# Can Critical Education Help Address Racial Discrimination in Irish Maternity Settings?

**Camilla Fitzsimons and Lilian Nwanze**
*Maynooth University, Maynooth, County Kildare, Ireland.*

## Abstract

*This study focuses on how self-selecting Muslim women navigated Irish maternity services and uncovers ways in which their care was shaped by often unconscious but nonetheless harmful discriminatory policies and practices. We share examples of overt racism, negative attitudes and a failure to support often basic cultural needs. Some healthcare workers corroborate the stories these women share, for others 'race' was an uncomfortable topic. We argue that although education can help, this must be rooted in Freirean, critical pedagogic philosophies that seek to politicise learners by not only illuminating their own prejudicial practices, but by locating these behaviours in an analysis of a global socio-economic model of neoliberal capitalism that relies on structural racism (and patriarchy) for its own survival.*

**Key words**: *Critical education, structural racism, maternity care, Muslim experiences, workplace education.*

## Introduction

A person's right to quality, affordable maternity care is protected under international law. However, for non-white ethnic minorities, dignified, respectful care has often been found lacking in many European countries and countries historically colonised by European nations including the US (Ali,

2004; Lauderdale, 2006; Lyons, Clarke, Staines, & O'Keefe, 2008; Hassan, Leavy, & Rooney, 2019; Firdous, Darwin, & Shaima, 2020). This study focuses on the experiences of over one-hundred self-selecting Muslim women's navigation of Irish maternity services and uncovers similar patterns in the quality of care they sometimes receive. It also uncovers insights from 38 professional healthcare workers some of who corroborated reports of at times substandard care, others for who 'race' was an uncomfortable topic. Across both cohorts, work placed education, or continuous professional development as it is sometimes called, is suggested as a panacea. Although education can be a welcome and important step in the right direction, we raise crucial questions about the nature of this education and the capacity of many of today's programmes to remedy structural racism.

Everyone who is legally resident in the Republic of Ireland can access free maternity care under a *National Maternity and Infant Care Scheme*[1] meaning, on paper, Ireland is well positioned to adhere to Article 12 of the *UN Convention on the Elimination of All Forms of Discrimination Against Women*.

This states:

> Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. (UN, 1979)

However, limited studies suggest Ireland falls short in this regard. As is the case internationally (Jardine, et al., 2021), there is evidence of higher-than-average maternity related mortality amongst women of colour. Ireland's most recent *Confidential Maternity Death Enquiry* noted "a five-fold difference in maternal mortality rates amongst women from Black Ethnic backgrounds and

an almost two-fold difference amongst women from Asian Ethnic backgrounds when compared to with white women" (CDE Ireland, 2019, p. 3). African women living in Ireland have a higher perinatal mortality rate and double the number of stillbirths than their Irish-born counterparts (HSE, 2020a). These figures could be even higher as maternity deaths can go unreported or are misclassified (Manning, 2014).

Some Irish studies have examined standards of care for ethnic minorities from the perspective of the provider experience. Lyons, Clarke, Staines, & O'Keefe, (2008) uncovered a range of issues including a 'them' and 'us' mentality and an overriding binary sense amongst staff that ethnic minority women must adapt to the system, rather than the system adapting to them. In another study, this time focusing on provider's experiences of people living in Direct Provision, Tobin & Murphy Lawless (2014) found disruptions in women's care because of national dispersal policies, poor communication, and negative and resentful attitudes from some midwives.

Before this study, little has been known about maternity care from the perspective of Irish-based Muslim women. However, international research has consistently found shortfalls in their care including general negative attitudes, harmful stereotyping, erroneous assumptions about pain tolerance, and individual acts of racism and bigotry (Ali, 2004; Hassan et al, 2019; Firdous et al, 2020). Firdous et al. (2020) maintain Muslims often don't vocalise their concerns for fear of a negative reaction and that this 'culture of silence' contributes to women shying away from antenatal and postnatal services. The research was funded by the Irish Human Rights and Equality Commission (IHREC) and was commissioned by Amal Women's Association (Amal), a Dublin-based, voluntary community development organisation that was founded by, and is run by, Muslim women. Amal responds to the culturally specific

needs of women and youths and seeks to increase their participation in, and contribution to, Irish society. The drive behind this project came from the experiences of some women in Amal who had themselves used maternity services in Ireland. Although they observed other Hijab wearing women at medical appointments there was a sense that these women were less visible at antenatal services, breastfeeding groups and other community-based services. Lower than average engagement with maternity services amongst migrant populations has been recorded in other countries (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientos, & Dias, 2013; Thomasen, 2018; Nellums, et al., 2021). Amal asked us to inquire into their observations in an Irish context, and uncover the experiences of Muslim women more broadly.

Amal was particularly concerned about women who live with multiple, oppressive intersections of inequality. Although some migrants travel to Ireland to take up high-skilled jobs, others come to Ireland seeking international protection and are housed in Ireland's for-profit system of Direct Provision. The Irish government has acknowledged criticisms by the IHEC and several independent studies about direct provision agreeing these "often unsuitable congregated settings" are often not fit for purpose (Government of Ireland, 2020, p. 7). Another cohort are those who migrate and work in low-skilled, low-paid work with many (especially those undocumented) locked out of workplace relations mediation structures (MRCI, 2020) that could potentially improve their working conditions. Migrants are at greater risk of unemployment (McGinnity, et al., 2021, p. xi) and the financial poverty these circumstances create, along with precarious residency status can significantly disadvantage non-European Economic Area (EEA) migrants when seeking social housing (McGinnity, et al., 2022). Research on migrant experiences from other European countries has confirmed these intersecting features increase the incidence of premature births,

neonatal admissions and lower birth weights (Funge, Mathilde, Johnsen & Nørredam, 2020) and can intensify post-natal depression (Costa, 2018).

As well as these social determinants of health and wellbeing, we were equally interested in studies that contend discrimination in and of itself worsens maternity outcomes. For example, one US study by Diane Lauderdale (2006) found poorer birth outcomes amongst 'Arab-named' women in the six months following the September 11th 2001 terrorist attacks. Whilst Lauderdale acknowledges her research was led by the hypothesis that ethnicity-related stress and/or discrimination increases the risk of preterm and low birth weights, she finds little else that definitively explains negative birth outcomes and notes similar findings in comparative studies on African American mothers (Dole, et al., 2004; Collins, et al., 2004).

Setting aside these concerns for one moment, there is also much disapproval of the medicalisation of pregnancy and childbirth more broadly. Although many women experience birth as liberating and joyous, it can also be traumatic and can negatively impact a person's capacity to bond with their baby, adjust to parenthood, and plan their future family (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010). Obstetrics, the categorisation of medicine that focuses on pregnancy, birth and the postpartum period, is frequently criticised for pathologising the natural act of childbirth and placing little or no emphasis on a person's experience outside of a medical lens. To quote Heather Cahill (2001, p. 334) highly paternalistic, dehumanising, patriarchal environments view women as "essentially abnormal, as victims of their reproductive systems and hormones' where pregnancy is 'inherently pathological – a clinical crisis worthy of active intervention". There is growing global concern about the extent to which obstetric violence is often normalised within much healthcare practice impacting a person's subjectivity and agency during childbirth (Chadwick,

2017). In 2019, a United Nations special report on reproductive health highlighted growing concerns about obstetric violence and criticised many of the active management practices that are common in Irish hospitals (UN, 2019, p. 5-6). Informed consent and informed refusal in pregnancy, labour, birth and postnatal care is also often compromised. One Irish study by AIMS Ireland (2014) found of nearly 3,000 women who give birth between 2010-2014, 67 percent agreed that only basic consent had been sought during labour and childbirth, 52 percent didn't receive information on possible implications of tests, procedures and treatments, and just 50 percent felt empowered to refuse aspects of care during labour and birth.

There are also problems with the environment women are expected to give birth in. In 2020, a HIQA (Health Information and Quality Authority) report on inspections of maternity hospitals found these to be chronically underfunded, understaffed and often characterised by outdated physical infrastructure. HIQA (2020, p. 10) observed:

> When the physical environment is not up to standard, it significantly impacts on a woman's comfort, dignity and privacy and increases the potential risk of cross infection for women and new-borns. There is also the potential that cramped, overcrowded and cluttered environments will impede the timely attendance to a woman and or new-borns during an emergency.

To quote one of our own focus-group participants "the hospitals are just so old and decrepit and, in Irish maternity hospital it's a one size fits all".

Ireland's first *National Maternity Strategy – Creating a Better Future Together* (2016-2026) promises to address these shortfalls and provide "safe, high-quality care in a setting that is most appropriate to their needs; women and families are placed at the centre of all services, and are treated with dignity, respect and

compassion" (HSE, 2016a, p. 14). This national strategy sets out to address failures identified in a 2013 HIQA report into safety, quality and standards following the death of Savita Halappanavar, a 17-week pregnant Indian woman who presented to hospital actively miscarrying but was refused the abortion she requested because a foetal heartbeat could be detected. She died of septicaemia in October 2012. This refusal of care was because of a constitutional ban on abortion (called the eighth amendment) what gave equal rights to a foetus and a woman and which the Irish electorate voted to remove in 2018. Whilst around 15 people travelled overseas each day, some migrant women didn't have the papers or money to travel leaving them with no choice but to seek illegal abortions without medical care or carry unwanted and/or unviable pregnancies to term (MERJ, 2018). Although abortion is now available, barriers remain which again disproportionately impact some migrants (Fitzsimons, 2021, p. 160).

The Health Service Executive (HSE) who manage Ireland healthcare service acknowledge its responsibility to respect diversity and have produced a *National Intercultural Health Strategy* (2018-2023) to complement its *National Healthcare Charter* and *Good Practice in Person-Centred Intercultural Care* (HSE, 2009). These documents are a start, but Ireland's maternity services don't exist in a vacuum rather within a country where Islamophobia is an every-day experience for many Muslims (Carr & Hayes, 2015). Women frequently endure increased discrimination in the workforce (Pillinger, 2006; Soto & Ruiz Moriana, 2020) and put up with a range of myths and stereotypes that present them as subservient within the wider Muslim population (ENAR, 2016). The conceptual model we draw from to explain this phenomenon argues that racism (as well as patriarchy) isn't just deeply embedded within our psyche, it is fostered by mutually reinforcing structures where discriminatory practices are entrenched within the institutions of society including education (Brookfield,

2018). The foundations of what Bell Hooks (1994; 2010; 2013) repeatedly describes as "the white supremacist capitalist patriarchy" are colonial. Its ideology is one of white supremacy; a mentality that has enabled the historical dispossession of millions of indigenous people, all for economic gain. Although less stark than the slavery models of the past, expropriation remains a core feature of capitalism. As Cinzia Arruzza, Tithi Bhattacharya and Nancy Fraser (2019, p. 43) argue,

> In every phase [of capitalism] up to and including the present, the expropriation of racialized people has enabled capital to increase its profits by confiscating natural resources and human capacities for whose replenishment and reproduction it does not pay. For systemic reasons, capitalism has always created classes of racialized human beings, whose persons and work are devalued and subject to expropriation.

Another central feature of capitalism is to convince us that, as Sarah Jaffe (2021, p. 23) puts it "the work of cleaning, cooking, of nursing wounds, of teaching children to walk and talk and read and reason, of soothing hurt feelings and smoothing over little cries comes naturally to women". This sends out a strong message that her principal function is to give birth and raise the next generation. Much reproductive health care has been complicit in maintaining this patriarchal control and today's doctors work within deeply individualised, underfunded healthcare systems where there is growing obstetric control despite discourses that promise the opposite (Benoita, Zadoroznyjb, Hallgrimsdottira, & Taylor, 2010). Benoita et al. (2010) offer a variety of reasons why this is the case including the ongoing privatisation of healthcare, the growth in medical technology and pharmacology and the ongoing privileged position afforded the medical profession.

## The role of education.

This analysis of patriarchal capitalism also informs *critical pedagogy*, a dialogic, collective process where people are supported to unpack the circumstances of their life in an engaged manner. Contents are 'uncovered' rather than 'covered' as is the case in more traditional 'banking approaches to education' (Freire, 1972; hooks, 1994) so that many voices, and not just the voice of the educator, are heard and validated. Racist, sexist, gendered and ablest behaviours are explicitly brought to the fore, not as individual traits but as structurally caused. This doesn't mean individual behaviours don't have to change, rather it contextualises these behaviours within a critical understanding of social inequality. Importantly, the resultant learning from this 'Freirean' approach doesn't stay in the minds of the learners rather should be channelled towards a collective, cyclical process of praxis where people act together to transform environments. bell hooks (1992, p. 146) explains,

> One of the concepts in Freire's work and in my own work that is frequently misunderstood by readers … [is] many times people will say to me that I seem to be suggesting that it is enough for individuals to change how they think … Again, and again Freire has had to remind readers that he never spoke of conscientization [politicisation] as an end itself but always as it is joined by meaningful praxis … praxis is not blind action, deprived of intention or of finality. It is action and reflection.

There have been attempts to educate Irish healthcare workers with the dominant model being towards 'interculturalism'. One targeted example was the HSE 'Intercultural Awareness and Practice in Health and Social Care Training and the Train the Trainer Programme' that was delivered to 129 staff across the Southeast of the country in 2015. Participant feedback evidenced a better, more nuanced understanding of personal biases, a greater awareness of the barriers people face, more knowledge on local supports and a better sense of institutional practices designed to enhance inclusiveness (HSE, 2016b). In 2020,

a national online, Nursing and Midwifery Board of Ireland (NMBI) approved 'Intercultural Awareness' programme was launched by the HSE. Its overarching aim is "to reduce the potential harm that unconscious bias may cause" (HSE, 2020c). Staff individually log-in at their convenience and complete three modules; 1) Inclusive Practices and Intercultural Awareness, 2) Working with Others, and 3) Intercultural Awareness and Practice in Health and Social Care: Refugees Protection Applicants and Trauma.

## Methodology

The research that informs this contribution used mixed methods meaning it drew from qualitative and quantitative methods recognising limits to each in isolation (Creswell, 2009). One hundred and four women completed an anonymous, online questionnaire, eight participated in one-to-one semi-structured interviews and five took part in a focus-group. A person opted in by agreeing to the statement –

"*I confirm that I am a Muslim woman (culturally as well as through my faith), that I am over 18 years of age, and that I have used maternity services in Ireland at some stage in the last 3 years"*.

Eighty-seven percent of respondents self-identified as having migrated from a country outside Europe, 84 percent were women of colour[2] and 81 percent wore a Hijab. Most were recruited via Amal using outreach, networking, and snowballing methods. Participants came from wide-ranging contexts and backgrounds. A minority were doctors themselves or worked in other high-skilled professions. Others worked as the primary carer in the home. The research didn't ask people to share their occupation rather some spontaneously shared this.

We also engaged with 38 publicly employed professional healthcare workers (HCWs) who were recruited via networking and snowballing methods and using a variety of gatekeepers within obstetric and maternity care.[3] These HCWs completed a separate anonymous questionnaire and were invited to a one-to-one interview or focus-group. Nobody availed of this offer. Twenty-eight respondents (74 percent) were midwives working across labour wards, emergency departments, community care, lactation consultancy, hospital supported homebirths and clinical management. Five Public Health Nurses (PHNs), two general nurses, three obstetricians, one paediatrician, one junior doctor and one physiotherapist also participated. All but one, who was "Nigerian-Irish/Black-Irish", described their ethnicity as White. Everyone identified with the statement 'I am not a Muslim'.

All but one of the researchers were migrants and women of colour and all interviews were carried out by women who understood first-hand the impact of racism in their daily lives.[4] This created rich, authentic conversations where racialised dimensions of power were lateralised. Findings were collated and thematically analysed through a series of recursive and reflexive steps which attended to the emerging topics within the data and the externally defined research aim (Silverman, 2011).

As indicated above, our ontological assumption on entering the study is to believe that a person's racialised identity, and their subsequent experience of racism, can directly impact their health outcomes (Caratella & Maxwell, 2020). Our understanding of racism draws from the Irish Network Against Racism description as,

> Any action, practice, policy, law, speech, or incident which has the effect (whether intentional or not) of undermining anyone's enjoyment of their human rights, based

> on their actual or perceived ethnic or national origin or background, where that background is that of a marginalised or historically subordinated group. (INAR, 2020, p. 2)

Like racism, sexism must also be combatted not only by addressing internal biases but by dismantling patriarchy, a misogynistic logic that relies on gender binaries, heteronormativity, and often deep-seated concepts of male privilege (Manne, 2017).

We adopt an anti-positivist emancipatory feminist epistemology believing the task of uncovering subjugated knowledge requires resourcefulness and resilience, so this knowledge is not drowned out by the more prevalent 'truths' of dominant groups (Hill-Collins, 2008, p. 270). This is particularly the case within maternity care where 'expertise' is often located outside of the pregnant person and with the healthcare professional. Sara Ahmed (2017) describes feminism as "the releasing of a pressure valve" (p. 30) which gives women permission to inhabit their bodies with confidence and become more conscious of the many injustices' women experience daily, but often overlook. Feminism shows women they are not alone rather, as Ahmed (2017) further states "you are finding out about the many ways that feminists have tried to make sense, already, of the experiences you had, before you had them; experiences that left you feeling all alone are the experiences that lead you to others" (p. 31). Difficult histories, are not unique, including those relating to unnecessarily trauma associated with birthing (Reed, Sharman, & Inglis, 2017) feminist research (and indeed critical education) can support women to valiate, process and act on these experiences.

As with all social research there were limitations. There was lower than anticipated engagement with Pakistani, Bangledeshi and Afghan participants

who make up 28 percent of Muslims in Ireland (Fahey, McGinnity, & Grotti, 2019). This was partly because we were only able to produce a questionnaire in English and Arabic and not in Urdu, Pashto or Bengali. The Covid19 pandemic also had an impact as it forced Amal to close their drop-in centre limiting direct contact with many women. It is also hard to ignore the low recruitment of healthcare workers which fell short of our ambition to of 50 professionals. They too were operating within extreme, pandemic related circumstances and many may not have prioritised taking part in research. One hospital gatekeeper reported many don't regularly check emails as is the norm in other occupations. However, our experience was people were disinterested in our research. Many potential gatekeepers did not respond, and lots of the 38 healthcare workers that did participate left much shorter comments than those provided by their patients.

## Research findings

Our research found many examples that mirror problems identified in other jurisdictions including lower than average engagement with services. Four percent first presented for care when they were in active labour and just 21 percent attended antenatal classes. Several women reported simply not having the time because of other caring responsibilities. This is best summed by the comment, "we don't have family; we don't have support. There is no place to put our children and if it's an emergency we don't have a mother who will be available 24 hours, we don't have someone who can accept our children straight away" (focus-group participant). Others couldn't go to antenatal classes because of work, or because they struggled to navigate a system that over relies on the English language. Two respondents believed the classes on offer were culturally inappropriate because they were mixed gender, something known to incongruent with nurse-patient interactions for many Muslims (Halligan, 2006). The most common reason for nonattendance was that antenatal classes were

perceived to be unbeneficial. When we probed within one-to-one interviews, three out of eight women didn't understand the purpose of antenatal classes. In our focus-group, where nonattendance was discussed in some detail, women reported feeling isolated and alone because of a broader sense of being 'othered' within Irish society.

When women did engage with services, most were happy with their overall care. One participant shares, "everyone, including in my follow up care, was so cooperative, understanding and patient", a sentiment that is often echoed by others. In particular, there was much praise for PHNs. For instance, "the Public Health Nurse do a beautiful job by visiting me and my baby regularly and phoning me sometimes", and examples of PHNs doing repeat visits and organising referrals to other services. However, there was a dominant trend where although women determined that they were treated well, this was often interpreted as the absence of being treated badly rather than the actuality of experiencing an excellent or even equal services as their non-Muslim counterparts. When we looked for specific stories about their care, 85 percent identified shortfalls across familiar international trends namely difficulties sourcing a halal diet (72 percent), no understanding of their need for modesty (39 percent), inadequate interpretation services (10 percent), not being able to access female healthcare workers (8 percent), and a lack of appreciation for cultural differences (10 percent). Overall, a pattern emerged where, although some staff tried to accommodate the needs of these Muslim women, there was an overriding sense of what one woman describes as "a tick-box approach".

Many women felt they were not listened to with respect to modesty meaning simple solutions were not implemented to prevent unannounced entrances to women's bedsides or, as this woman puts it, "respect for the Hijab and giving time to dress properly before doctors enter". The constant flow of unannounced

visitors, doctors, nurses and cleaners created high levels of stress for Hijab-wearing women. To give an example of the impact this had,

> …Whilst trying to breastfeed my child (not wearing a Hijab) a male student doctor opened my curtain and proceeded to ask me questions and check my chart. I had to cut him off and explain that I'm a Muslim and would like a minute to wear the Hijab and then he can come back and proceed to ask me questions. Which he did. But it had since happened again twice more. So, I just remained in my Hijab throughout my stay.

Where women felt exposed during birth (likely not unique to Muslim women) this was particularly stressful. This survey participant shares the following,

> At one point, almost in pushing stage and on "all fours" a male intern or a student as I believe came into the room to observe. Thankfully I had my husband near me to cover me with a sheet and started shouting myself 'no men'! I believe no unnecessary personnel should be allowed to enter especially without notice.

This is just a sample of several similar stories shared. Unsurprisingly, these situations created long-term negative impacts for some of those affected. Within one-to-one interviews and focus-groups, women talking about being "very upset" and how they felt just a little more care and attention could have prevented the level of distress experienced. After sharing a similar story about her birthing experiences, Khadija (a pseudonym) tells our interviewer "I just think they should have asked". The researcher probes further asking, "at what stage would it have been helpful to ask?" to which Khadija replies "They should have asked before the birth. They knew I was different. They were giving me halal food etc. before this, there should be a way for them to ask … For example, just to be asked 'how you feel about male attendees?"

Some women described situations where their birthing choices were respected. For example, “they made me comfortable and give me confidence to give vaginal birth, while I was in delivery room” and “they respected my plan even though it didn't go as I want at the end, but they did all their effort to help me”. For others, the issue of informed consent and informed refusal emerged with one in five not feeling in control of decisions made about their body. One explained “my birth preferences weren’t really discussed”, a sentiment that was repeated by others also. Others reported having to repeatedly clarify and describe their medical history and their birthing preferences and of feeling largely unheard in a power-laden relationship where, as this woman puts it, “… whatever the midwife and doctor suggested, I just agreed to it”.

Although communication problems within maternity care are not unique to Muslim women’s experiences (Van Helmond et al, 2015), a particular theme emerged related to communication and there was much emotion conveyed about the challenges of not being able to fully express yourself to a caregiver during such a significant life event, something Halligan (2006, p. 1569) describes as “a major barrier in developing a good rapport” between nurses and their patients. The impact of this is illuminated within our focus group discussion,

> … lots of women cannot explain about themself, their feelings, there pain in another language and in a critical condition like pregnancy and labour pain. And I have seen myself lots of Arabic and Muslim women starting to cry in the hospital just because they cannot understand what the doctor says about her baby or her foetus, they are a lot and they really need help…

Hospitals do provide interpreters. But the service was not always effective and there can be a shortage of phones. It can also be difficult to explain personal concerns to often male interpreters who have no specific healthcare training.

We posed the hypothesis "*during my maternity care I experienced racism/discrimination because of my skin colour and/or Muslim Faith*". Bracketing off racial oppression like this might seem contrary to the structural concepts at the heart of our study, but it helped reveal some important patterns. Twelve percent of survey respondents answered 'yes from a member of staff' when presented with our hypothesis. A further three per cent answered 'yes from a member of the public'. When we asked "*if there was/is a situation(s) that made you feel excluded or discriminated against because of your faith*" the positivity rate rose to 20 percent. There are several reports of negative questioning, feelings of being ignored or dismissed and of being treated differently to other patients. For example, "I get 'looks' sometimes, because I look Muslim, but I'm used to it" or, "one of the healthcare staff spoke roughly and accused me of lying. I couldn't answer back or clarify my situation…My physical emotional circumstances and being a migrant were not considered, which made me feel alone with no one to help". There are reports of people's requests being dismissed or minimised, of women being shouted at, and even reports that women's babies were treated differently. One woman shared, "my baby was not attended to while she was crying. The nurse on duty was a racist." From someone else,

> I feel like my baby's situation was overlooked. She showed signs of slow growth and no movement from early in the pregnancy, yet nothing was looked into. We later found out she contracted a virus whilst I was 13 weeks pregnant (and the virus showed on my booking bloods when retested at a later date).

One woman was "told to be quiet when experiencing contractions because she was 'scaring other patients" continuing "I was not given gas and air or an epidural when asked and I was treated with a very negative attitude…I was quite shocked and so was my husband." Some were asked to remove their

Hijab. Many women minimised these experiences. For example, in her one-to-one interview, Dihaya described a doctor being "a bit rude", shared that she was abruptly asked, "why are you screaming" and relayed an overall sense that her Muslim identity contributed to her "not being listened to". Throughout her four day stay in hospital she repeatedly asked for help bathing her baby but didn't receive any support (potentially a symptom of understaffing). However, she distances these experiences from discriminatory behaviour stating, "but there was no racism at all". This finding corroborates Lauderdale's (2006, p. 187) assertion that ethnic minority women often struggle to articulate oppression within maternity services.

A final theme to emerge was reports of negative attitudes towards male partners as captured in the comment "I was pressed on more than one occasion to say that my husband was abusive. I felt this was based solely on the colour of our skin". Another shared "I don't mind the need to be vigilant in terms of gender-equality but our partners are under more suspicion than 'white-Irish' partners." This additional suspicion is corroborated by one HCW who reports "a [universal] perception that her partner is abusing her" which they link to situations they have witnessed where consent was "not being gained for certain procedures due to language barrier".

Other healthcare workers substantiate the women's broader experiences. Twelve (or 32 percent) report negative attitudes, stereotyping, and racist behaviours by other healthcare workers. For example, one midwife shares,

> I've witnessed staff not wanting to care for Muslim women, asking other staff to care for the 'mussies'. I've seen pain relief denied and after giving birth Muslim women being described as 'precious' if they seem a little lost (which is normal for every new

> mother) after their baby is born. Lack of willingness to support needs in relation breastfeeding etc.

Another midwife talks about "other patients making racist type comments about Muslim women and staff stereotyping Muslim women as behaving a certain way in labour." In one final example this healthcare worker comments,

> I don't have any recollection of any staff to patient verbal racism however, I noted on numerous occasions that staff were generally less interactive with Muslim patients. Less chatty, and appeared to spend less time caring for them in comparison to other women. It was an observation that I wondered was this due to language barrier and a barrier for a women to voice her needs correctly. Allowing a barrier to care facilities is racism in my eyes.

Some healthcare workers (nine out of 38) did their best to accommodate female carers and regretted not always being able to cater for this especially during night shifts or where there is little attention paid to the gender of anaesthetists, obstetricians, or paediatricians. Many others do their best to provide suitable diets. Regarding communication, HCWs agreed that translation services were often inadequate. Some resorted to using *Google Translate* or family members. One midwife wrote "language barrier is massive especially coming in unexpectedly such as in labour or in an emergency". Others understand communication as much more than the act of translating from one language to another rather as a holistic endeavour that is essential in "developing a rapport with a woman". This midwife continues,

> I wonder how many major issues do we miss such as domestic abuse, mental health concerns? We don't even scratch the surface, 'don't ask and it'll all be grand' diminishes me as a midwife, let alone vulnerable families.

Just one in four participating HCWs were aware of any hospital policies/practices that supported the needs of Muslims, and some resisted any suggestion they should reflect on their practice. One midwife goes so far as to blame Muslim women for "not identifying their particular needs.… which we could attempt to facilitate". Another left the comment "I would prefer if the approach to Muslim women didn't seem like something to be extra mindful of and just treated them like they were not a special case".

Others were more conciliatory with eight healthcare workers acknowledging their current practice is below par and most respondents acknowledged they could do better. Staff point to what this contributor describes as a "lack of current information/education" or from another, the absence of "education regarding Muslim cultures and beliefs around labour and pregnancy etc". One HCW shares "I need to educate myself more. I need to update on all ethnic minorities", another proposes "Further Education in traditional practices of Muslim women, and all minorities, to better prepare staff for adapting practice to each individual". And again, "education, education, education" continuing "funding, resources plus the development of the role of specialised midwifes in catering for BAME [Black, Asian, Minority Ethnic] community, like what is in the UK".

Participating Muslim women also suggested we should "train all staff to be culturally aware" and, to quote someone else, offer training that would "correct the false information they have". Some suggested Amal or other community-based organisations could provide this training. Amal is also proposed as a potential site for separate antenatal and postpartum classes that would be less reliant on the English language and that would be more culturally appropriate. One focus-group participant wants both actions simultaneously explaining,

> If we can teach medical staff about our culture, our needs … that will be great - like to give them an information session about the women needs, that will be also a good idea. So, it's like to give the information on both sides. And maybe one day the women would be happy to go to the hospital for the classes, if they felt it's more appropriate than now.

**How community-based, critical education might help advance change.**

According to Reni-Eddo Lodge (2017, p. 640) "structural [racism] is often the only way to capture what goes unnoticed – the silently raised eyebrows, the implicit biases, snap judgements made on perceptions of competency". Through this lens, our research reveals clear patterns of widespread discrimination within Irish maternity hospitals. Seemingly small issues such as the absence of Halal food isn't just a failure to provide nutritious meals during such a critical stage in a person's life, something hospitals often fail to do more broadly (HIQA, 2016), it is about the coded messages this sends about acceptance, belonging and value.

The study also reveals most participating healthcare workers realise there are shortfalls and want to be part of a solution. Education can help. However, the current HSE, INMB approved programme is an illustration of an approach that fits neatly into individualist, skills-based frameworks and less obviously within the critical pedagogic approach outlined earlier. For example, where programmes emphasise cultural difference (with interculturalism seen as the solution) culture is typically, and not incorrectly, understood as the conscious and unconscious enactment of certain customs and rituals. Learners are thus taught to appreciate and respect different ways of being. Less emphasised is how the 'cultural fields' within which these differences are exercised repeatedly privilege existing social hierarchies (Fitzsimons, 2017).

If we are truly committed to advancing change, people should be supported to understand race (and of course gender) as social constructs with people who are

racialised as white enjoying privileges that are often invisible to them (Kendall, 2013; Andrews, 2018; Race et al., 2022). Turning a blind eye to racial difference doesn't equal equality, it upholds white supremacy and normalises racist, everyday practices within social institutions (Bonilla-Silva, 2006; Flowers, 2010; Brookfield, 2018). If work placed education is to make a difference, it must create communities of practice that are led by a critical pedagogic philosophy that confronts white supremacy in the first instance. This involves creating environments that are often uncomfortable for people who hold white privilvege to be in (Brookfield, 2018; Fitzsimons & Nwanze, 2022; Race et al., 2022). This isn't to berate white people but to arouse deep dialogue that not only addresses deeply held prejudices, but that examines the multiple ways institutional, or structural racism is endemic. As Race et al., (2022, p. 83) put it,

> This is a proclamation that calls for the creation of a safe learning environment to allow robust and honest conversations about race and racism. We know this is not easy. It is a complex and difficult process. However, if we do not do this and do not provide students with the space to talk about their experiences, then we are not going to be able to make the kind of transformation of culture that is needed. Unless we say that this issue is a priority, we are going to have a slow change if any at all.

Moreover, if anti-racism, diversity-based and/or intercultural education wants to truly commit to improving the circumstances of these women, it must be prepared to unmask a neoliberal socio-economic system that, according to Henry Giroux (2021, p. 4) "cannot be separated from the spectacle of racism, ultra-nationalism, anti-immigration sentiment, and bigotry" that promotes fear rather than shared responsibility.

Whilst critical education philosophies can also guide the alternative models of antenatal and postpartum group processes many of these women suggest, in fact

the HSE's *National Intercultural Health Strategy* (2018-2023) promises collaboration with community organisations including "small organisations that promote inclusion and access" in caring for "minority ethnic groups" (HSE, 2018, pp. 16-17). However we must problematise the concept of 'community' - a social system that is continually negotiating its relationship with wider society and where certain population groups do not feel the solidarity, significance and safety communities ideally characterise (Clark, 1996). It is in the absence of these conditions that groups have little option but to seek out separate spaces more likely to nurture their overall wellbeing. In the want of a more democratic world, these spaces can become consciousness-raising, feminist spaces that seek to collectively articulate the negative impacts of medicalisation on the all aspects of pregnancy, birthing and the postpartum period and the racism that our institutions perpetuate.

**Notes**

[1] This is usually through the combined care of a General Practitioner (GP) and an obstetrician within one of 19 maternity hospitals. The scheme allows six GP visits during pregnancy, ante-natal classes, in-patient and outpatient public hospital services. It also includes two GP visits postpartum and Public Health Nurse (PHN) care to monitor a baby's development and offer supports especially in breastfeeding.

[2] In describing their "ethnicity/skin colour", 39 percent chose Middle-Eastern, North African (MENA), 28 percent Asian, 16 percent 'White/Caucasian' 10 percent 'Black/African descent' and 2 percent another categorisation.

[3] We sought ethical approval from three Dublin hospitals. One gave consent and circulated the survey but the method they used was unsatisfactory. The two other hospitals took many months to respond to our queries leaving no option but to proceed without using them as a gatekeeper.

[4] The research team were [redacted]

**References**

Ahmed, S. (2017). *Living a feminist life.* Durham and London: Duke University Press.

AIMS Ireland. (2014). *"What Matters to YOU?" 2014 Report on Consent in the Irish Maternity System.* Dublin: The Association for Improvements in the Maternity Services in Ireland. Retrieved September 21, 2021, from http://aimsireland.ie/what-matters-to-you-survey-2015/womens-experiences-of-consent-in-the-irish-maternity-services/

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine,, 40*(11), 1849-59.

Ali, N. (2004). *Experiences of Maternity Services - Muslim Women's Persectives.* The Maternity Alliance. Retrieved May 31, 2022, from https://www.maternityaction.org.uk/wp-content/uploads/2013/09/muslimwomensexperiencesofmaternityservices.pdf

Almeida, L. M., Caldas, J., Ayres-de-Campos, D., Salcedo-Barrientos, D., & Dias, S. (2013). Maternal Healthcare in Migrants: A Systematic Review. *Maternal and Child Health Journal*(17), 1346–1354.

Andrews, K. (2018). *Back to Black Retelling Black Radicalism for the 21st Century.* London: Zed books.

Arruzza, C., Tithi, B., & Fraser, N. (2019). *Feminism for the 99%.* New York: Verso.

Benoita, C., Zadoroznyjb, M., Hallgrimsdottira, H., & Taylor, H. (2010). Medical dominance and neoliberalisation in maternal care provision: The evidence from Canada and Australia. *Soc Sci Med., 71*(3), 475–481.

Brookfield, S. (2018). *Teaching race: How to help students unmask and challenge racism.* New York: John Wiley and Sons.

Cahill, H. (2001). Male Appropriation and Medicalization of Childbirth: An historical analysis. *Journal of Advanced Nursing, 33*(3), 334-342.

Caratella, S., & Maxwell, C. (2020). Health Inequalities by Race and Ethnicity. *Centre for American Progress*. Retrieved August 31, 2021, from https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/

Carr, J., & Haynes, A. (2015). A clash of racializations: The policing of race and of antiMuslim racism in Ireland. *Critical Sociology, 41*, 21–40.

CDE Ireland. (2019). *Confidential Matenal Death Enquiry Ireland. Data Brief no. 4.* Cork: MDE Ireland. Retrieved November 26, 2020, from https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/MDEDataBriefNo4December2019.pdf

Chadwick, R. (2017). Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism and Psychology, 27*(4).

Clark, D. (1996). *Schools as learning communities. Transforming education.* London: Cassell Education.

Collins, J. W., David, R. J., Handler, A., Wall, S., & Andes, S. (2004). Very Low Birthweight in African American Infants: The Role of Manternal Exposure to Interpersonal Racial Discrimination. *American Journal of Public Health, 92*, 2132-38.

Costa, M. (2018). The Particularity of Migrants and Ethnic Minorities in Ireland. In MERJ, *We've Come a Long Way, 2nd Edition* (pp. 29-33). Editora Uruta.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches (3rd ed.).* Sage Publications, Inc.

Dole, N., Savitz, D. A., Siega-Riz, A. M., Hertz-Picciotto, I., McMahon, M. J., & Buekens, P. (2004). Psychosocial Factors and Preterm Birth Among African American and White Women in Central North Carolina. *American Journal of Public Health, 94*, 1358–65.

ENAR. (2016). *Debunking Myths of Women's Rights, Muslim WOmen, Feminism and Islamophobia in Europe.* European Network against Racism. Retrieved May 31, 2022, from https://ec.europa.eu/migrant-integration/library-document/debunking-myths-womens-rights-muslim-women-feminism-and-islamophobia-europe_en

ENAR. (2016). *Forgotten Women: The Impact of Islamophobia on Muslim Women.* Europe: European Network Against Racism. Retrieved May 24, 2022, from https://www.enar-eu.org/forgotten-women-the-impact-of-islamophobia-on-muslim-women/

Fahey, E., McGinnity, F., & Grotti, R. (2019). Irish Attitudes to Muslim Immigrants. *The Economic and Social Review, 50*(3), 491-514.

Firdous, T., Darwin, Z., & Shaima, H. M. (2020). Muslim women's experiences of maternity services in the UK: qualitative systematic review and thematic synthesis. *BMC Pregnancy and Childbirth*.

Fitzsimons, C. (2017). Adult education responses to the 'othering' of Muslim identity: Perspectives from Irelan. *Journal of Adult and Continuing Education, 23*(2), 263-280.

Fitzsimons, C. (2021). *Repealed: Ireland's ongoing Fight for Reproductive Justice.* London: Pluto Press.

Fitzsimons, C., & Nwanze, L. (2022). Towards, critical, engaged, antiracist learning environments. *The Adult Learner; The Irish Journal of Adult and Community Education*.

Fitzsimons, C., Hassan, B., Nwanze, L., & Obasi, P. (2021). *The Experiences of Muslim Women in Irish Maternity Settings.* Amal Women's Association.

Flowers, D. A. (2010). Mammies, Maids, and Mamas : The Unspoken Language of Perceptual and VErbal Racism. In V. Sheared, J. Johnson-Bailey, I. Scipio A. J. Colin, E. Peterson, & S. B. Associates (Eds.), *The Handbook of Race and Adult Education* (pp. 271-282). San Fransisco: John Wiley and Sons.

Freire, P. (1972). *Pedagogy of the Oppressed.* London and New York: Penguin.

Funge , J. K., Mathilde , C. B., Johnsen , H., & Nørredam , M. (2020). "No Papers. No Doctor": A Qualitative Study of Access to Maternity Care Services for Undocumented Immigrant Women in Denmark. *International Journal of Environmental Research and Public Health*.

Giroux, H. (2021). *Race, Politics and Pandemic Pedagogy; Education in a Time of Crisis.* London: Bloomsbury Academic.

Government of Ireland. (2020). *Report of the Advisory Group on the Provision of Support including Accommodation to Persons in the International Protection Process.* Dublin: Government of Ireland. Retrieved May 24, 2022, from https://www.gov.ie/en/publication/ee7d5-report-of-the-advisory-group-on-the-provision-of-support-including-accommodation-to-persons-in-the-international-protection-process/

Halligan, P. (2006). Caring for patients of Islamic denomination: critical care nurses'experiences in Saudi Arabia. *issues in Clinical Nursing*(15), 1565–1573.

Hassan, S. M., Leavy, C., & Rooney, J. S. (2019). *Exploring English Speaking Muslim women's first-time maternity experiences: a qualitative longitudinal interview study.* BMC Pregnancy and Childbirth.

Hill-Collins, P. (2008). *Black Feminist Thought.* New York: Routledge.

HIQA. (2013, October 7). Investigation into the safety,quality and standards of services provided by the HealthService Executive to patients, including pregnant women, at risk of clinical deterioration, ncluding those provided in UG and as reflected in the care and treatment... Retrieved from https://www.hiqa.ie/sites/default/files/2017-01/Patient-Safety-Investigation-UHG.pdf

HIQA. (2016). *Report on the review of nutrition and hydration care in public acute hosptials.* Dublin: Health Information and Quality Association. Retrieved May 25, 2022, from https://www.hiqa.ie/sites/default/files/2017-02/Review-nutrition-hydration-hospitals.pdf

HIQA. (2020). *Overview report of HIQA's monitoring programme against the National Standards for Safer Better Maternity Services , with a focus on obstetric emergencies.* Health Information and Quality Authority. Retrieved October 4, 2020, from https://www.hiqa.ie/sites/default/files/2020-02/Maternity-Overview-Report.pdf

hooks, b. (1992). Bell Hooks speaking about Paulo Freire, the Man, his Work. In P. &. Leonard, *Paulo freire : A critical encounter.* Taylor and Francis Group.

hooks, b. (1994). *Teaching to Transgress: education as the practice of freedom.* New York: Routledge.

hooks, b. (2010). *Teaching Critical Thinking: Practical Wisdom.* New York and London: Routledge.

hooks, b. (2013). *Writing Beyond Race: Living Theory and Practice.* New York: Routledge.

HSE. (2009). *Health Services Intercultural Guide.* Dublin: Health Service Executive. Retrieved May 31, 2022, from https://www.hse.ie/eng/services/publications/socialinclusion/interculturalguide/interculturalguide.pdf

HSE. (2016a). *National Maternity Strategy 2016-2023.* Dublin: Health Service Executive.

HSE. (2016b). *Intercultural Awareness in Practice in Health and Social Care in the on a Train the Trainer Basis Model of Training.* Health Service Executive Community Healthcare Organisation Area 5. Retrieved from https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/training/intercultural-awareness-and-practice-in-health-and-social-care.pdf

HSE. (2018). *Second National Intercultural Health Strategy.* Dublin: HSE Social Inclusion .

HSE. (2020a). *Perinatal Statistics Report 2017. Healthcare Pricing Office.* Health Service Executive . Retrieved August 31, 2021, from www.hpo.ie/latest_hipe_nprs_reports/NPRS_2017/Perinatal_Statistics_Report_2017.pdf

HSE. (2020b). *Irish Maternity Indicator System (IMIS).* Dublin: Health Service Executive.

HSE. (2020c, June 11). *New accredited Intercultural Awareness ELearning Programme now available*. Retrieved May 31, 2022, from HSE.ie: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/news/new-accredited-intercultural-awareness-elearning-programme-now-available.html

INAR. (2020). Understanding Racism: Defining racism in an Irish context. Dublin: Irish Network Against Racism.

Jardine, J., Walker, K., Gurol-Urganci, I., Webster, K., Muller, P., Hawdon, J., . . . Van Der Muelen, J. (2021). Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study. *The Lancet*. doi:10.1016/S0140-6736(21)01595-6

Kendall, F. E. (2013). *Understanding White privilege; creating pathways to authentic relationships across across race. 2nd edition.* New York: Routledge.

Lauderdale, D. (2006). Birth Outcomes for Arabic-Named Women in California before and after September 11. *Demography, 43*(1), 185-201.

Lyons, S., Clarke, A., Staines, A., & O'Keefe, F. (2008). Cultural Diversity in Dublin Maternity Services: the experiences of maternity service providers when caring for ethnic minority women. *Ethn Health. 2008*.

Manne, K. (2017). *Down Girl: The Logic of Misogyny.* USA: Oxford University press.

Manning, E. (2014). *Establishing a Maternal Death Enquiry in a low maternal mortality context.* World Health Organisation. Retrieved from https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/ireland/en/

McGinnity, F., Privalko, I., Russell, H., Curristan, S., Stapleton, A., & Laurence, J. (2022). *Origin and Integration: Housing and Family amongst Migrants in the 2016 Irish Census.* Economic and Social Research Institute. Retrieved May 23, 2022, from https://www.esri.ie/system/files/publications/BKMNEXT422_0.pdf

McGinnity, F., Russell, H., Privalko, I., & Enright, S. (2021). *Monitoring Decent Work in Ireland.* Dublin: Economic and Social Research Institute. Retrieved May 23, 2022, from https://www.esri.ie/system/files/publications/BKMNEXT414%20%281%29_0.pdf

MERJ. (2018). *We've Come A Long Way: Reproductive Rights of Migrants and Ethnic Minorities in Ireland* (2nd ed.). Dublin: Editora Urutau.

MRCI. (2020). *All work and Low Pay: The experince of Migrants working in Ireland.* Dublin: Migrant Rights Centre of Ireland. Retrieved May 23, 2022, from https://www.mrci.ie/app/uploads/2020/02/MRCI-All-Work-and-Low-Pay.pdf

Nellums, L., Powis, J., Lucy, J., Anna, M., Rustage, K., Russell, N., . . . Hargreaves, S. (2021). "It's a life you're playing with": A qualitative study on experiences of NHS maternity services among undocumented migrant women in England. *Social Science & Medicine, 270*.

Pillinger, J. (2006). *An Introduction to the Experience of Women Migrant Workers in Ireland.* Dublin: The Equality Authority.

Race, R., Gill, D., Kaitell, E., Mahmud, A., Thorpe, A., & Wolfe, K. (2022). Proclamations and provocations: Decolonising curriculum in education research and professional development. *Equity in Education and Society, 1*(1), 82-94.

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth, 17*(21).

Silverman, D. (2011). *Interpreting Qualitative Data. (4th Edition).* London: Sage.

Soto, N., & Ruiz Moriana, S. (2020). *Employability of Migrant Women in Ireland: A survey by the Migrant Woman - Opportunities for Work Project of New Communities Partnership.* Dublin: New Communities Partnership. Retrieved May 31, 2022, from https://www.newcommunities.ie/assets/files/pdf/162202995215370681.pdf

Thomasen, K. (2018). *Perilous Pregnancies: Barriers in Access to Affordable Maternal Health Care for Undocumented Migrant Women in the European Union.* Centre for Reproducive Rights.

Tobin, C., & Murphy-Lawless, J. (2014). Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. *International Journal of Women's Health*.

UN. (1979). *Convention on the Elimination of All Forms of Discrimination against Women* . New York: United Nations General Assembly. Retrieved May 23, 2022, from https://www.ohchr.org/sites/default/files/cedaw.pdf

UN. (2019). *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.* New York: United Nations General Assembly. Retrieved May 31, 2022, from https://digitallibrary.un.org/record/3823698?ln=en

Van Helmond, ,. I., Korstjens, ,. I., Mesma, J., Nieuwenhuijze, ,. M., Horstman, ,. K., Scheepers, ,. H., . . . de Vri, R. (2015). What Makes for Good Collaboration and Communication in Materntiy care - A scoping study. *International Journal of Childbirth, 5*(4), 210-223.

**Author Details**

**Dr Camilla Fitzsimons** is a Lecturer at the Department of Adult and Community Education at Maynooth University, Co. Kildare, Ireland. She has published extensively in adult and community educaiton (https://www.maynoothuniversity.ie/people/camilla-fitzsimons#3) Her email is camilla.fitzsimons@mu.ie

**Lilian Nwanze** is a PhD Candidate, Irish Research Council Scholar and Occasional lecturer at the Department of Adult and Community Education at Maynooth University, Co. Kildare, Ireland.