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A Qualitative Study of Pakistani Immigrant Women's Experiences of Childbirth in Germany

by Huda Al-Kebsi

*WATER FOOD DIABETES AYURVEDA GENETICS POVERTY YOGA STDS HISTORY SEX
SOCIETY FAMILY PLANNING CASTE GENDER RIOTS RELIGION HEALTH
DEMOCRACY FLOODING WASTE-MANAGEMENT UNANI PSYCHOLOGY FOLK
MEDICINE AFFIRMATIVE ACTION GLOBALISATION BIOCHEMISTRY OLD AGE
REPRODUCTIVE HEALTH MALARIA POLICY HIV AIDS WHO MEDICOSCAPES
COLONIALISM PHARMACY RELIGION LEPROSY BOTOX DEHYDRATION NGOs*

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A Qualitative Study of Pakistani Immigrant Women's Experiences of Childbirth in Germany

Master's Thesis

in partial fulfillment of the requirements for the degree of
Master of Arts in Health and Society in South Asia

submitted by

Huda Al-Kebsi

Supervisors:

Dr. Karin Polit

Dr. Roman Sieler

Heidelberg, Germany, October 2014

Name: Al-Kebsi, Huda

Declaration

For submission to the Examination Committee
regarding my Master's Thesis with the title:

“A Qualitative Study of Pakistani Immigrant Women’s Experience of Childbirth in Germany”

I declare that

- 1) It is the result of independent investigation.
- 2) It has not been currently nor previously submitted for any other degree.
- 3) I have not used sources other than the ones mentioned in the bibliography. Where my work is indebted to the work of others, I have made acknowledgments.

Heidelberg, 30th of October 2014

Huda Al-Kebsi

This thesis is dedicated to my husband who has been my constant source of inspiration.

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Abstract

Although there has been clear interest in immigrant women's maternity health, there are no studies on Pakistani immigrant women in Germany. The study presented in this thesis helps to fill this gap by seeking to examine the childbirth experiences of this group of women. The study was based on qualitative research of participant observations, in-depth interviews and focal group discussions with a sample of 19 Pakistani immigrant women living in the cities of Worms, Mannheim and Ludwigshafen. In addition, expert interviews were conducted with health professionals and specialists on immigrants' issues to complement the results of this study. The stories of the women revealed how they perceive themselves, their identity and personhood and allowed deep investigation of the various meanings attributed to their childbirth experiences. As Pakistani immigrant women, they needed to learn about a new system while lacking basic needs of mutual understanding. Among the chief complications the women faced was a sense of powerlessness and ignorance about their birth experience due to lack of control, having no active say in decisions about their care and being poorly prepared for the birth process. Some of these women were under more pressure because of the absence of their traditional family and social support structure. Upon migration, traditional practices observed in their societies of origin were not possible in a different social environment. These women found themselves unable to follow some traditional beliefs and practices. To deal with these challenges, the women developed strategies, represented by establishing new social networks and developing self-dependence attitudes, that helped them to adapt to the different social settings. The study recommends a more responsive and immigrant-friendly health approach based on increased access to information and an attentive and culturally competent attitude – one that takes into account woman's knowledge and bodily experience. Such an approach has the potential to reduce anxiety and discomfort on the side of immigrant women as well as among healthcare providers.

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Chapter One: Introduction

A large body of literature confirms that for immigrant women, considerable economic, social, cultural, and health issues arise when they migrate to independent, individual-oriented and competitive societies (eg. Messias 2011). Women are particularly vulnerable when they struggle to adapt to a foreign society and, simultaneously, try to preserve their own cultural and social traditions (Mitu 2009). This issue becomes even more challenging when it involves a childbirth experience. Certain cultural aspects act as significant determinants of a woman's emotional progression to motherhood and can highly affect her reproductive life cycle. Immigrant women bring with them beliefs in regard to what facilitates a good pregnancy, as well as negative impressions that may be difficult to ignore. Once these women encounter other persons who are not familiar with their customs and beliefs, they may begin to doubt themselves and question their traditions (Choudhry 1997).

Social and psychological problems have an impact on the dilemmas of motherhood as a reaction to bicultural conflicts, changing family structures and social networks that immigrant women face (Tummala-Narra 2004:167-168). Issues such as emotional and physical support become even more important for immigrant women to facilitate a smooth transition into motherhood. Withdrawn from their extended families and native social networks, immigrant women have limited access to social and family support, both which play a very important role in the process of childbirth. While this process is universally treated as "a marked life crisis event" (Jordan 1993:3), the experiences arising from migration such as communication problems, discrimination and negative stereotyping, the degree of integration with or isolation from the dominant society, socioeconomic condition, cultural factors and barriers in accessing the healthcare system are potentially able to expose immigrant woman to higher psychological and physical risks and ultimately lead to poor maternal health outcomes.

First and second-generation female immigrants are more vulnerable to maternal morbidity and mortality compared to native born women. In Germany, despite the lack of data and official statistics that confirm stillbirth and maternal mortality and morbidity to be higher among migrants than the German population (Razum et al 1999; Kohls 2011; Reeske et al 2011), studies

comparing women with and without migrant backgrounds confirm the fact that immigrants have long been at a disadvantage.

Razum et al (1999) examined the causes of maternal death and how they changed over time and found that maternal mortality is higher among women of non-German as compared to German nationality. However, both groups have experienced considerable absolute decreases in risk between 1980 and 2004 (Razum et al 2008). In addition, studies found that stillbirth among women from migrant nationalities is often higher than those of German women (Reeske et al 2011; Reime et al 2009; Spallek et al 2010). Reeske et al (2011) specified that women from the Middle East and North Africa (which includes Pakistan) showed a higher risk. In contrast to David et al (2006) and Spallek et al (2014), who found that later use of antenatal check-up is associated with higher risks of stillbirth in some migrant groups, Reeske et al (2011) and Reime et al (2009) showed that some migrant groups who sought early antenatal care and received the appropriate number of visits were at a higher risk of negative perinatal health outcomes. These disparities hint toward my hypothesis that there are differences in the quality of perinatal care which also varies among ethnic groups over time, highlighting the need for research in this area.

The results of the above studies illuminate the fact that maternity healthcare in Germany is far from optimal when it comes to immigrants' maternity health. The system is only slowly adapting to the needs of immigrants (Spallek et al 2010). In Germany, over the last two decades, immigration reached its highest point; the country is currently host to 7.3 million international immigrants (i.e. 9% of the entire population) of which 48.6 percent are female (Federal Statistical Office 2014). The country has the highest percentage of immigrants in Europe and has become the largest destination for immigrants after the United States (Faiola 2014). This increased inflow of immigrants presents a real opportunity to counter the declining growth of population in a country characterized by aging natives. Accordingly, an increased interest in immigrants' health and that of their descendants is needed to insure adequate healthcare for the immigrant population.

Numbering nearly 70.000 people (Zakar 2012; Haque 2012), Pakistanis represent a small immigrant group in Germany; yet they comprise a growing share of the German population. In addition, one third to half of the Pakistani population in Germany are Ahmadis seeking political asylum. Ahmadis are regarded as a heretical and deviant sect of Islam by the Pakistani

constitution; therefore, they are discriminated against in Pakistan. Nevertheless, this population group is classified as Muslim Pakistanis in German population statistics (Haque 2012). It is worth mentioning that this study includes participants of both the Ahmadi and non-Ahmadi Pakistani population. For many of these participants, moving to Germany goes with the expectation of a better quality of life and access to superior healthcare.

Although there has been clear interest in immigrant women's maternity health in social science and anthropology, there are no studies on Pakistani immigrant women in Germany. The study presented in this thesis helps to fill this gap by seeking to understand the meaning of being an immigrant Pakistani woman giving birth in Germany. The study aims to examine Pakistani immigrant women's experiences with the maternity healthcare system in Germany and to recommend ways to afford more responsive and culturally sensitive maternity healthcare services for these women and other with similar sociocultural backgrounds. It also aims at providing a comprehensive overview of their childbirth beliefs and practices. I hope that this study will be of value to researchers, policy-makers and practitioners.

The following chapters of this thesis seek to provide a deeper understanding of the Pakistani women's experiences from a variety of perspectives and to assist in achieving the research objectives. Chapter two provides the background for the current research by outlining the relevant literature on topics raised throughout the study. The chapter introduces the field of research known as the Anthropology of Birth and discusses the legitimation of the Western medical systems of birth. It continues by reviewing the maternity healthcare system in Germany and providing an overview of the traditional social structures of childbirth in Pakistan. The chapter also offers the reader a brief discussion of previous studies on childbirth experiences of immigrant women.

Chapter three describes and discusses the methodology of this research. In this chapter, I mainly concentrate on my fieldwork experiences; namely, my role in the research process, sampling models and access to participants, research methods and ethical issues considered throughout data collection. The findings of the study are presented and analyzed in chapter four. In this chapter, I seek to help the reader understand how my research participants perceive themselves, their identity and personhood, as Muslim Pakistani women. I also explore the factors affecting their selection of a doctor, their experience with the German healthcare system, the way immigration

influences their beliefs and practices and their adaptation and acculturation to the different environment. Chapter five concludes the study by summarizing the core findings and presenting recommendations for future action and speculations about future trends.

Chapter Two: Review of Literature

2.0. Introduction

This chapter outlines the relevant literature on childbirth and migration which provides the background for the current study. An introduction to the anthropology of birth is presented, followed by a discussion of the dominance of medicalized childbirth. Consideration is then given to the maternity healthcare systems in Germany and the traditional social structures of childbirth in Pakistan, which play an important role in the childbirth experiences of Pakistani women. This is followed by an overview of immigrant women's health.

2.1. The Anthropology of Birth

In all societies, the birth process is not a merely physiological function but a socially and culturally marked and shaped event (Sargent 2004, Jordan 1993). However, it took time for anthropologists to employ this fact within their ethnographies. The study of childbirth was never essential to anthropologists in earlier research; therefore, "childbirth did not exist in anthropology"(Jordan 1997:55). According to Browner & Sargent (1996:221), earlier data on childbirth has been contained within literature covering other subjects rather than works devoted to birth research. This can be the consequence of lack of interest in childbirth or the difficulty to access birth experiences by male anthropologists, who represented most of the ethnographers during anthropology's first century (Davis-Floyd and Sargent 1997:1).

In 1978, the first edition of Brigitte Jordan's foundational cross-cultural ethnography *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States* signaled the field of research now known as the Anthropology of Birth and initiated its principal methods of cross-cultural comparison and analysis. Jordan's study was not the first to explore childbirth from a cross-cultural perspective; however, she established the groundbreaking framework to view childbirth from a biosocial standpoint. Jordan notes, "to speak of birth as a biosocial event, then, suggests and recognizes at the same time this universal¹

¹ Female gender and sexuality are not necessary interpreted as a universal biological fact. This topic has generated a large anthropological discussion since the 1970s.

biological function and the culture-specific social matrix within which human biology is embedded” (Jordan [1978] 1993:1).

Based on her fieldwork in the United States, Yucatan, Holland, and Sweden, Jordan compares the similarities and differences of birthing systems in these different cultures. Her research is based on direct observation and, whenever possible, actual participation in births in all four countries. The cross-cultural comparison of childbirth experiences reflects a critical exploration of how childbirth practices, although physiologically the same, are culturally preserved, employed and legitimized. She views birth as a social interactional production where people know “how to do” birth rather than talk about “what they do” (Jordan 1978:8). As a result, Jordan argues that “childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural” (Jordan 1993:1).

Jordan’s work seeks to address the culture-specific definition of the event as follows: in the United States birth is considered a medical procedure; in Yucatan it is regarded as a stressful, but normal part of family life; in Holland it is perceived as a natural process; and in Sweden it is viewed as an intensely personal and fulfilling achievement (Jordan 1993:48). She proposes the accommodation between biomedical and local birthing systems to help resolve the hegemony of each of the different systems. In other words, to work on “a phenomenon that is produced jointly and reflexively by (universal) biology and (particular) society” (Jordan 1993:1).

Accordingly, successive ethnographic research in this field has built up a corpus of literature following Jordan’s approach to consider the social and cultural, as well as the biological phenomenon of childbirth. Among the first prominent ethnographic studies during the 1980s were the works done by Sargent (1982, 1989), Laderman (1983), and (MacCormack [1982] 1994). These detailed ethnographic works have depicted how various indigenous birthing systems are challenged by a newly introduced and legitimized biomedical system. They have successfully described childbirth from sociocultural perspectives like gender ideology, domestic power relations, professional specialization, and the components of particular ethnomedical systems (Sargent 2004:226-227).

Subsequent research on childbirth has involved a more multifaceted prospect of culture than was marked in Jordan's ethnography. Contemporary works examine the influence of childbirth technology and the domination of biomedical practice on indigenous birth systems. Davis-Floyd

(1992), Jordan (1993), and Davis-Floyd and Sargent (1997) are among the principle scholars to address these trends.

2.2. Medicalization of Childbirth

Childbirth medical technology has gained momentum over the past few centuries. Currently, medical intervention is the preferred practice in the West, and increasingly around the world. Medicalization² of childbirth has become the driving force where women perceive childbirth as a risky event that cannot be safely processed without medical interventions.

In her book, *Birth as an American Rite of Passage*, Davis-Floyd examines the manner by which ideologies relating to birth are constructed. The author notes that birth systems in American hospitals are based on what she termed the “technocratic model” of birth in which a society is organized around an ideology of technological progress and where “a female body is viewed as an abnormal, unpredictable, and inherently defective machine” (Davis-Floyd 2004:53). According to Davis-Floyd, a woman's response to a technocratic model is determined by her view of birth. She argues that the western cultural attitude toward birth is fear-based; therefore, it is viewed that medical intervention through technology improves the process of childbirth by making it safer (Davis-Floyd 1994:6).

Jordan discusses how the domination of Western obstetric systems, the medical profession and highly specialized medical technologies represent the constitution of authoritative knowledge within the field of childbirth. Jordan (1993:152) argues that medicalization of birth is the consequence of the legitimation of one kind of knowledge. The author creates the concept of authoritative knowledge which holds the view that,

... for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both (Jordan1993:152).

² Medicalization is referred to by Conrad (1992) as “defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to “treat” it” (Conrad 1992:211).

This is evident in the replacement of traditional “low technology” practices with technology-dependent approaches of cosmopolitan obstetrics or, what she described as “cosmopolitical obstetrics, that is, a system that enforces a particular distribution of power across cultural and social divisions” (Jordan 1993:196).

As a result, a main decision-making role is given to those who hold authority and control medical technology. This medical authority and control constrain woman's knowledge and bodily experience; they exclude the woman from her own birth experience, her essentially personal sphere.

2.3. Maternity Healthcare System in Germany

The situation in German does not differ greatly from that in the United States where birth is mainly a medical event controlled by the medical profession. An early phase of the medicalization of childbirth in German-speaking countries goes back to the late eighteenth and early nineteenth centuries where obstetricians, like in other parts of the western world, declared to save the lives of mothers and children (Schlumbohm 2013:3). As physicians gained authority over the birth process women were left with less control and fewer choices. Medicalized birth, with its reliance on technology, resulted in the hospitalization of childbirth attended by reputable obstetricians, a decrease in home deliveries and midwifery practices and the increasing trend toward operative deliveries like forceps births and caesarean sections³ (Scheuermann 1995:441).

Medical authority has not just taken power away from women but also shifted it away from midwives towards medical professionals. Childbirth in Germany has increasingly been dominated by physicians who promote themselves as the best sources of maternity care (Wagner 1996:208) and take over antenatal examination, deliveries, and postnatal care. Midwives “act merely as obstetric nurses” (Porter 2004:154). However, the government has been trying to challenge this trend and provide more options that empower midwives. In fact, the German legislature passed a bill in 1985 which stated that

“eine Hebamme (a midwife) is trained and qualified to provide care and counsel women during normal pregnancy, delivery and postpartum; ..., a midwife is solely

³ The percentage of caesarean deliveries has risen steadily in Germany from 15.3% in 1991 to 31.8% in 2013 (Destatis 2013; Destatis 2014).

competent to manage a normal delivery and provide care for the newborn; ... a midwife is the only skilled person, other than a physician, in the healthcare profession who is legally entitled to deliver medical care independently (ie. without a nurse and/or a physician)” (Scheuermann 1995:442).

This has given rise to a less medicalized trend in childbirth. A woman in Germany is free to choose a midwife or a physician as her main maternity care provider during and after pregnancy. Midwives can perform prenatal examination, provide antenatal classes and counseling, attend normal deliveries, perform episiotomies, and offer complete post-delivery care for at least ten days, including nutritional counseling and newborn follow-up. A midwife can also provide treatment for disorders during pregnancy, such as diabetes mellitus, hypertension, and anemia.

However, certain limitations exist, as a midwife can only perform such treatment after she informs the woman about both the disorder and the treatment options provided by the physician, who must be consulted for additional tests. In case the woman opts for a midwife’s treatment, she first has to give her consent. Moreover, a woman who chooses a midwife has to see a physician for diagnosis of pathological conditions before being admitted to the hospital (Scheuermann 1995:443).

Despite the fact that the midwifery tradition in Germany has remained functional, with midwives having had an official position since the 1930s and being formally legitimized in 1985, their profession is still restricted under certain conditions as they become even more dependent on physicians. In addition, midwives are trained under the instruction of physicians (Scheuermann 1995:441) and midwifery practices no longer rely on traditional birth knowledge, like herbs and homeopathic therapies, but are totally dependent on “techno-obstetrics” due to the westernization of German hospitals (Davis-Floyd and Sargent 1997:14).

Although the medical profession in Germany is interested in providing women with alternatives such as delivering their babies at a birthing center (*Geburtshaus*) or hiring a midwife to support them during a homebirth (*Hausgeburt*), the vast majority of women still give birth in hospitals. According to Loytved (2014:13), only 1.5 per cent of women in Germany give birth out of hospital. To encourage women to opt for hospital delivery, birthing rooms in hospitals are adapted to their needs where physical accommodations are made to create home-birthing atmosphere. Another alternative birth model that has been applied in different European countries like Scandinavia, Austria, Switzerland and the UK over the last ten years is the midwife delivery

room (*Der Hebammenkreißsaal*) located at the hospital, where a woman can choose to be assisted solely by a midwife without medical intervention (BZgA 2014). Such an alternative is becoming more common in Germany as it offers the birthing women the confidence of being in hospital where medical assistance is available when needed. However, the woman can choose these alternatives only if there is no foreseeable risk or complications to mother and child (eg. diabetes, high blood pressure, multiple pregnancy or a breech position) (BZgA 2014).

Emons and Luiten (2001:59) argue that the tendency of the majority of women to deliver in hospital or to go first to a physician for pre and postnatal care is because they lack the information about the care provided by a midwife which might make them decide differently. This can also be due to the fact that there are more practicing obstetricians and gynecologists than midwives in Germany (Emons and Luiten 2001:57-60). Additionally, due to the substantial increases in the liability insurance premiums that midwives have to pay, many have begun looking for other jobs (Wiese 2014). Such a dilemma results in a declining number of birth centers and shortage of homebirth midwives.

The attempts to accommodate the needs of women can be seen as part of a larger initiative of the German government to promote birth and encourage families to have more children in order to counter the low demographic development in the country. Germany faces a continuing decline in the native birth rate which is the lowest in Europe and one of the lowest in the world (Castaneda 2008:341). Compared to today's population of 82 million, it is estimated that only 70 million people will be living in the country by 2050 (Spiegel 2012). To provide incentives for parents, the government offers financial support in the form of parental allowance (*Elterngeld*), parental leave (*Elternzeit*), child benefit (*Kindergeld*), legal protection for working mothers (*Mutterschutz*) and the maternity benefit (*Mutterschaftsgeld*). The parental allowance is a state benefit which can be shared by parents for 12 to 14 months after the birth. Parents receive an amount up to 67% of the yearly average net income before birth. The minimum monthly payment is 300 Euros and the maximum is 1,800 Euros. For parents with an income below 1000 Euros, the compensation rate is increased to 100 %. Parents who do not have a job can still receive a parental allowance (Vogler-Ludwig and Giernalczyk 2009).

Parental leave gives employed parents the right to take leave until their new child reaches the age of three. Since their job remains reserved for them, both the mother and father can take parental

leave individually or jointly by sharing the period and, therefore, sharing child care. Parents are also entitled to a child benefit, which is a monthly payment to a child's parents or legal guardians until the child reaches the age of 18 or until the child's 25th birthday if the child is studying or doing a professional training. However, the parents' as well as the child's place of residence must be in Germany or a European Union country and the parents must pay income taxes in Germany. Parents receive monthly child benefit payments of 184 Euro for the first and second child, 190 Euro for the third child and 215 Euro for every subsequent child (bamf 2011).

Additionally, the German Maternity Protection laws (Mutterschutzgesetz or MuSchG) protect the health of the employed mother by providing legal protection. Generally it runs for six weeks before and eight weeks after birth, during which a woman is not expected to work and her job is kept open until she returns to it at the end of her maternity leave. Regardless of family or marital status and nationality, an employed mother is entitled to receive maternity pay during this period (bamf 2011).

Clearly, the German government has worked on the institutional and legal framework to help make birth financially and physically manageable. Yet, the total fertility rate is on a downward trend as the number of potential mothers is falling. This could be explained by the hypothesis that motherhood is associated with the decline of a woman's status (Kneuper 2004). Elsbeth Kneuper, studying motherhood in Germany, explored how pregnant women perceive themselves as actors in the process of the "procreation" of their own society. The author discussed women's concerns with the radical social and economic changes resulting from motherhood and leading to a disadvantaged economic and professional status as well as financial dependence. She emphasized the fact that motherhood closes women's access to higher professional positions reflecting considerable weaknesses in German family policy.

In her study, Kneuper questions whether women's contribution to the "procreation" process is either financially or symbolically appreciated. She argues that motherhood in Germany is a marginal phenomenon where the mother stands as a shadow of the fetus. The author described how the pregnant woman's status is ignored when medical and social attention is solely directed towards the baby; the main focus is given to her role to protect the life of the new child. Using case studies from her research data, Kneuper described how one participant explained her husband's concern about the baby's health and ignorance about her situation as a pregnant

woman. When the mother started feeling the load of the baby and complained about it, her husband showed his anxiety and fear that his child might be affected. According to Kneuper (2004:264), this focus on the fetus creates conflict between the child and mother which is specifically featured in German society.

Given all this, it can be argued that birth in Germany results in the marginalization of women not only as a consequence of social ignorance and disadvantaged economic status, but also due to a hegemonic biomedical-oriented healthcare system which removes the woman largely from the process of birth.

2.4. Traditional Social Structure of Childbirth in Pakistan

Exploring the birth experiences of Pakistani women sheds light on the traditional structures of childbirth as well as related beliefs and practices in a Pakistani society. Margaret Chesney, in her empirical study examining the life and birth experiences of women in Pakistan (Chesney 2004), and one of very few studies to explore the maternity health of Pakistani women, refers to birth in Pakistan as “a place for women, with women, by women”. Therefore, birth is seen as a women’s issue and can only be discussed among women in the family, where information is spread verbally to people “who have the right to know” (Chesney and Davies 2005:26). According to Chesney, this common view of birth as a “women’s business”, which cannot be examined in papers, results in a lack of literature exploring maternity health in Pakistan.

As a women’s concern, birth also affords women the agency to be strong, positive and powerful (Chesney 2004:373). The author argues that “this strength, conviction, determination and faith culminated in a glowing power, this emanated from the strong belief that they could do that which only women can do - give birth” (Chesney 2004:375). Given this, no wonder motherhood is a definitive aim in life for the Pakistani woman.

This uniquely female strength is derived from the Pakistani culture that traditionally justifies a high level of emotional support and care for the woman during the antenatal, natal and postnatal period, normally provided by her family. The family also provides different forms of support like financial help and routine child care to ensure the physical and emotional wellbeing of the woman (Qureshi 2010:201). Therefore, the woman does not hold responsibilities for the

household chores or the newborn and is expected to rest during this period. *Chilla* is a ritual tradition based on the belief that “the grave keeps its mouth open for a mother for 40 days after delivery” (Khadduri et al 2008:184) and practiced through a post-delivery confinement of the mother for 40 days. During this time, all responsibilities of the new mother are taken over by other female family members (Rahman et al 2003:1164-1165). Additionally, in order to protect the new mother from exposure to cold, the family restricts her from using water for washing her hair or having a bath for a certain number of days after birth (Chesney 2004:342).

The woman also depends on the elderly women in her family to prepare her meals and watch her diet. Pakistani women adhere to a special diet during pregnancy and the postpartum period. This diet includes eating a lot of fruit and drinking milk as well as consuming special Pakistani meals like *panjeeri* which are believed to restore the mother’s strength (Qureshi 2010:204). These meals are prepared from special ingredients that help to maintain a balance of the body before and after birth. In South Asia, the human body is traditionally viewed as being in a balanced state between hot and cold. Such views are based on healing practices that developed historically from the 5000-year-old Ayurvedic medical system. An imbalanced state can cause illness, which can be treated by restoring the proper balance through “hot” and “cold” foods or herbs (Foster 1976:775; Reed 2003:47). The hotness or coolness of ingredients does not indicate the temperature or spicing of food but refers to its properties (Choudhry 1997:534). Pregnancy in South Asian cultures is considered a hot condition and women are advised to consume food with cooling properties (eg. milk, yogurt, buttermilk, coconut, wheat, rice) to maintain a balance in the body. On the other hand, lactation is a cold condition and foods that are considered cold are restricted during the postpartum period; instead, hot foods (eg. meat, eggs, fish, ghee, onion, garlic) are recommended (Nag 1994:2427; Choudhry 1997:534).

As the focus of all members in her family, the woman receives special attention during certain celestial events like the lunar and solar eclipse, which are believed to have a harmful effect on the pregnant woman. In the Indian subcontinent, lunar and solar eclipses are considered to be an inauspicious time where evil power is strong (Astrosage 2012). People in Pakistan believe a solar/lunar eclipse during pregnancy to be the main factor causing of cleft lip and palate, clubfoot and other anomalies (Burfat et al 2013; Chowdry et al 2013). A pregnant woman is recommended to avoid sleeping but also to be cautious about the activities she carries out during this period.

Some activities like using a knife to cut fruit and vegetables, sewing, going outside the home and wearing metals or jewelry during solar/lunar eclipse can cause harm to the unborn child (Burfat et al 2013:150; Astrosage 2012).

The *dai* (traditional birth attendant) who is an important and trusted member of the family and community in Pakistan also plays an important role in the pregnancy, delivery and puerperium experiences of Pakistani women. In Pakistan, more than 65% of births take place at home (43% urban vs 74% rural), where almost half of these births are attended by *dais* (Bhutta et al 2011:403; Chandrasiri et al 2012:2). According to Chesney (2004:280-281), the *dai* can be a close relative like a mother or mother-in-law, have honorary family membership or simply be a member of the community who shares the same cultural values and social norms. As part of the family, she is prepared to undertake special duties with more “understanding of the holistic needs of the childbearing woman” (Chesney 2004:282). The *dai* provides emotional support to the expectant mother and takes on physical responsibilities like cleaning the delivery room, washing clothes and cooking. One of her special duties is massaging the newborn, to help build strong bones (Qureshi 2010:55), and the woman before and after childbirth. Massaging the woman is a common practice which is believed to aid muscle relaxation, relieve pain and increase milk supply (Khadduri et al 2008:184).

Besides the mother, the new baby also becomes the focus of the family. There are special practices and Islamic customs concerning the newborn child. Fikree et al (2004:915) and Khadduri et al (2008:184) find that, although breast milk is the preferred newborn food, the Pakistani family tends to provide the baby with supplementary foods like honey or *ghutti* (herbal paste) immediately after birth. These supplements, believed to strengthen and clean the baby’s stomach, are provided to the child by an elderly, pious relative and often sucked from his/her finger. This also transfers the provider’s qualities to the newborn child. In addition, according to Islamic custom, an older member of the family recites the *azan* (the Muslim call for prayers) in the baby’s right ear after birth so it is the first words the baby hears. Reciting *azan* is a means of inviting the newborn to become a Muslim (Khadduri et al 2008:184; Qurshi 2010:210). Another Islamic custom is to shave the baby’s head and to circumcise the male baby about seven days after birth (Khadduri et al 2008:184).

Additionally, an important Islamic ritual is the *aqiqa* ceremony celebrated by the family after the birth of the baby. Qamar (2012:390) indicates that “*aqiqa* is considered a virtue to invoke Allah’s blessing and to remove the calamities that may happen”. The ceremony is not obligatory, but recommended if the parent of the newborn can afford it. On the seventh day after birth, two goats are sacrificed for a son and one for a daughter (Qurshi 2010:210; Qamar 2012:390). According to Qamar, two goats are sacrificed for a son to indicate his social worth and the role he will play in the future as a family head.

Drawing upon these traditions, it is clear that, unlike in Germany, the woman and her newborn become the center of attention of the family in Pakistan, which plays a big role in the maternity experience of Pakistani women. This supports the argument made by Stern and Kruckman (1983:1039), that in traditional non-western settings, the attention is mainly given to the new mother, or mother and infant together, which presents a strong contrast with the pattern in western societies where the focus is primarily on the newborn baby. The social structuring of birth events in Pakistani society makes maternity a desirable experience for the mother and her family.

2.5. Immigrant Women and Maternity Health

Pregnancy and childbirth experiences are directly associated with sociocultural changes that immigrant women experience. As discussed by Qureshi (2010), these changes had a negative influence on Pakistani immigrant women’s maternity experiences in the US. Many of the cases studied reflected depression, encountering a new alien healthcare culture and the loss of family support.

Similarly, Proctor and Smith (1992), studying social stress and depression during pregnancy and in the postnatal period among British Pakistani mothers, found that depressed mothers were dissatisfied with the social support they received and felt socially isolated. Moreover, they reported dissatisfaction due to communication barriers, discrimination and culture-blaming. Tsianakas and Liamputtong (2002) also noted that although Muslim women in Australia showed satisfaction with the level of care and support they received during pregnancy, they also reported negative discrimination issues. Women felt that because they wore a *hijab* (headscarf), they were

not treated well by health providers and only judged by their appearance. Interestingly, studies also noted physicians' dissatisfaction with their interaction with migrant patients in German health institutions, especially their lack of familiarity with certain traditional practices (Castaneda 2012:834).

Research that has been conducted on Muslim immigrant women has also shown that these women experience difficulties with foreign healthcare systems. In a study to articulate how immigrant women from the Middle East and the Sahel perceive medical competence in clinical settings in Australia, Manderson and Allotey (2003) discussed the limitations of conventional models of communication between patients and healthcare providers. They argued the need for health providers to appreciate the possible barriers of education, ethnicity, religion and gender that can impede communication. Similarly, in their study exploring the maternity healthcare needs of immigrant Muslim women living in Canada, Reitmanova and Gustafson (2008) noted that maternity healthcare services designed to meet the needs of mainstream Canadian women lacked sufficient flexibility to meet the needs of immigrant Muslim women.

Although studies on immigrant women's maternal health exist in social science and anthropology, this literature review has found no studies on Pakistani immigrant women's health in Germany. The sole study that specifically studied Pakistani immigrant general health experiences in Germany was conducted by Khan et al (2013). It revealed that Pakistani immigrants in Germany face several barriers to accessing German healthcare services. Among the important barriers the study identified are culture, language skills, individual attitudes towards medical treatment, religious discrimination faced by Muslim women, doctor-patient relationships, and attitudes of health facility registration staff towards immigrants.

2.6. Conclusion

A literature search highlights the need for studies on the social and cultural factors that influence Pakistani immigrant women's health in Germany. The study presented in this thesis helps to fill this gap by seeking to examine Pakistani immigrant women's experiences of childbirth in a German social context.

Chapter Three: Methodology

3.0. Introduction

This qualitative research has the purpose of exploring the childbirth experiences of Pakistani immigrant women in Germany. In this chapter I reflect on the qualitative research methodology chosen for this study. The chapter starts with describing my role as a researcher throughout the research process. This is followed by a discussion of the way the participants were sampled and accessed. Further, research methods used for data collection and analysis are discussed as well as ethical issues that were considered throughout the data collection process.

3.1. My Role in the Research Process

My background as a Yemeni female Muslim resident in Germany influenced the purpose of my study and my choice of the research topic, to study the childbirth experiences of Pakistani immigrant women in Germany. Issues regarding maternity are especially interesting since so many Muslim cultures share the same traditions, practices and beliefs related to pregnancy, delivery and puerperium.

Having read substantial literature on the research topic, I was aware that although Yemeni and Pakistani societies share similar practices and beliefs, Pakistani women still have their own special traditional healthcare practices. I recognized the significant linguistic, ethnic and social differences between myself and my participants. I, therefore, approached this topic from the outsider perspective. However, as the research progressed, I began to realize that there were a number of commonalities between me and the participants which facilitated shared understanding on several grounds; I found that I sometimes shared views, feelings and perceptions with my participants. Holloway & Wheeler (2002) and Corbin Dwyer & Buckle (2009) propose that this perception can affect the accuracy of information and result in a research shaped and guided by the researcher's assumptions and experiences rather than those of the participants. Therefore, I adopted a careful and reflexive approach to refrain from such a challenge. Still, it did not necessarily mean that I positioned myself as an insider instead of outsider; rather, I found that I occupied the "space between" (Corbin Dwyer and Buckle 2009).

Correspondingly, my research participants have also positioned me as both an insider and outsider, depending on the context. For instance, being a Muslim, married immigrant woman was certainly advantageous and decisive for my participants to identify salient commonalities between myself and them. My participants had ascertained my Islamic background from my first name⁴ and Muslim appearance. I also tended to wear traditional South Asian dress, *Salwar Kameez* (loose pajama-like trousers and a long shirt), in most of the interviews and Focus Group Discussions which helped to develop better familiarity.

Additionally, my gender and marital status were critical aspects for a successful entry into the field of research. Talking about topics related to sex and reproductive health is considered a taboo for unmarried women in Pakistan. As a married woman, I was able to ask questions regarding maternity and childbirth. Obviously, by sharing experience, gender, marital status and religious background, I was positioned as a member of the group. This insider position allowed me more rapid acceptance by my participants and facilitated a greater depth to the data gathered (Corbin Dwyer and Buckle 2009:58).

However, although the insider role afforded a successful entry to the research, it had the potential to impede the research process as it progressed (ibid). As I shared the same religious context with my participants, they repeatedly made the assumption that I was already aware of and entirely familiar with the Muslim practices and beliefs related to pregnancy, delivery and puerperium. Therefore, I was uncertain whether my participants were leaving out relevant information, supposing that I already knew them. To overcome this concern, I explained to the women that I had not experienced childbirth yet and that it was my hope to learn from their experiences to reinforce my knowledge.

On the other hand, my participants were also aware of the fact that there were considerable ethnic and social distinctions between myself and them. I found that sometimes the outsider position was an advantage because it facilitated the identification of some details which might have been difficult for a Pakistani researcher to investigate. Weigl (2010), in her study of the reproductive health behavior of an Indian Muslim community, found that her outsider status as a white foreigner woman was positively advantageous given that she was able to ask questions about contraceptive practices, mainly because she was not an Indian woman. Similarly, seen as a non-

⁴ Huda as a word is mentioned several times in the Quran. It means a guidance to the right path.

Pakistani, my participants felt it easier to discuss with me issues they considered embarrassing to reveal to Pakistani women, out of shame and modesty⁵. According to Fay (1996), we tend to hide ourselves from ourselves out of self-protection and guilt; therefore, not being a member of the group implies being able to identify issues that are difficult to discern by an insider (cited in Corbin Dwyer and Buckle 2009:59).

Additionally, my status as a non-Pakistani and particularly as a non-Ahmadi, in some cases, impacted the level of trust and openness between me and my participants. For instance, I noted that some women, especially Ahmadiis seeking asylum, were careful not to criticize the German healthcare system. To deal with such a challenge, I tried to build rapport with my participants through frequent meetings. I also conducted participant observations to help me to deeply investigate these issues. I found that the more time I spent with some of the participants, the more challenges I observed and they reported.

Throughout my research I found myself within a circle of both insider and outsider worlds. My participants and I could not position my status as either a true insider or a complete outsider. Following Corbin Dwyer and Buckle (2009:60), I recognized that it is “restrictive to lock into a notion that emphasizes either/or, one or the other, you are in or you are out”; therefore, I maintained a “dialectical approach [that] allows the preservation of the complexity of similarities and differences”. Within this circle, I obtained the space between.

3.2. Research Participants

This study was conducted in southwestern Germany, in the cities of Mannheim, Ludwigshafen and Worms, where large number of Pakistani immigrant families live. The sample consisted of 19 Pakistani immigrant women interviewed, comprising 2 focus groups and 9 individual interviews. The women, aged 21-50 years, have experienced pregnancy, delivery and puerperium in Germany. The participants were married to men with similar ethnic backgrounds. They all had legal permanent residence status in Germany and some had already obtained German citizenship. All participants were middle class, without financial problems. They all had a high school diploma or a university degree; yet, all were stay-at-home mothers. For the purpose of covering

⁵ This topic will be discussed in details in Chapter Four.

different immigration experiences, the sample included women from first, 1.5, and second-generation immigrants⁶. Therefore, a purposeful sampling technique was carried out to obtain research participants for this study and to draw out rich and wide variety of stories.

The first starting point to gain access to participants was to contact the Ahmadiyya Muslim Community in Germany. Another strategy I used while waiting for approval from the community was to build a network with participants who voluntarily agreed to participate in the study. I met Nayab spontaneously at a gynecological clinic where she works as an assistant. After I explained to her about my study she offered to introduce me to her mother and aunt, with whom I built good rapport. Similarly, I met Saadia at the supermarket; she showed her willingness to take part in the study. These contacts helped to provide me with additional information about other women in their social networks whom I can interview. This strategy allowed me to also use snowball sampling to get an adequate number of respondents.

3.3. Data Collection Methods

Since the aim of this qualitative study is to explore birth experiences of Pakistani immigrant women in Germany, it was important to choose methods that allow the positioning of these experiences in a broader context. Jordan (1993:102) proposes that “in anthropological birth research we are interested in two basic kinds of data: our observations of birth participants’ behavior, and birth participants’ talk about their behavior”. For this purpose, I used a set of complementary qualitative methods including participant observations, in-depth interviews and Focal Group Discussions. Data collection started in May 2014 and lasted three months.

3.3.1. Direct and Participant Observations

Qualitative research highlights the value of the investigator’s engagement in the data through fieldwork and observation. I undertook participant observations which broaden my knowledge

⁶ First generation immigrants are individuals who arrived to Germany as adults, 1.5 generation immigrants are those who arrived as children while second generation immigrants are German-born individuals of Pakistani immigrant parents. For the purpose of this study, 1.5 and second generation immigrants are referred to as young generation.

and provided the framework to other data I collected. It also covered issues my participants were reluctant to talk about. I participated in several social and religious activities such as the annual gathering of Ahmadiyya Muslim Community in Germany, a wedding ceremony, an *aqiqa* event following the birth of a son and Quranic classes provided at the local mosque.

I also accompanied one of my participants who was pregnant during the period of data collection, Saadia, to her pregnancy clinical checkups. I also conducted direct observation of a midwife's postnatal home visit which took place at Zainub's house. These clinical and home visit observations provided the basic framework of how these women interact with the healthcare providers. I also participated in Saadia and Zainub's general lives at home which allowed me to document their family and daily dynamics. These observations were recorded contemporaneously in my research field diary.

3.3.2. In-depth Interviews

In-depth, open-ended interviews have long been the foundation stone of anthropological data gathering (Pelto and Pelto 1996:309). Because they allow in-depth examination of issues and expand existing understanding (LeCompte and Schensul 1999:121), open-ended interviews were used as a discovery-oriented method to seek interpretation, obtain thick description and deepen knowledge of the topic.

This study used unstructured and semi-structured interviews with 9 Pakistani immigrant women. Unstructured interviews were conducted with participants whom I had the chance to accompany and participate in their daily lives, with the idea of getting them to open up and express themselves in their own terms and space (Bernard 2006:211). Doing unstructured interviews was more of a conversational interaction with the women while sitting on the tram, the clinic waiting room, around the kitchen fire, and anyplace where my participants were willing to talk (Jordan 1993:102). Although the interviews were open to any and all relevant responses, the questions were based on a clear plan.

Semi-structured interviews were designed on the basis of an interview guide (Bernard 2006:212; LeCompte and Schensul 1999:149) to help focus on issues surrounding the research question. However, the questions were not covered in a particular sequence with all the women, since it

followed the responses of the individual participant. Furthermore, since the respondent could influence the topic where unexpected issues emerged, the interview guide was modified throughout the early stage of fieldwork. As Holloway and Wheeler (2002:90) suggest, the interview guide “focuses on particular aspects of the subject area to be examined, but it can be revised after several interviews because of the ideas that arise”. Each semi-structured interview lasted between two to three hours and took place in locations that were most convenient for the participants. Most of the interviews were conducted at the participants’ houses. One interview took place in the local mosque and another was held in my house.

The interviews were conducted in Urdu and English, depending on the preference of participants. Although I have studied Urdu for two semesters, it was still difficult for me to speak or to follow a conversation in Urdu; therefore, I had to seek the help of interpreters. I also conducted expert interviews with different health professionals and specialists on immigrant issues, who provided me with important information and helped to complement the results of this study. I interviewed Dr. Nasir Khan, an internist and a researcher at Charité University of Medicine. I met Dr. Khan in Berlin where he conducted a study on the barriers to accessing the German healthcare system for Pakistani immigrants. I also interviewed Dr. Magdalena Stülb, professor, expert and researcher in the areas of migration, intercultural competence and transcultural networks at Koblenz University of Applied Science. Dr. Stülb is also an anthropologist and gained her PhD degree in transnational networks of immigrants in the context of pregnancy and childbirth. In addition, I conducted interviews with Dr. Farideh Safai-Elahi, a female gynecologist and Mrs. Wafa Ouda, a midwife.

3.3.3. Focus Group Discussions

Focus Group Discussions (FGDs) were conducted to complement the other research methods in this study. This method resulted in a more comfortable environment where the women became increasingly encouraged to exchange their views and share their experiences with each other. Although the stories and experiences the women were asked to share can be considered personal and sensitive to elucidate, the women demonstrated their willingness to exchange and share them in a group. Hardon (2007:238) suggests that sensitive topics are better handled through an FGD since participants usually tend to feel more comfortable or secure when exploring such issues in a

group. It was clearly noticed that while women showed ambivalence about not complaining in regard to the German healthcare system, the use of the FGD approach displayed a remarkable synergic effect and interaction where participants revealed different issues, building on each other's responses. This helped to explore the problems and their causes in greater depth.

Two focus groups were conducted with a total of 10 Pakistani women. Because participants in FGD should be roughly of the same age, background and sexual composition (Hardon 2007:240) and for the purpose of comparing different generations, the women were recruited from two age groups. The first focus group comprised 6 first generation Pakistani women between the ages of 40 and 50. The second was conducted with 4 young generation women between the ages of 28 and 33. Because participants were interviewed in their free time, it was difficult to organize the FGD with young generation immigrants who are mostly new mothers, busy with their households and children. These women hardly had time for a FGD; therefore, I tended to be flexible as to the number of participants needed for this group. However, although first generation women were more flexible with time, it proved difficult to organize this FGD due to their unpunctuality and non-commitment with appointments.

As previously stated in interviews, FGD were also held in the language of preference of participants. The FGD with first generation immigrant women was conducted in Urdu while FGD with young generation women was in both German and Urdu.

3.4. Data Analysis

Analysis started before the collection of data, in which I read a lot of literature, gathered information and developed research questions, and continued throughout the research process (Bernard 2006:453). During data collection, I tended to transcribe interviews and FGDs, translate them into English and type my daily field notes at the end of each day. These processes were followed by immediate data analysis which helped me to plan further for the next day in the field. According to Smith and Osborn (2003:67), "qualitative analysis is inevitably a personal process and the analysis itself is the interpretative work which the investigator does at each of the stages".

Smith and Osborn's Interpretative Phenomenological Analysis (IPA) inspired me strongly to examine in detail how my participants "are making sense of their personal and social world" and

to articulate what the particular experiences, events and states mean for them (Smith and Osborn 2003:53). The authors propose to begin “with particular examples and only slowly working up to more general categorization or claims” (Smith and Osborn 2003:67). Although I did not follow Smith and Osborn’s proposed stages strictly, their approach guided me through the research process and data analysis. Since the main purpose of this research is to examine the childbirth experiences of Pakistani immigrant women, following Smith and Osborn, I started by looking for themes in the experience of my first cases, connected these themes, and continued the analysis with the other cases. This helped to investigate the women’s human experiences greatly.

The data was categorized, labeled, coded and organized manually to emphasize the intuition and empathy of qualitative data analysis as well as the “thinking part” of the analysis process (Webb 1999:328). I intended to avoid the use of computer-assisted qualitative data analysis software (CAQDAS) like Atlas/ti and NVivo for the purpose of creating a sense of familiarity with what my research participants have expressed, as at the same time to reflect on the data throughout the thesis. As Webb (1999:328) notes, “it is as if the ideas almost literally flow up one’s arm as one annotates transcripts and makes notes, enter one’s brain, and then flow back to the paper on which the analysis is written”.

A word about the difficulty of language difference during data gathering is appropriate at this point. The use of interpreters potentially increased the risk of misinterpretation or taking out of context some of what the women reported. Additionally, as interpreters evolved into interactive discussions with the participants, they tended to add their own interpretive insights into the process of the interview. In order to avoid these problems I discussed the transcripts again with my interpreters while listening to the tape recordings. However, I did not need to use interpretation in all interviews as some of my participants had no problem conducting interviews in English and German, which helped to deepen my knowledge of the responses.

3.5. Ethical Consideration

Anthropologists have moral obligations to the scholarly discipline, the society or culture they study and to humankind; they are required to develop and maintain certain ethical choices when conducting their human work ((American Anthropological Association 2009). In this research, to

make sure I carefully considered ethical concerns, I started my field work by preparing an informed consent, following Ulin et al (2002:61) who propose that all human research should begin with the informed consent of participants. I used verbal informed consent to avoid discomfort among my participants as previous work with Pakistani women proved the request, to sign a written consent form, to be “potentially intimidating and offensive” (Chesney 1998:59). According to Chesney, “this is based on the belief that, where a culture values the spoken word as a binding contract, written consent may imply mistrust” (ibid).

The informed consent was read to the women in the language of their preference which was mostly Urdu. It explained to the women that their participation was voluntary and that the collected information was stored in a secure location. I also asked permission to tape record the conversations. Additionally, I made it clear to every participant that the research had no known risks and that she had the option not to answer any question she did not wish to give information about, although this was never an issue. To preserve the anonymity of the participants, identifying details like names have been replaced with pseudonyms.

3.6. Conclusion

The women’s experiences I sought to examine in this research not only contributed to my understanding of the issue in question but also assisted me personally to comprehend my own experience. My fieldwork experience and interaction with the research participants continued to inform my research knowledge and influenced me to think about my identity in the field. This helped me to view my research as an ongoing, continual process, rather than a series of steps.

Chapter Four: Findings

4.0. Introduction

This chapter presents and analyses the findings of the qualitative data. It aims to explore the meaning of being an immigrant Pakistani woman giving birth in Germany. Four main themes emerged from the analysis of data: personhood and identity, factors affecting selection of doctor, experience with the German healthcare system, changed beliefs and practices and adaptation and acculturation to the different environment.

4.1. Personhood and Identity

The stories and experiences of the Pakistani immigrant women in this study demonstrate how these women perceive themselves, their identity and personhood, as Muslim Pakistani women in their native land as well as in a host country. Their self-image reflects their roles as mothers, wives, daughters and sisters. The women in this study narrated their childbirth experiences within the framework of their migration stories during which they were able to personalize, identify and reflect on themselves as Pakistani immigrant women in Germany. As Smith and Osborn (2003:66) say, “the respondent’s story can itself be said to represent a piece of the respondent’s identity”.

The presentation and analysis of the women’s stories provided a view on important concepts that remained central in shaping their identities and described how these concepts implicitly influenced all other aspects of their lives. Generally associated with numerous social forms and psychological features of Pakistani society, notions of *izzat* (honor), *sharm* (shame) and *purdah* or female modesty set up the status of a Pakistani woman.

Thompson (1981:44-45) has pointed out the association and close correlation between the two concepts of *izzat* and *sharm*. According to Thompson, a person, especially a woman, can lose *izzat* when he/she does not maintain a sense of *sharm*. A woman’s concern about her *izzat* is essentially a concern about her reputation; therefore, *sharm* and *izzat* can be linked to woman’s purity and sexual innocence. However, *sharm* can be interpreted as a “positive socially desirable behavior” or, in other occurrences, as “a result of negative or undesirable actions” depending on the situation (Thompson 1981:43).

Chesney, referring to Thompson's positive and negative connotations on the notion of *sharm*, explicitly discusses its contextual use in Pakistani society. She notes,

“As stated, *sharm* can only be ascribed according to the context when such a term is used. For example when it is related to women's behaviour, can be either good *sharm*, which is being bashful and respectful, conversely bad *sharm* evokes a feeling of embarrassment, which follows a breach of the moral rules of propriety set within the culture of the society, e.g. divorce in the family. Young men will display positive *sharm* through obeying their parents. Woman's negative *sharm* is often related to sexuality” (Chesney 2004:352).

Sharm, as implied by Thompson (1981:44), can also indicate “a psychological form of *pardah*”. *Purdah* controls social relations and identifies female modesty and familial *izzat* and *sharm* through a strictly social set of norms and standards of behaviors. The concept of *pardah* is considered a significant institution among Muslims in Pakistan and India (Papanek 1971). General *pardah* guidelines are acquired from different verses in the Quran⁷; however, its social presentation can differ between cultures. Literally, *pardah* is a Persian word which means a veil, a curtain or barrier and a covering that is used to protect or hide something (Abdul Hamid 1998:14). However, in practice, *pardah* is used at various social and psychological levels. On the one hand, it acts as a notion of creating “separate worlds” and on the other, it is conceptualized as a “provision of symbolic shelter” (Papanek 1971: 518).

“Separate worlds” implies the tradition of segregating the sexes, generally by veiling (women covering their bodies and heads) and avoiding contact between men and women outside the immediate family (Khan 1999). Women and men are secluded in living spaces. In social activities women are provided with allocated spaces to maintain their privacy and to assure physical and visual gender segregation⁸. The symbolic shelter aspect of *pardah* is believed to provide protection to the woman and her family's *sharm* and *izzat*. By preserving her *pardah*, the woman is protected from impulses like sex and aggression (Papanek 1971).

Associated with their culture, Pakistani immigrant women preserve their social values by synchronizing between Pakistani traditions and western norms in a host society. For them *pardah* is “an inner code of conduct” (Khan 1999) within which they maintain their modesty. According

⁷ See Abdul Hamid (1998) for more discussion about Quranic rules.

⁸ Personal observation in the annual gathering of Ahmadiyya Muslim Community in Germany, and an *aqiqa* ceremony followed the birth of a son of a Pakistani family.

to my participants, *purdah* indicates a symbol of modesty and a Muslim female identity. An embodiment concept of *purdah* is developed from the women's words. During a conversation with Nayab after meeting her mother at the mosque for an interview, she indicated that for her, female modesty is an inner feeling.

“You should feel it. I was raised in German society and there was no pressure from my parents that I should cover my head. But I grew up in a Pakistani house and with the time I recognized that a good Muslim woman should maintain a modest dress and proper behavior. I decided then to cover my head... It is not only about how you dress but also how you act. My parents trust me and I respect that... I will not do anything that could shame my family. They know I will not have a forbidden (avoiding the word sexual) relationship with a male” Nayab (24).

The perception of trust is strictly related to *izzat* and positive notion of *sharm*. Trust is counted as an aspect of self-esteem and being creditable of others' confidence by preserving and also enhancing acceptable standards and behavior.

Woman's appropriate behavior and maintenance of *izzat* is an essential measure of her family's status. In Pakistan, puberty or the occurrence of menarche is a sign of womanhood and an indication that a girl is ready for her new role as a wife and mother. Because a woman's virginity is considered a symbol of the family's *izzat*, until married the girl is potentially able to bring shame on her family (Chesney 2004:345). Her status is governed through the preservation of positive *sharm*. In a western society like in Germany, the maintenance of *sharm* and *izzat* of a Pakistani girl can be endangered. Confirmed by the words of other women, it was worth noting Najla's clear concern about this.

“There is a difficulty in raising the children here in Germany. In Pakistan at home or outside, the children are raised in one culture. But in Germany there are two cultures; one European culture outside the house and the other is a Pakistani culture at home. So you have to put a lot of extra effort to provide them with the Muslim Pakistani culture at home. If you don't put this extra effort in Germany, your children will go in the wrong path of life” Najla (44).

Marriage provides protection to the woman's as well as the family's *izzat*. When asked why her daughter was married at a young age, Fauzia replied,

“I was married at even a younger age. I got married at the age of 17. It is not bad. I felt more comfortable when she got married. Marriage is a protection for the woman.

He was then responsible of her. We knew (father and mother) that her husband is a good person for her” Fouzia (48).

All my participants got married between the ages of 17 and 23. To maintain *izzat* and *sharm* is to respect her parents' choice of an applicable marriage partner. The women believed that their parents will find them a good companion who will protect them and provide them with proper familial life when they move to their future roles as wives and mothers.

Lubna was married at the age of 20. Her marriage had been arranged since her childhood.

“We (Lubna and her husband) knew each other from childhood. His family used to live here in Worms and my family in Kiel...but the two families used to visit each other because we are relatives. It was planned that we will get married once we grow up. My family asked me if I agree to marry him... I felt shy and nodded in agreement” Lubna (30).

Parents may seek their daughter's agreement, but the choice is still made by them as her guardians. Nafisa's parents found her a husband from Pakistan to whom she got engaged at the age of 14. When she reached her 19th birthday, Nafisa and her family travelled to Pakistan to do *Nikah* (matrimony contract) and celebrate the marriage ceremony. Before knowing that her husband was her family's choice, I asked Nafisa why she married someone who lives in Pakistan and not in Germany. She immediately responded,

“It was not my decision. My parents chose him. This is the norm in Pakistan” Nafisa (21).

The decision-making during her lifetime is made by her family before marriage and her family-in-law afterwards. Lubna did not show an interest in completing her studies or getting a job as long as it is not the interest of her family or in-laws.

“I don't know if I want to work. What kind of job I can find. I have only done school and three months praktikum (practical training) at a dental clinic. I wanted to do Ausbildung (academic training) then but I didn't manage. My father said 'you don't need Ausbildung you will get married'. Also my husband's family thought I don't need to study. A woman doesn't need an Ausbildung and work. Her father and then her husband are responsible of providing her with all her necessities” Lubna (30).

According to Chesney (2004), the acknowledged social tradition of segregated gender roles takes place within the family grouping in Pakistan. “Men go out into society to earn for the family and

the woman's role is within the home, bearing and caring for children, maintaining the home and cooking for all" (Chesney 2004:277).

Pakistani women in this study articulated an identity based on their familial roles. They devoted all their attention towards being a good mother and wife which is for them the definite aim in life (see Chapter Two). They were entirely content to fulfill their familial and domestic duties by keeping a good marriage and raising righteous children.

However, Pakistani cultural norms and social values restricted the women's information about sexual and reproductive health. In Pakistan, like in many South Asian countries, discussions about issues related to sex are considered to be immoral or a social taboo (Ranjha and Hussain 2003). For a young woman, enquiring about reproductive concerns like marriage, sexuality, and pregnancy can be interpreted as a sign of having no shame and being sexually active (Mane and McCauley 2003; Hamid et al 2010). For a Pakistani woman, marriage marks the first sexual relation during which she learns about married life and childbearing.

As Shazia reported,

"This is my second pregnancy experience but still I am learning a lot. My mother never told me what I should expect. Only after marriage a woman should know about sexual relations and childbirth" Shazia (28).

During interviews, young unmarried women were sent out of the room. The interview with Sabeen was conducted in my house. Sabeen came along with her mother and 18-year-old daughter. After explaining about the topic of my research I left the room to serve my guests tea and cookies. When I returned, I unexpectedly saw the young daughter leaving. Sabeen told me that the topic was not clear for her when it was explained first time we met. Knowing that she will have to go into some details, which she does not want her daughter to know about, Sabeen and her mother had to ask the young daughter to leave.

Yet, after the interview, Sabeen's mother asked Rabia (my interpreter), if we, Rabia and I, are already married. When Rabia indicated that she is not married yet, the mother looked at Sabeen and said,

"You should not have told her about all these stories" Sabeen's mother (58).

According to my participants, sexuality and reproductive health issues are shameful topics not to be discussed openly and shared with others.

“It is difficult to discuss these issues (sexuality and reproductive health matters) with others. I didn’t use to speak about it even with my mother or sisters before getting married” Bushra (25).

Many women feel inhibited and anxious about asking questions related to sexual problems or exchanging childbirth experiences with each other as they believe that keeping silent about women’s reproductive matters is a sign of their purity and *izzat*.

“I feel ashamed to ask other women about what I feel. If I have a problem then I go to the doctor and ask her. But it is still difficult to tell her everything. This is because of the culture I grew up in. We learned since childhood that a woman should not ask or speak about these issues (sexual matters) because this might affect her virginity and izzat” Saadia (30).

Woman's sense of self is maintained through the preservation of *purdah*, shame and honor code of conduct. These concepts personify her being and self-esteem as an individual, within her family and social context. Her social and cultural identity is fulfilled along the line of her familial role as a wife and mother.

4.2. Factors Affecting Selection of Doctor

Purdah, shame and honor are central concepts in exploring the process of selecting a doctor by Pakistani immigrant women in this study. All my informants stated their preference for female physicians, either gynecologists or obstetricians, due to their concerns about *purdah*. They attributed their preference to modesty in the presence of males as well as the feelings of shyness and anxiety about discussing sexual and reproductive issues with male doctors. In their words,

“She should be a female doctor... because in our culture it is easier to speak to a woman about women’s issues more comfortably. It is about feeling ashamed that a male doctor sees you. We grew up like this... that we only share this with females but not males. If there is an option then a lady doctor is preferred” Momina (37).

“My Frauenarzt (gynecologist) is a female doctor. If I have the choice I will prefer a female doctor because she understands me more. I don’t know if the male doctor will understand me the same... I didn’t try it before... but I feel that she will understand me more. I will also feel shy if a male doctor examines me regularly” Saadia (30).

Although the women reported that they endeavored to find a female doctor, they did not mind being treated or examined by a male doctor when it is really needed. Drawing upon evidence from earlier research, I expected that my informants would be sensitive about the unavailability of female ob-gyn physicians. In a study to examine the experiences of women of Pakistani descent seeking contraception in the UK, Lowe et al (2007) described Pakistani women's hesitation to be treated by male doctors. The study reported the case of a woman who skipped her appointment, thinking that she would be examined by a male doctor. Another refused to complete the procedure of inserting a contraceptive device, knowing that a male doctor would be involved. However, Pakistani immigrant women in this study indicated their willingness to accept a male doctor when serious conditions emerge. Lubna said,

"If I am sick then I am seeking treatment and not the sex of the doctor. In emergency cases I don't mind whether a male or a female doctor ... for me health is more important. At the hospital the nurse asked me if I want a male or a female doctor to attend my delivery. That was the first time I am asked this question. Then I asked her, can I choose?...what if birth pain comes early morning and only a male is there ... what will happen then?... or do you always have two?... I had to ask. Maybe if only male is there then I will have to wait for a female doctor. I might have complications because we waited for long time. Then she said if only a male doctor is available we will have to call a female doctor. I told her sometimes a woman cannot wait. I told her if you ask me I would say I want a female doctor but if no female doctor is there then it is not important for me. Of course if it is an emergency or an urgent case, a male doctor shouldn't be a big problem." Lubna (30).

Some of my participants criticized the stereotyping from healthcare providers that a Muslim woman will refuse the presence of a male doctor. Khadija indicated,

"I know that some Muslim women are so strict about this. Therefore, they (healthcare providers) think we will all refuse a male doctor. When I was pregnant with my daughter at the hospital the doctor told me that if I don't want him to examine me then he will not. He said a lady doctor will come but it will take time. I asked him why he thinks I wouldn't want him to examine me. He said that it is because I am wearing the scarf. Because I am a Muslim then he thought he should ask. I asked him if he has a problem that I am wearing the scarf. He said no but there are some women who would not like it. I asked him 'is this good or not?' He said 'if you ask me I say I am a doctor. For me you are my patient either a Muslim woman or not. If there is pain then I should look. For me it is the same. I only do my job. I don't look at how a woman looks. I only want to help others. But there are woman who are very strict and I don't know how you are'. I said when you say you are a doctor and I

am your patient then it is ok. Then he said 'can I examine you now'. I said 'yes' because I don't have another choice. If I wait for a female doctor then I don't know if she is coming after two hours or two days" Khadija (27).

It is interesting to notice how these women adapt to local social and cultural norms. Both first generation women as well as young generation did not consider it an offensive matter as might be the case in Pakistan.

Additionally, I found that the cultural background of the doctor was of great importance to the participants of this study. Most of Pakistani immigrant women living in Mannheim tend to consult a female Muslim Iranian gynecologist, Dr. Farideh Safai-Elahi, for general reproductive health matters. This induced me to visit her clinic in the center of Mannheim and ask her for an interview. According to Dr. Safai-Elahi, more than 30 per cent of her patients are Pakistani Muslim women. She declared that these women believe that she, as a female Muslim doctor, can understand their problems more than a non-Muslim doctor can.

"These women know that we have close culture and same religion. It is a psychological matter as well. You feel more comfortable to speak with somebody from your culture and religion especially in such sensitive topics" Dr. Safai-Elahi.

Similarly, my informants indicated that their preference for the Muslim doctor is because she shares the same Islamic culture and she is more aware of their problems and concerns.

"Since the last 17 or 18 years I used to go to her and all my female family members also. The Muslim doctor understands our culture and the problems of a Muslim woman. For example if I ask the non-Muslim doctor that I need a female doctor at the hospital, she will ask what and why not a male doctor. But the Muslim doctor understands our culture and preferences. She refers us to the other hospital where more female doctors are working" Abida (45).

According to Ilkilic (2002), the Muslim's value system was formed by traditional and Islamic frameworks in Muslim countries. Muslim patients in Germany find themselves encountering a German modern healthcare system which may result in potential conflict of values. Similarly, for a Pakistani immigrant woman in Germany, having the availability to consult a doctor who shares her Islamic background helps reduce potential culture care conflicts.

Interestingly, while choosing a Muslim female doctor is of high preference for a Pakistani woman, this is not the case when her husband chooses her gynecologist⁹. A Pakistani husband's sense of shame, to explicitly discuss his wife's sexual concerns with a Muslim doctor, drives him to search for a non-Muslim doctor with whom he does not share the same *purdah* notion. According to Saba,

“My husband used to accompany me and he didn't like to take me to a Muslim doctor. He preferred to take me to a non-Muslim doctor. As a man he felt ashamed to speak with a Muslim woman about female issues. It is a purdah issue. He wouldn't feel ashamed in front of a non-Muslim doctor because she doesn't have that purdah view in her mind as it is the case with other Muslims” Saba (42).

Momina agreed with her and gave another example,

“For example if my husband comes and sees German ladies sitting with me, he will simply join us. But if there are ladies with scarf, he will immediately feel ashamed to sit with them in the same room” Momina (37).

While a woman's positive sense of shame requires her to dress modestly, a man's positive shame is determined by lowering his gaze and not ogling women whom he knows must veil before him.

Another important factor is language which will be discussed in detail later in this chapter. I found that Dr. Safai-Elahi speaks German, English and Farsi. In addition, she employs assistants from different cultural backgrounds who speak different languages like Turkish and Urdu. This makes it attractive for an immigrant woman knowing that language is not an issue to worry about in this clinic. During two hours of direct observation in Dr. Safai-Elahi's clinic, I noticed that most of her patients come from different Islamic backgrounds. As emphasized by Bushra,

“The doctor assistants help with translation. This is a big advantage for me and other women who have difficulties with the language. So not only Pakistani women would like to go to her but I also know many Arab, Turkish, Iranian and Bangladeshi women who would prefer to go to her” Bushra (25).

However, it is worth mentioning that the clinic of Dr. Safai-Elahi is located in the center of Mannheim where the majority of Pakistani families live. This makes her clinic the easiest to reach. One participant indicated,

⁹ For many of my participant, the presence of their husbands during clinical consultation was of great importance.

“I only go to the Muslim doctor because she is the closest and everybody I know goes to her” Munazz (34).

Therefore, women’s selection of a doctor is also based on the distance between the doctor’s clinic and the participants’ residence. Farhana reported that although she prefers a female doctor, she has to go to a male doctor because his clinic is close to her residence. However, she indicated that she is very satisfied because the doctor understands her Islamic background and tries to help her feel less hesitant and embarrassed. She said,

“He knows how I feel when he asks me embarrassing questions which I find difficult to answer. To let me feel good, he looks at the computer and do something so I can avoid looking at his eyes” Farhana (28).

Another view, expressed by Momina, is that the qualifications and experience of the doctor are more important for her in choosing her physician.

“I used to go to the Muslim doctor but then I searched in the internet and I read about other doctors who had better academic qualifications and experience. I then changed my doctor” Momina (37).

The results indicate that although cultural and social taboos affect Pakistani immigrant women’s selection of doctor, in which the gender of the physician is most important, their preference is also mainly based on the cultural background of the physician, residential location of the patient and physician’s clinic as well as the academic qualifications of the latter.

4.3. Experience with the German Healthcare System

Earlier studies concerning women’s satisfaction with their labor and birth experiences suggest that factors like access to information, personal expectations, emotional and physical support offered by caregivers, the extent of involvement, control and choice and having an active say in decisions about their care as well as exposure to intervention are critical salient components in terms of women’s satisfaction (Lavender et al 1999; Lothian 2006; Hodnett 2002; Brown and Lumley 1994; Lazarus 1997). All women, regardless of ethnicity, want safe, high quality, attentive and individualized care (Small 2014). However, such choices are more limited for immigrant women due to a variety of additional difficulties they encounter when dealing with an alien healthcare system. The childbirth experiences of Pakistani immigrant women in this study

represent the concerns and views expressed by this group of women and reflect their degree of satisfaction with the factors mentioned above.

Most of the women interviewed reported general satisfaction with the German maternity healthcare system which was considered to be on a largely different and higher level compared to healthcare in Pakistan. However, some women reported specific barriers which are also identified during participant observation and data analysis of their childbirth experiences.

Each woman's story is investigated to find out what she determines as being important factors of a positive birth experience. The data analysis found that one of the chief complications the women faced was a sense of lack of control and involvement during their prenatal, intrapartum, and postpartum periods. A general issue is that the woman needs to be aware of what is happening in her birth surroundings. Saadia rated her care negatively due to feeling powerless and ignorant about her birth experience.

As Saadia stated,

"I felt lost and powerless. It was a very difficult experience" Saadia (30).

Every woman is likely to be dissatisfied if she experiences limited influence over her birth process, but what makes it even harder for this immigrant group is that they have to face additional challenges which tend to influence their birth experiences more drastically. These difficulties essentially comprised lack of familiarity and preparation for the birth experience, linguistic and cultural communication barriers as well as prejudice, stereotyping and discrimination.

Most of the women in this study, especially those experiencing their first pregnancy, were unprepared for their childbirth experience. Coming from a culture where issues around sexuality and reproductive health are considered social taboos not to be discussed with unmarried women, these women are poorly prepared for the experience of childbirth. When the mother is traditionally the sole source of information after marriage, her absence causes a double burden at a time of excessive vulnerability.

Missing this traditional source of information is compounded by lack of familiarity with a new healthcare system. One of the biggest complaints reported by immigrant women in both FGDs is

ignorance about the services provided by the maternity healthcare system in Germany. As pointed out by Bowler (1993:171), these women “lack conventional 'common sense' knowledge about the system”. According to Dr. Khan, the differences between the healthcare system in Germany and Pakistan generate barriers for Pakistani immigrants in Germany. They encounter difficulties acquiring information about available services and ascertaining proper approaches to access the healthcare system. Having no physical access and knowledge of the services available left these women unprepared for their childbirth experience.

“It was my first pregnancy and I didn’t know what to expect” Khadija (27).

These women identified lack of sufficient information and awareness on sources of help as significant barriers. Although preparation courses and information are generally available, these women did not know how to get access to them or enquire about their availability. A crucial problem is that healthcare providers assume that the woman knows about the services provided or, at least, knows what kind of questions are there to ask. Yet, many of the participants indicated their ignorance about available services and the ability to take advantage of them. Many assumed that even if they were available they could not comprehend it.

A basic formal approach for a pregnant woman to access information related to her maternal healthcare is generally provided in her gynecological clinic in the form of sheets and pamphlets on birth preparation courses, lists of midwives to contact for prenatal, intrapartum, and postpartum care and welfare associations assisting with birth related complications. In addition, hospitals and birthing centers provide information evenings once or twice a month, during which a pregnant woman can enquire about personal issues directly with the physicians and midwives (BZgA 2014). However, such information is mainly disseminated in German. When access to any of this information and taking advantage of the services available is likely to be a challenge, no wonder most of these women had to encounter difficult delivery and postpartum experiences.

“I wasn’t prepared for the birth experiences. I didn’t know what was going on during labor. I also left the hospital without knowing what to do if I have bleeding or if I am feeling unhealthy” Saadia (30).

Language barriers have been identified as an important focus of complaints by most of the participants. Such barriers reportedly prevent equal access to maternity resources and awareness of the available health services. Access to printed information is limited since most of this is

published in German. It is evident that the German healthcare system recognizes such a problem and already published information in other languages; however, they are in most cases available in English and Turkish. The problem is not that a woman cannot find the information in other languages, but that it is not the language these women speak. Still, according to Dr. Stülb, even when this information is available in different languages, they are not accessible to or circulated among the target group. Even healthcare providers do not know how to access this information so they can provide it to their clients. That being the case, it is evident that although the government is taking serious steps to solve this dilemma, there is still a failure in utilizing them on the lower level.

The language difficulty is a problem that is carried on and only gets more problematic as the woman proceeds with seeking healthcare. Failure in communication due to language barriers can make the experience with the healthcare providers threatening for the woman. At the same time, poor communication is potentially able to reduce healthcare providers' willingness to try to communicate with this group of patients. Abida discussed the unpleasant behavior of the registration staff at the gynecologist clinic she goes to. She complained about being dealt with more hastily than other patients because of language difficulties. Abida stated,

“They do not try to understand that we have difficulty with the language so they speak quickly to end the conversation or ignore attempts at discussions” Abida (45).

I observed the same problem when I accompanied Saadia to her gynecologist appointment. Although we arrived on time, we had to wait for almost 45 minutes before she was called. According to Saadia, she had to wait longer because she is not German or someone who speaks German fluently. When I tried to ask the registration staff at the clinic, using poor German, why we have to wait although we came on time, I got a quick and unfavorable answer, *“The clinic is full of patients today and I know my job”*.

Such disruptive behavior was also reported by Dr. Khan, who noticed this problem with his informants. According to him, many of the second generation female informants in his study reported that by wearing *Hijab*, the counter or registration staff considered them foreigners and treated them inhospitably. The registration staff assumed that they do not speak German which disturbed his informants. In a study to examine disruptive behaviors among healthcare workers, Longo (2010) finds that such behaviors have negative effects on the safety and well-being of both

patients and staff because it undermines the communication and co-operation between the two. The registration staff is basically the first point of contact the patient comes across in her search for healthcare. A negative perception can hinder subsequent procedures where the patient is hesitant and uncomfortable about meeting the second caregiver.

Clearly, language is not the only cause of mutual misunderstanding. Some of the participants indicated different challenges due to the superior attitude of the healthcare professionals and prejudice and stereotyping based on the physical appearance of the woman. Ayesha stressed that she did not encounter any language difficulty during her labor experience. She reported being competent in German in everyday life as well as in the medical situation. Ayesha perceived her “hospital German” as “very good” because she spent all her life in Germany in hospitals due to her daughters’ illness. She was eager to talk about her experience in a FGD. It was obvious that she gained relief by being able to share the experience. Ayesha wanted us to report her suffering so it reaches the staff who attended her delivery.

“I want you to write this question to the doctor and midwives. Ask them why didn’t they listen to me?” Ayesha (50).

After the death of her two daughters, aged 10 and 14, due to muscular dystrophy, Ayesha was afraid of an unsuccessful delivery where she might lose her new baby. Her baby weighed 4.120 kg and it was decided by her gynecologist that she should give birth naturally. On the day of delivery, Ayesha went through a difficult delivery experience after which, according to her, she lost the desire to experience childbirth again. In her words,

“It was my first birth experience in Germany and the last in my life. I didn’t want to experience childbirth again. It was a very difficult experience. My gynecologist said that my baby weighs 4 kilograms but I am strong enough and I can deliver my baby naturally without complications during birth. Then when I went to the hospital for my childbirth the doctors also said that I can give birth naturally. But I knew it will be difficult. I knew that my child was big and I didn’t want it to be born naturally so I asked them for a cesarean delivery. They didn’t listen to me. They don’t listen to the women. They think they are only right. I asked many times for a cesarean delivery but they didn’t listen to me. They thought that there is no need but I knew that I needed it. The doctor insisted that I am strong as it is written in my mutterpass (literally,

motherhood passport¹⁰) and I should give birth naturally as it is written in the mutterpass. He was only convinced with what he read from the gynecologist. He kept saying 'she is strong it is written here. She can do it.' And he left. Three midwives were there to follow his instructions. My baby was also tall. He was 61 cm long. He did not come out. I was conscious but I didn't know what was going on around me. They didn't try to explain to me what was going on. Nobody was explaining to me. I knew something was going wrong because the baby was not coming. They kept saying 'oh what a big baby'. I had to ask many times. Then they told me that they will place the suction cup because the baby was not coming. They said it was normal and then he was for two weeks at the baby station (neonatal intensive care unit). Even if the child gets hurt they say it is normal. After many grueling hours my son was born. But then I had a placenta complication (placenta accrete). The placenta wasn't delivered. Only part of it was delivered while the rest remained. I was lying down and wondering why I was not finished yet if my baby was delivered. I had to ask them and they said that I had to wait because part of my placenta was not delivered and it was an emergency that needed a surgery. It was a Sunday and the chief doctor was not available. We had to wait for him because he came from Ludwigshafen to do the surgery. I still don't know why the placenta was not delivered and if it was because my baby was big. I had to stay at hospital for 14 days after that. My baby was also in the baby station for 14 days because he had swelling on his scalp after the vacuum extractor delivery" Ayesha (50).

Patient-provider communication, including having an active say and personal control as well as involving the woman in the labor process, are essential aspects which Ayesha, as a Pakistani immigrant woman, missed during her narrated birth experience.

According to midwife Ouda, immigrant women's inadequate access to maternity services as a result of lack of proper communication and less involvement of women appear to play a role when healthcare providers assume that immigrant women are insufficiently able to communicate or make choices relating to their care, instead they are more likely to be directed. These assumptions emerge as a result of long-established prejudice and stereotyping based on physical appearance of the woman and presumed characters of a categorized group to which that woman belongs.

Farhana also expressed a negative experience with the midwives at the hospital where she delivered her first baby. As narrated by her,

¹⁰ A small booklet which the mother has to carry during her entire pregnancy. The booklet contains all details regarding the mother's and baby's health, previous pregnancies and expected date of delivery.

“It was one week earlier my estimated delivery date. I was in the mosque and I felt the pain. I went alone. The midwives at the hospital didn’t believe me. They wanted to send me home. They said it was not true that I already have pain. They checked with their machine (cardiotocography) and they said that it didnt show that it was time yet. They said it was not true that I had pain and I should go home. I knew I had pain but I thought maybe they know better. I was preparing myself to leave but I recognized that I cannot walk. I told them ‘excuse me I can’t even walk I can’t go home’. They were very unfriendly. They said ‘don’t stand here go home you don’t have pain’. They said that I was acting. Then I went myself to the labor room and I asked them to please check again... I told them it would be my responsibility... I couldn’t go... I couldn’t even lie down... I had extreme pain. They didn’t take me serious. I was waiting for 50 minutes. I didn’t come with anybody...I was afraid...I didn’t want them to leave me alone. It was my first experience... it was all new for me. They were simply going and coming. I was asking a lot but nobody was responding or explaining to me. They didn’t have the desire to help. They were moving very slowly. One of them went simply to the toilet and the other one was looking at me and saying ‘let’s see what you want to prove’. She was putting her gloves very slowly and suddenly we heard a sound. I didn’t know what this sound was. I was shocked. Then she moved quickly. She noticed that the cervix had strongly opened up to 5 cm. They said it was a tough opening. I told them that it was their fault because they didn’t respond to me and they didn’t check well” Farhana (28).

What is evident in the cases of Ayesha and Farhana is the coexistence of “two versions of reality, two alternative claims to relevant knowledge” (Jordan 1993:160). Although both participants represented their knowledge in different ways, their “version of reality” was explicitly disregarded. While Ayesha’s knowledge was dismissed by the medical authority in a situation where the gynecologist’s and obstetrician’s knowledge was the most logical and reasonable to follow by the midwives, Farhana’s salient expressions were overlooked by medical, technological machines. It was obvious that the midwives were not aware of the machine’s job to only provide data when their duty is to interpret that data by essentially taking into account the patient’s bodily knowledge.

In both cases, the women’s knowledge and bodily experience were neglected, devalued and even demoted when other ‘superior’ knowledge was considered more authoritative. The women felt compelled to accept instructions and comply with certain supposedly ‘rational’ decisions that specifically excluded them from a process where they justifiably expected to be essential focal participants. Authoritative knowledge held by medical staff clearly can have the effect of creating

a poor caregiver-patient relationship, during which women lose control over their own birth experience and become the object of medical and technological authority.

Though any woman may undergo a childbirth experience where her knowledge is not taken into consideration, for this group of immigrants, such an experience is more troublesome and even more acute since it is commonly accompanied by prejudice and stereotypes. As discussed earlier, these threats are potential contributing factors to a poor caregiver-patient relationship. Midwife Ouda emphasized that assumptions made by healthcare providers that immigrant women are “difficult patients” who demand special treatment and large amount of time to deal with are the main cause of the unequal attitude conveyed by healthcare providers. In Farhana’s case, she was not taken seriously by the midwives since she was also perceived as a Pakistani immigrant who might be complaining and making a fuss about nothing (Bowler 1993). These assumptions resulted in them not even checking her case when she came seeking their assistance.

This was confirmed in the words of my informants,

“The problem with some midwives is that when we go with pain they take us like a burden. They think oh my god here is another work. Those are usually really aggressive and only want to finish their work” Nadira (33).

These findings support other works that highlight the way midwives and other healthcare providers express stereotyped views of South Asian women as bad patients who are difficult to deal with (Bowler 1993; Cross-Sudworth 2007). Bowler (1993:172) pointed out that caregivers’ attitudes and behaviors can be affected by ethnicity and cultural background of the woman which “makes her more likely to be categorized as an undesirable patient because of her knowledge and expectations of the medical services are different to those of indigenous patients”.

They also confirm the hypothesis made by Castaneda (2012:834) that migrants are often categorized as “problem patients” in German medical institutions, which results in different forms of discrimination and aggressive treatment, including emotional distance and intolerance to their complaints of pain. Discrimination, according to Pollock et al (2012:62), can be experienced in different scales ranging from “conscious and unconscious interpersonal interaction” among individuals. Race, ethnicity, language, religion and culture can act as grounds where a person or a group of people be discriminated against (Pollock et al 2012). Such discrimination was perceived by a number of my participants.

Zainub reported being directly discriminated against by the night shift nurse at the hospital where she gave birth. According to her, such discrimination occurred due to the assumption that healthcare providers have about immigrants and especially Muslim women that they are different and cause more troubles. Zainub considered this as discrimination against her because she noticed that the nurse was very kind to the German lady who shared the room with her. Zainub said,

“I spent seven days at the hospital after my cesarean birth and I was looked after by different nurses who used to change shifts. They were nice except one night shift nurse whom I felt she did not like me. I didn’t understand why. On my first night at hospital I asked her to bring me water but she replied with ‘why do not you help yourself’. I didn’t know why she acted like this. I told her that it was difficult for me to move because of the operation. The German lady with whom I was sharing the room left her bed and brought me the water. She told the nurse, ‘this is discrimination and your job here is to help us’. The next day I wrote a complaint that I want to change the nurse and I didn’t see her again in our room” Zainub (32).

Castaneda’s (2008) study uses participant observation in conjunction with interviews with undocumented migrants, NGO staff, physicians, and local experts in Berlin, examines the experience of undocumented pregnant immigrants with the German healthcare system and explores the popular anxieties of high birth rates among foreigners, or what she terms “demographic theft”. Castaneda notes that such anxieties lead to discrimination against migrant women based on race and specific notions of inclusion and results in “hierarchical arrangement of valued reproduction” which “places German mothers at the top” (Castaneda 2008:355).

It is worth mentioning that as of January 2000, the German government compromised on the "option model" where children born in Germany to non-German parents automatically acquire dual citizenship at birth by *jus soli* if at least one parent had lived legally in Germany for at least eight years prior to the birth. An “option model” allows children to decide between the ages of 18 and 23 whether to retain their German nationality or the nationality of their parents (Torry 2013; Federal Foreign Office 2013). According to Castaneda, such a model creates “popular anxieties that high birth rates among foreigners will one day displace the native population” (Castaneda 2008:356). Consequently, the connotation of being a pregnant or birthing immigrant implicitly draws upon ideas of demographic theft. Immigrant women are often perceived as aiming to

deliberately give birth with the object of claiming citizenship for their children. Such portrayed prejudice exposes these women to higher risks of discrimination.

A significant question in this section is whether Pakistani immigrant women can access and benefit from the maternal health services in Germany in the same way as native German women do. The women in the study reflected a positive attitude towards the system during which they chose it, valued its services and were interested and willing to participate. However, they reported that their feeling lost, powerless and insufficiently informed, as well as the superior attitude of the healthcare professionals impacted their access to maternal health services. Every woman is hypothetically at risk of such an experience but what makes it even more fraught for this group is lack of proper language and communication skills and the prejudice, stereotyping and discrimination they face from caregivers, which negatively influence their childbirth experiences in Germany.

Healthcare providers should consider women's personal circumstances and different preferences to emphasize adequate and individual-based care. Services provided should go beyond prejudice and stereotypical views based on woman's ethnicity or religion (Woollett et al 1995). Understanding shown by caregivers is important for more positive experience of childbirth. However, one cannot attempt to attribute the problem to all healthcare providers. Some of the participants showed high appreciation for the help they get from helpful and kind staff.

“We cannot generalize. Others are very kind and really want to help. One can feel their kindness. They work from hearts” Nadira (33).

This was also evident in the example of Khadija's doctor (discussed earlier in this chapter) who tried to show his sensitivity and understanding that she might not want her delivery to be attended by a male doctor. Khadija was not satisfied with such sensitivity, referring it to presumption and prejudice. This indicates that although healthcare providers are trying to show understanding and be sensitive, they lack the knowledge on how to act properly in these situations. Because they are normally unfamiliar with what the woman is bringing with her, it commonly has to be an individual solution.

Therefore, it is dangerous for healthcare providers to learn as they go because this can lead to mutual misunderstanding (Ulrey and Amason 2001). Because it is essential for healthcare

providers to learn about the cultures of their patients to avoid dissatisfaction and stress for both providers and patients (ibid), it is crucial for these providers to consider the importance of intercultural communication training programs that help them to develop cultural competence in accordance with culturally diverse groups. It is also important to consider the reception staff in these trainings. This staff can create the positive atmosphere at the very beginning of the experience where the woman feels welcomed and valued.

4.4. Social Isolation and Loss of Family Support

Earlier studies suggest that immigrant women are more vulnerable to prenatal and postnatal depression (Fung and Dennis 2010; Zerkowitz et al 2004; Nahas and Amasheh 1999; Stuchbery et al 1998). These studies articulated the loss of social support and sense of social isolation as predictor factors defining immigrant women's experience of traumatic childbirth.

Childbirth in Pakistan is a collective family and social event. It is a time for supporting, nurturing and appreciating the woman physically and emotionally. The social structuring of birth events is rooted in Pakistani culture (Chapter Two). The deficiency of this tradition of structural support plays a central role in the aetiology of distress these women face as immigrants. After migration, most of the women in this study experienced a loss of supporting networks. They recounted their feelings of social isolation, loneliness and alienation after being deprived of the traditional family and social support they were accustomed to in their home country. These feelings permeated their immigration experience and influenced their lives at a further psychological level.

These women reported that, unlike in Pakistan where they felt content and happy with birth, they always felt tense and depressed being alone in Germany. They lacked time to care for themselves where they were worn out with responsibilities put on them.

“The body experience is the same in Germany and Pakistan. But emotionally it is different. In Pakistan I was with my family...there were my sisters and my mother to take care of me. I was happy to have a child. They were there to take care of me so I didn't realize any difficulty. It was good experience. But here it was not the case. I was alone. I had only my husband and he had to work the whole time. I had to take care of myself and the newborn. I also had to attend my children's and my husband's needs. Even if I don't feel well and my husband needs something then I have to do it. I cannot lie down and there are others to do the work for me. The husband thinks this

happens to every woman in the world. He believes that this is a normal thing and everyone else is also giving birth so we should continue our lives normally. That was difficult. It was not that easy” Momina (37).

These women expressed their need for emotional support. They reported feeling dispirited, disoriented and isolated after moving to a new social context. As described by Saba,

“I was always alone at home. I wasn’t able to meet a lot of women. At that time I was afraid if the delivery date is near and my husband is not around...how do I do. I was also afraid that there might not be enough time to call my husband or wait for him to come” Saba (42).

Momina is a mother of four. She gave birth to two of her children in a small village near Darmstadt where her husband used to work. Other than their husband and children, she did not have any friends or relatives. Momina described her life and childbirth experiences in this village as very lonely and extremely hard.

“I lived alone there. I had my husband and children but I didn’t know anybody else. I didn’t use to go out. In our culture it is not usual for a girl or a woman to go out alone. So I never went out alone and I wasn’t able to know other people. If I have a doctor appointment, then my husband will take me to the clinic when he is going to his work and will leave me there. Later, he will take me home. Or if he doesn’t have time, he will call the taxi to take me home” Momina (37).

However, Momina’s life changed when she moved to Mannheim and created a social network with other Pakistani women living in the city.

“In Mannheim I knew many people and I got to know many things. Before the fourth child was born I moved to Mannheim. Only then my whole world changed. I then felt like living in Pakistan. I knew many people who also supported me a lot. My fourth child was born in Mannheim. It was a different and much easier experience because I was surrounded by many people I knew and who provided me with a lot of help and support” Momina (37).

Momina revealed that even when physical difficulties are tolerable, childbirth can be experienced as a traumatic event due to lack of familiar emotional support.

“I remember my fourth child was born on a Saturday. On Sunday evening I left the hospital and went home. I had to ask the doctor to let me go home because nobody was taking care of my children. I had to write down that I am responsible if anything goes wrong with my health. That was in December. It was very cold. The next day I took my children to school. My husband didn’t have time for that. He had to work. On that cold morning I met my Pakistani neighbor and she didn’t know I already

gave birth. She was wishing me a good and easy delivery. But I told her 'can't you see that I gave birth'. Then she realized that I already gave birth. She asked me to please go home and take rest. She offered to take care of the children and she did that for 11 days. It was the first time I enjoyed my postpartum period and I cannot forget it. I needed this support. It was this emotional support...to know that somebody is sharing you your feelings" Momina (37).

The women believed that the mother's emotional state has a significant influence on the wellbeing of their new baby. Momina stated,

"The mother's feelings play a big role also for the child. During the third pregnancy I was very sad because I already had two children and again I am pregnant and not feeling well and alone. My child was born too early and he was very small. That was because of my state. I wasn't happy. I was afraid how to do it again. But with the last child I moved to Mannheim where I was very happy. Therefore, my child was very healthy. He weighed 4 kg" Momina (37).

Lacking practical help that is traditionally provided through family and social support and the absence of the mother was significantly challenging for women who had to migrate to a different social structure. As Munazz reported,

"Since I arrived to Germany what I missed the most is my family. The family system is very important for us. It was very difficult time to give birth here because it was my first birth experience. I missed my mother a lot. I didn't know what to do and how to handle the situation. I wished at that moment that I was still in Pakistan and close to my mother" Munazz (34).

The women used to rest during pregnancy and postpartum period. Lack of assistance and guidance on how to take care of the newborn was a major concern commonly reported by the women. As pointed out by Fung and Dennis (2010:344), the presence of cultural values and practices protects the woman from potential depression; however, barriers preventing these practices may aggravate negative feelings in different occurrences.

Some of my informants had to contact their mothers in Pakistan to guide them on how to take care of themselves and the baby.

"My first child was born in Pakistan when I was 20-year--old. After delivery there was my mother to take care of me and do everything for the child When I was in Germany I felt it was really my first experience I didn't know even how to take care of my child. What to feed him? How to change his diaper? I used to simply call my mother. I told her ok now I am smelling something what should I do. My mother told

me I know you wouldn't be able to change it so just bath him. I had always to call my mother and ask her. It was expensive to call her always so I was also calling some relatives who live in Germany but in another city. It wasn't easy to do phone calls. Only my husband had a phone and in most cases I had to wait for him to come so I can make phone calls" Momina (37).

Although the women described that because they missed their families and social networks in Germany they did not receive enough emotional and practical support, some of them considered family practical support as negatively affecting their childbirth experience where they missed the opportunity to provide attention to their newborn and get practical experience on how to handle their childbirth event.

"In Pakistan you are not alone everybody is there to help you. Of course it is good to be assisted but the mother should also have her own experience. It is her duty in the first place. It is her own task to do it and not her family's. Therefore, it might not be that good to let the family do everything. It was difficult for me here because I am not used to it. I had to train myself. I am happy that I was able to take care of my child myself" Saba (42).

"The mother can lie down and do nothing. There will be others to take care of her needs and the child's for the whole 40 days. This is the custom. I personally don't like that. I can do everything myself. It is my responsibility. I was happy to be with my child here without the involvement of my mother or other people. I am mature enough and I think there is no need. For me I think a woman, especially the one who already had the experience of childbirth, should be able to take care of herself and the baby" Munazz (34).

However, for young generation participants, the presence of family and mother's support played a significant role in avoiding a stressful and challenging confinement. There were considerable differences in the two groups' experiences. Their existing networks proved to be helpful and provided physical and emotional support.

Lubna grew up in Germany. After getting married she lived within a few blocks from her parents and in-laws. Lubna reported less stress because she was provided the network her mother lost when she migrated 20 years ago.

"I have three children. I didn't have much stress because I have my family here. I have a mother and a mother-in-law who cared a lot. I used to stay at my parent's house. I go there few weeks before delivery and then I stay for the whole postpartum period which is 40 days in Pakistan. My first son was born in a joint family house where we used to live with my in-laws. My son was the first in the family. Everybody

was around to take care of me and him. I was totally free. With my other children I was all the time with my mother” Lubna (30).

Others sought their mothers’ support for one week postpartum care; however, they also reported less stressful experience.

“I go to my parents’ house where my mother and sisters take care of everything. Normally I stay for one week. I think it is enough. With my last delivery, my mother came and stayed with me in my house. This helped a lot’ Nadira (33).

Their mothers managed to perform their culturally embedded roles in a short, modified version of what is traditionally provided to women in Pakistan. However, their mothers, uprooted from their familiar networks, were provided with a different kind of support. In the absence of family support, the husband was the only source of help for those who had to experience childbirth away from their families.

Most of the woman considered their husbands’ support as essential to help them cope with their pregnancy, delivery and postpartum period. They described their satisfaction at the presence of their husbands in their spheres. The loss of family and social support ensured the participation of the husband in his wife’s pregnancy, delivery and puerperium experience, during which he acted as a source of help and emotional support.

“I gave birth to my first child in Pakistan. My family was around me but not my husband. In Germany when I gave birth to my second child my husband was with me all the time. I recognized then how important it is to feel his presence. I was happy he is with me during pregnancy and delivery. He was also very supportive after that” Munazz (34).

The women acknowledged the attention they received from their husbands and the closer relationship and increased unity the couple was able to develop upon emigration.

“Usually in Pakistan the female relatives will take care of the woman. In Pakistan you live in a joint family where everybody looks after the other but not necessarily the husband and wife. But here because they live alone the wife and husband are more close to each other” Saadia (30).

The women described how their husbands helped with housework and childcare and became more involved than they might have been in Pakistan, where they live within their extended family.

“He cooks at weekends and tries to help whenever possible. He cooked yesterday. He used to take care of the house and the elder son when I am busy with the new baby. He wouldn’t do that if we are in Pakistan” Saadia (30).

“The main problem for me was bathing the child. I was afraid it will slip away from my hands. I used to wait for my husband so we bath the baby together. My husband had more experience because he was the youngest in his family. He had a lot of sisters in law and he used to see them bathing their new babies. He didn’t use to get involved but now he does” Saba (42).

The involvement of husband in his wife’s care emerged as a result of the loss of family and social support and sense of isolation in a foreign country. Sharing family responsibilities and the existence of the autonomous nuclear family facilitated the alternation of traditional gender roles rooted in Pakistani culture, where childbirth is considered a women’s issue (Chapter Two). The husband’s non-traditional role of supporting his wife during childbirth shed light on other inquiries regarding changes in the traditional childbirth beliefs and practices.

4.5. Changed Beliefs and Practices

Jordan (1993:4) asserts that people in most societies “tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context”. Accordingly, in Pakistan, many cultural beliefs and practices around the process of birth exist to ensure the physical as well as psychological safety of the mother and infant (Chapter Two).

However, traditional birthing systems and beliefs are changing under the influence of Western medicine and in reaction to cultural forces (Jordan 1993:5; Lozoff et al 1988; Steinberg 1996). In Pakistan, Chesney (2004) noted a decline in calling the *dai* for birth over the last decade where the best option is currently the hospitalized birth or a western-valued medical model. Women from wealthy classes opt for more western, technologically medicalized models of birth, like caesarean section, and travel to western countries for such an easier yet more expensive birth (Chesney 2004:382). She interprets this as a result of western practices and media influences. According to Chesney, the current birth system in Pakistan is based upon economic needs and

trust (Chesney 2004:276). This supports the argument made by Colfer & Gallagher (1992) that western biomedicine, and more specifically western medicalized childbirth, is gaining dominance in non-Western societies which can afford the necessary medical resources (cited in Conrad 1992:226).

Western influence also affected the choice of birthplace by Pakistani immigrant women in Germany. Most of the participants reported that they will never opt for a home delivery. They appreciated the Western biomedical childbirth system which they recognized as safer than the traditional model of birth practiced at home and attended by the *dai* in Pakistan.

“The hospital birth system in Germany is very good. I think that giving birth at hospital is much better because at home you only have the dai who cannot understand the complications. But the doctor at the hospital can react immediately to any problem. At home there is no chance. Also in Pakistan I would prefer to give birth at the hospital. Women in Pakistan who live in the villages would love to give birth at hospital because it is more secure. But it is difficult because they need time to reach the city where hospitals are. I lived in Pakistan in my in-laws house in the city so I gave birth at hospital. My sister lives in the village and she died while giving birth at home. She lost a lot of blood and the midwife couldn’t do anything” Najla (44).

These women also revealed their acceptance of Western practices regarding their maternity health. Momina did not mind taking her first bath soon after delivery although she believed in the traditional practice of bathing the woman and newborn child.

“The woman should take her first bath only after three days of delivery and then on the fifth day, seventh day and eleventh day. After that she can take bath whenever she wants. The same is with the child. On the 40th day she should take a real bath when she can wash herself well and then she can do salat (prayer). When I gave birth to my son at the hospital the nurse came and asked me three hours after birth if I took a bath. I said no. Then she told me that I should go and take a bath and I did it. I really felt very good after that” Momina (37).

Nevertheless, the women in this study demonstrated how, following immigration to Germany, they had to face striking cultural and social changes. As discussed earlier, in Pakistan, these women lived within, and were looked after by their extended families. Such care includes full rest and relaxation during the forty-day postpartum period (*chilla*). In the absence of their culturally embedded family support, my informants reported that they had no other choice but to resume their daily work within few days after delivery.

“It is only in Pakistan where women can enjoy their chilla. No Pakistani woman in Germany or abroad does this. Because in Pakistan you have so many relatives who will take care of you and your children during these forty days but here you are alone in your apartment and you have to do everything yourself. You go outside and buy the things yourself, you take your kids to school. But in Pakistan you stay at home, be relaxed and enjoy yourself” Munazz (34).

Some of these women reported that they suffered from weaknesses as a result of carrying out household tasks and responsibilities shortly after delivery.

“In Germany it isn’t possible to enjoy chilla. I stayed at hospital for seven days but after that I went home and continued my normal activities. But I suffered from neck and shoulder pain because I had to prepare bread at home. I had nobody to help me. I had to continue my life” Najla (44).

However, Najla confirmed that she did not practice the *chilla* tradition in Pakistan, either.

“Normally in Pakistan the mother should not work at house but stay in bed for forty days. But I actually started doing my housework shortly after giving birth because I thought why I should lie down all this time and let others do my work” Najla (44).

This supports other recent studies that highlight the way the *chilla* tradition is declining in Pakistan, where most women resume their daily work about seven days after delivery (Khadduri et al 2008:184).

Upon migration, traditional practices observed in societies of origin may not be possible in a different social environment. As a result of lack of family care and guidance, the women in this study found themselves unable to follow some traditional rituals and beliefs, such as avoiding the harmful effect of lunar and solar eclipses.

“The elders in Pakistan advise the pregnant woman that she should be active during lunar and solar eclipse so the child will not be affected. It happened when I was pregnant with my daughter in Germany but I didn’t know about it. My family was in Pakistan so I wasn’t told by anybody that I should lie down but be active. I knew about it very late. My daughter has a dark mark on her stomach. Maybe this is the reason” Sabeen (42).

“When I was pregnant in Pakistan my mother used to tell me that I should be active doing something during a lunar eclipse and I shouldn’t lie down. She asked me to put make up in order to be doing something. My child was born without any problem. My mother believes a lot in this. There were many children we knew who were born with very pale skin and hair (albinism) because their mothers were not active during solar eclipse. It can also cause problem for the child if the mother is sewing or

cutting vegetables during this time. My mother was sewing during a solar eclipse and my elder sister was born with small hole in her ear” Momina (37).

Most of the women interviewed reported that they did not observe the traditional Pakistani dietary precautions carefully. Although they believed that traditional diet is important to strengthen the woman and protect the newborn from illness, they found that without assistance and guidance it was inconvenient to adhere to a particular diet. It was also difficult to find the time to prepare special traditional meals that Pakistani women are used to consume during pregnancy and the postpartum period.

“I didn’t adhere to any special diet. Usually my mother takes care of this but she is in Pakistan. She used to cook panjeeri for my sister in Pakistan. Our mothers say that it is good for supporting and strengthening the woman. But I didn’t cook it here because I didn’t have time. It needs time to be prepared. I also didn’t have enough time to feed the newborn baby. I had to look after the other children” Shazia (28).

However, women who had created a social network and those who had their families in Germany relied on friends and mothers to take care of their diet.

“I had good friends living nearby who used to take care of what I should eat as a pregnant woman. They were also sending me some special dishes to strengthen my health. I felt like in Pakistan” Sabeen (42).

“I know panjeeri is good for the woman after birth but I only eat it if my mother prepares it. She knows how I eat it. It is made with Pakistani butter and it smells very strong...I don’t like it. But my mother prepares it for me with normal fresh butter so I can eat it. My mother in law prepares it with Pakistani butter and I don’t like to eat it” Lubna (30).

The results of this study indicate that although the immigrant women tried to incorporate their cultural beliefs and practices into their childbirth experiences, some of these traditions had to undergo modification due to the influence of the different social and cultural context. The *aqiqa* ceremony is believed to be an essential obligation after the birth of the baby. In the absence of their extended families, most of the women reported that they had to delay it until they could visit Pakistan, where they can celebrate it among their relatives. Therefore, most of the families had to postpone the ritual ceremony for numerous years.

I was in Pakistan last year and I did it for all my children. The family should gather and celebrate. It is very important to do aqiqa for every child. It is a sadaqa (voluntary charity) on the life of the child because you distribute food to the poor as

well. The main reason I did it in Pakistan is because there are many family members and also many poor people to whom to give it. I sacrificed six goats, one for each daughter and two for each son. /In Pakistan, there are many poor people and it is good for my children. It is also good for the children that they see and realize what is going on. They should also take part in distributing the meat themselves to their own relatives and poor people. They should know to whom this sadaqa goes and who needs it” Momina (37).

Some families tended to celebrate it in Germany alongside other ceremonies, like wedding ceremonies, because in most cases all family members are gathered for these events.

“We did aqiqa for my first two kids in Pakistan because we had our uncle’s wedding so we did it together. But for the others we didn’t do it yet. My brother will celebrate his marriage soon here in Germany. They already got married in Pakistan but she couldn’t come yet because of visa issues. Once his wife arrives we will do the other children’s aqiqa along with the marriage ceremony” Lubna (30).

The women also described how they had to delay their son’s circumcision which is recommended on the seventh day of infancy. They stated that, in Germany, doctors perform circumcision if there is a medical reason for it or only when the male child is three-year-old¹¹. Most of the women had to wait until their sons are three-year-old. Others reported that they were lucky to find an Arabic Muslim doctor in Mannheim who is willing to do it within few months of the child’s birth.

“I did the circumcision for both my sons here when they were two-month-old. I took my sons to a Muslim doctor’s clinic. I asked him and he said it is better when they are in this age than before. He said that I should wait until my son is two-month-old. The German doctors accept to do it but only when the child is three-year-old. But in this age the child understands and feels the pain because he recognizes what is happening” Lubna (30).

“I also asked my children’s doctor but he said that he can only do it if my son has a problem. He said that if we want then he can do it later when my son is three-year-old and it should be done at the hospital as a private operation. The best is when the child is very young because it is easier and faster, but we had to wait” Saadia (30).

Traditional Pakistani beliefs and practices about pregnancy and childbirth can influence the maternity experiences of Pakistani immigrant women in a different social environment. As pointed out by Manderson and Mathews (1981), these traditional beliefs and practices “provide

¹¹Male circumcision is considered a private operation which is not covered by health insurance in Germany.

the women with a social framework within which she is able to deal with the physiological-medical and psychological-personal changes brought about by her pregnancy and delivery” (cited in Rice 2000:23). Therefore, immigrant women’s vulnerability can be highly influenced by a decline in practicing their deeply rooted traditional beliefs. The women’s inability to perform their traditional practices leads them to disregard and modify some of these observations. As a result, they adapt to their new environment by trying to incorporate their cultural traditions along with newly acquired western observations.

4.6. Acculturation and Adaptation

One of the earliest and most widely used definitions of acculturation proposes that it “comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Redfield et al 1936:149). Additionally, in 1967, Graves introduced the concept of psychological acculturation to distinguish between individual and group level changes. Acculturation at the individual level referred to changes in the beliefs, attitudes, and values held by a group's member (Graves 1967:337).

The process of Pakistani immigrant women’s acculturation in this study has been measured through four strategies identified by Berry (1997): assimilation, separation, integration, and marginalization. Assimilation involves individuals who reject their own cultural identity and accept other cultural values. By contrast, separation occurs when individuals embrace their original cultural values and avoid interaction with the culture of host country. Integration takes place when individuals tend to maintain their own cultural identity and, simultaneously, accept and seek to participate in the host cultural practices. The last acculturation strategy is marginalization, which means rejection of both cultures’ values and identities.

Some of the women in this study reflected a sense of integration in the German society where they showed interest in both preserving their core religious and family values and, at the same time, connecting to and building new social networks in Germany.

“I like the German culture. I live in Germany for more than 20 years but I still feel like a Pakistani. I try to maintain the Pakistani culture at home so my children don’t lose their Pakistani identity. I can say that Germans are nice and friendly people. I

have many friends from Germany, Turkey, Pakistan, India and Arab countries,”
Abida (45).

However, through participant observation and interviews, I noticed that most of these women tended to avoid other cultural groups and remained primarily among themselves and their familiar Pakistani social context within which they shared social activities and religious ceremonies¹² (Berry 1997).

“I have many Pakistani friends. I also know Germans and people from different nationalities but I usually gather with Pakistanis. I also seek help from Pakistani friends. Germans have their own cultures and special behaviors” Saadia (30).

These networks proved to be of high importance to these women. According to Munazz, building social network is significant to help create a sense of social and emotional support; an issue they lacked being uprooted from their familiar social context.

“Everybody has the good and bad time in life and you need to share that with others. It is difficult to live alone. You need to have your social network...others with whom you can share your moments” Munazz (34).

They lived in a close-knit community and within a few blocks of each other. Living within a familiar environment helped these women and eased their adjustment.

“We live very close to each other. It is only a walking distance. We are always visiting each other. We share childcare responsibilities, problems and happy times. We always do it this way. For example, yesterday my neighbor called me and asked when I am coming. She had a problem and she wanted to talk about it. I told her I will come but I will stay for one hour...I was tired. She said ok. I was there at 7 pm and I left at 10:30 pm (laughing). I planned to stay for one hour but it lasted three and half hours” Bushra (25).

On the other hand, although Pakistani immigrant women and succeeding generations in this study proved to maintain religious values and preserved a Pakistani self-identity, some of these women reflected their growing unfamiliarity with and feeling of alienation toward the general circumstances of life in Pakistan. As Lubna pointed out,

“I think it will be difficult for me to live in Pakistan. I am not familiar with the life there. When I was in Pakistan last time for a visit, I went to the hospital with my sister because she was sick. Although I speak Urdu fluently the doctor was unable to

¹² Participant observation during *aqiqa* ceremony.

understand me. I tried to explain to him that my sister has diarrhea but he insisted that he didn't understand what I wanted to say. Then my uncle came and explained it to him and he understood. I felt that maybe I cannot speak well or I am not familiar with the system there. I thought if I live in Pakistan and need to go to the doctor he will not understand me and I will need somebody to go with me. Here, I go to the doctor alone. In Pakistan, I may not be able to do this" Lubna (30).

Correspondingly, Dr. Khan asserts that while first generation Pakistanis in Germany experience separation due to communication barriers, the second generation is increasingly adopting the values, attitudes, and behaviors of the native-born. According to him, in many cases, they depart from religious values and interpret the Islamic religion inaccurately.

These findings support the argument and distinction proposed by Grave (1967) that individuals differ generally in their respective acculturation process. The women in this study varied greatly, at different rates and different times, in the degree to which they integrate, separate or assimilate cultural values, attitudes and identity of the mainstream.

These changes can be argued to be largely oriented towards adaptation. According to Berry (1997), adaptation denotes the changes affecting the individuals or their groups as a response to environmental factors. "Here, psychological adaptations to acculturation are considered to be a matter of learning a new behavioral repertoire that is appropriate for the new cultural context" (Berry 1997:13).

My informants expressed the view that the various hardships they encountered throughout their migration experience have only helped to strengthen their character.

"In Pakistan we have a saying that 'when the gold goes through the fire it gets its perfection'. Because I had to do it all alone I learned a lot. Because I had to go through this difficult experience I am now a strong woman" Momina (37).

Upon migration, these women started adopting different perceptions of self-worth and individual responsibilities for the purpose of creating a smoother and more harmonious environmental context. The women in this study revealed that relocation from a patriarchal society where women are normally dependent on male members of their families into a society guided by self-reliance allowed them to develop and gradually attain a sense of independence and shared responsibilities.

“In Pakistan we tend to depend on the family especially the male to do everything. When I came to Germany I thought I cannot do anything by myself. I always needed someone to go with me wherever I go. But I decided then that I should know how to do it myself. People don’t always have time for me. Now I am used to it. I like to depend on myself” Najla (44).

“If I compare my situation with my younger sister in Pakistan I can say that I am more independent and stronger than her. Also when I visit Pakistan my sister tells me the same. Because, although she had her education and used to work, she was all the time dependent on her family and husband. I remember I used to complain that I am alone and have to do everything myself. But now I think if my husband was always there I would only be a shadow of him. I will always be dependent on him. At that time I didn’t like it but later I realized that this gave me the ability to be stronger. My husband actually helped me by giving me the freedom to depend on myself. He is now proud of me and I am also proud of myself. In my opinion a husband and a wife should be two tires of a car completing each other. Only now I feel we both are in the same status. But before, he was one and carrying me along with him” Momina (37).

Depending on opportunities provided to immigrant women, cultural adaptation can significantly improve their independence (Bui 2004:124). This culturally demanded self-dependence represents an adaptive behavioral strategy that these women developed throughout their acculturation process in Germany.

People’s experience of acculturation and adaptation is influenced by living in the host culture and the development of certain attitudes that correspond to environmental demands and cultural expectations. These attitudes emerge as a result of adopting different strategies that help acculturating individuals to carry on their lives in the host society. Pakistani immigrant women in this study established new social networks and developed self-dependence attitudes as part of new strategies to deal with the challenges they experience as part of the acculturation process.

4.7. Conclusion

The findings of this study offer insight into what it means to be an immigrant Pakistani woman giving birth in Germany. The stories and experiences of these women revealed how they perceive themselves and allowed deep investigation of the various meanings attributed to their childbirth experiences. As Pakistani immigrant women, they needed to learn about an alien system while lacking basic needs of mutual understanding. Some of these women are under more pressure because of the absence of their traditional family and social support structure. Upon migration,

traditional practices observed in their societies of origin are not possible in a different social environment. These women found themselves unable to follow some traditional rituals and beliefs. To deal with these challenges, the women in this study developed strategies, represented by establishing new social networks and developing self-dependence attitudes, that helped them to adapt to the different social settings.

Chapter Five: Conclusion and Recommendations

This qualitative study examined the childbirth experiences of Pakistani immigrant women in Germany. The specific objectives were to explore the women's experiences with the maternity healthcare system and to recommend ways to afford more responsive and culturally sensitive maternity care services for them and other women with similar sociocultural backgrounds. It also aims to provide a comprehensive overview of their childbirth beliefs and practices.

The analysis of women's birth stories represented a piece of their identity as Pakistani mothers. These women articulated an identity and sense of self through the preservation of shame and honor and expressed a devotion towards being a good mother and wife, which is for them the definite aim in life. Shame and honor were also central concepts in the process of selecting a doctor by Pakistani immigrant women in this study. Most of these women stated their preference for female physicians and attributed this preference to modesty in the presence of males as well as feelings of shyness and anxiety about discussing sexual and reproductive health issues with male doctors. However, these women indicated their willingness to accept a male doctor when serious conditions emerged.

Additionally, for these women, having the ability to consult a doctor who shares their Islamic background helped reduce potential culture care conflicts. Most of the women tended to consult a female Muslim gynecologist for general reproductive health matters, believing that she is more aware of their problems and concerns. However, their preference of doctor was also based on residential location of the patient and physician's clinic as well as the academic qualifications of the physician.

The study's results also indicated that the women faced difficulties with the German healthcare system. Although most of the women reported general satisfaction with the services provided, specific barriers were also identified during the data collection process. One of the chief complications the women faced was a sense of powerless and ignorance about their birth experience due to lack of control, having no active say in decisions about their care and being poorly prepared for the birth process. Although these complications have the potential to affect each and every woman's birth experience, the reception of these obstacles by immigrant women is arguably even more complicated due to their exposure to additional challenges. These chiefly

included linguistic and cultural communication barriers as well as exposure to prejudice, stereotyping and discrimination from healthcare providers.

We know from cross-cultural ethnographies that birth is a socially and culturally shaped and attended process (Jordan 1993). Birth in Pakistan is a socially structured event where the birthing woman and her newborn are the family's center of attention. It is a valuable time for supporting the woman physically and emotionally. After migration, most of the women in this study experienced feelings of social isolation, loneliness and alienation. However, for young generation participants, the presence of family and mother's support played a significant role in avoiding such stressful and challenging situations. In the absence of family support, the husband was the only source of help for those who had to experience childbirth away from their families. This new role played by the Pakistani husband emerged as a change in traditional gender roles in Pakistan, where childbirth is considered a women's issue. This traditional change occurred as part of other altered beliefs and practices the women had to experience as part of their immigration stories. The women in this study found themselves unable to follow some of their traditional childbirth beliefs and practices. Some of these traditions had to undergo modification due to the influence of the different social and cultural context. The women adopted these changes and, simultaneously, coped with new strategies of acculturation and adaptation during which they established new social networks and developed self-dependence attitudes.

The study proved that these women, despite the different disadvantageous circumstances upon migration, were often motivated and open to adapting to changes (Spallek et al 2010). The women showed their appreciation and positive attitude towards the healthcare system and general life settings in Germany. They displayed a true interest in their lives and confirmed this by their willingness to participate and gain the cultural competence they need to function in a new country. By learning the language, building new social networks and taking part in everyday life activities, these women proved their willingness and motivations to adapt and integrate. Their immigration experience was taken as an opportunity to learn about what is expected of them as mothers and citizens.

However, the potential to generalize these research findings is limited because of the small sample size of the study which cannot attribute the childbirth experiences of all Pakistani immigrant women in Germany. This study highlights the need for additional research with a

larger sample of Pakistani immigrant women. Future research is also needed to examine childbirth experiences of other ethnic minority groups.

The results of this study illuminate important recommendations for future actions and speculations on future trends, which have the potential to improve maternity health of immigrant women from other ethnic minorities with similar sociocultural backgrounds. The study recommends the necessity to consider the social, cultural and ethnic childbirth context of immigrant women. Intercultural communication training programs should be implemented in all healthcare profession curricula to help caregivers develop cultural competence in regard to culturally diverse groups.

Healthcare providers should be aware of prejudice and stereotyping based on physical appearance and presumed characteristics of a categorized group to which the woman belongs. To avoid this problem, it is recommended that caregivers consider each woman's individuality. As awareness of childbirth beliefs and practices varies between cultures, healthcare professionals like midwives, gynecologists and obstetricians are encouraged to consult with each woman about their preferences and the caring services they require and thus ensure they have an active say in decisions about provision (Mir 2007).

Study participants were concerned with gaining better information about how care is provided in Germany and ability to access this information. Healthcare providers and system hold the responsibility of making available and accessible information. They can assist immigrant women to identify information sources. This study suggests the development of awareness programs on reproductive health related issues and information on accessing maternity healthcare during existing special programs designed to provide assistance to immigrant women, like integration courses.

The healthcare system can and should become more responsive in terms of information provision through linguistic competence. Although printed information is becoming more common in languages other than German, these materials are often limited to English or Turkish translations. Additionally, even when these materials exist, it is not evident whether they reach the target groups, including patients and healthcare providers. It is recommended to make information available in different language and formats. Printed information can be made easy to read by including simple German and pictures to facilitate access for women from different minority

ethnic communities (Mir 2007). Finally, recruiting bilingual healthcare staff from different ethnic groups can potentially promise better culturally competent care, as it facilitates direct communication between patients and healthcare providers (ibid).

An approach that combines increased access to information and an attentive and culturally competent attitude – one that takes into account women’s knowledge and bodily experience – has the potential to provide more responsive and immigrant-friendly healthcare and likely to reduce anxiety and discomfort on the side of immigrant women as well as among healthcare providers.

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