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BradICS

Bradford Infant Care Study

**A qualitative study of infant care practices and
unexpected infant death in an
urban multi-cultural UK population**

Denise Crane

Department of Anthropology

2013

**Thesis submitted to
Durham University
For the degree of
Doctor of Philosophy**

ABSTRACT

BradICS

Bradford Infant Care Study

A qualitative study of infant care practices and unexpected infant death in an urban multi-cultural UK population

This study is conducted in collaboration with the Born in Bradford study and is a qualitative follow-up investigation to the BradICS quantitative study. The BradICS study explored the variability between white British and South Asian families (the vast majority were of Pakistani origin) in Bradford, West Yorkshire in the UK focusing on well-known Sudden Infant Death Syndrome (SIDS) related infant care behaviours. Utilising an evolutionary perspective this research qualitatively explores the infant care practices in relation to SIDS between white British and Pakistani mothers in Bradford. It is considered important to recognise the social and cultural environment where infant care is performed together with people's perceptions of motherhood and infancy to fully understand infant care practices adopted in the family micro-environment.

Methods

This study employed the method of focused narrative interviews with 25 white British and 21 Pakistani mothers (n=46). In addition all quantitative socio-demographic information regarding the participants was obtained direct from the mothers and from the main Born in Bradford database.

Results

Several differences were noted between the white British and Pakistani families regarding parental smoking, alcohol consumption and the overall family network and environment. Variations were noted between the two groups for infant night and day time sleep locations, sleep positions and the overall sleep environment as well as infant care practices of sofa sharing, bathing and pacifier use. Differences were also noted between the white British and Pakistani families for parental

concerns regarding infant temperature together with the use of infant temperature monitors and baby intercom monitors. Additionally, perceptions of motherhood and infancy showed variation between the white British and Pakistani mothers which influenced certain aspects of infant care.

Conclusions

The social and cultural ecology together with a mother's perceptions of motherhood and infancy influence how mothers negotiate the SIDS prevention guidelines; either adopting, dismissing or adapting the health care advice regarding infant care in relation to SIDS.

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Signed:.....

Denise Crane

Date:.....

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DEDICATION

I wish to dedicate this thesis to my late pet Doberman

Mr. George

Mr. G was my constant companion over the past 11 years
and during many lonely days working on this research study

Sadly Mr. G passed away earlier this year and I miss him greatly

CHAPTER 1

INTRODUCTION

The Bradford Infant Care Study (BradICS) is a sub-project of the Born in Bradford study (BiB) run by the Bradford Institute for Health Research. BradICS came about in response to nationally collected data indicating that immigrant mothers to the UK from the new commonwealth countries of India, Pakistan, Bangladesh and the Caribbean experience a substantially lower rate (42% lower) of Sudden Infant Death Syndrome (SIDS) than mothers born in the UK (Dattani and Cooper, 2000). In addition locally collected data for Bradford also reflects a low rate of SIDS for South Asian origin infants (0.2 per 1000 births) in comparison to European origin infants (0.8 per 1000 births). As the health of migrants is often known to be poorer in the new environment than the health of the resident population (Bollini and Siem, 1995) it is particularly important to examine examples such as this where immigrants exhibit better health outcomes than the host population. The BradICS quantitative study was undertaken in 2010-2011 and this qualitative follow-up study provides a detailed investigation of infant care practices of the two largest ethnic groups in Bradford (white British and Pakistani) adding an in-depth qualitative component to the previous protocol.

Previous research into infant care practices has revealed important connections between parental beliefs, attitudes, behaviours, and subsequent outcomes for infant health and lifetime health (Conroy and Smith, 1999; Ball, 2003; Blackburn *et al*, 2005). Furthermore, unexpected infant mortality (SIDS and accidental deaths) have been directly related to issues of parental care (Gantley *et al*, 1993) while studies in several countries have demonstrated that infant care practices of minority ethnic and immigrant populations vary substantially from those exhibited by members of the populations they migrate into (Tuohy *et al*, 1998; Van Sleuwan *et al*, 2003). In certain cases these practices may have health-enhancing outcomes and in others they may place infants at increased risk of early death or long-term adverse health outcomes. A superficial overview of infant care in Bradford suggests that the

practices of South Asian origin families somehow lower the risks of unexpected death in infancy in comparison to the practices of European origin families (FSID, 2009).

1.1 Aims and Objectives

The main aim of this thesis is to provide an understanding of cultural variability in, and consequences of, infant care practices (plus associated attitudes and beliefs) which is crucial for:-

- a) Determining the need for public health interventions aimed at modifying aspects of infant care.
- b) Designing interventions appropriately targeted towards (and engaging with) multi-cultural populations.
- c) Contextualising health promotion and risk prevention strategies within the larger cultural milieu.

The results of this study are anticipated to be of benefit for Public Health and the Medical and Social Sciences. It is acknowledged that interview findings may not be globally generalised, however, the understanding and knowledge gained may be transferred to relevant situations (Kvale, 2007) and the immense knowledge gained by in-depth explanation and understanding is one key to successful health implementations. The application of anthropology to the study and improvement of life depends upon these intimate understandings (McCracken, 1988).

The objective of this study is to address four main questions:-

1. How is the physical, social and cultural landscape of infant care constructed in these communities?
2. In what way does this physical, social and cultural landscape affect day-to-day infant care?
3. What are the dominant social and cultural themes of motherhood and infancy in each of the two major Bradford ethnic groups?
4. What are the priorities for infant care?

This study, conducted in collaboration with the on-going BiB and quantitative BradICS studies, provided a unique opportunity to fuse epidemiological and anthropological methods in order to explore the issues mentioned above. By incorporating the collection of detailed qualitative postnatal data on inter-cultural differences in infant care practices, perceptions regarding the needs of infants, understanding of infant development, and the physical, social and cultural context in which infant care is performed, this study illuminates key issues that will inform public health interventions in this and similar multi-ethnic populations.

Particular attention is taken here to unpick how cultural beliefs regarding infants and their needs affect the care infants receive and consequently their immediate risk of unexpected mortality and longer term health outcomes. It is recognised that this research will undoubtedly uncover factors already acknowledged, although by encouraging interviewees to describe their individual infant care practices and locate them within a broader ideology (Gantley *et al*, 1993) there is the possibility that other factors may be uncovered offering new considerations for potential research. It is important to examine in detail ethnic differences in infant care practices as they occur in the infant's micro-environment, especially where SIDS rates are extremely low or extremely high, as "we may find important clues to SIDS aetiology" (McKenna, 1995:263).

1.2 Overview of the Born in Bradford study

The Born in Bradford study is funded by the EU and is a ground breaking project designed to improve the health of children at present and in the future. Bradford is a city in West Yorkshire in the North of England with a population of approximately half a million people and is one of the most deprived cities in the UK (Raynor, 2008). Bradford is a diverse city which has grown to be the fifth largest in the UK (Raynor, 2008; Ball *et al*, 2011) and this fast growing, ethnically and culturally mixed population is seen as a major asset for academics and health professionals. Recent reports have highlighted that the city's health is a cause for concern and particularly

worrying is that Bradford's infant mortality rate (the number of babies who die before they reach their first birthday) is amongst the highest in the UK.

Bradford is served by a single maternity unit at the Bradford Royal Infirmary and almost all women resident in Bradford give birth in this unit (Raynor, 2008). BiB recruitment at the Bradford Royal Infirmary for this birth cohort study started in March 2007 and ended at the end of December 2010. BiB is tracking the lives of around 13,500 babies born in Bradford from pregnancy, through childhood until they become adults and in addition collects all parental socio-demographic and personal information. Therefore the BiB study has an excellent database of social and cultural background information regarding both the parents and infants recruited. The main aim of the Born in Bradford study is to increase understanding of the factors that affect health and wellbeing, and identify factors that influence the differences between people of Pakistani and white European origin (Raynor, 2008). Birth cohort studies provide powerful evidence about causes of disease by following children from before they were born all the way into adulthood and the BiB study aims to be the most thorough cohort study of health outcomes in a multi-ethnic population conducted in the UK to date.

1.3 Overview of the BradICS quantitative study

The BradICS quantitative study explored the variability in infant care practices between white British and South Asian families (Bangladeshi/Indian/Pakistani); the vast majority of the South Asian families were of Pakistani origin (Ball *et al*, 2011; Ball *et al*, 2012). The study utilised telephone interviews involving 2560 families with 2-4 month old infants enrolled in the Born in Bradford cohort study. Focussing specifically on well-known SIDS related infant care behaviours the study identified that South Asian infants, in comparison to white British infants, were more likely to sleep in an adult bed, have a pillow for infant sleep, sleep under a duvet, be swaddled for sleep, ever or regularly bed share, and ever breast feed. In addition the study identified that South Asian infants, in comparison to white British infants, were less likely to sleep in a room alone, use the 'feet to foot' sleep surface position,

use an infant sleeping bag, ever sofa share or use a pacifier (Ball *et al*, 2011). Furthermore, the study also identified that parent-infant sleep surface sharing practices differ between white British and Pakistani families (Ball *et al*, 2012). Why these behaviours are particularly relevant will be discussed below.

The BradICS quantitative study discovered that night time infant care differed significantly between white British and South Asian families and Ball *et al* (2011; 2012) suggest that South Asian infant care practices were more likely to protect infants from the most important SIDS risk factors. The main themes identified in the study were cigarette smoking, alcohol consumption, sofa sharing, and solitary sleep which Ball *et al* (2011; 2012) suggest could explain the lower rate of SIDS in the South Asian population. The study further identified that South Asian families prioritise close proximity, breast feeding, and maternal behaviours congruent with infant health and low SIDS risk as normal cultural practice. The BradICS quantitative study identified maternal smoking, non-breast feeding, sofa sharing, and alcohol consumption as clear targets for SIDS reduction advice among white British families.

1.4 Structure of the thesis

In Chapter 2 I discuss the evolutionary theoretical framework utilised for this study. There is a review of the literature regarding SIDS, especially in relation to infant care practices and ethnicity. I also review the literature regarding the different social and cultural perceptions of motherhood and infancy which impacts and influences parental infant care. Finally I review and discuss the practical, political and ethical considerations for this research.

Chapter 3 presents the methods used for this study including funding and ethical approval, planning and preparation, the study design, an overview of the study location, methods of recruitment, and the qualitative and quantitative data collection and analysis.

In Chapter 4 I present and consider the results from both the qualitative interviews and the quantitative data collected regarding the social and cultural ecology of the participants. I present and discuss the impact of the participants' social and cultural ecology on infant care practices.

In Chapter 5 I present the results from the qualitative interviews with regard to the participants' social and cultural perceptions of motherhood and infancy. I present and discuss how these perceptions of motherhood and infancy directly influence infant care practices.

In Chapter 6 I examine how knowledgeable the mothers in this study were regarding the links between infant care and SIDS and I present and discuss the primary source of the mothers infant care advice. I demonstrate and discuss how the mothers I interviewed adopt, dismiss or adapt their infant care practices in relation to the SIDS infant care advice.

Chapter 7 reviews and discusses the findings presented in Chapters 4, 5 and 6. I present two models of infant care that have been formulated to distinguish and encompass the differences uncovered between the infant care practices of the white British and Pakistani mothers I interviewed. I acknowledge and discuss the limitations of this study in addition to considerations for future research. Finally, I present a reflective account of the research process including reflexivity, the methods and techniques utilised in this study, and the researcher and participant interactions.

In Chapter 8 I conclude the findings of this study.

CHAPTER 2

LITERATURE REVIEW

This chapter discusses and explains the reasoning for deciding to utilise an evolutionary perspective in relation to this cross-cultural study of SIDS and infant care. The literature in relation to SIDS is reviewed, especially in relation to infant care practices and ethnicity. The literature regarding cross-cultural perceptions of motherhood and infancy is also reviewed and discussed. Finally the practical, political and ethical considerations for this research are presented.

2.1 Theoretical Framework

Anthropology is a 'broad spectrum' discipline with social and cultural anthropologists through to medical and biological anthropologists; anthropologists at either end of this 'broad spectrum' often stand fast in their own specialist fields. However, I would suggest that both the social scientists and the biological scientists in Anthropology have a great deal to offer each other and there is possibly a high degree of mutual compatibility and potential gains from trade between the social and biological sciences. As Nettle (2009) states there should be no conflict between the acceptance of human behaviour as culturally variable and the perception of biological and evolutionary theory. Gettler and McKenna (2011) state that qualitative anthropological perspectives are uncommon in contemporary SIDS research although there have been several studies that have applied anthropological and evolutionary perspectives to issues of mother-infant sleep practices. Overall it is considered that anthropology has the potential to contribute greatly to the understanding of SIDS and the SIDS prevention advice.

During collection and analysis of the data I concluded that an evolutionary perspective and theoretical framework would be most beneficial to the understanding of infant care practices in relation to SIDS and unexplained infant

deaths. An evolutionary theoretical framework is a powerful explanatory system in the human sciences and can amalgamate knowledge across otherwise incongruent research fields (Kruger, 2011). An evolutionary perspective does not dismiss the social and cultural determinations of behaviour, rather it is a theoretical framework that may help to understand why such determinations of behaviour exist and survive (Nettle, 2009). Humans take care of their infants invested with social and cultural meaning, and moral values and beliefs (Abel *et al*, 2001). However, it is argued that we cannot adequately address motherhood and infancy without acknowledging and understanding their underlying biological foundations (Gross, 2005). Therefore, it is suggested that utilizing an evolutionary perspective has the potential to add depth and value to social and cultural behaviours and practices. Nettle (2009) describes two kinds of culture, 'transmitted' where humans learn the things they think and do from others in their social group (social learning) and 'evoked' where humans think and do the things they do simply because their environments are different. The 'evoked' culture can be perceived as simply 'adaptations to the environment' and it is considered that under the conditions of the industrialised Western society humans have not always made fitness-maximizing decisions (Nettle, 2009). Issues of infant care and survival play a key role in evolutionary fitness and we might anticipate infant mortality to be greater under some circumstances than others. This can be related quite strongly to aspects of motherhood and infant care as human infant biology may not be able to accommodate the rapid pace of culturally based changes in infant care (Gettler and McKenna, 2011). It is considered that social and culturally derived differences in the nature of parental investment are therefore crucial.

Evolutionary processes are relatively slow in comparison to the rapid change that has occurred to human environments over the past 10,000 years. An evolutionary perspective would argue that contemporary health problems result, to some extent, from an incompatibility between our contemporary lifestyles and our evolved human form (Trevathan, 2010); this proposed incompatibility between humans' present day lifestyles and evolved human biology has been termed the 'discordance hypothesis' (Trevathan, 2010; Gettler and McKenna, 2011).

Health professionals and researchers employing an evolutionary perspective are few, but they benefit from an understanding of the principles of evolution and the present human physical form which is the result of millions of years of natural selection (Trevathan, 2010; Kruger, 2011). Evolutionary theory provides a solid framework from which to explore and understand factors contributing to numerous health problems and particularly in the understanding of pregnancy, childbirth, and infancy. It is argued that an evolutionary perspective is particularly relevant to different social and cultural constructions of motherhood.

Trivers (1972; 1974) constructed a theoretical basis for evolutionary perspectives of infant care with the concepts of 'Parental Investment' and 'Parent-Infant Conflict.' He describes 'Parental Investment' as being anything done by a parent for their offspring which increases the offspring's survival chances. The 'Parent-Infant Conflict' theory focuses on conflicts that arise between parents and their infants; offspring maximise their reproductive success by obtaining greater parental investment while parents balance the costs and benefits of different aspects of parental investment. Infant care or parental investment is shaped by social and cultural environments and differing models of parental investment produce different parent-infant conflicts that have either beneficial or hazardous consequences for infant health, safety and well-being. Ellis *et al* (2011) demonstrated the parent-infant conflict theory with examples from pre-birth through to adolescence and suggest how this can inform both empirical and theoretical research; for example they suggest that parent-infant conflict can be applied to maternal decisions regarding breast feeding. They argue that the social and ecological context (maternal workload, social support and ideology) influence weaning and subsequent parent-infant conflicts. How humans modulate their parental investment is of particular interest to anthropologists (Ball and Panter-Brick, 2011) and infant care practices show both similarities and variations within and between cultures and the social and cultural environments (together with individual circumstances and characteristics of each parent) affect parental investment strategies. For instance, in the case of societies where female kin reside in single households parental investment in infant care is reduced by the presence of

these allomothers who share infant care and other household duties. Therefore all mothers invest in their offspring but they may modify their infant care practices with different strategies due to different social and cultural ecologies. These differing strategies will have different benefits or risk implications for infant health and wellbeing and as such are pertinent in the study of infant care and SIDS.

The human infant at birth is less developed than other primates with only 25% of adult brain volume due to constraints imposed by bipedalism (which altered the shape and rigidity of the human pelvis) together with significant encephalisation (Gettler and McKenna, 2011). Therefore, due to neurological immaturity at birth, human infants are vulnerable and highly dependent requiring constant and prolonged care from their mothers (Trevathan, 2010). It is suggested that human infant biology lacks the ability to accommodate the swift pace of social and cultural changes in infant care that may stray from infant care optimised by natural selection (Gettler and McKenna, 2011). The parental practices we follow in many Western societies are social and cultural constructions that do not necessarily go 'hand in hand' with what is 'optimal care' for human babies (Small, 1998). In many Western societies there has been a large shift away from how mother-infant interactions evolved; families strive for separate sleeping spaces, personal privacy, independence and autonomy. As a result of these ideals in most Western families there are extended periods of separation between a mother and her baby, especially at night, which may be viewed as an effort to reduce parental investment.

A significant example of an evolutionary perspective in relation to infant care regards infant sleep and infant sleep environments. Over the past two decades several researchers and anthropologists have examined social and cultural infant care practices related to infant sleep and the evolved biology of infants. Mothers and their infants often sleep apart from one another in many Western societies which can be seen as a 'mismatch' between evolved infant biology and cultural norms (Gettler and McKenna, 2011). An evolutionary perspective supports the suggestion that solitary sleep does not provide optimal care for human infants for several psychological and physiological reasons (McKenna *et al*, 1993; Ball, 2009).

Intense and prolonged mother-infant contact would have evolved to protect infants from environmental assaults, vulnerabilities and physiological deficiencies (McKenna, 1996) and hence the human infant is not well equipped to cope with maternal separation (Morgan *et al*, 2011). In previous human history if an infant was not in close proximity with the mother during the night it would probably not survive due to predation, cold and hunger (Trevathan, 2010).

Anthropological and evolutionary perspectives are scarce in SIDS and paediatric research (Gettler and McKenna, 2011) and I am in agreement with several researchers who recommend that an anthropological evolutionary theoretical framework in the study of infant care practices in relation to SIDS has a lot to contribute to future research (McKenna and Mosko, 1994; McKenna, Mosko and Richard, 1999; Nettle, 2009; Trevathan, 2010; Gettler and McKenna, 2011; Morgan *et al*, 2011). There is much to be gained from an evolutionary perspective regarding health concerns and evolutionary analyses provide a theoretical basis for understanding parental investment strategies and conflicts between parental and infant needs (McDade, 2001; Beaulieu and Bugental, 2008). It is a logical assumption that infant care practices have evolved to prevent the most significant threats to infant health and wellbeing. Therefore an evolutionary perspective, and in particular the 'Parental Investment' theory, 'Parent-Infant Conflict' theory and 'Discordance' hypothesis, are relevant tools for understanding infant care practices in relation to SIDS.

2.2 SIDS

Sudden Infant Death Syndrome (SIDS) was formally recognised as a medical term in 1970 (Rognum, 1995) and is defined as "the sudden death of an infant or child which is unexpected by history and in whom a thorough autopsy examination fails to demonstrate adequate cause of death" (Blackwell *et al*, 1995:73). Therefore, a diagnosis is complex due to there being no specific cause of death and, although SIDS is not a common event, it still remains the most common cause of death in post-neonatal infants in the first year of life in Western countries (McKenna, 1996;

Byard, 2004). SIDS is often referred to as 'cot death' which would suggest that a 'cot' is the environment where SIDS occurs; it may be reasonable to assume that mothers may associate SIDS with infants sleeping in a cot which may prove to be a dangerous assumption. Indeed, in a study conducted by Aslam *et al* (2009) it was discovered that mothers who bed shared with their infants felt that SIDS reduction advice was not applicable to them as they did not place their babies in a cot for sleep.

Over several decades since the 1970's several triple-risk models have been suggested including a well-known triple-risk hypothesis presented by Filiano and Kinney (1994) which emphasised injury to the prenatal brainstem. However, as Guntheroth and Spiers (2002) argue, none of the triple-risk hypotheses have significantly enhanced our knowledge and understanding of the causes of SIDS. Over the past two decades there has been a dramatic decline in SIDS rates following the 'Back to Sleep' campaign launched in the early 1990's (discussed further in Section 2.3). As a consequence SIDS research has been hampered by a decrease in the number of SIDS cases available to study together with a lack of consistency in autopsy data (Bajanowski *et al*, 2007). Even though the primary cause of SIDS is still unknown theories related to breathing control and arousals during infant sleep are considered the most explanatory (McKenna, 1996). Byard (2004) suggested that infants who have died of SIDS have elevated body temperatures although this factor is not very well understood at present; nevertheless, SIDS prevention advice continues to stress the dangers of infants overheating. The most common epidemiological characteristics of infants at greater risk of SIDS are premature, low birth weight, age 2-4 months, prone sleep, exposure to cigarette smoke, maternal alcohol consumption, and maternal drug abuse (Rognum, 1995; Byard, 2004; Fifer *et al*, 2009; Ostfeld *et al*, 2010). Further possible explanations for the persistence of SIDS cases are the sleep environment, feeding practices and pacifier use, in addition to socio-demographic variables such as socio-economic status, educational status, maternal age, housing and ethnicity have been researched as possible explanatory factors.

Ostfeld *et al* (2010) concluded from a review of SIDS cases in New Jersey, USA that single risk SIDS cases are rare and most cases contain multiple risks. Overall, it is widely acknowledged that causes of most SIDS cases contain multiple risk factors and it is generally recommended that a theoretical framework which encompasses a multi-factorial causation involving a range of risk factor variables should be adopted (Byard, 2004; Blair *et al*, 2010; Ostfeld *et al*, 2010).

2.3 SIDS and Infant Care Practices

In the late 1980's a different way of researching SIDS was proposed utilising an anthropological evolutionary perspective in relation to infant care practices. The research attempted to identify risk factors amongst infants who die without a known cause and infant care practices and produced a breakthrough in reducing SIDS rates dramatically. It was ascertained that the prone sleeping position (that was recommended at the time) was a contributory factor in unexpected infant death. Subsequently the 'Back to Sleep' campaign was launched advocating that prone sleeping infants were at an increased risk of SIDS compared with those infants who slept supine (Fleming *et al*, 1990; Fleming *et al*, 1996). A substantial decline in SIDS rates were observed in countries where the supine sleeping position was advocated and was probably responsible for reducing SIDS rates by more than 50% (Rognum, 1995). This relationship between infant sleep position and SIDS has been subsequently confirmed in multiple studies around the world (Malloy, 1998) and proposed mechanisms to explain how the prone sleeping position may be related to SIDS include airway obstruction, CO₂ re-breathing and hyperthermia (Nelson, 1995). Discovering this risk factor for SIDS suggested that other child care practices may also be significant for further research (McKenna *et al*, 1999). Indeed, since the 'Back to Sleep' campaign various infant care practices have played a prominent role in SIDS reduction advice and McKenna (1996) states that researching infant care practices have provided the most important factors for helping to reduce the risks for infants dying from SIDS.

2.3.1 Infant Sleep

Leach *et al* (1999) and Blair, Sidebotham *et al* (2006) reported that 83% of SIDS deaths in England occur during night time sleep. This discovery had led many researchers to focus on all aspects of infant sleep and the infant sleep environment. Infant sleep evolved with close mother-infant contact and Small (1998) states around 90% of infants around the world sleep with an adult and additionally that co-sleeping may protect some infants from SIDS. Co-sleeping is defined as “any situation in which committed mothers sleep within sensory range of an infant (on the same or different surface) permitting mutual monitoring, sensory access, and physiological regulation” (Gettler and McKenna, 2011:454). However, co-sleeping is perceived as a risk factor for SIDS although the environment of co-sleeping is broadly defined; generally either sofa sharing or bed sharing (Blair, 2008). Bed sharing is a common night time infant care practice and research has concluded that in the UK, USA, Australia, New Zealand and the Netherlands approximately 50% of infants have bed shared with a parent for some of their night time sleep (Tuohy *et al*, 1998; Van Sleuwan *et al*, 2003; Blair and Ball, 2004; Ball, 2009). Due to the ambiguity of the term ‘co-sleep’ I have decided to not use this term during the remainder of this thesis, rather I shall describe the actual sleeping arrangements reported in this study; I shall use the term bed share and sofa share or I will actually describe the environment of infant sleep such as ‘parental bedroom’ or ‘separate room’ etc.

Placing infants in a cot separated from their mothers is normal practice in Western societies although as Morgan *et al* (2011) suggests this may be stressful for young infants as they are not evolved to cope with this maternal separation. Wailoo *et al* (2004) and Ball (2007) argue that the practice of solitary infant sleep is of no immediate benefit for human babies and has only a relatively short history in human infant care practices. Indeed, throughout human history infant sleeping has been a social, not solitary, practice (DeLoache and Gottlieb, 2000) and many researchers have studied evolved human infant biology and culturally influenced infant sleep practices. The majority of studies utilising this evolutionary perspective suggest that the most harmonious and safe environment for which human infant sleep evolved is

a close mother-infant proximity (Gettler and McKenna, 2011). A growing amount of SIDS evidence emphasises the protective effect of keeping infants in the parental room for night time sleep (McKenna, 1995; Blair *et al*, 1999) and advice to keep an infant within the parental bedroom for the first six months is now incorporated into the Department of Health's 'Reduce the Risk' guidance for SIDS prevention (Department of Health, 2004). This advice suggests that there is a risk associated with lack of parental supervision during night time infant sleep. Even though the majority of SIDS deaths do occur during night time sleep (Blair, Ward Platt *et al*, 2006) it is important that this advice should also be acknowledged and implemented during day time naps.

2.3.2 Bed Sharing

In many countries in the world, and amongst Asian women living in England, bed sharing is common and the SIDS rates are relatively low; in Japan, where mother-infant bed sharing is common, the SIDS rates are among the lowest in the world (McKenna, 1996). However, Japan has low maternal smoking and the normal sleep surface is futons which are a thin, firm surface placed on the floor; in contrast to Western sleep surfaces which are thick, soft and elevated from the floor. Hong Kong also has a low SIDS rate but bed sharing is commonly practiced even with high poverty rates and overcrowding but again Hong Kong has low maternal smoking. Beal and Byard (2000) state that, in several ethnic groups where bed sharing is common, the incidence of SIDS is low and this is particularly so for Asian infants. However in New Zealand, where bed sharing is common, the SIDS rates are relatively high and a distinguishing factor in this instance is a high level of maternal smoking, particularly among the Maori community who experience the highest SIDS rates in New Zealand. Therefore, it is significant to note that bed sharing is a common practice in certain populations and the rate of SIDS is high (e.g. black American, Maori and Aboriginal peoples) and in other populations bed sharing is a common practice but the rate of SIDS is low such as Japanese, Pacific Islanders, New Zealand peoples and the UK Asian populations (Blair, 2008).

Within the UK it appears that the practice of bed sharing is highly variable with approximately 50% of all infants bed sharing, at least occasionally, by the age of three months (Ball, 2003) and Blair (2008) reports that $\frac{1}{5}$ of infants are brought into the parental bed over the first year of life on a regular basis. Furthermore, Farooqi *et al* (1993) highlight that bed sharing is a prevalent cultural practice among the British South Asian populations with infants commonly sharing a bed with their mothers. However, there is a vast amount of conflicting opinions regarding bed sharing with studies recommending that bed sharing is a risk factor for SIDS (Mitchell and Thompson, 1995; American Academy of Pediatrics, 2005) and other studies recommending that bed sharing is a risk-preventative factor for SIDS (McKenna, 1995; Small, 1998; Wailoo *et al*, 2004).

The circumstances of the bed sharing environment appear to be key in determining whether infants are at risk and the most significant risk factors appear to be maternal smoking and alcohol consumption. Horsley *et al* (2007) carried out a systematic review of SIDS cases regarding the dangers and benefits associated with bed sharing; they concluded that there was an association between maternal smoking and bed sharing. Blair *et al* (1999) and Lahr *et al* (2005) concluded that there is no evidence that bed sharing is a risk factor for SIDS for infants of parents who do not smoke. Additional factors include who the baby sleeps with, how they are covered, whether the baby sleeps on or in the bed, and whether bed sharing infants are swaddled (a practice characteristic of some cultures) (Tuohy *et al*, 1998; Beal and Byard, 2000). Therefore, as McKenna and McDade (2005) and Blair (2008) suggest it is not the practice of actual bed sharing that is hazardous but the actual circumstances in which bed sharing takes place. Ball and Volpe (2012) highlight how bed sharing has both positive and negative effects on infant health outcomes and depends on parental characteristics and the actual sleep environment. Therefore, it is important to qualify “what *kind* of bed sharing may be dangerous” as health advisors may confuse what is a safe and adaptive sleeping environment for an unsafe maladaptive one (McKenna, 1995:264;*original emphasis*).

2.3.3 Sofa Sharing

The statistics for infants who succumb to SIDS whilst sleeping with a parent often do not distinguish whether infants were in the parental bed or sofa sharing. Blair, Sidebotham *et al* (2006) reported that over the past 20 years in the UK the proportion of infants who have died from SIDS while sleeping with their parents rose from 12% to 50% although the actual number of SIDS deaths in the parental bed halved. This was due to the fact that there was an increase in the number of deaths of infants sleeping with their parents on a sofa. Ball *et al* (2012) argue that bed sharing and sofa sharing are distinct practices which should not be combined in studies of SIDS as a single risk factor. Blair *et al* (2009) suggests that breast feeding mothers may be sleeping with their babies on a sofa to avoid bed sharing as bed sharing is being suggested as a risk factor for SIDS. Furthermore Ball *et al* (2012) discovered in the Bradford Infant Care quantitative Study that parents who sofa share do not usually bed share and that mothers who ever sofa shared were more likely to be white British cigarette smokers. Both Blair *et al* (2009) and Ball *et al* (2012) conclude that in the UK there should be more emphasis on advice regarding the risk factors for SIDS placed on sofa sharing together with parental smoking and alcohol consumption.

2.3.4 Infant Sleep Environment

As previously mentioned SIDS reduction advice advocates placing infants in a cot in the parental bedroom. However, the cot environment is not without potential safety hazards and it is recommended that soft objects such as pillows, quilts and toys be kept out of the infant's cot (Department of Health, 2004; American Academy of Pediatrics, 2005). Hutchison *et al* (2007) and Obladen (2012) documented the use of objects which are used in the infant cot environment such as pillows, foam wedges, rolled up towels and sleep wraps which are used to maintain infant sleeping positions in relation to plagiocephaly which is discussed further in Section 2.3.5. Certain infant sleep surfaces are known to be associated with a greater SIDS risk than others (Beal and Byard, 2000; Blair, Sidebotham *et al*, 2006) and cultural preference, together with socio-economic circumstances, play direct roles in determining both the type of surfaces used for infant night time sleep and their

relative safety (Blair *et al*, 1999; Ball, 2003). It is interesting to consider that an infant sleeping in a cot is not considered dangerous; rather it is the actual environment of the cot that is considered potentially dangerous and Blair (2008) points out this does not seem to be the case with the practice of bed sharing. Therefore in this regard, rather than considering bed sharing *per se* as dangerous, it may be more appropriate to consider the particular bed sharing environment as potentially dangerous. Additionally, further concerns have been raised regarding infants sleeping in baby carriers or car seats (Merchant *et al*, 2001; Dollberg *et al*, 2002) together with sofas (as mentioned previously in Section 2.3.3) and their association with a greatly increased risk of SIDS and accidental suffocation (Blair *et al*, 1999; Beal and Byard, 2000).

2.3.5 Infant Sleep Position

Since the 'Back to Sleep' campaign the prone sleep position is considered hazardous and the recommended sleep position for infants is supine; although placing infants on their side for sleep is still being commonly used (Gantley *et al*, 1993; Fleming *et al*, 1996; Blair, Sidebotham *et al*, 2006; Hutchison *et al*, 2007). However, the side position is considered to be unstable due to the fact that small infants may possibly roll into the hazardous prone position during sleep (Blair, Sidebotham *et al*, 2006; Hutchison *et al*, 2007). In the past neonatal nurses and midwives have placed infants on their sides for fear of the infant vomiting and obstructing the airways and Fleming *et al* (1996) suggest that this practice has been continuing in maternity units. Additionally, both Gantley *et al* (1993) and Hutchison *et al* (2007) found that parents were intentionally placing their infants in the side position due to cultural values and beliefs regarding plagiocephaly. Obladen (2012) documents the history and practice of infant head shaping utilising infant sleep devices such as cradleboards, pillows etc. and this intentional infant head shaping has been a common practice throughout human history. The majority of the world's cultures (past and present) have practiced some form of infant head shaping with motives such as the perception of aesthetic human attractiveness, symbols of ethnic identity or socio-cultural status, and believed health benefits (Obladen, 2012). Gantley *et al* (1993) discovered that Bangladeshi mothers in Wales in the UK placed their infants

in the supine position but turned them on their sides at times to promote a culturally valued rounded head shape. The practice of positional plagiocephaly is common amongst many Asian societies and parents may be negotiating SIDS advice with their own anxieties regarding plagiocephaly (Hutchison *et al*, 2007) as well as utilising infant sleep positioning devices such as pillows. Additionally the actual positioning of the infant on the cot surface has also been a concern, with the Department of Health advising parents to position their infant at the foot, rather than the head, of the cot (feet-to-foot). This infant care advice is to prevent the infant from sliding under the covers where it may be at risk from overheating, suffocation or CO₂ re-breathing.

2.3.6 Infant Feeding

Research has shown that night time feeding and infant sleep practices are closely intertwined (Ball, 2003) and breast fed infants exhibit very different sleep/wake development patterns to those of formula fed infants (Elias *et al*, 1986). It would appear that formula fed infants sleep more deeply and for longer periods at an earlier age than breast fed infants who are fed more frequently and consequently have significantly more night time feedings. There are some studies that have suggested that formula fed infants, in comparison to breast fed infants, have an increased SIDS risk (McVea *et al*, 2000; Alm *et al*, 2002; Vennemann *et al*, 2009; Hauck *et al*, 2011). This suggestion has been confirmed by Vennemann *et al* (2012) who carried out a meta-analysis to measure the association between breast feeding and SIDS. They concluded that breast feeding is a protective factor against SIDS and recommended that breast feeding should be promoted in SIDS reduction advice.

Many breast feeding mothers begin the night with their infants in a cot by their bed, bringing the baby into bed at the time of the first night time feed where the infant may subsequently remain to feed and sleep for the remainder of the night (Ball, 2003). Blair *et al* (2010) studied the relationship between breast feeding and bed sharing and highlighted the risks of advising mothers not to bed share; mothers feeding their infants in the night may avoid bed sharing and chose to feed their infants on more hazardous surfaces such as chairs or sofas (Wailoo *et al*, 2004; Blair

et al, 2010). Indeed, Kendall-Tackett *et al* (2010) studied night time feeding locations and concluded that to avoid bed sharing 55% of mothers fed their infants on chairs or sofas and furthermore 25% admitted falling asleep in these locations. Collection of prospective breast or formula feeding data and night time feeding locations is therefore important for understanding infant sleeping arrangements and the relative risk for SIDS and accidental suffocation.

2.3.7 Pacifier Use

Another consideration highlighted within the literature is the use of pacifiers with several studies demonstrating that pacifier use appears to reduce an infant's risk of SIDS (American Academy of Pediatrics, 2005; Li *et al*, 2005; Mitchell *et al*, 2006; Moon *et al*, 2012). Blair (2008) states that the use of pacifiers is commonly associated with poor socio-economic status groups. However, as Mitchell *et al* (2006) report, the use of pacifiers varies considerably within countries as well as between them and they express the lack of research undertaken to explain these variations. Several mechanisms have been proposed to explain the association between pacifier use and SIDS reduction and it has been suggested that the use of a pacifier decreases the threshold for infant arousal (American Academy of Pediatrics, 2006). Another suggestion is that the bulky handle of a pacifier may provide infants with an air passage and thus prevent accidental hypoxia (Li *et al*, 2005). However, the mechanism and effectiveness of pacifier use for SIDS reduction rates is little known and vague although some authorities were quick to adopt the recommendation that parents should use pacifiers to reduce their infant's risk of SIDS (American Academy of Pediatrics, 2005; Blair, 2008). However, Mitchell *et al* (2006) conclude that recommending the use of pacifiers is open to debate and Blair and Fleming (2006) warn that the reduction of SIDS from using pacifiers should be viewed with caution.

2.4 Infant Temperature Concerns

A central theme of the UK Department of Health's 'Back to Sleep' campaign of the early 1990's was the advice to prevent infants from overheating and the present

SIDS advice continues to stress the dangers of infants becoming too hot (Blair, Sidebotham *et al*, 2006). The relationship between SIDS and overheating is a result of the fact that human infants do not have a mature thermoregulatory system to cope with temperature extremes. As such human infants heavily depend on their mothers or other caregivers to help them cope with maintaining a thermal balance (Wailoo *et al*, 2004; Fleming *et al*, 1996). SIDS is a primary fear for parents in Western countries as it is the main cause of infant death in the first year of life, although it is not a major fear for parents in a global context. In many other areas of the world there are other major health concerns for infants; the main global concern for children under 5 years of age is pneumonia (World Health Organization (WHO), 2013). Regarding infant temperature, in Western societies parents' major concern is to prevent their infants from becoming too hot due to the fear of SIDS. However, in the developing world parents' major infant temperature concerns are to prevent their infant becoming too cold due to the fear that cold causes influenza and respiratory infections (Cronin-de-Chavez, 2011).

Social and cultural beliefs about physical illness that are understood to result from an infant being exposed to heat or cold have a direct influence on how mothers prioritise and provide thermal care for their infants. As mentioned, around the world in many societies cold is viewed as inherently dangerous to infants and parents go to great lengths to ensure that their infants remain well wrapped (Wilson and Chu, 2005). In direct contrast other societies around the world are more concerned about their infants overheating and so avoid overdressing and over wrapping (Gantley *et al*, 1993; Watson *et al*, 1998; Wilson and Chu, 2005). Duvet use, hat wearing and room heating have all been related to the presumed link between overheating and SIDS (Nelson *et al*, 1989; Watson *et al*, 1998; Wilson and Chu, 2005). Wilson and Chu (2005) studied infant bedding and insulation levels between Western and Eastern cultures and concluded that the lower rate of SIDS in Eastern countries does not appear to be associated with infant bedding and insulation levels *per se*. Overall it is considered that cultural beliefs and values regarding the effects of heat and cold should be particularly relevant and acknowledged accordingly in discussions of SIDS advice guidelines.

2.5 Smoking and Alcohol Consumption

Evidence in the UK suggests that maternal smoking prevalence has risen from 50% to 80% amongst SIDS mothers, whilst fallen from 30% to 20% in the general population (Fleming and Blair, 2007). Cigarette smoking, however, varies considerably between cultures, especially amongst women, and Gantley *et al* (1993) found that in the UK smoking amongst Bangladeshi women was very rare. Furthermore, Hilder (1994) found that globally maternal smoking was uncommon amongst all Asian cultural groups and as such this is one of the explanations given for the low rates of SIDS in South Asian infants (Blackwell *et al*, 2004; Aslam *et al*, 2009). Blair, Sidebotham *et al* (2006) state that maternal smoking is common in the UK amongst deprived groups and this factor can partly explain the high rates of SIDS in infants from socio-economically deprived backgrounds. Although maternal smoking is considered to be the most harmful to the health of infants, it should be noted that paternal smoking has also been linked to an increased risk of SIDS (Blackburn *et al*, 2005). Therefore, it is important that data regarding paternal smoking should also be gathered and considered in SIDS research.

Exposure to tobacco smoke, either prenatal or postnatal, can lead to a complex range of effects upon normal infant anatomical and physiological development which can place infants at an increased risk of SIDS. The variable for which there is the most compelling evidence regarding bed sharing and the risk of SIDS is whether the mother is a smoker; evidence suggests that there is a strong association between SIDS and bed sharing among smoking mothers (Mitchell and Thompson, 1995; Fleming *et al*, 1996; Moon *et al*, 2004; Horsley *et al*, 2007). Indeed several studies have provided evidence that maternal cigarette smoking is the strongest modifiable risk factor for SIDS (Blair *et al*, 1996; Leach *et al*, 1999; Lahr *et al*, 2005) and Hilder (1994) concluded that of all the risk factors maternal cigarette smoking is particularly associated with SIDS deaths. James *et al* (2003) examined SIDS and bed sharing with mothers who smoke in the UK and found that out of 25 cases, 9 bed shared (7 were maternal smokers), 5 reported alcohol or drug use on the night of death and 2 other cases were sofa sharing. Overall the vast majority of researchers

suggest that smoking is definitely an associated risk factor for SIDS and that mothers who do smoke should be advised not to bed share with their infants. It should be also noted that, as many researchers and health professionals recognise, SIDS risk factors do not operate independently and maternal smoking is a risk factor for both low birth weight and SIDS which makes infants particularly susceptible (Blair, Sidebotham *et al*, 2006).

Similar to the cultural variability regarding smoking is the cultural variability regarding alcohol consumption with beliefs of total abstinence within certain cultures through to a much more liberal approach to alcohol consumption within other cultures. Several studies have identified parental alcohol consumption as a primary factor of unsafe infant sleep practices and SIDS (Blair *et al*, 1999; Alm *et al*, 2002) and is therefore a strong and potentially modifiable risk factor for overlaying and accidental suffocation during bed sharing (Blair, 2008). Dattani and Cooper (2000) found, in their analysis of SIDS by day of death, there was an increased SIDS risk at weekends and public holidays and Phillips *et al* (2011) discovered an increase in both parental alcohol consumption and SIDS rates at weekends. The increase in SIDS rates alongside the increase in parental alcohol consumption at weekends and public holidays is not fully understood but it has been suggested that there could be changes in the parental routines which affect their infant care practices at these times and result in a higher risk of SIDS (Fifer *et al*, 2009).

Drug use is similarly regarded as a potential risk factor for SIDS and has the same associations that are considered for cigarette smoking and alcohol consumption. However, information regarding the use of drugs in parents is extremely difficult to obtain due to the illegal nature of their use. Therefore, published data on the use of drugs in relation to SIDS is sparse and difficult to collect and analyse (Blair *et al*, 2009) and as such is often an omission in considering SIDS risk factors in research.

2.6 SIDS and Ethnicity

According to the International Society for the Study and Prevention of Perinatal and Infant Death (ISPID) (2013) SIDS rates are the highest in countries such as the US (0.54 per 1000 live births) and New Zealand (0.8 per 1000 live births) and the lowest in countries such as Japan (0.16 per 1000 live births) and Hong Kong (0.1 per 1000 live births). Nationally collected data indicated that immigrant mothers to the UK from the new commonwealth countries of India, Pakistan, Bangladesh and the Caribbean experience a substantially lower rate (42% lower) of SIDS than mothers born in the UK (Dattani and Cooper, 2000). Ethnicity and culture have been identified as factors that can impact on infant health practices and outcomes, although, the link between culture and parental attitudes and behaviour and subsequent health outcomes is not always clear (Aslam *et al*, 2009). It has been noted that SIDS rates are the lowest in most Asian cultures and continue to be low even after they migrate to Western societies (McKenna, 1996) and differences in the rate of SIDS between ethnic groups have been researched and well documented. Petersen and Wailoo (1994) report that South Asian infants, despite a higher prevalence of some risk factors, are less likely to suffer SIDS. They concluded that their research did not reveal any physiological differences between Asian and white infants which might account for the Asian infants low vulnerability to SIDS. The lower rates of SIDS in Asian migrant groups has been attributed to much lower rates of maternal smoking and alcohol consumption as well as certain culturally influenced infant care practices (Byard, 2004; Ball *et al*, 2012). Therefore, it is important that further qualitative explanations be sought for the persistence of lower SIDS rates in the South Asian population.

Comparative data on infant care practices among Bangladeshi and Welsh families in Wales and among Maori and white families in New Zealand revealed qualitative differences in the infant sensory environments (Gantley, 1994; Abel *et al*, 2001). Cross-cultural studies have highlighted how migrant populations resist adopting the Western infant care practice of placing their babies to sleep in a separate cot and retain and value the practice of bed sharing with their babies (Dosanjh and Ghuman,

1996; Aslam *et al*, 2009). In addition it is interesting to note that cultural beliefs regarding infant illnesses and physical conditions can be understood in the context of infants being either too hot or too cold; hence, it is important to remember how mothers prioritise temperature. Due to SIDS preventative advice regarding infants overheating, the majority of Western societies may now perceive an infant being too hot as more dangerous and adjust their infant care accordingly. However, many other societies have historically perceived an infant being too cold as more dangerous and hence will adjust their infant care in different ways. As mentioned previously (see Section 2.3.5) the side sleeping position is considered unstable as infants may roll into the hazardous prone position during sleep and parental concerns in respect of plagiocephaly and supine sleep have been linked to cultural preferences regarding head shape which may encourage parents to sleep infants in non-supine sleep positions (Kane *et al*, 1996; Biggs, 2004).

Research from around the world has repeatedly demonstrated that there are several social and cultural differences exhibited in relation to infant care practices (Panaretto *et al*, 2002). Farooqi *et al* (1993) and Gantley *et al* (1993) researched infant care practices among families of South Asian and European origin in the UK which revealed differences in aspects of infant care known to modify SIDS risk such as lone infant sleep, infant wrapping and covering, and exposure to cigarette smoke. Furthermore, Aslam *et al* (2009) discovered that the retention of cultural beliefs and values were not related to migrant mothers' length of residency in Western societies.

2.7 SIDS in Bradford

The infant mortality rate in Bradford is amongst the highest in the UK with a rate almost double that for England and Wales (Raynor, 2008). In Bradford the SIDS rates of 0.5 per 1000 live births is higher than the national average of 0.4 per 1000 live births. However, the rate of SIDS among the South Asian infants in Bradford is 0.2 per 1000 live births which is actually 2.5 times lower than the average for Bradford (Westman, 2010).

People of Pakistani origin dominate the South Asian population in Bradford (Phillips *et al*, 2007) and the Pakistani populations of Bradford are predominantly from the Mirpur, Azad Kashmir region of Pakistani (Shaw, 2001). Almost half of the babies born in Bradford are of Pakistani origin (50% white; 44% Pakistani; 4% Bangladeshi; 2% other) (The Bradford and District Infant Mortality Commission, 2011) and even though Pakistani families have more infant deaths from metabolic or congenital abnormalities and perinatal factors they have far fewer infant deaths by SIDS (Balarajan *et al*, 1989; Bacon, 1994). In addition Kelly *et al* (2008) states that Pakistani infants are 2.5 times more likely to be of low birth weight (which is another risk factor for SIDS) compared with white infants and thus the relatively low SIDS rates within the Pakistani community of Bradford is considered to be quite a remarkable phenomenon (Aykroyd and Hossain, 1967). Therefore, Bradford is an ideal setting for research and to explore the differences in infant care practices between white British and Pakistani families as Anuntaseree *et al* (2007) suggest cultural differences in child care practices can probably explain the differences in the SIDS rates between Western and Asian societies. The advice not to bed share or sofa share is prominent in the SIDS guidelines although during the BradICS quantitative study Ball *et al* (2012) discovered that bed sharing was high amongst the Pakistani mothers even though the SIDS rates are low and as such suggests that bed sharing should not be discouraged. Furthermore and interestingly, Ball *et al* (2012) discovered that, although the Pakistani mothers often reported bed sharing, they did not report sofa sharing whereas the white British mothers did not often report bed sharing but did report sofa sharing.

2.8 Perceptions of Motherhood and Infancy

Humans learn how to behave and think for the most part from other members of their own social groups and this differs from group to group. Nettle (2009) explains this as 'transmitted culture' and humans will use this 'social learning' to improve their average reproductive success; for instance, if established members of a social group already feed and care for their babies in a certain way wouldn't it be more beneficial and successful to imitate their infant care practices (social learning) than

learning for oneself through 'trial and error'? The process of 'transmitted culture' can partly explain certain infant care practices but this 'social learning' also has an impact on differing perceptions, values and beliefs regarding motherhood and infancy. Ethno-paediatrics is the cross cultural study of parenting behaviours. Perceptions of motherhood and infancy are hugely important as they influence and impact on parenting behaviours, decisions regarding infant care, and the infant care practices adopted by parents. When studying parents' infant care practices it is vitally important that consideration is given to the broader social and cultural contexts and to acknowledge that people have diverse beliefs and attitudes in relation to motherhood and infancy (DeLoache and Gottlieb, 2000).

2.8.1 Perceptions of Motherhood

Becoming a mother is considered an important event in many women's lives and even for women who do not become mothers the effect of the institution of motherhood can be profound (D'Arcy *et al*, 2012). In the majority of cultures mothering (the way in which mothers take care of their infants) can be linked to beliefs and values of motherhood within their culture (Liamputtong, 2007). Motherhood relates to social and cultural concepts of kinship, women's roles, gender and identity (Barlow and Chaplin, 2010), although in Western societies today women have much more choice regarding motherhood and mothering than previous times in human history (D'Arcy *et al*, 2012). Particular themes relating to motherhood that have been researched and documented are 'solitary' or 'communal' motherhood (Dosanjh and Ghuman, 1996; Paris and Dubas, 2005; Valentin, 2005) and 'distal' or 'proximal' parenting (Meyers and Ballistoni, 2003; Keller, 2007; Keller *et al*, 2009).

Studies with British Pakistani communities have consistently acknowledged the importance of kinship, marriage and gender roles within these communities. Indeed, these themes are hugely important in the Pakistani community and have a direct influence on attitudes and behaviour in relation to motherhood. McKenna (1996) states that Asian women have very few illegitimate births and Dale and Ahmed (2011) highlight how the gendered role of Pakistani women is synonymous with

motherhood as marrying and having children is seen as the ideal identity of a woman in that society. Research has shown that British born Pakistanis tend to marry members of their extended family in Pakistan (Shaw, 2000; Charsley, 2006; Rytter, 2012) and common explanations for these transnational marriages are to maintain and strengthen values within the close family and extended kinship networks (Shaw, 2000; Rytter, 2012). A Pakistani marriage affects the futures and socio-economic statuses of a wide range of kin and for this reason marriage is not seen as an individual concern but more of a communal affair (Shaw, 2001). Stopesroe and Cochrane (1990) conducted an in-depth study across two generations of South Asians and found that, compared with the white British population, the Asian population considered close proximity and support of family members was a priority over individual independence. Indeed, even amongst the younger generation the sacrifice of individuality that the Pakistani culture requires is worth the advantages obtained from their family and community (Dosanjh and Ghuman, 1996). Phillips *et al* (2007) discovered that South Asians living in Bradford prefer to live within close proximity to other family members for feelings of security, support and socializing and 70% of households in Bradford had other people they regarded as family living within walking distance. As a result of the Pakistani family networks 'communal' motherhood is the normal social and cultural practice of the majority of Pakistani mothers. In relation to appropriate infant care advice, as Abel *et al* (2001) suggests, Western health care professionals should acknowledge the importance of the extended family in certain cultural groups.

For women living in Western societies the sanction of marriage and the role of motherhood has dramatically changed over the past several decades and for many white British women marrying and becoming a mother is not the primary ideal of their role as a woman. Many white British women today value education, career and independence prior to marriage and motherhood. If, or when, white British women marry and start a family they often return to paid employment shortly after having their children. In direct contrast to the high number of working white British women Brown (2000) reported that only 11% of working age Pakistani women were in paid employment in the UK. For the majority of Western societies the social and cultural

'norm' of kinship and the family household is the 'nuclear' family unit; the close proximity of family members is not as valued as individual independence. As a result many Western mothers in a 'nuclear' family unit report feelings of social isolation as they feel personally disconnected from other adults in their family and community (Paris and Dubus, 2005). Dosanjh and Ghuman (1996) discovered, in their research, how white British family members are often willing to help new mothers in their families but in many cases were not living in close proximity. Therefore, for white British mothers 'solitary' motherhood is the normal social and cultural practice. This is an important aspect of white British infant care as child rearing is extremely costly in terms of time and energy and it is very difficult for a mother to raise her child alone without help from family members or other caregivers. In evolutionary terms and throughout human history mothers have had support and assistance with their infant care from female relatives and friends who they were in close contact daily.

2.8.2 Perceptions of Infancy

Research has highlighted that different societies bestow differing personality and developmental values on infants. It has been suggested that some of these cultural differences between beliefs, values and infant care practices may account for the lower SIDS rates in South Asian infants (Anuntaseree *et al*, 2007; Liamputtong, 2007). Pachter and Dworkin (1997) studied mothers' expectations about their infant's development in four ethnic groups in America. They concluded that different ethnic groups had differing developmental expectations and stated that these differences are due to the various cultural beliefs and values of infancy. Additionally, the personality traits that are encouraged and those that are discouraged in infants and children often reflect deeply held cultural values and beliefs and it is important to recognise that societies vary in the degree of autonomy assumed for each person. In some cultures family members are viewed as mutually dependent and not truly autonomous, whereas, other cultures value autonomy and early independence (Morelli *et al*, 1992; Pearce, 1995; Hashioni-Dolev and Shkedi, 2007).

One of the differences that has been highlighted from extensive research considers the values and beliefs of independent versus interdependent orientations (Morelli *et al*, 1992; Dosanjh and Ghuman, 1996). DeLoache and Gottlieb (2000) document the independence and interdependence dichotomy and the contrast between individualistic and collectivist values. Within most industrialised Western societies the independence and individualistic traits are directly encouraged by parents in their infants and children. Other societies in the world hold the opposite belief and parents encourage interdependence rather than independence in their infants and children. Cultures vary substantially with regard to the emphasis they place on an infant's development of independence or interdependence (Keller *et al*, 2005) and an example of this dichotomy in relation to infant care practices is how Western societies prefer to place their infants to sleep in a cot, and many times in a separate room. Parents in Western societies believe that this separation at night encourages early independence in their infants (Ball, 2007). A study conducted with German parents found that the 'ideal' infant is self-soothing and developing solitary sleep and concluded that German parents value independent development rather than the immediate needs of their infants (Valentin, 2005). In direct contrast to the majority of Western societies many other cultures prefer to keep their infants close and often bed share and co-sleep reflecting a value of interdependence and connectedness (Abbott, 1992; Aslam *et al*, 2009). Indeed, bed sharing or co-sleeping in many cultures is guided by cultural values and beliefs and the ideology of interdependence rather than independence (Small, 1998). The current advice for infant sleep is mainly informed by biomedical discourse in regard to the prevention of SIDS. However, it is argued that knowledge of the social and cultural contexts of parental infant sleep practices is an important consideration for health care professionals (Rowe, 2003). Interestingly, an important attribute of the interdependent or collectivist is the value of respect to family elders and the extended family network (Dosanjh and Ghuman, 1996) which is a value held by Pakistani communities.

The practices of 'distal' and 'proximal' parenting practices are related to social and cultural orientations of independence and interdependence (Meyers and Ballistoni,

2003). Distal parenting being 'face to face' contact infant care and object stimulation practiced in many Western societies and proximal parenting being body contact infant care and body stimulation being practiced in many migrant societies (Keller *et al*, 2009). In addition it has been researched and documented that Western societies practice parent-led, competitive infant care with infant developmental goals and that migrant societies practice infant-led, cooperative infant care with no specific urgency for infant developmental goals (Meyers and Ballistoni, 2003; Keller, 2007; Keller *et al*, 2009).

2.9 Practical Considerations

2.9.1 Conducting 'Anthropology at Home'

It may be easy to assume that researching within one's own society will be unproblematic as advocates of 'anthropology at home' state they are free from the research obstacles of language barriers and culture shock (Aguilar, 1981). On the other hand a major criticism of researching one's own society is the problem of gaining enough distance (Abu-Lughod, 1991). However, due to the heterogeneity of society and the diverse ways in which individuals' feel they belong to different social or cultural groups it is considered that it is never possible to be completely 'at home' (Davies, 1999). I am in agreement with Clifford (1986:9) who states that researchers studying within their own societies offer accounts that are both restricted and empowered in 'unique ways.' It is suggested that with the increasing cultural diversity within the UK anthropologists researching at home cannot know everything about their own society (Aguilar, 1981). Indeed, as Jackson (1987) points out, a grave mistake is to assume that conducting research abroad has more to contribute to anthropological understanding than research conducted in one's own society. The majority of notions regarding infant care are culturally constructed and may be at odds with the emotional and biological needs of babies (Small, 1998). Therefore, within plural societies such as the UK it is important to pay attention to the different ways different groups of people socially construct their world (Rubinstein and Perloff, 1986).

Even though this study is fundamentally 'anthropology at home' there is a significant element of encountering unfamiliar cultural assumptions and interpretations due to the multi-cultural nature of this research. As such there is a vast array of issues to be negotiated including possible language barriers (and culturally specific body language), subjectivity (how do I interpret and determine importance across the familiar and unfamiliar?), and reliability and validity issues. Additionally, what will the overall influence of myself as a researcher have on my participants and hence their responses. It is beneficial to remember that the multiplex nature of identity will facilitate that certain aspects of the 'Self' will either emphasise the sameness or difference in relation to the aspects of the 'Other' (Narayan, 1998). It is considered that to prove successful in the conduct of research in one's own society the anthropologist must undertake a heightened state of self-awareness and reflexivity. In consideration of Murphy's (1992) resulting (and unplanned) 'ethnoethnography' it is recognised that both the researcher and the participant wrestle with aspects of familiarity and strangeness. McCracken (1988:12) postulates that the "intimate acquaintance with one's own culture can create as much blindness as insight." On the other hand another major criticism of anthropologists studying within their own cultures is that they cannot gain enough distance so as to analyse it objectively although, as argued previously, it is felt that objectivity cannot be achieved within the majority of qualitative research. Overall I am in agreement with Narayan (1998) who suggests that conducting research in one's own culture is neither a specific advantage nor an inherent handicap. Furthermore, I consider that anthropology is the study of the difference and sameness of human social and cultural life and as such "must not exclude anthropologists' own cultures" (Davies, 1999:34).

2.9.2 Methods

Empirical quantitative research is important to indicate variations, patterns and trends of infant care practices although research conducted employing this empiricist paradigm presents limitations. Qualitative research techniques provide a much more in-depth analysis of the social and cultural processes that affect parental perceptions and beliefs in relation to infant care. Without a qualitative understanding of how culture mediates human action we can only know what the

statistics tell us without being situated within their fuller social and cultural contexts (McCracken, 1988). In acknowledging that the world is socially constructed there is the possibility that different groups of people may see things differently providing alternative realities that may vary from culture to culture (Denscombe, 2007). Crane and Angrosino (1992) highlight three aspects of culture which are at the core of my research; what people do, how they do it, and what they think. They recommend that one means of getting at these aspects is the qualitative in-depth interview.

The research method of interviewing has been employed by many anthropologists and is an inductive and very flexible research strategy (Drever, 1995) which is used in some form within 70-90% of social research studies (Riach, 2009). A researcher who employs this technique reveals their ontological position that acknowledges the importance that peoples' perceptions, understandings and beliefs are not objective but rather human constructs subject to society wide interpretations (Mason, 1996; Arksey and Knight, 1999). Interviews facilitate a rich and in-depth collection of data regarding peoples' experiences and beliefs in relation to infant care and hence provide further insight into how infant care is perceived and carried out for particular people. However, researchers should be aware that the accuracy of information obtained through interviewing is a major problem and there is no absolute way of verifying information regarding individual thoughts and feelings (Bernard, 2006; Denscombe, 2007). Indeed a consideration recommended by Silverman (2004;*my emphasis*) is what people '*say*' may be quite different to what they '*actually do*' and furthermore is there '*always*' a perspective behind every action. In a similar vein Gomm (2004) expresses concern regarding 'demand characteristics' in which interviewees provide responses which they deem appropriate or moral opposed to what they actually believe or implement. This is a major concern when questioning peoples' infant care practices as they may report practices they feel that health advisors or professionals recommend rather than what they actually implement.

One form of interviewing is the semi-structured interview and research based primarily on this research strategy has become a very popular and important form of

qualitative research, especially in anthropology (Davies, 1999). Semi-structured interviewing is the most appropriate approach in situations where there is only one chance to interview someone and an interview schedule should be followed if reliable, comparable qualitative data is needed (Bernard, 2006). An interview schedule is a framework for the main part of a semi-structured interview based on the key issues that the research study will be addressing (Kvale, 1996; Arksey and Knight, 1999). This prepared list of questions can eliminate the possibility of omitting vital information and is also useful when a conversation “grinds to a halt” helping the interview to flow (Ellen, 1984:233). This series of questions is enhanced with further exploration of the interviewees’ responses using a technique termed ‘probing’ (Drever, 1995; May, 2001; Bernard, 2006). The ability to probe the interviewee to elaborate or clarify their responses provides further insight into perceptions and beliefs surrounding their infant care practices. Bernard (2006) emphasises the importance of probing and provides several ways to use this technique effectively and Kvale (2007) presents useful variations of the probing technique such as follow-up questions and interpreting questions.

Spradley (1980) highlights the concern that focusing on a few related domains and the relationship of these domains may be due to the theoretical interests of the researcher. Consequently, certain issues should be addressed such as, ‘how much of these research questions are already subjectively answered prior to the research?’ and ‘how much does theory and the literature direct the research?’ (Spradley, 1980). This, together with Bruyn’s (1966:218) concern that “interpretations...tend to be theoretically orientated rather than seriously concerned with the original meanings in a culture,” requires a critical self-awareness by the researcher and raises the questions, ‘will I merely find what I have been taught to look for?’ (Frankenburg, 1990). In contrast Ellen (1984:225:*original emphasis*) proposes that we should freely explore interesting features, without preconceptions, and suggests that by following a schedule of our own devising we are merely displaying the “contrivances of our *own* minds” rather than discovering the minds of those we want to study. Ellen (1984) further states that, by not fixing an interview schedule with pre-determined questions, an interview will permit the freedom to introduce responses previously

unanticipated. Morse (1998) recommends that initial interviews should be kept broad letting the participants narrate freely and subsequent interviews can then be used to obtain more targeted information. The narrative approach to interviewing is virtually unstructured, often beginning from a single narrative question (Wengraf, 2001) and is very close to a more natural conversation. Nevertheless, the researcher will usually have questions they want to pose and topics they wish to explore and therefore the conversation is still often directed with theories of the research in mind (Davies, 1999). Chase (2005) states that researchers use narrative interviews to emphasise patterns paying attention to similarities and differences between them. In this sense it should be acknowledged that a narrative is a “socially situated interactive performance” and the subsequent reported interpretations are both enabled and constrained by the social, cultural and historical identity of the researcher (Chase, 2005:657). Furthermore, Arksey and Knight (1999) caution this form of interview strategy as it has the potential to encourage long and detailed stories that may not always be relevant to the research subject; however, the notion of research necessarily implies some kind of structure. This can be imposed by a priori (by using structured or semi-structured techniques for obtaining data), or after obtaining data by identifying patterns, themes and structures within the data. In this thesis the latter option is implemented.

Although interviews are generally considered by social scientists to be a productive research tool they are not without their limitations (Denscombe, 2007). A key criticism of qualitative interviewing is subjectivity, both personal and epistemological. However, it is argued that the total elimination of subjectivity is considered unavoidable in the majority of qualitative research and a competent researcher will constantly be aware of the impact of their beliefs and theoretical ideas. Another major concern regarding interviewing is the problem of ‘interviewer bias’ where the characteristics of the interviewer such as sex, age, ethnicity, etc., may influence the responses elicited from the interviewee and thus reduce the validity of the data (May, 2001; Gomm, 2004). It is also suggested that in the interview situation there may often be a suspicion and lack of trust toward an interviewer due to the possible differences in status levels. However, Miller and

Glassner (2004) and Fontana and Frey (2005) advocate the process of 'rapport building' to overcome this issue; the interviewer needs to be aware and spend a little time and effort to gain confidence and good communication with their interviewee. In following the postmodern approach researchers should realise and acknowledge that they need to interact as persons with their interviewees (Fontana and Frey, 2005). Hence, the knowledge we elicit as researchers from our interviews is ultimately intrinsically bound with who we are, for ourselves and for others (Moore and Saunders, 2006). Consequently, in addition to the theoretical and practical design of an interview, the researcher should also consider what manner, demeanour and approach they will adopt (Mason, 1996).

2.9.3 Reflexivity

Reflexivity is found in all phases of the research process from initial selection of the topic to final reporting of the results (Davies, 1999) and Myerhoff and Ruby (1982) explore the relationship between reflexivity and anthropological theory and practice; they express how this increased self-awareness can produce more penetrating and reliable research studies. Rosaldo (1989) relates how knowledge we gain through our own life experiences influences how we interpret and understand what we observe or hear from our subjects of study and our position is constantly changing with new life experiences and hence new or different perspectives. Therefore, our understanding and interpretations can only ever be a provisional product of how we view the world and more significantly how we understand and interpret the lives of others at one particular moment in time. Rabinow (1977) advises that in the writing-up process we should pay particular attention to both the participants' reactivity and our own biases. It is considered vital to understand one's own 'Self' and consequently the 'Self's' interaction with the 'Other' and this together with the understanding of vague aspects of culture will also assist interpretation.

Reflexivity evolved primarily from feminist research and has become a significant aspect of the qualitative research process (Riach, 2009). Reflection on the research process, especially researcher and participant interactions, confirms my belief that qualitative research should always include the researcher's reflexivity. In

experiencing qualitative interview interactions I do not feel that an interviewer can be objective or detached from the knowledge and evidence they are generating (Mason, 1996). Postmodernists have argued that any form of knowledge is to some degree subjective and as such a researcher is unable to portray other peoples' knowledge independent of biases (Sobo and DeMunck, 1998). In agreement with Omvedt (1979), Ellen (1984), Arksey and Knight (1999), Chase (2005), and many others, it is felt that to eliminate reactivity and subjectivity in the interviewing process is impossible. Therefore, as a qualitative researcher utilising interviewing methods I am in concurrence with Scheurich (1997) who critiques the positivist view of interviewing as hugely underestimating the uniqueness and complexity of each human interaction. Furthermore, in agreement with a valued aspect of the feminist research process, it is considered that "engagement, not disengagement" is vital when expecting someone to reveal important or personal information (May, 2001:135). Consequently I subscribe to the views of an ever increasing number of social scientists who realise the importance of interaction within the interviewing process and as such the need to acknowledge that I am doing so (Fontana and Frey, 2005). A heightened self-awareness and reflexivity of myself as a researcher will demonstrate how the research may have been influenced by the methods used and my characteristics and these disclosures can make studies more reliable (Myerhoff and Ruby, 1982). Therefore, being reflexive will intentionally reveal the underlying epistemological assumptions that formulated the research questions, sought the answers to those questions, and the presentation of the findings (Myerhoff and Ruby, 1982). Overall it is recognised that the beneficial influence from the postmodernist position has "enhanced our understanding of and sensitivity toward, the inherent subjectivity of qualitative research" (Sobo and DeMunck, 1998:22).

2.10 Political and Ethical Considerations

The collection of ethnicity data in health information has often been criticised due to two main concerns, the preservation of equality and to avoid stigmatization (Bollini and Siem, 1995). However, it is considered that the availability and appropriate use of ethnic data is the only way to adequately identify and respond to many health

concerns and although the concepts of ethnicity have historically been abused, they are potentially crucial in aspects of public health and epidemiology (Bhopal, 1997; 2006). Research into health and ethnicity in the past has been deemed unethical and ineffective due to the vaguely defined variables of ethnicity (Bhopal, 1997). Gantley *et al*, (1993) discovered how ethnic definitions within the health sector can be inconsistent; for example by self-reporting or based on a person's country of birth. Information based on nationality may lose possible variation in cultural practices and beliefs and therefore determining appropriate ethnic definitions is vital to facilitate the recognition of high and low risk groups and thus the possible identification of high and low risk practices (Gantley *et al*, 1993). Additionally, it is equally as important to pay attention to, and identify, the different ways in which different groups of people socially construct health and wellbeing (Rubinstein and Perloff, 1986). The Born in Bradford study has identified 5 main ethnic groups (European, Pakistani, Indian, Bangladeshi and Caribbean origins). The BiB classifications of ethnicity are the same as the 2001 Census and are adopted for this study; the white British participants are self-defined as white and British and the Pakistani participants are self-defined as South Asian and Pakistani.

Peoples' origins are at the centre of the definitions of ethnicity within this study and hence may be first, second or even third generation migrants. Consequently an additional consideration, that Layton (1989), McDonald (1989) and Rabinow (1977) highlight, is the importance of time and history as it is possible that changes in infant care practices have occurred over the generations. Indeed Bruyn (1966:207) relates this importance and states "it is time that tells us how long it takes an outside influence to become a meaningful part of the lives of people in a culture" and these cultural influences have "an incubation period which takes time and close association to study." For instance, in relation to infants' sleeping position, Farooqi *et al* (1993) discovered how recent immigrants to the UK tended to place their babies in the supine position for sleep and that this figure decreased with an increase in the duration of maternal residence in the UK. Additionally, it should also be remembered that religion is an important aspect of peoples' cultural and social

lives and that each religion is inclined to have its own particular practices and customs (Crane and Angrosino, 1992).

Overall it is an endeavour of this study to examine the practices and beliefs of the white British mothers in the same ethnographic manner as the Pakistani mothers. In the case of culturally valued traditions there is a constant awareness and acknowledgement that certain practices may be imbued with socio-cultural benefits outweighing any collateral health concern; for example, infibulations where the negative consequences of lifetime social stigma greatly outweigh effects on childhood or lifetime health for their adherents (Schweder, 2000). To facilitate ethical research, systematic and explicit methods should be utilised and it is crucial that the values of ethical research on human subjects be adhered to (Sobo and De Munck, 1998). An interview is an ethical and moral endeavour and issues of consent, confidentiality and consequences should be fully considered (Kvale, 1996). In relation to confidentiality in the study of infant care serious legal issues may be raised if a researcher obtains knowledge by the promise of confidentiality of mistreatment or child abuse either by the interviewee or others (Kvale, 2007) and this is a significant consideration for this study.

2.11 Summary

The literature reveals how certain infant care practices can reduce or increase the risk of infants succumbing to SIDS (Rognum, 1995; Fleming *et al*, 1996; Tirosh *et al*, 2000; Blair *et al*, 2010; Ostfeld *et al*, 2010) and cross-cultural research has identified physical, social and cultural variations in infant care practices both in the UK and globally (Farooqi *et al*, 1993; Gantley *et al*, 1993; Abel *et al*, 2001; Panaretto *et al*, 2002; Cronin-de-Chavez, 2011). In addition the literature highlights how there are cross-cultural variations regarding perceptions of motherhood and infancy which influence parental infant care decisions and practices (Morelli *et al*, 1992; Dosanjh and Ghuman, 1996; Deloache and Gottlieb, 2000; Valentin, 2005; Liamputtong, 2007; Keller *et al*, 2009). Therefore to adequately address the aims and objectives of

this study it is considered vital to understand both how and why infant care is performed in the infant's micro-environment.

The vast majority of the literature regarding SIDS provides quantitative research and it is suggested that qualitative research is the only way to provide an in-depth account of the physical, social and cultural environment of parents and their infants alongside parental perceptions and beliefs regarding motherhood and infancy. This study intends to explore infant care practices adopted by parents and the perceptions underlying these parental infant care decisions together with an investigation of how mothers understand and relate to the present infant care advice in relation to SIDS. Therefore this thesis will provide a qualitative detailed impression of how infant care is performed in the infant's micro-environment alongside values, beliefs and perceptions underlying these parental infant care practices. It is suggested that this information together with how mothers are adopting, adapting or dismissing infant care advice will provide valuable evidence to add to the current literature and understanding within the infant health care arena.

CHAPTER 3

METHODS

This chapter provides information regarding the funding and ethical approval I obtained for this study together with a description of the planning and preparation undertaken including the pilot study. I present the study design, an overview of the study location and the ethical and personal safety considerations I confronted in this study. Finally the study protocol is described including methods of recruitment, the sample size, and the qualitative and quantitative data collection and analysis.

3.1 Funding and Ethical Approval

I was the Principal Investigator for this study with Professor Helen Ball of Durham University and Professor John Wright of The Bradford Institute for Health Research as co-investigators. Funding was obtained by MRC/ESRC 1+3 Interdisciplinary Studentship Award which was awarded in 2008. Ethical Approval was granted by Durham University and the NHS National Research Ethics Service Committee of Yorkshire and the Humber. Additionally, R&D management approval was granted by Bradford Teaching Hospitals NHS Foundation Trust and the Bradford Institute for Health Research as this study involved recruitment of their patients and the BiB participants at the Bradford Royal Infirmary.

3.2 Planning and Preparation

During my MA year I was involved in the implementation of the quantitative BradICS study which further broadened my knowledge of this project, the community, and the infant care practices of the participants. I have undertaken inputting of the data obtained through the questionnaires which allowed me to gain insight into the responses gleaned from the participants in the study. I also attended several of the BradICS meetings at the Bradford Royal Infirmary with Professor Helen Ball where I

became acquainted with several key figures involved in the project. The meetings also gave me an insight into the concerns and problems that may arise when undertaking such research.

3.2.1 Qualitative Interviewing

Literature provides invaluable guidelines regarding the interview process, although as Kvale (1996) and Bernard (2006) state; a researcher can only master the art of interviewing by actually conducting the interviews. Fontana and Frey (2005) express that it is pointless to pit one method of interviewing against another. However, in concurrence with May (2001), it is argued that to understand and explore social relations and events the strengths and weaknesses of different interviewing methods should be examined and understood. Therefore, in preparation for this research my MA thesis entailed a pilot study to explore two different qualitative interviewing strategies. In comparing and contrasting semi-structured and narrative styles of interviewing it became apparent that both approaches had their own advantages and disadvantages in the qualitative research of infant care practices. I found that the semi-structured interviews did not encourage a natural flowing conversation which would allow the interviewees to express their own beliefs and opinions freely, although all predetermined topic areas of the study were systematically obtained. Contrastingly the narrative style of interviewing encouraged the interviewees to converse freely on themes of infant care which they considered most significant. However, the narrative approach was very time consuming and several key predetermined topic areas of infant care in relation to SIDS were omitted due to the fact that I did not have personal notes to hand. Therefore, I concluded that in conducting the narrative interviews a list of key topics and issues would be beneficial to eliminate this risk of omitting vital aspects of infant care.

Upon evaluation of the strengths and weaknesses of the two interviewing methods I concluded that an interviewing strategy that combines certain techniques from both the semi-structured and narrative approaches would be beneficial. Due to the fact that authenticity is at the core of qualitative research, it was considered that a narrative approach (although focused) would be the most effective route. Kvale

(1996) states that focused interviews should be conducted in such a way that an interviewer leads the interviewee to certain themes without impacting on their opinions about these themes. In light of this, although an interview schedule should not strictly be followed, a list of the key topics and themes should be at hand to guard against the possibility of omitting vital information which I experienced within the pilot study. Therefore, in evaluating and reflecting upon the pilot study I was of the opinion that a focused, narrative approach would elicit more informative and fruitful information. I felt that this approach would encourage a greater in-depth exploration of people's attitudes and cultural conceptualisations in relation to infant care practices whilst still allowing the discovery and exploration of unanticipated issues.

During my pilot study I also adopted the routine of keeping a reflective journal; taking notes immediately after each interview. As Riach (2009) advocates, this post-interview reflective account facilitates the questioning of my own epistemological assumptions in addition to documenting the interview process. However, it is acknowledged that memory is a highly subjective method abound with biases (Kvale, 1996) and therefore this reflective journal was my own interpreted observations being intimately part of myself as a researcher, both personally and epistemologically (Andrews, 2008). Nevertheless I still felt that during my PhD research keeping a reflective account of the interviews would prove constructive in allowing a written documentation of the interview. I felt that this reflective account may prove useful for recollection and contextualising the interview during analysis.

In conclusion I found the process of piloting different interviewing strategies to be immensely valuable and informative for considering the most beneficial approach to be adopted for this study. I felt more appreciative of the different methods and techniques involved and required to conduct successful interviewing.

3.2.2 Characteristics of 'Myself' as a Researcher

In addition to the practicalities of the research process I learnt the importance of the impact I may have on my research. A most significant consideration of qualitative

interviewing is the characteristics of interviewers (for example age, gender, ethnicity, socio-economic status etc.) directly affecting information elicited (May, 2001). In this respect I was aware of the characteristics of myself as a researcher and the impact that this may have on the information gained through the interviews; being a white English, mature, female with a grown-up family. However, in consideration of the topic of this study and the fact that my interviewees were all mothers, I felt that being an older female researcher with children of my own was an advantage. I consider that I had the potential to have a more positive influence for conversation than if; for example, I was a male researcher or a young female researcher with no experience of being a mother. Nevertheless, during my MA pilot study I noted that in a lot of the interviews I conducted a certain degree of assumption was awarded to me regarding infant care which may be due to the fact that at the outset of several of the interviews the mothers enquired whether I was a mother myself. As mentioned I initially felt that this characteristic of being a mother was going to be an advantage, although during my MA pilot study when I probed the interviewees to elaborate on their responses they appeared a little frustrated. For example, in one of the interviews the mother kept stating to me "*well you know what I mean*" and "*you know how it is*" rather than explaining the issue I was exploring. Therefore during my MA pilot study I discovered that by sharing the fact that I was a little 'rusty' in the role of motherhood (my children are now grown adults) encouraged the mothers being interviewed to express more detail and explanation within their responses. I adopted this technique within my interviews with the participants in this study and found it most useful and advantageous in eliciting the depth of information needed.

I discussed my position as a PhD student researcher with no medical qualifications and therefore hoping to portray no particular bias as to 'correct' infant care practices. With regard to my attire I aspired to be professional yet approachable; I did not want to portray myself as 'too official' and hence possibly threatening. However, on the other hand I did not want to come across as too casual and therefore unprofessional. In considering my appearance I believe I achieved a 'happy medium' and felt both friendly and professional with my interviewees and consider

that (hopefully) they felt the same way. However, Omvedt (1979) states that the average woman will perceive a questioner, whether male or female, as a supporter of the common values of society unless she is given reason to feel otherwise. This is an important consideration when questioning mothers' infant care practices as they could provide responses which they feel are acceptable or appropriate rather than what they actually implement on a day-to-day basis. In this respect I was constantly aware of my verbal and bodily responses following an answer as these subtle traits can act as positive or negative reinforcers and thereby influence the mothers' responses to further questions (Kvale, 1996).

Due to the experience obtained conducting a pilot study for my MA thesis I believe I am more sensitive to aspects of researcher and participant interactions, subjectivity and bias, and reflexivity, and the issue of studying anthropology at home between cultures as well as within cultures. Overall this in-depth exploration, evaluation and reflective account of the pilot study enabled me to develop the knowledge and methodological skills required to successfully conduct this PhD research more effectively, efficiently and reflectively.

3.3 Study Design

This study is designed to be a qualitative follow-up investigation to the quantitative Bradford Infant Care Study (BradICS) which was designed to examine SIDS risk related infant care practices in multi-cultural families with 2-4 month old infants in Bradford. BradICS is conducted in collaboration with the Born in Bradford study and this quantitative study provided statistical data which is invaluable to glean differences in infant care practices that may or may not exist between ethnic groups in Bradford. However, there were limitations in the depth of information gathered and the quantitative study cannot explain or elaborate upon why (or why not) such differences may exist and what underlying beliefs determine parents' infant care practices. Indeed, the vast majority of research conducted into infant care practices and their relation to SIDS have adopted a more quantitative epidemiological approach utilising health statistics, telephone surveys and structured questionnaires

(for example Mitchell and Thompson, 1995; Fleming *et al*, 1996; Blair *et al*, 1996, 1999; Beal and Byard, 2000; Alm *et al*, 2002; Blackburn *et al*, 2005; Lahr *et al*, 2005, 2007). In addition studies researching ethnic differences in infant care practices and the possible relation to SIDS have also generally tended to adopt quantitative approaches (for example Farooqi *et al*, 1993; Farooqi, 1994; Pachter and Dworkin, 1997; Tuohy *et al*, 1998; Ball *et al*, 2011; Ball *et al*, 2012).

These quantitative studies into ethnic differences in infant care practices have highlighted considerable variation, not only in the practical infant care practices implemented but also opinions and beliefs. Horsley *et al* (2007) express the need for cohort studies to improve our understanding of the mechanisms underlying the relationship between infant care practices and potential risks or benefits. Due to the fact that time scarcity and concerns for participants' privacy impede the qualitative study of contemporary life (McCracken, 1988), total immersion in the studied site was not possible. Therefore, the technique of qualitative interviewing is utilised to explore and understand cultural themes, landscapes of infant care, and parental priorities. Due to the negative experience of the omission of vital infant care data which occurred in my MA pilot study a list of key topics and themes regarding infant care practices was at hand during the interviews to ensure all relevant information was elicited (see appendix 1). This list of key topics and themes was prepared utilising the BradICS quantitative study questionnaire which covered all aspects of infant care practices that have been suggested to relate to risk or preventative factors for SIDS.

This study provides a qualitative component and generates in-depth information that is not readily observable or quantifiable and therefore cannot be fully explored using quantitative methods. Consequently, this study is designed to enhance and elaborate the BradICS quantitative study by providing data of individual knowledge in the micro-environment to explain and complement the macro findings of the quantitative study.

3.4 Study Location

Bradford district is in West Yorkshire in the north of England (see Figure 1) with a population of approximately half a million people and is one of the most deprived cities in the UK.



Figure 1

<http://www.cosgb.org/cosgbv1n13.htm>

Bradford is a diverse city with a rapidly growing population and recent reports have highlighted that the peoples' health is a cause for concern; particularly the infant mortality rate which is amongst the highest in the country. Between 1996 and 2003 infant mortality peaked at 9.1 per 1000 births in Bradford which is almost double the 5.3 per 1000 births recorded for England and Wales overall (The Bradford and District Infant Mortality Commission, 2011). There has been a lowering of this figure since 2003 but it still remains higher in Bradford than the average for the country as a whole.

Bradford is served by a single maternity unit at The Bradford Royal Infirmary and almost all women resident in Bradford give birth in this maternity unit. Approximately 6000 babies are born at the Bradford Royal Infirmary every year; about half of these babies are from families of South Asian origin and half from families of white British origin (Raynor, 2008). The Bradford and District Infant Mortality Commission (2011) report figures for the families having babies in Bradford being 50% white British, 44% Pakistani, 4% Bangladeshi and 2% other. This fast growing, ethnically and culturally mixed population is seen as one of Bradford's major assets for academics and health professionals and is an ideal setting for research and especially to explore differences between white British and Pakistani origin families.

3.5 Ethical Considerations and Personal Safety

Durham University has in force a policy providing legal liability cover and the activities of this research are included within that coverage. The Association of Social Anthropologists of the UK and Commonwealth (ASA) ethical guidelines (2006) were fully considered and adhered to, in particular Part I (4 and 5) and Part II (4). In light of these recommendations the 'gatekeeper' and prospective interviewees were provided with verbal information regarding this study and both anonymity and confidentiality are maintained.

As a lone researcher conducting interviews in people's own homes I thoroughly acknowledged and implemented the advice directed in the NHS 2007 'Lone Working Policy' (see appendix 2). This policy was used as a guide and all relevant safety procedures were followed. As an additional safety procedure I placed details of the addresses in Bradford I would be visiting on a certain day in a sealed envelope which was left at my residential home. This was an extra safety precaution that was adopted so that in the unlikely event that I would not return home my husband would have contact details for my supervisor, Professor Helen Ball, and details of the addresses I would be visiting on that day. Upon my safe return home at the end of

each day of interviewing I would destroy the unopened envelope containing this information.

3.6 Methods of Recruitment

Recruitment took place at the Bradford Royal Infirmary Maternity Unit when mothers-to-be were at 28 weeks gestation and were being recruited for the main Born in Bradford study. I approached 137 potential participants (an equal number of the predetermined white British and Pakistani origin mothers-to-be) and informed them of the nature of this study and provided them with a participant information sheet (see appendix 3). Initially no emphasis of SIDS was expressed to prevent potential reporting bias in the subsequent interviews; mothers may suppress reporting certain infant care practices due to fear of disapproval or criticisms (Ball, 2003). They were asked if they would be prepared to be interviewed when their infant was between 2-4 months old and consenting participants contact details were obtained (see appendix 4) so that I could contact them direct when their infant was between 2-4 months old to arrange a mutually convenient time for an interview. Of the 137 mothers-to-be I approached, 69 expressed their willingness to be included in this study and 68 declined. Ethical recommendations provided by the Association of Social Anthropologists of the UK and Commonwealth (ASA, 2006) and the National Research Ethics Service (NRES, 2010) were used to guide the recruitment and consent procedures.

Participants were selected for this study based on their ability to converse in English due to lack of funding available for interpreters and the difficulty in accessing non-English speaking women in these communities. This factor means that recent immigrants whose infant care practices could arguably provide the biggest contrast to those of the white British mothers will be omitted. In light of this factor I acknowledge that this study sample will be biased. However, this concern was raised and discussed with the Director of the Bradford Institute for Health Research, Professor John Wright, who informed me that by not interviewing non-English speaking Pakistani mothers my data only excludes approximately 15% of the South

Asian population in Bradford. I argue that sufficiently informative data was gleaned from the English speaking Pakistani participants in this study and concur with Gantley *et al* (1993) that the generations maintain many aspects of their religious and cultural beliefs alongside their value of the extensive family network being closely involved in child rearing.

3.6.1 Inclusion Criteria

Women were eligible to be included in this study if the following criteria were met:-

Participant of the main Born in Bradford study.

Mother of 2-4 month old infants at the time of the interview.

Participant of white British or Pakistani origin.

Indicate that they would be willing to take part in the qualitative BradICS study.

Provide consent and contact details to be contacted at the time their infant will be between 2-4 months old to arrange an interview.

Provide informed consent for their participation in the qualitative BradICS study.

Able to converse in English, due to the in-depth qualitative nature of the interviews.

3.6.2 Consent and Confidentiality

An initial Information Sheet (see appendix 3) and Contact Details Form (see appendix 4) was provided to participants. Consenting participants provided their contact details enabling me to contact them when their infants were between 2-4 months old to arrange a mutually convenient time for the interview. At the time of the interview I reiterated the information regarding the BradICS qualitative study and answered any questions the participants had prior to obtaining the written Informed Consent Form (see appendix 5).

Participants were assured that the information they provided was confidential and they would not be identified in any written reports. Participant information and all written documentation were anonymised and only identifiable by an interview number or the participant's 'Born in Bradford' ID number. All written documentation were stored securely in a locked cabinet within the Sleep Lab Project Office at Durham University which is kept locked at all times and monitored by building

security patrol officers. All computerised data files and digital audio tape recordings of the interviews were stored on a password protected secure server at Durham University.

In relation to confidentiality in the study of infant care serious legal issues may be raised if a researcher obtains knowledge, by the promise of confidentiality, of mistreatment or child abuse either by the interviewee or others (Kvale, 2007) and this was a significant consideration prior to conducting this PhD research. Therefore, prior to the interview the participants were made aware that I was legally obliged to disclose information regarding child abuse or neglect via the provision of the Participant Information Sheet and they were required to acknowledge this obligation by signing the Informed Consent Form. In the event of encountering distressing circumstances or information I intended to seek a second opinion from my Supervisor, Professor Helen Ball, and/or a senior member of the BiB team at the Bradford Royal Infirmary prior to acknowledging my full legal obligations although this unpleasant situation did not arise during my research.

3.6.3 Withdrawal

During the interviews undue intrusion into the participants' privacy was avoided and participants were informed orally and in writing of their right to terminate the interview or withdraw from this study at any time during the research process. None of the recruited participants exercised their right to withdraw from this study, However one participant's husband was present at the interview and requested that the interview be terminated early, but did not request to be withdrawn from this study.

3.7 Sample Size

A purposive sample of 41 white British and 28 Pakistani mothers were initially recruited at the Bradford Royal Infirmary. A condition of my ethical approval was that I had to recruit my participants for this study alongside the recruitment team for the main BiB study. Unfortunately, due to bureaucratic delays I only gained R&D

approval 2 weeks prior to the end date for recruitment of the main BiB study and due to this time constraint within my research it was not possible to achieve a larger study sample. However, it is considered that conducting between 15 and 20 interviews from each ethnic group will achieve thematic saturation, or close to it (Kvale, 2007; Bryman, 2008). Participants who consented and provided their contact details were placed on a 'password protected' Microsoft Office Excel spread sheet which was required to enable email communication with the Born in Bradford research staff. This email communication was important to establish so that I could ascertain with the Born in Bradford research staff that no unfortunate circumstances had occurred to either the participants or their infants prior to my contacting them to arrange a mutually convenient time for the interview. In addition, and to maintain good relations with the intended participants, I posted a 'Thank You' letter to each of the participants confirming that I would be contacting them when their infant is between 2-4 months old (see appendix 6).

I split the intended participants into 4 groups depending on when their baby was due to be 2-4 months old. I emailed the Born in Bradford team for each group requesting confirmation that no unfortunate circumstances had occurred for mother or baby. As soon as this confirmation was received I then contacted participants by telephone to enquire if they would still be available for an interview and mutually convenient times and places were arranged with consenting participants for the interview. I allowed 3 phone call attempts to each participant before deciding to re-check the contact details I had obtained. Table 1 below shows the number of participants originally recruited, the number of participants who declined or were not available for an interview, and the eventual number of participants interviewed.

	White British	Pakistani
Recruited	41	28
Declined Interview	1	4
Moved out of the Bradford area	2	0
Did not show for appointed interview	2	0
No answer to 3 telephone calls	7	0
Wrong contact number	4	3
Interviewed	25	21

Table 1

Participant Recruitment Statistics

As Table 1 shows there are 5 participants (1 white British and 4 Pakistani) who declined to be interviewed and there are 2 white British participants who had relocated out of the Bradford area. There are 2 white British participants who did not show for their appointed interview and I decided to not pursue these 2 participants further. However, there are 14 of the recruited participants who either did not answer the telephone call after 3 attempts or I was in possession of the wrong contact numbers and I posted each of these participants a letter (see appendix 7). In the letter I requested them to contact the Born in Bradford office to update their contact details if they were still willing to be part of the Born in Bradford study. I also expressed my gratitude to the participants for enrolling into the BradICS study and asked if they would still be willing to participate to contact me direct to arrange a convenient time to be interviewed. I received 4 responses to the letters I had posted and all 4 updated their contact details with the Born in Bradford study but declined to be interviewed for the BradICS study.

3.8 Qualitative Data Collection

Interviews were conducted in 4 equal batches from each of the two ethnic groups concurrently to ensure that developing themes were explored and cross-checked

amongst both groups. The method ensured that themes emerging in earlier interviews were validated by questions introduced in subsequent interviews allowing the determination of whether a comment or insight made by one respondent was a commonly shared or individual opinion.

Interviews were conducted utilising a focused narrative approach. Prior to engaging in the main part of the interview I initially enquired how the mother had found her pregnancy and birth as I had experience from my pilot study that this opening conversation tended to put the mothers at ease and that they also appeared to really enjoy chatting about their experiences. After this initial rapport building, I then asked the participants to narrate a typical day caring for their infant; this allowed the interviewee freedom to express their own infant care routines and their relative importance. However, a list of key topics and themes regarding infant care practices (see appendix 1) was at hand during the interviews to ensure that all relevant information was elicited. The list of key topics and themes was prepared utilising the BradICS quantitative study questionnaire which covered all aspects of infant care practices that have been suggested to relate to risk or preventative factors for SIDS. In terms of interviews Atkinson (1998), Bernard (2006) and Kvale (2007) provide a number of guidelines that should be followed whilst Arksey and Knight (1999) similarly provide a good account of how interviews should be constructed. Kvale (1996) and Gomm (2004) emphasise the dangers of leading questions and express how it makes a difference whether questions are framed positively or negatively. Furthermore, Drever (1995) highlight the concern of vague or ambiguous wording which can lead to miscommunication. Therefore, particular care and attention was acknowledged and considered in relation to the wording and expression used within the interview process. Additionally, Gomm (2004) reminds us of 'demand characteristics' that may be evident in the interview situation where the interviewees' responses are driven by what they feel is sensible or moral. In this regard I was constantly aware of my demeanour and responses to the interviewees' narratives.

All interviews were conducted in the interviewees own homes as it was felt that the convenience of myself as a researcher going to the interviewee would facilitate a larger uptake; for instance the interviewee may not have direct access to transport or may have several domestic obligations within the confines of their own home. As a lone researcher conducting interviews in peoples' homes I thoroughly acknowledged and implemented the advice directed by the National Health Services 'Lone Working Policy' (2007) (see appendix 2). Audio recorded interviews provide a permanent record of an interview conversation (Bryman, 2008). For this reason and also for transcription purposes all face-to-face interviews were digitally recorded with the participants' permission; the use of the audio recording equipment was explained and the participants were free to reject their use, although all 46 participants provided full agreement and consent for the interviews to be audio recorded. The presence of recording equipment can have a negative impact on the interviewee (Denscombe, 2007); the respondent may feel inhibited by the mere fact that their 'word for word' accounts are being recorded. Both Gomm (2004) and Denscombe (2007) recommend that additional hand written notes be taken to complement audio recorded interviews in order to capture non-verbal communications. However, I decided not to be over-occupied with hand written notes as I felt that this would detract from the general flow of the conversation; sensitivity and eye contact seemed a more appropriate interviewer response (Bryman, 2008). Nevertheless, I did make certain notes during the interviews but this was kept to a minimum, and I did write a reflective journal immediately after each interview for reference. Riach (2009) advocates that, the post interview reflective account facilitates the questioning of epistemological assumptions, in addition to documenting the interview process. However, it is acknowledged that memory is a highly subjective method abound with biases (Kvale, 1996) and this reflective journal is my own interpreted observations being intimately part of myself as a researcher, both personally and epistemologically (Andrews, 2008).

I scheduled the interviews so that I did not conduct more than 2 interviews in one day to ensure I did not have to 'clock watch.' I therefore was able to dedicate a full morning, afternoon or evening to each interviewee. Nevertheless, I was also

conscious not to 'overstay my welcome' and was sensitive to verbal or non-verbal cues from the mothers as to when they appeared to become anxious to terminate the interview. In addition I was completely flexible as to the time of day the mothers requested for the interview; several of my interviews were conducted at weekends or in the evening due to the mothers' preferences. The time duration of the majority of the interviews conducted with the mothers in this study are between 90 minutes and 150 minutes. Two of the interviews I conducted with white British mothers were quite short in time duration (51 minutes and 69 minutes) due to the mothers' requests; they expressed the need to conduct other chores or activities. One of the interviews with a Pakistani mother lasted only 35 minutes due to the mother's husband requesting that I terminate the interview (although consent was still given to be included in this study). Four of the interviews I conducted with 3 Pakistani mothers and 1 white British mother were extremely in-depth and lengthy in time duration lasting between 178 minutes and 231 minutes.

During the interviews many of the mothers gave me the privilege to hold their babies and additionally I bottle fed 2 Pakistani and 5 white British infants which I enjoyed immensely. During several of the interviews I assisted the mothers in attending to their babies (soothing, changing nappies and clothes etc.) and also I was included in the families' activities or chores. For instance, I assisted a white British mother in the kitchen with her laundry and I helped a Pakistani mother to prepare and serve snacks for male relatives who were socialising in a separate room of the house. During this physical involvement with the mothers and their babies the interview dialogue proceeded and was fully recorded.

Transcripts were compiled using a digital Dictaphone as soon as possible after the interviews had taken place and were transcribed 'word for word' by myself solely. I decided to transcribe all interviews personally as I am a competent typist; I also felt that this would help to increase my familiarity with all the interview data as it was being collected and would be beneficial for the method of thematic analysis that I was utilising.

I retained all aspects of the West Yorkshire accent and dialect in the transcripts; for example, in Bradford people tend to leave the word '*the*' out of their dialogue and say "*I don't feed him in night*" as opposed to "*I don't feed him in the night.*" Therefore, within the quotes used in the results chapters of this thesis all Bradford dialogue is retained fully. In addition, during transcription, I changed all distinguishing names and places; for instance, if one of the participants had said "*Jeff usually feeds her in the evening*" I transcribed as "*[husband] usually feeds her in the evening.*"

Several of the Pakistani mothers I interviewed used the terms '*modern*' and '*traditional*' within their narrations relating to the perceived personal identities of themselves and their female relatives; generally regarding education, clothing, hair styles and cosmetics. In the context of infant care the Pakistani mothers used the term '*traditional*' several times in their narrations but they did not use the term '*modern*' in relation to infant care practices. I would not personally decide to use the descriptive labels of '*modern*' and '*traditional*' but as several of my participants repeatedly used these labels I feel that I had to retain these descriptive words within the mothers' narrations in the results chapters of this thesis. I reflect and discuss the use of this terminology further in section 7.5 of Chapter 7.

3.9 Qualitative Data Analysis

A continuous comparative method for thematic analysis (e.g. modified grounded theory) was used to analyse interview transcripts as they were generated in order to identify themes (Glaser and Strauss, 1967). This method required that themes emerging from earlier interviews were validated by questions introduced into subsequent interviews, allowing the determination of whether a comment or insight made by one respondent was a commonly shared or individual opinion. I transcribed all the interviews myself within the same week as the interviews were conducted and therefore became very familiar with the content of the interviews as I was going along. I also kept a reflective journal which had many comments and thoughts about the interviews I had undertaken at the time and at the transcription stage.

Initially I intended to utilise a computer software programme for qualitative analysis and decided to use NVIVO. However, I found this method of analysis really difficult to immerse myself into, but did persevere for almost one month before deciding to revert back to analysing the interviews manually. I felt that sitting with hard copies of the interviews and my reflective journal was much more beneficial as I could really connect with all of the data I had collected. Although utilising a manual method to analyse data is laborious and time-consuming it allowed me to revisit the data several times to ensure all the relevant themes were being allocated to all the relevant data. Repeatedly combing through the data also allowed me to gain a really in-depth knowledge with additional perspectives and insights; this proved invaluable when I needed to locate relevant information and quotes.

During the second and final stage of the analysis, and after I was satisfied that all relevant themes that had emerged from the data had been allocated, I combed back through the data to choose the most informative and appropriate themes to focus on. I discovered that several themes did not produce enough data to justify being the main focus for this study and decided to mention and discuss these themes but not to make them the main concentration.

3.10 Quantitative Data Collection and Analysis

All quantitative socio-demographic information regarding the participants was obtained from the main Born in Bradford database utilising the participants' unique Born in Bradford ID numbers. Additionally, I also validated this information with the participants at the time of the interview. I obtained all the quantitative infant care practices information at the time of the interviews; including information such as infant sleep arrangements, infant feeding, and pacifier use etc. All the quantitative socio-demographic and infant care practice information data was then entered into Microsoft Excel spread-sheets purely for comparison and exploration and not for statistical analysis. Although quantitative data is not the objective of this study I felt that it was essential to collect this information in order to compare and contrast the

mothers' socio-demographic information in addition to the statistics regarding their infant care practices.

CHAPTER 4

SOCIAL AND CULTURAL ECOLOGY

This chapter presents the background data about the study participants collected from the Born in Bradford database and also from the interviews conducted with the mothers themselves in relation to their social and cultural environment. The data collected and presented in this Chapter include parental and infant characteristics together with information regarding infant care practices. Therefore, this chapter explores how the social and cultural ecology of being a mother differs for white British and Pakistani mothers in the UK and how social and cultural ecology influences infant care; and how mothers modulate or modify infant care practices in response to their social and cultural environments.

4.1 Generational Status of the Pakistani mothers

The Pakistani mothers in this study were categorised as first generation if they came to live in the UK after the age of 16 and second generation if they were born in the UK and/or spent the majority of their childhood in the UK. First generation Pakistani mothers are generally difficult to access for research purposes due to a variety of cultural reasons and language barriers which is unfortunate as they have the highest infant mortality rate of all ethnic groups in Bradford. However, out of the 21 Pakistani mothers I interviewed I managed to interview 5 first generation mothers (all 5 mothers born in Pakistan) and the remaining 16 interviews were conducted with second generation mothers (all 16 mothers born in the UK).

It may be considered that interviewing a majority of second generation Pakistani mothers may present assimilated evidence of infant care practices. Several Pakistani mothers expressed how they considered themselves to be more '*modern*' in comparison to some of their '*traditional*' female relatives.

“Me and [husband] have quite a modern marriage and we like our time on our own but some marriages, some Pakistani marriages, like my sisters-in-law don’t seem to have that modern outlook.” (Participant P65)

In my interview with Participant P70 she referred to several of her family members and told me

“They are different cos they’re not in the modern way of life. I think they don’t bother about modern stuff but I have a lot of friends and that outside the family and I think I’m quite modern in comparison to my sisters-in-law.”

Even though some of the Pakistani mothers related their feelings of being ‘modern’ they did not relate this descriptive term in relation to their infant care practices.

“I do think I’m more modern, yeah, but when it comes to babies and looking after them then I think the traditional Pakistani ways are better, better than most of the English ways but I don’t think that makes me less modern.” (Participant P54)

“It’s expected that you do things in the traditional way and use traditional stuff and not try and be over your head thinking you were more modern and knew better. I mean our mothers and mothers-in-law know proper ways to bring babies up and they have lots of experience in that so you do listen when it comes to babies. You don’t want to be like the English mums in that way, well not in any way really. I actually think the Pakistani way is best, better than the way the English mums do things. That is one thing about our ways, yeah, Pakistani families really do take care of their babies well.” (Participant P63)

Even though a small number of the Pakistani mothers described themselves as more ‘modern’ in comparison to some of their more ‘traditional’ female relatives they tended to accept and practice their Pakistani cultural traditions regarding infant

care. The use of the descriptive terms '*modern*' and '*traditional*' are discussed further in Chapter 7.

4.2 Geographical and Socioeconomic Status of the Participants

The participants in this study inhabited very similar geographical areas in Bradford. 20 (95%) of the Pakistani mothers and 23 (92%) of the white British mothers resided in the inner-city areas of Bradford; 1 Pakistani mother and 2 white British mothers resided in slightly more suburban areas of Bradford. Figure 2 (below) displays the location of each Bradford Ward and Table 2 (below) presents the number of participants in each of the Bradford Wards.

The Indices of Multiple Deprivation (IMD) incorporate measures of both social and material deprivation using a range of factors including income, employment, health and disability, education, skills and training, barriers to housing and services, living environment, and crime (ONS, 2010). The English IMD 2010 is made up of 32,483 small geographical areas known as 'lower super output areas' (LSOA) and each LSOA is ranked from 1 (most deprived) to 32,482 (least deprived); the bottom 10% is generally used to define the most deprived LSOAs in England (ONS, 2010). Figure 2 below presents an overview of the findings of the English IMD 2010 for the Bradford District which show that there are 94 LSOAs in the Bradford District which fall into the most deprived 10%. The deprivation scores are an average of that particular areas population circumstances and as such they inevitably may under or overestimate personal circumstances of individuals in any given area. However, this is a widely used method to indicate a household's socioeconomic status and therefore a valuable means to compare the social positions of the participants in this study.

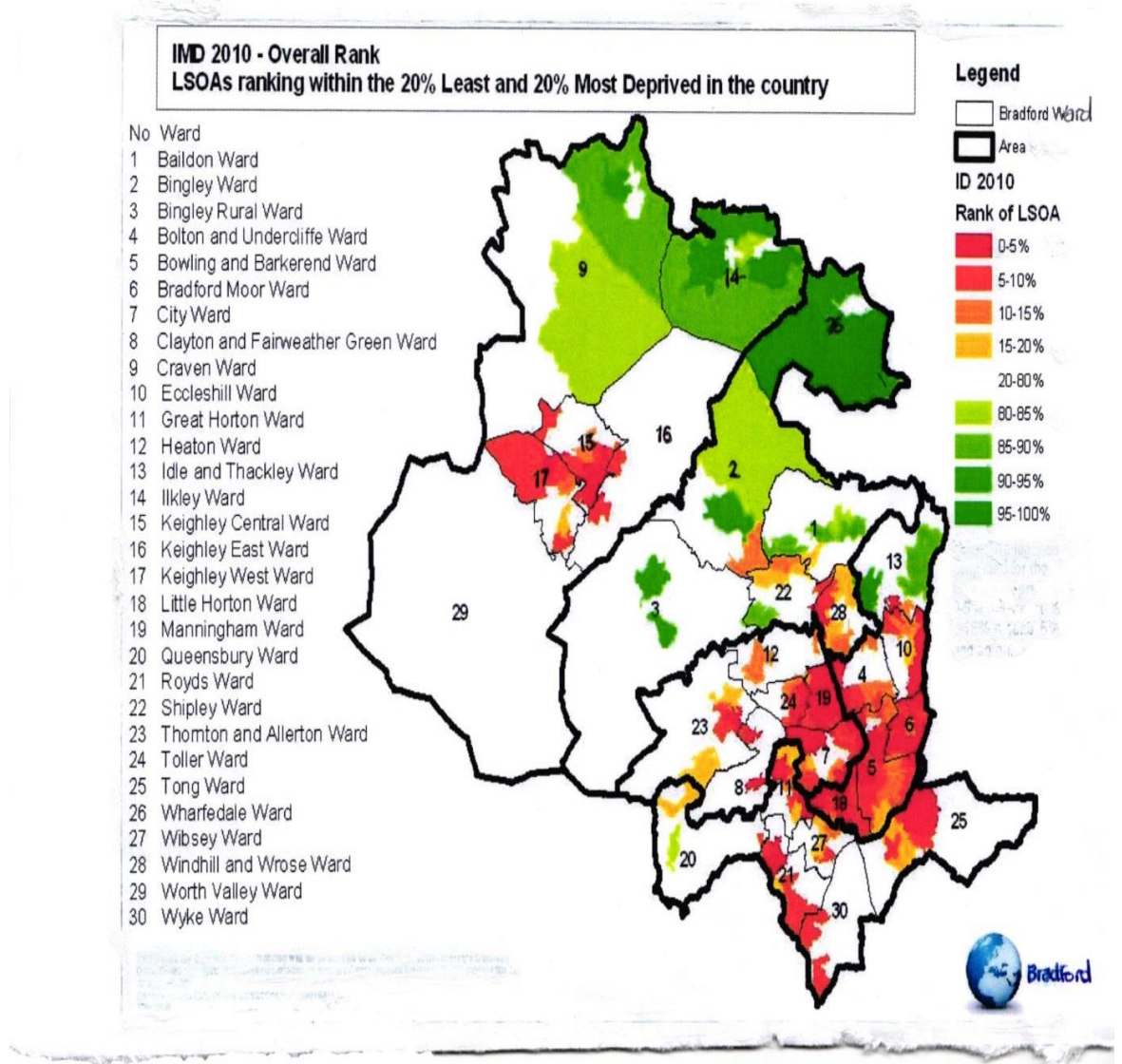


Figure 2
Map presenting LSOA Ranks in the Bradford District

<http://www.bradford.gov.uk/NR/rdonlyres/064D099F-3844-41AA-88BD-CEA7EE95452A/0/Deprivation.pdf>

Figure 2 shows there are Bradford Wards which present differing LSOA ranks and therefore it was important to utilise the study participants' full postcodes to pinpoint the exact locations of the households within each Ward. Table 2 presents the number of participants in this study who reside within each of the LSOA rank categories.

LSOA Rank	Bradford Wards	Number of white British Participants	Number of Pakistani Participants
0-5%	5, 7, 8, 17, 19, 21, 23	13 (52%)	7 (33%)
5-10%	4, 17, 28	2 (8%)	7 (33%)
10-15%	12	1 (4%)	5 (24%)
15-20%	22	3 (12%)	0
20-80%	1, 2, 8, 13	5 (20%)	2 (10%)
80-85%		0	0
85-90%	13	1 (4%)	0
90-95%		0	0
95-100%		0	0

Table 2

Table of LSOA rank with Bradford Wards

As displayed in Table 2 the majority of the white British mothers (60%) and Pakistani mothers (66%) live in the bottom 10% of LSOAs of Bradford. Furthermore, 76% of the white British mothers and 90% of the Pakistani mothers live in the bottom 20% of LSOAs in the Bradford District. There are 5 (20%) white British mothers and 2 (10%) Pakistani mothers who live in the moderately deprived 20-80% LSOAs and only 1 white British mother who resided in one of the least deprived LSOAs in Bradford.

In conclusion the two ethnic groups in this study reside in similar geographical locations of Bradford; the vast majority live in the inner-city areas. The two groups in this study also exhibit similar socioeconomic status; residing in the most deprived areas of Bradford (bottom 10%). There are no Pakistani mothers and only 1 white British mother in this study who live in the least deprived areas of Bradford (80-100%). This data indicates that any differences observed in infant care practices between the two groups are more likely to be associated with ethnicity than with geographical factors or socioeconomic status.

4.3 Characteristics of the Mothers

All parental socio-demographic information and characteristics were obtained from the main BiB database and also validated during the interviews with the mothers themselves. However, the financial income status of the mothers interviewed in this study is not included in the data as this information was very difficult to obtain and was therefore unreliable for comparative analysis. I attempted to obtain this information from the Born in Bradford database but they did not have accurate records of the families' financial incomes. The Born in Bradford recruitment team told me that it is difficult to compare the incomes of white British and Pakistani mothers as the Pakistani mothers often did not answer the questions relating to income and finance. The vast majority of the Pakistani mothers reported that their husbands dealt with financial matters and therefore did not answer these questions or were instructed by their husbands not to answer these particular questions. Furthermore, many of the Pakistani mothers were living in a multi-generational household which makes assessment of family income very complex in comparison to nuclear family units.

Table 3 below presents the mothers' age, marital status, whether they were first time mothers, educational status, and whether the mothers were on maternity leave from employed work at the time of the interview. Table 3 also shows if the mothers I interviewed reported maternal or paternal cigarette smoking and alcohol consumption.

	White British	Pakistani
Number Interviewed	25	21
Age Range	19-38	20-41
Mean Age	27.2	28.5
Marital Status	Married = 15 (60%) Partner = 4 (16%) Single = 6 (24%)	Married = 19 (90%) Partner = 0 Single = 2 (10%)
First Time Mother	Yes = 15 (60%) No = 10 (40%)	Yes = 9 (43%) No = 12 (57%)
Educational Status	Degree or Higher = 3 (12%) A-level or equivalent = 10 (40%) GCSE or equivalent = 12 (48%) No qualifications = 0	Degree or Higher = 1 (5%) A-level or equivalent = 6 (29%) GCSE or equivalent = 11 (52%) No qualifications = 3 (14%)
Employment	Yes = 6 (24%) No = 19 (76%)	Yes = 3 (14%) No = 18 (86%)
Maternal Cigarette Smoking	Yes = 3 (12%) No = 22 (88%)	Yes = 0 No = 21 (100%)
Maternal Alcohol Consumption	Yes = 15 (60%) No = 10 (40%)	Yes = 0 No = 21 (100%)
Paternal Cigarette Smoking	Yes = 2 (8%) No = 23 (92%)	Yes = 4 (19%) No = 17 (81%)
Paternal Alcohol Consumption	Yes = 17 (68%) No = 8 (32%)	Yes = 0 No = 21 (100%)

Table 3
Characteristics of the Mothers

It is noted from Table 3 that the age range and mean age are similar for the white British and Pakistani mothers. However, there is a difference in the marital statuses of the mothers as 19 of the 21 (90%) Pakistani mothers were married in comparison to 15 of the 25 (60%) white British mothers. There is a slightly higher number of first time mothers amongst the white British families (60%) compared to the first time mothers in the Pakistani families (43%). Additionally, the educational statuses of the mothers show a slightly greater proportion of higher educated white British mothers in comparison to the Pakistani mothers; 13 of the 25 white British mothers interviewed were educated to A-level or degree status in contrast to 7 of the 21 Pakistani mothers interviewed being educated to this level. It is also noted that 3 of the 21 Pakistani mothers reported that they had no educational qualifications whereas none of the 25 white British mothers reported not having any educational qualifications. However, for the 3 Pakistani mothers who reported no educational qualifications, it is noted that they were of first generation and had come to live in the UK from Pakistan to marry their husbands and live with their husbands' families. Regarding the employment statuses of the mothers 6 of the 25 white British mothers and 3 of the 21 Pakistani mothers were on maternity leave from paid employment. The marital and employment statuses and perceptions regarding careers and paid employment will be discussed further in Chapter 5.

Within this study none of the 21 Pakistani mothers interviewed reported that they were cigarette smokers in comparison to 3 of the 25 white British mothers interviewed who reported that they were cigarette smokers. All 21 of the Pakistani mothers interviewed expressed that cigarette smoking and drinking were not something that would be acceptable for women in their culture, although cigarette smoking was generally acceptable for Pakistani men. Regarding paternal smoking it was reported that 4 of the Pakistani fathers and 2 of the white British fathers smoked cigarettes and that other family members and visitors to the household were cigarette smokers. This suggests the non-smoking mothers may have been exposed to second hand cigarette smoke during pregnancy as well as their infants being exposed to second hand cigarette smoke.

The majority of the white British mothers expressed their distaste regarding cigarette smoking although alcohol was something that many of the mothers consumed and did not express any aversion to. All 21 of the Pakistani mothers reported that neither they nor their husbands consumed alcohol due to the religious prohibition of alcohol in Muslim society. In contrast 15 of the white British mothers reported that they did consume alcohol although the majority of the white British mothers who reported alcohol consumption always said that they only had an alcoholic drink at the weekends or on special occasions. 17 of the white British fathers were reported to consume alcohol although the white British mothers told me that the fathers, similar to themselves, only consumed alcohol on weekends or special occasions.

4.4 Characteristics of the Family and Home

All of the white British mothers were residing in a single 'nuclear' family unit either being married, co-habiting with their partner or living as a single mother. All of the white British mothers lived in their own homes and described that they were almost always alone with their babies during the day. For the majority of the time it appears that the only help or company they have is when their husbands/partners come home from work.

In contrast 7 of the Pakistani mothers were residing either with their parents or parents-in-law and of the remaining 14 Pakistani mothers interviewed the majority stated that when they first were married they also resided either with their parents or parents-in-law. It transpired from the interviews that the Pakistani women often lived with their parents or parents-in-law for several years after their marriage and then as their own family grew they would find their own homes. There were only 2 Pakistani mothers who resided in their own home from the birth of their infant and these 2 mothers were not married and expressed that they had been disowned by their family as they had conceived and given birth outside of marriage. These 2 Pakistani mothers were therefore often alone with their babies without family help

in the day-to-day care of their infants, similar to the environment experienced by the single white British mothers.

In contrast to the white British mothers interviewed the Pakistani mothers were seldom alone during the day, often being surrounded by other female family members or friends. Although 14 of the Pakistani mothers did live in their own homes they stated how they always had visitors and family members around them for almost all of the day. Indeed, I discovered that this was a constant social and cultural practice involving close family contact throughout the day. It also transpired from my visits and interviews that the Pakistani females tended to spend their time together separate from the males of the household or family; generally males would chat and socialise in a separate room to females, or at the least at separate ends of the room. The issues relating to solitary and communal motherhood will be discussed further in Chapter 5.

4.5 Characteristics of the Infants and their Care

All the infants in this study were full term single births and were all aged between 8-12 weeks old at the time of the interview. Table 4 below presents the infants' sex, feeding method and details regarding their 'normal' night time sleeping environment.

	White British	Pakistani
Sex	Male = 11 (44%) Female = 14 (56%)	Male = 10 (48%) Female = 11 (52%)
Feeding	Breast = 10 (40%) Formula = 15 (60%) Both = 0	Breast = 8 (38%) Formula = 10 (48%) Both = 3 (14%)
Sleep Location	Parents Room = 18 (72%) Own Room = 7 (28%)	Parents Room = 21 (100%) Own Room = 0
Sleep Surface	Cot or similar = 23 (92%) Bed Sharing = 2 (8%)	Cot or similar = 13 (62%) Bed Sharing = 8 (38%)
Sleep Bedding	Sleeping bag = 17 (68%) Sheets/blankets = 8 (32%) Pillow = 0	Sleeping bag = 4 (19%) Sheets/blankets = 17 (81%) Pillow = 11 (52%)
Sleep Position	Back = 17 (68%) Back/side = 8 (32%)	Back = 21 (100%) Back/side = 0
Sleep Surface Position	Feet to Foot = 25 (100%) Top/middle = 0	Feet to Foot = 9 (43%) Top/middle = 12 (57%)

Table 4
Characteristics of the Infants and their Care

It is evident from Table 4 that there are several differences between the characteristics of the white British and Pakistani infants. Breast feeding was not noticeably different between the white British and Pakistani infants; all the white British mothers reported feeding their babies exclusively either by breast or formula whereas 3 of the 21 Pakistani mothers reported that they both breast and formula fed their babies.

The sleep location for white British and Pakistani infants was notably different with the majority of the white British mothers expressing their intent to place their infants in a separate bedroom before the recommended age of 6 months. Indeed at

the time of the interviews there were already 7 of the 25 (28%) white British infants sleeping in separate bedrooms to their parents.

"I had him with me when he were little. I only put him in his own room about 3 to 4 weeks ago." (Participant W11)

"About 4 weeks ago we put him in his big cot in his own room. My husband did his room out before he were born and it's lovely in there for him." (Participant W13)

"She's got her own room now...I kept her in our room until she weren't feeding in night...when she stopped waking for night feeds, when she stopped wanting me there. That's really when we decided to put her in her own room." (Participant W20)

The Pakistani mothers did not express the same intent or desire to be separated from their infant for night time sleep and all 21 Pakistani infants at the time of the interviews were sleeping in their parents' bedroom.

"I like him where I can keep my eye on him. I prefer him with me." (Participant P59)

"Pakistani mums like to have babies with them all time...I know some English mums have babies sleeping in different bedrooms...I wouldn't like that cos you can't keep your eye on them...I suppose it's just different ways." (Participant P60)

Bed sharing was reported much more amongst the Pakistani mothers with 8 Pakistani mothers (38%) in comparison to 2 white British mothers (8%) reporting that they exclusively bed shared with their infants. The practice of bed sharing is hugely contentious and I felt that during some of the interviews not all the participants may have been totally honest with me. Many of the mothers stated

how they understood bed sharing was dangerous for their babies due to information from health care professionals and SIDS information leaflets.

There was a contrast between the white British and Pakistani mothers with regard to the infant bedding used. 17 of the 25 white British mothers (68%) in comparison to 4 of the 21 Pakistani mothers (19%) stated that they used infant sleeping bags for their babies' night time sleep. The majority, 17 of the 21 Pakistani mothers (81%), reported that they used sheets and/or blankets for their babies' night time sleep. The main reason for the white British mothers preference for infant sleeping bags was to prevent baby kicking off sheets and blankets and thus having to keep attending to their babies to replace bedding during the night.

"I really like the baby sleeping bags cos you don't have to keep getting up in night to put the covers back on your baby when they kick them off. They are much better than covers and blankets I think." (Participant W04)

The use of an infant pillow was not reported from the white British mothers in their interviews but 11 of the 21 Pakistani mothers (52%) interviewed reported using an infant pillow. The use of infant pillows is seen as being a cultural tradition amongst the Pakistani mothers as Participant P58 told me *"a lot of Asian families in Bradford have baby pillows, it's just part of tradition."* These pillows are not like Western adult pillows; rather they are quite flat and moulded with a flat or hollowed out middle circle to maintain an infant's head in the supine sleep position similar to the pillow depicted in Figure 2 below. The majority of the Pakistani mothers believe that using these special pillows will promote a culturally valued rounded head shape in their infants.

"Babies have soft bones in the head and the pillow can help to make the head a nice shape, back to how it should be." (Participant P60)



Figure 3

Asian Infant Pillow

http://www.tradevv.com/chinasuppliers/comhome_p_102534/china-Baby-Pillow.html

The cultural belief regarding head shape appears to be strong amongst the Pakistani mothers I interviewed as the mothers narrated stories of how different methods were employed when an infant pillow was not available.

“My mum told me that when I were born she used a little plate thing under my sheet to put my head in cos she thought I were getting a flat head.”
(Participant P56)

“My mother-in-law had put a little saucer under sheet and put his head in it until we, well my father-in-law got back with pillow. I told my sisters and they said they know, they said that if you don’t have a pillow you can put babies head in a saucer, under sheet like, and that sort of does same thing, well same thing as the pillow but I can’t imagine it being very comfy for baby.”
(Participant P67)

Many of the Pakistani mothers gave similar reasons for using infant pillows; being their cultural belief in the value of a rounded head shape. However, in some instances this was not the main reason that the mothers were using the pillows.

“I didn’t really decide to have a pillow, we just have one. My mother-in-law bought us it and it would be disrespectful not to use it. A lot of the Asian families in Bradford use pillows and I suppose it’s just what you do...it’s just part of tradition for Pakistani families here in Bradford.” (Participant P58)

“It’s quite an Asian tradition but I’m more modern and I don’t think they need a pillow but I just use it anyway cos it’s just tradition.” (Participant P62)

“I found that in the Moses basket she’d turn her head and nuzzle right up in corner of the basket and I would be worried that she would suffocate so then I let her have the pillow. It wasn’t to do with her head it’s just to keep her in place really. I’ve just used it to stop [baby] from nuzzling up in corner, just to keep her in the middle of basket.” (Participant P54)

The cultural use of infant pillows in the Pakistani communities may also promote the use of sheets and blankets as the pillows are often provided in a full bedding set. Although 11 of the 21 Pakistani mothers reported that they did use a pillow for their babies I felt, due to the Pakistani mothers being told by health professionals not to use a pillow, that maybe some of my participants did not disclose their use of a pillow to me.

“They tell us Pakistani mothers not to use pillows but I think they know we do but we never tell them we do cos they would just tell you off. I would be surprised if any of the mothers you go and see will tell you they use one cos they think you will probably tell them not to, so don’t expect them to tell you. They get told not to use them but they do cos it’s part of the traditional bedding we get for new baby but don’t expect them to tell you.” (Participant P55)

During one of the interviews with a Pakistani mother (Participant P67) she told me she did not use a pillow but later in the interview it transpired that she did use a pillow. She explained that *“it’s just easier to say I don’t have a pillow for him cos...well it’s just easier”* and she reported that the health visitor had *“told her off”* for using the pillow.

The actual sleep position and sleep surface position were also quite different between the two groups of infants. All 21 Pakistani infants were sleeping in the recommended supine sleep position whereas only 17 of the white British mothers reported the supine sleep position exclusively. The 8 white British mothers, who reported that their infants regularly slept on their back or sides, generally stated that they did place their infants in the supine sleeping position but that their infants often rolled onto their sides in the middle of the night. The side position is considered unstable for infant sleep as young babies can roll into the dangerous prone position. However, the white British mothers did not accept the dangers of the side sleeping position as they did not believe their babies could roll into the prone position.

“I put him down on his back and he’ll turn on his side but he can’t turn fully over.” (Participant W01)

“I put him down on his back but sometimes he wakes up on his side He can’t really roll fully over onto his tummy though so he’s ok, he’s not able to roll right over.” (Participant W15)

All 25 of the white British infants were placed to sleep in the recommended ‘feet to foot’ position although 12 of the Pakistani mothers (57%) stated that they placed their infants at either the top or middle of the sleep surface and not ‘feet to foot’ as recommended. The ‘feet to foot’ position is recommended due to the dangers of babies nestling down the sleep surface and being covered by their bedding and therefore at risk of suffocation. The sleep position and the sleep surface position of the Pakistani infants could be due to the use of infant pillows as this does not enable

the baby to turn onto their side due to the pillow construction. It was also noted that the pillow is placed at the top of the crib or Moses basket and therefore the mother was placing her baby at the top or middle of the sleep surface to utilise the pillow. The structure of the infant pillows appears to inhibit babies from moving around on their sleep surface and from sliding down the sleep surface and being covered by their bedding.

“Using the pillow keeps babies in the same position, she can’t roll over, she can’t get stuck up against side, she can’t wriggle down basket and get accidentally covered by blanket either. I really use it cos of that, to keep her in middle and not get stuck against side or bottom of basket.” (Participant P54)

“The pillows we use are safe, yeah, not like big things adults have. They are important cos it’s part of our tradition to use them. They help to keep babies in same position when they’re sleeping. They keep babies on their backs, yeah, and that’s good, yeah. They stop babies from getting suffocated under the blankets as well cos they can’t wriggle down under their covers.” (Participant P62)

4.6 Additional Infant Care Practices

During the interviews I gathered additional infant care information from the mothers and noticed differences between the white British and Pakistani mothers’ practices of sofa sharing, location of infant day time naps, time of infant bathing, infant temperature concerns and the use of pacifiers, baby intercom systems and infant temperature monitors. This data is summarised in Table 5 below.

	White British	Pakistani
Sofa Sharing	Yes (more than once) = 5 (20%) Yes (once) = 3 (12%) No = 17 (68%)	Yes (more than once) = 0 Yes (once) = 0 No = 21 (100%)
Infant Day Time Nap Location	Separate Room = 16 (64%) Same Room = 9 (36%)	Separate Room = 4 (19%) Same Room = 17 (81%)
Infant Bathing (time of day)	am = 1 (4%) pm = 24 (96%)	am = 18 (86%) pm = 3 (14%)
Infant Temperature Concerns	Hot = 23 (92%) Cold = 0 Both = 2 (8%)	Hot = 0 Cold = 14 (67%) Both = 7 (33%)
Pacifier Use	Yes = 13 (52%) No = 12 (48%)	Yes = 3 (14%) No = 18 (86%)
Use of Baby Intercom Systems	Yes = 18 (72%) No = 7 (28%)	Yes = 0 No = 21 (100%)
Use of Infant Temperature Monitors	Yes = 25 (100%) No = 0	Yes = 3 (14%) No = 18 (86%)

Table 5
Additional Infant Care Practices

When asked whether the mothers had sofa shared with their babies 8 of the white British mothers told me that they had (3 stated only on one occasion and 5 stated they had sofa shared with their babies more than once).

“I have only been on sofa with her when she’s been having a crabby night, just to calm her but we don’t be on sofa a lot just when she needs me to calm her in night really. It’s quite safe cos I’m aware of them telling you not to sleep on sofa with your baby cos you might smother them so I’m always careful.” (Participant W08)

“I’ve only done it once when she weren’t sleeping well but I don’t really do it all time just that once and I made sure she were safe. I wouldn’t do it if I weren’t careful with her.” (Participant W10)

One of the most enlightening discoveries in the interviews regarding the unsafe practice of sofa sharing is that I discovered for Pakistani women it was socially unacceptable to lie on sofas or chairs as Participant P56, amongst several other Pakistani mothers, said *“It’s just not acceptable really. It’s not something a Pakistani woman would do. That’s what your beds are for.”*

Participant P53 explained that sleeping on the sofa or chairs is *“showing that you’re lazy or the family might think you were ill”* and this explanation was repeated by several other Pakistani mothers I interviewed. In fact none of the 21 Pakistani mothers reported sofa sharing or feeding their babies on an armchair during the night. When the Pakistani mothers were questioned about this they elaborated on their responses and said that it would also be socially unacceptable for a woman to leave the bedroom in the middle of the night.

“Women really shouldn’t be downstairs on their own in middle of night. It’s just not what a Pakistani would do, it’s not a respectful thing for family.”
(Participant P53)

“It’s just a sign of respect to the in-laws and even your own family. I mean I would be uncomfortable to be downstairs in night. I definitely wouldn’t go and lay on chairs and the sofa. I wouldn’t do that in day or in night.”
(Participant P67)

I questioned whether this was uncomfortable for the mother or whether being downstairs during the night was unacceptable for all the family and Participant P61 explained

“Because it’s the middle of the night I wouldn’t feel right being down here, it would not be nice for my family. My family would be unhappy with me to be down here in night on my own. It’s something I wouldn’t want to do, for myself and for them. A Pakistani woman shouldn’t really leave her bedroom in night, it’s just not right for a woman to do that really.”

Of the 21 Pakistani mothers, 8 were bed sharing and so their babies fed throughout the night in the parental bed, 11 stated that they would prop themselves up in bed to feed their babies and 2 reported that they would lie in bed with their babies to feed during the night. Of the 25 white British mothers interviewed 15 reported that they fed their infants during the night propped up in bed, 8 reported feeding their babies in some kind of chair and 2 reported that they would lie with their babies in the parental bed to feed during the night. However, 5 of the white British mothers did report that they had sofa shared sometimes although they had told me that this was not a normal practice and that they did not lie down on the sofa with their baby. The white British mothers believed that as they did not lie down on the sofa they could not fall asleep with their babies and therefore considered it was safe.

“She wasn’t sleeping well when she were smaller so I’d bring her down here some nights so that my husband could get a proper night sleep but I never laid down with her. I sit up, not lay down, so I can’t drop off so we’re ok.”
(Participant W10)

“My husband works and needs to sleep through really and it wouldn’t be fair to wake him when he has to get up in morning. I always sit in the chair anyway and I didn’t want to feed him on sofa cos they say it’s dangerous and you can fall asleep but I know I wouldn’t do that.” (Participant W13)

During the interviews the mothers were asked when and in what environment their babies had their day time naps. The responses to these questions highlighted several differences between the white British and Pakistani mothers. 16 of the 25 white British mothers (64%) reported that they placed their infants upstairs in a cot or

Moses basket for day time naps but only 4 of the 21 Pakistani mothers (19%) reported placing their infants upstairs for day time naps. It was noted that out of these 4 Pakistani mothers 2 were single unmarried Pakistani mothers and as mentioned previously these 2 mothers expressed their isolation from their families due to having a child outside of marriage. This is an important consideration when understanding why infants are placed in solitary environments for day time naps as these 2 single Pakistani mothers stated similar reasons as the white British mothers for this practice; being alone with their infants for the majority of the day.

The white British mothers expressed that they preferred placing their infants in a 'quiet and safe' environment. The white British mothers often cared for their infants in a solitary environment and said that this enabled them to carry out domestic chores or have a little time to themselves.

"I put her in her cot upstairs cos it's quieter for her...I can get on better with stuff if she's upstairs." (Participant W06)

"I like to put her down in her own room upstairs so she can get a bit of a nice sleep and to be honest it gives me time to get some stuff done." (Participant W20)

Participant W20 explained that her concept of 'a nice sleep' was *"somewhere where it's nice and quiet for her so she don't wake up all time."* The majority of the white British mothers felt that a 'quiet' environment for their infants' day time naps was important.

The majority of the Pakistani mothers often had many family members and visitors in the household during the day and they preferred having their babies with them in the same room and did not seem to like the idea of placing their babies alone upstairs for day time naps. Participant P71 told me *"I don't like them too far away; I like them to be with me."* As the Pakistani mothers often had other caregivers to assist during the day the need to place baby in a quiet and safe environment to

enable them to carry out domestic chores was not an issue. The Pakistani mothers also felt that they did not think it was a 'good' thing to do and that they preferred having their babies in the same room so that they could 'keep an eye' on them. It was evident from the interviews with the Pakistani mothers that having time on their own away from their babies was not a need or desire they experienced.

"He just sleeps on and off down here. I don't think it's nice to put him upstairs in bedroom, not in day, no." (Participant P59)

"He's always down here with someone; I wouldn't put him upstairs cos we're all down here. He sleeps on and off and it's best he's down here with me otherwise I'd be running up and down all time to see him. I like him here with me really, I like to keep him with me." (Participant P63)

The social environment that the mothers and infants occupied also appeared to dictate bathing times for their babies. 24 of the 25 white British mothers (96%) reported that they bathed their infants in the early evening in direct contrast to 18 of the 21 Pakistani mothers (86%) who reported bathing their infants mid to late morning. The interview responses highlighted that the white British mothers preferred to bathe their babies in the early evenings as they liked to involve their husbands/partners in this activity.

"We bath him after tea time or before his last feed probably cos my husband is usually around then and we can do it together. He likes to help." (Participant W03).

The vast majority of the white British mothers echoed the same reason; their husbands or partners were home and they felt they either needed the help or as Participant W15 told me *"my husband is home in the evenings and he likes to help out."* Additionally the white British mothers believed that their babies *"sleep better when they've had a bath"* (Participant W19). This opinion or belief was told to me from several of the white British mothers and may be a belief handed down from

mother to daughter as Participant W14 told me *“my mam actually says that babies sleep better after a nice warm bath.”*

The Pakistani mothers, however, did not express that the babies’ fathers were involved in the bathing of their infants. They chose to bathe their infants mid to late morning because later in the day they had many visitors and their households would be too busy to bathe their infants.

“I bathe him in morning cos it’s easier I think. The house is busy later on with visitors or family and so it’s easier in morning.” (Participant P56)

“Mornings are best for me, the house is quieter, less hectic, during morning.” (Participant P58)

They also gave reasons of wanting their babies to be ‘nice and clean’ when they received family and friends.

“Later in morning, maybe 11 time or a bit earlier sometimes. I like to make sure he’s clean and dressed for visitors. We have lots of visitors most days, you know, so I like him to be done when they are here...I wouldn’t bathe him in the evening cos all family is here and it’s too busy.” (Participant P66)

Because infant care advice in the UK stresses the importance of not allowing babies to overheat, the mothers were asked in the interviews if they were concerned about their babies becoming too hot, too cold or both. The mothers’ responses regarding their concerns provided a noticeable difference between the white British and Pakistani mothers. It is noted that 23 of the 25 white British mothers (92%) expressed their concerns regarding their babies becoming too hot and the remaining 2 expressed concerns regarding both hot and cold. The vast majority of the white British mothers explained their concerns regarding their infants overheating due to fears regarding their knowledge of the risk factors for SIDS. Contrastingly none of the Pakistani mothers expressed any concerns regarding their babies becoming too

hot but 14 of the 21 Pakistani mothers (67%) expressed their concerns regarding their babies becoming too cold. One of the self-acclaimed 'modern' Pakistani mothers told me

"When I was round my mother-in-law's she would always make sure I had [baby] wrapped up in a shawl cos if she got cold she would get a bad belly ache...That's a cultural thing I think cos when I go to the surgery I see all the mums with these really thick blankets and their babies wrapped up in them. There's a lot of Polish mums there as well and they seem to wrap their babies up a lot too. Maybe it's a Bradford thing as well but it's definitely a thing all the Pakistani families do round here." (Participant P54)

The remaining 7 Pakistani mothers (33%) did not express a concern regarding their babies overheating although they expressed that they just made sure their babies were neither hot nor cold. Participant P55 stated

"I just make sure she isn't too hot or cold. Asian families tend to wrap their babies a lot; I don't know why they just do. I don't think the Pakistani mums worry about their babies getting too hot like the English mums do. The English worry about cot death but I think the Pakistani mums worry more about their babies getting too cold cos really that's worse cos babies can get colds and infections and cot death don't happen that much really."

All 25 of the white British mothers interviewed reported using baby temperature monitors to provide reassurances regarding their babies' temperature.

"I have a temperature guide in her room so I always know it's alright."
(Participant W20)

"I'm not really that worried cos we've got a baby temperature monitor and it tells you all that...that it's alright, yeah." (Participant W03)

The use of temperature monitors amongst the Pakistani mothers was low (3 of the 21 interviewed) and the interviews highlighted that this is mainly due to the fact that the Pakistani mothers were not as concerned about their babies getting too hot. Participant P53 told me *“He can’t really get too hot cos I’d know”* and indeed, as mentioned previously, the majority of the Pakistani mothers displayed no concern regarding their babies becoming too hot. Many of the Pakistani mothers told me how they were more concerned about their babies becoming too cold

“She don’t never get too hot but I worry she gets too cold cos she could get ill, like a cold or bad chest you see.” (Participant P64)

“Since he were born we have fire on all time for him...my mum says that even when it’s warm there’s still draughts getting to him and so we keep him wrapped up...my mum says that the English worry about babies getting too warm all time and she says it’s not right cos they can’t get too warm, I mean she says that you’d know when they were hot.” (Participant P63)

It was also noted during the interviews that the white British mothers tended to rely quite heavily on baby intercom systems; 18 of the 25 white British mothers (72%) reported using them regularly and the other 7 white British mothers (28%) stated they had baby intercom systems but only used them sometimes. In stark contrast only 1 of the 21 Pakistani mothers reported having a baby intercom system and this mother further added that she had not even opened the box and had never used it. It was evident from the interviews with the white British mothers that the use of the baby intercom systems was mainly due to their solitary environment and they felt the need for reassurances which the baby intercom systems provided. The majority of the white British mothers were very content at leaving their babies alone and relying on up-to-date technology to take over the role of monitoring their babies. Additionally, the use of the baby intercom systems amongst the white British mothers appeared to provide the confidence in placing their babies in separate sleeping rooms both at night;

“She is in her own room now but I have a baby monitor and I can hear her if she wakes up.” (Participant W08)

“He’s in with his big brother now cos he sleeps though night now but I’ve got a baby monitor so I can hear he’s ok.” (Participant W18)

and during the day;

“I can get on with stuff when she has a sleep upstairs and I can hear her through the intercom if she cries.” (Participant W07)

“It’s quieter for her upstairs during day and anyway I can hear her if she needs me cos I’ve got baby monitor with me.” (Participant W23)

All of the white British mothers mentioned that they believed that their babies needed a ‘quiet’ environment to sleep and related this need to their own adult beliefs regarding sleep. Participant W18 summed up this opinion by telling me *“It’s better if they sleep in a quiet room isn’t it? Well would you be able to sleep if there were noises going on all around you? I know I wouldn’t and nor would most people.”*

It was noted by interviewing the Pakistani mothers that in general they tended to keep their babies very close and almost always within the same room so that baby intercom systems were not really a requirement.

“Pakistani mums like to have their babies with them all time and some English mums don’t have them with them all time...they put them down all time to sleep, don’t they?...I wouldn’t like that cos then you can’t keep your eye on them. I suppose it’s just different ways and what you get used to but I need to keep an eye on my babies.” (Participant P60)

Participant P61 summed up what the majority of the Pakistani mothers I interviewed felt regarding baby intercom systems and told me *“I don’t have one of those things...I prefer keeping her here with me so I can watch her.”* It would seem important to note that none of the Pakistani mothers mentioned the need for a

'quiet' environment for their babies sleep and never compared the needs of infant sleep to the needs of adult sleep as was noted from several of the white British mothers.

There were only 3 of the 21 Pakistani infants (14%) who used a pacifier in contrast to 13 of the 25 white British infants (52%) using pacifiers. I could not establish any cultural reasoning from the participants for either the use of a pacifier or not. From my data, however, it was noted that the bottle fed infants were much more likely to be using a pacifier than the breast fed infants. The 3 Pakistani infants using a pacifier were all bottle fed and of the 13 white British infants using a pacifier 10 were being bottle fed.

4.7 Discussion

Smoking is known to vary considerably between cultures, especially amongst women (Bhopal, 2006) and Hilder (1994) found that maternal smoking was uncommon amongst all Asian cultures. Furthermore, Ball *et al* (2011) reported how Pakistani infants in Bradford were less likely to be exposed to maternal smoking. I concur with Hilder (1994), Bhopal (2006) and Ball *et al* (2011) as the results of this study show that none of the Pakistani mothers interviewed were smokers compared to 3 of the white British mothers who reported that they were smokers. Although there has been much less research into the role of paternal smoking it has been linked to adverse health outcomes in infants including an increased risk of SIDS (Blackburn *et al*, 2005). More conclusively, however, Fleming and Blair (2007) state that paternal smoking is a risk factor for SIDS and is more strongly associated with nocturnal deaths, but the reasons are not fully understood. The BradICS quantitative study discovered that there were a greater proportion of Pakistani fathers who smoked than in any other ethnic group (Ball *et al*, 2011) and I acknowledge that, even though none of the Pakistan mothers smoked, 4 of the Pakistani fathers were smokers. In addition 2 of the white British fathers were smokers and therefore it is important to acknowledge that the mothers, both prenatally and postnatally, and their infants may be exposed to second hand cigarette smoke.

Ball *et al* (2011) found that the consumption of alcohol was rarely reported among the Pakistani mothers and fathers and I ascertained from the interviews that none of the Pakistani mothers or fathers consumed alcohol due to the religious prohibition of alcohol. However, 15 of the white British mothers and 17 of the white British fathers did consume alcohol, although the white British mothers told me that they only consumed alcohol on weekends and special occasions. This information is interesting as Dattani and Cooper (2000) state that analysis of SIDS by day of death showed increased risk at weekends and public holidays rather than weekdays and discuss how this could possibly be related to a change in parental routines. This may be quite an important factor as Phillips *et al* (2011) also found that both alcohol consumption and SIDS rates increase significantly at weekends. They further suggest that infants of mothers who consume alcohol are more likely to succumb to SIDS than infants of mothers who do not consume alcohol, although this suggestion has not been confirmed and supported by other researchers (Leach *et al*, 1999).

McVea *et al* (2000) report their analyses indicated bottle fed infants are twice as likely to die from SIDS compared to breast fed infants, although this may be related to confounding variables. However, Vennemann *et al* (2012) meta-analysis has confirmed that breastfeeding is a risk preventative factor for SIDS. It is possible that frequent feeding of an infant, which occurs whilst breastfeeding, and the resultant closer contact between mother and baby decreases the risk of SIDS. The social and cultural environment is important in a mother's decision and experience of feeding their babies (Twamley *et al*, 2010). Indeed, I did discover that the decision of whether to breast or bottle feed appeared to be influenced by the social and cultural ecology of the mothers I interviewed. Newson and Newson (1963) in their study reported that mothers who stopped breastfeeding gave reasons of their baby not being 'satisfied' or similar and also reasons of inconvenience. The Newsons' findings still seem to be pertinent as the main reasons the mothers in this study gave for this decision were returning to work, the need to be able to be away from their babies, and the belief that they thought their babies were not 'satisfied' or 'getting enough' and would sleep better through the night if they were bottle fed. On the other hand, the Pakistani mothers were not influenced by the thought of returning to work or

being able to spend time away from their babies. Furthermore, the Pakistani mothers never mentioned the belief that their babies would sleep better through the night if they were bottle fed.

Night time sleep generally began in the early evenings for the white British infants and later in the evenings for the Pakistani infants. This seemed to be due to the need for the white British mothers to have time on their own, or to spend time alone with their husbands or partners. The Pakistani mothers did not express this need and have lots of visitors and family around them in the evenings. The BradICS quantitative study identified that only 2% of Pakistani infants slept in a room alone compared with 24% of the white British infants (Ball *et al*, 2011). Indeed, during the interviews I found that none of the Pakistani infants slept in their own room compared with 28% of the white British infants who were sleeping in their own rooms during the night.

Day time naps were markedly different between the white British infants and the Pakistani infants, in both location and time of day. The information I elicited during the interviews regarding day time naps would appear to support findings reported by Gantley *et al* (1993) whereby Bangladeshi infants were always in the same, relatively busy and noisy, room as other family members in contrast with Welsh infants who had their day time naps alone in a quiet, and often upstairs, room. White British mothers often placed their infants to sleep for their day time naps in separate rooms; in fact 16 of the 25 mothers stated that they placed their babies upstairs in the bedroom to sleep during the day. In addition the white British mothers often dictated when their baby was allowed to have their day time naps with the reasoning being that if their babies slept too long during the day then they would not sleep 'properly' during the night. However, the Pakistani mothers appeared to have a much more 'laid back' approach to day time naps for their babies and often narrated how they just let their babies sleep 'as and when' throughout the day. The majority of the Pakistani infants were sleeping on and off throughout the day in the same room as their mothers and other family members and only 4 of the 21 Pakistani mothers interviewed said that they placed their

infants upstairs to nap during the day. I established in the interviews that the main reason for this difference between the white British and Pakistani families in day time naps is that the white British mothers are often on their own for the majority of the day and so they desire some time to carry out household chores or simply just to have some time on their own. In contrast the Pakistani mothers, being surrounded by female kin, share household chores and infant care with these allomothers.

The use of baby intercom systems was high amongst the white British mothers but non-existent amongst the Pakistani mothers. The reasons are obvious as the Pakistani mothers always had their babies with them or other family members were around, whereas the white British mothers were almost always alone and placed their infants in separate rooms for solitary sleep. The baby intercom systems appear to give the white British mothers a sense of security which replaces their own immediate motherly responses to their infants. Indeed, many of the white British mothers I interviewed expressed their feeling of safety for their infants' well-being due to the use of these monitors. The use of baby intercom systems, although apparently useful for infant solitary sleep, may be leading the white British mothers into a false sense of security in regard to their infants' safety. Mothers are relying on audio disturbances from an infant to warn them of their babies' distress and are not relating any importance to possible inaudible visual cues of distress from their infants.

Ball *et al* (2012) reported that regular bed sharers were more commonly Pakistani and I found that 38% of the Pakistani mothers I interviewed were regular bed sharers compared to only 2% of the white British mothers. Blair (2008) suggests that advice telling mothers not to bed share ignores cultural preferences and also reduces the options of where mothers can feed their infants at night. During the night time white British mothers often brought their infants downstairs to feed or pacify with the main reason that they did not want to disturb the baby's father. Only 5 of the 25 white British mothers interviewed reported that they did sometimes sofa share with their infants and the rest of the mothers said that they would sit on chairs as they thought that by sitting upright with their babies it would not be likely

for them to fall asleep. Ball *et al* (2012) analyses indicated that mother-infant bed sharers were different from mother-infant sofa sharers and that sofa sharing was less likely in Pakistani families. I found that none of the Pakistani mothers I interviewed stated that they brought their infants down stairs in the middle of the night and did not sofa share at all. I discovered from several of the Pakistani mothers that it was not acceptable for a woman of the household to leave her bedroom and come down stairs in the middle of the night. The Pakistani mothers also informed me that it is disrespectful and unacceptable for a woman to lie down on a sofa as it would be viewed as being lazy or as signs of illness. In contrast to white British families the Pakistani fathers often had a separate single mattress in the parental bedroom and mother and infant seemed to have priority over fathers night time sleep.

The actual sleep environments of the babies also showed differences between the two groups of this study. Pakistani mothers were often influenced by their mothers or mothers-in-law especially regarding infant bedding. The BradICS quantitative study reported that 28% of Pakistani infants slept with a pillow compared to 3% of white British infants. Hutchison *et al* (2007) conducted a study into sleep position and infant sleep devices and recorded the use of foam wedges and rolled towels in their study which were used to maintain an infant's sleep position. They discovered that parental anxieties regarding plagiocephaly was one of the main reasons that parents expressed for the use of these infant sleeping devices. The use of infant sleep pillows is a cultural practice amongst the Pakistani mothers and they believe that using these pillows will facilitate their babies developing a 'rounded' head shape. Therefore, many of the Pakistani mothers I interviewed did use pillows and also the majority used sheets and blankets rather than sleeping bags which were the favourite choice for the white British mothers. Indeed, Ball *et al* (2011) reported 50% of the white British infants using sleeping bags in comparison to 14% of the Pakistani infants. In my interviews the white British mothers reported that the reason they preferred the sleeping bags was their babies could not wriggle out of them and therefore they did not have to keep getting up in the middle of the night to put sheets or blankets back on to their babies.

During the interviews it became evident that there were differences between the white British and Pakistani infants sleep positions. All 21 of the Pakistani mothers reported supine sleep solely for their babies although I did not find any evidence that the Pakistani mothers turned their infants onto their sides during sleep as Gantley *et al* (1993) documented amongst the Bangladeshi community. 8 of the 25 white British mothers reported both supine and side sleep positions although all of the white British mothers reported that they placed their infants in the supine sleep position but that their babies turned onto their sides during sleep. It has been suggested that infants who sleep on their sides are at an increased risk of SIDS because they may roll into the more hazardous prone sleeping position (Mitchell *et al*, 1999; Hutchison *et al*, 2007) although this risk did not appear to concern the white British mothers.

Regarding the recommended 'feet-to-foot' cot position, I found that all of the white British mothers placed their infants 'feet-to-foot' in comparison to 43% of the Pakistani mothers. Similarly, Ball *et al* (2011) reported that more white British infants (79%) compared to Pakistani infants (50%) was placed in this recommended 'feet-to-foot' cot position. During my interviews it transpired that the Pakistani mothers did not place their infants 'feet-to-foot' due to the use of pillows for infant sleep; these pillows are generally placed at the top of the sleep surface.

Several studies have highlighted that temperature concerns are a socio-cultural belief and that perceptions of hot and cold vary considerably between ethnic groups (Watson *et al*, 1998; Tirosh *et al*, 2000; Wilson and Chu, 2005). A major concern for the white British mothers was their babies becoming too hot and they did not express the same concern regarding their babies being too cold. In direct contrast the majority of the Pakistani mothers stated that they were not very concerned regarding their babies temperature although when pressed for an answer they did state that they were more concerned about their babies getting too cold. These figures are interesting when considering the fact that overheating in infants is considered a risk factor for SIDS; the results of the mothers' temperature concerns in this study, along with several other studies (Watson *et al*, 1998; Tirosh *et al*, 2000;

Wilson and Chu, 2005; Cronin-de-Chavez, 2011), do not help to explain the lower incidences of SIDS in South Asian infants. Ball *et al* (2011) discovered that 83% of white British infants compared to 75% of Pakistani infants had a temperature monitor in their room. However, regarding temperature concerns in my interviews, it was noted that the majority of the Pakistani mothers did not use temperature monitors even if they did have them present in the home. This may be due to the fact that they usually had female relatives with them for most of the time that provided reassurances regarding whether baby was too hot or cold. The white British mothers did not usually have this female network around them for the majority of the day or night for reassurances regarding their babies' temperature and therefore relied more heavily on temperature monitors.

Pacifier use varies considerably within communities and cultures as well as between them (Mitchell *et al*, 2006) although there is no research that has been undertaken that can explain adequately this variation. Ball *et al* (2011) state that pacifier use at night was more common among white British families and indeed I found this to be the case amongst the participants in this study; 52% of the white British families used pacifiers compared to 14% of the Pakistani families. It is proposed that maybe the requirement of a pacifier is due to the social environment of the mothers and infants. The white British mothers were alone with their infants for the majority of the day and often practice solitary infant sleep and so depended on pacifiers to soothe their babies whereas the Pakistani mothers have constant companionship and help throughout the day and therefore the soothing of their babies was generally carried out by friends and family members. Several researchers have suggested that the use of a pacifier may be a preventative factor for SIDS due to some kind of protective mechanism, although little is known as to why. However, Blair *et al* (2009) do not support this hypothesis and most researchers and health advisors are undecided as to whether pacifier use should be advised in the SIDS guidance.

4.8 Summary

The mothers I interviewed in this study are from similar geographical locations within Bradford; the vast majority from the inner-city areas. My sample was also largely from high multiple deprivation areas of Bradford. Therefore, it would seem that any differences in infant care practices noted between the white British and Pakistani families are due to factors not particularly related to geographical or socioeconomic issues.

The social and cultural ecology of infant care in this study exhibits several differences regarding maternal and paternal smoking, alcohol consumption, and the overall family network and environment. During the day the majority of the white British mothers are alone with their babies compared to the Pakistani mothers who are almost always in the company of family members and friends. In the evenings the white British mothers are usually in the sole company of their husbands or partners whereas the Pakistani mothers are generally still surrounded by family members and friends. These differing environments influence certain aspects of infant care especially regarding infant night and day time sleeping locations, sleep positions and the actual sleep environment. Differences were also noted in the infant care practices of sofa sharing, bathing, pacifier use, and baby intercom systems together with infant temperature concerns and the use of infant temperature monitors. Additionally, as a result of these differing environments, the white British mothers appear to rely more heavily on current technologies such as baby intercom systems and temperature monitors for reassurances regarding their babies' wellbeing. Contrastingly, the Pakistani mothers did not utilise these current technologies and appear to rely on their female relatives and friends for reassurances and advice regarding their infants' wellbeing.

CHAPTER 5

PERCEPTIONS OF MOTHERHOOD AND INFANCY

This chapter explores the social and cultural perceptions of motherhood and infancy and addresses the questions “How do perceptions of motherhood and infancy differ for white British and Pakistani mothers in the UK?” and “How do these perceptions influence mothering and infant care practices?”

5.1 Perceptions of Motherhood

Perceptions of motherhood are the cultural ideal of the position of motherhood in one’s own society which influences the practices of mothering. Mothering is the actual interaction between a mother and her infant and influences all aspects of infant care and therefore understanding the mothers’ perceptions of motherhood is vitally important in this study.

The interviews conducted with the Pakistani mothers revealed that they perceived marriage and motherhood as expected and desired. They viewed motherhood as a definite social and cultural norm within their community. All but 2 of the Pakistani mothers interviewed were married and the 2 single mothers I interviewed told me how they had been disowned by their families as being a single mother or having a baby outside of the marriage institution was not socially or culturally acceptable within the Pakistani community.

“It’s not good to be a single Pakistani mum you know. They think I’m bad and have brought them shame so I understand that they don’t want to see me.”

(Participant P51)

“I could go to the clinic but it’s full of Pakistani mums and they won’t bother with me. I just manage on my own we’re fine. I haven’t given my family respect cos what happened and so I understand that. I regret I didn’t respect them but I guess I’m just not a good typical Pakistani woman.” (Participant P52)

In contrast only 15 of the 25 white British mothers I interviewed were married; 4 were living with a partner and the remaining 6 were single mothers. During my interviews with the 6 single mothers there was no expression of shame in their narratives for themselves or their families. The white British single mothers did not narrate any explanation or feeling that being an unmarried mother was not an ideal situation which the 2 single Pakistani mothers seemed to feel the need to explain in their interviews. Of the 10 white British mothers who were not married there was never an occasion during the interviews where being a single mother or co-habiting with a partner was perceived as being not acceptable by either themselves or their families.

Many of the Pakistani mothers I interviewed conveyed the importance of the family network and especially being married and having children of their own.

“I can’t imagine what it must be like for women who don’t have babies, it’s not natural I don’t think, I just can’t imagine feeling that you don’t want babies. I think it’s not something a Pakistani woman would want. You wouldn’t get your family’s respect if you didn’t have children.” (Participant P55)

“I would work if I had to but I don’t have to but I wouldn’t like to have to work with my babies being only little, I couldn’t do that and I don’t think the family would like it. I would not like to not have children though, like some of the English women, they don’t have any children ever some of them. I would hate not having my own children. It’s important to Pakistani families that we have

our own children. It's how things are normal, family and that, it wouldn't seem right without family." (Participant P69)

When talking with the Pakistani mothers they frequently relayed their opinions regarding the family and how important the family unit was to them. Participant P53 expressed her opinions that *"English women do what they want and do not respect their families."* The issue of respecting one's family arose several times during my interviews with the Pakistani mothers and one of the Pakistani mothers I interviewed went on to explain.

"The family is very important for a Pakistani and you always should respect your family. I think it's just how things are in our families, maybe just differences in the way you are brought up by your parents. I think the English aren't as into families, well I mean they don't see their close family all time, do they? I don't think they are brought up in the same way as a Pakistani would cos they don't really have all their family round them all time like us. The family is real important to a Pakistani for loads of reasons and I don't think it's the same for English people."

When I asked the Pakistani mothers about becoming a mother and whether they intended to also follow a career the mothers all seemed to express how important being a wife and mother was in their opinion and that having a career was not an important aspect in their lives.

"I don't think it's that important to go to work for us Pakistani mums, well most of us don't really have to do that. It's more expected to stay with your family really, to look after your children properly and you can't really do that if you have to go out to work for someone. I wouldn't really want to have to work for someone. Being a good mother to your children is more important and I think that's how it should be." (Participant P60)

"I'm not really interested in a career like some women are. I suppose I'm not really ambitious in that way cos I think your family is more important, especially your babies cos they need to be with their mum." (Participant P57)

In contrast the majority of the white British mothers interviewed did not attach as much importance to marriage and motherhood. Many of the white British mothers told me in the interviews of their intentions to either return to paid employment or pursue a career when their babies were older.

"I want to go back to work eventually; I don't want to just stay home all time, for the rest of my life. I'm not sure what I'll do yet but yeah I will be back to working when my children go to school probably." (Participant W01)

"I will be working when she's older. I really do want to get back to work cos I think I would be bored at home all day when she's older." (Participant W24)

Regarding the perceptions and opinions of having a career or employment in addition to being a wife and mother the majority of the Pakistani mothers did not express the desire to have a working life outside of their family unit; the need or intention to have employment was not brought up and when questioned stated that they had no intentions of taking any employed work and viewed their status of being a wife and mother as their expected and desired role in life.

"I were born in Pakistan, you see, and so my mother were not here in Bradford. I came here to live with my in-laws back then...I suppose I just look after my babies, how I know, how a Pakistani family does things looking after the family and the babies is what you do, not going to do things for someone else, not working. It's getting now where the younger Pakistani women want to do other stuff, like work, but it's not really how most of us want things. The family and that is more important especially to the husband, even the younger husbands as well." (Participant P59)

"I don't want to go out to work really and I don't have time. We have guests, family and that, all time and I need to be looking after them when they visit. Families are more important than work, especially my baby, I don't want to leave my baby." (Participant P61)

"I don't work no...I have no time to work because I look after the baby and also look after the family when they visit so I couldn't work." (Participant P68)

However, I did interview several mothers who appeared to have a more 'westernised' or self-acclaimed 'modern' outlook.

"Me and [husband] have quite a modern marriage...but some marriages, some Pakistani marriages, like my sisters-in-law, well they don't seem to have that modern outlook. They are all happy being at home bringing up babies and the men like that but me and my husband have more of a modern life." (Participant P65)

The 3 Pakistani mothers who were on maternity leave from paid employment viewed themselves as 'modern' in comparison to the more 'traditional' Pakistani mothers in this study.

"His family see me as being very, very modern...I love me job and I'm proud of where I've got to at work. My sisters and sisters-in-law don't bother about working cos it's not important to them but I definitely feel more in the modern world than them and they think I'm a bit mad for liking to be working." (Participant P54)

"My sisters-in-law think I'm a rebel...I had a good education...and I've got a good job and so I mix with lots of modern people. They always say to me 'why work? You should be taking care of the babies and home' and they don't understand but cos I mix with lots of modern people I feel a bit different about it." (Participant P70)

Although some of the Pakistani mothers expressed how they viewed themselves as 'modern' in comparison to 'traditional' women in their community they still appeared to retain aspects of infant care practiced by their mothers or mothers-in-law. Participant P63 told me that although she had been told by health professionals not to use a pillow for her baby but she did use a pillow and explained that *"it's expected that you would use the traditional stuff and not try to be over your head thinking you were too modern and knew better."* Although some of the self-acclaimed 'modern' Pakistani mothers acknowledged that they did take notice of health advice for their babies, they still told me how they did listen to their mothers, mothers-in-law and other female kin regarding infant care practices.

"I really did get most of the stuff I know from my mother-in-law. I do listen to the doctors and that but they don't always appreciate our ways of doing stuff so I listen to my mother-in-law a lot. She knows the best ways for us, the way we like to bring up our babies and after all she's had all her own and they are all ok." (Participant P60)

For the white British women it appeared that marriage and motherhood was not as expected or desired within their community. The white British mothers appeared to embrace motherhood but on a more temporary basis and narrated how they valued their time without having their babies with them.

"I don't want to be just a mum. I don't want to just be her mum, you know, I want to be me as well." (Participant W07)

"Getting her into a good routine at night is best for us cos we need to have our own time. Not all my friends have kids and so we want to be able to be just, well on our own without her all time. You need to just have some adult company sometimes and it's not fair on our friends who don't have kids to take her with us all time. I am quite independent and I'd like her to be independent from me as well." (Participant W17)

“Don’t get me wrong, I love me kids, but I love the time when I’m not with them as well. I like to go out with my mates without them cos it’s good for me. Anyway most of my mates don’t have babies yet and they’re not really ‘kid friendly’. I mean they like them, yeah, but it’s understandable that they don’t want me to take them out with me all time.” (Participant W21)

A great number of the white British mothers I interviewed often expressed their intention of either returning to employment or their desire to have a working life as well as having children.

“I want to go to work when she’s a bit older. I don’t want to just be nothing and stay at home all time. I need to know that there’s some light at the end of the tunnel. I get bored now being here all time so I know definitely want to be back into work soon.” (Participant W02)

“I need to get back to work eventually...don’t know what yet...just know I couldn’t not work especially when they’re at school. Sometimes I feel like nobody but his mum. I do like being a mum but that’s not the ‘be all and end all’ for me.” (Participant W25)

However, some of the mothers who were on maternity leave at the time of the interviews stated how going back to work was a necessity for financial reasons and expressed their dread at having to work whilst their infants were so small.

“I’m dreading it; don’t want to think of it yet. I was hoping to go back part-time but I don’t think we can afford for me to be just part-time so probably going to have to go back full-time. I don’t know what I’ll be like cos I can’t bear the thought of having to leave him yet.” (Participant W04)

“I definitely will be going back to work; I’m on maternity leave at minute. I sometimes think I’d like to be a stay-at-home mum but really I don’t think I would...I know I’d get bored and anyway we need the money, me working

and that. I must admit to you though that I'm quite scared and not really looking forward to leaving my baby to go back to work. Things would be really tight with money if I didn't go back to work thought so I suppose that makes your mind up really...finances and that." (Participant W13)

During my interviews I discovered that the vast majority of the Pakistani mothers' practiced communal motherhood as they were seldom alone with their babies during the majority of the day. Seven of the 21 Pakistani mothers interviewed resided in their parents' or parents'-in-law household and therefore in the company of their mothers, mothers-in-law and other female relatives. The Pakistani mothers who lived in their own households were also seldom alone with their babies during the majority of the day as they welcomed numerous visits from family and friends; as Participant P66 told me *"we have lots of visitors most days."* Due to this fact Pakistani infants were always cared for close to their mothers and other female relatives and were never placed in separate rooms for day time naps as *"we have visitors, family and that, and they come to see her so she is always down here with me"* (Participant P68). However, it was noted that the 2 single Pakistani mothers were often alone for the majority of the day and night with their babies due to the fact that their families had disowned them due to the birth of their babies outside of marriage.

In direct contrast to the majority of the Pakistani mothers, the white British mothers I interviewed experienced more solitary motherhood as the vast majority of the mothers were alone with their babies for the majority of the day. Participant W01, who was a first time mother with a partner who worked during the day, stated *"I do all the night shifts, all the day shifts, just me and him most of the time."* Many of the white British mothers told me how difficult they found being alone with their babies all day.

"It's difficult to get any stuff done when you have the baby with you all time and we're always on our own in day. It gets real lonely being on your own all time and quite hard to get other stuff done, like housework and that. It's even

really hard to just get yourself dressed and that in morning and I've seen myself still in my jamas till lunchtime some days.” (Participant W23)

This fact explains why so many of the white British mothers tended to place their infants in separate rooms (often upstairs) for their day time naps as they felt that by doing so they would have time to get their household chores done or sometimes it was simply to have an hour to themselves. The responses about when the infants had day time naps also provided an insight into differing practices between the white British and Pakistani mothers. The white British mothers often reported that they had certain routines for their babies' day time naps with a mid-morning nap and mid afternoon nap being the most common routine.

“He was just having these little short naps but I couldn't do anything and I were stuck. My other friend said that she puts her baby to bed once in morning and once in afternoon and I started doing that. It's brilliant and gives me time to do some things in house. I definitely think that having a sleep routine helps cos you need that routine to get all your other stuff done and it's better for him cos he has a better sleep as well.” (Participant W04)

Participant W06 told me *“I started keeping her awake a bit more during day. I think that's why she sleeps better at night.”* Indeed many of the white British mothers I interviewed stated how they often would keep their babies awake later in the afternoon and early evening as they thought that by doing this their babies would sleep better through the night.

“I don't let her sleep too much during day cos she wouldn't be as tired at night. I wanted to get her in to a proper night time routine.” (Participant W07)

“I'm not confident that if he slept over tea time he might sleep at night. I don't intentionally keep him awake – well yeah I suppose I do. It's not doing

him any harm cos he sleeps so much better when he's not been kipping on and off all day." (Participant W25)

The vast majority of the white British mothers told me how important having a routine for their babies was to them, especially sleep routines as Participant W21 states *"I have her in a routine. No matter whether they're babies or not, they have to go in to a routine for me."* The Pakistani mothers, however, did not seem to be preoccupied by having a routine for day time naps and often reported that they would just let their babies sleep 'as and when.' The Pakistani mothers did not generally express the intent that they kept their babies awake in the late afternoon or early evening to facilitate their babies sleeping through the night. Participant P63 told me what most of the Pakistani mothers expressed *"I have been letting her do her own thing really, we have no routine to speak of."* It transpired that the white British mothers practiced parent-led infant care while the Pakistani mothers practiced infant-led infant care.

The 8 Pakistani mothers who reported that they bed shared explained how they perceived this practice as *'natural'* or a more *'traditional'* way of mother-infant night time sleep. They explained to me how the baby's father would sleep on a separate mattress to the mother and baby and that the family generally viewed this practice as *'normal'* night time sleeping arrangements.

"My husband has a single bed to sleep on and so she [baby] stays with me. It's just easier, how we do things when they're small, yeah." (Participant P60)

"We have a spare bed, a single bed, in room and he [father] sleeps on that a lot anyway but he don't mind cos it's only babies and a good Pakistani husband expects that." (Participant P67)

The Pakistani fathers appeared to facilitate the close proximity of mother and infant during the night and alternative arrangements to the parental bed was one of the adaptations that occurred in many of the Pakistani households. In direct contrast the

white British mothers often expressed how they and their infants often had to leave the parental bed during the night to facilitate their husbands' or partners' night time sleep. This is an interesting difference in how mother-infant night time proximity is embraced or negotiated between the Pakistani and white British households.

All 25 of the white British mothers in this study resided in their own households and explained that in order to socialise, for themselves or their babies, they had to leave the family home; as Participant W23 expressed *"If I didn't go out now and then I'd see no one, I wouldn't see anyone but her."* The interviews highlighted that white British mothers often needed to make a conscious effort to socialise for themselves and their babies. They often stated how they have to go out to achieve this socialization, either visiting friends or family or attending mother and toddler groups in their area.

"I take her out a couple of times a week to the centre cos if I didn't I'd never see no one. It's good for us both really cos there are lots of other mothers and babies there. If I didn't take her out then we'd be in all day on our own all week and I think I'd go nuts." (Participant W04)

"The only time I see anyone during day is when I take her down to the clinic cos they've got a mother and toddler group there. [partner] is home later, in evenings, but during day we are always on our own so I have to get out and the mother and toddler group is really good cos you get to talk to other mums and that." (Participant W02)

The Pakistani mothers, however, did not express this need to go out which is due to the fact that for most of the day they are socializing at home with their family and other visitors.

5.2 Perceptions of Infancy

The Pakistani mothers I encountered embraced infancy and viewed it as an enjoyable and expected part of their family life. They displayed no evidence of any urgency to rush their infants through stages of development as was evident during the interviews with the white British mothers. The Pakistani mothers exhibited a much more relaxed approach to their babies and their babies' development.

"Babies are the most important thing in the family, babies are well looked after in the family – the whole family. If you go to any Pakistani house then babies are always there, they are important and everyone wants to see the new babies but all of the children are important for a Pakistani family." (Participant P59)

"He sleeps wherever; he sleeps on me or my mother in law. Someone's always got him. He just sleeps where and when he wants really." (Participant P58)

"They are precious in the family, all the family visit the new babies and they are more important than anything else. I keep him with me down here all time, all Asian families have their babies with them all time." (Participant P57)

"All babies find their own way; get to do things like walking, talking and that when they're ready. I don't think there's any real need to push things. They all get where they need to be in end, don't they?" (Participant P64)

The white British mothers also embraced infancy, although they often expressed their desire to get their babies through certain stages of development, especially with regards to sleeping and feeding. Participant W01 expressed her urgency to have her baby sleeping through the night as soon as possible stating *"it's every mother's dream, isn't it? That's how it should be, teaching them the right way, you know awake in day and sleeping in night."* This desire to have their infant sleeping

through the night was evident from almost all the interviews I conducted with the white British mothers.

“I think that getting them into some sort of night routine when they’re still young is better than trying to change things when they’re older. It is important that they learn to sleep at night more, well right through night as young as possible then they’re used to it.” (Participant W19)

Although not many of the white British mothers mentioned their desire to wean their infants earlier than the recommended 6 months they did mention how they attempted to feed their babies larger quantities at less frequent times. However, I could not ascertain the exact reasoning for this. Some of the mothers mentioned that their infants slept better when they had more feed at a single time and some mothers relayed the desire to be independent from their babies. Indeed, many of the white British mothers reported that they felt they would be more independent from their babies if they bottle fed or eventually bottle fed their infants. Participant W06 summed up what most of the white British mothers reported saying

“Well it’s better isn’t it? Just better for them to have more milk less often cos then they start getting into a proper breakfast, lunch, tea kind of thing, like us. It is better as well if you can get them on to a bottle instead of breast feeding all time cos then you can be a bit more independent and they don’t have to be with you all time.”

The desire or intent to be independent from their babies or striving to achieve a meal time routine was not at all evident in the narrations from the Pakistani mothers in this study and was not noted in any of the interviews I conducted with the Pakistani participants.

The majority of the white British mothers in this study expressed many rules and expectations they held for their babies and this was often determined by either age of the infants or time of the day. They narrated many stories of how they were

striving to attain and complete certain stages of infant development such as sleeping through the night, weaning and physical and intellectual development. Many of these narratives regarding babies' development were expressed in quite a competitive way and often the white British mothers would compare their babies' developments to other babies' developments.

"The easy part has gone now and we didn't have much of it cos she wasn't a baby 2 minutes, where some people have babies in their arms until they're quite old. She's getting to that age where she wants to be up and about and she's really advanced compared to some babies. She'll be walking and talking before long...I can't wait." (Participant W02)

"He's really doing well now cos he's awake more in day and so he sleeps better in night now. He goes right through, and that's good compared to some of my friends' babies. I think he'll be crawling soon cos he tries to pull himself up. He's getting out of the dependent baby stage now and it's great." (Participant W13)

"I let him explore stuff himself. I haven't got the time to just sit and play with him all day but he's such an advanced baby and we think he's going to do most stuff earlier than other babies like crawling, walking and that. We are lucky with him cos he's doing so well compared to other babies of his age." (Participant W18)

The white British mothers often stated in the interviews that they compared notes with other mothers about their babies. Many of the white British mothers expressed their desire to advance their babies through certain stages of infant development such as sleeping through the night and to be more independent. Participant W19 told me *"when he were 6-8 weeks old, when he were getting bigger, I wanted him to go into his own cot in his own room."* When I asked her if she knew of the recommended guidelines for keeping babies in the parental bedroom until they were 6 months old she told me *"I think the younger they are, well they get used to it*

better. I don't know any of my friends who've kept their babies in same room that long...it's a bit extreme." This was not an uncommon opinion with the majority of the white British mothers and several had already placed their infants in a separate room for night time sleep at the age of 6-10 weeks. Several other white British mothers also expressed that they intended to place their infants in a separate bedroom before the recommended age of 6 months. This desire to occupy separate bedrooms from their children amongst the white British mothers relates to issues of privacy and independence and contrasts to the Pakistani mothers who did not express any importance to issues of privacy or independence.

It was also interesting to note how many of the white British mothers narrated that they often compared how their baby was developing in comparison to other mothers' babies.

"My friend's baby sleeps right through and she gave me some advice when I were talking with her about how she trained her baby to sleep through night. So I decided to try her advice and I keep her awake more during day now and it works, well up to now, touch wood. She only has a couple of naps in day and I keep her awake a bit more later on, at tea time yeah, and she's sleeping so much better in night now, it's really good." (Participant W02)

"One of my friends keeps her baby up til she goes to bed but I won't cos I think it's nice to have a couple of hours on your own. Sometimes we do stuff the same but I think her baby don't do as well as mine cos she keeps hers up with her at night." (Participant W24)

One of the white British mothers I interviewed was married to a Pakistani man and told me how she noticed a difference between her white British friends and her Pakistani sisters-in-law in relation to the competitive nature regarding mothers and their babies.

“I see both cultures with me being in a mixed race relationship...What I think is a big difference is the bragging about their babies, yeah. When I have my friends over and when I visit my friends everyone’s always saying how ‘so and so’ is doing ‘this and that’, yeah. I don’t have that with his sisters you see. I’ve noticed that they don’t really do that. I mean they do chat about what their kids are doing but they don’t really brag about it like some of my friends do. There doesn’t seem to be the competition of when little ‘so and so’ is sleeping through the night or how many ounces he’s took and how much weight he’s put on. They don’t seem to brag like me friends do, yeah. A lot of the English mums are like that, everybody wants their baby to be the best.” (Participant W21)

As Participant W21 stated, I found that the Pakistani mothers I interviewed did not express any competitive narratives. Overall this competitive aspect of infant rearing that the white British mothers displayed was not at all evident in the interviews conducted with the Pakistani mothers.

Whilst conducting my interviews I did notice that the majority of the Pakistani households I visited did not have evidence of a great deal of infant toys which I sometimes had to climb over whilst entering the white British households. This difference was explored in the interviews when I questioned how the mothers interacted with their babies. I asked if and how they played with their infants and if they had many toys for their babies – this aimed to ascertain whether the toys evident in the white British households did indeed belong to the infants in question or if they belonged to other family members. Participant W09 told me

“she has lots of stuff down here to play with...at least they keep her occupied so I can get stuff done”

and further responses were similar to the narration from Participant W18 who stated

"I usually sit him in his bouncy chair and it has the mobile on it which he loves...I just let him explore stuff himself. I haven't really got the time to sit and play with him all day. I've got plenty to do and he likes it in his bouncy chair, he'll sit there for hours."

I also explored this line of questioning with the Pakistani mothers to establish whether they did have infant toys but had cleared these away before I arrived for the interview. The typical responses were similar to Participant P58 who said *"he doesn't really play much yet, he's only 3 months old see"* and Participant P57 who said *"We have visitors most days and they all want to hold and play with him."* Further responses to this line of questioning were very interesting and it was apparent that there was a marked difference in how the white British and Pakistani mothers viewed infant toys and interactions with their babies.

"I don't have toys for him as yet, I don't believe he needs them yet. I have an opinion that some of the baby toys are targeted at such a young age and they are really just a waste of money cos babies at this age don't really need them. I think maybe some mums feel that they should buy them toys or maybe they like to give them something to occupy themselves. I find quite a lot of mothers are selfish in the way they let their babies play with toys. I think it's because they want time away from holding their babies... I really don't believe that babies, say under the age of 4 months, need any kind of toys. It's just a big waste of money. I think that it's just the way English mothers do it, they buy too much stuff. It's not important to Asian mothers, not me or my family anyway, it's just not important really." (Participant P66)

"English mums always get their babies lots of toys. I don't know why, it just doesn't make sense to have all that stuff, toys for such young babies but I suppose it's just what they do, what they learn isn't it?" (Participant P60)

I would suggest that the use of infant toys may be due to the apparent solitary nature of the white British mothers and their infants that they tended to have a vast selection of toys which were not noted within the Pakistani infants' environments.

"I'd never get my stuff done if we didn't have all these things for her to play with. They keep her occupied, you see, while I do my stuff." (Participant W14)

Indeed in this study the white British mothers often said they liked having a lot of toys so that their babies could amuse themselves. Another reason given by the white British mothers for having many toys was to facilitate the amusement of their babies in order to keep them awake. They often stated that they would amuse their babies at certain times of the day to keep their infants from sleeping as they believed that their babies would then be more likely to sleep through the night, or at least sleep better through the night. However, the majority of the Pakistani mothers showed no interest in young infant toys and often said how they considered them to be a waste of money.

"My friend has so many toys for her little girl and she's only 2 months old you know. My friend's English see and she don't have a lot of people going to see her in day so maybe it's just to keep baby occupied with something cos no visitors come and talk to the baby. Not sure if it's a cultural thing or not – maybe just cos we live differently." (Participant P57)

Indeed, several of the Pakistani mothers interviewed told me that they thought the English mothers who purchased so many toys for their young babies was quite amusing to them.

"I think the English go way over the top with toys cos at this age they don't really want them. Most Asian families will tell you the same, we laugh about that. My friend's friend has a baby, she's English, and my friend said when she went to see her she couldn't see the baby cos it were in middle of floor full of toys. It made us laugh." (Participant P56)

This aspect of infant care relating to the use of infant toys can be directly related to 'distal' and 'proximal' parenting and these differing parenting strategies are influenced by cultural beliefs regarding infancy and independent or interdependent values. Many of my interviews with white British mothers related their preference for their babies' independence which was not a value expressed by the Pakistani mothers.

"I think it's good for him to be on his own...I suppose him being independent is important really cos then he's going to be better when the time comes that I'm not here...I want him to be happy when I'm not around. I don't want him to be a clingy baby like some babies cos then it's really hard to leave them and it ain't good for them either cos they cry all time for you." (Participant W04)

The white British mothers appeared to advocate the practice of 'self-soothing' for their infant which was not evident from the interviews with the Pakistani mothers. Several of the white British mothers told me how they would often let their babies cry so that they would not be too "clingy" or dependent.

"[husband] will try and pick her up but I say 'no' cos I think that sometimes it's good for her. There are times when she gets older that she will have to wait and she's gonna have to get used to that. I try not to pick her up as soon as she cries cos sometimes she is just wanting me and she needs to be able to fall asleep on her own now really. Some mothers just pick em up whenever they cry and that just makes it harder cos then they just cry to be picked up. I don't want her to get too spoilt so I let her cry a bit sometimes before picking her up." (Participant W02)

The Pakistani mothers displayed proximal parenting with values of interdependence and connectedness in infancy. It was apparent from their narratives that they practiced infant led and cooperative infant care and they did not narrate any values

of rules and expectations of development for their babies. Many of the Pakistani mothers stated how they cared for their babies with an 'as and when' attitude.

"I keep him with me even if he's sleeping. I just let him sleep and feed when he's ready, just sort of as and when really, yeah. There's no real schedule to babies they should just be able to let you know when they need something like a feed or a change of nappy and that. There is no rules is there? I mean they are just too young and you have to just see to them when they let you know." (Participant P57)

"I keep a close eye on him and he's never far away. I see to him when he needs it, he lets me know. There's no real routine to it cos it's just as and when he needs me. Do you know what I mean? That kind of thing." (Participant P59)

The term 'as and when' was narrated many times in the interviews I conducted with the Pakistani mothers and they displayed no specific urgency for their babies to attain or complete certain stages of infant development such as sleeping through the night, weaning or physical and intellectual development as Participant 64 told me *"she'll do more things and that when she's ready."* The Pakistani mothers did not seem concerned or competitive about their babies' development which was displayed numerous times in the white British mothers' narratives.

"You can't worry about babies cos they all are so different. Babies grow in their own time and in their own ways. They just do all the stuff in their own time and you can't really expect or worry about it." (Participant P59)

"I suppose they let you know when they're ready...they'll sleep longer when they're ready, they'll talk and walk when they're ready. Babies are all different and you can't make them when they're not ready. You can't really compare babies cos they're all different but they all get where they need to be in end, eventually. They do things in their own way and at their own time."

You can't compare one baby to another cos they are all so different."
(Participant P61)

5.3 Discussion

Many South Asian communities have high marriage rates and 75% of Pakistani women are married by the age of 25 compared to 55% of white British women (Dale and Ahmed, 2011). Peach (2005:23) states "marriage is almost universal" within the Pakistani communities and indeed this was evident from my data and furthermore as Dale and Ahmed (2011) state Pakistani women appear to view marriage as a family concern rather than an individual affair. The majority of the Pakistani mothers I interviewed relayed how important their families were and how they were in constant daily contact with both their immediate and extended families. In a study in a Pakistani community by Shaw (2000) she noted that there was a distinctive pattern of living near to close family and Stopesroe and Cochrane (1990) found that, even among young Asian people, they preferred to be close to their parental families. Shaw (2000) highlighted that, despite living separately, the married daughters return to their parents' house almost daily. I would agree with these observations as I discovered through my interview data that this was often the case for the Pakistani mothers in this study.

The white British mothers, however, did not express the importance of their families in their narratives and the majority of the white British mothers did not live within close proximity of their close and extended family members. Although, the white British mothers expressed feelings of isolation with their babies they never mentioned that maybe it would have been an important consideration to have located their family unit closer to other family members. Many of the white British mothers I interviewed expressed how they were not in close proximity to their family members and as Dosanjh and Ghuman (1996) state white British family members do not consider living close to other family members as desirable and this factor impacts on the help, support and company available to the white British mothers. Similarly in Germany Keller *et al* (2005) researched motherhood and

discovered that family members were not available to German mothers as they did not usually live in the same neighbourhood. Several of the white British mothers expressed their feelings of isolation and narrated how they had to leave the family home to socialise, either visiting friends and family or 'mother and toddler' groups.

Regarding employment Peach (2005) and Dale and Ahmed (2011) highlight the fact that there is low female participation in the labour market within the Pakistani community and this was very evident amongst the Pakistani mothers I interviewed. The main reasoning appeared to be the beliefs and values regarding their identity as a Pakistani woman; priority was given to the role of wife and mother and being a working woman or having a career was not apparently a valued aspect of their identity. Dale and Ahmed (2011) suggest that the gender based division of child care is much more evident in Pakistani communities in comparison to white British society. I found this observation to be true in the Pakistani households I visited as child care was almost always in the domain of the mother and female relatives. In contrast, I found that many of the white British mothers I interviewed expressed how their husbands or partners desired and expected to be involved in many aspects of child care, especially feeding and bathing.

Mothering for the white British mothers entailed quite strict routines for their babies whilst the Pakistani mothers showed a much more relaxed approach to mothering. Gantley *et al* (1993) reported that Bangladeshi mothers' idea of time emphasizes "*fluidity and flexibility*" whereas Welsh mothers emphasize "*regularity ad routine*". I found this idea of time related to the Pakistani and white British mothers in this study and had a huge impact on night time sleep and day time naps in regard to when and where. The Pakistani mothers emphasized the idea of fluidity and flexibility and had a much later bed time for their infants and none of the 21 babies were placed in their own bedrooms for night time or day time sleep. Contrastingly the white British mothers emphasized the idea of regularity and routine and had an early evening bed time for their infants and scheduled day time naps. It was also noted that the white British mothers displayed strong desires for their infants to sleep through the entire night which was a much lesser issue for the

Pakistani mothers. McKenna (1996) suggests that conditioning babies to sleep alone throughout the night as early in life as possible is a Western infant developmental aim. Many of the white British mothers I interviewed did appear to find that this developmental aim for their babies was most important and were striving to achieve this as soon as they could. It is considered normal and expected within Western societies that infants develop adult sleep routines by the age of 3-4 months and that solitary sleep is considered normal and desired (Klonoff-Cohen and Edelstein, 1995). The white British mothers all tended to be striving to have their infants sleeping through the night which was not an issue with the majority of the Pakistani mothers. Furthermore, the white British mothers almost always expressed their desire for a 'good' routine for their babies whereas the Pakistani mothers narrated a more 'as and when' approach to infant sleep.

Differences were noted during day time naps generally with a morning and early afternoon nap for white British babies and unscheduled day time naps for the Pakistani babies. In addition 16 of the 25 white British babies were placed in separate rooms (often upstairs) for their day time naps whilst only 4 of the 21 Pakistani babies were placed in separate rooms for their day time naps. Aslam *et al* (2009) suggests that placing an infant in a separate environment is a reflection of social and cultural values of early independence and self-reliance and these values conflict with social and cultural values of Pakistani mothers. Overall the majority of the Pakistani infants' day time naps were unscheduled and they napped throughout the day in the company of their mothers and other friends and relatives.

Ball *et al* (2011) discovered that Pakistani infants were less likely to sleep in a room on their own; they found that 24% of white British infants slept in a room on their own compared to fewer than 2% of Pakistani infants. As presented in this study, none of the Pakistani infants slept in separate rooms to their parents in comparison to 7 of the 25 white British infants who were placed in their own bedrooms for their night time sleep. Western society values seem to favour early autonomy and individualism over familial interdependence (McKenna, 1996) and Western societies believe that infants should have their own bedrooms as this encourages

independence and facilitates privacy. However, as Ball (2007) states this is a practice that has a relatively short history and has no explicable advantage for infants; the only advantages appear to be for parents. Solitary infant sleeping environments are a recent Western practice and the majority of the world still has their infants in close proximity during sleep (McKenna, 1996; Small, 1998; DeLoache and Gottlieb, 2000; Ball, 2009). The disadvantages of infant solitary sleep are reasonably obvious as a mother cannot be sensitive to an infant experiencing any difficulties with breathing, bedding or positioning whilst sleeping in a separate room. Pakistani mothers often prefer to bed share with their infants and a great deal of parents and children often prefer to sleep in one room. Some Pakistani women now see this as a distinct advantage, saying “our babies do not die from cot deaths because we do not put them in cots in separate rooms like the English; we sleep with our children” (Shaw, 2000:88). Bed sharing helps to develop a connectedness by providing an opportunity to be physically close with an infant and by instilling values of connectedness in the child at a young age (Aslam *et al*, 2009:673). Western child care practices tend to value the development of independence and disconnectedness in contrast to Asian child care practices which tend to value the development of interdependent relations and family connectedness (Anuntaseree *et al*, 2007).

The interview data highlighted the different opinions regarding breastfeeding with the white British mothers viewing breastfeeding as rather inconvenient and reporting desires to be more independent from their infants. The white British mothers felt that by bottle feeding their infants they would be more independent and able to spend time away from their babies. Regarding infant feeding practices the white British mothers also appeared to be influenced by their belief that if they fed their babies on formula they would sleep better through the night; they believed that their babies would be “fuller” and therefore content. Although the white British mothers often expressed the knowledge that breast is best they felt that if they fed their babies for the first few weeks on the breast then that would be good enough. These opinions regarding inconvenience and independence were not noted from the Pakistani mothers who did not relay any desires to be able to spend time away from their babies. Furthermore, the Pakistani mothers did not narrate any beliefs

regarding an infant sleeping 'better' through the night if they were bottle fed. However, I did not ascertain whether they did actually have this belief but were just not concerned to have their babies sleeping *better* through the night. The Pakistani mothers interviewed expressed different reasons for formula feeding, usually due to the advice from health care workers or their inability to breast feed. It was evident from a lot of the interviews I conducted that both midwives and health visitors in Bradford prompted the mothers into bottle feeding their infants if they were experiencing difficulties. The acceptance and uptake of advice from health care workers by the Pakistani mothers in this study relating to infant feeding seems a little odd as they did not appear to pay too much attention to the majority of infant care advice they received.

The white British mothers displayed evidence of competitiveness regarding infancy and often narrated about how well their babies were developing (both mentally and physically) in comparison to other infants. Many of the white British mothers expressed how well their babies were doing with regard to sleeping, feeding, physical movement and signs of intellectual progression. This observation of infant competitiveness was not evident in the Pakistani mothers' narratives and they did not appear to desire or expect certain developmental goals for their babies. During the interviews conducted with the Pakistani mothers I never once encountered a statement regarding how well their baby was doing in relation to infant physical, mental or developmental progression.

The white British mothers utilised many toys as stimulants for intellectual development and also as a means to amuse their babies to facilitate scheduled sleep times. Many of the white British mothers said how they stimulated their babies with toys in order to keep them awake so their babies would be more likely to sleep *better* through the night. The white British infants were also expected to entertain themselves with infant toys to enable the mothers to have some time on their own or carry out domestic chores. Keller *et al* (2005) suggests that the use of infant toys in Western societies is due to the fact that there are hardly any other caregivers around to enable mothers to have some time away from their babies. In contrast the

majority of the Pakistani mothers saw toys as unnecessary and did not show any competitiveness for their babies' intellectual development. Indeed many of the Pakistani women expressed how they were amused by *English* mothers and their obsession with infant toys for their babies.

5.4 Summary

Perceptions of motherhood and infancy held by the mothers in this study have several variations and these differing perceptions can influence certain aspects of infant care. The white British mothers practice solitary mothering and distal parenting strategies that is parent led with several routines, rules and expectations. They hold beliefs and values of independence and disconnectedness in infancy and display competitive values and expectations for infant development. The Pakistani mothers practice communal mothering and proximal parenting strategies that are infant led with a relaxed 'as and when' approach. They hold beliefs and values of interdependence and connectedness in infancy displaying no competitive values and expectations for infant development.

CHAPTER 6

“NOT REALLY FOR US”

KNOWLEDGE OF INFANT CARE PRACTICES IN RELATION TO SIDS ADVICE

This research is a qualitative follow-up study to the BradICS quantitative study which collected data on infant care practices in relation to SIDS advice and guidelines. Please see Appendix 8 for a copy of the NHS SIDS reduction leaflet readily available at the time that I conducted my interviews. This chapter will address the questions “How knowledgeable are mothers regarding the antenatal and postnatal SIDS advice that is presented to them?” and “How and why do the Pakistani and white British mothers I interviewed follow, dismiss or adapt the SIDS advice regarding infant care practices?”

6.1 Smoking and Alcohol Consumption

None of the 21 Pakistani mothers I interviewed reported smoking as this was not socially or culturally acceptable within their communities although 4 of the Pakistani fathers were smokers. All the Pakistani mothers were aware of the link between maternal smoking and SIDS risk although they did not appear to be fully aware of the association between paternal smoking and SIDS risk.

“I know mothers shouldn’t smoke and good Pakistani women don’t smoke. I don’t think it’s as important about fathers, is it?” (Participant P58)

“I don’t know if the English dads smoke around their kids but Pakistani dads don’t. I mean my husband don’t smoke anywhere near the baby or other babies. Maybe it’s something the English dads do and maybe that’s it.” (Participant P61)

3 of the 25 white British mothers reported smoking and 2 of the white British fathers reported smoking. The 3 white British mothers who reported smoking acknowledged the risks associated with maternal smoking and SIDS and justified their persistence in smoking as they stated that they never smoked around their babies and always smoked outdoors.

"I tried to stop but can't. I never smoke near her, never. I don't smoke a lot anyway and when I smoke I go outside. I only smoke outside, never in here so it don't affect her. I know they tell you to stop and I really did try but really it don't affect her at all cos she is never near me when I smoke anyway."
(Participant W09)

Similar justifications were given to the issue of paternal smoking and all the mothers (both white British and Pakistani) when questioned felt that their babies were not subject to someone directly smoking in the same room and therefore there would be no risk to their babies' health.

"[husband] don't smoke in the house. I make him go out in garden for his fags now and he would anyway cos he knows not to smoke around babies or kids."(Participant W13)

"He would never smoke near the babies, he don't never smoke around us. The men sometimes smoke but the Asian women don't and so the men don't smoke near us...it's a respect thing, they don't do that." (Participant P55)

In addition, the white British mothers who did smoke cigarettes also told me how they had interpreted the relevance of the SIDS advice regarding smoking. Participants W09 and W18 stated how as they never bed shared with their babies that the advice was not really relevant to them.

"I know you shouldn't sleep with babies in your bed if you smoke. I have her in a cot and I never have her in bed with me to sleep so she's ok. I wouldn't

smoke around her and I don't sleep with her cos I know they say that's a bad thing to do. Maybe some of the mothers who do smoke are breast feeding their babies and sleeping with them but we don't do that." (Participant W09)

"I know I smoke, yeah, but never around my baby, ever, and don't have her with me in bed cos I don't do that with my baby...the advice is maybe more for women who breast feed and have their babies in bed with them cos that's what they say in the leaflets you get, 'don't smoke and bed share,' and we don't bed share so I know it isn't dangerous for her." (Participant W18)

In relation to alcohol none of the Pakistani mothers or fathers consumed alcohol due to the religious prohibition on alcohol in the Muslim Pakistani community. However, no such prohibition exists in white British society and 15 of the 25 white British mothers I interviewed reported consuming alcohol either at weekends or on special occasions. In addition the white British mothers I interviewed reported that 17 of their partners or husbands consumed alcohol. All the mothers acknowledged the advice regarding alcohol consumption but justified consuming alcohol as they felt they only drank at weekends or on special occasions and as they did not get 'drunk' it was perfectly acceptable: they told me that they believed they were fully alert and aware of their babies' needs.

"I only have a couple of glasses of wine at weekends really and special occasions, times like Christmas and that I'll drink but not in middle of week." (Participant W02)

"I do like a drink but only at weekends when I'm relaxing but I never drink a lot, I don't get drunk. I just like to have a drink when it's special times as well like birthdays and special occasions but don't we all?" (Participant W13)

It transpired from the white British mothers' narratives that they did not consider their or their husbands or partners alcohol consumption to be of any concern purely because they did not consume alcohol during the week or in large quantities. I did

question why the mothers felt that having an alcoholic drink at the weekend was different to having an alcoholic drink during the week as they still were taking care of their infants at weekends the same as during the week. However, none of the mothers questioned could adequately justify their recent narrations although the general belief expressed was similar to Participant W02 who said

“Well it’s just during week you only have a drink if you have a problem. I mean most people have a little drink on the weekends. It’s just cos you don’t have work and that and so people tend to chill out more...I suppose...I think.”

In addition, and interestingly, several of the white British mothers also linked alcohol consumption to breast feeding and/or bed sharing.

“He’s on formula so it don’t affect him cos I’m not breast feeding. He has his own bed, the basket yeah, and he don’t sleep in our bed ever. I think they tell you not to drink in case you fall asleep in bed with them when you breast feed and squash them or smother the baby if you’ve got a bit drunk.” (Participant W01)

“I know you shouldn’t drink alcohol when you’re breast feeding and it’s breast feeding mothers who might bed share really so it’s not really relevant to me cos I don’t breast feed or bed share.” (Participant W18)

“I know there’s risks with drinking, well alcohol, when you have your baby in bed with you but I can’t see how a little drink can affect a baby when you’re not sleeping together. Obviously you can’t really drink when you are feeding them, breast feeding them. I don’t have my baby in bed with me and I don’t breastfeed now so it don’t affect us.” (Participant W22)

It is interesting to note that none of the white British mothers who did consume alcohol considered how their decision making and judgement might affect their babies or other aspects of infant care whilst they had been drinking.

6.2 Infant Sleep

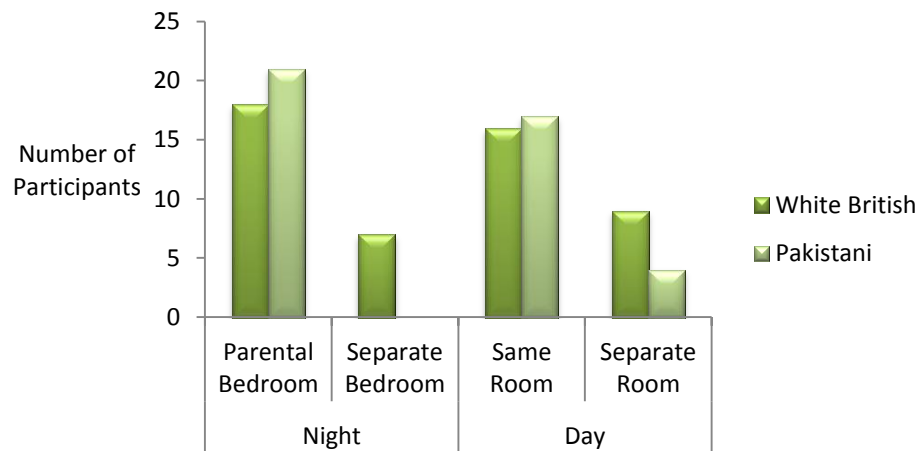


Figure 4

Graph displaying night and day infant sleep locations between the white British and Pakistani participants

Figure 4 above displays the 'normal' night and day time sleeping environments for the white British and Pakistani babies and as can be seen all 21 Pakistani mothers reported that their babies slept in the parental bedroom for night time sleep and the majority also kept their infants in the same room as themselves for their day time naps.

Participant P53 told me *"I like him with me all time"* and the majority of the Pakistani mothers gave very similar reasons for keeping their babies close both at night and during the day.

"I like to keep my eye on him. I keep him with me even when he's sleeping. I wouldn't feel happy if I couldn't keep my eye on him so he's with me all time really. I don't think babies should be alone when they are this young anyway, babies shouldn't be on their own." (Participant P57)

All the Pakistani mothers expressed how they preferred keeping their babies close and would not consider the practice of solitary sleep even during the day and

therefore the majority would have their babies in the same room during day time naps. However, there were 4 Pakistani mothers who did state that they sometimes placed their infants in a separate upstairs bedroom for day time naps. It was noted that 2 of these mothers had been isolated from their families due to giving birth outside of marriage. Therefore these 2 mothers were often alone with their babies and gave similar reasons to the white British mothers for placing their babies in a separate upstairs bedroom for day time naps.

“Well cos I’m on my own a lot I need to get stuff done and I have no family around to help so it’s easier for me to put [baby] upstairs so I can get on with stuff. I need to get stuff done on my own and I have no help see.” (Participant P51)

The other 2 Pakistani mothers who reported placing their infants in separate rooms for day time naps narrated how they perceived themselves to be more ‘modern’.

“It’s nice to relax a bit with them not around. In my mother-in-law’s house they’re all together all time. Me and [husband] have quite a modern marriage and we like our time on our own as well. Not all Pakistani husband and wives have time on their own but we do cos we are a bit more modern like that. I suppose for a lot of Pakistani wives there is always other family around and so it don’t really seem as important cos you wouldn’t be on your own with your husband anyway.” (Participant P65)

During the interviews I mentioned that infant care advisors recommend infants stay in the parental bedroom until 6 months of age and enquired if the Pakistani mothers were aware of this advice. Many of the mothers were not really completely aware of this fact as they admitted not really taking too much notice of the SIDS advice leaflets they had obtained and in fact many reported not even reading them.

“I haven’t really read much of the papers they give you cos well I don’t get the time. I am sure if it were really important they wouldn’t have it just written

down they'd tell you. They have said some stuff like placing babies on their backs and that, yeah. I don't really bother with leaflets and things like that cos they tell you what you need to know." (Participant P52)

"Well I don't need to be told that cos that's what Asian mothers do anyway. This is why I don't bother reading all the leaflets and that cos it's just common sense really and maybe it's more for mothers who don't have any experience with babies." (Participant P59)

In contrast 7 of the 25 white British mothers reporting that their babies were now sleeping in their own separate bedrooms, even though they did acknowledge that they knew the recommended guidelines to keep babies in the parental bedroom for the first 6 months.

"I know they say it's best for babies to stay in the same room as the mother but she's doing so well that I don't see why a few weeks makes any difference. I suppose they have to give you some age but all babies are different and she's doing so well that she will be fine in her own room now." (Participant W02)

"I really don't want him to get used to being in our bedroom...I think the 6 month thing is just too old. It's not like he knows cos he's asleep anyway. I don't know what all the fuss is about really – it's just a guideline isn't it?" (Participant W19)

In addition there were also several more white British mothers who intended placing their infants in separate bedrooms before they were 6 months old as Participant W14 told me

"She's going to be in her own room soon. I don't think she needs to be with me till she's as old as 6 months. I've done all her room for her already and it's really lovely and cosy in there for her so she's gonna love it."

However, approximately half of the white British mothers I interviewed did state how they knew the SIDS advice and guidelines and intended to keep their babies in the parental bedroom until they were at least 6 months old.

“He will be with me until he’s ready. I wouldn’t put him in his own room before he’s 6 months old cos that’s the advice really so he’ll stay with me. I think it’s easier to keep them in your room till they are past that age anyway cos they still wake up in night sometimes and it saves you having to go into a different room in night.” (Participant W01)

“They tell you to wait at least 6 months before they should be in their own room and I agree cos they wouldn’t say that if it weren’t right.” (Participant W25)

As discussed in Chapter 5 the majority of the white British mothers were alone with their babies during the day and would place their infants in separate upstairs bedrooms for day time naps in order to carry out domestic chores or simply to have a break away from their babies. Due to the white British mothers regularly practicing infant solitary sleep they did rely quite heavily on baby intercom systems which was also discussed in Chapter 5. I highlighted to the mothers I interviewed that infant care advice did not advocate lone infant sleep although the majority of the white British mothers did not appear to have fully absorbed this information. They often stated how they felt that this practice was not really lone infant sleep as they had the baby intercom systems and so they felt that this was just the same as being in the same room as their babies. Participant W02 summed up the general reasoning and justifications of the white British mothers for solitary night time sleep using baby intercom systems.

“I know they aren’t right next to you but cos you’ve got the monitor right next to you it’s sort of just the same really. I mean you hear them just as clear as if they were right there so you’d know if they wake up or if there’s something wrong.”

And Participant W23 summed up the general reasoning and justifications of the white British mothers for solitary day time naps using baby intercom systems.

"I need to get sorted and so I put her in her crib but it's not like she's on her own really cos she's fine and I can hear her if she needs me cos I've got a baby monitor. I know she's fine in her crib upstairs cos of the monitor so it's like she's with me really all time even though she isn't if you know what I mean."

6.3 Bed Sharing

Regarding exclusive bed sharing only 2 of the white British mothers reported this practice in contrast to 8 of the Pakistani mothers. One of the white British mothers who reported exclusive bed sharing with her infant was quite abrupt with me during this line of questioning until I explained that I was not a health professional. I proceeded to explain that I was not medically qualified and was not there to judge her infant care; rather I was interviewing mothers in an academic sense to ascertain how they cared for their infants on a day-to-day basis. She seemed quite comforted and relieved and went on to say

"I apologise if I seem a little curt with you but I sort of expect you to disapprove when you asked me about that. You see the health visitors round here are clueless, they just follow what they've been taught. To be honest with you [name] is my health visitor and is just a kid and I just cannot imagine her telling me anything I would find useful." (Participant W15)

The vast majority of the white British mothers told me how they understood bed sharing with their babies as a dangerous practice due to the advice they received from infant care leaflets and the health care professionals.

"I never brought her in bed with me cos I know that's dangerous. I've read all the leaflets and that...anyway my health visitor has told me never to do that and so I don't. I have heard from some of the other mothers round here that they have heard of babies being suffocated or that when they have been asleep with their mothers in bed so it's best not to take the chance." (Participant W06)

"You know the risk of them dying when you sleep in bed with them. I've read about that...one of the worst things to do is to sleep with your baby in bed with you and I think women who do are being really selfish, probably cos they don't want to keep getting up in night." (Participant W09)

"I've read all the leaflets and things like that and I heard from the hospital that babies have died in beds with their parents and I even think someone did in the hospital you know. Apparently she had the baby in bed with her and suffocated the poor thing." (Participant W13)

Interestingly, several of the white British mothers directly related bed sharing only with night time feeding

"I think that maybe they presume you're still doing night feeds when they talk about bed sharing so I think it's more for the breast feeding mums. I mean you don't need to bed share if you're not breast feeding." (Participant W19)

"Well some babies are still waking up in night for feeds at this age but I'm lucky I have a real good baby and she's so good in night so I don't think it refers to mothers like me." (Participant W20)

Some of the white British mothers told me how the advice against bed sharing made them have to negotiate different options for feeding their babies during the night.

“I used to let her sleep with me cos she were feeding 2, 3 or even 4 times in night and I were really careful with her. I suppose I stopped cos I felt guilty cos I know it’s not recommended cos it’s a bit dangerous for them but it was just so much easier for her to feed and for me to be honest. I know it wasn’t the best thing so I stopped doing it and tried to get her to sleep longer between feeds so that I didn’t have to bring her into bed with me.”
(Participant W10)

“What I usually do is just prop my pillow up against the wall and sit up in bed with him and feed him like that so I don’t fall asleep.” (Participant W12)

The recommendations regarding the dangers of bed sharing with an infant was also known to the Pakistani mothers. However, the Pakistani mothers dismissed this advice as they often felt that the information was not directed to them and was only relevant to the white British mothers.

“I don’t really take much notice; it’s more for the English mothers. Most of the stuff they write is meant more for the English mothers and not the Asian women. I know what’s best for my babies and I like them with me at night.”
(Participant P71)

The Pakistani mothers expressed strong beliefs and values in relation to bed sharing with their infants and believed this was a totally natural and expected infant care practice. They did not envisage any dangers regarding bed sharing even though several of the Pakistani mothers acknowledged the dangers outlined in the SIDS guidelines such as maternal smoking and alcohol consumption and Participant P53 told me

“They go on about smoking and we don’t smoke cigarettes and drinking alcohol (laughs). They should know it’s not even something a good Pakistani woman would even think about doing so they should acknowledge our ways more and not just the English ways. All the stuff seems to be geared to the

English mums really and it doesn't seem relevant for the Pakistani mums so it's hard to really take note of what you should do cos most of the stuff isn't really what we would do anyway, like smoking and that."

6.4 Sofa Sharing

The white British mothers made it clear to me that they did know the dangers of sofa sharing. Nevertheless, 8 of the white British mothers told me that they had sofa shared with their babies. Of the 8 white British mothers who reported sofa sharing with their babies 3 stated they had sofa shared only on one occasion.

"I know it's dangerous but it only happened the once when she were going through a really restless time, she weren't real well. It was a bit of an accident really cos I brought her down here to settle her and she were much more settled with me here. I was really aware of the dangers though and I never done it again...just that once." (Participant W07)

"I don't sofa share ever, well just that one time cos he was having a really unsettled night. I was just comforting him cos he was upset. We weren't down here on sofa all night just for a short while but having said that I do know how bad it is and I know it won't happen again, the sofa sharing, yeah." (Participant W24)

However, 5 stated that they had sofa shared on more than one occasion but expressed how they thought by being 'careful' that it would be safe.

"I know that they tell you not to but sometimes it's hard when they're up in night and you're trying to soothe them. I know I wouldn't do it if I thought that I could hurt my baby so I was always careful, ok?" (Participant W09)

"I have done it on more than one time, but I am so careful and try to be safe. I know that sometimes mothers aren't that careful but I am." (Participant W14)

Several of the white British mothers gave reasons for using chairs or being propped up in bed to feed their infants during the night was to avoid using the sofa. They stated how they believed that they could not fall asleep and possibly harm their babies if they were propped up in bed or sitting on chairs.

"I feed her in the chair but I wouldn't fall asleep with her. I don't lay on the sofa cos I know that you shouldn't do that cos it's dangerous. I never brought her in bed with me cos I know that's dangerous. I would bring her down here and feed her in chair." (Participant W06)

"I think it would be easier for me to fall asleep and hurt her in bed cos it's all cosy...I know I can fall asleep in bed much easier than down here on chair so it's safer for us. I always just sit on chair, like. I don't sit on sofa cos I know it's dangerous and it's more possible to fall asleep on sofa." (Participant W14)

All the white British mothers seemed fully aware of the SIDS advice regarding the unsafe practice of sofa sharing through leaflets and information provided from health care professionals.

"I read about it in books and leaflets and stuff and the midwife also said that you can smother babies on the settee...so I just feed him upstairs in bed with me. I sit up in bed though, I don't lay down with him." (Participant W03)

It is important to note that although all the white British mothers acknowledged the dangers of sofa sharing they dismissed any dangers associated with feeding their babies during the night on arm chairs or propped up in bed. The majority of the white British mothers considered that, as they were not lying down, it would not be possible for them to fall asleep.

As previously discussed in Chapter 4 sofa sharing was not at all reported amongst the Pakistani mothers due to the social and cultural unacceptance of this practice. Participant P59, amongst several of the Pakistani mothers, told me *“The leaflets they give you say that you shouldn’t sleep on sofas with babies cos it’s dangerous but it’s just something the English do cos a respectful Asian woman just wouldn’t do that.”* The Pakistani mothers did not appear to relate to the SIDS guidelines in this instance and again felt the literature and advice directly related to the white British mothers.

6.5 Infant Sleep Environment

Regarding bedding used for infant sleep 17 of the white British mothers reported using sleeping bags, only 8 reported using sheets and blankets, and none of the white British mothers reported using infant pillows. In direct contrast only 4 of the Pakistani mothers reported using sleeping bags with 17 of the 21 Pakistani mothers reported using sheets or blankets and 11 reported using pillows for their infants’ bedding. The Pakistani mothers all seemed highly aware that the use of these infant pillows was not advised by the health professionals.

“When the midwife came to see me she took the pillow off me and said ‘she shouldn’t be having that, she shouldn’t have a pillow.’ They don’t even try to understand that it’s just tradition with us they just tell you not to use the pillow cos that’s what they’ve been told to tell us.” (Participant P54)

“They don’t think you should use a pillow but it’s just tradition and if I didn’t use one my mother-in-law would anyway. I just nod and agree for a quiet life and then do what I want anyway. I don’t think they really try to understand about our ways and what we think is important especially the bedding and that.” (Participant P66)

Although 11 of the Pakistani mothers I interviewed reported using pillows for their infants’ sleep I suggest that this figure could be higher in reality as I was aware that many of the Pakistani mothers sometimes did not admit using the pillows. As

mentioned previously Participant P55 told me *“most of the mothers probably won’t tell you that they have the pillow for their babies cos they get told not to use them.”* Therefore I was very aware that some of the mothers who stated that they did not use infant pillows may not have been telling me the truth due to the contentious feelings between themselves and health care professionals regarding this cultural practice. During one interview with a Pakistani mother she told me at one point in the interview that she did not use a pillow but later in the interview she mentioned the use of a pillow. When I asked her to clarify if she actually did use a pillow or not she said

“I know I said that I didn’t have one but, well it’s just the stuff we use and they are not like proper pillows...I suppose it’s just easier to say I don’t have one.” (Participant P67)

Indeed, several of the Pakistani mothers I interviewed told me that they were told by health professionals not to use the pillows for their infants but they did use them anyway.

“Even if they tell you not to use them, the mothers still use them anyway. I mean, they aren’t there 24/7 so the mothers just say they don’t use them and when they’re gone they get them back out. It’s daft really but it just saves the hassle.” (Participant P55)

6.6 Infant Sleep Position

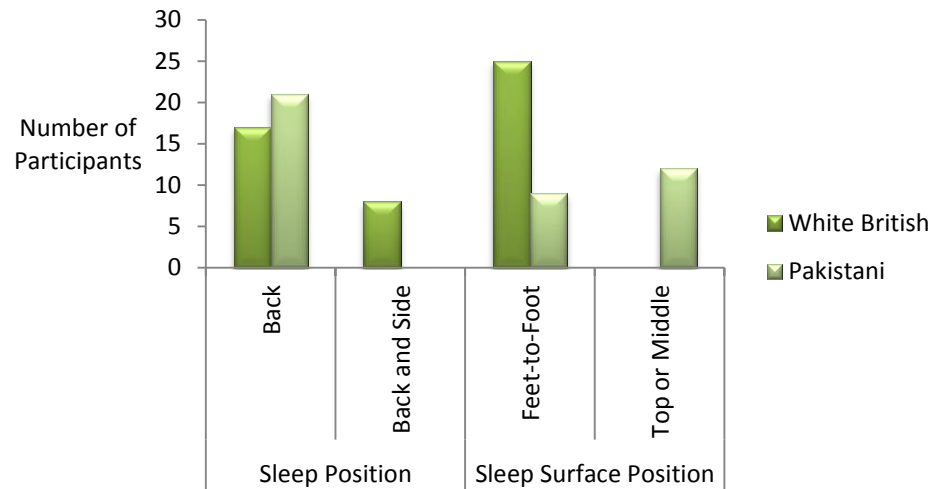


Figure 5

Graph displaying infant sleep position and sleep surface position amongst the white British and Pakistani participants

As displayed in Figure 5, of the 25 white British mothers interviewed, 17 reported that their babies slept in the recommended supine sleeping position with the remaining 8 reporting that their babies slept on both their back and side. However, all the white British mothers stated that they did place their babies down to sleep supine but that their babies turned onto their sides during sleep. The white British mothers did not perceive the side sleeping position as hazardous as they believed that their babies could not roll into the prone position during sleep.

"I put him down on his back and he'll turn to his side but he can't turn fully over so he's ok." (Participant W01)

"I always put her down on her back, yeah, but she gets on her side. It's ok though cos she can't turn fully over yet onto her tummy. I think she just likes getting on her side and that's ok, isn't it? I mean she's too little yet to be able to get herself right over onto her tummy." (Participant W24)

All 25 of the white British mothers reported that they placed their infants in the recommended 'feet to foot' sleep position. All the white British mothers stated how they were fully aware of the advice and guidelines for placing their infants 'feet to foot' to avoid their babies wriggling under the bed covers and perhaps suffocating.

All 21 of the Pakistani mothers reported that their babies slept in the recommended supine sleeping position which may possibly be more to do with the use of infant pillows rather than the actual advice presented to them; none of the mothers expressed that they placed their infant supine because of advice they received from health professionals. Only 9 of the 21 Pakistani mothers stated that they placed their babies in the recommended 'feet to foot' position; 12 reported that they placed their infants at the top or middle of the sleep surface. When I questioned the mothers about this I could not conclusively establish why they did not place their infants in the 'feet to foot' position. I would suggest that they tend to place their infants in the middle or at the top of the sleep surface due to the use of the infant pillows. A couple of the Pakistani mothers, however, did express their knowledge of the recommended infant sleep position and provided evidence that the use of the Asian infant pillows dictated their babies' sleep surface position.

"Of course I'm aware of all the help and advice but we use certain bedding for our babies and it isn't really easy to put our babies right at the bottom of the cot. To be honest with you I think they know about what we use but just don't mention it. I mean the pictures they use don't show what we use so it's not really easy to suss out. It's more for the English mums anyway as Asian mothers always put their babies on their backs so we don't need to be told that either." (Participant P56)

When asked many of the Pakistani mothers stated that they were not very interested in, or fully aware of, the SIDS advice regarding infant sleep position. They once again narrated feelings and opinions that this particular information did not relate to them or their Pakistani community.

“I’ve seen the advice about position and that but I think it’s meant more for the English mums cos we always put our babies on their backs. The ‘feet to foot’ thing, well I don’t really understand that. Is it to stop the baby getting under the covers or something? Yeah that’s the advice but I think it’s more for the English mums really.” (Participant P67)

As discussed in Chapter 4 (Section 4.4) the Pakistani mothers told me that using infant pillows would not enable their babies to wriggle down the cot under their covers and therefore they felt that the ‘feet-to-foot’ advice was not specifically for them.

“I think the ‘feet-to-foot’ thing is for the English mothers really cos they don’t use the pillows like us. Maybe it’s for all mothers who don’t use pillows for their babies cos then their babies can wriggle down under the blankets but using the pillow helps to keep her from doing that, getting covered by the sheets I mean. Maybe they should all use a pillow instead of trying to get us not to use them.” (Participant P54)

“I can’t put the pillow in middle really, can I? Putting a baby with their feet at bottom would be weird cos the pillow wouldn’t be at top. I know the English worry about their babies getting under covers but if you use one of these pillows then the baby can’t do that, I mean the pillow helps to keep your baby from doing that, yeah.” (Participant P51)

6.7 Infant Temperature Concerns

As presented and discussed in Chapter 4 23 of the 25 white British mothers expressed their concerns regarding their babies becoming too hot whilst the remaining 2 mothers stated they were concerned about both hot and cold. Contrastingly none of the 21 Pakistani mothers I interviewed expressed concerns regarding their babies becoming too hot; 14 stated they were concerned about their babies being cold and 7 were concerned about both hot and cold.

When I questioned the white British mothers regarding temperature concerns they expressed their knowledge of the SIDS guidelines and advice regarding the dangers of babies overheating.

“I read in some of the stuff you get from the hospital that it can cause cot death, or they think it can, and I would be more worried about that than a cold as a cold won’t kill him. I’ve also seen it in some of the books about pregnancy and birth. They’ve got bits in their about cot death and how to avoid it so I take notice of that. They always say about your baby getting too hot and never really go on about being cold.” (Participant W04)

“I don’t think he’s ever too cold but I do worry about him getting too hot cos that’s dangerous and can cause cot death.” (Participant W13)

Upon questioning the Pakistani mothers regarding infant temperature concerns they also expressed their knowledge of the SIDS advice guidelines regarding the dangers of babies overheating. However, once again this factor was interpreted as not being applicable to them.

“I don’t think the Pakistani mothers worry about the hot like the English do cos that’s always in the leaflets and stuff cos of cot death and that. They don’t ever mention anything about how being cold can make you poorly as well though do they? I suppose it’s all more for the English.” (Participant P56)

“My mum says that the English worry about their babies getting too warm all time and she says it’s not right cos they can’t get too hot. She’s had 6 of us and she knows.” (Participant P63)

One of the Pakistani mothers who was concerned with her baby being both too hot or too cold, told me

“The doctor said to me ‘a hot baby is a dead baby.’ He’s an Asian doctor as well and he said that! So I get worried about both. I worry about her getting hot or cold cos of that, cos of what he told me.” (Participant P54)

I found this statement from Participant P54 very interesting as it appears that she was only worried about her baby being hot because it was an *Asian* doctor who discussed the dangers of babies overheating. Unfortunately, this comment was not questioned further during the actual interview as the mother was in the midst of quite a long narrative. I did not want to stop her from expressing her opinions at the time and frustratingly forgot to pursue this issue with her during the interview.

6.8 General Knowledge of Infant Care

I asked all the mothers in this study who they turned to for infant care advice and the vast majority of the white British mothers would state that they most often would ask their own mothers.

“My mam is really good cos she’s had 3 herself. She knew I needed to bottle feed her cos she weren’t getting enough and she were right. My mam says I can also give her solids earlier than what they tell you. Don’t tell anyone that though, I mean my mam said she gave us baby rice when we were only 6 weeks old and we’re all still here.” (Participant W07)

Although nearly all the white British mothers reported that they would often ask their own mothers for advice regarding their babies several of the white British mothers expressed feelings such as Participant W14 *“My mam didn’t know some of the stuff we got given in leaflets and that so I definitely would take the health visitors advice over my mam’s cos they know all the right things cos they’ve trained.”* However, many of the white British mothers told me how difficult it was to try and get professional advice from their midwives or health visitors.

“The health visitor is there if I needed to ring about anything but they’re so short staffed here in Bradford and she don’t come round at all now so I would probably have to ask my mam.” (Participant W11)

“It’s real difficult round here to get to see your health visitor. They haven’t got enough staff here in Bradford and it’s just lucky I’m alright and my mam’s great cos she’s had 3 of us.” (Participant W20)

All of the 21 Pakistani mothers I interviewed told me that they took their infant care advice directly from female relatives. Some of the Pakistani mothers told me they took infant care advice from their mothers as Participant P53 *“My mam really, cos I’m one of 5 and she’s really good.”* However, the vast majority of the Pakistani mothers I interviewed told me that they took infant care advice mostly from their mothers-in-law for similar reasons.

“I suppose my mother-in-law really and my sisters-in-law. I were born in Pakistan you see so my mother were not here in Bradford. I come to live with my in-laws back then and I suppose most of the stuff I’ve learnt was from my mother-in-law. (Participant P59)

“My mother-in-law for everything really, she’s had 7 so she knows everything.” (Participant P61)

“I’d say my mother-in-law probably cos we stayed there when I had my first and I think I picked up a lot of stuff from her.” (Participant P67)

“I really did get most of the stuff I know about babies from my mother-in-law cos we lived with her then and you respect your in-laws. Anyway she really is good and knows everything about babies and that.” (Participant P60)

I asked the Pakistani mothers to explain to me how important they considered the advice from their mothers-in-law was compared to their health visitors or midwives and again the vast majority of the mothers gave me similar responses.

“My mother-in-law probably cos she has him a lot and she’s had 5 of her own and so knows how to do things. Sometimes the health visitor says one thing and my mother-in-law says another. I know they both mean well but it’s hard not to take my mother-in-law’s advice cos she’s here all time and she’d know if I didn’t do something she said.” (Participant P66)

“Mostly my mother-in-law. I take what the health visitor says, yeah, but they only see you now and then and my mother-in-law is always there so I think that I learnt most stuff from her, yeah. When I came to Bradford my mother in Pakistan said to me ‘don’t be disrespectful and listen and learn’...so I respect my mother-in-law always.” (Participant P68)

Participant P70 explained why mothers-in-law are so important to the Pakistani mothers and told me

“Asian mothers do what they’re told, follow what their mothers-in-law do. It’s impossible not to when you have to live around your in-laws all time and you’re not near your own mother. You get taught to respect at all times and that is really important in an Asian family even if you don’t always agree you have to respect, yeah. It’s practically impossible to not do what your mother-in-law says cos she’s with you all time.”

Even the Pakistani mothers who thought of themselves as more ‘modern’ did not really feel that they could get the advice they needed from the health care professionals.

“I would ask my mam first to see what she thought. The health visitor has only been here once and she’s young and I don’t think she’s had any children

so it's all just text book talk with her. When she came she just talked through a list of do's and don'ts. Would you ask a woman advice who never had kids? I have her number if I wanted to speak with her but I don't think I would. I have a big family and many babies so I would rather talk with my mam or my sisters.” (Participant P56)

It was very interesting to note from several of the interviews conducted with the Pakistani mothers that they did not take as much notice of the SIDS advice leaflets that were provided during their pregnancies as the white British mothers. Many of the Pakistani mothers I interviewed felt that the SIDS information was not targeted towards their community and they feel the advice is directly targeted to the white British mothers. Their reasoning for this opinion was the advice not to smoke cigarettes or consume alcohol and the emphasis on sofa sharing. They consider that if the advice was for them these factors would be more acknowledged and understood within their own social and cultural contexts. The general consensus from the Pakistani mothers was that they felt they could not relate to the SIDS advice.

“The leaflets you get say that you shouldn't sleep on sofas with babies cos it's dangerous but it's just something the English do cos a respectful Asian woman just wouldn't do that. They go on about cigarettes and alcohol as well and an Asian woman don't do that either so these leaflets aren't really meant for us.” (Participant P53)

“The pictures they use don't look like we look after our babies anyway and some of the stuff they say doesn't make sense. I think they are meant more for the English mothers as they show all the stuff they use and they go on about stuff the English do. I think we must be doing stuff ok and it's just the English women doing it all wrong like smoking and that.” (Participant P51)

6.9 Discussion

All of the Pakistani mothers did not smoke or consume alcohol due to social and cultural unacceptance and religious prohibition. Multiple studies (Hilder, 1994; James *et al*, 2003; Fleming and Blair, 2007; Phillips *et al*, 2011) have confirmed an association with maternal smoking and alcohol consumption with SIDS and several of the white British mothers acknowledged that they were aware that smoking and alcohol were risk factors for SIDS. However, they justified their persistence in either smoking or drinking alcohol giving very similar reasons. There were 3 white British mothers who reported smoking but justified their persistence in smoking as they thought that their babies were safe as they did not smoke in the same room as their infants. Of the 15 white British mothers who reported alcohol consumption they justified this as they felt that they only drank at weekends and/or on special occasions, and as they did not get 'drunk', they felt their babies were not at any risk. Similar justifications were given by the white British mothers in relation to paternal smoking and alcohol consumption. This discovery of the white British mothers' attitudes to alcohol consumption is disconcerting as they did not seem to acknowledge that even a small amount of alcohol could cloud their infant care judgements and decisions. Furthermore, and quite significantly, many of the white British mothers stated how they associated smoking and alcohol consumption as risk factors for SIDS only if you breast fed or bed shared with your infant; this assumption seemed to have developed from misinterpretation of the SIDS advice leaflets and literature in some way.

There has been mounting evidence that infants who sleep near their parents will have a reduced risk of SIDS, possibly due to increased arousals (McKenna *et al*, 1993; Mitchell and Thompson, 1995; Byard, 2004). One of the SIDS advice guidelines is to keep babies in the parental bedroom until they reach 6 months of age. The BradICS quantitative study discovered almost a quarter of the white British infants were sleeping in a room on their own compared to fewer than 2% of the Pakistani infants (Ball *et al*, 2011). The vast majority of the Pakistani mothers I interviewed kept their infants close by for both night time sleep and day time naps. Nearly all the Pakistani

mothers said how they preferred to keep their babies with them (or at least in the same room) for sleep and did not express any intent or desire for their infants to sleep independently. The 2 self-acclaimed 'modern' Pakistani mothers who did place their infants in separate rooms for day time naps are perhaps displaying assimilation to Western infant care practices in respect of solitary infant sleep. However, this was the only time that evidence of assimilation was noted throughout all the interviews with the Pakistani mothers. Nevertheless, this small indication of assimilation should be noted and could highlight how maybe assimilation regarding infant care is occurring but is taking a relatively longer time to happen. However, keeping their babies in the parental bedroom until they reached 6 months of age was dismissed by many of the white British mothers as they stated how they just did not want to do this. Many of the white British mothers had already placed their infants in their own bedrooms for night time sleep and several more of the white British mothers reported their intent to place their infants in their own bedrooms before they were 6 months old. In addition the white British mothers placed their infants in separate rooms for day time naps and thus the practice of solitary sleep both at night and during the day appeared to be a normal infant care practice. The values regarding privacy and independence held by the white British mothers appeared to outweigh the risks of SIDS. The majority of the white British mothers were using baby intercom systems and they did not feel that their babies were 'truly alone' and therefore safe. Farooqi *et al* (1993) studied ethnic differences in infant care practices in relation to SIDS and concluded that separate bedrooms may be contributing to SIDS. It should also be considered important that mothers need to be made more aware that supervising their babies during day time naps is equally as important as supervising night time sleep (Blair, Ward Platt *et al*, 2006).

Several of the Pakistani mothers reported exclusive bed sharing during night time sleep with their infant and several other Pakistani mothers reported they bed shared with their infant during the night to facilitate feeding. Ball *et al* (2012) highlighted how Pakistani infants were significantly less likely to ever sofa share. Indeed I discovered that the Pakistani mothers did not report ever sofa sharing with their infants and explained that this was due to the fact this practice was viewed as

socially or culturally unacceptable. I was told that a Pakistani woman would not lie down on communal seating areas either in the night or during the day as this was viewed as a sign of illness or laziness. Blair (2008) suggests that there is no specific advice to parents on how to feed their babies safely during the night apart from the recommendations to avoid bed sharing or sofa sharing. This is an important omission as this limits the choices for mothers of where to feed their babies in the night safely. Many of the white British mothers in this study narrated how they avoided bed sharing and sofa sharing and would prop themselves up in bed or use chairs to feed their infants in the night. Even though the SIDS advice guidelines includes the avoidance of arm chairs as well as sofas for infant night time feeding the mothers gave reasons for dismissing this aspect of the SIDS advice as they felt that they would not fall asleep propped up in bed or sitting on a chair whilst feeding their babies. They expressed opinions that if they were not lying down then they could not fall asleep and held beliefs such as 'that happens to other people – not me.'

The SIDS guidelines state how the infants sleep environment is an important location for SIDS risk factors; the use of certain bedding, infant toys etc. have been identified as modifiable risk factors. All the white British mothers seemed highly aware of the dangers within their babies sleeping environment and the majority did not use pillows or blankets but preferred to use baby sleeping bags for their infants night time sleep. In direct contrast the Pakistani mothers preferred using sheets and blankets and also 11 of the Pakistani mothers I interviewed reported using infant pillows. The Pakistani mothers were very much aware of the disapproval from the health care workers regarding the use of infant pillows but many of the mothers stated how they just told the midwives or health visitors that they did not use them when they actually did. The use of infant pillows and bedding provided for Asian infants seems to be a highly valued cultural tradition and not one of the Pakistani mothers I interviewed envisaged any harm or danger for their babies by using these infant pillows.

All of the white British mothers stated their knowledge of the recommended supine infant sleep position and the 'feet-to-foot' sleep surface position and followed these recommendations. However, it was narrated from several of the mothers that, even though they placed their infants supine for sleep, they believed their babies often rolled onto their sides during sleep. The mothers who reported the side sleep position were unaware of the instability of this position and were of the opinion that their babies were not capable of rolling fully over into the more hazardous prone position. Studies from England (Fleming *et al*, 1996) and New Zealand (Mitchell and Scragg, 1994) have shown that the side sleeping position is unstable and has a risk for infants to roll into the prone position. The instability of the side sleep position in infants is an important consideration that these mothers should be more aware of as their infants could possibly roll into the prone sleep position and this possibility should not be dismissed. All the Pakistani mothers reported placing their infants in the recommended supine sleeping position although the majority did not place their infants in the recommended 'feet-to-foot' sleep surface position. It was evident that the Pakistani mothers did not place their infants supine due to the recommendations; rather it was due to the use of the Asian infant pillows. The use of the infant pillows, similarly, was the reason that the Pakistani mothers did not adopt the 'feet-to-foot' sleep surface position; to utilise the infant pillow they placed their infants at either the top or middle of the sleep surface.

All of the white British mothers were aware of the SIDS advice regarding infants overheating and stated how they were more concerned about their babies becoming too hot directly due to the fear of SIDS. All of the white British mothers used temperature monitors for reassurances regarding temperature for their infants in direct contrast to the Pakistani mothers who all reported that they did not use temperature monitors for their babies. The Pakistani mothers were not concerned regarding their babies overheating and were more concerned with their babies being too cold, although several of the Pakistani mothers did state they were concerned about their babies becoming both too hot or too cold. An important discovery during one of the interviews with a Pakistani mother was that she acquired a concern for her baby becoming too hot from a comment made by an

Asian doctor. Could it be possible that advice from 'Asian' health care professionals, or at the very least leaflets designed from an *Asian* perspective, prove to have a more positive impact on Pakistani mothers? Unfortunately, however as I stated, this discovery was not fully appreciated until after the interviewing process and was not pursued further. Watson *et al* (1998) studied the use of bedding and found that cultural factors regarding temperature influenced infant thermal environments and they found that Asian infants were cared for in an unnecessarily warm environment; this factor does not help in trying to explain the relatively low SIDS rates in Asian communities.

Aslam *et al* (2009) found that there was significantly less knowledge of SIDS risk factors in migrant Asian mothers (from India) when compared with Australian-born mothers and this was not related to mothers' length of residency in Australia or their educational levels. Although my findings do not completely agree with their study I am in agreement with certain aspects they describe from mothers who justified why they may not acknowledge and follow the SIDS advice guidelines. For instance Aslam *et al* (2009) describes how the Asian mothers understood SIDS with the term 'cot death' and as they did not use a cot felt this was not applicable to them. I found that many of the mothers I interviewed stated how certain aspects of the guidelines were also not applicable to them. For instance the Pakistani mothers felt that, because of the importance given to smoking and alcohol consumption, the advice was targeted more towards the white British mothers. The Pakistani mothers also noted how pictures and diagrams within the literature did not depict their own social and cultural environments and therefore dismissed that the information was relevant to them. Tipene-Leach *et al* (2000) discusses valued infant care norms that inhibit changes known to reduce SIDS risks and I am in agreement with their argument that valued practices need recognition in order to make messages more effective.

One reason for dismissing or adapting the SIDS advice that was expressed by both the white British and Pakistani mothers was 'experience.' Several mothers I interviewed who were not first time mothers expressed how they believed that

because they had other children that they 'knew everything' and therefore were quite confident in deciding which aspects of the SIDS advice was important to them and either followed, adapted or dismissed the advice accordingly. The importance of the value of 'experience' in relation to infant care practices is evident amongst both the white British and the Pakistani mothers and as such the mothers often sought advice and reassurances from female relatives and friends who had reared their own families; rather than health care professionals. The majority of the mothers narrated in their interviews of how difficult they found it to approach health care workers for infant care advice. One of the reasons for this was the fact that they felt that their health visitor or midwife was not personally experienced as they did not have their own children. However, the main barrier that deterred them from contacting their health visitors etc. appeared to be their belief that the health care workers are short-staffed in Bradford.

6.10 Summary

The white British mothers generally appear to follow the advice and guidelines regarding infant care and SIDS such as the prone sleep position, 'feet-to-foot' sleep surface position, avoidance of bed sharing and sofa sharing, together with concerns regarding their babies becoming too hot. However, there are several aspects of the SIDS advice and guidelines that the mothers appear to dismiss such as smoking and alcohol consumption, feeding their babies at night on armchairs, not keeping their babies in the parental room until the recommended 6 months of age, and avoiding the practice of solitary infant sleep, especially during day time naps.

On the surface it appears that the Pakistani mothers are also following the SIDS advice but it was noted that sometimes this is purely coincidental. For example, Pakistani mothers do not smoke or drink alcohol due to social and cultural unacceptance and the religious prohibition on alcohol. In addition, keeping their infants close is a cultural norm for Pakistani mothers and sofa sharing is socially and culturally unacceptable and therefore does not appear to occur within the Pakistani community. Placing their infants supine for sleep is always practiced within the

Pakistani community and is most probably due to the fact that they use pillows for their infants because of their cultural value for a 'rounded' head shape. However, the Pakistani mothers dismiss certain aspects of the SIDS advice such as the recommended 'feet to foot' infant sleep position and this is mainly due to the use of infant pillows within the Pakistani community which dictates that mothers place their infants either at the top or middle of the sleep surface. Pakistani mothers are also not concerned with the issue of their infants overheating and state that they are more concerned if their babies become too cold which has been demonstrated to be a cultural belief regarding heat and cold.

CHAPTER 7

DISCUSSION

This chapter is a discussion of the results of this research presented in Chapters 4, 5 and 6. I explore and discuss how the social and cultural ecology and the perceptions of motherhood and infancy directly influence notions of 'good mothering' and how this is represented among white British and Pakistani mothers in Bradford. In addition I discuss the differing aspects of infant care discovered in this study between the white British and Pakistani mothers utilising an evolutionary perspective. I propose and present two models of infant care which encompass the values, beliefs, opinions and practices of the Pakistani and white British mothers in this study; these encapsulate the notion of 'good mothering' and 'appropriate infant care' for these two different groups. I revisit the main aim of this study outlined in Chapter 1 and discuss how the findings from this qualitative investigation address these aims. In addition I acknowledge and discuss the limitations of this study and suggest considerations for future research. Finally I present a reflexive account of the research process including reflexivity, methods and techniques, and researcher and participant interactions.

As presented and discussed in Chapters 4 and 5, the social and cultural ecology and the perceptions of motherhood and infancy directly or indirectly influence decisions regarding how the mothers care for their infants. Humans inhabit a huge variation of environments around the world and as such human behaviours tend to vary also. However, as Nettle (2009) suggests there are certain aspects of human behaviour that is evoked through 'transmitted culture' which are an outcome of tradition and may persist for long periods even when the environment changes. This 'transmitted culture' is evident amongst the Pakistani families I visited in Bradford and especially in relation to aspects of infant care; for example, the cultural tradition of the use of infant pillows and the cultural perceptions regarding infant temperature. Research into the risks (or benefits) in the use of the specific infant pillows used by Pakistani

mothers in Bradford is non-existent and therefore attempting to inform Pakistani mothers that infant pillow use is a risk factor for SIDS has, to date, no scientific basis. It is considered that the use of infant pillows amongst Pakistani families in Bradford is an important aspect of their infant care and I suggest that it may be possible that these pillows are not a risk factor for SIDS as many of the health care professionals advocate. The specific infant pillows used by the Pakistani mothers are considerably different in composition and structure (see Figure 2 in Chapter 4) to common adult pillows. It is proposed that attempting to eradicate the use of these infant pillows under the guise of them being a risk factor for SIDS without scientific research is unsatisfactory.

Abel *et al* (2001) conducted a cross cultural qualitative study on infant care practices in New Zealand and discovered a substantial involvement of female kin in infant care advice and practices in the Pacific and Maori populations which maintain continuity of many beliefs and practices of infant care. Indeed the British Pakistani social and cultural ecology in Bradford is an important factor which facilitates the maintenance of traditions, values and beliefs regarding motherhood and infancy. Kinship is hugely important amongst the Pakistani community in Bradford with constant contact between close and extended family members across the generations. The elder generations are viewed with a great deal of respect in Pakistani societies and as such the younger generations are often influenced by their knowledge and experience which maintains the effect of 'transmitted culture.' This aspect of the Pakistani social and cultural ecology is especially true amongst Pakistani female kinship networks in Bradford regarding motherhood, infancy and infant care practices. Western health care professionals advise several infant care practices that directly clash with the advice given to Pakistani mothers from their female kin. For instance, health care workers advise Pakistani mothers to refrain from bed-sharing and not to use infant pillows; as evident from my qualitative interviews with the Pakistani mothers' bed sharing and the use of infant pillows is recommended and supported by their female family members. It is also evident from my interview data that the Pakistani mothers in this study tend to dismiss the advice from health care workers and follow their mothers' or mothers-in-laws' practices in infant care. It is suggested

that it is vital that health care advice should therefore acknowledge this factor and include the extended kin networks in infant care advice for such communities (Abel *et al*, 2001).

The white British mothers also exhibited values and beliefs that are an outcome of 'transmitted culture' such as believing their babies would sleep better through the night after being bathed or being formula fed (as opposed to being breast fed). The white British mothers narrated to me that these beliefs were an acknowledgement of their own mothers' beliefs regarding infant care. However, due to the fact that many white British mothers do not socialise daily with their female family members, there were many external influences that the white British mothers absorbed which may undermine the acceptance and continuation of certain infant care practices. For white British mothers external influences are inevitable due to their solitary environment and not having a network of family and friends close at hand to facilitate 'transmitted culture' in relation to infant care advice and practices. The white British social and cultural 'norm' is the nuclear family unit; other close and extended family members do not often live within the same communities. Therefore, white British mothers do not constantly socialise and gain knowledge and experience from their elder female relatives regarding motherhood, infancy and infant care practices. Abel *et al* (2001) states how 'nuclear' family units in New Zealand experience less family support and advice and therefore rely on professional advice which adhere to Western biomedical understandings of infant health and well-being. Hence, it is logical to assume that white British mothers may be much more directly influenced by society's external perceptions, values and beliefs regarding motherhood and infancy.

The parental investment theory addresses the ways in which parents balance the need to invest in an infant while ensuring that such an investment does not unduly threaten their own survival. All the mothers invested in their offspring but modulated their investment differently which has implications related to different risks. Indeed, as Ball and Panter-Brick (2011) state, infant care behaviours are correlated with a large number of socio-ecological variables and perceptions of

'good mothering' are a cultural manifestation of the different ways in which parental investment is apportioned in different social and cultural ecologies. McDade (2001) highlights the relevance of social environments and how extended kin networks provide support for mothers by relieving them of their usual infant care, domestic chores and economic obligations. The social and cultural environment is quite different between white British and Pakistani mothers; white British mothers are usually alone with their babies for the majority of the day whilst the Pakistani mothers are usually surrounded by many other female family members. Therefore, as a result Pakistani families utilise alloparenting for their day-to-day infant care which reduces the parental investment burden of the mother. Again, in this regard, I agree with Abel *et al* (2001) that Western health advice should acknowledge and appreciate the importance of the extended family networks.

The white British families solve the parent-infant conflict by reducing their parental investment via the use of current technologies and promoting longer periods of sleep to reduce active infant caregiving. The white British mothers in this study embraced current technology for assisting in their day-to-day infant care such as infant temperature monitors, baby intercom systems and infant toys whereas these products were seldom utilised by the Pakistani mothers. It would seem that possessing and utilising current technologies is part of being a 'good mother' for white British mothers in comparison to Pakistani mothers who feel that being surrounded by allomothers and following the lead of their mothers or mothers-in-law is being a 'good mother.' Both represent strategies for infant care that aim to reduce the investment burden on the mother by interpersonal or technological means.

The use of current technologies or man-made products has been documented by Liu *et al* (2007) and has been termed CHNS (Coupled Human and Natural Systems). Liu *et al* (2007:640) state "many human-nature interactions occur indirectly due to the production and use of human-made products" and "these products insulate humans from the natural environment, leading them to perceive less dependence on natural systems." The white British mothers' confidence in relying on these current

technologies may be providing them with a false sense of security as the baby intercom systems only alert mothers to possible audio distress from an infant and cannot alert mothers to possible inaudible distress that infants may encounter during solitary sleep scenarios. The white British mothers' reliance on present-day technology is a direct result of the solitary motherhood they experience with little or no assistance from friends or family members. This was in direct contrast to the communal motherhood experienced amongst the Pakistani mothers I interviewed who almost always had female friends and family members around them for most of the day. Furthermore, Klonoff-Cohen and Edelstein (1995) found in their study that parents who had bed shared with their babies were much less likely to use baby intercom monitors for both day time and night time sleep. This is interesting as it would appear from my findings that indeed this is the case and could be related to values of independence and interdependence in infancy; the white British mothers were often alone most of the day and valued independence in their infants in contrast to the Pakistani mothers who had a constant family network around for most of the day and valued interdependence in their infants. The white British and Pakistani mothers display different models and notions of what it means to be a 'good mother.' It is evident that being a 'good mother' for white British mothers is raising independent children and for Pakistani mothers raising interdependent children.

In infant development, cultures vary substantially regarding autonomy and differ with the emphasis they place on either independent or interdependent values. Keller *et al* (2005) describes how human existence can be viewed through social and cultural emphasis placed on either agency or communion; agency as individual autonomy and communion as cooperative and harmonious relations with others. Attributes associated with interdependence and communion is respecting ones elders (Dosanjh and Ghuman, 1996) and this interdependent/communion value is highly evident amongst the Pakistani families in Bradford. The Pakistani mothers did not seem concerned regarding being independent from their babies or of babies being independent from their mothers. In most Western societies emphasis is placed on infant independence and individual autonomy as indeed is evident

amongst the white British families in Bradford. The white British mothers I interviewed narrated how they expected and desired to be independent from their babies and also narrated how they desired and intended to instil independence in their infants.

The independence/interdependence dichotomy is quite evident in the practice of infant sleep. The majority of the white British mothers I interviewed often left their babies in a solitary environment, either playing or sleeping and narrated their belief and value of independence. The Pakistani infants, on the other hand, were seldom alone either during the day or night as the Pakistani mothers appeared to value interdependence. The difference between the white British mothers and the Pakistani mothers with regard to leaving their infants in solitary environments was also, however, probably a direct consequence of solitary or communal motherhood together with their values of independence and interdependence. Throughout the majority of human history infant sleep has not been a solitary practice and infants have slept in the company of their mothers and other family members. Byard, Beal and Bourne (1994) conducted a study in Australia of infant death scenes that identified a variety of risky scenarios that caused accidental asphyxia in infants. They documented and concluded that a lack of supervision was a factor in each of the cases they reviewed.

I concluded through my interviews that all the Pakistani mothers did not perceive both smoking and alcohol consumption as socially and culturally acceptable and, although the majority of the white British mothers expressed an aversion to smoking, they did not express a similar aversion to alcohol consumption. This is important as several studies have highlighted parental alcohol consumption as a modifiable risk factor for SIDS (Blair *et al*, 1999; Alm *et al*, 2002) due to overlaying or accidental suffocation during co-sleeping or bed sharing (Blair, 2008). It seems that the white British mothers sanctioned maternal self-investment in smoking and alcohol consumption as a means to relax and minimise stress but made efforts to ameliorate risk to their infants by not smoking directly around their babies and consuming alcohol in reduced quantities and 'only' at weekends. Anderson *et al*

(2002) states that a mother's awareness of the dangers of smoking is not enough to overcome the stresses on mothers that drive them to smoke; mothers feel through smoking they can overcome potential risks associated with stress and anger. The fact that many of the white British mothers felt that by 'only' consuming alcohol at weekends alleviated risk to their babies is quite disconcerting as days of the week are much the same when caring for an infant and it appeared that somehow they did not fully acknowledge this fact. This may be related to notions of independence; the white British mothers feel that they 'need' or 'deserve' to be independent and 'have a break' away from their infants.

The advice not to bed share is not being adopted by the Pakistani mothers as they view this infant care practice with value and tradition. However, the Pakistani mothers do not practice sofa sharing as this is viewed as socially unacceptable within their culture. The advice not to bed share or sofa share has been widely acknowledged amongst the white British mothers in this study although by demonising these locations it appears that mothers are choosing alternative places to feed their infants during the night, for example arm chairs or propping themselves up in bed. The mothers do not seem to believe they can possibly fall asleep if sitting upright in an arm chair or propped up in bed. Therefore, as Blair *et al* (2009) suggests, the increased risk of unintentional suffocation in these circumstances needs to be reinforced and parents need to be advised against any location where they may fall asleep with their babies. The quantitative BradICS study suggests that bed sharing should not be discouraged as bed sharing is high but SIDS rates are low in Pakistani families (Ball *et al*, 2011; 2012). Therefore, as Baddock *et al* (2004) suggest, it may be more realistic to identify ways to make bed sharing safer rather than demonise this common and much valued infant care practice.

This study discovered that all the mothers placed their infants in the recommended supine sleep position although several of the white British mothers reported that they often found their infants in the side sleep position and it is suggested that the instability and dangers of the side sleeping position should be made more aware to mothers. The recommended 'feet to foot' infant sleep surface position was adopted

by all the white British mothers but not all the Pakistani mothers. The fact that many Pakistani mothers place their infants supine and at the top or middle of the infant sleep surface (as opposed to the recommended 'feet to foot') is a direct result of their value in utilising infant pillows. As Hutchison *et al* (2007) propose mothers may be negotiating fears regarding head deformation with SIDS safety issues.

In conducting this qualitative infant care study and understanding the social and cultural environments and values and beliefs that determine parents infant care I have highlighted how the Pakistani mothers are not always consciously following the recommendations and SIDS advice; rather their infant care practices are coinciding with the recommendations and SIDS advice. For instance FSID responded to Ball *et al* (2012) quantitative BradICS study with a statement that "Bradford's Pakistani community...follow FSID and department of Health's advice." However, it is evident from this qualitative research that the Pakistani mothers are practicing supine sleep, avoiding sofa sharing, avoiding cigarette smoking and alcohol consumption and avoiding solitary sleep as these are Pakistani infant care 'norms' and is viewed as what a 'good mother' does; not because they have acknowledged and adopted the SIDS advice and guidelines.

There are variations in parental investment strategies utilised in white British and Pakistani families which appear to be a direct result of the differing social and cultural ecologies. This, together with the values and beliefs of motherhood and infancy, affect infant care as it relates to SIDS reduction advice. It appears that if the SIDS risk reduction messages support the social and cultural standards of being a 'good mother' together with values and beliefs of infancy then they will be easy to adopt, however, if they do not then they may be resisted. For example, white British mothers resist keeping their infants in the parental bedroom for the first six months because they value privacy and independence and Pakistani mothers resist advice not to bed share and not to use infant pillows because they value interdependence and babies with rounded heads.

One of the most significant differences between the white British and Pakistani families regards communal/solitary motherhood and proximal/distal parenting. Overall, the Westernised infant care practices adopted by the majority of the white British mothers do not seem to be 'optimal infant care' when perceived through an evolutionary lens. White British mothers practice solitary motherhood and also strive for privacy and independence which has led to increased mother-infant separation which is not how human babies have biologically evolved to cope with. As Trevathan (2010:148) reminds us, "it is part of the human evolutionary legacy that infants 'expect' to be with their mothers at all times." In direct contrast to the white British mothers, Pakistani mothers practice communal motherhood for the majority of the day and evening and value connectedness and interdependence and therefore Pakistani infants have continued mother-infant contact or contact with close female relatives.

7.1 Summary of the Major Research Findings

The results of this research have highlighted the social and cultural ecology and the perceptions of motherhood and Infancy directly influence how the mothers mediate their parental investment and implement their infant care practices. Comparing and contrasting parenting strategies, infant care practices and values and beliefs regarding infancy between the white British and Pakistani mothers is presented in Table 6 below.

I have termed the two models in Table 6 'Model A' and 'Model B' for ease of reference. It appears that the Pakistani mothers generally follow 'Model A' of infant care whilst the white British mothers generally follow 'Model B' of infant care. However, it is recognised that these two models are simplifications of both infant care practices and perceptions of motherhood and infancy. It is acknowledged that some of the mothers in this study utilise or dismiss certain aspects of both these models.

<u>Model A</u>	<u>Model B</u>
Communal Motherhood	Solitary Motherhood
∞	∞
Proximal Parenting	Distal Parenting
∞	∞
Values of Interdependence in Infancy	Values of Independence in Infancy
∞	∞
Values of Connectedness	Values of Disconnectedness
∞	∞
Infant Led Care	Parent Led Care
∞	∞
Cooperative Infant Care	Competitive Infant Care
∞	∞
‘As and When’ Driven Values	‘Clock and Calendar’ Driven Values
∞	∞
No Rigid rules and expectations	Rigid rules and expectations
∞	∞
No specific urgency for completion of stages of development	Striving for completion of stages of development

Table 6
Models of Infant Care

Throughout human history it is known that aspects of motherhood and infant care have tended to follow the characteristics displayed under ‘Model A’. Human infants are born both vulnerable and highly dependent on their mothers or other caregivers and communal motherhood is beneficial to alleviate the stress of parental investment on a single mother; promoting proximal parenting, values of interdependence and connectedness. Due to this communal environment infant led and cooperative infant care is adopted with little effort and enables relaxed expectations and values regarding infant development.

Considering the characteristics displayed under ‘Model B’ it is suggested that many of the factors of motherhood and infant care are the result of adaptive parental decisions due to differing social environments and contemporary lifestyles. In many Western societies solitary motherhood is the ‘norm’ due to the fact that family members do not live within close proximity of each other. Families strive for personal privacy and separate sleeping spaces together with values of independence

and as a result there are extended periods of separation between mothers and their infants. The parental practices and beliefs described in 'Model B' are ways in which solitary mothers may be reducing their parental investment and this is not considered to be 'optimal care' for human babies (Small, 1998; Trevathan, 2010; Gettler and McKenna, 2011). It has been suggested that human infants may not be physically and psychologically able to accommodate the rapid shift in this contemporary infant care; this proposed incompatibility between evolved infant biology and contemporary infant care practices is termed the 'discordance hypothesis' (Trevathan, 2010; Gettler and McKenna, 2011). Considering the majority of our human evolutionary history, solitary motherhood is a relatively novel aspect of infant care and parental investment is not alleviated by the help of other caregivers in close proximity. A solitary human mother would have to adapt parental decisions regarding infant care to provide less stress to their parental investment. It would be beneficial to practice distal parenting promoting values of independence and disconnectedness. Solitary mothers would feel the need to implement parent led infant care, allocating time to carry out infant care together with time to allow the mother to ease the stress of their parental investment. Thus, rules, expectations and values for completion of infant development stages would seem desirable for such solitary mothers.

7.2 Addressing the Main Aim of this Study

As presented in Chapter 1 the main aim of this study is to provide an understanding of cultural variability in, and consequences of, infant care practices (plus associated attitudes and beliefs) which is crucial in:-

- a) Determining the need for public health interventions aimed at modifying aspects of infant care.
- b) Designing interventions appropriately targeted towards (and engaging with) multi-cultural populations.
- c) Contextualising health promotion and risk prevention strategies within the larger cultural milieu.

This qualitative study has identified that public health interventions regarding SIDS risks and advice to modify certain aspects of infant care are having limited effect on the mothers I interviewed in this study. It is evident from both the white British and Pakistani mothers that they resist adopting certain aspects of the advice depending on their personal social and cultural environments alongside their personal perceptions of motherhood and infancy. The Pakistani and white British mothers I interviewed are predominantly from inner-city locations and areas of high deprivation in Bradford and therefore differences in the effect of the SIDS advice on these two ethnic groups must be due to factors that are not specifically related to geographical or socio-economic issues.

The white British families are generally not following the advice regarding keeping infants in the parental bedroom until the recommended 6 months of age due to the desire for privacy and independence in infancy. The practice of infant solitary sleep is common in white British infants and mothers often rely on baby intercom systems to be alerted to any infant distress during sleep; they should be made more aware that distress in infants may also be inaudible. Furthermore, due to the fact that many white British mothers are trying to avoid bed sharing and sofa sharing, many mothers are adopting dangerous practices such as propping themselves up in bed and using arm chairs during the night. In addition white British parents are justifying smoking as they believe that if they do not smoke directly around their babies that there is no possible danger. They also are justifying alcohol consumption by only drinking at weekends or on special occasions with little acknowledgement that when caring for an infant even a small quantity of alcohol may impair their infant care decisions.

The Pakistani families are resisting the advice not to use infant pillows due to their cultural preference for a 'rounded' head shape in their babies. The use of infant pillows also appears to be determining that Pakistani infants are not being placed in the recommended 'feet-to-foot' sleep surface position as the pillows are often placed at the top of the infant sleep surface. However, it should be noted that the present advice of not to use infant pillows in the sleep environment has no scientific

basis in relation to the specific infant pillows used by Pakistani mothers in Bradford. In addition, due to cultural infant temperature concerns, Pakistani mothers are not concerned regarding their infants overheating and appear to be more concerned about their infants becoming too cold. The qualitative interviews revealed that the public health interventions may be more effective to Pakistani mothers if they are designed appropriately and targeted towards different cultural populations. The majority of the Pakistani mothers revealed how they felt that the SIDS advice and guidelines were specifically targeted towards the white British mothers due to specific aspects of the guidelines such as smoking and alcohol consumption. The Pakistani mothers related how the leaflets and visual images did not depict their own social and cultural environments and as a result they often did not relate and engage with the SIDS advice literature.

The interviews conducted in this study have also highlighted how the background and characteristics of health care professionals appears to have an impact on how infant care advice is received and acknowledged. The characteristics of ethnicity and age together with a health care professional's background (e.g. having children of their own) appear to play a significant role in how the mothers accept or dismiss the infant care advice. In addition the issue was raised in several of the interviews regarded the mothers' perceptions that health care workers in Bradford are 'short staffed' and thus they had very limited contact with their midwives and health visitors after giving birth. Therefore, many mothers are requesting and receiving infant care advice from family and friends; unless their infant has a physical illness and then they would visit their GP.

This study has highlighted how the SIDS intervention strategy adopted by health care professionals is having limited effect on both Pakistani and white British families in Bradford for several reasons. Research conducted with British Pakistani couples by Shaw (2011) illustrated a range of strategies of 'responsible parenting' and concluded that responses to risk information are formed by social situations and moral concerns. However, it is acknowledged that providing SIDS reduction advice is important and should be continued to be presented to all parents. It is suggested

that perhaps the SIDS advice, literature and leaflets should depict aspects of the multi-cultural contexts in which infant care is performed. Potter (2010) describes Beattie's Health Promotion Model (1991) which includes the recommendation to embody communities so that they recognise commonalities and their own particular social and cultural factors. Indeed, it is felt that the Pakistani mothers may consider the SIDS advice more readily if they perceived that the literature acknowledged their cultural infant care practices; an important inclusion would be the acknowledgement of the use of Asian infant pillows. At present the advice to not use these pillows given by health professionals to the Pakistani mothers has no scientific research behind it and therefore it cannot be expected that Pakistani mothers would acknowledge any risk associated with the use of these pillows. It is also suggested that health care professionals should be significantly more aware and understanding of how parental infant care decisions are mediated and performed amid differing social and cultural environments alongside an individual mother's perceptions of 'good mothering' and their expectations of infant development. It is also recommended that there should be an acknowledgement of the mothers' social network, which may be of more influence to parents regarding their day-to-day infant care, especially amongst the Pakistani families in Bradford.

It is acknowledged that both midwives and health visitors within Bradford simply do not have the time to engage satisfactorily and intimately with their targeted families. However, to make a difference in the acceptance and understanding of the advice and information delivered to parents there is a need for the professional health care workers to endeavour to form strong partnerships with their targeted audience adopting a more negotiated approach rather than promote infant health care as a detached 'expert' authoritative figure.

7.3 Limitations of this Study

One of the limitations of this study is the small sample size obtained; although for in-depth qualitative interviewing it is considered that the sample size obtained would achieve thematic saturation. This study is also limited due to the fact that only

English speaking participants were recruited to be interviewed. Another consideration is the method of qualitative interviewing and self-reporting; a major criticism is the chance that people being interviewed may say what they think they should rather than what they actually do in practice. The main limitation in this study is the fact that interview data and findings cannot be generalised to other multi-ethnic populations. However, it is felt that this research does highlight how valuable qualitative research is in the knowledge and understanding of infant care practices in relation to SIDS and that cultural difference in values, beliefs and practices have direct implications for the effective delivery of infant health advice.

7.4 Considerations for Future Research

This study has highlighted the importance of research into the social and cultural environments and underlying values and beliefs of parents regarding their infant care practices in relation to the SIDS reduction advice. It is considered important that all different ethnic communities, not just migrant societies, are studied to understand the mechanisms behind the dismissal, adoption or modification of the SIDS guidelines. It is proposed that research would be beneficial to understand how mothers are interpreting the SIDS advice as this study has highlighted how many of the white British mothers in Bradford believed that smoking and alcohol were only a risk if they bed shared with their infants or breast fed their babies.

The lack of research and literature into the use of infant pillows is a void that should be bridged. Therefore it is considered important that research should be conducted regarding the use of infant pillows in the Pakistani community and also different societies. The fact that health care professionals are informing the Pakistani families in Bradford that using these pillows is dangerous without proper scientific basis to these claims is totally unsatisfactory. The use of infant pillows is such a strong cultural tradition amongst the Pakistani families in Bradford and it would be most beneficial to acknowledge and understand this practice (together with evidence regarding the risks or benefits) rather than trying to simply eradicate their use.

7.5 Reflexive Account of the Research Process

Although this study is considered to be ‘anthropology at home’ the diversity of culture in this study has led to the discovery of unfamiliar aspects of infant care. A major concern I wrestled with during the research process was the problem of whether I uncritically accepted responses due to the fact that I was familiar with them. Consequently I believe that, as Davies (1999) advises, I adopted a heightened state of critical self-awareness which guarded against assumptions that particular perspectives and interpretations are shared. I consider it is imperative to acknowledge the epistemological orientation and personal influences of myself as a researcher and how this may affect all stages of the research process (Davies, 1999).

I followed advice advocated by Fontana and Frey (2005) and Bernard (2006) to take a little time at the outset of the interview to build some rapport with each of the interviewees. I initially asked the mothers about their experience of pregnancy and childbirth as I know from my own experience, and of friends and colleagues, that the majority of mothers really like to chat about these events. All the mothers seemed to really appreciate this enquiry and I gathered huge amounts of data relating to this topic which was not relevant to my study but still I felt this opening conversation was worth the effort as the interviews seemed to progress into a more natural conversation. Additionally, I did not want to over emphasize SIDS and begin the interviews with questions regarding their present infant care; I was concerned that the mothers may respond with information they thought they should in relation to infant care advice from health professionals. This technique, I believe, was really worth the effort and in addition to putting the mothers at ease I felt I had successfully distracted their attention and focus from the issue of SIDS.

Kvale (2007:49) states that as an interviewer I would be the “instrument” of my research and hence the information gleaned from my interviewees would be dependent on my success as an experienced, knowledgeable and understanding interviewer. This includes knowing when to listen and when to speak and not be too quick to fill awkward silences sometimes experienced within the conversation. I

often refrained from filling these silences and allowed the interviewees to reflect and perhaps elaborate on their responses. In this respect both Bernard (2006) and Bryman (2008) provide informative guidelines on how to deal with silences in interviews with recommendations on how to judge or confirm that the respondent has nothing more to add. This perhaps was the most difficult aspect of my interviews as the overwhelming urge to fill these silences with my own voice was frustratingly hard to suppress.

In evaluation of all 46 interviews I felt that the audio recording equipment was not a major issue. I consider that the interviewees expected this method of documentation and perhaps I would have not been perceived as professional without it. Once the interviews were underway the interviewees appeared unconscious of the recording equipment and showed no signs of uneasiness. In addition to providing an accurate account of the interview, recording is considered invaluable for researcher and subject interaction as it allowed me to be more attentive to my interviewees (Bryman, 2008). The freedom for interaction facilitated by audio recording the interviews allowed my concentration on exploration, elaboration and clarification of the responses. As mentioned previously, I decided not to be too pre-occupied with hand written notes as I felt this would detract from my ability to engage with my interviewees although I did write a reflective journal immediately after each interview. I did, nevertheless, take some hand written notes during the interviews as during my MA pilot study some of the interviewees unexpectedly enquired why I was not taking any notes which made me consider that perhaps note-taking during an interview may be expected and not necessarily a distraction. Indeed, on reflection, I believe that being able to take some brief notes during the interview process is beneficial and facilitated a record of non-verbal gestures (May, 2001). The reflective journal proved to be immensely useful and documented aspects of the interviews which I would otherwise have forgotten and really helped to contextualise the conversations recorded. The journal also proved to be invaluable during the analysis as re-reading this journal transported my mind back to the actual interview environment.

In agreement with May (2001), I felt that by conducting the interviews in the mothers' own homes, a more informal and friendly interview environment was created. The interviewees appeared relaxed and provided refreshments for the occasion and facilitated a more 'natural' venture as opposed to an 'official' inquisition. Although Davies (1999) cautions against interviewing within the subjects' own homes due to the possibility of other people being present and therefore impacting on the information given by the interviewee I still feel that, in this study, the benefits outweighed this possibility. However, during one of my interviews with a Pakistani mother her husband was present and during the interview seemed annoyed at my presence. Approximately 20 minutes into the interview he asked why I was asking all these "*stupid questions*" and said he would prefer if I stopped and leave their home. The participant still gave her consent for the interview to be used in this study although I did not gather a great deal of informative data from this interview.

During the interviews I was sensitive to the attitudes and opinions that I may provide to the interviewees in the way I framed certain lines of enquiry and also to my facial expressions and body language. I attempted to establish a neutral stance to encourage mothers to report their actual beliefs and opinions and not responses that they felt appropriate or moral together with revisiting the questions several times to triangulate responses. Overall the mothers I interviewed appeared to find the interviews as a positive experience and I believe this was a result of someone expressing a keen interest in their attitudes and opinions (Kvale, 2007). The interviewees appeared both eager and pleased to provide information and opinions regarding their babies and their daily infant care practices and routines.

Finally, I conducted further analysis, reflection and consideration of the context in which some of the Pakistani mothers I interviewed used the terms '*modern*' and '*traditional*' in their narrations (descriptive terms that were not used by the white British mothers). The Pakistani mothers often used the term '*traditional*' but never used the term '*modern*' in the context of infant care. They expressed values and beliefs of infant care advocated within their own social and cultural family networks

and often referred to these infant care practices as '*traditional*'. I concluded that the descriptive term '*modern*' was generally used to describe aspects of themselves and others in relation to education and employment and particularly with regard to clothing, cosmetics and hairstyles.

Malson *et al* (2002) conducted interviews with Pakistani and white British women in the UK and highlight that younger Pakistani women expressed 'shifting identities' in relation to the above mentioned factors. There is a growing amount of literature documenting these 'shifting identities' of the younger Pakistanis living in the UK and it appears that young British Pakistanis are developing their own identities through aspects of dress and appearance (Malson *et al*, 2002; Woollett *et al*, 2004; Hampshire *et al*, 2011). I am in agreement with Ballard (1994:31) who describes young British South Asians as "competent cultural navigators" with the ability to behave and engage in different cultural arenas; being comfortable in both their family and white peers' surroundings. As highlighted in this study infant care of the Pakistani mothers differed from the white British mothers' infant care and it is suggested that ethnic identity together with notions of tradition and the family play into these differences in complex ways.

CHAPTER 8

CONCLUSION

Many contemporary urban populations involve multi-ethnic communities such as Bradford and these populations will exhibit variations in behaviour, perceptions, values and beliefs. SIDS related infant care decisions are created amid parents' social and cultural ecologies together with competing perceptions of motherhood and infancy (Aslam *et al*, 2009). Trevathan (2010) highlights how all aspects of human life are determined by social and cultural contexts and an understanding of the social and cultural ideologies that influence parents' infant care practices will help to ensure that different ethnic groups receive the appropriate health care information and advice (Aslam *et al*, 2009). This research has highlighted that certain aspects of the SIDS advice is being adopted, dismissed or adapted by the white British and Pakistani mothers in this study. The white British mothers were often alone and without much needed support for the majority of the day and measures that reduce tiredness and stress, and provide help and support, are likely to succeed. Anderson *et al* (2002) states how studies have shown that improving social support for mothers is beneficial and may improve health and safety outcomes for infants. I uncovered how the majority of the Pakistani mothers I interviewed interpreted the SIDS advice as 'not relevant' or 'applicable' to them. Furthermore, it appeared that attempts by health care professionals to change the infant care practices of the Pakistani mothers was falling on 'deaf ears'; Pakistani mothers were being told not to bed share and use pillows for their infants but were ignoring this advice.

It is not enough to heighten awareness regarding SIDS risk factors; rather the advice and literature should be culturally appropriate in differing communities (Abel *et al*, 2001; McManus *et al*, 2010). There should be an acknowledgement, understanding and appreciation of variations in different ethnic groups by health care professionals (Bollini and Siem, 1995; Abel *et al*, 2001; Aslam *et al*, 2009; Bhopal, 2009; Ball and Volpe, 2012) and subsequently health care advice relating to SIDS risks should be

adapted accordingly. If researchers take the time to understand the drivers of mothering in these communities they could find ways to align health care messages with cultural beliefs that would support behaviour change rather than foster resistance. Health care policies which attempt to change cultural values and beliefs only challenge peoples' cultural identity and as such risk reduction advice is being dismissed as culturally irrelevant (Ball and Volpe, 2012). Infant health messages may be much more effective if they did not try to prevent certain behaviours and practices that are culturally valued but try to identify ways to promote infant health and safety in the specific infants' social and cultural environments.

APPENDICES

APPENDIX 1

Interview Key Topics and Themes

Check – Age, marital status, educational status, employment, household arrangements, smoking and alcohol

Start with enquiring about their pregnancy and birth

Could you talk me through a typical day in the life of you and your baby?

Feeding

- Did you breastfeed your baby and why or why not? If yes how long and why?
- When was any other introduced (formula, drinks, solids) and why? What does baby get now?
- Is baby fed at night? How often and in what way?

Baby's Night Sleep

- What surface does baby sleep on?
- What room does baby sleep in (alone or not)?
- What position is baby put to sleep in and what position does baby wake up in?
- What does baby sleep with-pillow, duvet, gro-bag, hat?
- Is baby swaddled at night?
- Is the heating on in baby's room (day and/or night)?
- Is window left open?

Bed Sharing or Sofa Sharing

- Does baby bed share with mother or anyone else?
- If yes, does baby sleep on or in the bed, edge or middle of bed, separate covers (how many layers), swaddled, anyone else in the bed?
- Does baby sofa share with mother or anyone else?

Baby's daytime naps

- What is the sleep environment of baby's daytime naps and why?

Day Care

- Who? When? How often?

Temperature

- More concerned about hot/cold/both/none and why? Room temperature monitor?

Dummy Use

- Does baby have a dummy? If so why, when and for how long? If not why?

Infant's bath time

- How is this practiced – where/when/how often/by whom etc?

Daily Interactions

- Play and Stimulations – where/when/how often/by whom etc?

Household arrangements! - are mothers being influenced by family members?

Have mothers knowingly departed from cultural norms? - Why or why not?

Establish how much attention mothers pay to health information - who do they listen to for advice?

APPENDIX 2

The NHS 2007 'Lone Working Policy'

- The researcher's supervisor will know where the planned dates/times of interviews and will have access to participants contact telephone number and address.
- On the day of the planned interview the researcher will confirm to supervisor that they will be attending the address provided and inform of any changes to times or location of the interview.
- The researcher should make contact with supervisor prior to entering and on leaving the participants house using a mobile phone which will be left switched on at all times.
- The researcher should be able to make direct telephone contact with the supervisor during the times of the scheduled interview.
- If the interview takes significantly longer than planned the researcher must make contact with supervisor to update plans and timescale.
- Whenever possible interviews must be arranged to take place within daylight hours.
- If on arrival at the participant home the researcher is faced with an unexpected situation that causes concern they should leave and make other arrangements.
- The researcher should never enter a house if they are suspicious.
- If a domestic pet or animal at the participants home presents a problem causing the researcher to feel unsure or unsafe the researcher should ask the participant to remove the pet from the room or leave and make alternate arrangements.
- If the researcher feels unsafe at any time they should withdraw and seek further advice/assistance.
- The researcher will be travelling by car to the interview venue. During the journey the car doors should be locked at all times (this will not prevent rescue teams gaining access to the car in case of emergency).
- The researcher should plan the travelling route beforehand to avoid getting lost or having to stop to check a map.
- Valuables in the car should be kept out of sight, preferably locked in the boot.
- The researcher should park in open, well-light places.
- If the researcher is approached in the car they should only open the window slightly to allow conversation. The researcher should only offer help if they are sure that the person is genuine and if possible remain in the car and get help using a mobile phone.
- When returning to the car the researcher should have the key ready to open the vehicle, enter quickly and lock the doors.
- The researcher should avoid walking in poorly lit areas or subways.
- If an incident occurs even if no injury is sustained, the incident must be reported to the researcher's supervisor, and an accident/incident form completed.

APPENDIX 3

Bradford Infant Care Study Participant Information Sheet

I would like to invite you to take part in the Bradford Infant Care Study. The study is totally voluntary and before you decide if you would like to take part in this research please take the time to read the following information. Please do not hesitate to ask if any of the information is not clear.

What is the purpose of the Bradford Infant Care Study?

Questionnaire information has already been gathered regarding infant care practices of 2-4 month old infants in Bradford. However, this information cannot tell us everything we need to know for our research in relation to cultural differences in infant care practices. Therefore I would like to arrange interviews with mothers of 2-4 month old infants of both white British and Pakistani origin who would be able to spare an hour of their time to talk to me. During the interviews I would like to hear about all aspects of mothers' individual infant care practices on a normal day-to-day basis. The main aims of gathering this information is to identify cultural differences in parents' priorities of infant care and the physical, social and cultural ways in which infant care practices are performed. This information will help in determining the need for public health interventions aimed at modifying aspects of infant care and designing interventions appropriately targeted towards (and engaging with) multi-cultural populations.

Who will carry out the research?

My name is Denise Crane and I am a PhD candidate and research student at Durham University and will be carrying out the interviews as part of my PhD qualification.

Why have I been invited to participate in this study?

You have been selected to take part in this research due to your participation in the 'Born in Bradford' study and that you will soon be the mother of a 2-4 month old infant. You will be participating in this study with approximately 50-60 other selected mothers of either white British or Pakistani origin in Bradford.

Do I have to take part?

No, this study is totally voluntary. I will describe the study and go through this information sheet with you and then it is entirely up to you to decide to participate in this research. If you agree to take part, I will then ask you to sign a consent form and provide your contact details. If you do decide to take part please be assured that you are free to withdraw from the study at any time without giving a reason and all personal information will be destroyed. This withdrawal would not affect your involvement with the 'Born in Bradford' study or your NHS care.

What will happen if I take part?

After you have provided your consent to participate and your contact details you will not be contacted further until your baby is between 2-4 months old. I will then contact you by telephone or email to ask if you would still be willing to be interviewed for this study. If at this time you are still willing to participate then I will arrange a mutually convenient time for the interview which should take approximately 1 hour of your time.

When and where will the interview take place?

A convenient time will be arranged for me to visit you at your home to carry out the interview. Alternatively, if you would prefer, a convenient time can be arranged to carry out the interview at the Bradford Royal Infirmary.

What will happen to the information I give in the interviews?

All Interviews will be audiotape recorded as this is the best way to gather accurate information but if you specifically do not wish this to happen please feel free to let me know prior to the interview. The audiotaped interview will then be transcribed for analysis and will be totally confidential using only participant study numbers. Written documents will not contain information that will enable you, or your infant, to be identified individually in any way. The interview data will be retained for the maximum of 3 years to allow adequate analysis and completion of the PhD qualification at which time all electronic and written interviews will be destroyed.

How will the research affect me?

Being involved in the Bradford Infant Care Study will in no way affect your involvement in the 'Born in Bradford' study or your NHS care. All information gained from this study is confidential, stored securely and we will not release any personal information we collect from this study to anyone or identify you or your baby in any scientific publications.

What shall I do now?

Please fill in the accompanying consent and contact information sheet and I will telephone or email you to ask if you would like to take part in this research when your baby is between 2-4 months old. At this time I will be happy to discuss the project further and answer any questions you may have. A face-to-face meeting to discuss the research prior to enrolment can also be arranged on request.

What shall I do if I don't hear from you?

There may be occasions where it is difficult to reach participants because I do not have up to date contact details. Therefore, if you are willing to take part in the study but have not been contacted by the time your baby is 4 months old then please contact me by telephone or email (details below).

Remember you do not have to take part in this study if you do not want to, and even if you enrol and then change your mind, you can withdraw at any time without giving a reason.

If you have any questions or comments about the Bradford Infant Care study feel free to contact me (details below). Or if you would like independent advice on taking part in research you can contact INVOLVE: website <http://www.invo.org.uk/> or telephone: 02380 651088.

Kind regards,

Denise Crane. Contact: Tel: 07775811048 or Email: denise.crane@durham.ac.uk

This research is sponsored and funded by



APPENDIX 4

Bradford Infant Care Study Participant Consent and Contact Details

I volunteer to participate in the Bradford Infant Care Study and understand that Denise Crane will contact me when my baby is 2-4 months old to arrange a mutually convenient time for the interview.

Born in Bradford ID Number:.....

Expected Date of Delivery:.....

Name:.....

Address:.....

.....

Telephone Home:.....

Telephone Mobile:.....

Email:.....

Signature:.....

Date:.....

APPENDIX 5

Bradford Infant Care Study Consent Form

PLEASE READ THIS FORM CAREFULLY. INITIAL THE BOXES AND PRINT AND SIGN YOUR NAME BELOW IF YOU ARE WILLING TO TAKE PART IN THIS STUDY.

I confirm that I have read the Participant Information Sheet Version 2 dated 17/08/2010 for the Bradford Infant Care Study and have been contacted by Denise Crane who has fully explained the research to me and answered my questions.

I understand that all information about myself and my baby will be kept confidential by Denise Crane and will not be released to anyone without my permission.

I understand that all the information I provide for the Bradford Infant Care Study will be stored securely at Durham University for up to 3 years until Denise Crane has completed the PhD qualification.

I understand that I and my baby will remain anonymous and will not be identified individually in any written reports.

I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Durham University and the Born in Bradford study, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I acknowledge that Denise Crane is legally obliged to disclose information regarding child abuse or child neglect.

I understand that my involvement in the 'Born in Bradford' study and my NHS care will not be affected in any way by my participation in this research.

I am willing to be interviewed for the Bradford Infant Care Study by Denise Crane.

I am fully aware that the interview will be audiotape recorded unless I raise objection.

I understand that the study is voluntary and that I can withdraw from the Bradford Infant Care Study at any time without giving a reason and without affecting my participation in the 'Born in Bradford' study and my NHS care.

Participant's Full Name (PLEASE PRINT).....

Participant's Signature.....

Researcher's Signature.....

Date.....

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East Yorkshire & North Lincolnshire Research Ethics Committee. If you have a concern about any aspect of this study, you can speak to Denise Crane who will do her best to answer your questions ([contact 07775811048](tel:07775811048) or [email denise.crane@durham.ac.uk](mailto:denise.crane@durham.ac.uk)). If you remain unhappy and wish to complain formally, you can do this by contacting The Bradford Institute for Health Research at The Bradford Royal Infirmary, contact telephone 01274 383430.

This research is sponsored and funded by



APPENDIX 6

Participant 'Thank You' Letter



Parent-Infant Sleep Lab
Ebsworth Building
Queen's Campus
University Boulevard
Cleveland
TS17 6BH

Tel:0191 334 0794
Mobile:07775811048

Email:denise.crane@durham.ac.uk

Dear

RE: BRADFORD INFANT CARE STUDY (BRADICS)

I am writing to thank you for providing your contact details at The Bradford Royal Infirmary in December, 2010 for inclusion in the above study. I hope you have had time to read the Participant Information Sheet which should provide all relevant details. However, if there is any further information you require please do not hesitate to contact me.

Your participation in this research when your baby is between 2-4 months old will be immensely valuable to our understanding of infant care practices in Bradford. You will be helping to determine the care and advice given to mothers and their babies in the future in all aspects of infant care. Without mothers like yourself it would be impossible to carry out studies that provide future generations with life-saving and health enhancing information.

I once again thank you for providing your contact details and I look forward to speaking with you when your baby is between 2-4 months old.

Kindest Regards,

Denise Crane BSc, MA.
PhD Researcher in Medical Anthropology



APPENDIX 7

Participant 'Up-date Contact Details' Letter



Parent-Infant Sleep Lab
Ebsworth Building
Queen's Campus
University Boulevard
Cleveland
TS17 6BH

Tel:0191 334 0794

Mobile:07775811048

Email:denise.crane@durham.ac.uk

Dear

RE: BORN IN BRADFORD STUDY (BiB) and BRADFORD INFANT CARE STUDY (BRADICS)

I am writing to thank you for providing your contact details at The Bradford Royal Infirmary in December, 2010 for inclusion in the above studies and I have recently tried contacting you with regard to the BradICS study to arrange a mutually convenient time for an interview. However, it seems as if I and the BiB office may have the wrong contact details for you and I am writing today to request if you would be willing to update your present contact details.

I hope you have had time to read the BiB Participant Information Package and BradICS Participant Information Sheet which should provide all relevant details. However, if there is any further information you require please do not hesitate to contact me or the BiB team. Your participation in these studies will be immensely valuable to our understanding of infant health and wellbeing, and infant care practices in Bradford. You will be helping to determine the care and advice given to mothers and their babies in the future in all aspects of infant care. Without mothers like yourself it would be impossible to carry out studies that provide future generations with life-saving and health enhancing information.

You may decide that you would prefer to not continue being a participant in either of these studies and as such your details will be withdrawn or you may prefer to just participate in the BiB study which is absolutely fine also and I will withdraw your details from the BradICS study. Whatever you decide it would still be greatly appreciated if you let us know and we can then update our records accordingly. I once again thank you for agreeing to participate in these studies and do hope that you decide to contact myself or the BiB office to update your contact details.

Kindest Regards,

Denise Crane BSc, MA.

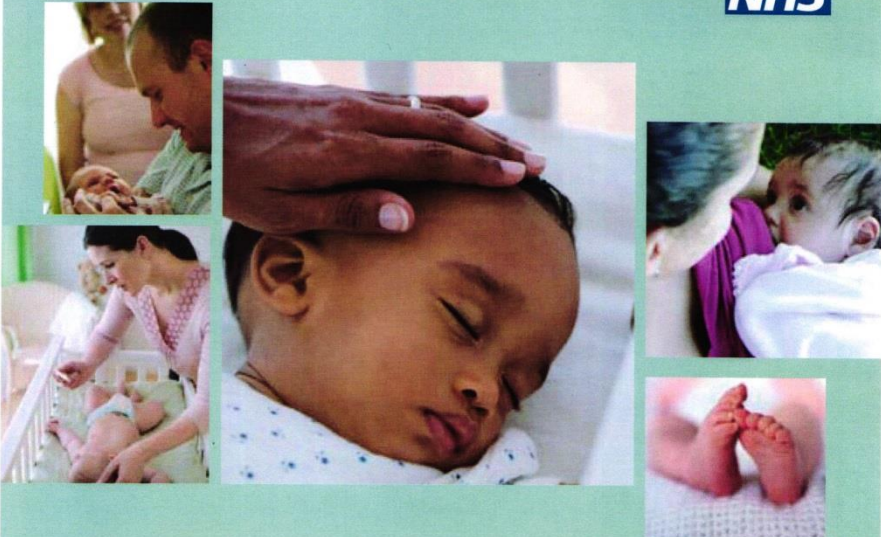

PhD Researcher in Medical Anthropology



APPENDIX 8

SIDS Prevention Leaflet

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4123625



Reduce the risk of cot death

- Place your baby on the back to sleep, in a cot in a room with you
- Do not smoke in pregnancy or let anyone smoke in the same room as your baby
- Do not share a bed with your baby if you have been drinking alcohol, if you take drugs or if you are a smoker
- Never sleep with your baby on a sofa or armchair
- Do not let your baby get too hot – keep your baby's head uncovered – place your baby in the "feet to foot" position

THE SAFEST PLACE FOR YOUR BABY TO SLEEP IS ON THE BACK, IN A COT IN A ROOM WITH YOU

Place your baby on the back to sleep from the very beginning for both day and night sleeps.

This will reduce the risk of cot death. Side sleeping is not as safe as sleeping on the back. Healthy babies placed on their backs are **not** more likely to choke. When the baby is old enough to roll over they should not be prevented from doing so.



Babies may get flattening of the part of the head they lie on (plagiocephaly). This will become rounder again as they grow, particularly if they are encouraged to lie on their tummies to play when they are awake and being supervised. Experiencing a range of different positions and a variety of movement while awake is also good for a baby's development.

sleep on the back

PLACE YOUR BABY ON THE BACK TO SLEEP



The safest place for your baby to sleep is in a cot in a room with you for the first six months.

If you or your partner:

- are smokers (no matter where or when you smoke and even if you never smoke in bed);
- have recently drunk alcohol;
- have taken medication or drugs that make you sleep more heavily;
- feel very tired;

do not share a bed with your baby.

The risks of bedsharing are also increased if your baby:

- was premature (born before 37 weeks);
- was of low birth weight (less than 2.5kg or 5.5lb)

There is also a risk that you might roll over in your sleep and suffocate your baby, or that your baby could get caught between the wall and the bed, or could roll out of an adult bed and be injured.

Never sleep with a baby on a sofa or armchair.

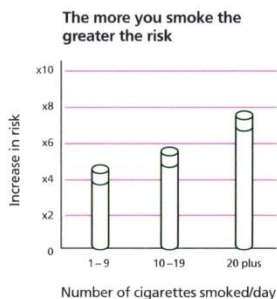
It's lovely to have your baby with you for a cuddle or a feed but it's safest to put your baby back in their cot before you go to sleep.

NEVER SLEEP WITH A BABY ON A SOFA OR ARMCHAIR

CUT OUT SMOKING DURING PREGNANCY – PARTNERS TOO!

Smoking in pregnancy greatly **increases** the risk of cot death. It is best not to smoke at all.

If you are pregnant and want to give up, please call the NHS Pregnancy Smoking Helpline on **0800 169 9 169**.



don't smoke near your baby

DON'T LET ANYONE SMOKE IN THE SAME ROOM AS YOUR BABY

Babies exposed to cigarette smoke after birth are also at an increased risk of cot death.

Nobody should smoke in the house, including visitors. Anyone who needs to smoke should go outside. Do not take your baby into smoky places. If you are a smoker, sharing a bed with your baby increases the risk of cot death.



For practical and friendly advice on giving up smoking, please call the NHS Pregnancy Smoking Helpline on **0800 169 9 169**.



PROTECT YOUR BABY FROM CIGARETTE SMOKE

DON'T LET YOUR BABY GET TOO HOT (OR TOO COLD)

Overheating can increase the risk of cot death. Babies can overheat because of too much bedding or clothing, or because the room is too hot.

- If your baby is sweating or their tummy feels hot to the touch, take off some of the bedding. Don't worry if your baby's hands or

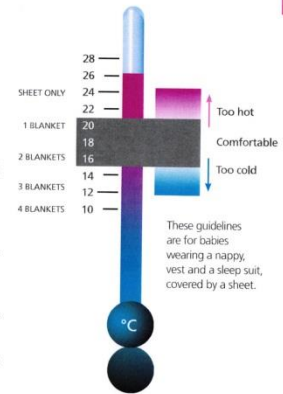


feet feel cool, this is normal.

- It is easier to adjust for the temperature with changes of lightweight blankets. Remember, a folded blanket counts as two blankets.
- Babies do not need hot rooms; all-night heating is rarely necessary. Keep the room at a temperature that is comfortable for you at night. About 18°C (65°F) is comfortable.

don't let your baby overheat

- If it is very warm, your baby may not need any bedclothes other than a sheet.
- Even in winter, most babies who are unwell or feverish do not need extra clothes.
- Babies should never sleep with a hot water bottle or electric blanket, next to a radiator, heater or fire, or in direct sunshine.
- Babies lose excess heat from their heads, so make sure their heads cannot be covered by bedclothes during sleep periods.



Remove hats and extra clothing as soon as you come indoors or enter a warm car, bus or train, even if it means waking your baby.

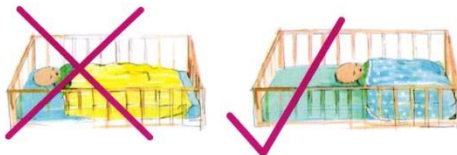


DON'T LET YOUR BABY GET TOO HOT (OR TOO COLD)

DON'T LET YOUR BABY'S HEAD BECOME COVERED

Babies whose heads are covered with bedding are at an increased risk of cot death.

To prevent your baby wriggling down under the covers, place your baby **feet to foot** in the crib, cot or pram. Make the covers up so that they reach no higher than the shoulders. Covers should be securely tucked in so they cannot slip over the baby's head. Use one or more layers of lightweight blankets.



KEEP YOUR BABY'S HEAD UNCOVERED

Sleep your baby on a mattress that is firm, flat, well-fitting and clean. The outside of the mattress should be waterproof. Cover the mattress with a single sheet.

Remember do not use duvets, quilts, baby nests, wedges, bedding rolls or pillows.

feet to foot in the crib

FEEDING

Breastfeeding your baby reduces the risk of cot death.

It's important to breastfeed your baby. Breast milk gives babies all the nutrients they need for the first six months of life and helps protect them from infection. It also reduces mothers' chances of getting certain diseases later in life and allows you and your baby to get closer both physically and emotionally. It's natural to have questions or need some extra support to breastfeed successfully.

Your midwife, health visitor or GP can help.



It is possible that using a dummy at the start of any sleep period reduces the risk of cot death. Do not begin to give a dummy until breastfeeding is well-established, usually when the baby is around one month old. Stop giving the dummy when the baby is between 6 and 12 months old.



AND SLEEP THEM "FEET TO FOOT"

IF YOUR BABY IS UNWELL SEEK MEDICAL ADVICE PROMPTLY

Babies often have minor illnesses which you do not need to worry about.

Make sure your baby drinks plenty of fluids and is not too hot. If your baby sleeps a lot, wake him or her regularly for a drink.

It may be difficult to judge whether an illness is more serious and requires prompt medical attention. The following guidelines may help you.

SERIOUS ILLNESS

There may be serious illness if your baby has any of the following symptoms:

- has a high pitched or weak cry, is less responsive, is much less active or more floppy than usual;
- looks very pale all over, grunts with each breath,

seems to be working hard to breathe when you look at their chest and tummy;

- takes less than a third of usual fluids, passes much less urine than usual, vomits green fluid, or passes blood in their stools;
- has a fever of 38° or above if the baby is less than 3 months, or 39° or above if 3 to 6 months old;
- is dehydrated – dry mouth, no tears, sunken eyes, or soft spot on the baby's head is sunken;
- has a rash that does not disappear with pressure.



seek advice promptly

IF YOUR BABY SEEMS UNWELL

Urgent medical attention is needed if your baby:

- stops breathing or goes blue;
- is unresponsive and shows no awareness of what is going on;
- has glazed eyes and does not focus on anything;
- cannot be woken;
- has a fit, even if your baby recovers without medical attention;

DIAL 999 and ask for an ambulance.

MONITORS

Normal healthy babies do not need a breathing monitor. Some parents find that using a breathing monitor reassures them. However, there is no evidence that monitors prevent cot death. If you have any worries about your baby, ask your doctor about the best steps to take.

IMMUNISATION

Immunisation reduces the risk of cot death.

REMEMBER THAT COT DEATH IS RARE;

so please don't let worry about it stop you enjoying your baby's first few months. Research is continuing to help us understand more about cot death.

SEEK MEDICAL ADVICE EARLY AND QUICKLY



If you have questions or want more information on reducing the risk of cot death, or to buy a simple room thermometer for your baby, contact the Foundation for the Study of Infant Deaths (FSID):

Telephone: 020 7802 3200
Email: office@fsid.org.uk
Website: www.fsid.org.uk

For the research evidence that backs the advice in this leaflet go to www.fsid.org.uk/factfile_2.html

The information in this leaflet will reduce the risk of cot death, but it is not guaranteed to prevent it altogether.

Since parents and carers have been following the risk reduction advice, the number of babies dying has fallen by over 70%.

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If you require further copies of this leaflet, quote 292301/Reduce the risk of cot death and contact:

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