of equity of access to health care has been an important buttress of the UK National Health Service (Goddard and Smith, 2001).

In the 2001 census there were 392,819 people in Manchester, with people with BME groups comprising 19% of the population, an increase from 12.6% in 1991. The Palestinian population is classified under 'other Asian group', which accounts for 0.8% (3,302) of the total population. People from these ethnic minorities are more youthful in age structure than the majority population, which means that ethnic minority population growth will increase over the coming years (Manchester City Council, 2001). However, the information about certain ethnic minority groups, such as asylum seekers, is poorly recorded and difficult to find in sources such as the

census and other national datasets (Szczepura, 2005). It was estimated in 2006 that 190 million people were living outside of their country, and in 2005 the UK hosted 270,000 refugees (Birgit et al., 2007). Globally, women make up approximately 70-80% of the total migrant population. These facts suggest that maternal and child healthcare provisions are essential for ethnic minorities. It is known that the maternal mortality in the UK is higher among these groups than among white native women (Birgit et al., 2007).

In overview then no previous study has focused on this specific group, and their needs may well differ from those of other minor groups. Whilst the current numbers of Palestinian women in Manchester are relatively small, the numbers overall in the UK are larger and growing.

IV. Plan for investigation

1. Study Design:

A sequential mixed method research design, which contained qualitative in-depth interviews with a quantitative questionnaire survey, will be used in this study (Tashakkori & Teddlie, 2003). This helped to increase the validity of the study findings and generalize the results. The aim of the first phase of the study is to investigate the access to, and use of, health services, particularly maternal and child healthcare, in the UK by Palestinian women. Based on the findings from the qualitative phase, an instrument will developed to examine this result with a larger population of Palestinian and British women in the UK. The aim of the second phase of the study is to examine the findings of the first phase of the study and then to generalise the results. A Liker Scale questionnaire was developed based on the in-depth interviews results from the first phase. A pilot study will be conducted to evaluate these questionnaires. A cross sectional survey will be conducted using e-mail and the postal services to send the questionnaire to potential Palestinian respondents in three cities in the UK: London, Manchester and Birmingham.

2- Sample- for first phase of study- qualitative In-depth interview:

Qualitative sampling usually requires a flexible pragmatic approach (Marshall, 1996). Hence the number up to 60 women eligible to participant, we estimate to have 20-35 women because some women may refuse to participate. They will select through different approaches, with the final number being determined by data saturation (Morse, 1995; Guest et al., 2006). Two approaches to sampling will be used (Marshall, 1996). Firstly, a convenience sample of women who have children in one of three Arabic schools in Manchester. Secondly, the snowballing technique will

be used to identify other Palestinian women living in Manchester, through contacts at the relevant schools and the Arabic Mosque.

For second phase of study - survey questionnaire:

The target population in this survey is Palestinian women aged 18 years and above living in the UK and this is consistent with the target population in the first phase of the study. In the lacking of a fitting sampling frame covering the whole community consecutive sample will be preferred. In other ward, it is impossible to identify all eligible Palestinian women in the UK. Therefore, a pragmatic approach in sample selection was followed and consecutive sample favoured. Consecutive sampling is considered as best of all non- probability sampling technique. It is a strict version of convenience sampling. It means to include all available subjects over a specific time period that makes the sample a better representation of the entire population (Lunsford, 1995; Szczepura, 2005). As vast majority of women will be recruited via the email list of the Palestinian Council in London and Palestinian Conflict Society. Others will be recruited via post questionnaire through Arabic schools, Mosques and Palestinian forum. Women who are not on these lists will be less likely to become part of the study. Therefore, the snowball technique will also be used.

3. Data collection: The research requires data collection from maps, name address lists, time sheets, identity and visiting cards, letters of introduction and leaflets about the study to leave with potential participants. In addition, the researcher should check the participants' name and address list (Bowling and Ebrahim, 2005). There are two phases to this study:

For first phase of study- Qualitative In-depth interview: Face-to-face interviews involve interviewing people in their own home or other sites, convenient to the participant. The duration of interview can range from few minutes to an hour or more. Semi-structured interviews using an interview schedule will be used. Demographic data will be collected using a standard demography protocol. The interview will provide an in depth understanding of personal opinions and expectations (Morgan, 1997). Once potential participants have been identified and they have indicated their willingness to be contacted, the researcher will contact the participants to arrange a suitable time and place (home or school) to interview the woman. A semi-structured topic guide will be developed which will provide the structure to the interview. This will assist with gathering the information in detail and keep the researcher within the context of study. The interview will be digitally recorded, with permission of the women, and it will take approximately one hour. The researcher will gain permission from the head manager and trustees to conduct the interviews in

the schools, if this is required. Before the interview, a full explanation of the study and an explanation of the consent form will be provided. Depending on the interviewee's preference, English and/or Arabic language will be used. The researcher will also conduct interviews with the teachers and other women in Didsbury Mosque in a similar way.

For second phase of study - survey questionnaire:

The duration of data collection will be for two months. The study will be conducted in three big cities in the UK. Once permission from the research settings (for example the Palestine Council in London, the Palestinian Forum that held in the Mosque, Arabic schools, and the Palestinian Conflict Society in three cities) and ethical approval from the Manchester Metropolitan University and NHS are obtained, the recruitments process will start.

First, the questionnaire, cover letter and information sheet about the study will be sent to participants via e-mail through the Palestinian Conflict Society and the Palestinian Council in London. From primarily contact, the Palestinian council email list contains few thousand Palestinian and British nationals, while Palestinian Conflict Society email list has few hundred.

Second, the questionnaire, cover letter and information sheet about the study will be sent to participants by post through the Arabic schools and the Palestinian Forum meeting that occur in the Mosque monthly. An introductory cover letter will explain the aims of the study, give notification of ethical approval, the time required for completion and clear instructions on how to complete and return the questionnaire. The respondents will be assured of the confidentiality and anonymity of their responses. After two weeks of sending the questionnaires and covering letter, a reminder will be sent to those who have not replied to the initial questionnaires. From primarily contact, there are around 150-220 students in each Arabic school in three cities, around ten percent of whom are Palestinian (detail information about location and exact number of school will provide later). The numbers of women who attend the Palestinian Forum meeting in the Mosque are around 20-25 in each city. The permission to conduct the studies in these locations will obtain from head of teacher, trustees, Imam, head of Palestinian Conflict Society and Palestinian Council.

4- Data analysis:

For first phase of study- Qualitative In-depth interview: data will be transcribed ad verbatim and analysed using framework analyses. The data will be coded and labelled during and after data collection (Spencer et al., 2003). The interviews can then be transcribed for data analysis.

The researcher will use framework analysis because this method is “suitable for systematically and comprehensively applying an analytic framework to a large quantity of qualitative data” (Yardley et al., 2006). Framework Analysis is suitable and useful in health services research (Thorne, 2000). The researcher will use NVivo as a computer programs for qualitative analysis to assist and organise the data. The data analysis requires three forms of activities: data management, descriptive accounts and explanatory accounts (Thorne, 2000). The researcher will follow the five stages of data analysis in the framework approach (Ritchie & Spencer, 1994): firstly, familiarisation and immersion in the raw data by listening to tapes, reading transcripts and studying notes in order to list key ideas and themes; secondly, identifying a thematic framework by identifying all the key issues, concepts, and themes by which the data can be examined and referenced; thirdly, indexing by applying the thematic framework or index systematically to all the data in textual form by annotating the transcripts with numerical codes from the index, usually supported by short text descriptors to elaborate the index heading; fourthly, charting, which is rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts (for example, there is likely to be a chart for each key subject area or theme with entries for several respondents); finally, mapping and interpretation, which involves using the charts to define concepts, map the range, create typologies and find associations between themes with a view to providing explanations for the findings. The process of mapping and interpretation is influenced by the original research objectives as well as by the themes that have emerged from the data themselves. (Pope et al., 2000; Ritchie et al., 2003; Spencer et al., 2003).

For second phase of study - survey questionnaire: SPSS will be used, data will be prepared for a four-step analysis: data checking, design of the database, data entry and data transformation. Several strategies will be followed to handle the data. For example, when the e-mail responses are received from participants, a specific number or coding will be given after the printing process. Also, a specific number will be assigned to a postal response so that it could be referred to again. Three main statistical approaches will be applied to this study. These are factor analysis, bivariate analysis and multiple regressions. Moreover, the demographic data will be analysed by calculating frequencies, percentage, mean and standard deviation.

Appendix 5. 3: Slip Letter - English

Form to be completed

“Access and Use of Healthcare Services by Palestinian women in Manchester”

I am interested in being contacted about the study “Access and use of healthcare services by Palestinian women in Manchester”

Your Name: _____

Your Home number: _____

Mobile No: _____

The best time to contact me is: _____

Please return this form in the stamped addressed envelope provided or to me at the following address:

Eman Alshawish

School of Nursing, Midwifery and Social Work

Postgraduate room 3rd floor 3.331

The University of Manchester

Jean McFarlane Building

Oxford Road

Manchester, M13 9P

Appendix 5. 4: Slip Letter - Arabic

نموذج للتعبئة

وصول و استخدام المرأة الفلسطينية للخدمات الصحية في مدينة مانشستر

أنا مهتمة ليتم الاتصال بي للمشاركة في دراسة " وصول و استخدام المرأة الفلسطينية للخدمات الصحية في مدينة مانشستر "

الاسم _____

رقم هاتف المنزل _____

رقم الموبايل _____

الوقت الأفضل للاتصال بي: _____

الرجاء إعادة هذا النموذج داخل المغلف المرفق وإرساله لي حسب العنوان المختوم عليه أو على العنوان التالي:

Eman Alshawish

School of Nursing, Midwifery and Social Work

Postgraduate room 3rd floor 3.331

The University of Manchester

Jean McFarlane Building

Oxford Road

Manchester, M13 9PL

Appendix 5. 5: Invitation Letter – English

School of Nursing, Midwifery and Social Work
The University of Manchester
Jean McFarlane Building
Oxford Road

Letter of invitation:

DATE 1-6-2010

Dear Madam

My name is Eman Alshawish from Palestine – Nablus. I am a lecturer at An Najah University-Nursing and Midwifery College. I am currently undertaking my PhD at the University of Manchester. My research study is exploring the access and use of health services by women from Palestine who currently live in the UK.

I would like to invite you, as a Palestinian woman living in Manchester, to assist me with my study. All that is involved is interviewing you at a convenient time and location about your experiences of health services in the UK. Please read the enclosed information sheet which will provide you with more information about the research study. I hope you will consider taking part in the research.

If you wish to take part in a face-to-face interview with me, please return the completed form to me using the enclosed stamped addressed envelope. I would be grateful if you could return this as soon as possible. If I do not hear from you within two weeks, I will send a reminder letter to you.

Thank you for considering taking part in this research. If you need any further information, please do not hesitate to get in touch with me.

I look forward to hearing from you.

With best wishes

Eman Alshawish

PhD Student

Appendix 5. 6: Invitation Letter - English

School of Nursing, Midwifery and Social Work

The University of Manchester

Jean McFarlane Building

Oxford Road

التاريخ: 2010-6-1

سيدتي العزيزة

أنا اسمي إيمان الشاويش- الجيوسي من فلسطين- نابلس اعمل كمحاضره في جامعه النجاح في كليه التمريض والقباله. وأنا أقوم حاليا بدراسة الدكتوراه في جامعه مانشستر. دراستي حول وصول و استخدام المرأة الفلسطينية للخدمات الصحية في مدينة مانشستر- المملكة المتحدة.

وأود دعوتكن كامراه فلسطينيه تعيشين في مدينه مانشستر مشاركتي بالدراسة. كل ما ينطوي عليه الأمر لمساعدتي هو إجراء المقابلة الفردية وذلك حسب المكان والزمان الملائم لك. والهدف هو معرفه خبرتك وتجربتك للخدمات الصحية المقدمة في المملكة المتحدة. اطلب من حضرتك قراءة ورقه المعلومات المرفقة – النشرة، والتي سوف تزودك بمعلومات حول البحث العلمي. وأتمنى أن تشاركني بالدراسه.

إذا كنت ترغبين بالمشاركة بالمجموعات البؤرية الرجاء إرسال ورقه النموذج باستخدامك المغلف الخاص المرفق. وكل الامتنان لك إذا تفضلتي و أرسلته بالسرعة الممكنة.

إذا لم اسمع منك في غضون أسبوعين سأقوم بإرسال رسالة تذكيره.

إذا كنت بحاجة للمزيد من المعلومات الرجاء عدم التردد والاتصال بي.

مع أطيب الأمنيات لكن والشكر الجزيل

إيمان الشاويش- الجيوسي

طالبه دكتوراه- جامعه مانشستر

Appendix 5. 7: Information sheet for In-depth Interview- English

Information Sheet: PhD Study on Access and Use of Healthcare Services by Palestinian women in Manchester

In-depth Interviews

I am undertaking a study of Palestinian women who are living in Manchester, UK . As part of my PhD study. I am looking into the experiences of Palestinian women in Manchester and how they access and use health services. It is important that I seek the views of individuals like yourself to learn more about your experience of UK health care services.

What is the purpose of the study?

The purpose of this study is to investigate access and use of health services. I am interested in looking of your experiences and opinions about the health services in the UK. By exploring and investigating the experiences of women using UK health services, I will be able to identify what has been good and what things need improvement. By learning more about your experience, I will be able to identify these improvements in services which need to be made. This study is being undertaken to obtain a PhD.

Why have I been chosen?

You have been chosen as you are a Palestinian woman who is currently residing in Manchester. Palestinian women are being identified through the Arabic schools and Mosques in Manchester. The study will invite approximately 60 participants to be interviewed.

Do I have to take part?

It is up to you to decide whether or not to take part in the study. If you decide to take part, please keep this information sheet and send the signed slip to me in the envelope provided. Once we have received your slip indicating your willingness to be contacted and contact details, I will get in touch with you to discuss the interview further with you and arrange a suitable time and convenient location to do the interview. You will still be free to withdraw from the study at any time without giving a reason.

What will happen to me if I take part?

The study involves an interview for one hour and it will be audio-recorded. At the beginning of the interview you will also fill in a one page questionnaire, which takes approximately 5 minutes to complete, which will just provide some background information. The interview will focus on your access and use of health services in Manchester, UK. We will ask you to considered what improvements you feel could be made to the health care services. I will also ask you to consider taking part in a second part to the study- joining a focus group to discuss these issues at a later

date. This is a separate part to the study and you can decide if you are interested in this after completing the initial interview.

What are the possible disadvantages and risks of taking part?

There are no direct risks; however, if you feel any distress, the interview will be stopped immediately.

What are the possible benefits of taking part?

There are no direct benefits to taking part in the study. However, we are hoping to identify what facilitators and barriers to care are experienced by Palestinian women living in Manchester and knowing about these may lead to positive changes to the health services in the future.

What happens when the research study stops?

When the study is finished, if you wish to receive a copy of the finding of the study, I will send you a summary.

What if there is a problem?

If you have any complaints or concerns about the research study you may get in touch with one of my supervisors on this number 0161-306-7865 or speak to the independent advisor Dr Cliff Richardson on this number 0161 306 7639

Will my taking part in the study be kept confidential?

All the information about your participation in this study will be kept confidential. No names will be used in the data and if any direct quotations are used these will be anonymised.

Contact details

The researcher who is undertaking the study is: Eman Alshawish, PhD Student. My supervisors for the study are Professor Chris Todd and Dr Gretl McHugh, from School of Nursing, Midwifery and Social Work, The University of Manchester. If there are any further questions you would like to ask about the study, please do not hesitate to contact me on: 0161-306-7869 or 07529755450.

Appendix 5. 8: Information sheet for In-depth Interview – Arabic

نشرة المعلومات: رسالة دكتوراة حول وصول و استخدام المرأة الفلسطينية للخدمات الصحية في

مدينة مانشستر

المقابلة الفردية

اقوم بعمل دراسة حول النساء الفلسطينيات اللاتي يقطن في مانشستر، المملكة المتحدة. كجزء من دراستي لرسالة الدكتوراة، اتطلع لمراقبة تجربة النساء الفلسطينيات في الحصول على الخدمات الصحية واستخدامها في مانشستر. انه لمن المهم ان نبحث حول تجربتك الخاصة كإمرأة في الحصول على خدمات الرعاية الصحية في المملكة المتحدة.

ما هو الهدف من الدراسة؟

الهدف من الدراسة هو تفحص الحصول والاستخدام لخدمات الرعاية الصحية. انا مهتمة بالنظر لتجربتك وارانكم حول خدمات الرعاية الصحية في المملكة المتحدة. بالتفحص والبحث حول تجربة النساء في استخدام الخدمات الصحية في المملكة المتحدة، سأتمكن من تحديد الجوانب الجيدة في الخدمات الصحية التي تلقينها والجوانب الاخرى التي بحاجة لتطوير. بالتعلم اكثر عن تجربتكم، سيكون بإمكانني تحديد الجوانب التي بحاجة لتطوير في الخدمات الصحية. سأقوم بعمل هذه الدراسة للحصول على درجة الدكتوراة.

لماذا تم اختياري؟

تم اختيارك كونك امرأة فلسطينية تقطنين حاليا في مانشستر. يتم التعرف على النساء الفلسطينيات من خلال المدارس العربية والمساجد في مانشستر. سيتم دعوة 60 مشاركة للمقابلات الفردية.

هل من الواجب علي المشاركة؟

القرار يعود لك بالمشاركة او عدم المشاركة في المقابلة الفردية. اذا قررت المشاركة، الرجاء الاحتفاظ بهذه النشرة وارسال ورقة الموافقة المبدئية لي موقعة في الظرف المرفق. عند استلامنا لورقة الموافقة التي تشير لرغبتك بالمشاركة سأقوم بالاتصال بك للاتفاق حول الوقت والمكان المناسبين لك لاجراء المقابلة. ولك الحق بالانسحاب من الدراسة في أي وقت تشائين ومن غير ابداء اية اسباب.

ماذا سيحدث لي ان قررت المشاركة؟

تتضمن الدراسة مقابلة لمدة ساعة وسيتم تسجيلها صوتيا. في بداية المقابلة سنطلب منك تعبئة استبيان من صفحة واحدة والذي سيستغرق 5 دقائق لتعبئته. هذا الاستبيان سيزودنا بمعلومات عامة عنك. ستركز المقابلة على حصولك واستخدامك للخدمات الصحية في مانشستر. سنطلب منك ابداء رأيك حول التحسينات اللازمة للخدمات الصحية. وسنطلب منك كذلك المشاركة في المجموعات البؤرية في يوم اخر كمرحلة ثانية لاحقة من الدراسة. هذا الجزء يعتبر جزءا منفصلا عن الجزء الثاني من الدراسة ولك ان تقرري المشاركة في الجزء الثاني بعد الانتهاء من المقابلة.

ما هي الجوانب السلبية والمخاطر التي تحملها المشاركة في الدراسة؟

لا يوجد اية مخاطر مباشرة تذكر، الا انه في حال شعورك بعدم الارتياح سيكون لك مطلق الحرية لمغادرة المجموعة البورية في أي وقت.

ما هي الميزات المحتملة للمشاركة؟

لا يوجد ميزات مباشرة للمشاركة في الدراسة. لكننا نأمل في التعرف على المسهلات والمعيقات الصحية التي تواجهها النساء الفلسطينيات اللاتي يقطن في مانشستر. وهذا سوف يساعد في احداث تغيير ايجابي للخدمات الصحية في المستقبل

ماذا سيحدث عند انتهاء الدراسة؟

عند انتهاء الدراسة، اذا رغبت في الحصول على نسخة من نتائج الدراسة، سأقوم بتزويدك بملخص حول النتائج.

ماذا ان كان هناك أي مشكلة؟

اذا كان لديك أي شكوى او قلق ما بشأن الدراسة، بإمكانك الاتصال بمشرفي الرسالة على الرقم التالي: 0161 306 7865، او التحدث للناصح الاكاديمي الخاص بي الدكتور كلف رتشاردسون على الرقم التالي: 0161 306 7639.

هل مشاركتي بالدراسة ستكون محاطة بالسرية؟

جميع المعلومات حول مشاركتك في هذه الدراسة ستعامل بسرية تامة. لن يتم استخدام الاسماء في البيانات واية اقتباسات مباشرة من كلام المشاركات سيتم التعامل معها بطريقة مناسبة وبدون ذكر الاسماء.

للاتصال بنا

الباحثة المسؤولة عن الدراسة هي: ايمان الشاويش، طالبة دكتوراة. مشرفي الرسالة هم: البروفيسور كريس تود والدكتورة جرتل ماكهيو من كلية التمريض والقبالة والبحث الاجتماعي في جامعة مانشستر. ان كان لديكم أية اسئلة اضافية حول الدراسة، لا تتردد بالاتصال بنا على الارقام التالية: 0161-306 7869 او 0752975545

Appendix 5. 9: Consent form for In-depth Interview- English

School of Nursing, Midwifery and Social Work

The University of Manchester

Jean McFarlane Building

Oxford Road

Manchester, M13 9PL

Participant Identification Number for study:

CONSENT FORM: In-depth interview

Access and Use of Healthcare Services by Palestinian women in Manchester

Name of Researcher: Eman Alshawish, PhD student

Please initial box

1. I confirm that I have read and understand the information sheet dated 10th May 2010 (version 5) for the above study. I have had the opportunity to consider the information and ask questions. If I have asked questions they have been answered satisfactorily.

2. I understand that my participant is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand the interview will be audio- recorded and transcribed.

4. I understand that relevant sections of my interview and data collected during the study, may be looked at by another researcher from the University of Manchester. ☐
5. I understand that data may be used in the future for other studies. ☐
6. I confirm my permission to use anonymised quotations and data to publish in journals. ☐
7. I agree to take part in the above study. ☐

Name of Participant_____ Signature_____ Date_____

Name of Researcher: Eman Alshawish Signature_____ Date_____

Appendix 5. 10: Consent form for In-depth Interview- Arabic

School of Nursing, Midwifery and Social Work

The University of Manchester

Jean McFarlane Building

Oxford Road

Manchester M13 9PL

Participant Identification Number for study:

نموذج الموافقة: المقابلة الفردية

وصول و استخدام المرأة الفلسطينية للخدمات الصحية في مدينة مانشستر

اسم الباحثة: ايمان الشاويش، طالبة دكتوراة

1. أقر انني قرأت وفهمت نشرة المعلومات المعدة بتاريخ 15 نيسان 2010 (النسخة الخامسة) للدراسة بالعنوان اعطيت لي الفرصة للاستفسار وطرح الاسئلة حول الدراسة. اذا كنت قد طرحت اية اسئلة، فقد تمت اعلاه الاجابة عليها جيدا.

2. اعرف ان مشاركتي تطوعية ويمكنني الانسحاب في أي وقت وبدون ابداء اسباب، حتى وان لم يكن هناك أي ضرر للصحة او تجاوز لحقوقي.

3. اعرف ان المقابلة سيتم تسجيلها صوتيا وتوثيقها كتابيا.

4. اتفهم ان اجزاء من نقاشات المجموعة البؤرية والبيانات التي تم جمعها في هذه الدراسة من الممكن ان يتم الاطلاع عليها من قبل باحثين اخرين في جامعة مانشستر.

5. اعرف ان البيانات من الممكن ان يتم استخدامها في دراسة تحليلية لاحقا.

6. أوكد تصريحى لاستخدام اقتباسات ومعلومات من حديثى تحت اسم مجهول فى المجلات العلمية.

7. اوافق على المشاركة فى الدراسة ذات العنوان اعلاه.

اسم المشاركة: _____ التوقيع: _____ التاريخ: _____

اسم الباحثة: ايمان الشاويش التوقيع: _____ التاريخ: _____

Appendix 5. 11: Interview Schedule

Outline interview guide for in-depth interviews

Study of Access and Use of Healthcare Services by Palestinian women in Manchester

At the start of the interview, participants will be asked a number of preliminary questions (See demographic questionnaire)

The interview will cover four key areas:

1. Knowledge of the NHS and UK health care system
2. Health care services and utilisation
 - a. Individual's experience of primary and community health provision
 - b. Individual's experience of hospital services
3. Communication and information provision and needs
4. Cultural variations

1. Knowledge of the NHS and UK health care system

- When you first moved to Manchester, how did you find out about your local health services? (Prompts: did you have any problems with finding out about services, such as how and where to find a GP, how to get certain medicines? Where local clinics were?)
- Tell me about any issues around accessing health care for you and your family (Prompts: any difficulties registering with GP; accessing services?)

2. Health care services and utilisation

- Exploring the individual's experience of primary and community health provision

- Discussion around the individual's contact/ use of health services at the primary and community level.
- Exploring the individual's experience of hospital services; Discussion around contact with and use of health services in hospital (Prompts: referred by GP for specialist treatment(s); recently been an in-patient or an outpatient; day surgery; maternity services etc)
- Tell me about any positive experiences in health care services (either primary or secondary care).
- Tell me about any negative experiences in health care services (either primary or secondary care).

3. Communication and information provision and needs

- Discussion around any difficulties with understanding what your doctor or health care professional was telling you.
- Explore access to link workers, interpreters etc.
- Discussion around information provision for understanding any health problems (Prompts: What has been provided; by who; in the language of your choice etc.)
- Discussion about improvements in information
- Discussion about use of other sources for assisting with health care information (Prompts: e.g. Internet, friends, local pharmacy etc)

4. Cultural variations

- Discussion about the similarities and differences between health care services in Palestine and the UK? (Prompts: what things about health care are good in Palestine; what things are good in the UK?; what things could be improved upon in Palestine?; what things could be improved upon in the UK?)

Finishing off interview

- Are there any other issues around accessing and using healthcare services in Manchester or in the UK that you would like to discuss?

Appendix 5. 12: Demographic information sheet- English

Study of Access and Use of Healthcare Services by Palestinian women in Manchester

Participant Identification Number:

The researcher will ask at the start of the interview the following questions:

1. What is your date of birth?
2. What is your marital status?
3. What is your country of birth? _____
4. When you arrived to UK? _____
5. When you arrived to Manchester? _____
6. What has been your main reason for residing in the UK?
a. Education b. Employment c. Family
7. How many children do you have?
a. How many children were born in the UK?
8. Do your parents resident in the UK? (please circle) **Yes** **No**
9. What level of education have you completed? _____
10. What is your current work/ employment? _____
11. How would you rate your **spoken** English? (please circle)
Very good Good Average Poor Very Poor
12. How would you rate your **written** English? (please circle)
Very good Good Average Poor Very Poor

Appendix 5. 13: Demographic information sheet- Arabic

استبيان- البيانات الديموغرافية

دراسة حول " وصول و استخدام المرأة الفلسطينية للخدمات الصحية في مدينة مانشستر "

Participant Identification Number:

سوف يسأل الباحث في بداية المقابلة عن الأسئلة التالية:

1. ما هو تاريخ ميلادك؟
2. ما هو وضعك العائلي؟
3. ما هو مكان ولادتك؟ _____
4. متى وصلت إلى المملكة المتحدة؟ _____
5. متى وصلت إلى مانشستر؟ _____
6. ما هو السبب الرئيسي الخاص بك للاقامه في المملكة المتحدة؟
(أ) التعليم (ب) العمل (ج) عائلة
7. كم عدد الأطفال لديك؟
8. كم عدد ولاداتك من الأطفال في المملكة المتحدة؟
9. هل والدك يقيم في المملكة المتحدة؟ يرجى وضع دائرة (أ) نعم (2) لا
10. ما هو مستوى التعليم لديك؟ _____
11. ما هو عملك الحالي؟ _____
12. كيف تقيم مستواك في اللغة الإنجليزية المنطوقة؟ (يرجى وضع دائرة)
جيد جدا جيد متوسط ضعيف ضعيف جدا
13. كيف تقيم مستواك في اللغة الإنجليزية المكتوبة؟ (يرجى وضع دائرة)
جيد جدا جيد متوسط ضعيف ضعيف جدا

Appendix 5. 14: Points of contact - English

POINTS OF CONTACT – TO BE GIVEN TO PARTICIPANTS

In the unlikely event that taking part in the interview or focus group in this study causes any discomfort or distress you would like to discuss, you may like to contact either:

1. Your own GP if you are registered with a doctor in UK.
2. The NHS Direct advice and information service on telephone number
 - 0845-4647

If you have any complaints or concerns about the research study you may get in touch with my supervisors Professor Chris Todd, or Dr Gretl McHugh. Alternatively you may speak to the independent advisor Dr Cliff Richardson. ;

1. Prof Chris Todd on this number 0161-306- 7865
2. Dr Gretl McHugh on this number 0161-306-7772
3. Dr Cliff Richardson on this number 0161-306-7639

All are at the School of Nursing, Midwifery and Social Work, The University of Manchester.

Don't forget that you can also contact me on the following:

Mrs Eman Alshawish

School of Nursing, Midwifery and Social Work

The University of Manchester

Jean McFarlane Building / Oxford Road

Manchester, M13 9PL

Tel: 0161 306 7869, mobile: 07529755450

Email: eman.alshawish@postgrad.manchester.ac.uk

Appendix 5. 15: Points of contact - Arabic

POINTS OF CONTACT – TO BE GIVEN TO INTERVIEWEES

للاتصال بعد انتهاء المقابلة-يتم اعطاؤها للمشاركات فى المقابلة

إذا جلبت مشاركتك في المقابلات الفردية او المجموعات البؤرية أي عدم ارتياح او قلق تودين مناقشته مع احد،
يمكنك الاتصال بمن ترينه مناسباً من الاتي:

1. الاتصال بطبيب العائلة اذا كنت مسجلة لديه
2. الاتصال بالرقم المباشر للخدمات الصحية الوطنية **08454647**

إذا كان لديك أي شكوى او قلق ما بشأن الدراسة، بإمكانك الاتصال بمشرفي الرسالة البروفيسور كريس تود والدكتورة جرتل ماكهيو او التحدث للناصح الاكاديمي الدكتور كلف رتشاردسون من كلية التمريض والقبالة والبحث الاجتماعي في جامعة مانشستر على الارقام التالية:

1. البروفيسور كريس تود : 0161-306- 7870
2. الدكتورة جرتل ماكهيو : 0161-306-7707
3. الدكتور كلف رتشاردسون: 0161 306 7639

ولا تنسين انكن يمكنكن الاتصال بي حسب الاتي:

السيدة ايمان الشاويش
كلية التمريض والقبالة والبحث الاجتماعي
جامعة مانشستر
مبنى جين مكفارلان\ اوكسفورد رود
مانشستر M13 9PL

هاتف: 0161 306 7869 موبايل: 07529755450

البريد الالكتروني eman.alshawish@postgrad.manchester.ac.uk

Appendix 5. 16: Distress policy for Interview

1) General points to consider before the interview:

- The interviews will be arranged at the participant's convenience in term of time, language and place. The researcher will offer the interviews to be at the Arabic schools or Mosque or the participant's home using English or Arabic language according to participant's preference.
- The participant will be provided with sources of support such as NHS pamphlets (attached) or the NHS direct telephone number in case they feel discomfort or any distress during the interviews.

2) At the start of the interview, the researcher will:

- Ask the participants to complete the one page demographic questionnaire.
- Ask the women if they are still happy to participate in the research project. If the researcher has any doubt, the interview will be cancelled or rearranged.
- Explain to the participant the confidentiality of information e.g. the data from the interview will be audio recorded , transcribed and kept confidential
- Tell the participant that the duration of interview is about one hour.

3) During the interview:

- The Researcher will assess the participant's level of distress or discomfort.
 - The researcher will ensure that the participant has information about NHS pamphlets and NHS Direct telephone number in case they need it.
- If the researcher feels that the participant is becoming distressed or experiences discomfort at the interview will be stopped and support will be provided. The researcher will encourage the women to contact their GP, specialist nurse, hospital consultant , other appropriate individual or through the NHS Direct telephone number.

Appendix 5. 17: Letter from Anoor school

To Mrs Eman Alshawish

School of Nursing, Midwifery and Social Work

Postgraduate room 3rd floor 3.331

The University of Manchester

Jean McFarlane Building

Oxford Road

Manchester, M13 9PL

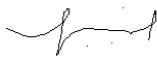
Date: 29/4/2010

Dear Eman

On behalf of the Noor Arabic School, I am writing to confirm that I am happy for your PhD study on "Access and use of health services by Palestinian women in Manchester" to be conducted in this school. I understand that you will provide me with a letter to distribute to mothers inviting them to participate in this study and I am happy to help in this way. Our school is open each Saturday from 10-4:30, and you are welcome to come to the school during these times.

We wish you success in your study

Yours sincerely



Mrs. Munira Alsusa

Appendix 5. 18: Letter from Alhijra school



مدرسة الهجرة العربية الإسلامية Hijra School

To Mrs Eman Alshawish
School of Nursing, Midwifery and Social Work
Postgraduate room 3rd floor 3.331
The University of Manchester
Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Date: 15.5.10

Dear Eman

On behalf of the Hijra School, I am writing to confirm that I am willing to help you to gather participants for your PhD study on “Access and use of health services by Palestinian women in Manchester” to be conducted in this school.

I understand that you will provide your participants with a letter to distribute to mothers inviting them to participate in this study and I am happy to. Our school is open each Saturday from 10.00 am -4.30 pm, and on Mondays and Wednesdays from 5.30 pm – 8.30 pm and you may attend on these days at agreed times to gather information from willing participants.

Under the data protection act, I am not authorised to provide you with any names, telephone numbers or addresses or any other personal information of any parents that are registered at the school.

Also, please note that I will not be held responsible for arranging any appointments between you and any participants. This will be solely your responsibility and Hijra School reserves the right to keep this matter completely separate from Hijra School and any member of its staff.

We wish you success in your studies

Yours sincerely
Yosra Agil
Head Teacher

Appendix 5. 19: Letter from Al-manar school

To Mrs Eman Alshawish
School of Nursing, Midwifery and Social Work
Postgraduate room 3rd floor 3.331
The University of Manchester
Jean McFarlane Building
Oxford Road
Manchester, M13 9PL

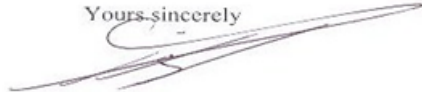
Date: 14/6/2010

Dear Eman

On behalf of the Al manar Arabic School, I am writing to confirm that I am happy for your PhD study on "Access and use of health services by Palestinian women in Manchester" to be conducted in this school. I understand that you will provide me with a letter to distribute to mothers inviting them to participate in this study and I am happy to help in this way. Our school is open each Sunday from 9 -3:30, each Tuesday & Thursday from 5-8:30, and you are welcome to come to the school during these times.

We wish you success in your study

Yours sincerely

A handwritten signature in dark ink, appearing to be a stylized name, possibly 'Eman' or 'Almanar', written over the 'Yours sincerely' text.

Appendix 5. 20: Letter from Didsbury Mosque



Shari'a Department
Manchester Islamic Centre
271 Burton Road
Manchester
M20 2WA

Mrs Eman Alshawish

School of Nursing, Midwifery and Social Work

The University of Manchester

Date: 28/5/2010

Dear Eman

On behalf of the Didsbury Mosque, I write to confirm that we are happy for the study about "access and use of health services by Palestinian women live in Manchester" to be conducted in this Mosque. I understand that you will distribute letters to women inviting them to participate in this study.

You are welcome to come at any suitable time for you. We wish you every success with your studies

Best Regards



Imam Salem Sheikhi

Shari'ah consultant/Head of Shari'ah Department

271 BURTON ROAD, WEST DIDSBURY, MANCHESTER M20 2WA
TELEPHONE: 0161 434 2254 / 4344 FACSIMILE: 0161 448 0324
EMAIL: INFO@DIDSBURYMOSQUE.COM

REGISTERED CHARITY No. 327345

Appendix 5. 21: Lone Worker Risk Assessment

Eman Alshawish

Lone working hours: weekdays , weekends and occasional evening

Risk of threat or violence: deemed to be low

Interviewer immunisations: N/A

Honorary contracts: N/A

Communication plans: interviews arranged by letter, telephone reminder to confirm interview time and date as appropriate

Travel to interviews: will be by car or public transport

Directions: print out of AA route planner. The telephone number of the participant and the office and mobile number of supervisor will also be to hand.

Before each interview: the date, time and place of interview given to the supervisors.
Lone worker unite: escalation policy from 1 ½ hours default

Interview timing:

Escalation: if the contact does not hear from the interviewer after default escalation, she will phone the interview's mobile phone. If there is no answer she will phone the participant's home and ask for the interviewer. If this is not successful the PI will phone the participant's home and /or the specified contact. If none of these things are successful the PI will phone the police, giving the details of the interview's car and last known location

Interviewer Home Address:

Interviewer home and mobile telephone number:

Contact telephone number:

Interviewer car:

Incidents: will be reported according to Appendix VI in the Safety Guidance for Research Staff

Appendix 5. 22: Example of Node Structure in NVivo 9

The screenshot displays the NVivo 9 software interface. The top menu bar includes File, Home, Create, External Data, Analyze, Explore, Layout, and View. Below the menu is a toolbar with various icons for file operations, editing, and analysis. The main workspace is divided into several panes.

Nodes Pane: Located on the left, it shows a hierarchical tree of nodes. The selected node is 'communication and information provision', which is expanded to show its sub-nodes: cultural variation, Health care services, NHS Knowledge, Relationships, and Matrices.

Search Results Pane: The top right pane shows the search results for the term 'communication a'. It displays a table with columns: Name, Sources, References, Created O, Created By, Modified On, and Modified By. The table lists 15 items, each with a blue circular icon and a plus sign.

Name	Sources	References	Created O	Created By	Modified On	Modified By
Interpreter	0	0	24/05/20	M	24/10/2011 15	T
communication	0	0	24/10/20	T	24/10/2011 12	T
INFORMATION	0	0	24/10/20	T	24/10/2011 13	T
Explanation	0	0	24/10/20	T	24/10/2011 13	T
receptionist tough	1	1	20/05/20	M	20/05/2011 01	M
Pamphlets	0	0	24/10/20	T	24/10/2011 14	T
simple term	1	1	22/05/20	M	22/05/2011 20	M
Racism	0	0	24/10/20	T	24/10/2011 14	T
read paper to know you	1	1	19/05/20	M	19/05/2011 01	M
Language	0	0	24/10/20	T	24/10/2011 15	T
plastic smile	1	2	20/05/20	M	20/05/2011 01	M
equity of health	1	1	23/05/20	M	23/05/2011 02	M
integration into society	1	1	22/05/20	M	22/05/2011 05	M
conspiracy theory	1	1	22/05/20	M	22/05/2011 05	M
self responsibility	1	1	23/05/20	M	23/05/2011 00	M

Timeline Pane: The bottom right pane shows a timeline view with a yellow background and a blue line representing the data. It includes a 'Click to edit' link and a 'Timespan' dropdown menu.

Bottom Bar: The bottom bar shows the current project name 'my_study3.nvp - NVivo' and the number of items '80 Items'.

my.study3.nvp - NVivo

File Home Create External Data Analyze Explore Layout View Media

Go Refresh Open Properties Edit Paste Copy Merge B I U Format Paragraph Styles Find Replace Insert Select Delete Editing

Workspace Item Clipboard

Look for: Search In: Health care servi Find Now Clear Advanced Find X

Nodes

- Nodes
 - communication and informa
 - cultural variation
 - Health care services
 - NHS Knowledge
 - Relationships
 - Matrices

Health care services

Name	Sources	References	Created On	Created By	Modified On	Modified By
HOSPITAL SERVI	0	0	24/05/2011	M	24/10/2011 14:	T
PRIMARY CARE-	0	0	24/10/2011	T	24/10/2011 14:	T
REFERAL SYSTE	0	0	24/10/2011	T	24/10/2011 14:	T
referral problem	1	1	21/05/2011	M	21/05/2011 05:	M
referral system	1	1	23/05/2011	M	23/05/2011 22:	M
referral to hospi	3	3	19/05/2011	M	21/05/2011 01:	M
referral to hospi	1	1	21/05/2011	M	21/05/2011 07:	M
referral to hospi	1	1	22/05/2011	M	22/05/2011 20:	M
referral to hospi	1	1	22/05/2011	M	22/05/2011 19:	M
referral to ortho	1	1	18/05/2011	M	18/05/2011 20:	M
referral to pedia	1	1	21/05/2011	M	21/05/2011 01:	M
referral to physi	1	1	24/05/2011	M	24/05/2011 03:	M
referral to speci	1	1	21/05/2011	M	21/05/2011 18:	M
research to foll	1	1	22/05/2011	M	22/05/2011 03:	M
request the co	1	1	22/05/2011	M	22/05/2011 04:	M

misuse of emergency referral to hospital

DPM034wafa+n areman (1) Muna (1) Nada17 (1)

0:00.0 10:00.0 20:00.0 30:00.0 40:00.0 50:00.0 1:00:00.0 1:10:00.0 1:20:00.0 1:30:00.0 1:40:00.0

Timespan Content

In Nodes Code At X

Sources: 3 References: 3 Unfiltered 0:00.0/1:45:11.3 1:45:11.3 3

Node Numbers - (430)

Nodes\\communication and information provision

Interpreter

husband as interpreter

Child interpreter

interpreter services

interpreter not available

interpreter booking

interpreter unavailable emergency

Offer an interpreter services

friend interpreter

communication

Not understand medical term

bad Communication

simple term

good communication

no eye contact

Language problem

bad experience

Doctor personality

not comfortable

Focus on PC

feedback

communication problem GP

communication problem with receptionist

Appendix 6. 1: Participants' demographic data

	Age	Marital Status	Country of birth	No of years living in UK	No of years living in Manchester	Reason for residing in UK	No Of children	No Of children born in UK	% of children born in UK	Parents in UK	level of education	current work	Spoken English	Written English
1.	28	married	Saudi Arabia	3	3	education	1	1	100	no	BSc	teacher	good	good
2.	44	married	Palestine	19	19	education and family	5	5	100	no	MS	teacher	very good	very good
3.	42	married	Qatar	20	8	family	4	3	75	no	BSc	teacher	good	good
4.	45	married	Palestine	16	16	family	4	4	100	no	BSc	teacher	good	good
5.	37	married	Kuwait	11	11	family	3	3	100	no	BSc	teacher	good	good
6.	30	married	Gaza	7	7	family	2	2	100	no	Level 3	housewife	good	good
7.	31	married	Gaza	3	3	family	3	0	0	no	BSc	teacher	good	good
8.	25	married	Jordan	2	2	family	pregnant	0	NA	no	BSc	housewife	very good	very good
9.	27	married	Jordan	27	2	family	pregnant	0	NA	yes	MS	housewife	very good	very good
10	30	married	Saudi Arabia	12	12	family	2	2	100	no	Level 3	housewife	good	average
11.	38	married	Kuwait	19	17	family	3	3	100	yes	A Level	teacher	very good	good
12.	33	married	Palestine	1	1	family	2	1	50	no	MS	housewife	very good	very good
13.	40	married	Palestine	12	12	family	4	1	25	no	BSc	teacher	average	average
14.	41	married	Qatar	17	14	education	5	3	60	no	BSc	teacher	average	average
15.	50	married	Kuwait	22	13	family	4	2	50	no	Diploma	housewife	average	average
16.	31	married	Saudi Arabia	4	4	education	1	1	100	no	MS	PhD student	very good	very good
17.	29	married	Palestine	11	11	family	2	2	100	yes	Level 3	housewife	very good	very good
18.	36	married	Palestine	10	7	employment	2	2	100	no	Consultant Paediatrician	Consultant Paediatrician	very good	very good
19.	25	single	Palestine	2	2	education	NA	NA	NA	no	MS	PhD student	very good	very good
20.	27	single	Kuwait	14	14	family	NA	NA	NA	yes	MS	student	very good	very good
21.	32	married	Jordan	5	5	family	3	1	33	no	Diploma	housewife	very poor	very poor
22.	29	married	Palestine	3	3	family	1	1	100	no	Diploma	housewife	average	average

Appendix 7. 1: Pilot Study Report Form and checklist

Pilot Study Report Form and checklist

Participant number:

Date:

1. Invitation letter	
2. Instruction	
3. Time of completing Questionnaires (Total) - Section A - Section B - Section C - Section D - Section E	
4. Observation	-For difficult or ambiguous to understand some questions by responders -For whether the respondent asks for clarification for some questions -For whether the respondent seems to have difficulty in following the questionnaire - Others
5. Check list form (12 questions)	-For evaluate wording, answering, ordering of questionnaires
6. Key Questions	-Why did you choose the option “not sure”? - For difficult or ambiguous to understand and/or answer questions Asking, what do you understand by this?
7. Comments	

Checklist for pilot test. Please give me your opinion regards the attached questionnaire

من فضلك زودي نى برأيك بالاسد تب بيان المرفق

الاسئلة- Questions	التعليق- Comment
1. Are there any typographical errors? هل هناك أي أخطاء مطبعية؟	
2. Are there any misspelled words? هل هناك أي كلمات بها أخطاء إملائية؟	
3. Do item numbers make sense? هل ترقيم ودال بن واضح؟	
4. Is the type size big enough to be easily read? هل حجم خط الكتابه مناسب للقراءه؟	
5. Is the vocabulary appropriate for the respondents? لمشاركين مناسبه المفرادات هل	
6. Is the survey too long? Is the style of the items too monotonous? طويل الاسد تب بيان هل ولهم	
7. Are there easy questions in with the difficult questions? هل توجد اسئلة سهله بجانب الاسئلة الصعده	
8. Are the skip patterns too difficult? هل نمط الاسئلة التخطي صعبه	
9. Does the survey format flow well? الاسئلة بسرد سلاسه هناك هل	
10. Are the items appropriate for the respondents? هل الاسئلة ملائمه لمشاركين	
11. Are the items sensitive to possible cultural barriers? المشاركون بين عادات وتقاليد بيه مع الاسئلة تماشا هل	
12. Is the survey in the best language for the respondents? لمشاركين هل لغه الاسد تب بيان ملائم	

Thank you very much

جميعا اشكركم

Appendix 7. 2: Letter of invitation- survey



Letter of invitation

Dear Madam

My name is Eman Alshawish from Palestine – Nablus. I am a lecturer at An Najah University- Nursing and Midwifery College. I am currently undertaking my PhD at Manchester Metropolitan University. My research study has two phases. The first phase has been completed. Interviews with women from Palestine currently living in the UK explored issue a round access to and use of Maternal and child health services. From these results, a questionnaire has been developed and the second phase of the study includes distributing these to other Palestinian women in the UK to generalize the result.

I would like to invite you as Palestinian women living in UK, to assist me with my study. All that is involved is filling the questionnaire about your experiences of health services in the UK. Please read the enclosed information sheet, which will provide you with more information about the research study. I hope you will consider taking part in the research.

Please return the completed questionnaire to me using the enclosed stamped addressed envelope or send it to my email. I would be grateful if you could return this as soon as possible. If I do not hear from you within two weeks, I will send a reminder letter to you.

Thank you for considering taking part in this research. If you need any further information, please do not hesitate to get in touch with me.

I look forward to hearing from you.

With best wishes
Eman Alshawish
Third year PhD Student

Appendix 7. 3: Information sheet -survey

Date: 23/12/2011

Information Sheet: PhD Study on Access to and use of healthcare services; focusing on MCH services by Palestinian women in the UK Phase 2 of study (Version 1.2, 23/12/11) Survey Questionnaire

I am undertaking a study about access to, and use of Maternal and Child healthcare (MCH) in the UK. As part of my PhD study. I am looking into the experiences of Palestinian women in the UK and how they access to and use of MCH services. It is important that I seek the views of individuals like yourself to learn more about your experience of the UK health care services.

What is the purpose of the study?

The purpose of this study is to investigate access to and use of MCH services. I am interested in looking at your experiences and opinions about the health services in the UK. By exploring and investigating the experiences of women using the UK health services, I will be able to identify what has been good and what things need improvement. By learning more about your experience, I will be able to identify these improvements in services, which need to be made. This study is being undertaken to obtain a PhD.

My research study has two phases. First phase was done and it was explored the access to and use of Maternal and Child health services by women from Palestine who currently lives in the UK. In the second phase of study, the survey questionnaire will be conducted in the UK to generalize the result.

Why have I been chosen?

You have been chosen as you are a Palestinian woman who is currently residing in the UK. Palestinian women are being identified through Palestinian community (Palestinian council in London, Palestinian forum, Mosque and Arabic schools in Manchester and Birmingham). The survey will include approximately 350 participants.

Do I have to take part?

It is up to you to decide whether or not to take part in the study. If you decide to take part, please keep this information sheet, complete, and return the questionnaire by email or using the pre-paid envelop enclosed to me. You will still be free to withdraw from the study at any time without giving a reason.

What will happen to me if I take part?

The study involves questionnaire. This questionnaire has five sections (A-E). In sections A to D, there are a series of statement, such as "I am satisfied with the care that I received during my pregnancy". You need to give your opinion on how much you agree or disagree with a certain statement. You will be asked to tick the response, which shows how much you agree or disagree with a certain statement. In section E, you will be asked

some information about yourself, such as your education, age and occupation. All the answer that you give will be considered completely confidential and anonymous.

What are the possible disadvantages and risks of taking part?

There are no risks to you of taking part in the study and your participation will not disadvantage you in any way.

What are the possible benefits of taking part?

There are no direct benefits to taking part in the study. However, we are hoping to identify what facilitators and barriers to care are experienced by Palestinian women living in the UK and knowing about these may lead to positive changes to the health services in the future.

Will my taking part in this study be kept confidential?

The questionnaire is anonymous. There is no information that can identify you or the questions. All data will be stored safely and used solely for this research project. For university audit procedures, the data will be kept for 5 years. After this time it will be disposed of securely.

What happens when the research study stops?

When the study is finished, if you wish to receive a copy of the findings of the study, I will send you a summary.

What will happen to the results of the research study?

The findings of the study will be used for academic purposes by the researcher. It is also hoped that findings from the research will be published in peer-reviewed scientific journals. Details of any publication will be sent to the Palestinian forum who will be asked to put them on their websites.

Who do I contact for further information?

For general information about research, specific information about this research project, or if you are unhappy with the study, please contact:

Eman Alshawish
Nursing Department
Manchester Metropolitan University
Elizabeth Gaskell Campus
Hathersage Road
Manchester
M13 0JA
Office: 0161-2472606
Email: eman.alshawish@stu.mmu.ac.uk

You will be given a copy of this information sheet and a signed consent form to keep

**Thank you again for your assistance with this study
With best wishes**

Appendix 7. 4: Survey questionnaire- English

Access to and use of healthcare services in the UK by Palestinian women *Focusing on Maternal and Child Healthcare (MCH)*

Please complete and return this questionnaire by email or using the pre-paid envelope enclosed as soon as possible.

If you want to complete this survey on your computer, move your cursor to the box which is your preferred answer, right click on the mouse select "bullets" in the drop down menu, then choose one of illustrated bullets and it will appear in the box

How to complete the questionnaire

This questionnaire has five sections (A-E). In sections A to D, there are a series of statements, such as “I am satisfied with the care that I received during my pregnancy” or “I can speak English fluently”. You need to give your opinion on how much you agree or disagree with a certain statement. You will be asked to tick the response. In the example below the choice “agree” has been ticked showing that this person agrees that the GPs registration process is easy.

Example

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
The GPs registration process is easy		✓			

In section E, you will be asked some information about yourself, such as your education, age and occupation. All the answers that you give will be kept without name and confidentiality will be maintained.

Please give us your opinion about the following statements:

A. Your Knowledge about the Maternal and Child Healthcare services in the UK

Statement	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. The National health care services (NHS) in the UK are free for all residents in the UK					
2. You must be aware of your rights otherwise you may miss out on some maternal and child health “MCH” services					
3. The delivery of maternal and child health services is better for British women than Palestinian women					
4. I feel it's good to have all the healthcare services, including dentistry, free for pregnant women and one year post-delivery					
5. Maternal and child healthcare services in the UK are fulfilling my needs					

	Strongly Agree	Agree	Not applicable	Disagree	Strongly Disagree
6. I found out about the NHS service before I came to the UK					
7. I had adequate knowledge about the NHS when I arrived to the UK					

8. Are you aware of the government plans to close some maternity hospitals and develop others (please tick the box)

- ☐ Yes ☐
☐ No ☐

	Positively	No difference	Negatively
9. In which way will this affect the services do you think?			

B. Information about accessing and using the general practitioner (GP) and maternity services

1. GPs

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
10. The GPs registration process is easy					
11. I am able to book an emergency appointment with my GP on the same day					
12. I am able to book regular appointments with my GP within 3 days					
13. My general practice has all the services that I need in one place such as child care, immunisation and a midwife					
14. I am not happy with the GP system- assessment by phone when I book an appointment					
15. The waiting time to see my GP is too long					
16. I would prefer a female GP to examine me at the GP surgery					
17. My GP relies on a verbal history rather than physically examining me					
18. I have to wait a long time for my test results					
19. The time between my GP referral and hospital appointment is too long					

2. Maternity and child health services

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
20. I had the same midwife throughout my pregnancy					
21. It is important to me to have the same midwife throughout my					

pregnancy					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
22. I contacted a healthcare professional before the 12th week of my pregnancy					
23. I had contacted my midwife before the 12 th week of my pregnancy					
24. I attended the antenatal class during my pregnancy					
25. Given a choice regarding the location of delivery, I would prefer to give birth at hospital rather than at home					
26. My baby is up to date with all his/her injections					
27. I can easily access the dental services in the UK					
28. The waiting time in emergency department is too long					
29. The waiting time in the paediatric emergency department is too long					

30. You delivered your baby at hospital (please tick the box)

- Yes, ☐ (Please go to question 31)
- No, ☐ (Please go to question 39)

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
31. My pain relief was adequate during my labour					
32. I received adequate support from the midwife to breast-feed my baby post delivery					
33. My baby was bathed in an unsatisfactory way in the hospital					
34. I prefer to use only water to bath the baby in the first week after delivery					
35. I received adequate care post-delivery in the hospital					

--	--	--	--	--	--

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
36. I received adequate pain relief post-delivery in the hospital					
37. I did not receive adequate attention post-delivery in the hospital					
38. I like the food provided at the hospital					

C. Information about language problems, Interpreter services and information provision in MCH services

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
39. The receptionists at my GP are helpful.					
40. The midwife provided me with information and leaflets					
41. I had adequate information in a language that I could understand					
42. There was not enough time during my visit for the midwife or doctor to answer my questions.					
43. I would prefer to have the leaflets about my pregnancy in addition to the midwife's explanation					
44. I would prefer to read the leaflets about my pregnancy in the Arabic language					
45. If I have health problems I prefer to deal with a doctor or nurse who speaks Arabic					

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
46. I can understand written English well					
47. Language problems make it hard to understand what the midwife, doctor and nurse are saying to me					
48. Language problems make it hard to explain my concerns to the midwife or doctor					
49. I find it difficult to book an appointment with my doctor because of language problems					

50. Do you need an interpreter during your visit to your doctor or midwife (please tick the box)

- Yes, ☐ I need an interpreter (please go to question 51)
- No, ☐ I do not need an interpreter. (Please go to question 54)

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
51. Interpreters are usually not available when I request them					
52. I prefer a family member or my friend to act as an interpreter					
53. My family member or friend who helps me with interpretation usually has difficulty in finding time to do it.					

D. Information about the Culture

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
54. I prefer to use a traditional herbal medicine					
55. I like to take antibiotics when I feel unwell.					
56. I brought my medication from my country - Palestine					

57. The system in the UK encourages the birth process to be natural					
---	--	--	--	--	--

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
58. I would prefer to be cared for by a midwife throughout my pregnancy					
59. I would prefer to be cared for by a specialist doctor throughout my pregnancy					
60. I would prefer not to have screening tests for Down syndrome during my pregnancy					
61. I would prefer not to have scanning tests during my pregnancy					
62. If the test or scan shows the possibility of abnormality, I would not terminate the pregnancy.					
63. I prefer to breast feed my baby rather than to use bottle feeding					
64. I would prefer a midwife to examine my baby post delivery					
65. I would prefer a paediatrician to examine my baby post delivery					
66. I would prefer the circumcision service to be available on the NHS for male babies					

	Strongly Agree	Agree	Not applicable	Disagree	Strongly Disagree
67. I feel the NHS - Maternal and Child Healthcare services in the UK are better than government sector in Palestine					
68. I feel the NHS - Maternal and Child Healthcare services in the UK are better than private sector in Palestine					

E. Demographic Data – about yourself

Please answer the following questions: *If you want to complete this part on your computer, move your cursor inside the box and type your answer.*

1. What is your date of birth?
2. What is your religion?
3. What is your marital status?
4. What level of education have you completed? (please tick the box)
a. Diploma ☐ b. BSc ☐ c. Master ☐ d. PhD ☐ E. other _____
5. What is your current work/ employment?
6. How many children do you have?
7. How many of your children were born in the UK?
8. What is your country of birth?
9. When did you arrived in the UK?
10. Where are you living now?
11. What has been your main reason for residing in the UK? (please tick the box, you can choice more than one)

a. Education ☐ b. Employment ☐ c. Family ☐

12. Do your parents reside in the UK? (please tick the box)

- ☐ Yes ☐
☐ No ☐

Do you have any comments that you would like to make about accessing and using MCH services in the UK?

Note: In the unlikely event that taking part in this study causes you any discomfort or distress which you would like to discuss, you can contact either:

3. Your own GP if you are registered with a doctor in the UK.
4. The NHS Direct advice and information service on telephone number 0845-4647*

Thank you very much for completing this questionnaire, Please return it by email or in the envelope provided as soon as possible.

If you have, any questions please feel free to contact me;

Eman Alshawish - PhD student

Manchester Metropolitan University

Postgraduate Office Tel: 0161-2472606

E-mail: Eman.Alshawish@stu.mmu.ac.uk

Appendix 7. 5: Survey questionnaire- Arabic

استخدام ووصول المراه الفلسطينيين للخدمات الصحية - خدمات الامومه والطفوله بالمملكه المتحده

يرجى استكمال هذا الاستبيان وارساله عن طريق البريد الإلكتروني أو استخدام المغلف المرفق مسبق الدفع وذلك باسرع وقت ممكن
إذا اردت ملء الاستبيان باستخدام الحاسوب عليك وضع الماوس بداخل المربع المختار ومن ثم الضغط على يمين الماوس وبعد ذلك اختيار البولت
من القائمه ومن ثم اختيار الرمز وادخاله او وضع علامه

كيفية ملء الاستبيان

يتكون هذا الاستبيان من خمس اقسام (ا-هـ). في الفروع من الف الى دال, هناك سلسله من البيانات, مثال على ذلك "أنا راض عن الرعاية التي تلقيتها خلال فترة الحمل" أو "أستطيع أن أتحدث الانجليزية بطلاقة". المطلوب منك ابداء رأيك بهذه العبارة اذا كنت تتفقي او تعارضي. والمطلوب منك وضع علامه بجانب اجابتك. ففي المثال ادناه يبين ان الشخص وضع اشارته اوافق مما يعني انه يوافق ان عمليه التسجيل عند طبيب العائله سهله

مثال:

العبارة	موافق بشده	موافق	محايد	معارض	معارض بشده
1. عمليه التسجيل عند طبيب العائله سهله			✓		

في القسم هاء والاخير، سيتم طلب منك بعض المعلومات عن نفسك، مثل سنك، والتعليم، والاحتلال. وسيتم التعامل مع جميع الأجوبة التي تعطيها على انها مجهوله المصدر، وسيتم الحفاظ و التعامل مع المعلومات بغايه السريه.

اجيبي عن العبارات الاتيه في خانه الحقل الممثل لاجابتك
ا.معلوماتك حول خدمات الام والطفل بالمملكة المتحدة

معارض بشده	معارض	محايد	موافق	موافق بشده	العبارة
					1. خدمه الرعاية الصحيه الوطنيه في المملكة المتحدة مجانا لجميع الناس القاطنين المملكة المتحدة
					2. سيفوتك بعض خدمات صحه الام والطفل اذا لم تكوني على بينه من حقوقك
					3. تقديم الخدمات الصحيه للأم والطفل هي أفضل بالنسبة للنساء البريطانيات من النساء الفلسطينيات
					4. اشعر انه شيء جيد توفر الخدمات الصحيه وطب الاسنان مجانا للمراه الحامل وسنه بعد الانجاب
					5. خدمات صحه الام والطفل المقدمه بالمملكة المتحدة تلبي احتياجاتي

معارض بشده	معارض	لا ينطبق	موافق	موافق بشده	العبارة
					6. لقد علمت عن الخدمات الصحيه المقدمه قبل وصولي للمملكة المتحدة
					7. كان لدي المعرفه الكافيه عن الخدمات الصحيه المقدمه عندما وصلت المملكة المتحدة

8. هل انت على علم ان الحكومه تخطط لاغلاق بعض مستشفيات الولاده وتطوير اخرى

نعم ☐ لا ☐

ب. معلومات حول استخدامك لطبيب العائله و خدمات الامومه والطفوله في المملكة المتحدة .

معارض بشده	معارض	محايد	موافق	موافق بشده	العبارة
					10. عمليه التسجيل عند طبيب العائله سهله

					11. باستطاعتي حجز موعد طوارئ مع طبيب العائلة بنفس اليوم اتصالي
					12. باستطاعتي حجز موعد عادي مع طبيب العائلة خلال 3 ايام
					13. كل الخدمات الصحية التي احتاجها موجوده عند عياده طبي العائلة وذلك يضم خدمات رعايه الاطفال وتطعيمهم ووجود قابله
					14. وقت الانتظار لرؤية طبيبي طويل
					15. انا غير راضيه عن نظام تقييم طبيب العائلة باستخدام الهاتف عند اتصالي لحجز موعد
					16. افضل وجود دكتوراه لمعالجتي بعياده طبيب العائلة
					17. طبيب العائلة يعتمد اكثر على تشخيص مرضي بناء على اسئلته الشفويه بدلا من الفحص السريري
					18. علي الانتظار فتره طويله لمعرفة نتائج فحوصاتي
					19. فتره الانتظار طويله بين تحويلي من طبيب العائلة للمستشفى

العبارة	موافق بشده	موافق	محايد	معارض	معارض بشده
20. كانت تعتني بي نفس القابله خلال حملي					
21. من المهم لدي ان تعتني بي نفس القابله خلال فتره الحمل					
22. تم تواصلتي مع القابله او طبيب العائلة قبل وصولي الاسبوع ١٢ من فتره الحمل					
23. تم تواصلتي مع القابله قبل وصولي الاسبوع 12 من فتره الحمل					
24. لقد شاركت بالمحاضرات والنشاطات خلال فتره الحمل التي تهيئني لاستقبال طفلي					
25. اذا تم سؤالي عن مكان الولاده المفضل لي ساختار ان انجب بالمستشفى وليس بالبيت برعايه قابله					
26. حصل طفلي على جميع الطعومات الملائمه لسنه					
27. لا استطيع الوصول واستخدام خدمات طب الاسنان بالمملكه المتحده					
28. فتره انتظاري قسم الطوارئ هي فتره طويله					
29. فتره انتظاري بطوارئ الاطفال هي فتره طويله					

30 . لقد تمت انجابك لطفلك بالمستشفى
☐ نعم الرجاء الانتقال الى سؤال 31
☐ لا الرجاء الانتقال الى سؤال 40

معارض بشده	معارض	محايد	موافق	موافق بشده	العبارة
					31. الادويه المخففه للالم كانت كافيه اثناء عمليه المخاض
					32. لقد تلقيت الدعم الكافي بعد الولاده من القابله لمساعدتي لارضاع طفلي
					33. تم حمام طفلي بعد الولاده بالمستشفى بطريقه غير مرضيه
					34. افضل استخدام الماء والقطن فقط لحمام طفلي لمدته اسابيع بعد الولاده
					35. تلقيت الرعاية الكافية بعد الولاده في المستشفى
					36. الادويه المخففه للالم كانت كافيه بعد عمليه الولاده بالمستشفى
					37. أنا لم احظ بالاهتمام الكافي في مرحلة ما بعد الولاده في المستشفى
					38. انا احب الاكل المقدم بالمستشفى

ج. معلومات عن مشاكل اللغة واستخدام المترجم والمعلومات الصحيه

معارض بشده	معارض	محايد	موافق	موافق بشده	العبارة
					39. موظفات الاستقبال متعاونات عند عياده طبيب العائله
					40. تزودني القابله بالمعلومات والتشيرات الصحيه الازمه
					41. تصلني المعلومات الصحيه باستخدامات اللغة التي باستطاعتي فهمها
					42. لم يكن هناك ما يكفي من الوقت خلال زيارتي للقابله أو طبيب للإجابة على أسئلتي
					43. أنا افضل ان احصل على النشرات الصحيه المتعلقه بحملي بالاضافه الى شرح القابله

					44. انا افضل ان اقرا التشرّات الصحيه المتعلقه بحملي باللغة العربيه
					45. إذا كان لدي مشاكل صحية أفضل للتعامل مع طبيب أو ممرضة الذي يتكلم اللغة العربيه
					46. بإمكانني فهم اللغة الانجليزيه جيدا
					47. مشاكل اللغة تجعل من الصعب علي فهم ماذا يقول الطبيب او القابله لي
					48. مشاكل اللغة تجعل من الصعب علي شرح ما يجوب في نفسي للطبيب او القابله
					49. انا لا استطيع حجز موعد مع الطبيب او القابله بسبب مشكله اللغة

50. هل تحتاجي لمترجم عند زيارتك الطبيب او القابله

☐ نعم _____ انا احتاج لمترجم الرجاء الانتقال لسؤال 49

☐ لا _____ لا احتاج لمترجم الرجاء الانتقال لسؤال 54

د. معلومات حول الثقافه والحضاره

معارض بشده	معارض	محايد	موافق	موافق بشده	العبارة
					54. انا افضل لاستخدام الادوية العشبية التقليدية مثل المرميه
					55. انا افضل استخدام المضاد الحيوي للالتهاب الفيروسي
					56. انا حضر ادويتي من بلدي فلسطين
					57. النظام في المملكة المتحدة تشجع على عملية الولادة أن تكون طبيعية
					58. انا افضل انا تقوم القابله برعايتي طوال فترة الحمل
					59. انا افضل طبيبه انا تقوم برعايتي خلال حملي
					60. انا افضل ان لا اعمل الفحوصات السريره خلال فترة الحمل مثل فحص الداون سيندروم او متلازمه داون
					61. اذا كشفت الفحوصات السريره والتصوير التلفزيوني وجود تشوه عند الجنين فانا افضل عدم الاجهاض
					62. انا لا افضل عمل صور تلفزيونيه خلال فترة الحمل
					63. انا افضل ارضاع طفلي رضاعه طبيعيه وليس استخدام حليب صناعي
					64. انا افضل ان تقوم قابله بفحص طفلي بعد الولاده
					65. انا افضل ان يقوم طبيب اطفال بفحص طفلي بعد الولاده

66. أفضل ان تكون خدمة ختان الاطفال الذكور متوفرة في الخدمات الصحية المقدمة

معارض بشده	معارض	لا ينطبق	موافق	موافق بشده	العبارة
					67. اشعر ان الخدمات الصحية المقدمه لرعايه الام والطفل بالمملكه المتحده افضل من القطاع الحكومي بفلسطين
					68. اشعر ان الخدمات الصحية المقدمه لرعايه الام والطفل بالمملكه المتحده افضل من القطاع الخاص بفلسطين

ه. استبيان- البيانات الديموغرافية

لتعبئه هذا القسم من الاستبيان باستخدام الحاسوب الرجاء وضع الماوس بداخل المربع وكتابه الاجابه

1. ما هو تاريخ ميلادك؟

2. ما هيا ديانتك ؟

3. ما هو وضعك العائلي؟

4. ما هو مستوى التعليم لديك؟ ا. دبلوم ☐ ب. بكالوريس ☐ ج. ماجستير ☐ د. دكتوراه ☐ ه. غيره _____

5. ما هو عملك الحالي؟

6. ما هو مكان ولادتك ؟

7. متى وصلت إلى المملكة المتحدة؟

8. متى وصلت إلى مانشستر؟

9. ما هو السبب الرئيسي الخاص بك للإقامة في المملكة المتحدة؟

(أ) التعليم ☐ (ب) العمل ☐ (ج) عائلة ☐

10. كم عدد الأطفال لديك؟

11. كم عدد ولاداتك من الأطفال في المملكة المتحدة؟

12. هل لديك يقيمان في المملكة المتحدة؟ يرجى وضع دائرة (أ) نعم ☐ (2) لا ☐

هل لديك أي تعليقات ترغبين في اضافتها حول الوصول واستخدام خدمات صحة الأم والطفل في المملكة المتحدة

غير محتمل مشاركتك بالدراسة ان تسبب لك الازعاج لكن اذا شعرت بذلك فبإمكانك الاتصال بطبيب العائلة اذا كنت مسجله مع طبيب في المملكة المتحدة او الاتصال بالرقم

*0845-4647 الخاص بخدمه المعلومات لآخذ التصيحه

شكرا لكن لاستكمال هذا الاستبيان والرجاء ارساله عن طريق البريد الالكتروني او المغلف المرفق مسبق الدفع ولا ترددي بالسؤال والاتصال بي على الرقم التالي

ايمان الشاويش- طالبة دكتوراه Eman Alshawish - PhD student
للاتصال رقم المكتب -0161-2472606 Postgraduate Office Tel:

Appendix 8. 1: Participants' responses to survey statements

Responses to the items by participant (237)

NA= Not applicable S=Statement

A. Knowledge	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree N (%)	Strongly Disagree N (%)	Missing N (%)
S1.The National health care services (NHS) in the UK are free for all residents in the UK	112 (47.3)	79 (33.3)	19 (8)	18(7.6)	9 (3.8)	0 (0.0)
S2.You must be aware of your rights otherwise you may miss out on some maternal and child health “MCH” services	65 (27.4)	105 (44.3)	30 (12.7)	27(11.4)	9 (3.8)	1 (0.4)
S3.The delivery of maternal and child health services is better for British women than Palestinian women	27(11.4)	29 (12.2)	51 (21.5)	80(33.8)	50(21.1)	0 (0.0)
S4.I feel it’s good to have all the healthcare services, including dentistry, free for pregnant women and one year post-delivery	152 (64.1)	72 (30.4)	6 (2.5)	2 (0.8)	2 (0.8)	3 (1.3)
S5.Maternal and child healthcare services in the UK are fulfilling my needs	72 (30.4)	100 (42.2)	40 (16.9)	18 (7.6)	3 (1.3)	4 (1.7)
			NA			
S6.I found out about the NHS service before I came to the UK	19 (8)	43 (18.1)	71 (30)	59 (24.9)	43 (18.1)	2 (0.8)
S7.I had adequate knowledge about the NHS when I arrived to the UK	18 (7.6)	67 (28.3)	61 (25.7)	65 (27.4)	26 (11)	0 (0.0)
S8.Are you aware of the government plans to close some maternity hospitals and develop others	Yes	61 (25.7)	No	161 (67.9)	Missing	15 (6.3)
S9.In which way will this affect the services do you think?	Positive 59 (24.9)	No deference 57 (24.1)		Negative 115 (48.5)		Missing 6 (2.5)
B. GP						
S10.The GPs registration process is easy	91 (38.4)	117 (49.4)	19 (8)	8(3.4)	2 (0.8)	0 (0.0)
S11.I am able to book an emergency appointment with my GP on the same day	44 (18.6)	100 (42.2)	32 (13.5)	45 (19)	16 (6.8)	0 (0.0)
S12.I am able to book regular appointments with my GP within 3 days	46 (19.4)	96 (40.5)	35 (14.8)	44 (18.6)	15 (6.3)	1 (0.4)
S13.My general practice has all the services that I need in one place such as child care, immunisation and a midwife	67 (28.3)	104 (43.9)	33 (13.9)	22 (9.3)	7 (3)	4 (1.7)
S14.I am not happy with the GP system- assessment by phone when I book an appointment	43 (18.1)	83 (35)	52 (21.9)	46 (19.4)	10 (4.2)	3 (1.3)
S15.The waiting time to see my GP is too long	40 (16.9)	79 (33.3)	47 (19.8)	59 (24.9)	10 (4.2)	2 (0.8)
S16.I would prefer a female GP to examine me at the GP surgery	128 (54)	74 (31.2)	23 (9.7)	7 (3)	3 (1.3)	2 (0.8)
S17.My GP relies on a verbal history rather than physically examining me	41 (17.3)	78 (32.9)	50 (21.1)	53 (22.4)	12 (5.1)	3 (1.3)
S18.I have to wait a long time for my test results	51 (21.5)	71 (30)	47 (19.8)	59 (24.9)	7 (3)	2 (0.8)
S19.The time between my GP referral and hospital appointment is too long	74 (31.2)	99 (41.8)	36 (15.2)	19 (8)	7 (3)	2 (0.8)

Maternity and child health services	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree N (%)	Strongly Disagree N (%)	Missing N (%)
S20.I had the same midwife throughout my pregnancy	45 (19)	68 (28.7)	40 (16.9)	68 (28.7)	13(5.5)	3 (1.3)
S21.It is important to me to have the same midwife throughout my pregnancy	64 (27)	119 (50.2)	32 (13.5)	19 (8)	0 (0.0)	3 (1.3)
S22.I contacted a healthcare professional before the 12 th week of my pregnancy	65(27.4)	99 (41.8)	26 (11)	36 (15.2)	7 (3)	4 (1.7)
S23.I had contacted my midwife before the 12 th week of my pregnancy	46 (19.4)	91 (38.4)	35 (14.8)	45 (19)	9 (3.8)	11 (4.6)
S24.I attended the antenatal class during my pregnancy	33 (13.9)	65 (27.4)	48 (20.3)	66 (27.8)	15 (6.3)	10 (4.2)
S25.Given a choice regarding the location of delivery, I would prefer to give birth in hospital rather than at home	136 (57.4)	74 (31.2)	14 (5.9)	6 (2.5)	3 (1.3)	4 (1.7)
S26.My baby is up to date with all his/her injections	137 (57.8)	78 (32.9)	9 (3.8)	7 (3)	2 (0.8)	4 (1.7)
S27.I can easily access the dental services in the UK	42 (17.7)	54 (22.8)	28 (11.8)	71 (30)	38 (16)	4 (1.7)
S28.The waiting time in the emergency department is too long	108 (45.6)	82 (34.6)	26 (11)	11 (4.6)	7 (3)	3 (1.3)
S29.The waiting time in the paediatric emergency department is too long	73 (30.8)	88 (37.1)	38 (16)	22 (9.3)	13 (5.5)	3 (1.3)
S30.Hospital Delivery N=222 Yes N= 222 (93.7%) No= 10 (4.2%) Missing 5 (2.1%)						
S31.My pain relief was adequate during my labour	54 (24.3)	102 (45.9)	23(10.4)	26 (11.7)	14 (6.3)	3 (1.4)
S32.I received adequate support from the midwife to breast-feed my baby post delivery	63 (28.4)	114 (51.4)	18 (8.1)	17 (7.7)	8 (3.6)	2 (0.9)
S33.My baby was bathed in an unsatisfactory way in the hospital	21(9.5)	36 (16.2)	51(23)	71(32)	39(17.6)	4 (1.8)
S34.I prefer to use only water to bath the baby in the first week after delivery	24 (10.8)	42 (18.9)	29 (13.1)	89 (40.1)	34 (15.3)	4 (1.8)
S35.I received adequate care post-delivery in the hospital	69 (31.1)	92 (41.4)	25 (11.3)	24 (10.8)	8 (3.6)	4 (1.8)
S36.I received adequate pain relief post-delivery in the hospital	57 (25.7)	115 (51.8)	25 (11.3)	20 (9)	2 (0.9)	3 (1.4)
S37.I did not receive adequate attention post-delivery in the hospital	23 (10.4)	30 (13.5)	32 (14.4)	99 (44.6)	34 (15.3)	4 (1.8)
S38.I like the food provided at the hospital	24 (10.8)	40 (18)	61 (27.5)	46 (20.7)	48 (21.6)	3 (1.4)

Communication & information (237)	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree N (%)	Strongly Disagree N (%)	Missing N (%)
S39.The receptionists at my GP are helpful.	65 (27.4)	122 (51.5)	30 (12.7)	13 (5.5)	5 (2.1)	2 (0.8)
S40.The midwife provided me with information and leaflets	63 (26.6)	147 (62)	20 (8.4)	7 (3)	0 (0.0)	0 (0.0)
S41.I had adequate information in a language that I could understand	52 (21.9)	106 (44.7)	39 (16.5)	27 (11.4)	10 (4.2)	3 (1.3)
S42.There was not enough time during my visit for the midwife or doctor to answer my questions.	12 (5.1)	51 (21.5)	46 (19.4)	94 (39.7)	31 (13.1)	3 (1.3)
S43.I would prefer to have the leaflets about my pregnancy in addition to the midwife's explanation	67 (28.3)	116 (48.9)	31 (13.1)	14 (5.9)	9 (3.8)	0 (0.0)
S44.I would prefer to read the leaflets about my pregnancy in the Arabic language	54 (22.8)	82 (34.6)	59 (24.9)	27 (11.4)	11 (4.6)	4 (1.7)
S45.If I have health problems I prefer to deal with a doctor or nurse who speaks Arabic	61 (25.7)	65 (27.4)	57 (24.1)	38 (16)	12 (5.1)	4 (1.7)
S46.I can understand written English well	79 (33.3)	98 (41.4)	29 (12.2)	20 (8.4)	9 (3.8)	2 (0.8)
S47.Language problems make it hard to understand what the midwife, doctor and nurse are saying to me	33 (13.9)	64 (27)	31 (13.1)	69 (29.1)	32 (13.5)	8 (3.4)
S48.Language problems make it hard to explain my concerns to the midwife or doctor	38 (16)	69 (29.1)	38 (16)	60 (25.3)	28 (11.8)	4 (1.7)
S49.I find it difficult to book an appointment with my doctor because of language problems	21 (8.9)	32 (13.5)	29 (12.2)	81 (34.2)	72 (30.4)	2 (0.8)
S50.Interpreters (N=73) Yes=73 (30.8) No=164 (69.2) Missing=0 (0.0)						
S51.Interpreters are usually not available when I request them	15 (20.5)	24 (32.5)	12 (16.4)	18 (24.7)	4 (5.5)	0 (0.0)
S52.I prefer a family member or my friend to act as an interpreter	14 (19.2)	38 (52.1)	11 (15.1)	8 (11)	2 (2.7)	0 (0.0)
S53.My family member or friend who helps me with interpretation usually	15 (20.5)	37 (50.5)	14 (19.2)	5 (6.8)	1 (1.4)	1 (1.4)

Culture	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree N (%)	Strongly Disagree N (%)	Missing N (%)
S52.I prefer to use a traditional herbal medicine	36 (15.2)	91 (38.4)	57 (24.1)	36 (15.2)	17 (7.2)	1 (0.4)
S53.I like to take antibiotics when I feel unwell.	44 (18.6)	89 (37.6)	40 (16.9)	42 (17.7)	21 (8.9)	
S54.I brought my medication from my country - Palestine	15 (6.3)	44 (18.6)	64 (27)	70 (29.5)	42 (17.7)	2 (0.8)
S55.The system in the UK encourages the birth process to be natural	95 (40.1)	101 (42.6)	31 (13.1)	6 (2.5)	2 (0.8)	2 (0.8)
S56.I would prefer to be cared for by a midwife throughout my pregnancy	80 (33.8)	108 (45.6)	34 (14.3)	13 (5.5)	0 (0.0)	2 (0.8)
S57.I would prefer to be cared for by a specialist doctor throughout my pregnancy	85 (35.5)	99 (41.8)	43 (18.1)	6 (2.5)	3 (1.3)	1 (0.4)
S58.I would prefer not to have screening tests for Down syndrome during my pregnancy	55 (23.2)	58 (24.5)	43 (18.1)	44 (18.6)	35 (14.8)	2 (0.8)
S59.I would prefer not to have scanning tests during my pregnancy	64 (27)	56 (23.6)	43 (18.1)	46 (19.4)	25 (10.5)	3 (1.3)
S60.If the test or scan showed the possibility of abnormality, I would not terminate the pregnancy.	33 (13.9)	38 (16)	44 (18.6)	72 (30.4)	49 (20.7)	1 (0.4)
S61.I prefer to breast feed my baby rather than to use bottle feeding	135 (57)	74 (31.2)	20 (8.4)	6 (2.5)	1 (0.4)	1 (0.4)
S62.I would prefer a midwife to examine my baby post delivery	54 (22.8)	72 (30.4)	40 (16.9)	51 (21.5)	18 (7.6)	2 (0.8)
S63.I would prefer a paediatrician to examine my baby post delivery	150 (63.3)	67 (28.3)	13 (5.5)	4 (1.7)	0 (0.0)	3 (1.3)
S64.I would prefer the circumcision service to be available on the NHS for male babies	156 (65.8)	67 (28.3)	10 (4.2)	2 (0.8)	0 (0.0)	2 (0.8)
			NA			
S65.I feel the NHS - Maternal and Child Healthcare services in the UK are better than government sector in Palestine	110 (46.4)	81 (34.2)	39 (16.5)	3 (1.3)	0 (0.0)	4 (1.7)
S66.I feel the NHS - Maternal and Child Healthcare services in the UK are better than private sector in Palestine	81 (34.2)	82 (34.6)	45 (19)	19 (8)	6 (2.5)	4 (1.7)

Appendix 8. 2: *Post hoc* comparisons- significant results of Kruskal-Wallis followed up with the Mann-Whitney U test.

***Post hoc* comparisons- significant results of Kruskal-Wallis followed up with the Mann-Whitney U test.**

Statement (S) Independent variable (IV)	Dependent variable (DV)	Groups of (DV)	Mann Whitney U test (Z, P value & mean rank)
S2-You must be aware of your rights otherwise you may miss out on some “MCH” services	Reason for residing in the UK	1-Family and education groups 2-Family and employment groups 3-Employment and education groups	$z = -0.80, P < .936$ $z = -1.831, P < .067$ $z = -1.758, P < .079$
S4-I feel it’s good to have all the healthcare services, including dentistry, free for pregnant women and one year post-delivery	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -3.050, P < .002$ Mean rank Worker (123.16) Housewife (100.54) $z = -.003, P < .997$ $z = -1.565, P < .118$
S24- I attended the antenatal class during my pregnancy	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -1.391, P < .164$ $z = -3.043, P < .002$ Mean rank Student (108.89) Housewife (72.64) $z = -2.110, P < .035$
S28- The waiting time in the emergency department is too long	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -1.683, P < .092$ $z = -3.065, P < .002$ Mean rank Student (110.1) Housewife (75.14) $z = -2.218, P < .027$
S42- There was not enough time during my visit for the midwife or doctor to answer my questions	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -2.855, P < .004$ Mean rank Worker (92.55) Housewife (116.98) $z = -.998, P < .318$ $z = -.541, P < .588$
	Reason for residing in the UK	1-Family and education groups 2-Family and employment groups 3-Employment and education groups	$z = -1.633, P < .102$ $z = -2.083, P < .037$ Mean rank Family (90.01) Education (116.96) $z = -.853, P < .394$
S44- I would prefer to read the leaflets about my pregnancy in the Arabic language	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -2.847, P < .004$ Mean rank Worker (92.55) Housewife (116.98) $z = -.856, P < .392$ $z = -.367, P < .714$
S46- I can understand written English well	Work	1-Worker and housewife groups	$z = -4.581, P < .000$ Mean rank Worker (133.7)

		2-Housewife and student groups 3-Worker and student groups	Housewife (95.38) $z = -.829, P < .407$ $z = -1.261, P < .207$
Statement (S) Independent variable (IV)	Dependent variable (DV)	Groups of (DV)	Mann Whitney U test (Z, P value & mean rank)
S47-Language problems make it hard to understand what the midwife, doctor and nurse are saying to me	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -3.041, P < .002$ Mean rank Housewife (115.12) Worker (89.11) $z = -.375, P < .708$ $z = -.869, P < .385$
S48- Language problems make it hard to explain my concerns to the midwife or doctor	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -3.180, P < .001$ Mean rank Housewife (118.09) Worker (90.47) $z = -.653, P < .514$ $z = -.812, P < .417$
S49- I find it difficult to book an appointment with my doctor because of language problems	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -3.696, P < .000$ Mean rank Housewife (120.23) Worker (88.58) $z = -.157, P < .875$ $z = -1.669, P < .095$
S54- I prefer to use a traditional herbal medicine	Work	1-Worker and housewife groups 2-Housewife and student groups 3-Worker and student groups	$z = -2.582, P < .010$ Mean rank Housewife (117.82) Worker (95.57) $z = -1.884, P < .06$ $z = -.523, P < .601$
S62- If the test or scan shows the possibility of abnormality, I would not terminate the pregnancy.	Reason for residing in the UK	1-Family and education groups 2-Family and employment groups 3-Employment and education groups	$z = -3.339, P < .001$ Mean rank Family (97.37) Education (131.66) $z = -1.123, P < .262$ $z = -2.524, P < .012$ Mean rank Education (33.17) Employment (21.33)

Appendix 9. 1: Publication Article

<http://www.intermid.co.uk/cgi-bin/go.pl/library/abstract.html?uid=100070>

