Chapter 10

Marginality and social exclusion: jeopardising health and life chances

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Key issues

- Social divisions, social inequalities and social exclusion

- How power and resources are distributed unequally contributing to social exclusion

- Neoliberal governments and actions which reinforce social exclusion

- The impact of social exclusion on pregnant and new mothers

By the end of this chapter you will have the tools for understanding

- the need for all women to have skilled, holistic midwifery care that incorporates women's control about the decisions relating to their care

- the nature and importance of the sociological concepts of social division, inequality and social exclusion

- the harm that entrenched social divisions and inequalities do to people's health and life chances

- how mechanisms of social exclusion work in our society

- why social exclusion impacts so severely on pregnant women and new mothers

- why a more equal society can help resolve the crisis of social exclusion

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10.1 Challenges for women in contemporary maternity services

The experience of childbirth is very often marred for women by deep exclusion and a lack of control over fundamental decisions about their care. This is in spite of the overwhelming research evidence on the importance of woman-centred care in achieving best outcomes. This evidence has helped to reinforce policy framework documents in a number of countries about the central role of women's decision-making during pregnancy and birth (see chapter 4). This process began in the UK twenty years ago with the Winterton Report that led to *Changing Childbirth* (Department of Health 1993) and has continued with documents like *Maternity Matters* (England Department of Health 2007) and *A Refreshed Framework for Maternity Care in Scotland* (Scottish Government 2011).   The Winterton Report stated that,

> 'It is the mother who gives birth and it is she who will have the lifelong commitment which motherhood brings. She is the most active participant in the birth process. Her interests are intimately bound up with those of her baby.' (England, House of Commons, Health Committee, *Winterton Report*, 1992: v)

This was reinforced further in 'Maternity Matters',

'Healthy mothers tend to have healthy babies; a mother who has received high quality maternity care throughout her pregnancy is well placed to provide the best possible start for her baby' (Maternity Matters, 2007: 8)

Early work on the sociology of childbirth by writers like Ann Oakley and Hilary Graham (Oakley 1980, Graham and Oakley 1981) presented findings on how it was routinely accepted in our maternity services that women have little voice and almost no control in this crucial period of making the transition to motherhood. Individual accounts of women's experiences published by birth activist groups such as the respected Association for Improvements in the Maternity Services (AIMS) regularly made clear how damaging this was for a new mother. Thus in an AIMS journal article from 1975, this account appeared:

'There were three of them shouting and nagging trying to force an unwanted mask on my face, which I fought off with vigour, I'm afraid; I hadn't even groaned and was so happy until then.' (quoted in Beech 2010:3)

There has been abundant research to contribute to reforming and improving our birth care systems since that period. National policies about women's choice and continuity of midwifery care have been underpinned by a vast array of evidence about outcomes with best midwifery care, a great number of innovative and well-evaluated community midwifery projects, and changes in midwifery training to reflect all these developments.

Activity1: Interpreting and acting on best evidence for maternity care

Below are two important perspectives from research findings on midwifery care:

Sandall, Davies and Warwick (2001) *Evaluation of the Albany Midwifery Practice.* Final Report,

March 2001. London: King's College.

http://openaccess.city.ac.uk/599/2/albany_final_rpt.pdf

'Throughout the women's responses, there is a clear pattern of woman centred care being offered and of partnership with women, which may contribute to the positive evaluations of antenatal care and good clinical outcomes'.

National Perinatal Epidemiology Unit (2011) Birthplace Cohort Study, Key Findings. https://www.npeu.ox.ac.uk/birthplace/results

'Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit.'

How do these findings affect your thinking about the importance for women of midwife-led care as they make the transition to motherhood?

What is it specific to midwifery care which can promote women's decision-making and result in the good outcomes cited above?

As a midwife how well prepared are you to undertake this level of autonomous care for women?

Yet it has proved very difficult to make best support for women a consistent part of their care on which they can rely. This observation from a recent account in an *AIMS Journal* by a woman about her three pregnancies lets us see that too little has changed:

> 'I struggle to understand why some go into the care profession. I have witnessed an obvious lack of humanity and empathy by not just one but several midwives' (Ellam 2010:23)

There are complex institutional reasons as to why we have failed to secure best care for women in line with policies and evidence. The eminent midwife, Mavis Kirkham (2010), observes that the industrial model of service delivery still dominates our care system. Within this model, she cites two specific factors that detract from best care. The first is the continuing push to centralise maternity services. This is usually justified by the argument that we must bring 'childbearing women to the experts', that is the 'consultant obstetricians', rather than the midwife. This has resulted in a pattern of small units being closed, while in many cities there is often just one large maternity unit with many thousands of births each year.

A second factor Kirkham cites is the standardisation of services. Here she sees two rationales at work to the detriment of women and midwives. The first is the need to shift clinical care to a basis of firm evidence. Then there is the stated need for better risk management. While both these steps seem admirable efforts towards improved services, in practice, they have resulted in the top-down application of often rigid protocols and directives which misunderstand the skill and autonomy of the midwife.

They mean that each woman's individual situation and needs, and the importance of the midwife-mother relationship are ignored as labour and birth unfold. Despite the emphasis on best quality evidence, evidence is frequently neglected when these protocols impose decisions about risk and safety based on abstract notions rather than the specific circumstances of each woman. These complex factors continue to make maternity services unresponsive to women's broad range of needs (Kirkham 2010: 3-5).

10.2 Social divisions in society and how they are created

While inflexible and unresponsive maternity services can pose problems for all women, they pose special problems for women who experience in their daily lives the effects and consequences of what sociologists term 'social divisions'. Social divisions are 'substantial differences between people' which can divide groups sharply from one another in our society, leaving some groups at an advantage in respect of power and material and cultural resources compared with other groups (Payne 2006: 2-3).

We create these social divisions and sustain them in a myriad of ways without always being aware of how and why this happens, and without examining what our perceptions are about the consequences of such divisions. Education provides an excellent example. We generally believe that it is valuable for people's long-term life chances to attain as high a level of education as possible. What is less apparent is the extent to which as a society we actively constrain access to education, with some social groups least likely to gain access to higher education.

At the beginning of their young lives, children whose parents are working class, or emigrants, or who are single parents, or who come from a minority ethnic background may have few material resources to support learning within the family home. To make up for this, poorer parents often rely on state-funded pre-school programmes and local children's centres because they understand that early learning is important for success in school later on. If those programmes themselves are cut back or funding is diverted or fewer staff are employed to look after greater numbers of young children, such decisions contribute over time to diminishing the life chances of these children. If they live in a geographically poorer area, the local schools they go on to attend may be less well-resourced than schools in middle class areas. Therefore the schools are unable to help children make up for the material disadvantages at home. As children get older, parents are unable to pay for additional books, personal computers and other learning tools for them, and funds for private tutors to help children with state examinations are beyond reach. Thus government decisions to reduce funding for schools in poorer catchment areas and for additional education resources concretely affect long-term educational attainment. As children who are worse off grow older, the disadvantages they face are cumulative and they are unable to make the same gains in educational achievements as their middle class counterparts.

About this outcome, the landmark Marmot Report on health and social inequalities comments: 'There is a strong relationship between the level of deprivation in a geographical area and educational attainment' (Strategic Review of Health Inequalities 2010:64). We also know that 'rates of unemployment are highest among those with no or few qualifications and skills'. Over time this leads to 'an increased

risk of one's physical and/or mental health worsening' (ibid: 68) (see also chapter 7). So although in everyday conversation we may comment that children from middle-class areas have a seeming ability to work harder at school, compared with children from a much poorer area, what we are actually seeing is a structural problem arising from the social divisions of class reinforced by political decisions about policies and funding for those who are worse off.

Activity 2: The negative consequences of poorly-funded early childhood education

Review the evidence below in your peer groups and discuss how it demonstrates how poorly-funded education has negative consequences for early childhood

'Investment in early childhood education as a proportion of GDP is significantly lower in the UK than in many continental European countries, most of which have better educational outcomes than in the UK.'

Joseph Rowntree Foundation, Response to the UK Government's Tackling Child Poverty and Improving Life Chances: Consulting on a New Approach (2011) http://www.jrf.org.uk/sites/files/jrf/tackling-child-poverty-response.pdf

'Children from disadvantaged backgrounds are more likely t begin primary school with lower personal, social and emotional development and communication, language and literacy skills than their peers

The Marmot Review (2010: 64)

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

10.3 How social divisions lead to multiple disadvantages for women

Social divisions, the way they are constructed and the way they are perceived lead to other substantial inequalities. In addition to social class, we can see injurious divisions reflected in such categories as gender, ethnicity, nationality and disability, amongst others (Payne 2006; Macionis and Plummer 2012: 253-254, see also chapter 6). In relation to gender, for example, the continuing perception that women are 'natural carers' simply because they are women and give birth feeds into concrete inequalities for women of pay and professional status (Abbott 2006). In occupational terms, 'caring' work such as childcare and midwifery are seen as more appropriately staffed by women than men. These occupations consistently attract lower wages than male-associated work such as mechanics and engineering. In order to combine paid work with childcare and domestic duties, the latter being considered largely women's work, women very often work part-time where wages are lower on a pro-rata basis (Office for National Statistics 2012).

The picture becomes more complex still because of the way social divisions can reinforce multiple inequalities in people's lives to have damaging, cumulative effects. Living with a disability provides us with a salient example (see also chapter 6). Within a medical model of disability, rather than asking the question about how society can make concrete changes to better accommodate individuals, people are seen to be inadequate by virtue of their disability. Hence people with disabilities experience considerable formal and informal discrimination and prejudice (Hyde 2006). Even though disability discrimination acts are now part of legal frameworks nationally and internationally, societies do not take responsibility for the many ways

they actively exclude people with disabilities from our social institutions, making it far harder for them to live fruitful and fulfilled lives. Instead this form of social division produces multiple layers of disadvantage.

Thus women from a lower social class background who have any form of impairment have an increased likelihood of a lower level of formal qualifications. With far fewer financial resources, qualifications are harder to access and, because of continuing informal discrimination, where they may be held unable to do a good job of work, there is less employment available than for an able-bodied person. Even if women with a disability can find work, they are subject to a very significant pay gap, earning considerably less when compared with a non-disabled worker (Papworth Trust 2011). Reliance on social welfare provision condemns them to economic deprivation along with a loss of personal autonomy due to the levels of bureaucratic regulation (Barnes 1991). Since 2011, deep cuts to disability allowances in the Britain have severely cut access for people with disabilities to transport, housing, education and employment making them significantly poorer.

Being poorer leads to damaging consequences for health, touching as it does, on every aspect of people's lives. If women with a disability become pregnant, they may encounter still more barriers and difficulties by virtue of these cumulative inequalities, as well as having to confront entrenched prejudices about their very capacity to be mothers (Goodman 1994, Prilleltensky 2003, Begley et al. 2010, Lewiecki-Wilson and Cellio 2011). The response to Heather Kuttai's pregnancy: ' "Oh dear" were the first words out of the mouth of the doctor I saw after I learned I was pregnant' (Kuttai 2010: 77) is not uncommon.

Box 10.1

Experiences of disabled women who are on the margins economically

'The midwifery manager wrote down on a piece of paper 'Why don't you go to the classes?' ... I said 'Yeah well there is a problem about me getting access. Like would you be willing to pay for an interpreter, provide the interpreter?' and she said 'Oh gosh no, we haven't talked about that. You have to pay for an interpreter'' Account of a hearing disabled woman from Cecily Begley et al (2010) http://www.nda.ie

'All disabled parents in our borough automatically get treated as a child protection issue.' Charlie Foulkes, disabled mother quoted in Tim Rushby-Smith (2010)
http://www.guardian.co.uk/society/2010/nov/23/challenges-disability-pregnancy

10.4 Social exclusion as a political problem for childbearing women

Within any highly stratified society, that is, a society with deep social divisions, resources, privileges and status are distributed so unevenly that people in certain categories become systematically excluded from being able to fully participate in

ordinary everyday life. We call this process social exclusion. As the examples above illustrate, social exclusion is actively created through our policies and our key institutions, with more powerful sectors of society imposing exclusion and marginalisation on other weaker sectors which then become even more deeply disadvantaged. People are shut out from fundamental social, economic, political and cultural processes (Byrne 2005). The phrase 'second class citizens' is one that reflects the extent of this exclusion and the way in which the ordinary 'social rights of citizenship' (Walker and Walker 1997: 8) are systematically denied. Those who are excluded also become subject to a much greater degree of state regulation and their poor social status is often linked to the perception that it is because of their individual failing that they are on the 'outside'.

It is worth noting that successive governments since the 1990s have used the term 'social exclusion' as if it were an unproblematic matter to resolve. The implication is that in a flourishing economy, all that needs to be done to eliminate 'social exclusion' is to assist people to move from the 'outside' to the 'inside' (Koller and Davidson 2008). However, this is by and large a move into low-paid and often temporary employment (Macionis and Plummer 2012: 514-515). These conditions, often called 'flexibility of labour', are important to the profitability of large-scale corporate enterprises like supermarkets, big retail parks and call centres. The acceptance of this rationale, that is, the need to move people from 'outside' to just 'inside', glosses over the extent to which governments have abandoned the pursuit of egalitarian social policies to genuinely support those with fewest resources to improve their life chances. This abandonment is central to the doctrine of neoliberalism which asserts

that the principal role of the state is not to support people, but to support the market to function in total freedom without regulation (Harvey 2005).

Neoliberalism argues that the state will impede the freedom of the market to function freely should it choose to honour agreements it might have made with its citizens in an earlier period to promote the social good. Yet when that commitment to the collective social good is abandoned by the state, our society 'is no longer identified by a set of values, rights and responsibilities' (Cameron and Palan 2004: 138) which we all share; rather the market becomes all. Letting go of such agreements has an immediate adverse effect on the provision of best quality health and education for all as we can see from the example of the 'postcode lottery' in health services with poorest areas in Britain having the poorest services. Another name for this is the 'competition state' which brings with it the notion that cost-cutting, especially of people's wages and their welfare entitlements, in order for business to become globally 'competitive' is a paramount aim (Cameron and Palan 2004). The impact of these policies can be seen in Britain where what has been described as the 'low-pay, no-pay jobs market' has resulted in there now being more people in working households, 6.1 million, who are living in poverty compared with those households where there is no work at all, 5.1 million who also live in poverty (Aldridge et al 2012). The working poor have become a major new social reality.

Activity 3: Understanding how neoliberalism works and what it does to public services which pregnant women need

Read the following two extracts explaining neoliberalism, its impact on public services and the need for state action to change the course of poverty.

'The rule of the market Liberating "free" enterprise or private enterprise from any bonds imposed by the government (the state) no matter how much social damage this causes.

Cutting public expenditure for social services like education and health care. Reducing the safety net for the poor.

Deregulation Reduce government regulation of everything that could diminish profits, including protecting the environment and safety on the job.

Privatization Sell state-owned enterprises, goods and services to private investors. This includes banks, key industries, railroads, toll highways, electricity, schools, hospitals and even fresh water.

Eliminating the concept of the "public good" or "community" and replacing it with "individual responsibility." Pressuring the poorest people in a society to find solutions to their lack of health care,

education and social security all by themselves, then blaming them, if they fail, as "lazy." '

from What is "Neo-Liberalism"?A Brief Definition by Elizabeth Martinez and Arnoldo García (2000) http://www.globalexchange.org

'Recognising how much poverty levels have changed over a longer period confounds any idea that poverty is inevitable and therefore beyond society's capacity to alter. Something has caused poverty to change; something else could cause it to change again.' from Hannah Aldridge et al, *Monitoring Poverty and Social Exclusion*. 2012: 7 http://www.jrf.org.uk/

Now discuss how cuts to public services affect midwifery care:

What do you think the impact might be on midwifery care in the community and in the hospitals and in the hospitals if NHS budgets continue to be cut?

What have you already noticed about midwifery care as services become more stretched?

How do you think this will affect disadvantaged mothers?

The withdrawal of the state from protecting the social good means that people with a low skills base cannot access good quality training because the cost is too high for

them as individuals and so they are condemned to work and exist on the fringes of society. The commitment to neoliberal markets lies behind government schemes in a number of countries known as welfare to work schemes or workfares (Harris et al 2012). Possibly the worst element of these schemes is the raft of mandatory regulations and surveillance that accompany them, while at the same time they actually provide virtually no scope for entry into decently paid jobs with long-term prospects. The expectation is that the individuals 'bear the burdens' of what the state will no longer carry (Harris et al 2012:824) even while the state presents these as necessary reforms for the economy to grow (Byrne 2005). These workfare schemes have had an 'adverse impact on people who already experience high levels of discrimination in unregulated markets' (ibid.). They are the ones who carry the personal and economic costs of 'job flexibility'.

This is very apparent in relation to single mothers who have been left stranded between these reformed welfare payment systems, poor state childcare facilities, and insecure jobs. As Melissa Benn has argued, we should recognise the urgent need to rethink how society should be supporting the work of mothers to rear their children in a loving and caring household as well as working in formal employment. As it is, there are working mothers who simply do not count because they are the unemployed or the very low paid or the mothers who are in prison (Benn 1998:146). The extensive policy talk about 'time-poor' women trying to balance work and family life (Hinsliff 2012) concentrates on the situations of middle-class women, not the poor. Benn interviewed single mothers in Cardiff in 1997 at a point when as a marginalised social group they were coming under increasing attack from the government and the media about being 'welfare mothers' and having 'babies on benefits'. Single mothers were

being pressured to exit from the welfare system, which itself was being cut back, and to take on paid work. Many women in these precarious circumstances did so. However, as Benn puts it

> 'These women understand the market. They know exactly how the job situation has changed. Everything is fixed-term contracts. The work is there for women but it is part-time and low-paid' (Benn 1998: 162).

They experience a very limited movement from the absolute margins stuck in the welfare system to just 'inside' the world of paid work, and then back to welfare again, when those temporary jobs come to an end, in line with the requirements for 'flexibility of labour'. As a result, most women experiencing social exclusion are having to manage their entire budget 'on what the well-off spend on food alone' (ibid.; 152).

The consequent strain on women suffering social exclusion spills over into other areas of their lives. Their status as disadvantaged mothers sees them potentially labeled by a health system not prepared to fully support them. We know that compared to women with a secure social and economic position, they experience problems with the access and uptake of maternity services, that they are less likely to breastfeed, more likely to experience teenage pregnancy, and more likely to have mental health problems (D'Souza and Garcia 2004; Raleigh et al 2010). We also know that they report their experiences of care as being poorer with less likelihood that they are treated with dignity and respect (Raleigh et al 2010: 190).

They are also more likely to be seen as problematic for their behaviours, with scant attention being paid to the structural factors that lie behind what appear as less acceptable or healthy patterns. Smoking is a case in point. Women living in severely disadvantaged areas are more likely to smoke and are more likely to smoke in the home in front of their very young children with implications for child health (Robinson and Kirkcaldy 2007). Amidst a raft of health care advice, promotional material, directives and regulations, what is not taken into account is how aware women are of possible damage, how guilty they feel, and the weight of their concern for their young children while they try to limit exposure and even their reliance on smoking (Robinson and Kirkcaldy 2007; Oaks 2003: 109-110). Regulating and even criminalising the women who smoke has already happened in the United States where, in some jurisdictions in the United States, smoking in publicly-owned housing is now banned (Winickoff et al 2010). This suggests that it is easier to regulate the poor about smoking simply because so many dimensions of their lives already fall under the surveillance of the state. Oaks (2001: 171) points out that women have actually lost custody of their children, their smoking officially labeled as 'fetal abuse'. The reasons for smoking, as a coping mechanism to deal with the stress of poverty, are too often avoided by governments. They are anxious not to deal comprehensively with the consequences of social exclusion, but once more to make individual women bear the burden of their failure. Women's capacity to cope as mothers despite the odds they face is consistently questioned by the very system which has withdrawn full support.

Activity 4: Women's experiences of social exclusion as mothers

Read these two extracts below and then discuss how social exclusion affects women as mothers

'There are parents who need more support, but all our evidence suggests that the real practical support isolated parents need is not there. Increasingly, health visitors simply report anyone with problems to social services - who also increasingly get care orders rather than providing real support.' from AIMS Press release - 1st October 2004

Health visitors are now the health police http://www.aims.org.uk

'One of the Whitehall cleaners who has featured in the *Observer*'s living wage campaign in support of an hourly minimum wage of £8.55 in London - has been evicted from her home with her family, just days before the birth of her baby. Anilsa Ramos, 36, who suffers from acute asthma, has been placed, along with her husband, mother, 12-year-old son and six-year-old niece, in bed and breakfast accommodation that is costing Newham council £1,200 a month – £300 more than its contribution to the cost of the family's privately rented house. Until earlier this month, Ramos worked 15 hours a week cleaning the Supreme Court building in Parliament Square, earning £58-£80 a week after travel costs – too little to make her eligible for maternity pay from her employer. She and her husband, Jose, who is also a cleaner, privately rented a three-bedroom house for four years. The council paid £900 a month; the family, £200. Last July, the landlord obtained a possession order because the house had been sold'. from Yvonne Roberts (2013)

http://www.guardian.co.uk/society/2013/feb/24/

In your experience, how does poverty impact on women's confidence and capacity to mother their children?

How can midwives help to really support pregnant women who suffer from deep poverty?

What do midwives need to learn in order to better support women in poverty?

The withdrawal of full support of our health services by the state, reflected in too few midwives, has already had serious consequences for women in our maternity services (Edwards 2008; Mander and Murphy-Lawless 2013). We urgently need to reclaim social exclusion as the fundamental challenge it is to the lives and well-being of the several hundred thousand women and their babies who are affected each year. As Rosemary Mander has written 'It is necessary to consider where power lies in relation to these groups of childbearing women and whether and how their position is changing or can be changed' (Mander and Murphy-Lawless 2013: 30).

10.6 The consequences of social exclusion on maternity service users

Internationally, health authorities endeavour to compile databases on incidents of serious maternal morbidity and maternal mortality in order to understand how to improve all women's maternal health and wellbeing. The oldest and most respected of these surveys is the UK National Confidential Enquiry into Maternal Deaths, now in its seventh decade and recently renamed *Saving Mothers' Lives* (Mander and Smith 2008; Lewis 2012).

In line with previous reports, the most recent *Saving Mothers' Lives* (CMACE 2011) breaks down the data on the numbers of women who died in the UK between 2006 and 2008 into different categories. This approach to data analysis, with a range of clinical conditions and social factors, yields important information to health care professionals about women who, if they share these factors, will benefit from early identification and additional support in order to have a more fulfilling and safe pregnancy, labour and birth.

The current report draws attention to, amongst others, women who were more vulnerable to poor maternal health stemming from a number of social factors, including their socio-economic status (SES). This is what sociologists refer to as social class which we have already encountered above. In reading Tables 1.22 and 1.23 of *Saving Mothers' Lives*, we learn that amongst those women who died in that triennial period, the vast majority were classified as unemployed (Table 1.22) or lived in the most deprived districts in England and Wales (CMACE 2011: 51-52).

This is not a new finding and it reflects the concrete effects of social exclusion. As Michael Marmot and Richard Wilkinson state: 'British statistics have shown, for as long as one has cared to look, that health follows a social gradient: the higher the social position, the better the health' (2006:2). This holds true for maternal health as much as for perinatal and infant health. Moreover, although there has been a downward trend in the numbers of maternal deaths from women in these categories since 2000 (Lewis 2012: 23), as Rosemary Mander comments, 'the gap remains disconcertingly large' (Mander 2011:257). Thus even if maternal deaths are infrequent, they place a microscope on how well or badly the maternity services are

functioning in relation to those women who are most in need. This has already been seen vividly in the United States where privatised medicine is the norm and where women in poverty must depend on a the barest minimum of public health care packages with terrible outcomes for them in respect of severe morbidity and mortality (Amnesty International 2009; Bridges 2011; Lane 2008).

In Table 1.25 of the CMACE report, women who had had no antenatal care at all or missed more than three visits are listed under categories such as

'Single unemployed'

'Partner unemployed'

'Most deprived quintile post code' (CMACE 2011: 54)

In other words, these were women who had been pushed to the margins of society. Thirty-five women who died received no antenatal care at all (CMACE 2011:35) while another thirty-five were listed as 'poor attenders', leading to their receiving 'less than optimal care' (ibid). The term itself is stigmatising and does not help us to understand why women would decide not to seek help. We have to dig more deeply to discover an interwoven pattern of personal and social need on the part of women with multiple burdens that for them, including services that remain far less accessible for them in their vulnerability. One of the cases tragically illustrates this point. A woman who had a 'complex social history' refused a hospital admission while pregnant for a chest infection 'because she was concerned her children would be taken into care' (de Swiet et al 2011:124). To surrender her children to local social service authorities is a terrifying prospect for a woman who is marginalised. Women in this position know how difficult and challenging it is to actually be reunited with their children once they

are taken into care (Robinson 2004). Although this woman was diagnosed HIV positive, her midwives were not informed, her HIV therapy was delayed and there was no protocol to deal with HIV when she went into premature labour.

This series of incidents and clinical mishaps ended in her death from sepsis and colitis, about which Rosemary Mander comments that protocols are disregarded or may not even exist (Mander 2011). Moreover, given the changes in healthcare provision and the needs that existing health care structures no longer meet, many responsibilities for their own care are being shifted on to the shoulders of women themselves (Mander 2011). If there is any degree of vulnerability or lack of resources or personal support, women may be unable to cope with any additional burden. Yet it may be very hard indeed for practitioners to comprehend why in their view, women are not 'complying' with their instructions (Mander 2011:256). Too few clinicians understand the intricacies of living with deep social exclusion. The 2010 NICE Guideline on Pregnancy and Complex Social Factors seeks to help clinicians identify women in need of additional support, including women who misuse substances, women under twenty years of age, women who experience domestic abuse and women who are recent migrants (National Collaborating Centre for Women's and Children's Health 2010) and proposes additional service provision, improved service organisation and better delivery of care. The authors do not comment at all on where the political will is to be harnessed to promote better services for vulnerable women.

Amongst a challenging matrix of factors that may confront women is actually being able to access a GP. In 2010, the majority of pregnant women, many in their second or third trimester, attending the Project London clinic (which is staffed by the

Doctors of the World UK voluntary group) were asylum-seekers who had been unable to register with a GP (Ramaswami 2012). This is an especially vulnerable group of women with their very status as 'asylum seekers' putting them at the absolute margins of society.

The term 'asylum seeker' itself is a deliberately exclusionary one, designed to indicate they are people stripped of worth (Hyland, 2001). In the last three decades, there have been mass movements of people fleeing their place of birth in sheer necessity due to countless major political, economic and environmental disasters. The scale of movement is unprecedented in the entire period of human history up to the present and has led to women giving birth in exile (Kennedy and Murphy-Lawless 2003). However, unlike the 1951 UN Convention on Refugees, the criteria for defining an 'asylum seeker' are even more strict as governments in wealthier states seek to limit the numbers of people crossing their borders and taking up residence permanently (ibid.). This is in line with the dictates of neoliberalism which within a globalised economy, wants people to move for purposes of work and living on its terms only.

Zgymunt Bauman (1998) has argued this economy designates some people 'tourists' with legitimate papers who can travel anywhere because they spend valuable tourist dollars, while others are effectively designated 'vagabonds', who against their best intentions for themselves and their families, become the flotsam and jetsam of an unstable world. The term 'asylum seeker' became widespread in the EU in the 1990s as the numbers of non-European people seeking refuge swelled.

In the UK, the Asylum Act of 1999 quietly changed the terms of reference so that people whom the state designates 'asylum seekers;' have virtually no legal protection at all (Hyland 2001). Warwick et al note in their work (2006: 129) how people so designated suffer from 'discrimination, racism, persecution and suspicion' and are effectively criminalised simply because they are trying to survive. The net effect is to leave them with the barest minimum or no access to health care facilities, legal employment, and secure legal papers. In other words, they are not even 'second-class citizens'. This lack of protection and the active measures to exclude them, including official dispersal policies around the UK, can be seen at once in the status of women who have died in childbirth.

Compared with white ethnic groups, women from black minority ethnic groups (BMEs) experienced higher numbers of direct maternal deaths, 42 per cent of the total numbers (CMACE 2011: 47), while women from black minority ethnic groups suffered 31 per cent of indirect maternal deaths (ibid). Twenty-eight women of black African ethnicity died. Nine women in this group were UK citizens with the remaining women being 'either recently arrived new immigrants, refugees, or asylum seekers' (CMACE 2011: 49). While the CMACE report discusses 'poor attenders' and the fact that non-attendance for antenatal care has been a recognised risk factor for decades (CMACE 2011: 47, 49), it does not allude to the full range of social factors that contribute to non-attendance. The report does draw attention to problems of communication and the consequent threat to women's wellbeing if for example, there can be no full booking history taken. The report recommends professional interpretation services for minority ethic women, pointing out how inappropriate and even dangerous it can be to women if children or male family members speak on their

behalf (CMACE 2011:50). However, it is worth pointing out the Danish and the Dutch governments have recently ruled that they would no longer cover the cost for professional interpretation services which as raised concerns straight across Europe about such discriminatory practices which will hit minority ethnic groups the hardest (Phelan 2012)

These women are at the sharpest edge of government actions to maintain social exclusion. Maternity Action and the Refugee Council (Feldman 2013) point out in their research how dispersal policies critically jeopardise the health and wellbeing of pregnant women who are asylum seekers. These are women who already deal with serious and chronic health conditions including female genital mutilation or cutting (FGM/FGC). Being moved from initial accommodation to sites across the country, often with no warning, to often deeply inappropriate environments including detention, interrupts still further the possibility of stable, continuity of care for them. It also breaks up the few fragile social networks that women might have begun to lay down.

Activity 5: Women's Experiences as Asylum Seekers

Read the two extracts below and then discuss what they tell us about maternity care needs of women who are registered as asylum seekers.

'Around half of the women in this study were not so fortunate, encountering indifference, rudeness, and racism. They described health professionals acting with contemptuous disrespect for their individuality and total disregard for their feelings, apparently unable to leave their personal prejudices out of their professional practice.

These experiences are far removed from the ideals of *Changing Childbirth.'* from Jenny McLeish (2002) Mothers in Exile: Maternity experiences of asylum seekers in England.

http://www.maternityaction.org.uk/

'Dana did not have enough money before she gave birth to buy clothes and necessities for the baby. She had received an initial payment of £90 when she first claimed asylum on arrival in the UK, but she used this money to pay for travel from outside London for her asylum interview and for fares to see her solicitor. Her next payment of £35 was due on the day she delivered, and she thought she would lose it if she did not collect it immediately. So, straight after giving birth, she left her baby in the hospital to go to the post office to collect her money to buy clothes for her baby.

"It was freezing (December 29th) but if I didn't go I would lose my money. For £35 I left my baby. Two hours after I gave birth I left the hospital to go to the post office. The nurses said, 'No you are not allowed to take the baby with you because you are not fine.' I said, 'No I have to go because she doesn't have clothes. I have to buy clothes.' So when she was born for two hours she didn't have any clothes so they covered her with towels." ' from Rayah Feldman (2013) When Maternity Doesn't Matter: Dispersing Pregnant Women Seeking Asylum. http://www.refugeecouncil.org.uk/

What do these accounts of women experiencing deep social

exclusion tell you about the failure of mainstream services?

What are the most critical empathic skills you need to develop in

order to support vulnerable women migrants in your practice?

Conclusion

In this chapter we have explored the problems of social exclusion and marginalisation

with the intention of showing that these are far from straightforward or naturally

occurring phenomena. They are in reality outcomes contingent on contemporary

hierarchies of power, wealth and resource distribution in our societies that work

actively to create inequalities. In turn, these inequalities jeopardise health and life

chances. We have also argued that commonplace assumptions about people who

experience social exclusion are often confused and misinformed. Above all, it is

important to bear in mind that people do not end up on the margins of society through

individual 'choice'. They have had virtually no 'choice' about their circumstances but

endure what the sociologist Pierre Bourdieu describes as the work of 'a social order

[which] has set up the conditions for an unprecedented development of all kinds of

ordinary suffering' (2006:4)

Michael Marmot describes the resulting serious health inequalities in the Marmot

Review and also comments: 'Serious health inequalities do not arise by chance …

Social and economic differences in health status reflect, and are caused by, social and

economic inequalities in society' (Strategic Review of Health Inequalities 2010: 16).

Marmot also argues that

> 'A fair society would give people more equal freedom to lead flourishing
>
> lives…
>
> If the conditions in which people are born, grow, live, work, and age are
>
> favourable, and more equitably distributed, then they will have more control
>
> over their lives in ways that will influence their own health and health
>
> behaviours, and those of their families.' (ibid)

For midwives, eager to support women as fully as possible in attaining a healthy,

confident and peaceful transition to motherhood, the ultimate goal must be a

flourishing and secure family life. We can see that this goal is inextricably bound up

with resolving the grievous burdens of social exclusion. These must first be

recognised and then responded to sensitively and effectively by midwives. Jean

Davies expressed this in her work over a decade ago when she wrote that midwives

need to make 'conscious efforts … to bridge the gap between the experiences and

expectations of the midwives as professionals and those of their economically

deprived clients' and this means paying attention to how women cope 'in their

everyday lives and how midwifery care [can] be adapted to fit their coping

mechanisms.' (Davies 2001: 120)

Davies' sensitive conclusion, that the 'aim should be that women will be enabled to

birth well and can see themselves as 'women who can', this being 'especially

important for women whose experience of much around them is that they cannot'

(Davies 2001: 140) is one on which midwives need to reflect very hard. This is especially pressing in this current period of contraction, destruction and privatisation of our health services with terrible consequences for midwifery (Mander and Murphy-Lawless 2013).

Davies speaks about how a 'midwifery service' that is 'truly community based' develops 'complex links' between 'midwives and families, which involve midwives in the lives of vulnerable women who would otherwise slip through the net' (Davies 2001: 140-141).

This of course was the work of the Albany Practice in Peckham in southeast London, one of the poorest districts in the whole of Britain with enduring problems of social exclusion. The Albany midwives consistently worked with women who had been abandoned by the wider society and brought them through to safe births and a remarkable understanding of what it is to be a mother. This is what one of the Albany mothers said:

> 'I think you grow because you grow to meet their expectations […]. They expected me to give birth well, they expected me to be a good parent afterwards and I grew to meet their expectations. You know? That's really powerful' (quoted in Edwards 2010)

The question for midwifery and midwives is whether they can now go against the grain of dominant institutional and political discourses, as the Albany practice did, and seek to protect vulnerable women. This will mean rejecting outright the notion

that women who have been marginalised are somehow a threatening 'other' that upsets mainstream society and instead recognising how that same society has jeopardised a significant minority of women by seeking to exclude them.

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Glossary

Neoliberalism is a set of economic policies that have become widespread since the

1970s and are associated with the rolling back of state funding for the common good.