

**CULTURAL CONSTRUCTIONS OF INFANCY:**

**An Anthropological Study of Infant Care in Cardiff**

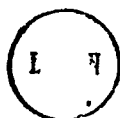
**Madeleine Gantley**

**A thesis submitted for the degree of PhD**

**The London School of Hygiene and Tropical Medicine**

**University of London**

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**ABSTRACT**

This thesis is about infancy, independence, and how medicalisation shapes mothers' perceptions of their infants. It draws on ethnographic research in Cardiff, undertaken during a period of heightened concern about the Sudden Infant Death Syndrome (SIDS), and funded by the Foundation for the Study of Infant Deaths.

Three "cultural constructions" of infancy are juxtaposed: the vulnerable and constantly accompanied Bangladeshi infant, the Welsh or English infant encouraged towards independence, and the autonomous infant of epidemiological analysis.

The thesis shows how the processes of medicalisation brought contrasting perceptions of infancy to light, suggesting that Bangladeshi women taking part in an "English for Pregnancy" project were not only learning language, but also learning about medicalised infant care. It argues too that health professionals shape the way in which mothers perceive their infants through the introduction of the language of "risk factors".

The infant body itself emerged at the boundary of powerful systems of meaning. If the boundaries of the Bangladeshi infant body were blurred through constant contact, those of the Welsh or English infant were marked intermittently through alternating periods of solitude with "attention". Some Welsh and English mothers spoke of infants and their care in terms of the care of domestic animals, and the mothers' own ambivalence about their own animality, while some Bangladeshi mothers spoke of the spiritual power and vulnerability of infants, and in doing so articulated their links with Bangladesh. For health professionals the infant body was a site for demonstrating expertise through both research (which constructed ethnic minorities as 'natural') and recommendations for action.

The thesis discusses the location of contemporary anthropology at cultural boundaries. Juxtaposing contrasting beliefs about infancy revealed very different perceptions of independence, marked in particular by contrasting perceptions of time, space, and the infant body itself.

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**CHAPTER 1: ORIGINS****PhD Student and Research Officer**

This thesis adopts a social anthropological approach to the topic of infancy. It discusses perceptions of infants and their care, and explanations of infant death. This opening chapter introduces the various elements which constitute the thesis. The chapter title, "Origins", is intended to draw attention to both the biological and cultural dimensions of infancy. In this sense, it encapsulates the perspective of the whole thesis, the meeting of the natural and the cultural - and indeed the cultural construction of the domain of the 'natural' - in both anthropology and in infancy.

During 1991-1992 I had the opportunity to undertake fieldwork in Cardiff to explore the possible association of infant care practices with the relatively low incidence of Sudden Infant Death Syndrome (SIDS) in infants born to Bangladeshi parents in Britain. A paper published in the British Medical Journal (Gantley et al, 1993: appendix I) shows how this research was presented to audiences with a specific professional interest in SIDS.

In describing myself above as both PhD student and research officer, I reflect the two roles I occupied throughout the fieldwork. This thesis moves beyond the analysis

suggested to health professionals with a specific interest in SIDS, to incorporate their perspective as a part of the broader context of infant care. I present an ethnographic account which contrasts the views of infancy expressed by Bangladeshi mothers, Welsh mothers, and health professionals. At this stage, these terms are used as a broad guide to the comparisons to be drawn; each of these categories incorporates variations, and they are best thought of as a continuum, an idea to which I return later.

In describing the particular populations with whom I came into contact, I draw on Cohen's 1985 discussion of the concept of community. Cohen's work lies within British social anthropology; this is an important distinction in that later in the thesis I refer to the work of McKenna, whose origins lie in American physical or biological anthropology.

Following Cohen's discussion of community as essentially a relational concept, I present people who took part in the fieldwork as 'communities of meaning'. This is not to suggest that people within each of these categories - the Bangladeshi, the Welsh, and the health professional - shared identical views. Rather, I use the concept of a community of meaning to reflect the contrasting views of infancy - particularly infant independence - that emerged during the data collection.

Broadly speaking, in Bangladeshi households infants were



constantly with other people, frequently in contact with their carers; it was rare for anyone to be alone, and simply unacceptable for an infant to be without adult company. In Welsh or English households infants were encouraged to develop at least an appearance of independence, being expected to sleep and play on their own, to 'go to anyone'. For health professionals, the autonomy of the infant body was taken for granted. While there was clearly vast overlap between health professionals and the Welsh and English mothers, during the fieldwork - particularly at the time when advice about infant care changed - the distinction between those delivering advice and those receiving it became clear.

During the fieldwork period, the infant son of a well-known television presenter died from SIDS, which resulted in both enormous media interest in the subject, and a change in the advice given by health professionals. This made particularly clear the distinction between those people delivering advice on infant care (the health professionals), and those receiving it. It contributed, too, to my decision to regard the wide range of health professionals with whom I came into contact as itself a "community of meaning".

Cohen describes a community as a group of people with something in common with each other that also distinguishes them from other groups of people. Here I suggest that what these groups have in common - and indeed what brings them

into contact with each other - is the care of infants; what distinguishes them from each other, however, is the way in which they perceive and understand infants and their care. Cohen places particular emphasis on the boundaries of communities of meaning, the boundaries marking the distinction between those who are members, and those who are not:

"the boundary encapsulates the identity of the community and, like the identity of an individual, is called into being by the exigencies of social interaction" (1985: 12)

This is a key quotation in that it draws attention both to the boundaries of communities, and to those of an individual: both of these are elements that emerge later in the thesis.

In emphasizing the relational concept of community, Cohen draws attention to the its potential as a boundary-expressing symbol. Following this perspective, I suggest that infancy too is a boundary-expressing symbol. Cohen's definition is:

"their range of meanings can be glossed over in a commonly-accepted symbol - precisely because it allows its adherents to attach their own meanings to it." (1985: 15)

Throughout the thesis I draw a distinction between the social processes of medicalised infant care, which draw Bangladeshi mothers into contact with health professionals, and Welsh and English women into contact with Bangladeshi mothers, and the contrasting cultural perceptions of infancy.

## A Particular PhD

As my discussion of my roles as both a PhD student and a research officer has already indicated, this thesis has two starting points or 'roots'. The first was my personal academic career, and the second a project for which a research officer was being sought. This section identifies the two 'roots'. I then move on to describe the particular PhD which has emerged, and to explain the choice of the title of "cultural constructions of infancy" and how this relates to an ethnographic method.

In the summer of 1990 I had completed four years of study, all undertaken as a mature student. These comprised a BA in Social Anthropology and Cognitive Sciences at the University of Sussex, and an MSc in Medical Anthropology at Brunel University. Encouraged by tutors at Brunel University, and willing as a mature student simply to explore possible future options, I applied for PhD research in the area of children's beliefs about medicines and drugs. Whilst being granted a place at the University, my application for funding was less successful. I therefore adopted a different tack, scanning the classified advertisements for research posts, giving preference to those which would also allow me to register for a PhD. In mid 1990 the research project described below advertised for a research officer, and towards the end of that year I was appointed as Research Officer to the project described below.

The research project was carried out with the financial support of the British charity which funds the majority of research into Sudden Infant Death Syndrome, the Foundation for the Study of Infant Deaths (FSID). Sudden Infant Death Syndrome - abbreviated to 'SIDS' and popularly referred to as 'cot death' - is the major cause of death between 1 and 12 months of life in industrialised countries. This remains the case even after the dramatic drop in incidence in 1992, which followed national prevention campaigns launched during the research period. SIDS is defined as the sudden, unexpected, and unexplained death of an apparently healthy baby (Golding et al 1985, and the Department of Health 1993, provide summaries of research on incidence, cause and prevention).

Early in 1990, David Davies, Professor of Child Health, and Dr Anne Murcott, Senior Lecturer in the Department of Psychological Medicine (both Departments within the University of Wales College of Medicine) and School of Social and Administrative Studies of the University of Wales College of Cardiff, submitted an application (see appendix II) for a research grant to the Foundation for the Study of Infant Deaths proposing a study of infant-care practices amongst two populations in Cardiff. The research proposal was designed to investigate infant care practices in two groups with contrasting rates of death from Sudden Infant Death Syndrome, in order to identify different and possibly protective practices among the group with the lower incidence. It was based on

epidemiological evidence indicating that Asian babies had a relatively low risk of SIDS. The proposal used a broad definition of 'Asian': it cited evidence from Hong Kong (Lee et al 1989) and from Indian, Pakistani and Bangladeshi families in Birmingham (Kyle et al 1990). During the research period further evidence of a lower incidence of SIDS among Bangladeshi babies in East London was produced by another researcher funded by the FSID (Hilder, unpublished data). Evidence of lower SIDS in Bangladeshi populations in Britain had the advantage of identifying an ethnic minority group with a lower incidence of a particular cause of death.

In addition to the epidemiological evidence, the proposal drew on work within physical anthropology and the social sciences. From physical anthropology came evidence which argued that human infants are uniquely vulnerable to imperfect respiratory control and that infant:parent proximity may protect against SIDS (McKenna 1986). From the social sciences came a focus on infancy (Murcott, 1993) and infant care in Britain (Newson and Newson 1963).

Given my own academic background in social anthropology, with a parallel strand of developmental psychology, many different theses could have emerged from the research project described above. I could for instance have chosen to focus on collecting empirical evidence on infant development, on parental beliefs about infant perception, on the transition to motherhood, on different styles of

parenting, on some of the issues associated more directly with SIDS and infant death, Bangladeshi and Welsh views of marriage, or British-educated Bengali women living in extended family households. My interest in infancy of course echoes a broad stream of sociological work on motherhood (for instance Oakley 1979 and 1986). Focusing on infancy, however, allowed me to adopt a different perspective, on how mothers saw their infants, on the comparisons made between infants and spirits by Bangladeshi mothers, and between infants and domestic animals by some Welsh and English women, and on the idea among some health professionals of ethnic minority infant care practices as 'natural'.

It would have been equally feasible for a thesis to focus entirely on Bangladeshi women, or on Welsh women, or on British-born Bangladeshi women, or English women in Cardiff. However, what emerged from the fieldwork was first the contrasting perceptions of infancy mentioned above; and second the powerful place of people who perceived themselves to be at boundaries - be they health visitors 'translating' epidemiological risk factors into the realities of motherhood as one aspect of daily life, or Bangladeshi linkworkers acting as 'mediators' between women recently arrived from rural Bangladesh and the new western culture of Cardiff.

As a way of narrowing down the possibilities, I turned to one of the texts that had been most influential during my

MSc in medical anthropology. This was Nancy Scheper-Hughes and Margaret Lock's "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology" (1987). I describe the article at this point not because it provides a theoretical framework for the PhD, but because it prompted a number of questions and interests, which helped me to focus on the particular PhD presented here. It therefore precedes rather than forms part of the literature review in Chapter 2.

Scheper-Hughes and Lock focus on the body, and in particular the relationship between the individual body, the social body and the body politic. I describe below each of these analytical aspects, and in particular how I saw it in the context of research about infant care practices, funded by a charity which raises much of its income from families whose infants have died from Sudden Infant Death Syndrome. Thinking about these different dimensions was the first stage in exploring some of the contrasts between sociological research and a medical, problem-oriented perspective.

Scheper-Hughes and Lock describe the body politic as the most powerful and far-reaching aspect of their analysis, recognising the varying ways in which individual and social bodies are regulated. It offered me two useful pointers in considering the focus of the research. First, they place the 'body politic' within a theoretical domain of poststructuralism, and characterise it as:

"the most dynamic in suggesting why and how certain kinds of bodies are socially produced" (1987: 8).

Second, they suggest that threats to healthy bodies and societies are dealt with by increasing control in a range of ways.

Looking first at the question of how specific sorts of bodies are socially produced, Young (1988) provides an example of the different kinds of bodies (or beliefs about bodies and causes of illness) associated with different kinds of societies. He distinguishes between external and internal disease causation, arguing that a belief in the cause of disease lying beyond the body (for instance in religion, ritual or witchcraft) tends to be associated with structurally simple societies, without specialised legal or medical establishments. In contrast, internal disease causation tends to be associated with more complex industrialised societies with specialised medical and other bodies of knowledge.

Scheper Hughes and Lock characterise western cultures as imposing industrialisation on nature, and suggest that in these circumstances increasing control over bodies is brought about through an emphasis on biomedical intervention to control the 'natural' domain of illness, coupled with increasing individual responsibility for health, achieved through a specific lifestyle. This kind of analysis would suggest that explanations for sudden infant death would be sought from within the physical



infant body. Chapter 7 shows how such internal explanations from the frameworks of, for instance, pathology and physiology, have thrown little light on SIDS; instead it is epidemiology, identifying infant care practices as "risky", that has apparently contributed to a fall in the incidence of SIDS. This emphasis on epidemiology, on identifying risk factors which in turn introduce more areas in which infant care lies in the domain of health professionals, seems to suggest increasing control of the management of infant care, not within but at the boundaries of the infant body.

Having argued that the body politic is the most powerful, Scheper-Hughes and Lock look at the the other two bodies - the individual and the social - essentially as culturally and historically specific constructions.

The social body - the body as natural symbol - emerges from an analytical approach based in structuralism and symbolism. It was this perspective which seemed most relevant to the type of data I was able to collect. Here Scheper-Hughes and Lock identify the relevance to medical anthropology of the symbolic equation of healthy body and healthy society. They draw particularly on the work of Mary Douglas and her emphasis on the power of the body as symbol:

"Just as it is true that everything symbolizes the body, so it is equally true that the body symbolizes everything else" (1966: 122)

While the varying ways in which infants were described was

the central focus at the outset of the fieldwork period, with the enormous publicity surrounding SIDS at that time, it was impossible to ignore the subject of infant death. Infant deaths in general pose a peculiarly potent threat to a healthy society: infant mortality rates are widely used as an indicator of the health of communities (Armstrong 1986), particularly in international comparisons. The Sudden Infant Death Syndrome, the unexpected death of an apparently healthy infant, poses particular problems. The infants are healthy, and explanations of cause of death remain unclear. The post-mortem category of SIDS is essentially a diagnosis of exclusion, a "mode of death" rather than a cause of death, according to one paediatric pathologist [conference fieldnote: Prof J Berry, paper to FSID Annual Conference 1992]. The apparently healthy but suddenly dead infant epitomises failure, at national, health professional and personal levels. Where the incidence has fallen, success is claimed at both national and professional level.

Scheper Hughes and Lock place the third aspect of their analysis, that of the individual body, in a theoretical approach drawn from phenomenology. This perspective places particular emphasis on the presentation of a "lived experience" of the body, the personal account, particularly in illness. Here the authors recognise the culturally specific nature of a western conception of a Cartesian body-mind duality, drawing attention to cultural variations in notions of the independent individual, and

understandings of the body and its organs. They describe a phenomenological approach as drawing on the lived individual experience of illness, often the patient's own account. The example they cite counterposes such a personal account with the perspective of a group of medical students. The students are attending a 'grand rounds' presentation, a relatively formal event in which students and their teachers 'meet' patients, as part of their medical education. On this particular occasion a middle-aged woman was 'presenting' - in the language of the doctors - with regular bad headaches. She described a long catalogue of domestic violence, caring for older and younger relatives; the medical students, whilst sympathetic, saw all these issues as incidental, focussing on identifying the "real", neurochemical cause which may be amenable to the treatment they are able to offer.

This section of their article offered me two thinking points, and in some ways posed more questions than answers. The first was a question about the nature of phenomenology and infancy. Is a phenomenological account possible when the person has no voice? To what extent is such a perspective reliant on language? In what other ways can infancy be observed and represented? Second, their example of medical students seeking the 'real' cause provided a nice parallel with Sudden Infant Death Syndrome: in presenting the research on infant care practices, I was often asked about the physiological mechanisms involved, sometimes couched in terms of "the real cause", and the

balance between the social and the physiological. This tension between the search for physiological or pathological explanations of SIDS, and the apparent but unexplained effectiveness of changes in infant care practices derived from epidemiological analyses of risk factors is one that I discuss further in chapter 7.

Citing the Scheper-Hughes and Lock article at this stage is not to suggest that I found it all useful. They argue, for instance, that their 'three bodies' are linked by emotions. This is not a conclusion I found particularly useful, since it entails questions concerning the constitution of emotions. Rather, I would argue that considering the three aspects of a specific set of empirical evidence emphasizes that the separation is analytical, and is useful at that level. Their linking is not an issue, in that they are aspects of the same thing, the human body, and the way in which it is conceptualised and experienced.

In the specific case of this research, my reading of their article emphasized that SIDS is defined and researched within a particular context in which infant death has become rare and shocking at a personal level, such that it generates considerable charitable funds. At the same time infant mortality rates have become a symbol of national wellbeing, and particularly the basis for international comparisons. Given the particular research opportunity open to me, I chose to concentrate on how the Bangladeshi, Welsh and English mothers, and health professionals,

described and categorised infant and their care.

Whilst the analytical perspective of Scheper-Hughes and Lock was useful in theoretical terms, I found Cohen's analysis of the symbolic dimension of community more useful in practical terms. The opportunity to undertake fieldwork for the first time highlighted for me the difficulty in making sense of a vast amount of data. Cohen's identification first of symbolic communities, and then of the importance of the boundaries at which they meet, was a useful step forward for me from a more theoretical starting point. The title of the thesis therefore reflects this idea of cultures as communities of meaning, and the particular methodological emphasis of ethnography, which are questions I discuss further below.

### **"Cultural constructions of infancy"**

As described above, the theoretical perspectives of Scheper Hughes and Lock, together with that of Cohen led me to conclude that the strength of the data I was able to collect lay in the notion of the infant as symbol among three different 'cultures' or 'communities of meaning'. Culture, however, is a term open to many definitions. Here I quote two examples which emphasise the often implicit nature of cultural beliefs.

Clifford (in Clifford and Marcus 1986:18) suggests:

"Culture, and our view of it, are produced historically, and are actively contested. There is no whole picture that can be 'filled in' since the perception and filling of a gap lead to the awareness of other gaps."

For Frankenberg (1992: 8)

"culture ... is not a thing that determines, it may rather be a set of possible processes which influences more what can't be done than what can."

The title 'cultural constructions' reflects more, however, than an ethnographic and anthropological focus on culture.

My focus on 'culture' also derives from my background in cognitive sciences and a contrast between implicit and explicit knowledge, and in particular some study of developmental psychology. I draw here on Toren's (1990) argument that all human interaction is essentially social. That is to say that there is no way in which human constructions cannot be social. So far as infancy is concerned, Winnicott captures it nicely:

"I once risked the remark 'there's no such thing as a baby', meaning that if you set out to describe a baby you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship." (1964: 88)

Within the framework offered by Toren, it is possible to distinguish, analytically at least, between how we come to hold certain perceptions, and what those perceptions are. From such an analytical perspective, the term 'social' would describe the social context within which infants develop certain beliefs or skills, and 'cultural' would refer to the nature of those beliefs or skills.

Infants, however, pose particular problems, in that we have no way of knowing what those beliefs are: infants, without language, challenge the idea of a phenomenological perspective, and emphasise the reliance of such a perspective on childhood and adult speech. The work of the phenomenological psychologist Merleau-Ponty (1962) on the development of perception through an awareness of spatial movement, however, was useful in approaching this research. It introduced for me a focus not simply on what parents said about their babies, but also on incorporating an observational element into the fieldwork, which would provide additional data on an infant's experience of contact, movement, sound and so on. I characterise this, in presenting it to audiences of health professionals, as the 'infant sensory environment'.

Of particular relevance to this research is the idea of medical knowledge as itself a symbolic system, or culture. Chapter 7 draws in particular on the work of Wright and Treacher, and their description of medical knowledge as "the child of social forces" (1982: 2). It draws, too, on Lock's introduction to "Biomedicine Reexamined" which describes the purpose of the collection as "to demonstrate the social and cultural character of all medical knowledge" (1988: 7). She cites the influence of Foucault and Armstrong in recognising that:

"the language of medicine does not merely describe a pre-existing biological reality, but instead creates its own objects of analysis" (1988: 6).

The particular relationship between medical knowledge and infancy is discussed further later in the thesis. It is introduced first in chapter 2 and later in chapter 7, which looks at the way in which the statistical analyses of epidemiology were reinforced by the apparent success of health education programmes advocating change in infant care practices.

The second element in choosing as a title 'cultural constructions of infancy', was to explore the idea of infancy as a liminal phase, in which the symbolic dimension of infancy would be particularly powerful. The work of Turner (1978) on liminality, and in particular its application by James and Prout (1990) to the concept of childhood, were particularly pertinent in this context. Developing Van Gennep's (1960) concept of liminality as separate, intermediate stages (between separation and reincorporation) of rites of passage, Turner uses liminality to

"refer to any condition outside or on the peripheries of everyday life" (1978:47).

Turner suggests that during these periods of liminality social relationships and symbolic meanings are constructed and reconstructed. Prout (1989) builds on Turner's notion of liminality in social space, to suggest that it may also apply over time. He argues that the shift from childhood to adult status is extended and fragmented. In discussing explanations of sickness among schoolchildren in their final year of primary school, he comments:



"The transition of contemporary English children into adulthood society, for example, is not tightly bound by rites of passage: it is a process which is extended in time and is marked by a number of different points at which adult status is taken on."  
(1990: 351)

In discussing perceptions of infants, I suggest that there are aspects of both space and time in conceptualising infancy as liminal. For some Welsh and English mothers there were parallels between the care of infants and that of domestic animals; Bangladeshi infants, in contrast, were sometimes placed in the world of spirits. Welsh and English mothers laid out the ways in which infants shifted into childhood - walking, talking, wearing specific sorts of clothes - suggesting that in some ways the shift from infancy to childhood was one that involved the move away from the animality of infancy.

It seemed to me that the opportunity to talk to people about infants and their care offered the opportunity both to look at infancy as itself a liminal stage, and at the shift from infancy to childhood, an area which has been little addressed by social scientists. Murcott's research on food ideologies with new mothers reviews the literature on babyhood and childhood. Introducing a discussion on "The estate of babyhood" she comments particularly on how the literature

"treats childhood as a fairly wide chronological age band" (1987: 361)

The contrasts between Bangladeshi perceptions of infants in terms of spirits, needing protection from evil spirits, with Welsh and English infant care being compared with

looking after pet animals, whilst health professionals offered advice to mothers based on 'risk factors' derived from epidemiological analyses emerge in Chapters 5, 6 and 7.

The title "Cultural constructions of infancy", as well as identifying the particular focus of the thesis on beliefs about infancy, draws attention to the method used in the research, that of ethnography. Ethnography as a research method is increasingly being referred to as "at the boundaries" of systems of meaning, a perspective which shares Cohen's interest in the boundaries of cultures:

"Ethnography is actively situated between powerful systems of meaning. It poses its questions at the boundaries of civilizations, cultures, classes, races and genders. Ethnography decodes and recodes, telling the grounds of collective order and diversity, inclusion and exclusion." (Clifford in Clifford and Marcus 1986: 2)

"...whatever use ethnographic texts will have in the future, if in fact they actually have any, it will involve enabling conversations across societal lines..." (Geertz 1988: 147)

Adopting a view of ethnographic texts as essentially artificial, as constructions, insists on recognising the "relations of production" of the text (Clifford 1986: 13). For these reasons I draw attention throughout to the original focus of the research on ethnic variation in the incidence of Sudden Infant Death Syndrome. I do not attempt to place myself and my own assumptions explicitly in the text, but do where possible show how my particular role (for instance as a non-mother asking questions about

infants and their care, or as a social scientist working with health professionals) became explicit throughout the research process. Using the metaphor of boundaries of overlapping cultures, derived from Cohen, allowed me to place myself at different points in the broader picture.

The term "cultural constructions" thus reflects three particular emphases:

- the specific fieldwork opportunity which allowed me to gather contrasting views of infancy and infant care;
- the power of infancy as a symbol at the boundary of different systems of meaning;
- the notion of ethnography as a research method at these boundaries of meaning.

The next section of this chapter turns to the three themes that run throughout the thesis. I have already suggested that I am distinguishing between the social processes of medicalisation, which brought these three different communities into contact with each other, and the ways in which each of these communities saw infant care. The themes relate to perceptions of infant care, and infancy. They identify the contrast between the embodied knowledge of the Bangladeshi mothers and the apparently objective knowledge of health professionals, and the increasing scope of medicalisation, particularly through the introduction of new advice concerning the prevention of the Sudden Infant Death Syndrome.

### Three Themes

Three themes emerged from the fieldwork and run through the thesis. Each is represented on a continuum which runs from Bangladeshi mothers at one end, through British-educated Bangladeshi mothers, then Welsh or English mothers, and Welsh or English health professionals. The continuum, and the three themes that are represented along it, may be represented as follows:

**Bangladeshi <-> Welsh/English <-> health professionals**

Embodied knowledge	Epidemiology or experience	Risk Factors
First encounters with medicalisation	Familiar medicalised infant care	Increasing medicalisation
No knowledge of SIDS	New advice on SIDS	'Reduce the Risk'

The first of the three themes to emerge along this continuum concerned contrasting forms of knowledge about infant care: Bangladeshi mothers, particularly those recently arrived from a rural village and living in an extended family, saw infant care in terms of usual practice, of embodied implicit knowledge. Bangladeshi women who had lived in Wales or England for longer periods were aware both of the practice of their extended family, and of the recommendations of health professionals. Welsh and English mothers had a range of sources of guidance on infant care, recognising both their own mothers' expertise in having brought them up successfully, and the fact that advice from health professionals concerning the prevention of SIDS had changed. Many of the health professionals were themselves parents, and found themselves recognising

that their own experience as parents was inconsistent with the apparently objective recommendations deriving from epidemiological analysis. Epidemiological analysis, which could be placed at the far end of this continuum, constructed infant care explicitly in terms of risk, identifying risk factors present in infants whose deaths had been attributed to SIDS, and thus providing the basis for campaigns by the Department of Health and Foundation for the Study of Infant Deaths campaigns whose theme was "reducing the risk".

The second theme which runs throughout the thesis relates to levels of medicalisation of infant care. For the recently-arrived Bangladeshi mothers their pregnancy was their first experience of contact with health professionals. In Cardiff, ante-natal hospital visits also resulted in referrals to an "English for Pregnancy" programme, which arranged for volunteer tutors to provide English lessons to mothers in their own homes. Chapter 4 describes my own experience as a tutor on this scheme, and shows how these Bangladeshi women were not only learning English, but were being introduced to the behaviour expected of them during the process of medicalised infant and ante-natal care. They were, for example, learning both the language involved in the provision of samples of blood or urine, and some of the ways in which they were expected to make their bodies available to health professionals for examination. For the Welsh and English mothers contact with health professionals was unremarkable,

particularly in the processes of pregnancy and childbirth. Health professionals' perspectives were different, their roles being centred on the 'production' and development of healthy infants. Chapter 7 shows how this medicalisation process expanded during the research period, and adopted the terminology of epidemiology, introducing the concept of risk into infant care.

The third theme to link the three communities relates to knowledge and experience of Sudden Infant Death Syndrome.

One of the starting points for this particular research was the low incidence of SIDS among the Bangladeshi population in Britain. This is explained further later in this chapter, and in chapter 7. Here, however, the salient point is that at the Bangladeshi end of the continuum there was very little knowledge of SIDS. Among the Welsh and English mothers there was concern about SIDS for some, and real fear for others. For epidemiological analysis SIDS was the starting point, infant death being a powerful domain in which to demonstrate professional expertise, and indeed to generate research funds.

These three themes emerge particularly strongly in Chapters 5, 6 and 7, which describe how the Bangladeshi, and Welsh or English mothers, saw their infants and their needs, and how this data was presented to health professionals. The themes emerge earlier, however, in the literature review in chapter 2, in the account of the processes of initiating the research which forms chapter 3, and in the discussion

of ethnicity in chapter 4, particularly in its comments on Bangladeshi women's first encounters with medicalised ante-natal care.

### **Thesis Outline**

The present introductory chapter has explained how the thesis originated, the particular PhD that emerged with its focus on infancy, and the way in which the term 'cultural construction' is used. Chapter 2 reviews some of the literature on infancy and childhood, and incorporates both a broad overview of the relevant literature and more detailed discussions of particular texts in order to provide a historical and political context for the specific research presented in later chapters. It identifies a number of issues which also arise from the data, the national and international impact of infant mortality rates, the professionalisation of and professional investment in infant care, and the mutual reinforcement of medical knowledge and infant well-being. Chapter 3 discusses some of the practical dimensions of the research process, and shows how these processes foreshadowed some of the issues that arose later in the fieldwork, for instance the contrasting perceptions of time in Bangladeshi and Welsh households.

The second part of the thesis moves on to the presentation of the substantive ethnographic data collected. Chapter 4 juxtaposes the three communities of meaning, showing where they cross, and posing questions about how each

culture views the other (for instance the health professionals' construction of ethnic minority infant care practices as 'natural'), and my own place as an observer at various different points of the research process. This emphasis on where they cross, or meet, reflects Cohen's comment that:

"people become most sensitive to their own culture when they encounter others" (1985: 70)

The chapter draws together both theoretical and ethnographic data on the concept of 'ethnicity' in order to examine the specific ways in which ethnicity was described, or 'culturally constructed' by Bangladeshi and Welsh mothers in Cardiff. It also discusses some of the distinctions drawn by these women about being either Welsh or English in Cardiff. The birth of an infant emerged as a period in which parents made explicit many of their beliefs about what constituted, for example, 'Bangladeshiness' or 'Welshness', a factor which contributed to my decision to focus on the symbolic power of infancy. The chapter touches too on the colonial history of Bangladesh, to show how this particular period of history paved the way for Bangladeshi populations to be found in many British cities; it also reinforces an international context for the comparison of infant mortality rates.

Chapters 5 and 6 describe beliefs about infancy and infant care practices among these same mothers, drawing contrasts between different perceptions of time and space, of the



infant body, and of dependence and independence. Chapter 7 describes how this data was presented to audiences of health professionals with a specific interest in Sudden Infant Death Syndrome (SIDS). Within the context of a discussion of what Lock terms "The culture of contemporary medicine" (1988: 3), the chapter shows aspects of the process of medicalisation, some of the assumptions inherent in epidemiological analysis, and how professional advice to mothers changed both in content (advocating back rather than front sleeping) and in form (conceptualising infant care as risk reduction).

Finally, Chapter 8 draws together the sets of data, showing how the symbolic power of infancy emerged in both contrasting perceptions of the boundaries of the infant body, and the ways in which the Bangladeshi, Welsh and English mothers, and health professionals came into contact through the processes of medicalisation of infant care. The thesis concludes by placing the discussion of infancy in a broader context, recognising the contribution of media interest in SIDS during the fieldwork period, and national and international comparisons of SIDS rates, to the potency of infancy and infant death as a symbol of personal, professional and national wellbeing. It turns finally to recognise the value of anthropology at the boundaries of different cultures.

**CHAPTER 2: ANALYSING INFANCY AND INFANT DEATH**

In the opening chapter I described how this thesis emerged from the opportunity to interview Bangladeshi and Welsh women about infant care, to present these data to health professionals with an interest in Sudden Infant Death Syndrome, and how I chose to present these data in terms of three overlapping cultures or 'communities of meaning'. Later chapters discuss the practical processes of the research and the results that emerged. Here I show the path I followed through the literature on infancy and infant death, and continue the discussion initiated in Chapter 1 on how I came to focus on the power of the infant as symbol. Cohen (1985: 16) suggests that symbols

"do not tell us what to mean, but give us the capacity to make meaning".

During this research infancy emerged as a powerful symbol, prompting the recognition and expression of different understandings of both the apparently similar infant, and the apparently similar social processes of infant care.

This chapter does not aim to provide an exhaustive review of all the literature on infancy, but to offer a broader context for subsequent chapters which present empirical data on infancy and infant care. In particular, it identifies literature relevant to the medicalisation of infant care, the ways in which infant death is analysed and explained, and the international importance of infant mortality. Where appropriate, I refer to specific areas

of literature throughout the thesis: this includes, for instance, chapter 4, which draws on literature concerning the history of Bangladesh, and chapter 7 which cites specialised analyses of the causes of Sudden Infant Death Syndrome.

There are four steps to this literature review. The first describes briefly the perspectives on infancy adopted within the academic disciplines of anthropology, sociology and psychology, and indicates the points at which these have informed more popular literature. It recognises that within anthropology and sociology there is increasing interest in the concept of childhood, but relatively little empirical research on the notion of infancy. It was for this reason that I chose to focus the thesis on how Bangladeshi, Welsh and English mothers described their infants and their needs, and how these perceptions were shaped when I presented them to health professionals.

The subsequent steps shift to infant death, presenting three papers in more detail. These are Philippa Mein Smith's "Truby King in Australia: A Revisionist View of Reduced Infant Mortality" (1988); David Armstrong's "The Invention of Infant Mortality" (1986); and Peter Wright's "Babyhood: The Social Construction of Infant Care as a Medical Problem in England in the Years around 1900" (1988).

### **Step 1: The Infant in Anthropology, Sociology and Psychology**

Step one of the literature review scans the broad field of academic literature on infancy. It aims to identify various areas of literature and research perspectives rather than to discuss them in detail. The literature presented here falls into the disciplinary domains of anthropology, sociology and psychology. These are broad categories, however, and there are clearly areas of overlap: cross-cultural psychology, for instance, could fall equally well into psychological anthropology, or equally anthropological psychology.

Given my own background in anthropology, my starting point in the literature on infancy was within this discipline. The infant in anthropology appears in ethnographic texts resulting from long periods of participant observation, focussing on for instance child-rearing practices or children's roles in different cultures (from Mead 1955 to Carsten 1991). Other accounts include Rabain's (1979) description of child-rearing among the Wolof people of Senegal which pays particular attention to the gradually expanding physical distance between mother and child, or Briggs' (1970) ethnographic account of the lives of Eskimo infants and children. Blanchet (1984) provides a detailed account of rituals of birth in Bangladesh which was of particular relevance given that some of the women whose

experience informs this research were recent migrants from Bangladesh. Cross-cultural comparisons such as these provide the basis for some more general baby-care books which emphasize the range of variety in 'natural' infant rearing (see, for instance, Kitzinger 1990 on "The Crying Baby").

Other texts which may fall into the category of anthropology (although a category of 'Development' may be more accurate) refer specifically to Bangladesh and are more problem or policy oriented, such as Talukder's (1986) work on family planning or Ahmad (1991) on the link between women's status and fertility rates. These texts provided valuable background against which to initiate contacts with Bangladeshi women in Cardiff. Perhaps the richest source of work on Bangladesh came from Gardner (1990, 1991, 1992a, 1992b), whose accounts of fieldwork in Sylhet provided an insightful analysis of the other end of the migration chain. Her descriptions of the relative wealth of the Londoni villages in which Bangladeshi migrants to the United Kingdom originate, and her reflections on her experience as a white westernised woman conducting fieldwork in a Sylheti village, were particularly relevant in the early steps of research and in developing analyses of contrasting perceptions of space and privacy. These are discussed further in Chapters 4 and 5.

Within the more specific domain of medical social

anthropology, there is interest in the cultural and historical specificity of particular constructions of health and illness. Scheper-Hughes' (1991) work in Brazil, particularly her discussion of the conceptualisation of infants as 'angels' (not named until they have survived infancy) and her insistence on placing her analysis within a broader context, suggested both differing notions of infancy itself (mediating the human and spiritual worlds), and foreshadowed some of the views expressed by Bangladeshi mothers in Cardiff who spoke of their babies as angels or spirits.

Scheper-Hughes also draws attention to the extreme poverty into which some infants in Brazil are born, and the frequency and familiarity of infant death. In such circumstances

"The process of anthropomorphisation becomes delayed until the mother is more certain that the infant will survive." (1991:1145)

Analysis of this kind draws parallels between particular views of health, in specific cultural and historical circumstances, and the broader political system. Crawford (1977) offers another example of this sort, suggesting that there are links between a definition of health as a resource, to be worked for through adopting a certain lifestyle, and a capitalist mode of production which values investment for the future. In the particular case of Sudden Infant Death Syndrome, health education material was

targetted at parents through a 'Reduce the Risk' campaign (discussed further in Chapter 7). It was not individual adult lifestyle that was the subject of concern, but the role of women as carers of infants, who were themselves symbols of the future.

One set of literature which was crucial to this research - and provides a nice example of the distinctive approaches of physical and social anthropology - was the work of the physical anthropologist James McKenna (1986, 1990a, 1990b) on SIDS. He argues that over the millions of years of human evolution infants would have been carried virtually constantly, and would have become accustomed to hearing and feeling the movement of their mothers' bodies. In particular, they would have been exposed to the movement and sound of chest and heart, which in turn may have contributed to the regulation of immature breathing.

McKenna draws comparisons with other primates, and finds that SIDS happens only in human infants, and within a relatively narrow time band. From this observation, he posits that the control of human infant breathing is placed under particular strain because of the development first of 'intentional crying' and later of language, both of which require sophisticated control of breathing. He argues that during this period it is to be expected that infant breathing will be imperfectly controlled, and that at the same time the environment to which the infant is adapted

through its evolutionary history is that of close proximity to a parent or 'mature breather'. The adult/child pair exchange a series of sensory cues through a series of physiological mechanisms, which in turn may contribute to the regulation of infant breathing.

McKenna argues that in western contexts it is precisely at this vulnerable period, when infant respiration is most influenced by this external input, that infants are likely to be placed on their own for relatively long periods of quiet sleep. From this base, he argues that keeping infants close to their carers may protect them against SIDS (McKenna and Mosko, 1990). This is an argument to which I return in Chapter 7. McKenna's work also provides an example of a particular use of 'evolutionary' evidence in medical journals, as an indicator of 'natural' and therefore good practice in infant care. Again, I return to this question in chapter 7 which shows how this research was presented to health professionals.

Evolutionary and cross-cultural research such as that of McKenna also provides some of the arguments used by Jean Liedloff in "The Continuum Concept" (1986) or Deborah Jackson in "Three in a Bed - Why you should sleep with your baby" (1989). Rather than being targeted at health professionals, these are books designed to appeal to specific groups of mothers living in industrialised societies but interested in 'natural' ways of infant care.



In discussing Welsh and English mothers' views of infants and their care in Chapter 6, I cite some mothers who were actively involved with the National Childbirth Trust, one of whom specifically referred to "The Continuum Concept".

Distinctions between anthropological and sociological accounts of infancy may be difficult to draw. Accounts of infant care practices in contemporary Britain, whether from a sociological or anthropological perspective, are rare. John and Elizabeth Newson's "Patterns of Infant Care in an urban community" (1963) was the closest parallel I could find to the research I conducted, although their perspective was more centrally based in developmental psychology and social research than my own.

Sociological and anthropological interest in the concept of 'childhood' is burgeoning. Aries' (1973) work on childhood is much quoted, introducing as it does the notion of a social category of childhood distinct from adulthood. It does not, however, elaborate just what it is that constitutes a "child". La Fontaine (1986) offers an anthropological perspective, placing ideas of child development and care within a broader cross-cultural context. This was a particularly valuable resource for my early contacts with the Bangladeshi mothers in Cardiff, for whom perceptions of time and routine were very different from those of the health professionals with whom they came into contact.

In chapter 1, I referred to Prout's (1989) argument that the shift from childhood to adulthood takes place in a fragmented fashion, over an extended period of time, rather than an taking the form of an easily identified 'rite of passage'. With James, he extends this argument to underline the importance of time, and specifically transitions, during childhood (James and Prout 1990), be they primary school children (Prout 1989), or adolescents (James 1986). On the shift from infancy to childhood, a subject I return to in Chapter 6, James and Prout comment:

"Within the school system the movement from nursery school to primary school...implicitly recognizes and reflects the movement out of infancy and into childhood, from the domestic world of the family to the culture of children." (1990: 233)

Whilst there is contemporary work on the power of the image of infants (Holland 1992), neither Aries nor the contributors to James and Prout (1990) or Waksler (1991) address the issue of the infant as distinct from the child. For some of the Welsh and English mothers who contributed to this research, and whose views are presented in Chapter 6, the steps from infancy to childhood were important markers in their child's development. Murcott (1987) opens the debate on infancy by characterising

"the estate of babyhood as a special instance of childhood" (1987: 361)

This provided an idea of central importance in this thesis.

I have already mentioned the way in which anthropological and psychological evidence underpins many popular childcare

books (Kitzinger 1990, Leach 1982). Hardyment's "Dream Babies: childcare from Locke to Spock" (1983) reviews popular publications, starting from the mid 1850s. This was the point at which they became available in English rather than in Latin, and were written for mothers rather than for doctors. Most advice was directed to the middle classes, on the assumption that it would 'filter down' into the working classes. Later in this chapter I refer to the increasing professionalisation of infant care, particularly through health visiting. Here I use a short extract to demonstrate the way in which information was mediated through class, the 'threat' the working classes were thought to pose to the middle classes, and attempts to seek protection through the control of germs. The extract accompanies a drawing of a middle-class woman visiting a working-class family. Next to the illustration is a picture of a banner reading "How to help the working classes". The banner is wrapped around a cross, suggesting that this was not simply an issue of class and hygiene, but that the church too had a role in encouraging specific ways of caring for infants. Infant health in this way became a matter of spiritual welfare - for infant, mother, and the lady volunteers involved:

"Well intentioned lady volunteers heralded the official state-paid health visitors of the early twentieth century. They brought the latest theories on hygiene and infant care into the backstreet slums - and were advised to sprinkle disinfectant powder around wherever possible" (1983: 143)

Hardyment comments too on the different ways in which

babies were perceived, identifying metaphors such as plants to be tended or animals to be tamed. She sweeps the wide range of experts into "cuddly or astringent - lap theorists or iron men (or maidens)" (1983: xiv). Whilst this is to reduce a variety of views to an apparently simple opposition, it does encapsulate both the strength of feeling about infants and their care and the stark contrast in approaches.

Similar to Hardyment is Beekman's "The Mechanical Baby: a popular history of the theory and practice of child raising" (1977). His range is broader, however, encompassing babies and adolescents, and placing particular types of advice within a broader historical and political context. His is an historical account of "the theory and practice of child raising" and moves from the 15th century "The Child of the Poets" to "The Collective Child" of the 1970s. More recently, Cooter's edited collection entitled "In the Name of the Child: Health and Welfare 1880-1940" (1992) explores the links between changing advice about childcare and shifts in Government policy. Urwin and Sharland contribute a chapter entitled "From Bodies to Minds in Childcare Literature: Advice to parents in inter-war Britain". In particular, they argue that a shift of emphasis towards children's emotions echoed parental and national anxiety in the face of the international events leading to the Second World War. They suggest that childcare literature was one source of information on how

specialised knowledge was passed on to parents early in the 20th century. Their analysis accepts, however, the notion of "specialised knowledge". The subject of the cultural construction of medical knowledge has already been identified in Chapter 1, and is one to which I return later in this chapter and in more detail in Chapter 7.

Also within this sociological category would fall historical accounts of infancy and infant care practices such as Georgina O'Hara's "The World of the Baby (1989), Diana Dick's "Yesterday's Babies" (1987) and De Mause's (1976) "History of Childhood" which has frequent references to infants and their care, but no specific discussion of the nature of infancy in contrast to childhood. He comments on how frequently 'baby-stools' or walking devices are mentioned in historical accounts of infancy: later in the thesis I describe how unfamiliar baby-walkers were to Bangladeshi households, but how they were an integral part of the process of encouraging Welsh or English infants towards an appearance of independence.

In addition to anthropological and sociological perspectives on infancy, psychology offers a wide range of analyses of infancy. In Chapter 1 I raised the question of phenomenology of infant experience. In phenomenological psychology, O'Neill (1982) and Merleau-Ponty (1962) draw attention to the physical experience of the infant, the role of touch, and movement around particular axes, in the

development of an understanding of space and perception through the body. This ties in with Piaget's (1952) description of infancy as the "sensorimotor" stage of development, in which the primary mode of perception is through physical experience gained in movement. Coupled with my interest in the possibility of a phenomenology of infants, given their lack of language, this literature was particularly influential in developing a research perspective which focused on the infant experience as well as on some of the social processes of parenting.

Within developmental psychology, one strand of commentary develops a focus on the infant as an individual, and on the physical, cognitive and affective development (for instance, Richards 1980). An enormous literature deals with the perceptual abilities of the infant in the first few months of life. Trevarthen (1988) asks how infants begin to know the language and culture of their parents, and develops a theory of innate cognition for social and cultural skills. He suggests that:

"Modern psychological theories ... systematically undervalue the competence of the infant for having feeling and desires, for acting with purpose, for dealing with persons and for co-operative life" (1988: 37-8).

In support of his argument, he summarises a range of work on the reaction of newborn babies to their mothers: this includes the work of Meltzoff and Moore (1977) on infant imitation of facial expressions, and De Casper and Fifer's

research on newborn infants' preference for mother's voice over other female voices (1980).

Similarly, Maurer and Maurer (1990) offer an excellent summary of the data on infant perception. An early comment in their book, however, identifies their own view of the infant as an independent and autonomous body. They describe a new mother coming into their laboratory with her baby in the following way:

"We take the baby from her arms, set him in an infant seat, then begin to show him a series of pictures that allows us to gauge how well he sees" (1990: 3).

This may not seem very significant; however, it echoes a comment made by McKenna (1986) in discussing SIDS, that much of the research on infant sleep patterns has been done from an ethnocentric perspective which assumes that infants sleep either on their own, or some distance away from other members of the household. Second, it illustrates one of the major contrasts that permeates this thesis: on the one hand the vulnerable Bangladeshi baby constantly close to its extended family; on the other hand, the Welsh or English infant alternately with a carer or encouraged to sleep, play or sit alone, often in specially designed and purchased 'baby equipment'.

A separate strand of work within psychology seeks to identify the series of cognitive stages through which all infants will pass (Piaget and Inhelder 1958), how these may vary or remain the same in different cultures (Cole and

Scribner 1974), and the relationship between particular infant care practices and personality types (Whiting and Child 1962, Whiting and Whiting 1975). Cross-cultural research focusing on the contrasting development of motor skills is described by Super (1981). Behavioural psychology provides a particular theory on breathing as learned behaviour which they relate to Sudden Infant Death Syndrome (Burns and Lipsitt 1991). They suggest that while all babies are able to breathe through their noses, the control of breathing through both nose and mouth is learned behaviour and therefore can be taught. More generally, behavioural psychology underpins many of the popular childcare books (for example, Leach 1982).

Having identified the broad range of literature within anthropology, sociology and psychology which relates to infancy, and in particular the lack of empirical evidence on how mothers conceptualised their infants, the next section of this chapter moves on to a more detailed account of three articles which concentrate on the context of infancy and infant death in 20th century Britain.

In Chapter 1, I described Scheper-Hughes and Lock's focus on the body politic as "the most dynamic in suggesting why and how certain kinds of bodies are socially produced" (1987: 8). This second half of the literature review pursues the idea of the body politic: that is, how certain sorts of bodies are produced. It explores some of the



specific historical and cultural contexts in which infancy and infant mortality have become subjects of concern.

## **Step 2: An International Context**

Philippa Mein Smith presents what she terms "A Revisionist View of Reduced Infant Mortality", in a paper for the New Zealand Journal of History entitled "Truby King in Australia" (1988: 23-43). She argues that the infant health movement was a response to, rather than a cause of, the dramatic fall in infant mortality in Australia in the first ten years of the twentieth century. Its relevance here lies first in identifying the international context in which infant death lies. This emerged very clearly during the period in which I was interviewing mothers. Chapter 1 has described how during the research period there was enormous media interest in SIDS in the United Kingdom. At this time evidence from New Zealand was cited to indicate that specific infant care practices affected the incidence of Sudden Infant Death Syndrome (a point to which I return in chapter 7). Second, Mein Smith looks to social explanations for falls in infant death, rather than attributing these to medicalised infant care. Third, she shows how recent is the emergence of the professionalisation of infant development and care.

She tells the story of Dr Federic Truby King, a New Zealand doctor, who "came to personify the baby health movement in

the inter-war years" (1988: 27). His views of infant care were, according to Smith, based on his experience of caring for mentally handicapped people and of breeding young animals. This led him to combine a eugenic ideal of 'promotion of the white race' with a model based on the feeding patterns of young calves. He disapproved of birth control among the white population, preferring instead to encourage the birth of healthy infants. This article then, in addition to drawing in some of the international context for infant death, introduces the dimension of colonialism. This is a subject discussed further below, and one to which I return in Chapter 4, which draws into the thesis some of the history of Bangladesh, and Bangladeshi migration to the United Kingdom.

Truby King founded the Plunket Society, which was named after his patron, the wife of the then Governor General of New Zealand. The Plunket Society provided specialist training in infant care for nurses, based around twelve rules which included a rigid timetable of feeding and sleeping, regular exposure to fresh air, and discouraging displays of affection. His views enjoyed enormous popularity, to the extent that, according to Mein Smith, branches of the Plunket Society emerged around the world and

"the little Princess Elizabeth, was advertised in Sydney's press as a Truby King baby" (1988: 27).

Truby King's agenda, however, was broader than that of infant care. It extended into the moral domain, and the

ideology of colonialism. In Mein Smith's words:

"Medical moralists, nationalists and imperialists in Britain, Australia and New Zealand interpreted the decline in the birth rate in the white countries of the Empire in the context of infant mortality and presumed low replacement rates, and turned it into an imperial problem that exemplified racial decadence" (1988: 27)

She quotes his description [Mein Smith 1988: 33 from Truby King 1917 "Save the Babies"] of the Plunket Society as:

"one of the first organizations in our Empire to recognize the germ of degeneration that had begun to sap our own vitality. It saw that if we could not do anything in the meantime to check the falling birthrate, we could do something locally to lower our infant death-rate, and to improve the mental and physical characteristics of our future generations".

Smith's central argument is that the improvement in infant health contributed to the influence of the infant health movement, leading to an increasing prescriptive mode of child rearing. She attributes the improvements in infant health, however, not to the infant health movement but to declining fertility rates and to the shift away from high mortality and morbidity associated with infectious diseases and poor nutrition, to the majority of deaths occurring in old age. The major cause of death in Australia had been infant diarrhoea, a symptom of various conditions with a variety of causes and its decline led to a significant fall in infant deaths. Again this foreshadows another issue which emerges later in the thesis: while the change in advice concerning infant care was followed by a fall in the incidence of Sudden Infant Death Syndrome, there is evidence of a downward trend in Scotland before the risk reduction programme was introduced (Gibson 1991). I return

to the question of the relative contributions of infant care practices and social circumstances in Chapter 7.

Smith's particular interest is in suggesting that health professionals had claimed the credit for a fall in infant mortality, which in her view was more properly attributed to a fall in the birth rate. In making her case, she shows how a situation in which fewer healthier babies are born, and can be expected to survive, prompted a burgeoning of advice about how infants should and should not be cared for. This article makes clear the investment of health professions in infancy, and the competing claims for reducing infant death. These were live issues in the debate surrounding SIDS during the research period. In addition, she provides a context for the discussion of both SIDS and infancy and infant care which extends into both the international importance of SIDS, and the impact of colonialism. The next paper moves on to look at the relationship of medical knowledge and infancy, in particular the link between the social categorisation of infant death and the explanations offered.

### **Step 3: Categorising Infancy and Infant Death**

David Armstrong's (1986) analysis in "The Invention of Infant Mortality" shows the shifting categorisation of infant death and draws contrasts between the domains of the natural and the social. This was useful to me in three

ways. First it helped me to understand how I was perceived as a social scientist, based in a Department of Child Health and working on a project associated with SIDS. I was placed by my medical colleagues in the 'social' domain. That is to say that their explanations of SIDS were divided into the 'natural' (the physiological or biological, which were open to analysis but would be difficult to change), and the 'social' (infant caring practices which were, in their view, relatively amenable to change). Second, Armstrong discusses the importance of recognising the relationship between the category and the categorised, the way in which the use of particular systems of classification reinforces the apparently discrete reality of what is being classified. This was particularly useful for me in discussing the social and cultural construction of both ethnicity and epidemiology, topics to which I return in chapters 4 and 7 respectively. Third, in arguing that analyses of infant deaths emphasize particular facets of infant identity, he suggests that SIDS is open to analysis from a range of perspectives, and so provided a focal point at which perspectives could coincide on the "whole" infant rather than on one aspect.

In describing the "Invention of Infantile Mortality", Armstrong draws on the approach of Foucault, tracing the emergence of what he terms the 'new pathological medicine'. This new form of analyses saw death coming from within the boundaries of the body, rather than from beyond it: in

other words, infant death was no longer conceptualised as 'natural', or within the realm of nature. This new view of death had implications not only for understanding the cause and treatment of illness, but also for the way in which the body was perceived:

"With this new configuration in the relationship between disease and the body, medical practice had an important new effect: by investigating, diagnosing and managing pathological states the doctor was also mapping and defining the limits of the discrete individual body". (1986: 222)

Chapter 1 has described how three themes run through the thesis, each on a continuum running from Bangladeshi perceptions at one end, through Welsh and English, and to health professionals at the other end. These themes related to the increasing importance of medicalisation, the independence of the infant, and the explicitness of infant care practices. Here Armstrong offers an explicit link between a new "medical gaze" and the individual bounded body of the infant. Chapter 1 set out the three themes that run through the thesis, and each of these may be seen as related to the infant body. This is an idea to which I return at various points throughout the thesis, in particular in presenting the empirical data on Bangladeshi and Welsh or English perceptions of infancy in Chapters 5 and 5, and the construction of infants by health professionals in Chapter 7.

The article charts the introduction of the recording and analysis of deaths in general, and the way in which infant

deaths became a subject of concern. Until the early 19th century, Parish Registers or coroners' courts had provided the only source of information on deaths and their causes, cause being divided into human agency, visitation from God, or natural reasons. With the introduction of Registration Acts in the 1830s, deaths were recorded by sex, age, occupation, but also by cause stated in terms of disease. Armstrong cites this as an early example of the extension of pathological medicine into the public domain, a shift to assigning death to an internal rather than an external cause, a natural rather than a social domain of explanation.

By the middle of the nineteenth century, death in adults was attributable to specific pathological cause, whilst in infants and older people it was deemed 'natural'. Armstrong comments in passing that it remains difficult from what he calls the 'new pathological' medicine to separate the notion of death as a normal biological event, from the abnormal and pathological. He argues that it is the relationship between social identity and form of death which kept infant death in the 'natural' domain for so long.

During the 20th Century attributions of cause of death moved away from the physical parameters of sex differences, urban or rural environment, and climate. Explanations were couched instead in terms of poor nutrition and social

conditions in urban areas, with legitimacy and social class also being introduced as social parameters. In this way death moved from the natural to the social domain. With pressure to improve accuracy, explanations 'of uncertain seat' and 'atrophy and old age' were introduced. The 'uncertain' category, in geographical analyses, accounted for a large number of deaths particularly in the first year of life. These were mostly atrophy, debility, malformation and sudden causes "imprecise yet specifically identifiable". Only congenital malformation was exclusive to children. So in 1855 a category of 'disease of growth, nutrition and decay' was introduced to cover congenital malformations, premature births and debility, atrophy and old age.

By the end of the 19th century, causes of death were being analysed by age. This in turn led to the availability of an infant mortality rate. However, the emergence of a of death rate specific to infants was not simply a new set of calculations which revealed an already-existing situation. Armstrong argues that it indicated a shift in the perception of infancy. Before an Infant Mortality Rate had been available, it had not been possible to separate out infants in statistical analyses. However, as causes of death specific to infancy became clearer, then the 'infant as a person made a tentative appearance'. Armstrong consistently emphasizes that statistics do not simply



reveal, but actively constitute, the identify of the infant and the category of infant deaths. They reflect changes in perception, dominated by what Foucault terms the 'medical gaze', rather than revealing a particular reality. This type of perspective, placing the infant as having an existence which is simply revealed by 'neutral analysis', has for Armstrong a political significance, in that it provides a moral foundation for policies relying on maintaining the family, and a particular social order.

At the end of the 19th century, with more interest in the infant, causes of death from atrophy and decay declined, and allocation to prematurity increased. Premature birth provides an instance of trying to separate out the attribution of death to mother or child. It was both the death of a child and an attribute of the mother: only if there was a specific disease could the infant be separated analytically from the mother. By the mid 1950s, however, there was a recognition of premature death as a vague description, and of 'immaturity' as context rather than cause. Specific causes were organised into prenatal, natal and postnatal, with immaturity the most important factor in prenatal and natal deaths, which became described in terms of the mother as "premature labour". Thus notions of mother:child interaction, of bonding, and of the foetus as a second patient emerged. Armstrong suggests that if the early 20th century saw analyses which established the infant as a discrete social being, then post-war analysis

served to integrate the child into physiological and emotional maternal and family bonds.

The 20th century saw a clarification in the status of the unborn foetus, and subdivision by age of death in the first year into stillbirths, perinatal, neonatal and infant deaths. In the early part of this century there had been no distinction between miscarriage and stillbirth: Armstrong argues that whilst from a biological perspective the pathway from foetus to infant would be seen as a continuum, in social terms it became important to distinguish between the death of a foetus and that of an infant once the latter has attained its own social identity. The definition was based on length of pregnancy - after 28 weeks the death of a foetus was categorised as a stillbirth. There were implications too in terms of care: a miscarriage would fall in the domain of ante-natal care, a stillbirth within hospital birth care.

The idea of the social, however, did not remain as a single source of explanation. Armstrong argues that the social dimensions of infant care shifted into public and particularly domestic space, and introducing the need for social surveillance and intervention. In this way the domestic domain shifted into public gaze, as did the relationship between the infant and its mother which

"both physiologically and psychologically, rapidly became entangled in the web of analyses which reconstructed domestic life and gave maternity and

motherhood a new status and new meaning". (1986: 213)

In this way infant mortality became the point at which the importance of social factors - infant surveillance via new welfare schemes, an analysis of home life and hygiene, and an evaluation of motherhood - was made explicit. More broadly it became an important indicator of well being, particularly in international comparisons. Armstrong cites the particular case of Sudden Infant Death Syndrome as an "ideal case" of the way in which different perspectives on infancy, and particularly the link between infant death and caring practices, come together. He locates his discussion in the broader historical context of explanations for infant death in the late 19th and early 20th century.

During the late 19th and early 20th centuries fewer infant deaths were attributed to atrophy or decay ('atrophy' as a category was removed in 1921), and an associated shift away from infant death being seen as 'natural'. Stillbirths became registerable, and the infant became a discrete analysable category. The 'whim' of the natural was replaced by discrete and essentially social causes of infant death. In the interwar years, Armstrong describes the emergence of specialised institutions and professional organisations, all 'deployed around the newly fabricated body of the child'.

Armstrong draws on the example of Sudden Infant Death Syndrome, which is of particular relevance to this thesis.

He suggests that an analysis of infant deaths identifies particular facets of infant identity: congenital malformations, for instance, focus on the biological elements of the infant body; immaturity points to the maternal and physiological interaction; and child abuse to parental and social context. He comments that "a totalising gaze", capable of integrating different perspectives, had been lacking. The first reports of Sudden Infant Death Syndrome in the early 1950s provided such an opportunity, a way which any number of analytical perspectives could be articulated - the micro and the macro, bacteriological and viral, nutritional, familial and social. Immediately post-war the emphasis had been on surveying normality, bonding, centile charts, the normal child - a 'normalising gaze'. He suggests however that between the wars such deaths would have been seen as a methodological artefact, whilst post-war, with the interest in unexplained anomalies, it became an ideal focus of interest. SIDS, like all other infant deaths, was as much constituted by the statistical framework, as constituting it.

#### **Step 4: The conceptual power of infant death**

The third paper to which I turn at this point is Wright's "Babyhood: The Social Construction of Infant Care as a Medical Problem in England in the years around 1900" (1988). He describes his social constructionist approach

as being based in a recognition that all knowledge is the product of human social activity which makes sense of individual lives and experiences. His approach is very close to my own, although as I suggest in chapter 1, my focus is on the "cultural" in order to explore the contrast between the different conceptual systems with which I came into contact.

I cite Wright's work in some detail because he recognises that medicine is the product of human social activity, but further that science and medicine play a central part in generation and establishing human experience. His paper argues that a new set of concepts emerged between 1890 and 1915. He identifies these concepts as: the emergence of infant death as a problem to be addressed; the location of this problem within the domain of medicine; infant death as a problem to be addressed socially and, finally, the incorporation within the problem of infant mortality of the culturally powerful idea of the germ pathogen theory. He locates the origins of his analysis at a culturally and historically specific moment, a time when the germ pathogen theory was able both to legitimate scientific knowledge, and to provide a framework for expressing fears about threats to the society of Victorian and Edwardian England.

The particular historical moment of concern came at the outbreak of the Boer War (1899-1902) which prompted a recognition of the poor health of the population,

specifically army recruits. Earlier in this chapter, in discussing Mein Smith's analysis of the professionalisation of infant care, I suggested that there was an international, and particularly a colonial interest in infant wellbeing. The emergence of concern at the time of the Boer War, which recognised both the need for both a fit army, and a work force able to operate the industrial base of the British Empire, emphasize the importance of infant wellbeing to national and international government.

In terms of my interest here in explanations of infancy and infant death, and in particular Sudden Infant Death Syndrome, Wright's perspective highlights the ways in which medical practice is itself a social force, and shapes the way in which people understand and experience the world. Looking at the particular instance of SIDS, it was clear that fear of SIDS became very important during the research period, and that the apparent success in reducing its incidence drew media attention, and accorded public prestige to specific researchers. It contributes too to the medicalisation of infancy and infant care and infant death. If Wright's question, which I describe later, is 'what gave germ pathogen theory its cultural power at that particular time?', one of the questions I pose is 'what gave SIDS its cultural power in the current context?' In chapter 7 I discuss how SIDS allowed health professionals to introduce the concept of risk into infant care, and in chapter 8 I look at the broader question of the symbolic

importance of infancy and infant death.

Wright outlines the changing perceptions of infancy and infant health between 1890 and 1915: the views which became dominant were those of the 'public figures' of doctors, administrators, journalists and politicians. The changes had significant implications for social control, bringing a powerful scientific discourse into everyday life. A number of different features contributed to these changes, including the new professional practice of infant welfare, a preoccupation with imperialism in British politics, shifts in the definition of medical knowledge, changes in bacteriology, a focus on the social position of working-class mothers and families, and acceptance of 'common-sense' metaphors for making sense of events.

As I have described earlier, Wright divides his argument into four elements: the emergence of infant death as a problem requiring action, which had political importance in Victorian England, and the chance of a successful solution as infant deaths moved away from being attributed to 'natural' causes; the increasing medicalisation and professionalisation of infant care; the new professional activity involving social action to reduce infant death; and the emergence of germ pathogen theory.

Wright suggests that in Victorian England 'the problem of infant mortality' proved a powerful generative metaphor

which allowed the drawing together of phenomena that had previously been separate - such as infants and bacterial infection - and separating phenomena that had previously been linked - such as infant death and natural wastage or bad weather.

He makes a distinction between changes in attitudes to children and their worth, and changes which resulted from infant death being seen largely as a social problem. He comments that only around 1900 did infant mortality come to be seen as a potentially resolvable national problem, and like Armstrong draws attention to the availability of the infant mortality rate in 1877. He places particular emphasis on the contrast with other death rates, which were falling for adults. Together with the shift of infant death away from being seen as inevitable and natural, interest focused on seeking a reduction similar to that in adult deaths. He presents the final break from the view of infant death as being something natural which is - beyond human control - as the introduction of the category of 'Sudden Infant Death' in the 1950s.

Among the historical forces which provided the background for increasing importance being attached to infant death, Wright identifies conflicting attitudes among the medical profession towards the causes of infant death, a rise in public visibility of infant death linked to changes in social imagery and the political circumstances of Edwardian



England, and a recognition that many of the major factors which saw such deaths as preventable had actually originated in the social rather than the medical domain.

In Victorian England explanations for infant death had shifted away from blaming parents for immorality, drunkenness or cruelty, towards accepting it as the outcome of good intentions but ignorance of correct care. This paralleled a more general shift of public attitudes in the late 19th century, seeing infant mortality as one of the 'costs of progress' of industrial capitalism. Together with the need to produce both a healthy work force (and a healthy army to serve the needs of the British empire) this had led to addressing social problems through instrumental and institutional channels, often based on apparently objective technical knowledge such as that of medicine. It was the Boer War that brought a particular awareness of the poor health of the working classes who made up the army and the work force. This lack of fitness did not only threaten the extension of empire and the maintenance of the industrial base; it pointed too to a poor standard of health in comparison to other countries. Concern at the health of the working class became more severe as it became clear that the birth rate among the higher social classes was falling, which in turn led to concern about the 'quality' of the subsequent generation.

In addition to the recognition of an emergent problem of

infant mortality, Wright suggests that it was during the late 19th century that infant mortality became a part of the medical domain. Previously, when GPs were consulted about conditions such as prematurity, wasting or diarrhoea there was little they could do. By the early part of the 20th century, however, advice on child rearing had taken on a more precise rational discourse, based on scientific knowledge and the medical training which was thought to be essential. A crucial element in this knowledge was the germ pathogen theory.

Wright is careful to emphasize that the changes in the discourses of infant care were not simply those of 'medicalisation', but that two additional factors were crucial. These were the creation of new forms of professional practice, and the reconceptualisation of the medical categories used for infant death: these are the principle features of his analysis and are discussed further below.

The third conceptual shift Wright identifies is the appearance of infant care not only within the medical domain, but also within the social domain. Within this social domain, a range of health professionals emerged as experts in infant care, surveying infant care practices in the larger population (much as Armstrong shows the shift of surveillance into the domestic domain). New forms of professional practice, legitimated by a medical training,

emerged during the early part of the 20th century, and included health visitors, midwives, visiting mothers and infants in their homes, infant welfare centres, and training mothers and schoolchildren in infant care. Infant care acquired a new mode of transmission, and the new authority of scientific knowledge. Health visitors (continuing the practice of middle-class visitors described earlier in this chapter by Hardyment) and midwives for the first time took knowledge into working-class homes, which was more effective than infant welfare centres. There was an increased emphasis on women and babies being in the home, and a policy of reducing the number of children under five attending school. Wright suggests that for the first time working class mothers had access to large-scale networks of knowledge.

In addition to this new way of passing on knowledge, the notion of instrumental recommendations based on scientific knowledge brought credibility to both the information and its users. The germ theory, in Wright's view, also provided the basis for all sorts of advice for which there was no scientific base, such as disapproval of excessive kissing, demand feeding or dummies, and recommendations concerning regularity, order and abstinence.

The final element in Wright's analysis is the relationship between the emergence of the germ pathogen theory and explanations for infant death. The new theory provided an

explanation of cause and transmission of infection in, for instance diarrhoea. Wright argues that diarrhoea, in particular, provided the ideal opportunity to validate the germ theory, a practical demonstration of its success, rather than an abstract idea. Until then, he describes it as a kind of medical 'top-dressing' to legitimise practice. Medical officers of Health produced epidemiological studies linking infant death with poverty and poor urban areas, but could do little to address the causes of death. However, attempts to establish which measures would be effective, and prioritising such measures, met little success.

Wright suggests two reasons why this theory achieved such a firm foothold. First, it provided an example to the public of the benefits of scientific knowledge, and specifically medical knowledge. This was one aspect of a more general increase in the prestige of such knowledge. In addition, however, the theory offered the metaphorical power to make sense of life more generally. At this point in the early part of the 20th century, Wright describes the purity and maintenance of particular categories as particularly important. The germ pathogen theory provided a cohesive explanation which made sense of a general fear of degeneration. It articulated a desire to protect the health of the nation, which was perceived to be under threat from both the deteriorating health of the population, and from external enemy forces.

For the purposes of my analyses, Wright identifies several pertinent issues. He suggests that the reason this theory became so powerful lay in its demonstration of the value of scientific knowledge, and its more general potential to explain ways in which health - and the health of the nation itself - could be protected. In this way, Wright too shows the importance of infant health to national government. This lays the ground for the argument in part of this thesis, that infant death is a particularly potent fear in industrialised contexts where infant mortality is low, and that a reduction in SIDS has been achieved through medical research (epidemiology) which was used to promote, and may have resulted in, individual changes. In chapter 7 I suggest that the fact that physiological explanations for both the cause of SIDS, and the effectiveness of changes in infant care practices, are unclear has served to reinforce the power of epidemiology. The medicalisation and professional surveillance of infant care in the home, the introduction of a "Reduce the Risk" campaign, shows how women's experience of caring for infants is shaped by medical knowledge. More generally, it reinforces the ideology of individual (in this case parental) responsibility for health, and the value of running health education campaigns, and following their admonitions.

### **Professionalising, Individualising and Risking Infant Care**

This chapter set out first to show the types of research on

infancy, and then to look in more detail at three specific papers. Step 1 showed some of the ways in which infants and their care and development have been dealt with in psychology, sociology and anthropology. In particular it drew attention to the relatively narrow range of research generating empirical evidence on infancy, despite the burgeoning interest in childhood as a social construct, which was one of my reasons in choosing to focus this thesis on the cultural construction of infancy.

Step 2 provided a broader context for infancy and infant death. Mein Smith showed how infant mortality rates carry symbolic importance in international comparisons, and how health professionals have their own professional investment in demonstrating their effectiveness in reducing infant death through changing individual caring practices. She shows too the relative recency of the professionalisation of infant care. This provided an important background against which to look at health professionals' views of infant care and its relationships with Sudden Infant Death Syndrome. It was media pressure in the UK that caused health professionals to turn to New Zealand where new research seemed to be indicating the need to change advice about infant care, and the resulting campaigns focussed on individual 'modifiable' caring practices rather than 'non-modifiable' social factors.

In Step 3 I described in some depth Armstrong's analysis of

the way in which explanations for infant death have shifted from the natural and 'unpreventable' to the social, particularly the domestic, domain in which infant death could be constructed as 'preventable'. This shift, however, took place as part of a more general pattern in which statistical analysis both identified a new category of infancy, and reinforced that category through use. In this way the infant, and particularly the infant body, emerged as an individual bounded entity. In discussing the contrasts between Bangladeshi and Welsh or English infants I comment on the way in which Bangladeshi infants are constantly close to other people, whilst Welsh or English infants were alternated between quiet solitude and noisy attention. From an infant perspective, I suggest that the body boundaries of the Bangladeshi babies are constantly blurred with those of their surroundings whilst the body boundaries of Welsh and English babies are alternately strongly marked and ignored. In discussing how health professionals and epidemiological analyses construct infants, I suggest that they appear as independent bodies, which allows caring practices to be seen as both independent of each other and of the broader social context.

Finally, in step 4 I draw on Wright's social constructionist approach to look at the relationship between infancy and broader cultural belief systems. Infancy, in this analysis, appears as a vital stage in the

widespread acceptance of the germ pathogen theory. Wright argues however that this was part of a broader search for explanation of a national fear of invasion, and the search for a way of offering resistance. For my purposes, this analysis lays the ground for my argument that epidemiological analyses of SIDS both introduced a new way in which infant care came to be perceived as risk management, and reinforced the apparent effectiveness of health education campaigns based on changing individual practices.

These three articles all inform my discussion of infancy and infant care, and the themes of medicalisation, specifically associated with SIDS, and the contrast between implicit practice and explicit recommendations, which link the various parts of the analysis. I now turn, however, to the more practical aspects of the research, before moving on to present the empirical data.



**CHAPTER 3: FROM PROTOCOL TO PRACTICE**

Chapter 1 has described how two 'roots' - the one my personal academic career, the other the opportunity to undertake research into beliefs about infants and their care - came to meet in a particular project in Cardiff. Chapter 2 identified some of the ways in which infancy has been analysed in different areas of academic literature, and in particular commented on the relative lack of empirical evidence on infants and their day-to-day care in western contexts. The present chapter addresses more practical concerns, but shows how these also constitute early stages of data collection. It reports the various stages in moving from a research protocol to recruiting and working with an interpreter, negotiating access to informants, data collection, recording and analysis. In addition I describe the formal processes of seeking ethical approval, and my own personal ethical concern which centred on whether or not the research should be presented as associated with Sudden Infant Death Syndrome.

The discussion, however, is not limited to describing the various processes involved. I identify too how some of the practical issues foreshadowed, or provided initial data for, the period of more formal data collection through ethnographic interviewing. For instance, in

recruiting an interpreter some of the distinctions within the Bangladeshi population became evident: these included, for instance, the separation of the domains of women and men, the relationship between women from rural and urban Bangladesh, and between Sylheti and Bengali speakers, and how British-educated Bangladeshi women relate to those who had only recently arrived from Sylhet. Similarly, in recruiting mothers to the study I learned about the timetables of Bangladeshi households, which tended to be shaped by men working in restaurants, making certain times of day better than others for visitors. Among the Welsh and English mothers I found a wide range of commitments outside the household, and a desire for either privacy or 'peace and quiet' which both shaped when interviews could best be arranged and suggested that infants and young children at times were perceived as intruding on this peace and quiet. In my initial meetings with health professionals, particularly Health Visitors, I found a history of interest in both SIDS and ethnic minority health, indeed Cardiff has a 'Minority Cultures' interest group of Health Visitors, reflecting its long history as a port with a wide range of minority populations. This is a subject to which I return in the following chapter.

This chapter opens with a description of the research proposal, and goes on to discuss three aspects of the early stages: the ethical issues that arose, the

processes of recruiting an interpreter, and gaining access to and recruiting mothers. I then discuss various aspects of data management, focusing particularly on data collection, recording, analysis and presentation. Finally, I outline how these early practical steps in initiating fieldwork also provided preliminary data and sensitised me to possible analytical concepts.

### **Research Protocol**

The research proposal (extract at Appendix II) had been submitted to the Foundation for the Study of Infant Deaths by the Departments of Child Health and Psychological Medicine of the University of Wales College of Medicine. The applicants were Professor David Davies, Dr Anne Murcott, and Dr Joe Sibert. The proposal outlined a comparative study of a small number of Bangladeshi and Welsh mothers in Cardiff, focussing on infant care practices. These mothers were to be drawn from two different ethnic groups, amongst whom differing rates of Sudden Infant Death Syndrome (SIDS) had been recorded. The aim was to identify possible variations in caring practices that might contribute to the different rates of SIDS. Evidence on which the proposed study was based came from data collected by the Office of Population Censuses and Surveys (OPCS) and analysed by Balarajan (1989) and indicated a lower incidence among Asian babies. In this context, 'Asian' was used to

refer to babies born to Indian, Pakistani and Bangladeshi parents. This research finding was reinforced during the research period in 1991-1992 by work in Birmingham (Kyle 1990) and east London (Hilder: unpublished) which also showed a lower incidence of SIDS among Bangladeshi infants.

The Bangladeshi population in Cardiff had been chosen principally for its size and its demographic profile; in addition, it was discrete and easily identifiable. OPCS data collected during the research period shows a Bangladeshi population in Cardiff of some 1600 people, although there is some evidence to suggest that census data on ethnic minority populations in general, and the Bangladeshi population in particular, may be inaccurate (Anwal 1990, Peach 1990). The size and demographic features of the Bangladeshi population in Cardiff, however, suggested that in the time period available it would be possible to recruit a sufficient number of mothers of young infants. In addition, many of the mothers had only recently arrived from Bangladesh, and had little contact outside their own extended families. This was an important factor in the light of evidence from both the United Kingdom and the United States indicating that ethnic minority lifestyles increasingly adapt towards those of their new country of residence with increasing period of residence (Watson 1977, McKenna 1986, Grether 1990).

The proposal built on Davies' (1985) work in Hong Kong which had suggested that there was a paradox in the epidemiological evidence relating to SIDS. Despite exposure to many of the variables then regarded as risk factors, SIDS was very rare among infants in Hong Kong. These risk factors were back sleeping, bottle rather than breast feeding, and low socio-economic status indicated by crowded living conditions. Chapter 1 has already commented on the impact of the enormous publicity about SIDS during the fieldwork period, and on the change in the advice given by health professionals, and I return to this in Chapter 7. At the time the proposal was written, however, Davies posited that some aspect of the apparently crowded living conditions in Hong Kong and perhaps elsewhere may protect infants against SIDS. A similar paradox was emerging with the evidence on Asian infants in Britain. SIDS seemed to be lower, despite exposure to many of the factors regarded as potentially harmful. This paradox provided the spur for this particular work, and influenced the choice of a qualitative method.

The case for using a qualitative method was made on the grounds of the absence of evidence on cultural variation in infant care practices. It was argued that a qualitative approach would identify relevant phenomena, whilst a quantitative analysis would address the frequency and distribution of such phenomena. The

specific method identified was "the standard anthropological technique of intensive, unstructured audio recorded interview" (Appendix II: p1 and 4). This wording was designed to maximise the acceptability of the method to the funding body. I discuss the way in which I used ethnographic interviews, together with periods of observation to add depth and context to the interviews, later in this chapter.

After submission to the Foundation for the Study of Infant Deaths, the proposal was passed by them to referees for comment. These referees were drawn from their Scientific Committee. One referee suggested (Appendix III) the inclusion of middle-class mothers in the study. I understood from this comment that this referee had assumed that all the Bangladeshi mothers, and thus all the comparable Welsh mothers, would fall into a working class category. From the literature (for example, Alam 1988) and from initial contacts in both Cardiff and London, it seemed likely that there would be a small number of women who would fall into a "middle-class" category, although Alam emphasizes that the more appropriate contrast for Bangladeshi women would be between urban and rural origins. I therefore ensured that among the middle-class mothers I recruited to the study there were some Bangladeshi women. I justified this on the grounds of ensuring that the sample reflected as wide a range of beliefs and practices as possible.

There was no question of claiming that the composition of the sample was representative of the general population.

Having received funding, the grantholders then advertised for a Research Officer: this was the point at which the two 'roots' to which I have already referred 'met'. I applied for, and was appointed to, the post as Research Officer to the project: from there, I moved on to the practical aspects of initiating the fieldwork.

### **Initial Steps**

The initial stages of research entailed familiarisation with "the field". I had moved to a new city, and had acquired a desk in an office shared with three Muslim men in the School of Social and Administrative Studies of the University of Wales College of Cardiff, and my own office in the Children's Centre of the University Hospital. All these places, and the gradually increasing circle of academic and health professionals with whom I came into contact, as well as the women who acted as informants, made up the "field". My contacts in the field grew initially from three parallel processes, to which I now turn. The first discusses some of the ethical issues that arose for me, the second the process of recruiting and working with an interpreter, and the third the recruitment of mothers through a number of different channels.

## **Ethical Issues**

In the early stages of the fieldwork my principal concern in seeking permission to interview mothers was to obtain their agreement to talk to me for the hour or so that an interview would take. Seeking the opportunity to ask their permission, however, involved obtaining the authority of an apparently ever-widening net of health professionals. As the research progressed, however, and in particular with increasing publicity about Sudden Infant Death Syndrome, a second concern emerged, that of how to present the research to mothers who were taking part. This section deals first with the process of seeking formal ethical approval, and second with how I introduced the work to Bangladeshi and Welsh mothers, and to health professionals.

The first step in seeking formal ethical approval was presenting the research proposal to the Paediatric Division of the local District Health Authority who approved it on first submission. It is relevant to record here that the project's principal grantholder, Professor David Davies, chaired this Committee. Comparisons with other researchers not attached to medical departments made clear how fortunate the project was to have this link: accounts of repeated deferrals and requests for additional information were common.



Later in this chapter I describe how possible recruitment channels were explored. In practice, the processes of seeking ethical approval and initiating recruitment were undertaken in parallel, and one of the possible channels to emerge was the Cardiff Birth Survey, through which we were to receive listings of Bangladeshi and Welsh births. Its Director, however, indicated that babies whilst in hospital would be "patients" of the Obstetrics Division, and once at home would be "patients" of their General Practitioners. It therefore became necessary to seek the approval of both the Obstetric Division, and local General Practitioners. Informal contact with the Obstetric Division was made by Professor Davies, and agreement received. For General Practitioners, a letter of information concerning the research was sent to all the practices in the relevant areas of the city (Appendix IV). This process was time consuming, but indicated both the wide range of professional investment in infant care (to which I have already referred in Chapter 2), and the complex social networks in which professional infant care is embedded. These are aspects to which I return in the discussion of health professionals and infant care in Chapter 7.

As part of the process of granting approval, the Paediatric Division, also approved an information letter and consent form (Appendix V). These were based on similar letters used previously within the Department of

Child Health. The information letter served several purposes. It not only provided an outline of the research, but also allowed me to leave some information with mothers so that they had a record of my identity and my affiliation with the University Hospital, and could if necessary contact me. The research period coincided with media and public concern about bogus social workers, and on two occasions I was asked for proof of identity. The letter and form were translated into Bengali, following advice from local Health Visitors that "something in Bengali would go down well" (Appendix VI) and could facilitate access. In practice, I found that most of the mothers did not want to keep the letter, although it was easily available, and that the Bengali version was indeed appreciated. As many Bengali women could read neither Bengali nor English, interviews often started with the interpreter 'reading' the letter aloud. Most mothers could write their own names and signed the consent form; when they were not able to do so, someone else in the household, generally their husband or sister-in-law, was asked to sign in their place. This ability to write their own name generally showed that these women had taken part in an "English for Pregnancy" scheme, which I both describe later in this chapter and discuss further in Chapter 4.

Having received the approval of the Paediatric and Obstetric Divisions, and having informed the General

Practitioners in the area, I thought that all possible permissions had been received. In approaching Welsh and English mothers through "Well Baby" clinics, however, I found myself having to approach the Director of Community Nursing Services. My initial letter to her early in the research period had received no answer, and I had not followed it up. When the issue of her approval was raised at a later stage, informal contact was established via Professor David Davies, which avoided possible delays at that stage of fieldwork. Again, this emphasized the power of the professional networks of those involved in infant care.

The second ethical issue for me was the extent to which the research was or was not explicitly associated with Sudden Infant Death Syndrome, or 'cot death', and how this link should be presented to both health professionals and mothers in my first contacts with them. While preliminary contacts with Health Visitors and ethnic minority workers were being established in late 1990 and early 1991, it was possible for me to say that "specific caring practices may protect young children against certain causes of ill health". This was the wording used on an Information Sheet I produced for fairly wide distribution (appendix VII). The Information Sheet, however, also explained that the research was funded by the Foundation for the Study of Infant Death, and this was a clear indicator to some

people that the research would focus on SIDS. This was particularly clear for those well-informed health workers, usually Health Visitors, who were aware of the lower incidence of SIDS in Asian babies (Kyle 1990), and that the major cause of infant death between one and twelve months is SIDS (Golding 1985, Department of Health 1993). Both Health Visitors and hospital Nurse Managers, however, felt that I should not mention SIDS, as it would only increase mothers' concerns.

As the initial familiarisation work continued, I referred to "the infant care study, looking at how babies are cared for by mothers from different cultures" or "in different countries". I described interviews as being structured around the theme of "a day in the life of your baby" and this too became an easy frame of reference. As the research period progressed, however, concern about "cot death" became much more common as media publicity increased, and was frequently mentioned by mothers.

In presenting the research to Bangladeshi mothers, I could say that we knew that Bangladeshi babies were healthier than Welsh babies, and our research interest lay in finding out how they were looked after, and possibly to learn from any practices which appeared to be different. Whilst there was good evidence for this (Pearson 1991, Kyle 1990), there was also some research that indicated higher levels of malformation at birth for

Asian babies (Kyle 1990). Other research, however, has suggested that in east London the lower SIDS rate among the relatively large Bangladeshi population is not being achieved at the cost of higher neo-natal mortality (Hilder, unpublished).

In introducing the research to all the mothers, I adopted a form of words which could be used to respond to questions concerning the possible implications of the work, but without prejudice to the results. As public interest in SIDS increased during the fieldwork period, more and more people asked me what the results of my research might be. I first asked them to complete the interview and then explained that it may be protective for infants - whether awake or asleep, day or night - to be close to other people. To those people who asked, I suggested that one practical implication that could be drawn once the research was complete would be that for the first 6-9 months babies should sleep in their parents' room. In this way I respected the research need that informants' responses should not be shaped by their knowledge of the link between the research and SIDS, and my own wish to respect mothers' contribution to the research and treat them as equal partners in the research process. By the end of the research period, the recommendation in South Glamorgan was that health professionals advise that infants should be in their parents' room for the first six months - this was linked

to general health promotion, for instance the early identification of symptoms, rather than explicitly directed towards the prevention of SIDS. When the research was published in the British Medical Journal, the Secretary of the Foundation for the Study of Infant Deaths was quoted in the national media suggesting that infants may be better placed to sleep in the same room as their parents for the first six months or so of their lives, but emphasizing that research was by no means conclusive.

All the mothers who took part - Bangladeshi, Welsh and English - were assured that the data collected would be confidential, that it would be used as the basis of a report to the funding body, and that any quotations would be anonymous. I explained that I was required by the local Health Authority Ethics Committee to ask them to sign a form consenting to the interview, but that I was the only person who would have a record of who had given interviews. I was asked why signing a form was necessary on one occasion, by a Bangladeshi father, who made the very reasonable point that if it was all confidential anyway there was really no need for him to give me his name or to sign a consent form. Once the form had been signed, I asked for agreement to the use of a tape recorder (a deliberately small, familiar, "personal stereo" type). At this stage I explained that each tape would be numbered and the interview would be

typed up. At first I used the phrase "stored in machine readable form", but found after a few interviews that it caused confusion. Explanations in terms of "Typed on a word-processor" or "computer" were more easily understood although it is difficult to say exactly what sort of meaning was attributed to the phrase. From my point of view, I was able to say in good faith that the interview would be anonymous, and that no-one else would have access to the names of the informants. The simple numbering of tapes, and handwritten recording of names and numbers, also avoided the requirement of registration under the Data Protection Act, which comes into play when names and data are stored together in a computer data base.

This discussion has dealt not only with some of the ethical issues which arose during the research, but has shown how the early stages of the research also provided initial ethnographic data. In negotiating the applications for ethical approval, the extensive professional networks of infant carers became visible, and discussing issues of confidentiality with Bangladeshi participants suggested differing perceptions both of confidentiality and of subjects which should be treated as confidential. Similarly, during the search for an interpreter, investigating practical issues provided new insights into data collection. It is this process to which I now turn.

## Recruiting and Working with an Interpreter

Recruiting an appropriate and competent interpreter was crucial to the research, and was initiated at an early stage. The process provides a nice example of the importance of an ethnographic approach, of recognising and drawing on existing expertise, in the context of my particular academic and personal orientation to the research discussed briefly in the introduction.

The search for an interpreter was initiated through two channels. The first was the Health Visitor with responsibility for minority cultures, who worked with a health services linkworker of Sylheti origin. Sylhet is the rural region of north-eastern Bangladesh from which the majority of recent arrivals in Cardiff originate (see map at Appendix VIII); chapter 4 discusses some of the issues associated with migration. The second channel was the local Social Services officer with a specific remit for ethnic minorities. In addition, however, as the project became more well known, advice was sought more widely - from, for example, the English for Pregnancy Campaign, the Asian Women's Network, and the Bangladeshi Ladies' Group. I drew also on the work of Curren (1986: 186) with Pathan mothers in Bradford, during which her interpreter acted as a research assistant. She comments that the interview process became "dictated by the social norms of the women



involved", that is to say that interviews developed into group rather than individual discussions. Again, much as in my comment on the contrasting perceptions of confidentiality in introducing the research, this suggested that my own emphasis on the privacy of interviews was simply unimportant. In looking for an interpreter I also drew on my own experience of working as a secretary in Paris for five years, during which moving between two languages (or more) and interpreting was a constant feature. This experience had taught me of the alliances that can form between the interpreter and either or both of the other parties to an interview. For this reason, I was anxious to encourage the interpreter appointed to make explicit her own beliefs about infants and their care, and how she saw her role in relation to the women we would interview.

At this early stage, two distinct schools of thought emerged, one arguing that Sylheti was simply a dialect of Bengali, and that a Bengali-speaking interpreter would be appropriate, and the other insisting that an interpreter of Sylheti origin was essential.

The first case was put by a full-time worker on the English for Pregnancy project, herself a former English teacher. One of the linkworkers working with this programme was a Hindu Bengali, that is to say she originated in the West Bengal area south-east India,

rather than East Bengal which is the original land now named Bangladesh. This linkworker was married to a General Practitioner, and presented herself as an "expert", encouraging ethnic minority women to go to ante-natal classes, providing transport and acting as an interpreter for them both at these classes and on hospital visits. From her point of view, her role as an 'outsider', as an Indian Hindu rather than a Muslim Bangladeshi, living outside the city centre, allowed Bangladeshi women to be more open with her, and to seek advice on issues such as family planning which are regarded as "personal" and which they may not want to become more widely known, fearing both gossip and religious disapproval. Gardner reports similar advantages of using a Hindu rather than a Muslim interpreter during her fieldwork in Sylhet (personal communication 1990).

For the purposes of this research, however, I concluded that this Bengali Hindu linkworker's personal links with the medical profession and her own professional links with encouraging use of the health service, together with her views on the Bengali language, would not make her an ideal interpreter. I explained to her that I thought she was too much of an expert, and the research had specifically been set up to be conducted by non-health-professionals. This had been made clear to me when I was interviewed for the post and had asked why an

anthropologist was being sought: the answer I had received was "we don't want a clinician". On a personal level, this linkworker remained very helpful and enthusiastic throughout the research, possibly as a result of my recognising and complimenting her on her expertise. I became aware later, however, that having said she was "too expert", it would be clear that whoever was appointed could be said - by her - to be "not an expert". So far as I know, this did not happen, but I remain cautious about using such an explanation again.

The case for a Sylheti-speaking interpreter was put by both the initial contacts; it is made too by Gardner (1990). The Sylheti linkworker based with the local Health Visitors was very committed to the project, and adamant that good interpretation was essential. She was keen to do the work herself, but her own workload - together with reservations expressed to me by her Health Visitor colleagues - precluded this. I wanted neither to find that I had an interpreter who was over-committed, nor that I had created tensions between her and her Health Visitor colleagues, nor indeed to generate difficulties in my own links with the Health Visitors. She clearly, however, wanted to be involved in the appointment of an interpreter, and acted as an advisor throughout the process. In the event, the person appointed turned out to be a closer friend of hers than I was aware of at the time. This may or may not have

been influential. It was certainly helpful at a much later stage in the process when one Bangladeshi family wanted to verify the status of the research and turned to this particular linkworker for reassurance.

Contacts with local Social Services generated three possible interpreters, all of whom were attending training days organised by Social Services and the Race Equality Council, and were described to me as Sylheti. I did not consider the one man on the list, given the focus of the research and the separation of the male and female domains within Islam. On the advice of the Sylheti linkworker, I found that only one of the other two applicants was Sylheti: she, however, was a young woman, married with no children. Whilst her language skills were not in question, her low status (as a relatively young woman without children) made her inappropriate. The second possible candidate at this stage was an older, middle-class, Bengali-speaker, with strong family links with the medical profession: this was a combination I was seeking to avoid.

In the event, it was through one of the Health Visitor linkworker's contacts that I eventually recruited an interpreter. Her principal asset so far as I was concerned was that she had the recommendation and approval of the Sylheti linkworker; whilst in fact originating from the Bangladeshi city port of Chittagong,

she was married to a Sylheti, and therefore spoke both Bengali and Sylheti. She had two teenage children, both born and educated in Cardiff, and worked in the creche in the local community centre which was the focal point of activities for minority cultures in Cardiff (including the English for Pregnancy campaign). Her work in the creche meant that she had contacts with mothers and young children beyond those associated with her middle-class area of residence.

It was clear that no interpreter - or indeed interviewer - would be perfect, and I recognised a number of disadvantages in her appointment. Bangladeshis in Britain divide into those from urban and rural areas (Alam 1988), and she clearly fell into the first - minority - category. In Cardiff, the vast majority of Bangladeshi men work in restaurants, and as the wife of a restaurant owner, she occupied a relatively powerful position (recognised by Karseras 1987 in her comments on the influence of restaurant owners' wives on the infant-feeding practices of restaurant workers' wives). The links with the restaurant workers proved the major route for recruitment of Bangladeshi women to the research: her status lent credibility to the research and facilitated recruitment of mothers; on the other hand, it may too have made it difficult for interviewees to refuse.

While the power dynamic between a middle-class, restaurant-owner's wife and a rural, restaurant-worker's wife is important to recognise, at the time I found it a difficult problem to avoid. Finding an interpreter with good levels of both languages, through the channels open to me at the time, meant a middle-class woman. As the research progressed, however, I met a small number of British-educated Bangladeshi women, and it is possible that one of these would have proved a good interpreter. This was the approach adopted by Mayall (1991). It may also have been, however, that British-educated Bangladeshi women would have had little in common with women who had recently arrived from rural Sylhet. This was certainly the experience of some of the British-educated Bangladeshi women whose views I cite in the following chapter.

The interpreter chosen, as well as having the language skills necessary, and being acceptable to the essentially middle-class groups of health workers consulted, also solved another dilemma. Before recruiting her, the two most widely-known linkworkers for Bangladeshi women in Cardiff were keen to offer their services, and choosing one could have prejudiced the interest and goodwill of the other. Given the nature of the recruitment process, and the relatively small numbers of births expected during the fieldwork period, I attached high priority to maintaining the enthusiasm of all concerned.

As a part of this initial process of familiarisation with the qualities thought to be suitable to an interpreter, a set of values about my own role started to emerge. These became clearer as I started to work with the interpreter and to establish a friendship with her. Clearly, at 37 years old, I should, in her eyes, have been married with children, if not grandchildren. I at first did not admit [I choose the word with care - that is how it felt] my divorced status, perhaps thinking that this would add barriers, and reflecting my own feeling that marital status simply was not relevant in a context where working and personal lives are seen as quite distinct. This in turn provided further research insights into the way in which work is separated from personal life, and the different ways in which time is organised as either "work" or "spare" in a western context, a division which was not so explicit amongst the Bangladeshi mothers. When I did explain that I had been married, I found to my surprise that it gave me added status, although - with echoes of my own Catholic past - my interpreter's firm view was that I should have stayed with my husband regardless of any problems, that marriage was forever and for children, and that was the main route through which women achieved status. The subject of why I actually left my husband remained one of fascination for her: it was very unusual for anyone to be unmarried. My academic qualifications and my job at the Medical School gave me a certain credibility, but

even this did not in her view compensate for the lack of husband and children.

It was in her hopes for her own children that the interpreter made clear some of her ideals. She planned that her own daughter would go to university, with the aim not that she should work, but that the better the education she received the better the mother she would make, and therefore the better potential marriage partner. With two teenage children, she was already thinking clearly about their marriage prospects.

In the eyes of the less educated Bangladeshi women with whom I worked on the English for Pregnancy scheme, and whose first question to me was "babies?", the reaction to my negative response was simply pity: their whole lives were devoted to childrearing, with six or seven children being quite unexceptional. Blanchet's work on rituals of childbirth in Bangladesh (1984) and her own experience of giving birth in both Canada and Bangladesh (1991: personal communication) makes clear the prestige associated with motherhood in Bangladesh, rather than the sympathy she was offered in Canada at the birth of a third child. The prestige, however, has an opposite in the shame experienced by women who are unable to have children: the ultimate sanction in Britain is for a wife who does not produce infants to be returned to her own family of origin, be it in Bangladesh or Cardiff, or for



the husband to take a second wife. There is little role amongst the Bangladeshis in Cardiff for women alone, or wives without children: it is motherhood which provides status.

In parallel with the processes of recruitment of the interpreter, a number of possibilities for recruiting mothers to the study had been explored. With the interpreter chosen, we began contacting mothers: this next section describes the various steps involved.

### **Recruiting Mothers**

Various different ways of contacting Bangladeshi, Welsh and English mothers were discussed in the early months of the research period. These included contacting pregnant women either at hospital appointments or at ante-natal clinics held in the community, and arranging an interview when the baby was approximately 3 months old. In an attempt to reduce the time between initial meeting and actual interview, I also explored the possibility of meeting mothers whilst they were still in hospital immediately after the birth of their babies; this option was opposed by the consultant paediatrician involved in the research, who felt that mothers at that time would be particularly vulnerable. Midwife managers, on the other hand, felt that mothers would be less vulnerable on the ward than on their own at home. Their view was that

mothers would be better placed to refuse to take part in the study if they were in a group of other mothers who had also just given birth. I describe below how we negotiated both access to and recruitment of mothers.

A number of different channels of recruitment were used, the main criterion being practicality. The majority of Bangladeshi mothers were contacted via the interpreter.

Some, however, were referred to me by the two local hospitals or by the Health Visitor or English for Pregnancy linkworkers, and initial contact made via the interpreter. We did not take up the option of meeting mothers whilst still in hospital because their stays were so short (2-3 days) that I was generally notified on the day they were going home, or even afterwards, by one of the hospitals, and not at all by the other. Where I did receive notification of a birth, it was common for the name and the address to be incorrect, the woman often being registered under her husband's surname, or under the name "Begum" - a title approximately equivalent to "Mrs". It was for this reason that in practice most of our contacts were made through the interpreter, and her links with the Bangladeshi population and the local ethnic minority health workers

The second major source of information concerning local births came from the Cardiff Birth Survey. After initial contact via the Professor of Child Health, I met

the Director in January 1991, and she agreed to make available listings of all the Bangladeshi mothers giving birth during the year, together with a list of comparable Welsh or English mothers. These comparisons were made on the grounds of date of birth, place of mother's birth, address, and number of other children. In the event this information took eight months to start to become available. This made it all the more important to use other ways of recruiting mothers. Once the information did become available, however, it proved very useful in providing information on the numbers of Bangladeshi women who had had babies, and as a way of tracing the few Welsh mothers with larger families, some of whom I was keen to include in the research sample. The length of time taken for the information to become available, however, even once the computer programs were set up and listings being sent to me every two months, meant that babies were generally at least three months or so old, and that those mothers who worked outside the home - Bangladeshi, Welsh and English - would have finished their maternity leave, making arranging interviews much more difficult.

The third means of recruitment was via "well-baby clinics" in specific areas of the city. Having devoted the early months of the fieldwork period to working with the interpreter, and tracing and interviewing Bangladeshi mothers, I then started to explore the best ways of meeting Welsh mothers. Local clinics had the advantage

that I could find Welsh mothers living in similar areas, and with access to similar health services, as Bangladeshi mothers.

Each clinic had a mixture of middle-class and working-class, and Health Visitors were very helpful in providing thumbnail sketches of their "client groups". Nonetheless, I found myself using all the stereotypical cues - language, speech, clothing - to define people as either working or middle class, in the early stages of contact (Goffman 1959). Whilst there is a growing body of literature on the inappropriateness for women of the Registrar General's social class classification (for instance, Arber 1990), in this particular instance allocation to class was not too problematic. Given that Bangladeshi mothers were recruited first, the particular urban:rural division of the Bangladeshi population in Britain, and the relatively small numbers of Bangladeshi babies born each year (between 35 and 40, according to the data available via the Cardiff Birth Survey), a policy of recruiting every possible Bangladeshi mother - followed later by Welsh and English mothers living in comparable areas of the city, and with access to the same health services - was quite feasible. I made some early contacts with Welsh and English mothers via the Birth Survey records, but the most prolific source was clinics run either by Health Visitors or General Practitioners, or both together. Attending these clinics also provided

an opportunity for limited direct observation of mothers, babies, and health professionals.

Gaining access to each of the three clinics involved a slightly different approach on my part. I had met the Health Visitor who ran the first one through a colleague of hers, and this in turn led to an informal visit to the clinic when I recruited several mothers. On my second visit, however, she insisted that I should meet the General Practitioner "as it's his clinic really" and the Community Midwife. This Health Visitor in turn suggested that I contact a specific colleague of hers in another clinic.

I had chosen the clinics to allow me to find a group of Welsh mothers sharing similar housing and health services to those of the Bangladeshi mothers already interviewed, and to include the middle-class mothers specified by FSID. It was this Health Visitor who was insistent that I should have the approval of the District Nursing Officer, who in turn referred me to the Director of Nursing Services in the Community Unit (it was at this point that the intervention of Professor Davis described earlier preempted my having to seek a further round of ethical approval). I chose the third clinic to try to find some non-Bangladeshi mothers in one of the areas of the city in which the Bangladeshi population was concentrated. The Health Visitors advised me not to go

to the HV-run community clinic since it was "all Asian". They suggested instead a well-baby clinic run at one of the local GP surgeries. It took persistent telephone calls to receive the GP's agreement, but once achieved, I was greeted with great interest and enthusiasm.

In making contact with the Welsh and English mothers through these three clinics, I gradually developed a short, informal introduction which explained who I was and what I was doing, emphasizing that I would simply be asking them to talk about the baby, not "doing anything" to the baby. I found it helpful to include this phrase in order to recognise and meet the concerns of mothers whose first reaction to the idea of 'research' was that I would need the baby to give some blood, or to be subjected to tests of some kind.

On my first visit to a clinic, I made appointments to see the mothers at home within the following week, only to find several of them out. Chatting to the Health Visitor concerned, her weary response was "Welcome to health visiting". I then tried taking telephone numbers and ringing within a few days to arrange an appointment either that day or the following day, and that solution worked well, with far fewer people being out. When I met mothers with no telephone, I made an appointment as soon as possible, ideally the following day. Each visit to the clinic generally lasted between one and two hours,

and yielded approximately 12 names, of whom at least half were followed up successfully.

I now go on to describe how the data was collected through interviews and observation. Describing these processes separately may suggest that the process was a linear one, of recruitment, interviews and analysis. In practice, these processes took place in parallel. For instance, whilst interviewing Bangladeshi mothers, and reviewing the transcripts, I was in the process of negotiating access to Welsh and English mothers. I emphasize this at this point simply to underline that although they are presented separately, recruitment and data collection and analysis were concurrent processes.

#### **Data Management: Collection, Analysis and Presentation**

My starting point in considering how best to collect data was the method of ethnographic interviewing identified in the research protocol. Having consulted a range of authors, I saw it as important to incorporate an observational or participative element into the work with mothers (Spradley 1979, 1980, Atkinson 1990). Chapter 1 has described how I sought too to use the opportunity of working with a range of health professionals interested in Sudden Infant Death Syndrome both to participate in and observe what Lock terms "the culture of contemporary medicine" (in Lock and Gordon 1988: 3).

Definitions of "ethnographic interviewing" go beyond an emphasis on informality and extensiveness within interviews towards placing the interviews, the interviewer and the interviewed in their broader social and cultural context. I therefore devoted considerable time and attention to familiarisation with the area of the fieldwork and, as I have emphasized throughout this chapter, regarded the early contacts in the field as initial steps in data collection. This familiarisation process included attending regular meetings and occasional parties organised by the Asian Women's Network, establishing contacts with workers at the local multi-cultural community and resource centres, and talking both formally and informally with Health Visitors and their linkworkers. Initial contacts were made with all of these groups during the recruitment of the interpreter and maintained throughout the research period.

By focussing not only on the content of the interview, but also on the context in which it took place, I hoped to preempt some of the problems identified by Cornwell (1984). She suggested that there was an enormous difference between what people were prepared to say in public and in private, and that the 'one-off' interview was likely to be regarded as a 'public' interaction. In her experience, it had taken some time to be taken into the domain of 'private' conversation.



The literature on anthropologists working in their own societies, such as the examples cited in Jackson (1987), was also relevant at this point. These examples included, for instance, Okely's work in England with gypsies ("Fieldwork up the M1: policy and political aspects"), and Mascarenhas-Keyes on fieldwork in Goa ("The native anthropologist: constraints and strategies in research"). All, however, worked in situations in which participant observation was feasible: I did not view as practicable the possibility of becoming a participant observer within either an extended Bangladeshi family or a nuclear Welsh or English family in a small Cardiff house. One critic - an anthropologist - asked "Why weren't you in bed with these babies?" For me, the priority was to talk to as broad a range of mothers as possible, incorporating recently arrived women from rural Sylhet, women from both rural and urban Bangladesh who had lived in Britain for a longer period, and some who had been education in Britain, as well as middle and working class Welsh and English mothers in Cardiff. Interviews undertaken against a background of observation offered a workable approach within the time and resources available.

Anthropological and sociological literature also suggested that observation in families was a delicate business, sometimes undertaken in the observer's own family (Whitehead 1981), via questionnaires using local

interviewers (Wallman 1984) or with interviewers drawn from specific ethnic minority groups (Mayall 1991). I therefore looked for ways of getting access initially to Bangladeshi homes, as the least familiar to me. As both a non-mother, and a non health professional, however, I anticipated that Welsh homes would be equally unfamiliar, particularly where the focus of the household was on childrearing. I describe below how I undertook observation in Bangladeshi homes, and in the mother and baby clinics whilst making contact with Welsh and English mothers. In fact, the interviews themselves, each lasting around an hour, offered the opportunity for observation. For instance, one of the broad contrasts to emerge simply from participating in interviews was the public, shared nature of infant care in Bangladeshi homes, and the care undertaken largely by mothers within the essentially private Welsh and English households.

My first step in initiating some participatory work with Bangladeshi mothers started in the local city library. A poster in their Ethnic Minorities section was advertising for volunteers for an "English for Pregnancy" scheme, which provided home tutors for non-English speaking women during pregnancy. The scheme was run by the local education and health authorities, and provided one full-time worker who both taught English and organised a series of volunteers.

During 1991/2 I tutored three Bangladeshi women, spending one or two hours a week with one tutee, during which the household simply continued around me. This provided a more relaxed picture of the busy household, in contrast to the slightly more formal atmosphere generated during interviews with the presence of the interpreter, the signing of consent forms, and the use of an audio tape recorder. In this way I came to see how friends and neighbours knocked on the window and walked in, that babies whether asleep or awake were always with other people, often in the same chair as their mother, aunt or older sibling. It was rare for anyone of any age to be alone. Cots and cribs, if owned, were often in the front room; otherwise sleeping babies were in prams or pushchairs, or surrounded by cushions on a sofa, but always close to other people. Clearly this is not participant observation of the kind undertaken by Gardner in a Sylheti village, or Okely in a gypsy camp in England. It did however provide some observational material, and as such was a very useful context for the interviews during which infant care was our topic of conversation, rather than the backdrop.

As well as allowing me to spend time in Bangladeshi households, acting as a tutor had another advantage. The coordinator of the English for Pregnancy scheme ran occasional support groups for tutors, which proved a rich source of knowledge about the differences in how other

households operate: the frequency with which mothers would have forgotten about the lesson, perhaps having gone to visit relatives in London, the number of people in a household, the tutors' common perception of difficulty in getting "peace and quiet" for a lesson, the "strange man" who would answer the door. Meetings of these volunteer tutors, or of Health Visitors working with ethnic minority groups, or the Asian Women's Network, all provided excellent sources of data and help.

At the same time, my attending their meetings ensured that they both knew about the research, and had the chance to seek further information if they wished to.

I discuss this programme in more detail in the next chapter, in particular my view that the women participating in the programme were not simply learning a language, but were being taught the 'culture' of medicalised childbirth, with which they were unfamiliar.

The possibilities for participant observation prior to interviews with Welsh mothers proved limited. If Bangladeshi mothers were always in their houses, Welsh mothers were much more often out, at work, visiting friends, or family, or shopping. If they were at home, they were likely to be on their own. As I looked at ways of recruiting mothers, it became clear that the mother and baby clinics were one of the few places where mothers with young babies could meet each other. Of

course they met other mothers in hospital, but very few had made contacts which had lasted. It was the Health Visitor or General Practitioner clinics, serving small local areas, which provided a possible way of meeting other women with young children. Even these occasions, however, were limited in the opportunities they offered. One mother who took part in the research described her own mother's surprise, when she accompanied her to 'the baby clinic', at the absence of any encouragement to stop and chat: "where's the tea urn?" There were other ante- and postnatal classes run by Health Visitors: these included post-natal exercise sessions, "babycraft" classes, but none of the mothers I met had been to these.

As I have described above, I used mother and baby clinics as one route for recruiting mothers to the research. My experience within these clinics was that they were very busy, particularly on a fine day. Some had rows of chairs where mothers sat with babies either on their knees or in push chairs. Babies were taken in turn to the Health Visitor. They were weighed, their weight recorded, and any weight gain attracted approving comments. Mothers were asked if there were 'any problems', and were offered the chance of a private consultation with either one of the Health Visitors or a General Practitioner. Otherwise, the weighing and checking was done in the presence of at least some of the other mothers, depending on the spatial arrangements of

the clinic. The interactions were largely between Health Visitor and mother, or 'client'; in walking around and chatting to mothers I seemed to be the only person who was actively initiating contacts. Mothers seemed to stay a short time, waiting to see the Health Visitor, seeing her, having the baby weighed, and then leaving. Again this emphasized for me the individual responsibility of each mother for her child, rather than the shared infant care within Bangladeshi homes. Fortunately, the nature of the research meant that there was ample opportunity for observation of mothers and infants actually during the interviews.

Interviews with Bangladeshi families often took place with mother and baby, other children, mother-in-law, father-in-law, husband, cousins, with apparently no feeling of resentment at other activities going on at the same time, be it watching "Neighbours" (interviews often took place between 1-3pm, which fitted in with the schedule of restaurant work) or other children riding bicycles around a small front room (or both). Interviews with Welsh mothers were very different. Generally, simply mother and baby, but if another child were present s/he was likely to be described as "needing attention" or "interrupting".

From the outset in talking about infants I made it clear that I had no children, and was likely to ask apparently

very simple questions. This had both advantages and disadvantages: on the one hand, it led the interpreter to comment that I couldn't understand how mothers feel about their babies; on the other hand, she also attempted to explain both how she felt, and how those mothers we interviewed felt. From my own point of view, it allowed me to ask very basic questions, and genuinely to say "I don't know" when asked for my opinion.

Asking Bangladeshi women, at the start of interviews, to sign a form which guaranteed confidentiality, was an early indication of rather different notions of "confidentiality" and privacy from my own, and from those in Welsh and English households. These included both contrasting notions of personal privacy and space, and infant care shared within the household rather than being the sole responsibility of the mother. This was echoed in two ways. The first was Gardner's (1991) account of her year in a Sylheti village, particularly the villagers' amazement at her request for a room to herself in which she could sleep and work. Her conclusion was that "privacy" is not a concept which is used in Sylheti households, indeed it is very odd to want to be alone.

The second incident to sensitise me to a rather different view of confidentiality was an unannounced visit to a mother of a young infant, which produced an insight into the networks among the Bangladeshi population in Cardiff.

I had called on a young Bangladeshi woman whose name (and address, but not her telephone number) I had received via the birth survey. Anticipating a non-English speaker, I was accompanied by the interpreter. This mother did not wish to take part: she had arrived from Sylhet very recently, and had had very little contact with anyone outside her immediate family.

During this visit, however, I met her sister-in-law, who had grown up in "the valleys" to the north of Cardiff and asked if she would like to take part. She agreed, but made it clear that she would only talk to me on my own: she asked me to telephone her to arrange a time when we could meet, and emphasized that there was "no need to bring the other lady". We met later in the week, and she explained how "gossipy" she found the Bangladeshi population, and her mixed feelings about being both of it and not of it. This is a subject to which I return in the following chapter.

All the interviews were transcribed in full. The bulk of the fieldnotes comprised typed transcripts of the sixty interviews, each accompanied by an analytical memorandum, as recommended by a reading of some of the literature on qualitative data analysis, amongst which Wright Mills (1959) Glaser and Strauss (1967), Lofland (1971) and Strauss (1987) were particularly helpful. I describe below how the analysis proceeded. One of the



many advantages of the funded project was the availability of a secretary to transcribe both interview tapes and memoranda. The latter were either dictated or handwritten as soon as possible after the interviews (often in the car) and contained both descriptive material and analytical pointers, underlining or questioning earlier assumptions or analyses, and foreshadowing other possible research avenues. The disadvantage in having all the interviews transcribed in full was the vast amount of paper it produced. The advantages however lie in the easy availability of the complete transcripts, which continue to provide a resource to which I return regularly.

One of the unanticipated problems was the difficulty in predicting how long transcription of tapes would take. For Bangladeshi mothers, the interview included the voices of interviewer-interpreter-interviewee(s) -interpreter-interviewer. This involved more "listening" but less "typing" time. For Welsh mothers, the interviews were generally interviewer-interviewee, all the spoken words being transcribed, and thus produced a longer transcript. In practical terms, the Bangladeshi interviews were carried out gradually over a period of several months, and transcripts were available within a week or two. The Welsh and English interviews, in contrast, were concentrated into October, November and December 1991, which resulted in a delay of several weeks

between interview and the transcript becoming available. At this time, I handwrote the memoranda, partly to reduce the amount of taped material being passed on to the secretary, and partly to have the memoranda available immediately for consultation.

Interview transcripts and memoranda were filed chronologically. Each interview and its accompanying memorandum was numbered, and extracts are identified by this number, preceded by an M where the extract is from a memorandum. In the chapters that follow extracts from interviews or memoranda are identified by this interview number, followed by the page number.

I have chosen not to give pseudonyms to all the mothers who took part following a lengthy discussion during a postgraduate seminar in Cardiff of an appropriate name to allocate to a woman of Catholic extraction who was married to a man from the Welsh valleys. As an outsider in Cardiff, I realised that I would simply not have understood the meaning hidden in the names chosen.

Rather than attempt to describe the women who took part in the research by pseudonyms that implicitly inform the reader of their class and ethnic origins (or, for the Bangladeshi women, their rural or urban origin), therefore, I have chosen the rather simpler option of numbering interviews and extracts, and providing brief

descriptions of the women concerned when they are first quoted.

Interspersed with the typed transcripts were notes of meetings of various kinds, from "English for Pregnancy" volunteer support groups, to post-graduate seminars for doctors within the Department of Child Health where I was based. This ordering of material provided both a linear representation of the way in which research proceeded, and an indication of the context in which I was working.

When significant media coverage of Sudden Infant Death Syndrome occurred, I included a note or press cuttings, or copies of relevant material such as new advice leaflets for parents. When I was invited to present research seminars or lectures, I included a description of the audience (for instance at conferences on Sudden Infant Death Syndrome, a mixture of health professionals and bereaved parents) together with an account both of my own presentation and the questions which it prompted. An example of a presentation I made to the Scientific Committee of the Foundation for the Study of Infant Deaths provides the basis for the discussion in Chapter 7 on how this data was presented to health professionals.

In analysing the data, it was clear that for those interviews during which I had worked with the interpreter there was less variety in words and phrases than amongst the Welsh mothers. Whilst this may have limitations for

analysis based on the use of specific words or phrases, it did not present problems for the generation of issues, concepts and categories. I treated each transcript and memorandum as a text for analysis: drawing particularly on the advice of Strauss (1987) on coding I identified both specific issues which arose, and gathered these into broader categories, and then into the three themes which run throughout the thesis. Relevant parts of the transcripts were marked by hand, and recorded in analytical memoranda. Using long strips of continuous computer paper stuck to my office wall, I gradually built up a long list of possible analytical axes. As interviews proceeded, I either added new items to existing categories, or occasionally introduced new categories. Some issues, such as an interest in perceptions of time and space, reflected my own theoretical background; others grew directly from the data, for instance the use of "bedtime" as a sanction. In each case, I attempted to record the source of the categorisation, for instance the interest of health professionals in how infants were fed.

Transcripts, however, do not record hesitations or emphases, boredom or enthusiasm, and for this reason I listened to each tape as soon as possible after the interview, annotating as appropriate. Whilst each interview was typed on a word processor and recorded on floppy discs, software for the storage and analysis of

the complete data set was not available. The process of analysis was iterative, that is to say one that Glaser and Strauss (1967) call "constant comparison": as issues or concepts of interest started to emerge I returned to earlier transcripts with that new question in mind, and incorporated it into the ongoing interviews.

Spradley (1979: 186) characterises a cultural theme as a "cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning", suggesting that themes should both recur and connect. Early in the research process, there were areas of overlap, and themes apparently unconnected with each other, and it was simply a matter of recording the possibilities as they arose.

In addition to the formal and routinised production and storage of fieldnotes, Sanjek (1990) comments on the importance of "headnotes", suggesting that these are even more important, and referred to more frequently, than fieldnotes. In the same way that Becker (1986) emphasizes that there comes a point when social scientists simply have to sit down and write, Sanjek suggests that it is at this stage that headnotes have their full impact. In writing the present chapter, "headnotes" were crucial in determining emphases and direction, but the interview transcripts and memoranda remain a potential source of data as yet unanalysed (on,

for instance, Bangladeshi use of western clothing according to age and gender).

Having identified the issues and concepts which arose, and the analytical axes around which I wished to group them, the next process was simply one of grouping extracts from interviews and memoranda around the analytical axes. For instance bedtime arose as an area where there were stark contrasts between the Bangladeshi and the Welsh and English infants: this was at first an issue, and then became part of my analysis of concepts of being alone, within a broader category of beliefs about infants. This in turn fed into the broader themes in which infant care was simply a matter of practice among Bangladeshi mothers, a place where experience and advice may conflict for Welsh and English mothers, and a site of professionalisation and medicalisation.

In presenting this data I am adopting an ethnographic style, part narrative and part analytical. If fieldnotes were the starting point in the recording of data, the presentation of an ethnography is an endpoint. Geertz describes the ethnographer's task as being:

"to enlarge the possibility of intelligible discourse between people quite different from one another in interest, outlook, wealth, and power, and yet contained in a world where, tumbled as they are in endless connection, it is increasingly difficult to get out of each other's way."  
(1988.147)

This perspective was one of the factors that led me to present the data in terms of contrasting perceptions of infancy, and to develop the discussion into a broader exploration of the symbolic power of infancy.

At this stage I leave the discussion of the early stages of practical aspects of the research and turn to the broader themes that run through the thesis, introduced in Chapter 1.

### **Identifying the Themes**

Chapter 1 (p28) has identified the three themes that run throughout the thesis, each based on a continuum which has Bangladeshi beliefs and practices at one end, Welsh and English in the centre, and health professionals at the other end. Along this continuum, moving towards the health professional perspective, there is increasingly explicit medicalisation and awareness of Sudden Infant Death Syndrome, and recommendations about infant care.

The continuum proposed in Chapter 1 was this one:

**Bangladeshi <-> Welsh/English <-> Health Professionals**

Describing some of the early practical stages of the research, however, has identified a number of intermediate points along the continuum. Rural and urban Bangladeshi women, Bangladeshi women who have grown up in Britain, health professionals who work closely with mothers (such as Health Visitors) and those who focus more on the infant as it is represented in statistical analyses, would each have a place in the intermediary positions along this continuum. These contrasts become more explicit later in the thesis.

The present chapter has shown how the initial negotiations concerning access and recruitment with the interpreter, health professionals and mothers themselves, constituted early stages of data collection. I summarise below the ways in which this initial stage



identified both some of the issues which emerged, and the broader themes. I show too how my attempts to include participatory research, and to incorporate my own experience of working with health professionals, generated data on how I was perceived. Finally, I draw together some of the points on ethnicity which arose in this chapter and which form the rationale for the chapter which follows, with its focus on ethnicity in Cardiff.

Early in the fieldwork contrasts emerged in perceptions of time and space, and in the social networks in which infant care was embedded. In arranging interviews the importance of the effect on restaurant work on the daily cycle of Bangladeshi homes soon became evident: late morning or midday was a good time to visit, early morning was not. For Welsh and English households the priority was attached to arranging a time during which we would have "some peace and quiet": that is to say a time when there would be no other demands on the mother. In Bangladeshi households interviews were a shared social event, whilst for the Welsh and English households they most frequently involved the mother, the baby and myself (on two occasions, the mother had arranged for someone else to care for the baby).

Infants born into Bangladeshi households were immediately within a large household, which was itself part of a relatively small population of Bangladeshis in

well-defined areas of Cardiff. Welsh and English infants, in contrast, were parts of smaller household units, in which infant care was regarded as primarily one of the roles of the mother. The infant was also 'born' to a network of health professionals. My early contacts with the range of hospital midwife - neonatologist - community midwife - Health Visitor - General Practitioner - paediatrician made clear just how many people felt they were involved either in the care of particular infants, or had a professional investment in infant wellbeing in general. It was partly this contrast in social networks - which brought together the different 'cultures' involved through medicalised childbirth and infant care - that prompted me to present the data as three broadly contrasting cultures which appear in Chapters 5, 6 and 7.

Incorporating elements of participatory work led me to involvement in the English for Pregnancy scheme, and to spend some time in mother and baby clinics. I was inevitably also drawn into the world of health professionals interested in SIDS, and have used the experience to show how their perceptions work from SIDS towards the production of explicit recommendations. This participatory element was valuable in a number of ways, but particularly in providing some reflection on my own role as a researcher. When working with health professionals, I was placed in the 'social' domain, that is - echoing Armstrong's analysis - in the social realm of

infant care practices rather than the natural domain of, for example, physiology. For the Welsh and English mothers I was neither a health professional nor a mother, which meant both that I could ask apparently simple questions, and be genuinely interested in their responses, and that I could avoid expressing opinions based on either personal experience or professional expertise. The Bangladeshi mothers with whom I spent time as an English tutor were quick to ask if I had "babies?": whilst I had status from my role as a researcher, their reaction to the idea of a woman in her 30s with no children was one of both disbelief and pity.

It was the process of leaving the field that brought me to realise that my own perception of myself had changed from an anthropological researcher to a health professional, at ease in all parts of the hospital in which I had an office. With some of my colleagues, I had reached a measure of mutual recognition, such that I was perhaps regarded as an 'honorary health professional'; with others, however, simple familiarity led to my being accepted as a member of the hospital staff, and the particular capacity in which I was employed was largely irrelevant.

Once the data collection period was complete, that is to say once the required number of interviews had been completed, I faced the choice of remaining in Cardiff to

continue analysis and writing up of the data, or moving away. It was a difficult choice, because in some ways Cardiff had become 'home'. In Clifford's terms of "making the familiar strange" (1986: 2), I had made the familiar strange, but that strangeness was wearing off, and had become familiar. This became clear to me one day when, searching for some boxes in the hospital, I was directed to the pharmacy. I confidently walked through several doors marked 'private', and ended up on the 'inside' of the counter alongside the pharmacists. This was the point at which I realised that I had started to feel more a member of the hospital staff than a researcher with a social scientific perspective, and therefore made the decision to move away from the field of research.

Throughout this chapter I have identified a number of issues concerning ethnicity. In particular, recruiting an interpreter had identified the importance of recognising distinctions between Sylheti and Bengali languages, Hindu and Muslim Bengalis, and women from rural or urban backgrounds. Taking part in the English for Pregnancy programme suggested that Bangladeshi women were not simply learning English. They were being taught in their homes because of the unacceptability of women going outside the home, and by women because childbirth and rearing were viewed as the domain of women. In addition, they were being taught about the

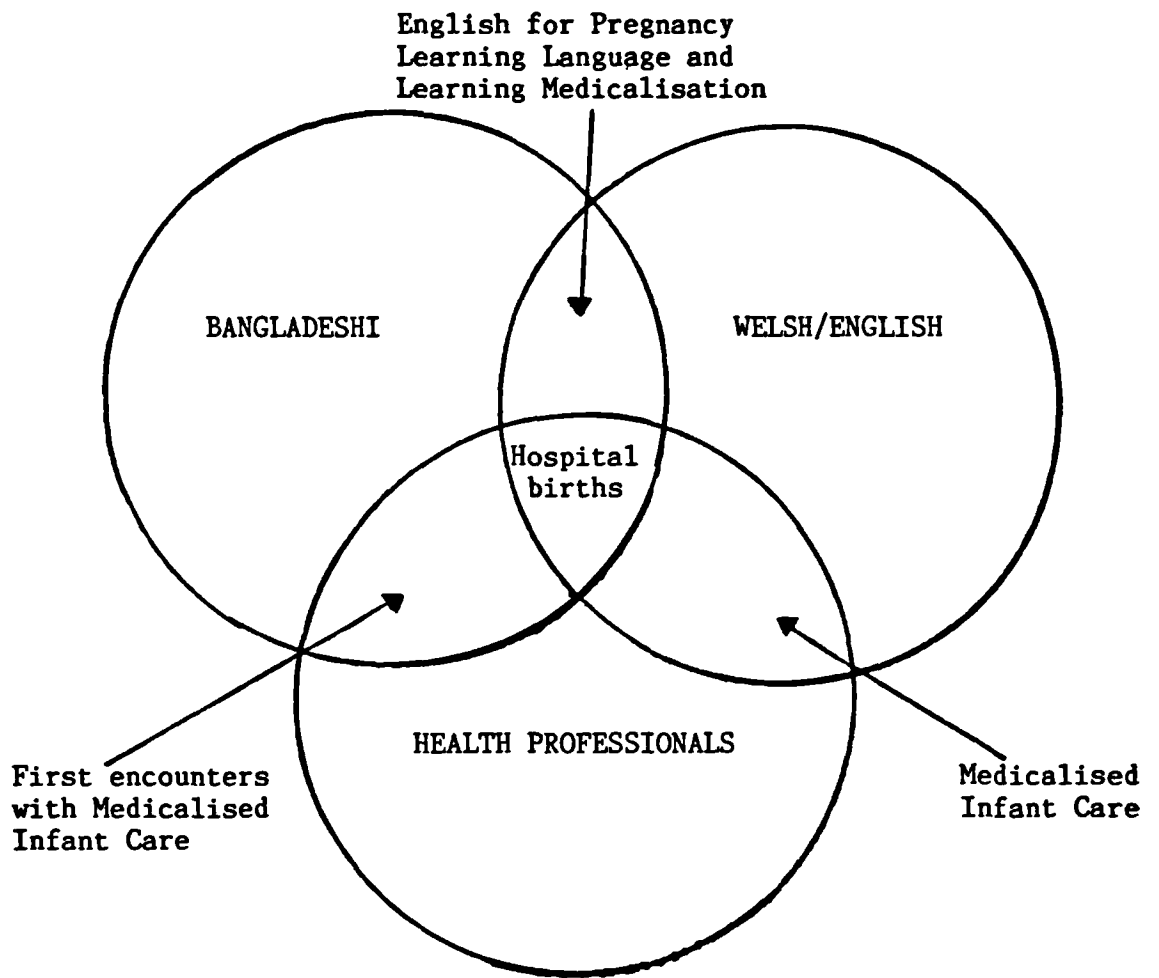
processes of medicalised childrearing. I have also carefully referred to "Welsh and English" mothers rather than assuming that all the women in Cardiff could be described as "Welsh". The next chapter addresses directly the issue of the experience of ethnicity. It recognises that whilst I draw broad overall comparisons between the Bangladeshi and Welsh or English perceptions of infancy, a closer look suggests that the apparently simple variable of ethnicity used in epidemiological analysis covers a wide range of experience. The way in which epidemiology constructs its analysis is a subject to which I return in Chapter 7.

**CHAPTER 4: ETHNICITY AND INFANCY**

The preceding chapter has identified a number of issues concerning ethnicity which arose during the early stages of initiating the research. Here I explore these further, showing how the three 'cultures' around which the thesis is based - Bangladeshi, Welsh and English mothers, and health professionals - came into contact with each other through the processes of infant care. In particular, I describe the English for Pregnancy project, and how my involvement generated observational data on a population which was experiencing its first contacts with health professionals, and whose expertise in infant care drew on experience rather than epidemiology. The Bangladeshi mothers marked one end of the continuum of infant care I have identified, having little knowledge of medicalised infant care or of Sudden Infant Death Syndrome, and drawing on implicit practice rather than explicit recommendations.

While later chapters separate out the three cultures, this one shows all three of them against the background of Cardiff, and within the historical frame of migration. It provides context for the presentation of data on infancy, from the different perspective of each culture, in later chapters. Figure 1 uses overlapping circles to

Figure 1: Where Cultures Cross



show how the three populations came into contact. The diagram is not intended to show the extent of overlap: the majority of the health professionals would also form part of the Welsh/English circle, but their perspective on infant care was shaped in specific ways which are described in Chapter 7. Instead, the diagram shows how those involved in infant care - be they Bangladeshi, Welsh or English mothers, or a variety of health professionals - came to meet through the processes of language teaching, hospital birth, or health professionals working in the community. The English for Pregnancy project appears as one of the rare opportunities for a few Welsh and English women to come into contact with Bangladeshi women. The central area was the one place where all three groups came into contact, through the processes of childbirth in hospital.

Working with the English for Pregnancy project identified distinct variation within the Bangladeshi population. To look further at these variations, later in this Chapter I pose the question 'Why is there a Bangladeshi population in Cardiff?' and in answering it draw on historical and contemporary data on migration. I then turn to the different ways in which Bangladeshi, Welsh and English mothers talked about their own ethnicity. Whilst this may seem to be a diversion from the subject of the thesis, that of infancy, I include it for several



reasons. The birth of a child emerged as a time when Welsh and English mothers spoke about their own and their children's ethnicity. The processes of ante-natal care, childbirth and infant care were the first, and for some the only, time when women from rural Bangladesh came into contact with the city beyond their extended family households; and at childbirth, mothers and grandmothers from Bangladesh sometimes sent 'home' for amulets to protect their newborn infants. In this way I hope to show that whilst epidemiological research (discussed more fully in Chapter 7) uses ethnicity as an apparently straightforward way of categorising and comparing both infant deaths and infant care practices, this one 'variable' encompasses a wide range of practices and beliefs. More generally, the infant, and the care of infants, emerges here at the boundaries of different systems of meaning. Further, infants and their care prompt the different perspectives to come into contact, and the recognition of difference in both understanding and practices. This is an aspect to which I return in the final chapter of the thesis.

#### **English for Pregnancy: Learning Language and Learning Medicalisation**

Figure 1 (page 127) places the English for Pregnancy Project at one of the few points where newly-arrived Bangladeshi women could come into contact with Welsh and

English women in Cardiff. Acting as a volunteer tutor for the Project allowed me a number of insights, gained through spending one or two hours each week with each of the three households. In presenting this data, I use either pseudonyms to make the text more accessible, or numbered 'EP' (English for Pregnancy) fieldnotes. A fieldnote from a visit to the second Bangladeshi woman for whom I was a tutor records:

"Arrived to find her brother-in-law and his wife in the process of putting together a white rocking crib which they had just got from Toys R Us... The cot is for the baby who is now c.5months old: father said it's time he had his own cot now - they put the cot once assembled in the living room, put a towel in the base, and the baby on top of that, with one blanket... He slept for 40 minutes or so, before his mother picked him up and carried him round for a while. Then she gave her little girl (and me) sweet tea into which we dipped white bread that had been fried in beaten egg" [EP2 fieldnote]

This extract refers to a household shared by two brothers and their wives; both brothers worked as waiters in an Indian restaurant on the outskirts of Cardiff. The older brother and his wife had a daughter of 2 and a baby, for whom they were assembling the cot. The woman for whom I was acting as a tutor, Mina, was expecting her first baby. Her sister-in-law (that is to say the wife of her husband's brother) had also received tuition through English for Pregnancy, and had had both her children in Cardiff, although the baby had had specialist care in Southampton. Both men left the house for the restaurants in the which they worked around 5pm, after

the principal shared household meal of the day. This was the time of day they suggested that I should visit for tuition.

Seeing the cot being assembled allowed me the opportunity to ask where the baby had been sleeping previously, and to observe where the new cot was going to be kept, the kind of bedding and clothing used, and so on. Seeing the cot each week in the front room, as I did in many other houses, was one of the early indicators that Bangladeshi infants were not placed to sleep in quiet parts of the house, but were kept with other family members. Their care, too, did not seem to have to be fitted in with a wide range of other commitments: for the mothers, unlike the fathers, it was rare to move from the house.

A separate fieldnote, some six weeks later, records a conversation with the co-ordinator of the English for Pregnancy project who had received a message that Mina was worried about going to hospital to have the baby on her own. Her suggestion was that I try to explain the possible sources of help to Mina, possibly enlisting the help of her husband or brother-in-law, or one of the neighbours, if we needed interpretation. In the event, everyone in the household, and several neighbours became involved in this exchange:

"Her suggestion was that a lady in the same street, Benessa Begum, who speaks good English, might be prepared to accompany her. She however, has a 'little baby' and would need someone to look after her. She suggested that Benessa should accompany Mina, and get Mina's sister-in-law to look after Banessa's baby." [EP3 fieldnote]

I cite this extract to show the fear some women felt about moving outside their homes into the unfamiliar territory of the city and the hospital. It indicates too the density of the population within specific areas of the city, and the wealth of knowledge about this particular population accumulated by health professionals and linkworkers. It also shows how a programme essentially designed to teach English, was functioning as a network of information and help, and how I, as a volunteer tutor, became drawn into this web of messages and practical arrangements.

As a guide to the teaching we were expected to do, volunteers were provided with a series of cards published by the HELP Maternity Language Course. Two examples are attached as Appendix IX. What became clear was that we were not just teaching language, but how to survive the processes of living in an industrialised society, and in particular hospital ante-natal clinics and childbirth, and medicalised infant care.

The first card with which volunteers were provided was described as "Core Dialogue for the first appointment at

an ante-natal clinic". It included a list of questions relating to name, address, telephone number, age, date of birth, marital status and husband's occupation. Women were being taught how to identify themselves in terms which would allow them to fit into hospital records. This included, for instance, understanding how to define their names in western terms, and how to describe periods of time in weeks and months.

The second card at Appendix IX relates to "Instructions prior to examination" and deals with the familiar instructions to "roll up your sleeve, take off your shoes, take off your clothes, put on this gown, wait over there, get dressed - please". I choose this card because it shows something of Clifford's process of "making the familiar strange": these are all phrases and activities with which I, as a white western woman with occasional experience of hospital care, was completely familiar. For the Bangladeshi women, particularly those from rural Sylhet with little or no experience of hospitals, they were completely new.

Other cards deal with instructions during an examination, tests and samples (blood, blood pressure, urine, weight), the foetus in the womb, and birth. I cite these two simply to show the extreme unfamiliarity of the early contacts with health professionals, ante-natal clinics,

and hospitals. In the broader context of the themes which run throughout the thesis, this is the group at the furthest pole from medicalised infant care.

The particular linkworker associated with the English for Pregnancy project was from India: like the Bangladeshi women she was Bengali, but her origins lay in Indian West Bengal, whilst theirs lay in the land of East Bengal that became first East Pakistan and later Bangladesh. This meant that there was an Indian Hindu linkworker working with the Bangladeshi Muslim women. Some of the historical background for these divisions, together with the contrast between Sylheti and Bengali identified in the previous chapter, is discussed in the next section of this chapter "Why is there a Bangladeshi population in Cardiff?"

#### **Why is there a Bangladeshi population in Cardiff?**

In initiating this research, I moved from Brighton to Cardiff, and in this shift a number of contrasts emerged. I anticipated that I would at least still be close to the sea. One of the most striking differences between the two places, however, was in attitudes towards the sea. Brighton is a seaside resort, with tourist and conference trade drawn to the town partly because of its proximity to the sea, and the availability of a wide range of

leisure facilities. In Cardiff, on the other hand, it was difficult to find the sea. The docks form a slightly separate area of the city, and finding what I regarded as "the sea" - beaches and waves, rather than docks - meant a journey of several miles.

The importance of the docks is one of the factors which explains why there is a Bangladeshi population in the city. Like other British ports, such as London and Liverpool, Cardiff has a relatively long history of immigration. McFarland (1991), in his account of seafarers or 'lascars' arriving in Glasgow from India and China, goes back to the 16th century, but suggests that they arrived in greater number in the 1850s. Little (1947) in his account of "a coloured community in Cardiff", makes only passing reference to "Lascars from the East Indies, and Chinese seamen" and the sorry conditions in which they lived, between voyages, in 19th-century London. He introduces his anthropological fieldwork as relating to:

"the coloured population of a large Welsh seaport city, mainly made up of the families of African, West Indian, and Arab seamen." (1947: 25)

The rapid development of coal mining in the early to mid 19th century prompted waves of migration into Wales from both other parts of Britain and from Europe. The majority of the population of Cardiff now lives in

terraced housing built in the late 19th century, as the city was growing prosperous on the coal mined in the valleys to the north of the city. Cardiff's development as a port led to migration from further afield, and the first Bengalis came over as cooks or labourers on British troop ships during the 1914-18 war.

The area around the docks became the first step in settlement for various different ethnic minority groups. Whilst I was in Cardiff, I heard two accounts of this area early this century, one as a romantic, "melting-pot" of different nationalities in an area called "Tiger Bay"; the other as a violent centre of racial tension around "the docks", geographically quite distinct from the remainder of the city. In the early 1990s, as the research was carried out, some parts of "the docks" were being transformed into "the Bay", and attempts were being made to attract commercial investment and conversion to a "leisure amenity". Other parts of the dock area remained apparently little changed, and provided homes for the latest wave of refugees from Somalia.

The shifting identity of the docks, from working port to commercial, residential and sporting facility, is of course also being tracked by local historians and oral history groups. "Below the Bridge" (Evans et al 1984) refers to the way in which the docks are separated from



the remainder of the city. The authors cite Little's work:

"Professor Kenneth Little, an anthropologist, came to do some research in Cardiff, and had this to say about Butetown [redeveloped with tower blocks in the 1960s and 1970s]: 'The warren of cosy and insanitary, tiny houses has gone...it has been replaced by honey coloured brick, spaciousness and cleanliness... One's first impression must be one of relief that a neglected slum has been removed. But apart from the housing, the area looks empty, bare and less intimate than before.'"

Evans et al conclude, however, with an expression of dissatisfaction:

"Butetown is no longer individual. One council estate looks much the same as another. The major difference is that it replaced a thriving and unique community, unlike other estates in Cardiff." (1984: 66)

Whilst early Bengali settlers lived in this dock area, they have now moved towards the centre of the city. During the research period the majority of Bangladeshis lived in a small area of Cardiff bounded by the River Taff, a dense network of railway lines, the brewery, and the international rugby stadium. Dicks (1984: 89-90) comments on the rapidity with which this area grew, and how street names reflect the speed of building, and the impact of the railway lines being built to transport coal from the mines to the docks:

"Street names are themselves an indication of the degree of haste with which housing was thrown up...there is more than a passing nod in Riverside towards those responsible for the revolution in transport - Trevithick, Telford, Brunel and Stevenson." (1984: 89-90)

The mention of early Bengali settlers around the docks raises the distinction, already identified above in discussing the English for Pregnancy project, between Bengal and Bangladesh. A history of Bangladesh is beyond the scope of this thesis, and has been well documented elsewhere (see for instance Alam 1988). For the purpose of discussing the Bangladeshi population in Cardiff, it is sufficient to note that Bangladesh came into being in 1971, having until then been known as East Pakistan. East and West Pakistan separated from India in 1947, at the time of independence from Britain, the division having been created in order to provide separate lands for Hindus (India) and Muslims (East and West Pakistan). The two separate areas which formed Muslim East and West Pakistan remained one country until Bangladesh seceded from Pakistan in 1971. Prior to 1947 the land which now forms Bangladesh was East Bengal, sharing a language with neighbouring West Bengal.

As well as the distinction between the Hindu Bengalis of India and the Muslim Bengalis of Bangladesh, within Bangladesh there is the distinct area of Sylhet (shown on the map at Appendix VIII). This was an issue which first arose during the processes of recruiting an interpreter. Gardner's (1990, 1991) account of anthropological fieldwork in a Londoni (or migrant) village in Sylhet provided a valuable source of data on

both the history of Sylhet, and the specific factors which led the Sylheti people to migrate to the United Kingdom. She traces the area's history back to a Muslim overthrow of Hindu rulers in the late 14th century. From then until the late 18th Century, and the rapid growth of the British East India Company, the area remained under Moghul rule. Rice was the main crop, but some tea was grown on British-owned plantations worked by labourers brought in from neighbouring states. Gardner draws particular attention to the belief that working on another person's crop was an unworthy occupation:

"The local disdain for labouring is of great importance to the area's economy, history and culture" (1990: 66)."

Under British rule, Sylhet was seen as a troublesome frontier region, and in 1874 the British decreed that it should be part of Assam rather than Bengal. This lasted until 1947 when it was reassimilated into Bengal. Gardner argues that it was this period of Assamese rule, and in particular contrasting systems of land tenure, which account for the cultural and linguistic differences between Sylhet and the rest of Bangladesh.

While under Assamese rule the land tenure system differed from the Bengali system. The Assamese system had many independent single tenures, rather than the small number of large tenures created in Bengal under the usually Hindu land owners, or zamindars. This resulted in a

relatively large number of independent peasant farmers who owned and cultivated their own land, rather than being tenants. So far as migration was concerned, Gardner suggests that there was no one factor that 'pushed' people to migrate. Instead, the possibility of selling land in order to pay for the journey, together with the shame associated with working on another man's land, combined to make migration both possible and desirable.

Gardner (1992b) also describes how Sylhet has remained a place of particular spiritual power. She identifies the distinction between desh and bidesh which crystallises this point. Sylheti views of migration are part of a broader sphere of beliefs in which the term bidesh refers to distant countries, and the hope of prosperity and modernity in foreign lands; it is counterposed to desh or home. Economic investment in bidesh (in this case Cardiff) is seen as worthwhile, in desh there is little point; at the same time desh remains the source of spiritual strength. Earlier in this chapter, for example, I described Bangladeshi mothers or grandmothers sending home for amulets (often seeds from their home village) to place around the neck of new-born infants to provide the spiritual protection of desh.

Gardner's reference to the British East India Company, and to British plantation owners, raises the issue of colonialism. It is not central to this thesis, but it is an important element in the history of Bangladeshi migration to Cardiff and other British cities. Indeed Gardner argues that it was through British rule, in particular the passing of Sylhet into Assamese control, that the colonial relationship was established and that it was later replayed in men working on British ships and then in factories. In her analysis, if 19th century Britain exploited raw materials and goods, in the 20th century the commodity was cheap labour.

In Watson's introduction to his 1977 collection of essays by anthropologists working with ethnic minority populations in Britain he draws attention to the way in which all the contributors recognised migration as a process. They had therefore studied both ends of the 'chain', including the impact of migration on the 'emigrant communities'. This was not possible for me, but Gardner's (1990, 1991) accounts of anthropological fieldwork in the Londoni villages of Sylhet provided an invaluable source of data on the broader context of Sylheti migration.

The Bangladeshi women I met in Cardiff did not speak of colonialism, although they frequently drew contrasts

between Britain and Bangladesh. The long quotation below shows the more explicitly political perspective adopted by some Bangladeshi women who have been in Britain for a longer period.

The extract is taken from the Secretary of the Bangladeshi Womens' Association, speaking at a session on "Organising to Come Here" at a 1982 conference "Black and Immigrant Women Speak Out and Claim our Rights". It makes the point that colonialism casts a long shadow, and remains relevant to the discussion of an ethnic minority population in Britain and specifically to the position of women within that population.

"After political independence, even that political independence didn't take into consideration the people who are made independent. As you know India was divided on an artificial basis, on the basis of religion; the country was divided on the basis of Muslim and non-Muslim. If you imagine this hall is the country, just by sheer luck part of it went to India and part in Pakistan, and by that many people suffered. Like the part of the country I come from. Someone got up early in the morning and saw that her daughter's home is in India and her home is in Pakistan. And she can't go to see her daughter unless she has a visa. So this is the political effect of partition. The independence of India was agonising.

And coming to the economic issue, it was more so - we paid for that artificial division. These are the issues of colonialism; after all these years we couldn't get over the hangover of that colonialism. And the reason I say that it is still there - how we came, at least in my situation how I came: in my particular case the work wasn't the attraction, but somehow my husband thought that he will have the benefit of British education, as if the education he had wasn't enough. And that's the reason he came here. And to give my children a proper home, a

family environment, and not have a so-called single-parent family, I followed my husband. And that's how I am here.

So that's why I say that the effect of colonialism didn't finish, it's still there, people have still the feeling that if they come to Britain they will have a better life; and if they go back from here, that they will have a much better life. So this is the reason we have come here. But this comes from the head of the family, that is, men, and we are the tails of the family and never counted. That's why I feel that it's great to be able to say how the tails feel then they had to carry the burden of the head." (in S James 1985: 69)

In answering the question of why there is a Bangladeshi population in Cardiff, I have drawn on an historical account of the development of coal mining and export in Cardiff, the arrival first of Bengali seamen and later other migrants, and the linking factor of British colonialism. This however has been an 'outsider's' perspective. I now turn to describe the Bangladeshi population in Cardiff during the fieldwork period, and to discuss how Bangladeshi women spoke about their own ethnicity. The subsequent section, on how Welsh and English women spoke about their ethnicity and that of their infants, shows broad contrasts which emerged in discussing their infants' ethnicity.

### **Being Bangladeshi in Cardiff**

There are few accounts of Bangladeshi populations in Britain: Eade's (1989) analysis of local political

organisation in London, and Alam's (1988) argument that British social class definitions would be better replaced by an urban:rural comparison for Bangladeshis in Britain offer two examples. Shaw's (1988) ethnography of a Pakistani population in Oxford, and Ballard's (1977) work with Sikh populations, provide descriptions of other South Asian populations in Britain. Wilson (1978) offers an insight into the views of young Asian women who have grown up in Britain, and Westwood and Bhachu (1988) address the specific subject of British-educated ethnic minority women in paid employment in Britain.

Ballard and Ballard (in Watson 1977) have suggested that there are four stages through which South Asian ethnic minority populations pass in Great Britain. They describe the particular case of Sikhs in Leeds but claim the stages to be common to all. First, the individual pioneers, seamen and pedlars who started to settle in major cities between the two World Wars. Subsequently, in the 1940s and 50s, a demand for labour drew mass migration from the Indian subcontinent; this was followed by a wave of entry of wives and children which resulted in fewer all-male households; and finally the emergence of a more prosperous British-educated generation. Whilst this pattern may be observed in the larger British cities, in Cardiff the Bangladeshi population remains relatively small and recent. OPCS



data collected during the fieldwork period found a population of 0.6% of the city's c280,000 (OPCS 1991).

The majority of the interviews I undertook were with women and their children. Their husbands and sometimes their husbands' brothers and fathers were present occasionally, and generally for part of the interview only. For this reason this section is based on how the Bangladeshi women I met described their "Bangladeshi-ness". The majority of the men had grown up in Bangladesh, and arrived in the last twenty years or so to work in restaurants set up by earlier migrants. Echoing the progression identified by the Ballards, their wives were relatively recent arrivals; the population was young, and the first generation of children was at school. A small number of both men and women had been educated in Cardiff or London or Manchester. A few wealthier Bangladeshis, restaurant owners rather than chefs or waiters, were living in detached houses in middle-class areas of the city.

Broad contrasts emerged among the mothers in their views about their ethnic origin. For the Bangladeshi women who had recently arrived in Cardiff, there was no question, they simply and easily described themselves as Bangladeshi. For the Welsh and English mothers, explanations were necessary: they sought and presented

reasons for describing themselves and their infants as either Welsh or English. There was a third, smaller group, the Bangladeshi women who had grown up in Cardiff or another British city. They divided into those who found themselves poised 'between two cultures': some were actively encouraged to reclaim their Bangladeshi beliefs and practices in caring for their infants, others were actively creating a new identity for themselves, that of 'British Asian'.

The Bangladeshi women who contributed to the research fell into four broad categories which are described below. However, even with these relatively broad bands - which I describe further below - there were exceptions. These included, for instance, two women who had married in Bangladesh and whose husbands had been unable to obtain permission to enter Britain, and one of Bangladeshi and English parentage whose Bangladeshi father had - in the explanation she offered to me via the interpreter - "kidnapped" her and brought her up in Bangladesh. That is to say that he took her back to Bangladesh against the wishes of her English mother; there she had been brought up by her father and his second Bangladeshi wife.

The first of the four categories mentioned above comprised the majority of the Bangladeshi women I

interviewed, who came from villages in Sylhet. They were relatively recent arrivals in Cardiff, having gained entry as wives to men working in the city. The general pattern described to me was of young men coming to British cities in which they had either family or village contacts, from whom they could expect assistance in obtaining work, housing and money. Once these young men had established themselves, they arranged a marriage in Bangladesh and returned there briefly to marry. They subsequently returned to the UK, and applied for immigration papers for their wives.

These rural women spoke Sylheti, and a few were able to both read and write it. They mostly had little spoken English, and it was rare for them to read or write English. For this reason, interviews often began with the interpreter reading the letter of consent, and asking them to sign it. Most were able to write their names; where they were unable to do so, their husband or another family member signed. These interviews tended to be different in that I needed to ask more questions or to offer more prompts in order to encourage women to talk. This may reflect my own ethnocentric approach in asking mothers to talk about "a day in the life" of their babies, which assumes that days have a linear thread to them, and that they are divided into different activities. The varying perceptions of time and space

in infant care are major themes in the chapters which follow. The slightly more structured shape of these interviews may also suggest that talking about and reflecting on our lives, and on our own and other ways of life, is a peculiarly western, perhaps middle-class and academic, preoccupation. It is possible too that these women may have been overawed by the interpreter and/or me, and frightened of saying the "wrong" thing. This seems unlikely, however, in the light of the familiarity of infants and infant care within these households, and the way in which British-educated women echoed these village women's perceptions of infancy.

A second category of women was made up by the few village women who were married to men who were older and relatively wealthy, and so found themselves making a rapid transition from rural Sylhet to middle-class Cardiff. It was more common for women in these circumstances to be second wives. It may have been that the first wife had died, or that she and the children of the marriage were living in Bangladesh whilst the husband worked and lived, with a new wife and family, in Cardiff. Whilst this latter pattern did not seem to be very frequent, it was described to me on at least one occasion. Some had learned English at school in rural Sylhet, but most needed the interpreter for any

discussion beyond responding to my questions about their names and the names and ages of their children. By the end of the interview it was often clear that they understood more English than they spoke; however, from experience teaching on the English for Pregnancy programme I learned that women were often wary of using the little English they had acquired, because this tended to lead to an assumption that they understood and spoke more English than they actually did. If this happened a linkworker would not be called by the hospital; if, however, the hospital thought that communication between the mother and the health professionals would be improved by the contribution of a linkworker, they were able to request their presence. For the mother, this brought not only specific help with language, but the possibility of more general support.

A third category was the small number of women who had moved from urban Bangladesh to middle-class Cardiff. Their husbands were either restaurant owners or involved in "business" of various kinds (the only broad explanation of this I received was 'import:export'). These women were not professionally qualified, although in Bangladeshi terms they were well educated, and found themselves working in intermediary jobs, as 'cultural brokers'. Their paid and unpaid roles included acting as linkworkers for health and social services, or in the

multicultural resource centres. Their English was not the idiomatic local speech of the few Bangladeshi women who had been educated in Britain, but retained the intonation and vocabulary of a second language. Most were members of Cardiff's Bangladeshi Ladies' Association. The interpreter for this project fell into this category, and saw it as her "duty" to help "our people". One other member of the Association described her role as a community worker as "more for future generations than for the present". Watson describes this process as common to many ethnic minority populations in Britain:

"With few exceptions, the self-proclaimed 'immigrant spokesmen' or 'community leaders' are highly-educated, middle-class migrants from larger cities" (1977: 6).

Alam (1988) makes this urban:rural axis central to his discussion of Bangladeshis in Britain. Similarly, Blanchet (1984: 7-8), in her work with village women, identifies specifically the emergence of a Bengali Muslim rural culture, quite distinct from the experience of these urban women.

This generation of women is structurally and temporally 'in between'. Their working lives, whether voluntary or paid, are involved in "helping" - an ideology of charity rather than empowerment - by improving access to health or education services, or to employment (often via their

husbands). They are temporally in between because as more Bangladeshi children are educated in Britain they may have less need of this kind of patron:client relationship, and indeed will outstrip the current 'patrons' in language skills and educational qualifications. These are the women who are aware, particularly via their children, of the differences between Bangladeshi and Welsh culture, and who explain it to their children in terms of "it is our culture, equal but different". They act as "guardians" of their culture, encouraging their children (particularly their daughters) to learn and speak Bengali.

These women were, in Watson's words (1977) "Between Two Cultures". Their experience was very different from that of women who had grown up in British cities, and I describe below some of the tensions between the two groups, the second creating a new British Asian or British Bangladeshi identity.

The few British-educated Bangladeshi women comprise the fourth category in this section. Watson suggests that the title of his edited collection - "Between Two Cultures" - encapsulates the most important theme to emerge. He describes ethnic minority populations born in Britain as being:

"caught between the cultural expectations of their parents (the first-generation migrants) and the social demands of the wider society" (1977: 3).

Of the few British-educated Bangladeshi women in Cardiff, some fitted into Watson's characterisation, finding themselves in between Cardiff and Bangladeshi expectations of infant care; others, however, were creating a new identity, distancing themselves from Bangladesh and its beliefs.

These women had been born in either Bangladesh or Britain, but had received the majority of their education in London, Manchester or Cardiff. Their English was totally idiomatic, accented with the particular city in which they had grown up. In this way it was very different from the English of those women identified earlier who had learnt their English in Bangladesh. Some identified themselves as Bangladeshi, some as Welsh, one as British Asian. All lived in extended households with either their husband's parents or their own parents; one, whose husband was still in Bangladesh, lived with an older brother and his wife and family. The majority of these women worked only in the home; one combined that with being a full-time nursery nurse and one with part-time work as a supermarket cashier.

One of the problems these women faced in going back to



visit Bangladesh was that of language. One young woman had learned standard Bengali as a child, through attending classes rather than through learning within her family. On going to visit relatives in Sylhet, however, she commented:

"Although it's the same language it's completely different" [M9.3]

Another mother, married to a Bangladeshi man but unable to acquire the documentation necessary for him to enter the United Kingdom, foresaw problems in the future arising from differences between her own expectations for her daughter's future and those of her husband:

"The reasons she thought it would be difficult were associated with possible conflicts she saw between what she wanted for her daughter, what her husband would want, and what her daughter would want. She could see herself being the mediator, with her daughter wanting more education and more freedom, and the father wanting to keep her more closely controlled and part of the family." [M15:2 (second interview)]

The same woman, who worked part-time as a cashier in a supermarket, described her dislike of being known as Bengali. She described herself as being 'neither Welsh nor Bengali', and often labelled as 'Paki'. I met her three times during the research period, and by the end of this time she had been on an interpreting course, and was describing herself as 'British Asian'. My fieldnotes following our first meeting include the following comment:

"Before the interview started she said 'I must tell you straightaway that I am much more western than Bengali'.

She is happy to be thought of as Indian rather than as Bengali, she doesn't like to be known as part of the Bengali community which she describes as 'very nosy'. Apparently the interpreter (to whom she had obviously taken a great dislike) as soon as she met her had started asking 'who is your father, who is your mother? do I know you?' trying to fit her into a web of family and other connections.

I asked if these were the normal sorts of questions that Bangladeshi people would ask each other when they meet. She said, yes, that was quite normal, but she does not want to be part of it. She obviously wants to be more private - 'that's the way I like it' - she didn't want everybody to know her business, that her husband was in Bangladesh. She said - 'somehow word has got around that there is a Bengali girl working in the supermarket'. She mentioned particularly an incident in which a customer replied to her [when she had spoken to her at the checkout in English] in Bengali - despite the fact that there was nothing in her appearance (her jewellery or clothing) that would tell people she was Bengali." [M15: 2-3]

This early interview identified particular tensions in relationships between British-educated Bangladeshi women, and those women who were either recent arrivals from Bangladesh or who had been in the UK longer and created roles for themselves as interpreters or community workers, brokers between the two cultures. On this particular occasion, as described in Chapter 3, I had called without telephoning earlier on a young woman who had just had a baby, and whose name I had received via one of the hospitals. She was very shy and nervous of us - possibly because her husband was out at the time -

and did not wish to take part in the research. However, it was through this visit that I met her British-educated sister-in-law, took her phone number and rang her later: it was during this conversation that she agreed to an interview, but specified that I should not 'bring the other lady' with me.

Another woman, married but still living with her new husband in her own family of origin, spoke of some of the tensions between British and Bangladeshi-educated women:

"There are lots, you know, I can go to but, you know they just kind of like 'back-talk' behind .. we have been brought up in this country ... you know we tend to get on well, whereas people brought up in our country kind of, like they don't mix with me, they find it kind of, like we are different. Although I dress and speak everything the same they tend to find me like English people ...

But do you feel more Bangladeshi than English or Welsh?

I think I am 50:50, whereas I find it, I think because I was brought up here I find it, you know speaking to people, even our people, in English I find it easier than talking Bengali." [18:20]

While this mother described herself as 50:50, one of the others, who had lived with her parents in Cardiff since she was three, was more emphatically Bangladeshi:

"I would call myself Bangladeshi: there is no way I'm going to change the colour of my skin, so there is no way of pretending." [19.1]

I then asked if she sometimes felt more Welsh, and her response introduced another issue, that of daughters

being drawn back into their Bangladeshi family, and Bangladeshi beliefs and practices when they marry and become mothers:

"I used to before I got married, I think, when I was in school, I used to sort of have mixed feelings about it then, but now I don't care what people think about me. Whereas before I wouldn't be seen dead in a sari, now I am quite proud to wear it."  
[19.2]

I met each of these women at least twice, and it was with some of them that I could see friendships developing had I remained in Cardiff. Many of them were very interested in the research, and in the idea of recognising and attaching value to the differences they lived with constantly. Some of the conflicts with which they lived constantly were the contrasts which were to emerge later from the fieldwork: for instance, on one occasion a British-educated mother described the difference of opinion she had with her mother-in-law over letting her infant son sit on the floor. It was, however, sometimes difficult to make contrasts, since we ran into language problems when attempting to define "what we do" and "what you do", since our shared experience was so strong. This was particularly so in one case, where the woman concerned wanted at least the interpreter's job, if not mine:

"..when you look at ths country's [the UK] history and ours [Bangladesh], we are sort of like a hundred years back in our beliefs, but it's all changing now, brothers are splitting up so you will find families like this [she was married to an only son; they lived with her parents-in-law in a terraced

house]... I don't like to use the word 'yours' and 'ours'".[19.2 (second interview)]

This extract draws specific attention to the changing household patterns among Bangladeshi families. The dismay in the voice of this woman as she said "brothers are splitting up" reflects her shock at both Bangladeshi families shifting from extended to nuclear households, and the specific impact this had had on her own particular family of origin. Household composition is a subject to which I return in the following chapter.

Earlier in this chapter (Figure 1) I showed how the three cultures in this thesis came into contact, and set this in the context of an historical account of how there came to be a Bangladeshi population in Cardiff. Part of the reason for including some background about Bangladesh was to reflect that Bangladeshi women themselves talked about the experience of visiting Bangladesh. This memo recorded a conversation with a woman who had grown up in Cardiff, and was the sister-in-law of a woman who had taken part in the fieldwork:

"'Oh, I've only been there twice, everything is better here, the food is better, easier to get food for babies'. She said she wouldn't want to take her there until she knows that she can eat the sort of food that they have or she would have to take all the food with her. Everything here is 'more hygienic, more scientific, more civilised' - all those words associated with modernity and western values." [M21:3]

In commenting on Bangladesh, views of the benefits of living in a western country became explicit. This is discussed further in the next chapter, where I show how baby milk and baby food fitted into the category of 'more western, more modern', and were adopted eagerly; the idea of leaving an infant in its own room, however, whilst recognised as being more western was unacceptable. Continuing for the moment the question of how women viewed Bangladesh, I asked one British-educated mother if she would take her three sons back to Bangladesh:

"Yes, that will come, 'cos I don't want them to forget their culture, and 'cos that's what my parents have done with us. You know although we have been mostly living in this country we have been going back so we don't get to forget, so I'll be doing that".[18:19]

On the other hand the same mother commented on her children's tendency to get diarrhoea when they were in Bangladesh, but for their asthma and eczema to improve with the change of weather. Her two older children had visited, and enjoyed the closer contact with animals, but would not want to live there because they thought it was dirty. The reference to animals is a passing one here, but I return to it later in the thesis in showing how Bangladeshi mothers spoke of their infants in terms of the spiritual world, whilst Welsh and English mothers drew comparisons between infant care and the care of domestic animals.

For all these groups of women, links with Bangladesh remained strong, even if they had only visited it once and regarded it as "dirty" and "uncivilised". It was still seen as "home", spiritually significant desh rather than economically important bidesh. This fieldnote records an informal conversation after an interview with a British educated mother and her husband. That is to say the time when the tape recorder was turned off, when I was no longer asking them to describe to me how their baby spent its days. It makes clear their views of Bangladesh and Cardiff:

"Their perception was that in Bangladesh there were a few rich people, but their interest was in staying rich and getting richer. Their perception was that in the UK, in contrast, there was more sharing of wealth, and it was possible for even poor people like them to accumulate wealth... The husband described Bangladesh as a 'free country' in that you did not have gas, electricity and water for which you regularly had to pay bills. On the other hand, it was a poor country because the electricity supply wasn't built into each house, it came through overhead cables which made the streets very messy and quite dangerous at times." [M18.6]

One father, working in a take-away, was more succinct:

"There is no comparison between these countries, the richest country in the world, and our country is the poorest country." [11.4]

To conclude this section I use fieldnote extracts to describe some of the Bangladeshi houses I visited in Cardiff. The first extract comments on the different priorities in a wealthier household of a British educated Bangladeshi woman and her chef husband; later in the

chapter, in describing British Bangladeshis, I cite their descriptions of the expectation that they should provide financial support to his family in Bangladesh, and take expensive presents when they visit:

".. she and her husband own the house. They used to live in an upstairs flat, they now live downstairs which means the three boys can run in and out of the garden and they rent upstairs out to a group of students. It's a big end of terrace, and it has still got original things like the original glass in the interior doors [many of the wealthier Bangladeshi families replaced this with modern stained glass]. It's a bit tatty and run down, but still very solid and full of consumer durables of various different kinds, there was a copy of 'Which?' magazine on the coffee table, and there was a modern television and video." [M18:1]

My own expectations of house maintenance and furnishing were evident here in my comment on the lack of expenditure on decorations and furniture. They emerge too in the following extract which describes one pattern of the extended family, choosing to remain living together rather than separating into nuclear families, and wishing to stay in an area with which they were familiar and part of a larger network of Bangladeshi families. One way of doing this, for those who could afford it, was through extending their existing house:

"Both in this household and in the first one today ... it was obvious that although there was a lot of money around, that money is not spent on household furnishings. They are extending this house, and we have come across one other house just north of Cowbridge Road that has also been extended... [M30:1]

A later fieldnote following an interview with an English



mother, working part-time as a secretary, comments on "the tyranny of the house". In the course of a long account of her own feelings about picking up her baby, and the conflicting advice she was receiving about its possible effects (discussed further in Chapter 6) this woman commented on the competing demands of housework as well as infant care:

"...the few times I was on my own and she had been really content, which wasn't very often, she would fall asleep on my arms feeding, and a few times I just sat there on the sofa with her, and it was lovely - it didn't happen very often because I always thought 'no, I've got to do this, I've got to do that, she is asleep, right, so much to do in the house...'" [59.14]

Another conversation with a Sylheti man who lived in Cambridge, but was visiting Cardiff, emphasized how family in Bangladesh saw visitors from the UK as rich:

"He was saying it 'costs him a fortune' every time he went back because he took presents for everybody, and he was expected to be rich and wealthy - as was anybody who worked or lived in England" [M26.5]

In a fieldnote following the last interview with a Bangladeshi mother in a poorer household, I commented on the importance of recognising the poverty in which many people were living, particularly in view of what I thought of as a tendency to "romanticise" the Bangladeshi infant care practices. This was a perspective I met among some Welsh and English mothers, often members of National Childbirth Trust, who would ask me "What else do Asian mothers do?" My notes record:

"...typical front room, loose ill-fitting carpet, no heating other than a gas fire on a wall, a big fireguard with baby clothes draped over it ... I think it's important also at this stage - thinking about this being the last [Bangladeshi] interview - to emphasize the poverty of these homes. Ill-fitting carpets, thin curtains that don't fit, windows that don't fit, often no central heating... [36:4]

For many families, the option of extending their house described earlier was simply not an option. On one visit to a typical three-bedroomed terraced house (to use the kind of description with which I am familiar) I commented:

"...we were let into the house by a young woman who turned out to be the niece of the mother, and was one of about 20 people living in the household... The front room that we were in had a couple of mattresses on their sides propped against the wall, clothes hanging up on coat hangers on the picture rails, various bits of furniture stacked at one end of the room." [M8.1]

This first section of ethnographic data collected in Cardiff has suggested that for Bangladeshi women there was no question about their ethnic origin when compared with the majority white population. I use the term 'white' here because that was how I heard Bangladeshi men and women characterise the majority population of Cardiff. Comparison with the white population reinforced ethnic differences, with obvious contrasts such as skin colour, clothing and language being evident in every encounter.

Among the Bangladeshi population there were clearly distinctions between the social networks of men and women, the men being more likely to be in regular contact with white people through their work in Indian restaurants, while women came into contact with the white population principally through their contact with the health services.

There were clear contrasts too between those women who had grown up in rural or urban Bangladesh, and again between the few who had grown up in a British city and the majority who had arrived from Bangladesh within the previous five years or so.

#### **Being Welsh and Being English in Cardiff**

Thus far in the thesis I have not addressed the specific differences that emerged between Welsh and English populations in Cardiff. Here, I redress this balance slightly. In the first year or so of research, I referred to the non-Bangladeshi or "indigenous" mothers as "Welsh" in order to save words when writing, and time when speaking. When presenting this research to various audiences I adopted the practice of drawing comparisons between Bangladeshi and Welsh, although carefully specifying that neither term was homogeneous and that each reflected a wide variation in beliefs and practices.

On one occasion this caused great concern to a Welsh member of an audience in London - mostly comprising white English Health Visitors and Indian, Pakistani and Bangladeshi health workers. She commented that the research would have been completely different if it had been done by a Welsh woman, and that "things were very different up the valleys". I cite this to recognise the dangers of using verbal short-cuts in making comparisons, and perhaps an over-awareness of my statements concerning Bangladeshi mothers, and a lack of consideration in the way I spoke about Welsh mothers. More generally, this experiences recognises the issue of presenting comparative research, which may suggest that one groups is in some way 'better' than another.

This encounter had the effect of changing my practice: I subsequently always spoke of "Welsh and English" mothers in Cardiff. This holds its own dangers of course: describing this incident to a Welsh colleague, he was slightly affronted, commenting "this is 'Welsh' research", as if I was trying in some way to render it more English.

This incident also suggests that place of residence is significant in accounts of ethnicity: to be either English or Welsh in Cardiff has particular values; being Welsh in London is to be protective of one's own

ethnicity and sensitive to any perceived criticism.

In earlier chapters I have referred to the work of Cohen, and in particular his view of community. Following his emphasis on exploring the ways in which the term 'community' is used, I saw the particular importance of ethnicity in the use to which definitions were put. The following discussion therefore draws on how the women who took part in the research described their own 'Welshness' or 'Englishness'. In practical terms, my purpose in asking mothers to define their own ethnic origin was to allow comparison. Ask mothers, rather than to relying on my own or a health professional's assessment, or mother's country of birth, revealed a number of different elements which I and they considered to contribute towards ethnicity.

In talking about ethnicity, and in particular the contrast between Welsh and English, I was surprised at how often I was asked if I was Welsh. I had anticipated that a very "English" accent would identify me as English. When asked, I described myself as English, although if the conversation became more detailed I referred to my very ethnically varied grandparents (one English Quaker, one Italian Jewish, and two Irish Catholic). Thus my own definition of my ethnicity had two versions: a brief one which simply reflected my

place of birth; and a more considered one that drew on the religious and racial origins of grandparents.

I asked each mother about their ethnicity - generally in terms of an introductory question such as "would you describe yourself as Welsh or English?" Their answers varied from firm replies such as "Welsh definitely" from a Welsh woman who described herself as a lapsed Muslim, to the more vague "English I suppose", "English - whatever that means", or "I call myself Welsh or British, whatever".

In describing their own origins, mothers referred to their grandparents, and their husband's grandparents (I use the term husband rather than partner deliberately, the majority of the women interviewed were married).

Many of the mothers who took part in the research, particularly in the middle-class category, described themselves as English but were clear that "my baby's Welsh". For them the baby's place of birth was a determining feature in being described as Welsh or English;

"Are you English rather than Welsh?" [my question was phrased in this way because she had just told me that she was born in the north of England]

"I was brought up in England, yes"

"So are you English?"

"Well my father is Welsh, so ...

"What about the baby?"

"Well my husband is Welsh, so that defeats me, this baby is definitely Welsh." [54.1]

Bangladeshi mothers, in contrast, described their babies as Bangladeshi, despite their having been born in Cardiff. It was only among the smaller group of Bangladeshi mothers who had grown up in Britain that an identity of "British Asian" was starting to emerge. This suggests that place of education, and of work, may also be factors contributing to some people's definitions of ethnicity.

One way in which people dealt with my question concerning Welshness or Englishness, was to identify what they were not. One mother, a dentist, who was born in England, replied to my question "Would you describe yourself as being English?" :

"I would, well I would describe myself as being British, being as I'm not Welsh." [28:1]

A former secretary, married to a dock worker who had been out of work for over ten years, continued the idea of defining herself in terms of what she was not - almost a 'default' option. My question to her was "would you describe yourself as Welsh?"

"Um, well, I was born in Cardiff, more Welsh than anything" [41.2]

Another issue that emerged in discussing ethnicity was that of religion. Prompted both by the strength of the Bangladeshi assertions that "we are Muslim women", and by my own experience of ethnicity as incorporating a religious element, I asked Welsh and English women about their religion. For the Bangladeshi women, their identity was associated with both their country of origin and their religion. This was not so for the Welsh women. A few had a strong religious identity; in general answers varied from "Christian" to "Church of England" or "Church of Wales". Again responses often referred back to grandparents, "my grandmother went to Chapel", as a part of their history rather than of their present. In some cases babies were christened, but more to fulfil social expectations than from conviction. Where a strong religious identity was expressed, it was obviously an important part of their lives.

One mother, who had worked as a legal secretary in a solicitor's office, commented on the baby being a Catholic, although she was not:

"Do you have a religion?"

"Yes, we got married in a Catholic Church. I'm not Catholic but the baby is christened in a Catholic Church and I'm changing" [41:2]

From my own experience of living in France for five years, I viewed language as an important feature of



ethnicity. For the Bangladeshis in Cardiff, their skin colour and clothing were immediate indicators of difference. In a context where it is difficult to tell a person's origin by their appearance, language seems to become more important.

Cardiff is, in theory, a bilingual city, with roadsigns, household bills and television programmes in both Welsh and English. In practice, everyone (that is to say, the Welsh and English population) speaks English, and it becomes a point of principle rather than convenience for Welsh speakers to seek out, for instance, the one person in the Post Office from whom stamps can be purchased in Welsh. My own limited experience of Welsh learning found me in a class of 16 people, the majority of them men learning Welsh in order to keep pace with their children who were in Welsh medium schools in or around Cardiff. I heard accounts of, but did not meet, parents learning Welsh because they would be in a better position to enter children to Welsh-medium schools if they were themselves Welsh speakers. A smaller number were learning because it would be useful in their working lives, which were mostly in the media. HTV and BBC Wales were at the time the largest employers of Welsh speakers, though substantial redundancies have occurred since then.

A few mothers had grown up in Welsh-speaking families, and retained a strong allegiance to the language. Some, for instance, chose to go to one of the few general practices in Cardiff which were predominantly Welsh speaking. It was also one of these women who referred to the Welsh shawl, which was used by her mother; she had a blanket hanging on the radiator and described how her mother would use this to carry the baby when she came on a weekly visit. This is described more fully in chapter 6.

One mother, living with her baby in a flat, with the baby's father a regular visitor, described the importance of the baby being sent to a Welsh nursery:

"She will go to the same Welsh nursery that the other two went to, 'cos I think it's important for them to speak Welsh, even though I don't speak it myself. The other two I taught them to speak English more or less, they knew their alphabet all before they went to school, so when they went to nursery all they were learning there was Welsh..." [44.18]

As this extract suggests, non-Welsh-speakers often had a strong sense of Welsh identity. For them, their identity was constituted in their origins in south or north Wales, in Cardiff or outside (Cardiff was often described as "not really Wales"). It was demonstrated most frequently (and most noisily) in allegiance to rugby teams, either local towns, or the national side, depending on the context. Amongst this group, Welsh

speakers were often the subject of disparaging comment about "Welshies".

Cardiff has its own specific dialect of English, popularly associated with local folk singer and broadcaster, Frank Hennessey. Cardiff English is sometimes referred to as 'Wenglish', sometimes as 'Talk Tidy'. It incorporates both a specific accent and Welsh words being used in English: for instance, 'he's twp' ('he's daft'); to 'mitch' (to 'truant'); and 'by there', 'there's lovely', and 'there's tidy'. A word I came to hear often was "cwch". Many non-Welsh-speaking mothers used "cwch" for a close cuddle with their babies, and I also heard adults use it for a hug - "come and have a cwch". Its meaning in Welsh was explained to me as a kind of small corner hideaway, typically a "cupboard under the stairs".

Here I quote one woman's reponse when I asked her how long she had been in Cardiff: we had already established that she had been born in Maesteg and described herself and the baby as "definitely" Welsh. For her it was a question of her identity, rather than the rather unsure responses, such as "Welsh, I suppose", which I met from many people and which are described later in this chapter.

"How long have you been in Cardiff?"

"On and off since I was about 20, sort of. I lived on the road for ten years you see in a truck, it was great, loved it, so then came back to Cardiff then, I don't know, we always end up coming back to Cardiff. It's originally why I left home for, and then I went from here to myriads of other places, abroad, travelled around the world, and then came back here again, then went on the road, then came back here again."

"So Cardiff is home?"

"Well, I don't know - home, if you ask me where home is, I'd tell you Maesteg. Where I live, at the moment it's Cardiff, my home where I live is here, but the home where I originated is still the Valleys."[52.2]

Her identity with the valleys was such that she chose to have her baby there rather than in the Cardiff hospital:

"My baby was born in the Valleys. I was determined - everyone thought I was mad, you can't go all the way there - I timed it in a car, it would take me exactly the same ..." [52.6]

The valleys were in some ways a reserve of "how things used to be". This was the area that was consistently identified as different, where I was told I would still find whole streets whose residents were all related to each other, and where I would "see the Welsh shawl".

In describing the history of migration to Cardiff, I commented on the way in which the docks were in some way a separate area to the south of the city, and the first step for Bangladeshi and other migrants. The valleys similarly were at a distance from the city, and represented a sense of other ways of living. Many Welsh mothers in Cardiff saw a 'repository of Welshness' to the

north of the city 'in the valleys'. These formerly prosperous coal mining villages were a constant reminder of the shift in Cardiff's economic base from coal and railways to light industry. During the research period, 'the valleys' were referred to as areas of material deprivation and unemployment: three coal mines remained operational. In the 1840s, the Cardiff and Gwent valleys could be described as "one of Britain's most important and densely populated industrial regions" (Dicks 1984: 26). Since that time, however, people from the valleys had either moved into the city, or had remained to face high unemployment.

During the research, I met one mother whose own mother would visit her from the Valleys, and use the shawl to nurse her grandchild. Chapter 6 includes her account of this; at this stage I include a brief historical note. The shawl is a large blanket, originally woven by hand from local wool: pattern and colouring indicated the particular areas in which shawls originated. It was both an integral part of women's dress, and the way in which young infants would be carried. Describing Welsh costume in the nineteenth century, Etheridge writes:

"A large shawl was used, too, to wrap up or nurse a baby in the Welsh fashion. The shawl was folded in half across its width - or sometimes diagonally - then one end wrapped round the child, while a helper would hold out the other. The mother would then take the child in her left arm and the helper would wrap the rest of the shawl across the mother's back

and pass it round to her right hand, which would tuck in the remainder under the child and round her waist, thus leaving the right arm free. Men are sometimes seen nursing children in this way. It is an ancient custom, and is commented upon by many travellers." (1977: 61)

Characterising Cardiff as a city receiving migrants is not to say, of course, that people do not leave.

As well as the London Welsh population, perhaps the most famous Welsh population beyond Cardiff is that in Patagonia. Attending a Welsh evening class quickly taught me the significance of all the references to Patagonia. This population was originally formed of skilled labourers hired to work the South American mines being exploited by British colonists. Bruce Chatwin's "In Patagonia" has a colourful description of walking to a village called Bethesda, and being invited to visit a farm:

"A Welsh sheepdog barked and then licked our faces... Their living room was blue and had a Welsh dresser with postcards from Wales on it. Mrs Powell's first cousin had left Patagonia and gone back home to Wales. 'He had done well', she said. 'He's now the Archdruid'. Their grandfather came out from Caernarvon but she couldn't say where that was. Caernarvon wasn't marked on her map of Wales. 'You can't expect much', she said, 'when it's printed on a tea-towel'." (1977: 26)

Clearly, after two generations, Wales remained 'home', more through ideas about it than actual experience.

For the Welsh and English women, the process of describing their ethnicity was more likely to be couched

in terms of a reason and a conclusion, for instance, "My Nan goes to Chapel, so I'm Welsh". A number of different reasons for claiming Welsh nationality emerged: these included place of birth, grand/parents' ethnicity, language and religion. Some of all of these were cited as important, in various different combinations. For some of the Welsh and English women, there was no doubt about their being "Welsh, definitely", or "I'm English". The English women in Cardiff, however, were clear that their babies were Welsh: "She was born in Wales, so she's Welsh".

For many of the Welsh and English women, it was the process of being asked about their ethnicity that prompted them to think about it. I, as an English researcher, was asking them about their ethnicity because we were involved in research about infancy and infant care. This returns us to the central subject of the thesis, that of infancy; this data on ethnicity suggests that infancy is a period during which many beliefs may be made explicit. The next two chapters explore beliefs about infants and their care in more depth, among first Bangladeshi women, and then Welsh or English women, in Cardiff.

Before moving on, however, I return to the broader context of the thesis, to draw attention to the way in

which this data has shown Bangladeshi women experiencing their first contact with health professionals, and with Welsh and English women, as part of the broader processes of medicalised infant care.

### **The Social Processes of Medicalised Infant Care**

This chapter has shown how those involved in infant care in Cardiff came into contact with one another. In particular, it has drawn on the English for Pregnancy scheme to show how Bangladeshi women received tuition not only in language, but also in how to behave within the culture of medicalised ante-natal care and childbirth. In the context of the themes which run through the thesis, these mothers were moving along the continuum away from a pole at which they had little experience of medicalisation, and towards a more explicit model of infant care guided by a series of recommendations from health professionals.

In contrast to the chapters that follow, each of which presents specific perspectives on infant care, this one has placed the Bangladeshi and Welsh or English mothers in juxtaposition to each other, and against a background of Cardiff and Bangladesh. It has explored the different ways in which these women spoke about their own ethnicity, and identified a broad contrast between them.



Bangladeshi women showed a constant self-awareness of their own ethnicity, possibly as a result of their being a minority population in Cardiff; Welsh and English mothers, in contrast, associated ethnicity with a series of attributes such as speaking Welsh, or being born in England.

Talking about their infants was one way for both populations to make explicit their views about ethnicity, whether in sending back to Bangladesh for amulets to protect their infant, or in an English mother explaining "I'm Welsh, but my baby was born in Wales, so he's Welsh". This capacity of the infant to prompt explanation, to encourage carers to make explicit their views, is one element in the broader discussion of the thesis on the symbolic power of infancy. At this point, however, I turn to focus specifically on the perceptions of infancy within Bangladeshi households.

**CHAPTER 5: BANGLADESHI CONSTRUCTIONS OF INFANCY**

This chapter is the first of three discussing how Bangladeshi, Welsh and English mothers, and health professionals, understood and explained infancy. Figure 1, in the previous chapter, showed how these perspectives came into contact through the processes of infant care; here, my aim is to concentrate on the Bangladeshi infants, the households into which they were born and the ways in which they were described and their needs defined. The final chapter draws together the broad contrasts in the ways in which infants were perceived and their needs explained - the vulnerable Bangladeshi infant constantly close to other people, the Welsh or English infant encouraged to demonstrate indications of independence, and the infant constructed by health professionals in terms of caring practices associated with Sudden Infant Death Syndrome .

These data mark the least medicalised end of the continuum from Bangladeshi to health professional views of infancy, and reveals distinctions between rural and urban Bangladeshi women, and those who had grown up in Britain. On a continuum from infant care based on experience or advice on risk reduction derived from epidemiology, rural Bangladeshi women were drawing predominantly on their

experience, on the practice of the extended family into which the infant was born. Urban Bangladeshi women were more aware of western medicalised infant care recommendations, but judged their acceptability in the light of their own beliefs and experience. For the British educated women, there were pressures in two directions. Much as in their experience of ethnicity described previously, some women found themselves being drawn back into their extended Bangladeshi family, and some were developing their own British Asian identity. Infant care was one way in which this dilemma was articulated, some mothers being encouraged to reinforce their extended family caring practices, others moving towards a more western model of infant care.

The first section of this chapter presents a picture of the kinds of households in which Bangladeshi people in Cardiff were living, and into which their infants were born. These were generally extended families living in terraced houses, with relatively large numbers of infants who were not only familiar, but an essential part of each household. Households continued the pattern of shared living adopted in Bangladesh; the timetable of the day was shaped by men's roles as restaurant workers or chefs, but there was little concept of limitations of either time or space.

The second section concentrates on how the infant and infant care were conceptualised, focusing in particular on the notion of the vulnerability of the infant, and the unacceptability of leaving infants on their own. The following chapter has a similar structure, but deals with the world of Welsh and English infants. The two chapters reflect the different ways in which the data were collected. The present chapter relies more on participant observation, and shorter interviews often with an interpreter; it therefore cites fewer direct quotations. The following chapter uses more direct quotations, taking advantage of Welsh and English womens' ability and willingness to reflect on their roles as mothers.

#### **Bangladeshi households: kinship, space and time**

My contacts with Bangladeshi households, as both an English for Pregnancy tutor and during interviews, revealed marked contrasts with the Welsh and English households. These emerge in the following descriptions of kinship and household patterns, which touch particularly on marriage, motherhood and grandparenthood.

Bangladeshi households in Cardiff had several different forms. Most common was the pattern of two or more brothers living together, with their wives, and children. Occasionally the brothers' mother, or mother and father,

would share the household. In the more middle-class areas of the city, wealthier families lived as nuclear units in larger detached houses. There were also a few households, often flats above restaurants, in which young single men working as restaurant waiters were accommodated by the owner. As my interest was in households into which infants were born, these male-only households are mentioned only briefly in this chapter.

The majority of the population continued a pattern of extended, patrilocal living, within the terraced Victorian and Edwardian housing available to them in Cardiff. "Patrilocal" in this context meant women moving to their new husband's home at the time of their marriage, which had been arranged by the two sets of parents; in practice, in Cardiff this was either the home of her husband's mother (who had herself moved in to it from her own family of origin) or his brothers. Where there was a mother-in-law in the household, she occupied an influential position in relation both to her sons and to their wives.

The relatively large number of people in a household provided the basis for a common stereotype of ethnic minority housing among, for instance, some of the social work and health professionals I met in Cardiff, as both poor and crowded. It applied particularly to recently arrived immigrants around the dock area, notably the Somali

population who continued to arrive in the city throughout the research period. The stereotype is important in that it made explicit a general and professional concern about the number of people occupying a particular space. Contrasting perceptions of space and privacy are issues to which I return later in this chapter, and in the following one.

In the previous chapter I showed how there came to be a Bangladeshi population in the Cardiff, and how female migration tended to follow male migration. Similarly, the household - the men, women and children who formed it - followed the timetable of restaurant work. The majority of the men were waiters. A few were out of work, and a few worked in takeaway outlets either in the city or in nearby towns such as Caerphilly. Some owned old cars which they used principally to get to work. If waiters were at the bottom of the hierarchy of restaurant workers, chefs were in the middle, and owners at the top. This 'pyramid' reflects a combination of status, pay and the number of people involved.

Households of young, single men, often recently arrived in Cardiff and working in restaurants in order to save enough money to arrange a marriage, were essentially short term. They were a feature of the rapid change as men moved from rural Sylhet to urban Britain. When they had earned

enough money, these men were returning to Bangladesh to arrange marriages, and then attempting to bring their wives in to Britain. It was in this way that many of the rural women made the rapid transfer from their own extended families in Syhlet, to smaller households in Cardiff.

I came across only one man who was not involved in catering. He was in the British army and, whilst on leave, slept in the front room of a house occupied by 20 or so people (described in the previous chapter). Generally each group of husband, wife and children shared a bedroom, but younger unmarried brothers such as this one slept where they could. One of the linkworkers attached to the local health professionals estimated that over 90% of Bangladeshi men were employed in restaurants, the rest being spread over a range of activities including taxi driving.

One family with whom I developed close links provided several insights into a successful Bangladeshi family. They had lived in Cardiff since their marriage, and had urban rather than rural origins in Bangladesh. The teenage son had all the advantages of a middle-class family, with money and an interest in education: whilst his parents hoped that he would go to University, if he did so outside Cardiff his mother was likely to accompany him. He sat O-levels and passed his driving test during the research period, and worked occasionally as a waiter in one

of his father's restaurants. His parents saw his future in one of "the professions" of accountancy or law. Their teenage daughter was similarly being encouraged to achieve academically, but in the interests of making a good marriage and being a good mother, rather than fostering a successful career.

This family also showed me a video of a party to celebrate the 37th birthday of the husband, a restaurant owner. Approximately 100 people had been invited to their four-bedroomed house in a middle-class suburb of Cardiff, and the whole event was filmed by a professional video maker. One of the questions I asked was a purely practical one, whether they had had to borrow crockery for so many people. I was told that until a few years previously they had regularly held parties of this size to celebrate their children's birthdays. They could therefore cope easily with this number of people. The video showed families arriving together (grandparents, parents and children); once arrived, however, they split up. The men occupied the largest front room, television on, and were having a long discussion about the Gulf War (then dominating the news). Women gathered in the smaller, "dining" room with babies on their knees. Older boys were upstairs with the teenage (then aged 16) son of the family, with a Michael Jackson video; older girls were upstairs with the daughter (then aged 14), occupied with



comparing saris and nail varnish, and attempting various steps of Bengali dance. It was the little children who spilled across the boundaries, centering their activities on the stairs - a liminal area for a liminal group - but being allowed for a short time into each of the other areas.

Among the few Bangladeshi families living in more middle-class areas, babies' fathers were less likely to be in the house when I visited them, as a result of their working commitments either in restaurant management or other unspecified "business". However, paternal grandfathers and uncles (that is to say the fathers' younger brothers) were quite likely to be around, either sitting in the same room watching television, or coming in and out to see what was going on. Men's involvement in the interviews ranged from the absent, through standing in the doorway holding the baby, to complete domination resulting in the baby's mother's voice simply not being heard. This extreme tended to occur when the baby's father spoke considerably more English than the mother. On some occasions, the husbands left us to it, having established our respectability through talking with the interpreter who accompanied me, and sometimes me, and clearly viewing talk of infants as the domain of women.

While there were distinct differences between the few relatively wealthy Bangladeshis and the larger numbers of families from rural Sylhet, there were broad similarities in the importance they attached to both marriage and motherhood. I mentioned above the process of young men moving to Cardiff, and returning to Bangladeshi to marry once he had earned enough money to do so. An early fieldnote comments on how, in discussing an interview we had just conducted, the interpreter referred to "the son's family". I wrote then that she was

"making the point that it is sons and daughters who get married in Bangladesh, not husbands and wives, or men and women. It's much more a link between two families than a link between two individuals." [M24.1]

Arranged marriages continued to be organised for teenage children, with the age of the planned marriage being slightly higher for the middle class families whose children would be expected to complete A-levels and university degree. Of the women I met, all of those who had been born and educated in Bangladeshi had had marriages arranged there. Of the few who had grown up in Britain, some had had marriages arranged in Britain and some in Bangladesh.

As part of a general emphasis among Bangladeshi families on matching status and income, young women educated in Britain were generally expected to marry a man with similar qualifications. Potential candidates were sought both in

Cardiff and in other British cities, but this seemed not to work in practice. One British-educated woman described how she had "qualifications and no experience", whilst her husband had "experience but no qualifications". Another, working full time as a nursery nurse, had a husband who had been brought over from Bangladesh. Despite having their own house, they continued to live with her family in a large household which comprised her parents, siblings, and cousins. This was an arrangement which was generally regarded as low status. This combination of British-educated wife and a husband recently arrived from Bangladesh was one which resulted in the maximum potential for conflict of interests and expectations.

If marriage was the institution of a link between two families, as suggested above, the birth of children was the constitution of that link (much as Carsten [1991] suggests in "children inbetween"). The rarity of a woman without children became clear in comments on my own status as a non-mother. These often took the form of "Without a baby there is no life" [14.1], although one father - running a takeaway - remarked that life was "less hassle" [11.2] without children. Whilst I was seen as having professional standing from my work, I was often asked "What will you do when you're old? Who will look after you? Who looks after you when you're ill?" I have referred earlier to Blanchet's experience of having her third child, whilst

working in Bangladesh: there the response was enthusiastic, whilst in Candada the predominant reaction was of pity (personal communication). In contrast to the data presented in the following chapter, Bangladeshi women attained status from motherhood, but had few other roles open to them. For Welsh and English mothers, on the other hand, motherhood was one of many roles and was negotiated with both her other roles and activities, and those of the baby's father.

In an early interview I asked a Bangladeshi mother if she was tired with looking after four children, reflecting my own preconception of childcare as hard work. The response I received, via the interpreter, was "No, she wants another one .. she likes her children, everything about them." She spoke of babies as "gifts of Allah":

"she is happy that she is being a mother, to be another child's mother" [7.8]"

This extract is interpreted, and shows how the interpreter used the third person "she is..." rather than providing a word-for-word translation in the first person. Whilst some of the health professionals who often worked with an interpreter or linkworker preferred an apparently simple and straightforward interpretation using the first person, I found the use of the third person helpful. It made it clear when the interpreter was adding a comment of her own,

as she did at times, and in doing so made her views of motherhood and infant care clear to me. I was concerned at the possibility that she could introduce her own views without my being aware of it, but in practice the use of the third person reduced the likelihood of this happening.

The values attached to motherhood became explicit in the rare cases of women who were unable to conceive. In such cases the ultimate recourse was for the wife to be sent back to Bangladesh, and for a second wife to be sought. One health worker commented on the speed with which "Asians" [for her, this was a general category for Indian, Pakistani and Bangladeshi people in Cardiff] sought help at the infertility clinic, and in particular on the reluctance to accept that this was in some instances a problem associated with a relatively older husband.

Asking questions in a relatively formal interview (that is to say, with the involvement of an interpreter, and with my introducing areas on which I was keen to encourage discussion) was not a particularly fruitful way of gaining insights about what it meant to be a mother. However, one occasion provided a demonstration of what it was to be a bad mother. As I spent more time with the interpreter, I became involved in a web of reciprocity with her and her family, often for instance being asked to give lifts to her husband or her children. Whilst this was time consuming,

it sometimes provided further insights into very different lives.

On this occasion the interpreter had been asked to help an Urdu-speaking social worker who had a client family from Bangladesh, living in housing association property in a very poor area of the city where there were few other ethnic minority families. She in turn asked me if I would give her a lift to the social services office. This was a white working-class area, and the social worker felt that an Asian family was both unusual and unwelcome: as I described in the previous chapter, the majority of Bangladeshi families lived in two easily-identifiable parts of the city. Neither parent spoke English. We drove together to the house. After a long period of knocking, the front door was opened by a young boy (aged about 9 according to the social worker), who had been left in charge of four younger children. His parents had gone to the local health clinic, a bus journey of around half an hour. Their mother was expecting another child, and their father was diabetic. Both social worker and interpreter were concerned for the well-being of the children, angry because they had made an appointment which the parents had forgotten, and I think embarrassed at my seeing these children, dressed only in tee-shirts, and left on their own. There was no point in leaving the parents a note, as neither could read or write.

This incident crystallised the sheer unacceptability of leaving children on their own. Whilst leaving a similar group of children on their own would be equally unacceptable to Welsh and English mothers, they had available to them various social or commercial networks through which to organise childcare, and it would have been quite acceptable for them to leave children providing that arrangements had been made for their care. For Bangladeshi women, however, the idea of leaving children with a babysitter was simply unacceptable. On several occasions I came across a stereotypical view among the Bangladeshi mothers of 'white' mothers going out to the pub, and leaving their children 'with anyone'. The issue of leaving infants alone had two dimensions, associated with both the status of infants, and with the densely populated households into which they were born. I turn later to the idea of infants in need of protection from evil spirits, but now show how the involvement of three generations in households affected infant care.

In discussing three-generation households, I am in some ways describing the role of grandparents. However, the term 'grandparents' is one which carries with it a number of implicit meanings. Comparisons with the Welsh and English households, developed further in the following chapter, show that the distinction between parents and grandparents was clearer for Welsh and English families

than for Bangladeshi. Bangladeshi women had grown up with many siblings and cousins in large households, and the distinction between generations was much less marked. On several occasions I found myself in households where there was a grandmother who had a child of a similar age to that of the mother I was due to meet.

Grandmothers were often involved actively in infant care, to the extent that they could even be seen as closer to the infant than the mother. Several English for Pregnancy volunteer tutors commented on how mothers had on occasion - from their perspective - to 'compete' with other members of the household for time with their infants. Two Bangladeshi mothers - both working outside their households - commented that their babies responded more to their grandmothers than to them.

At the same time, some grandmothers appeared to be questioning their own expertise and experience, recognising that the circumstances in which infants were being brought up in Britain were very different from those of Bangladesh. Many, however, retained some of the tasks which they performed in Bangladesh. The tasks most frequently mentioned were oiling the baby before or after a bath, and head shaving: I return to these later in this chapter.



At several interviews it was difficult to tell which children were of which parents. This was particularly so when the grandmother of the household, perhaps in her late 30s or early 40s, had children who were themselves married and parents, whilst she also had young children. It was not unusual to find women in this age range with 7 or 8 children: as a grandmother with one or more of her sons and their wives living with her, it was possible for her grandchildren and her younger children to be similar ages. As an outsider, with my western focus on biological parents as "responsible" for, and living only with, their own offspring, I was struck by the frequent overlap of generations, of for example 4-year-old aunts and cousins playing together, and the direct involvement of mothers, aunts and grandmother in the care of children.

The organisation of space within these large households reveals both contrasts with the ways in Welsh and English households used space, but also contrasting perceptions of privacy. These reflect the childhood experience of growing up not only in large domestic groups, but also in a very densely populated country. Talukder, in a thesis concerned with limiting population growth, summarises:

"Bangladesh has a density of 1,903 persons per square mile - one of the highest in the world and little less than the city states of Singapore and Hong Kong" (1986: 13).

These large households adapted themselves to the physical accommodation provided by small terraced houses. Space was generally divided by nuclear families, each having one bedroom (described by one Health Visitor colleague as "all beds" - often two double beds pushed together and filling a whole room) shared by father, mother and children. Infants generally had a cot next to the mother, and the younger children shared the bigger beds with their parents. In some houses it was clear that the rooms downstairs were also used for sleeping, with mattresses propped up against the walls, and clothes stacked on hangers and propped on picture rails.

Sharing beds and bedrooms was not simply a matter of limitations on space available. Amongst the few wealthier Bangladeshi families included in the research, there were children of 11 or 12 who slept in the same room as their parents, and some with their own rooms who preferred to sleep in their parents' room.

Interviews generally took place in the front room of the houses, the public area of the house, generally used for receiving visitors. Some houses retained the classic two front rooms of Victorian and Edwardian terraces, which adapted well to the preservation of space specifically for visitors. In some the two front rooms had been knocked into one larger room. It was quite common for this 'front

room' to be either locked or lockable, and for a child to be sent to fetch the key when we arrived: this may have been a relic of former multi-occupancy, but the lock was still used in many cases.

In some houses, reflecting Goffman's (1959) identification of boundaries between public and private, frontstage and backstage, a line of shoes indicated that beyond the front room it was expected that shoes should be removed. It was acceptable for me, as an outsider, to be in the front room, and to keep my shoes on. An invitation to go beyond this front room, however, took some time. It was on the sixth of my weekly visits to one woman to whom I was teaching English that I was invited into the second room; in Goffman's terms, this was the point at which I made the transition between frontstage and backstage. This back room was also furnished as a living room, with seating and television, mostly used for watching Bengali and Urdu videos. It was here that the rest of the family sat whilst the front room was in use, for instance for an English lesson.

A striking example of the frontstage:backstage transition emerged during the one interview that took place in a 'take-away' in the city centre. My record of that day includes a description of the various boundaries we crossed in reaching the kitchen:

"In the kitchen, behind a takeaway Indian restaurant, just past St David's Hospital. We went behind the counter, through a narrow sliding door, past piles of empty 'fast chip' boxes, into a long narrow kitchen, with a long narrow table." [M11.4]

Here the frontstage was the familiar 'take-away' counter. Backstage was where the cooking was done, where as we talked - mostly with the baby's father - his wife cleaned the large cooker, his older children came and went through the back door (one was sent to collect a prescription for the baby from the chemist), and his elderly mother sat on the bottom stair chewing betel nut with her red-stained teeth.

The more middle-class homes, bigger houses with separate 'living' and 'dining' rooms, operated a similar hierarchy. In the interpreter's home, her husband had first claim on the living room, and on one occasion, when he returned home with a business associate, she suggested that we move to the (secondary status) dining room. When he returned home alone, there was no question of our moving. Again, it took several weeks of regular visits (cups of tea after I had collected her before an interview, and driven her home afterwards) for us to achieve what I saw as the easy familiarity of friends which allowed me to sit in the kitchen while she cooked or made tea.

There was a wider application of the public:private axis in the gendered use of public space, or space immediately

outside the home. Men left the house frequently, for both daily work in restaurants and weekly attendance at the mosque. The majority of young women went out rarely. Workers at local multi-cultural resource centres often commented on their difficulty in persuading Bangladeshi women to attend the various activities they organised. Boys and girls both went to mosque until they reached puberty, and after that girls remained at home. It was the middle-class and British-educated women who felt confident to leave the household, but their ability to do so depended on the particular household in which they lived. In some cases, husbands or mothers-in-law were unhappy at the prospect of young women going out on their own, and would insist on accompanying them, for instance, to ante-natal classes.

Use of space within these small houses was not an easy topic to address. I tried asking to see 'upstairs', but the resulting rather formal 'procession' of myself, the interpreter, and various household members had the feeling of an inspection. As an English for Pregnancy tutor, however, I was able to ask informally who slept where, how many beds they had, who slept in the same bed, and so on.

Sharing beds and bedrooms was not simply a matter of limitations on space available. Amongst the few wealthier Bangladeshi families included in the research, there were

children of 11 or 12 who shared the same room as their parents, and some with their own rooms who preferred to sleep in their parents' room.

In discussing the organisation of space I have concentrated up to now on its physical aspects. I now turn to the more symbolic domain of privacy. The notion of personal privacy, in the sense of time and space to oneself, did not arise during interviews with women who had recently arrived from villages in Sylhet. There was, however, a striking contrast for me between the interviews with Bangladeshi mothers, which were public and social occasions, and those with Welsh and English mothers, which tended simply to involve the mother, her baby and me. Welsh and English mothers often spoke, when arranging a time to meet, of finding a time when an older child and/or the baby would be asleep, a time when we would have 'some peace and quiet'. During my visits to Bangladeshi homes, children huddled close to their mother or to each other, watching me or, in a house with a television, "Neighbours", or even riding bikes throughout our conversations. An early fieldnote records my impression of the family "moving as a mass". It was this broad contrast between Bangladeshi and Welsh or English interviews that first prompted my interest in the contrasting perceptions of privacy within households, and specifically how this related to childcare.

Gardner, in her account of fieldwork in Sylhet, comments on the British notion of privacy, and particularly its close association with sleep:

"I soon learnt that privacy, our British obsession, counts for very little in Bangladesh. People simply do not understand why anyone should want to be alone. I considered myself very lucky because I had my own room, but to most people this was a definite sign of my oddness and masculinity. 'Aren't you afraid to sleep alone?' they'd ask me." (1991: 13)

The sheer oddity of wanting to be alone was commented on by an Indian psychologist who, whilst visiting London, had heard me present a paper about this research. Taking my head in her two hands, feeling my forehead, she described colourfully how the whole family would ask "what's wrong with you?" if you expressed a desire to be alone. She did, however, go on to comment that "you can be private and on your own even when you are with other people". In doing so she made clear to me just how unusual and unacceptable privacy - or being on one's own - was for her. This sensitised me to reflect on the meaning of privacy or being on one's own, for both infants and their parents.

Amongst the Bangladeshi women who had grown up in Britain, the contrasts in perceptions of privacy, and of being alone, emerged more clearly. After several interviews with Welsh and English mothers it became clear that one of the reasons why they chose to put their babies in separate rooms was their wish to maintain privacy for sexual

activity. I raised this issue on the few occasions possible, with British-educated Bangladeshi women. I report one quite lengthy exchange here in order to show how the conversation developed:

"Q: One question which I don't know whether to ask, which I only ask sometimes: one of the things which English or Welsh parents say is they don't like having babies in the same room as them because they don't like to make love in front of the baby.

A: Yeah, it has affected, I mean I make sure [the baby] is fast asleep and I say otherwise if he is not asleep and if it's one of those days when he is waking up every time, I say 'no way'. I think it does make a difference.

Q: Even if it's a baby?

A: Yeah, even if it's a baby. I mean he is not going to know anything but it makes a difference.

Q: What about in Bangladesh - would people even talk about it or ... ?

A: They wouldn't talk about things like that because it is like a taboo subject, isn't it? Back home where, Bangladesh, everybody lives together, it's a big extended family. The house is not that big so the mother, the children, everybody lives in the same room, so they would have no choice.

Q: So how do they manage having sex, I mean, do they?

A: I don't know because - it does work like that - I mean big families have to live together and they have only got two or three rooms which they literally eat in, sleep in, and sit in, and I know brothers, sisters, everybody lives in the same room.

Q: So it would be really difficult to get any privacy?

A: Yeah, there is no such thing as privacy back home. I mean in the village there is no bathroom. When we went back home we went to Dad's village and they bathe in this big pool, everybody goes in together...

Q: So when you say there is no privacy...

A: There isn't



Q: Do people want privacy or do you think there is no, or is it just not ..

A: It's something I think they all grow up with. There is no privacy and you just grow up with it because back home a woman says nothing. .. I mean her mother-in-law is the one who says, by the way, you are sleeping in this bed tonight, and that's just it. There is no such, I don't think there is any such thing as privacy.

Q: But do you think people would miss it?

A: Yes they might, yes, because when my auntie used to come to stay down my house she used to think it was fantastic having this room of your own to sleep in, you know change your clothes without having to find a corner or somewhere dark."

Q: Is it kind of frightening to be on your own?

A: For them it must be, yes.

Q: Are there people about always?

A: Yes, I mean when a friend of ours came to this country for the first time and she was left in the house by herself because the husband went back to work after a couple of days, and no matter how - it was 2 o'clock and I was knocking down the door and she wouldn't open it. She was upstairs, locked up in that room, she wouldn't come down. She was just frightened, never been used to being, because she had her mother-in-law, brother-in-law, everybody living with her. All of a sudden she was stuck in this huge house. By yourself, it must be frightening, yeah ... Especially if you think every little sound is a ghost or someone trying to break in or something like that.  
[19.31-2]

Privacy, as I suggested above, entails the idea of both space and time to oneself, and I now turn to look at perceptions of time. The woman quoted above shows how being on one's own was viewed with fear. This was not always made explicit, because the sheer number of people within a household made it very unusual for anyone to be on their own.

Later in the chapter I show how in talking to mothers about infant care, the notion of time as an organising axis for the day was less significant than for the Welsh and English mothers. Here I show how the day in a Bangladeshi household was shaped by restaurant work. Men tended to eat with their families in the late afternoon, leaving for work around 5pm and returning in the early hours of the morning. This meal coincided with the return from school of older children. The household tended to wake around 10 or 11am. Thus visitors, be they health workers or researchers, were most welcome around 1 or 2pm, which was the time Bangladeshi mothers most often suggested for interviews.

Interviews generally took place around what I think of as "lunchtime", 1 or 2 pm, to suit the timetable of the household which revolved around restaurant work. This meant that men had sometimes just got up, and were often wearing a sleeping cloth [the lungi] and vest; this clothing was often seen both in the house, and in the garden, as men sat, smoking cigarettes, on the front wall. In the street in which I lived for a part of my time in Cardiff, this was one of the ways in which a Bangladeshi house was recognised, and was often remarked on by white neighbours. Women had no such distinction between indoor and outdoor clothes, always being in a sari. Men changed from indoor clothes to restaurant white shirt and black

trousers after the household's early evening meal which was taken around 4pm.

As a volunteer English teacher to pregnant mothers, the time I generally visited the houses was around 5pm, after the main meal and the men's departure for work. On reflection it seems odd to me that the time suggested for tuition was different from that suggested for interviews: meetings after husbands had left for work, however, presumably offered the possibility that there would be fewer interruptions. My own concern at occasional lateness on my part was never a problem, perceptions of time were fluid and little influenced by external pressures. Indeed, both I and other tutors experienced arriving at a house to find the mother had forgotten a - to us - regular appointment, and had "gone to London to see her sister", "gone to stay with some friends", or whatever.

I was told, when I asked, that Muslim women prayed five times a day, but this was not mentioned spontaneously in interviews. This may have been because it was not thought to be relevant as I was asking about the baby's day. It may too have been a feature of the difference between the middle-class urban interpreter and the working-class rural interviewees: Blanchet (1984) speaks of the "veneer" of orthodox Islam, superimposed on rural Bengali women. For them, spirits were more influential than organised

religion, whilst for the educated urban women Islam was of prime importance. Islam shaped both the week and the year. Each week, men and older boys attended the Mosque on a Friday. Each year, the month of Ramadan concludes with the major celebration feast of Id, often compared with "your Christmas". During Ramadan, the household changed its pattern in order to fast during daylight hours.

One obvious contrast emerged around ideas of bedtime. For Bangladeshi mothers who were living on the boundaries of their own and the "other" culture of Cardiff, the idea of "bedtime" for children was extraordinary:

"I have seen - my husband's niece is married to a white boy and they are so different... I get surprised at their children are so trained, anything happens, it is 'go to bed' - they are so afraid of going to bed, as a punishment. Now it is bedtime they say 'I won't do it again'." [2.15]

Unlike the Welsh and English households whose timetables were tailored to meet the demands of workers expected to be in offices or factories at specific times, Bangladeshi homes followed the restaurant workers' timetable. This meant that the issue of children being late for school was of concern to both mothers and teachers. The same mother, who worked for one of the multicultural resource centres in the city, commented:

"All our children, everyone I know, it is a problem sometimes that children don't go to school on time, most of our children, just because they are so spoilt by us. You can say spoilt, but we don't see it that way, it's just the culture... If it is schooldays we have to be back by 9 or 10 o'clock, but if the weekend

we spend a lot of time, maybe 12 o'clock sometimes 1, sometimes they end up sleeping in their friends' house. A lot of time, because my husband is at the restaurant, a lot of the time my friends like me to come down, to sleep there and go home in the morning. But that is the difference I think with the children, especially separate rooms and sleeping all the time, even in summer. I don't know how the children go to bed so early."[2.13]

This was an early interview, and the identification of the issue of bedtime was an important step in sensitising me to the more general contrasts between Bangladeshi and Welsh or English perceptions of infancy, articulated particularly through notions of time and space. I return to these contrasts both later in this chapter, and in the following one.

In discussing perceptions of time, contrasts emerged in how Bangladeshi, Welsh and English mothers spoke of 'spare time'. One simple difference between interviews was in the timing of the offer of a cup of tea. Bangladeshi mothers tended to complete the interview and then offered refreshments; Welsh and English women, however, offered a drink as I arrived. This prompted me to think about the ways in which time was conceptualised, and to ask about what mothers would do with "spare" time. Bangladeshi answers to this question tended to be "I play with my baby". There seemed to be no idea of time away from an infant, or of defining time in terms of work and leisure, both of which emerged during interviews with Welsh and English mothers. Tea after an interview seemed to be a

signal for the interpreter and the family group to catch up on news of Bangladesh. At this stage, I asked for translation only occasionally, using the time either for observation or for talking to other members of the household who spoke English, often older children or sisters-in-law.

Another way in which contrasts in the conceptualisation of time emerged was in discussing age. As a way way of opening the interview, and in order to gather a small amount of systematic comparable data about mothers and their infants, I asked a few questions which I anticipated could be answered both quickly and easily. It soon became clear that asking the mother's own age or date of birth was not the simple question I thought it would be. Women who had recently arrived from rural Sylhet had no reason to define themselves in terms of their date of birth; if their husbands were present they sometimes provided their wife's year of birth but not the date or month. For Welsh and English mothers their own dates of birth and those of their children were familiar facets of living in a western society and were easily provided.

Similarly fluid perceptions of time, in contrast to those of Welsh and English mothers, emerged in several other ways. Asking Bangladeshi mothers about their own families of origin (as part of my interest in the amount of

experience of infant and child care a woman would have had) revealed an emphasis on relative ages rather than chronological years. In a context in which dates were unimportant, it was easy to see why - as many health professionals reported - the women were unlikely to have a record of the dates of their periods. Asking about an infant's date of birth tended not to get a direct response, but an older child would sometimes be sent to get "the book", which recorded birth date, vaccinations, and so on [this was South Glamorgan's "Parent held record"]. Among Bangladeshi children of school age, there was a keen awareness of their own ages, prompted in one mother's view by a desire to have birthday parties!

This part of the chapter has shown the large households into which Bangladeshi infants were born, and the ways in which extended families were adapting to living in small terraced houses in Cardiff. Space and time were articulated rather more fluidly and flexibly within the house than in those of the Welsh and English families. The second half of the chapter shifts the focus to the infant world, to describe both how infants were conceptualised and cared for, and how at the time of infancy families drew both on the spiritual protection of their home country, and the practical advantages they saw in living in a western industrialised country.

### **The Infant World: Familiar Infants**

The world into which Bangladeshi infants were born was that of the large extended family in which infants were familiar, and were constantly in the company of other people. Drawing both on periods of observation and on interviews, I describe the involvement of the extended family in infant care, and how they perceived infants as vulnerable to evil spirits and in need of protection, which was provided by both amulets and constant company. Interviews were useful in identifying a cyclical concept of the infant's day in terms of eating and sleeping, and I discuss these specifically below. Periods of observation were valuable sources of data on the ways in which infants - awake and asleep - were constantly with other family members.

The influence of the extended family was not simply that of direct involvement in childcare. It reached into the future, and into longer-term expectations of future generations. One mother of two children explained:

"Our children, especially our Asian children, we think about them ... especially 13-14 year-old girls, if they go out our parents are very worried, where is she going? what is she doing? Same as the boys, we take care you know in every way, about history. Sometimes we think about their childrens' childrens' future this way. [10.3 Interpreted]

The extended family in Bangladesh also retained its influence. This is illustrated in two examples: the



first of how some Bangladeshi people in Cardiff saw their own future, and the second of the naming of infants. One British-educated Bangladeshi couple with three sons, living in a middle-class area of the city, described their plans for the future as we chatted after the interview. I wrote the following note afterwards:

"She and her husband said that in the long term what they want to do is save up enough money to go back to live in Bangladesh so that when they are older - she said 'in our old age' - they will be able to go back to Bangladesh, which would mean that their children would have a home, would feel at home in Wales, or Cardiff, but would also have a home to go to in Bangladesh." [M18.3]

Choosing a name for a new infant was a process in which the extended family was often involved. Grandparents, either in Bangladesh or in Britain, were consulted. This happened only after the birth of the baby, reflecting the more general practice of making few preparations before the birth, which reappears later in this chapter. Among some of the British educated parents, naming had slipped from the grandparents' choice to seeking their agreement to the parents' suggestions. It had become for some people a process of negotiation and consultation, with a sense of "keeping them happy".

Both religious and practical reasons were given for choice of names. In one instance a baby's father explained with great care that he had chosen the name of Omar because it

met both religious approval, and would be easily accessible to the child's English-speaking peers (he was assuming they would all be familiar with the name of Omar Sharif). He himself had been teased about his name when he had been at school, and wanted to avoid this happening to his son. The practice of naming after the birth of the baby was a specific example of very different views of time and preparation than emerged from the Welsh and English interviews.

Extended family households also meant that close relationships sometimes developed across generations, with many family members other than biological parents being directly involved in child care. The birth of an infant did not disrupt the life of its parents, rather it made that couple - the son and daughter of two families - into a family and secured the woman's place in the household. It was quite possible for siblings, cousins, aunts, uncles and grandmothers to have close contact with infants.

One Bangladeshi mother, brought up in the South Wales coal mining valleys to the north of Cardiff, described how she had looked after her nephew, to the extent that she thought she was closer to him than his own mother; this in turn had led to a special closeness between her daughter and her nephew:

"My nephew is close to me, the oldest one because I sort of brought him up. He always used to stay here and we used to go swimming together, so he tends to give my daughter more attention ... he plays with her a lot."  
[15.7]

Another mother, also British educated, in speaking about what sort of parent she would be to her son, drew on her experience, as the eldest of five children, of 'bringing up' her younger sister:

"I will explain first, I won't say you can't do this and you can't do that, I'll give them the pros and cons. I don't know, it's not happened yet, but it's worked on my sister. I mean, my sister, when we went home she went through some terrible moments. She came here and not one single swear word did she utter, not one, she sat saying it and then she would stop. At home, every other word would be a swear word."  
[17.10]

While many of the mothers had had experience of looking after other young children, that familiarity did not necessarily mean knowledge. One woman, to whom I had been teaching English during the last few months of her pregnancy was, in the view of the linkworkers, discharged from hospital too early after the birth of her child. My notes record:

"The linkworker said she'd been called in to explain to Amina [a pseudonym] how to prepare bottle feeds, the Community Midwife had been out with Amina to buy a steriliser as 'she didn't have anything' [but then she wouldn't - preparations for baby's birth don't exist as such - and if you anticipate breast feeding you wouldn't think about bottles and sterilisers]. The linkworker said A had been letting the baby feed a little and then go to sleep, but she had explained that although it was boring you had to wake the baby up and make it feed more. So much for my assumption that in a household where there are already young babies there will be good advice about looking after

them. A's sister-in-law has three young children, but the lack of feeding was either not noticed or not considered important." [EP5]

Similarly, while most children were growing up in large extended families, where they had divided into nuclear families some women perceived that they received less help in Cardiff than they would have done in Bangladesh:

"'She thinks, you know, when she had the babies in Bangladesh she had lots of helpers and here she is alone, she thinks with small children it is better in Bangladesh'. There she would have had sisters-in-law living in the same house, whilst here they were in different houses. When they had been in Bangladesh she had lived with her husband and his five brothers, and their children. In Cardiff, they were all living in separate houses. In addition, servants were more common there, particularly in richer urban families; in village families a younger sister or niece was expected to take on the role of 'carrying the baby'." [EP5]

This mention of carrying the baby identified another issue to which I return later, the tactile environment of human infancy.

For the moment I turn to the two issues of eating and sleeping, which were frequently identified explicitly. I asked mothers what sort of things they thought were most important for their babies. In asking the question in this way I sought not to impose a particular set of categories and priorities on them, but to encourage them to talk freely. This question elicited a narrower range of responses than those from Welsh and English mothers. This may have been a result of the constraints of the interview,

or may reflect less separation between the various activities associated with infant care and the context within which it takes place. Later in the chapter I turn to the implicit questions of the tactile environment, and the conceptualisation of infancy itself.

Discussions of infant feeding centred around 'breast or bottle'. Whilst some mothers spoke of pressure from their parents or parents-in-law to breastfeed, as being better for the baby, there was in general a view of bottle feeding as "more western, more scientific" and so better for the baby. This was part of a more general contrast with Bangladesh, a belief in western medical care, and a recognition of the wide range of products available specifically for babies. In this context, bottle feeding was a symbol of wealth and sophistication, breast feeding of poverty and deprivation. Some mothers breastfed for a short time, and then shifted either to a combination of breast and bottle feeding, or wholly to bottle feeding. Mothers spoke of babies preferring bottle to breast, of babies sleeping better after bottle feeds, of easier checking of the amount of milk. Bottle feeding also allowed other members of the household to feed the baby.

Karseras (1987) suggests that Bangladeshi mothers do not breast feed because they would not wish to do so in front of men other than their husbands. In the large households

of Cardiff breastfeeding would involve going upstairs to a colder room in order to move out of the sight of father- or brothers-in-law. This was mentioned only once in interviews, in a comment added by the interpreter which may reflect either the interpreter's views or those of the mother: in either case, it suggests an association of shame with breastfeeding.

Q "And are you breast feeding or bottle feeding? Did you breast feed a little bit to start with? [this was a widespread practice]

A "Yes, for one month".

Q "Is bottle easier?"

A "She said both are easy"

Q "So why bottle?"

A "Yes, everybody said give her some breast milk, so she did, but she didn't like it. She didn't feel good. She felt ashamed, I think." [23.5 Interpreted]

One of the reasons why Welsh and English mothers were reluctant to breastfeed, which I discuss further in the following chapter, was a belief that breastfed infants would sleep for shorter periods of time. This was not mentioned by Bangladeshi mothers, possibly because nighttime was in any event generally marked by restaurant workers returning home around 3am, so it was quite usual for the household to stir at that time. I turn now to look at sleeping practices in more detail.

During the day in the big households of which they were a part, Bangladeshi babies slept - often in a pile of cushions on a sofa, sometimes in a pushchair or carrycot - surrounded by other people. They were very rarely left alone, and only one mother had introduced a bedtime. The return of restaurant workers sometimes coincided with an infant's feed. There was no particular emphasis on sleeping through the night, or the idea of "8 hours' sleep". Households woke around 10 or 11am, and I have already mentioned the perception that Bangladeshi children tended to be late for school.

Sleep was taken with other people, both by day and night. Babies went to bed at the same time as their mothers, either in a cot immediately next to her, or in the same bed. This was an occasion where I wondered if there might have been a reluctance among mothers to say that infants slept in the same bed as them, as some of the local health professionals did not encourage this. From both interviews and conversations with mothers to whom I was teaching English, however, the general pattern seemed to be that younger children were more likely to share the mother's bed, because they were believed to be more likely to wake up and to be frightened. There may also have been a feeling of cots being part of the "western" and therefore "more modern" way of caring for infants.

This close proximity during sleep was described as being as much for the mother as for the child - "I can't sleep without my child" or (when the baby's father was in Bangladesh) "she loves her tight". Several mothers described taking the baby into bed with them to feed, or to get the child off to sleep, and then putting it in a cot immediately next to the bed.

One mother described her experience of visiting Bangladesh. She had grown up in Britain, married in Bangladesh, and was working as a cashier in a supermarket in Cardiff. She was in the process of trying to obtain residence papers for her husband, and made regular visits to Bangladesh when she could afford it:

"That's another thing about Bangladesh, they don't bother with cots. They put them in their beds because of mosquitos. Bed is the best place, and there are little mosquito nets that go over the baby again so they have double protection which I do know because I have seen them being done, and they are always in the bed with parents then in Bangladesh."  
[15.22]

The question of the position in which the infant slept attracted attention only because of the publicity surrounding the changed recommendations concerning the prevention of Sudden Infant Death Syndrome. The new advice from both the Department of Health and the Foundation for the Study of Infant Deaths was that infants should sleep on their backs or sides, changing previous advice that they should be placed on their fronts. In



Bangladeshi households infants had always been placed to sleep on their backs, in order to develop the valued "rounded-head". They are turned on to their sides at times, and may be placed on a fine white sari in order to stop them rolling. Mothers also explained that a child should also sleep "straight", the head should not be turned from the body, as it would be if the infant were on its front.

The increased publicity concerning SIDS affected those mothers who spoke English, and particularly those who watched daytime television which carried regular items about cot death. The term 'cot death' however, had its own confusions. A fieldnote after an interview in which we had talked about bedsharing reads:

"she had had her baby in bed with her for the first couple of months and she said that mothers - she actually volunteered, I didn't suggest this at all - she said they are worried about cot deaths. I asked 'really, is that why they do it?' and she replied that for people who have heard of cot death that's why they do it. Otherwise they would just do it because that is the normal practice. She added that there had been a piece on television this morning about cot death, which I imagine followed up on Anne Diamond's baby dying last week." [M15.7]

This note reflects both confusion about the term 'cot death', and my concerns about the research itself. The term 'cot death' was understood by mothers who had not previously used cots, as 'if I put my baby in a cot it will die', which seemed to argue in favour of having the baby in the same bed. In terms of the research process, it shows

my concern at the research becoming too strongly associated with SIDS.

For Bangladeshi mothers who were not aware that Welsh or English mothers might put babies to sleep on their own the idea was shocking:

"No, if they are crying, if they wake up at night, so they can't see anybody, so they are crying. When they understand then they can go to their own room." [9.9I]

This mother suggested that age 12-13 would be an appropriate age, but this varied. One mother commented very simply: "we haven't tried ... it's not safe" and "he is happy as long as we can see him".

One urban mother living in a middle-class area described how a Health Visitor had advised that her son should go into his own room. Her husband had agreed, saying that it was "more modern", but she had simply felt uncomfortable at not being able to see and hear the baby. Another mother - a woman from rural Sylhet living in a large house in a middle-class area of the city - commented "I like to wake in the night and see my family asleep around me."

Amongst Bangladeshi families who were aware of differences between their own practices and those of their Welsh neighbours, there was shock at the idea that children could be left with babysitters. The issue of leaving babies on their own was the one way in which 'western' childrearing

practices were not regarded as 'more modern' and therefore to be emulated. In contrast, bottle feeding, baby foods, and disposable nappies were all examples of the acceptable benefits offered to Bangladeshi mothers bringing their infants up in Britain.

Part of the reason that infants were not left on their own, was that they were regarded as vulnerable and in need of constant protection, afforded by both constant company and the use of amulets around their necks. These were either extracts from the Koran, or beads and seeds: the first associated with urban origins and a strong belief in Islam, and the latter with rural origins and a belief in the power of spirits. One British-educated mother, herself a nursery nurse, described how on the birth of her first baby, her mother had moved into her room with the baby for the first 30 days, and her husband had moved out. Her mother had written to Bangladesh in order to obtain the seeds for the baby's amulet. Blanchet [personal communication] describes how in Bangladesh at least two people would be with a baby for the first 30 or 40 days of life, that there should be at least one person awake with the baby, and a flame would be kept burning.

Among mothers who had grown up in Britain, there was recognition of the power of spirits, and at the same time an ambivalence. Doctors were seen to be appropriate to

treat certain illnesses, but in the case of something caused by spirits this mother called in the "holy man" from the mosque:

"I don't know if I believe in ghosts but - I don't know if it's just the weather or what but you know he was ill, he had those fits and in our country they say it's a ghost or something nasty. I don't know, and I was really scared. And then after a day they would give us a reading [from the Koran] - you know once I gave him one so I don't know if I believe in it."  
[18.15]

Pregnancy, childbirth and infancy in Bangladesh are steeped in belief in the power of spirits. Gardner comments on talking about pregnancy:

"..I still made some terrible blunders. I asked women who were blatantly pregnant when their babies were due... Later on, when I had learnt the hushed and sufficiently conspiratorial tone of voice to use, and people had begun to trust me, I could ask almost anything." (1991: 15)

The same notion of vulnerability to spirits emerges in attitudes towards making preparations for a baby's birth. In early interviews I asked "What preparations did you make before the baby was born?" As the work progressed, I realised this question made little sense, being based in very different perceptions of both time and infancy. This was consistent with the views expressed by the middle-class Bangladeshi mother, interviewed early in the fieldwork, whose views are cited below:

"You can say in our culture mostly, maybe not a lot of the people follow suit, most do, it is like a superstition, they don't buy anything before the baby is born".

"Nothing?"

"Nothing, I didn't do anything either, they say if you buy a lot of things the baby may die. There is a lot of superstition. I was ready with the prams, just basic things, but the clothes I didn't get ready."  
[2.10]

There was only one occasion on which the idea of infants as spirits emerged explicitly during the fieldwork, although it was the central focus of Blanchet's work on pregnancy and motherhood in Bangladesh:

"Children are always with somebody, somebody has to be with baby, we believe it. Because baby, we think - like shall I tell them? - like religious - angels play with the children, so you know, so babies [are] like angels, so you should not leave the baby alone.  
[36: 10-11]

This interview was one of the final ones with a Bangladeshi mother, recently arrived in Cardiff from Sylhet. I found the interpreter slightly reluctant - "shall I tell them?" - to discuss the idea of infants as spirits, perhaps reflecting the contrast between urban and rural perspectives, the first favouring Islam, and the second attaching more importance to the spirits and saints with which the land of Sylhet has strong associations (Gardner 1992b).

The next extract quoted refers to shaving the infant's head and is very different in its attitude to the spiritual or supernatural world. It is part of an interview with a British educated woman, who had turned to calling her

mother's beliefs "superstitions".

"Within the first 40 days you have to, literally somebody has to be with the baby 24 hours because they think that the evil spirits will somehow possess him and they - I'll bring him in now - he has got all these little, not to give him the evil eye."

Q "Oh, like amulet things?"

A "Yes, he has got loads. Mum got loads for him, and we have to shave the hair of course at birth. Here we have to get rid of it in those 40 days."

Q "Why is that?"

A "Well, the Sikhs, we do everything totally opposite to the Sikhs and they keep their birth hair. That's why we have to get rid of it and - say Mum, she prays five times a day, if he had his birth hair she wouldn't touch him because he is not clean, until he has got rid of his birth hair he is not clean."[19.9]

All the Bangladeshi infants I saw had had their heads shaved, both at birth and regularly afterwards. Various different explanations were offered. One, also cited by Blanchet, was that birth hair was believed to be "polluting"; another was that it prevented babies from becoming too hot, and a third that it would encourage the growth of thick healthy hair. British-educated mothers tended to talk about shaved heads as "more hygienic" and "easier to keep clean", rather than using concepts such as "pollution".

It was often the grandmother who performed this task with a razor blade whilst the baby was in the bath, the mothers saying that they were too frightened to do it. This British-educated mother, living with her own parents and

siblings, was describing how head shaving fitted in with broader beliefs about vulnerability and pollution.

In addition to headshaving, another role for grandmothers was mentioned, that of bathing and massaging the infant. In Bangladesh babies would be bathed every day, but because of the cold they were bathed less frequently in Cardiff:

"The mustard oil, what they do is before the bath they rub, what is really like a massage. They massage the baby and play with the baby - it is mostly the massaging - the grandmothers do it, it's like exercising. In our country the grandmothers do it mostly, and they just put on the mustard oil for half an hour or an hour - that really helps a lot with the skin I think."[2.9]

The mention of massaging infants raises the general area of the tactile environment. Earlier I commented on there being a specific person who would be given the role of carrying the infant. When the notion of "carrying" first emerged during the interviews, I attached little importance to it. It recurred consistently, however, either as the role of siblings or cousins in poorer families, or of a specially-employed servant in richer families.

At around this period during the research I also happened to meet two Balinese dancers, performing in a multicultural musical in the dock (or perhaps 'Bay') area of Cardiff. This performance happened to include a pram, and it emerged that they had never before seen either a pram or a pushchair. This led me to start asking Bangladeshi

mothers about prams and pushchairs, and to the realisation that the majority from rural villages had simply never seen them before.

On one occasion during the fieldwork I was asked to talk about the research to students attending a day school on developmental psychology. After I had described how much time infants were carried, one questioner asked if the babies started to walk late. I explained that I did not have enough systematic data to respond to that specific question, but it was clear that they all did start walking. This led me to turn back to fieldnotes, and to check with subsequent interviewees, about babywalkers. Only one Bangladeshi mother said that her husband was going to buy a walker. Otherwise they were not a part of the trappings of babyhood in either poorer or wealthier homes. For the present chapter, babywalkers are more important in their absence than in their presence: the delineation and equipping of the infant world is dealt with more fully in the following chapter.

A comparison with the Welsh and English babies suggests that amongst Bangladeshi babies - living in a context where age and time are less significant - there may be less "push" to achieve specific developmental stages by specific ages.



Earlier in this chapter, in discussing the perception that Bangladeshi women may have had more help available to them in the extended households of Bangladesh, I quoted the suggestion that one person would be allocated the specific task of carrying an infant. Here I develop this discussion of carrying a little further. Carrying was described as a response to a crying baby:

"when the baby cries... it's important to carry the baby. She thinks the baby likes to be with her mother, and she feels comfort if she is with her child. Her brothers carry her, but if she doesn't stop crying then they give the baby to her mother."  
[7.2 Interpreted]

One of the Bangladeshi women who had grown up in Britain also indicated that in Bangladesh babies were constantly carried, and that someone would be specifically given this role:

"Over there, I think that they have a girl to look after the baby, and just, the mother is just at feeding times or while the baby is being all day looked after by somebody else and kept - you know - like changing time or feeding time the mother will take over" [18.14]

The periods of participant observation in Bangladeshi homes made it clear that the infant world is full largely of people. In the three different households in which I spent time teaching English, for the small children I rapidly became just another body to be climbed over, with the additional interest of shorter skirts - and tights which were a source of fascination.

Infants were picked up and held a great deal, often standing on their mothers' laps throughout the interview.

At every interview the baby was either sleeping in the room, or being held by the mother, father, grandmother, siblings or cousins.

One interview with a British-educated mother, living with her husband and his parents, made this clear. We were sitting talking during a second, social visit and she had put the baby on the floor with some toys: her mother-in-law came in, picked him up, and apparently said "what's he doing on the floor?" This exchange was part of an on-going tense situation between mother-in-law and daughter-in-law, and illustrative of the daughter-in-law's position at the boundary of the two cultures, one in which infants are constantly close to other people, awake or asleep, and the other in which they are encouraged to play on their own. It was in this household that, on my first visit, I was invited into the back room, after we had completed the interview in the front room, to see the baby and grandmother asleep, side by side, on the sofa.

Finally, the infant emerged in contrast to the Welsh and English, as a companion for the mother. Welsh and English mothers clearly found happiness at times in caring for their infants, but often spoke of their need for adult company. This Bangladeshi woman, however, turned to her

children in a number of ways:

"if you are bored you can talk to your children and they can make you happy, if you have worries you can play with them. If you are alone, you're bored, sometimes you can look at the baby and forget everything that happened" [9.6 Interpreted]

The following chapter shows marked contrasts in perceptions of time and space, particularly in the ways in which Welsh or English infants were encouraged to become accustomed to a measure of apparent independence. To complete the present chapter, however, I return briefly to the main themes of the thesis.

#### **First Encounters with Medicalised Infant Care**

This chapter set out to describe the households into which Bangladeshi infants were born, and what emerged was a picture of large busy homes, with the birth of an infant not causing major disruption, but consolidating the mother's position in the household. In these households, unlike those which feature in the following one on Welsh and English constructions of infancy, babies were familiar, and were constantly close to other people. The chapter also showed how the infant world was shaped by a relatively fluid perception of time, and the sheer ordinariness of constantly being with other people, the combination of which meant that infants were never left on their own. Infants were described as part of the supernatural world,

vulnerable to evil spirits. Protection was sought by the use of extracts from the Koran, and seeds or beads obtained from Bangladesh, carrying with them the protection of Islam and the spiritual power of home - or desh - the place of spiritual power, rather than bidesh - the place of economic power. Infants were also seen as potentially polluting to adults, and for this reason their heads were shaved regularly.

The fluidity of concepts of time meant that the infant day was seen as a cycle - "he eats and he sleeps" - rather than a schedule of activities for both mother and child, which emerges more clearly in the following chapter. This meant that infant care practices were rarely separated out explicitly, but were embedded in practice. The chapters which follow this one show Welsh and English mothers receiving a series of recommendations about infant care, and health professionals constructing and delivering these messages in the specific context of Sudden Infant Death Syndrome. In the context of the themes that run throughout this thesis, the present chapter has shown a group of mothers with limited but increasing experience of medicalisation. Those that follow show mothers and health professionals with a lifetime experience of medicalisation.

## CHAPTER 6

## WELSH AND ENGLISH CONSTRUCTIONS OF INFANCY

In contrast to the Bangladeshi infants whose worlds were described in the previous chapter, the Welsh and English infants who figure here appear further along the continuum of medicalisation and explicit recommendations about infant care, particularly in relation to SIDS, that runs through the thesis. If for Bangladeshi mothers much of how they cared for their infants was transmitted within extended families in the form of practice, Welsh and English mothers received a wide variety of sometimes inconsistent advice - from their own mothers, from their friends, from the media, and from health professionals. The health professionals' focus on SIDS, and the introduction of the concept of "reducing the risk", is discussed in the following chapter.

Throughout this chapter, I refer to Welsh and English mothers, distinguishing between the two when mothers themselves did so, as for example in their plans for encouraging their children to learn Welsh. In describing infant care among Welsh and English mothers, ethnic origin did not have the same importance as it had for Bangladeshi mothers. Those Bangladeshi women who recognised that their infant care practices were different in some ways from those of the white mothers and health professionals with whom they came into contact explained the differences in terms of ethnic origin. In discussing ethnicity in

Cardiff (in Chapter 4) I identified instances in which 'being Welsh' or 'being English' was important, and specifically the belief that in 'the valleys' to the north of the city infant care would have been different. In particular, this area was cited as a place where the Welsh shawl was still used, and later in the present chapter I describe the one instance in which I came across its use in Cardiff.

In parallel with the previous chapter, the current one falls into two sections. The first deals with the kinds of households into which infants were born: couples or nuclear family units living either in houses divided into flats, or as sole occupants of terraced houses similar to those occupied by extended Bangladeshi families. Welsh and English infants emerged as "additional" to the mother, or mother and father, rather than an essential part of their parents' lives, and were expected to fit in with the other work and leisure activities of each parent.

The second section shifts the emphasis to the infant and how infant needs were conceptualised. In contrast to the priority accorded to protecting vulnerable Bangladeshi infants, the emphasis among Welsh and English mothers was on encouraging infant independence, and negotiating parental and grandparental needs in conjunction with those of the infant. This contrast was most explicit in the importance attached to a specific "bedtime", identifying

both time and place at which infants were expected to sleep. Mothers identified a range of ways in which the shift from infancy to childhood was marked, echoing both the importance of transitions, and the fragmented nature of these transitions, introduced earlier (Prout 1989, James and Prout 1990).

If Bangladeshi mothers spoke of infants in terms of the spiritual world, Welsh and English mothers drew parallels between caring for an infant and caring for a domestic pet. These different perceptions of infancy form the basis of the final chapter on the symbolic power of infancy.

#### **Welsh and English households: kinship, space and time**

The immediate contrast which emerged during the fieldwork was in the number of people making up a household. In contrast to the Bangladeshi extended family groups described in the previous chapter, virtually all the Welsh and English infants were born into nuclear family household units of mother, father and no children, or one other child. Each unit occupied either a flat or a house, with its own entrance. Here I look at the way in which the women in these households spoke of their own roles as mothers. Welsh and English mothers all reflected on their different roles, and their conversations covered the possibility of not being a mother, the appropriate age for motherhood, and the changing social networks which

accompanied motherhood. Fathers and grandparents occasionally took part in interviews, and I describe their rather more peripheral roles in infant care.

These different roles emphasized the importance of the separation of activities, and of the individuals within the household. This first section shows how mothers attached particular significance to separating the time and place of infant activities, in order to create privacy (that is time and space) for their own work or leisure. This separation is articulated more clearly in the second section which shows how infants were encouraged towards independence. The following two chapters develop this focus on the independence of infants, and the broader cultural values associated with independence.

Within these households, the relatively small number of children posed practical problems in terms of selecting Welsh or English mothers who would be comparable with the Bangladeshi mothers. I found one mother with five children, but none with the six or seven children which, according to the records of the Cardiff Birth Survey, were by no means unusual for the Bangladeshi mothers in Cardiff. It would have been possible to trace the few mothers who did have larger numbers of children via the computer listings provided by the hospital. I chose not to do so, as this would have involved going beyond the area in which the majority of women I interviewed lived; this would in



turn have resulted in the loss of similarity of housing and access to health services.

This pattern of small families meant that Welsh and English mothers had fewer siblings and cousins. Thus few had had experience of infants, having grown up either on their own or with one or two siblings of a similar age. Obtaining comparative data on fertility rates was fraught with problems: the Cardiff Birth Survey recorded mothers' country of birth, as did OPCS (see, for instance, Balarajan 1989 on SIDS) thus 'losing' births to British-born Bangladeshi women among a larger category of British women.

If infants and their care were familiar in Bangladeshi households, they were sometimes completely unfamiliar to Welsh and English women. Bangladeshi men and women had grown up in bigger households where babies were common, and had observed or taken part in their care. One Welsh mother, born and bred in the valleys but living in Cardiff, was working as a Research Nurse in the University Department of Child Health. She described the birth of her first child as "like a bomb dropping on my head". My notes of our conversation, relatively early in the research period, comment on my impression of how her experience contrasts with those of the Bangladeshi women to whom I spoke:

"There is a real contrast with Bangladeshi women, for whom the cycle of growing up and having babies isn't separated in any way by diversions into careers." [M25.3]

As well as the relatively small number of people in households, a second contrast emerged in the constitution of the household. All of the Welsh and English households I visited were founded on a relationship, be it marriage or shorter or longer-term partnership, between the baby's biological or (in one case) adoptive parents. The relationship between the man and woman was the basis of the household. In the majority of cases this two-person household had existed (for a shorter or longer period) before the infant had been conceived. In others, the parents started to share a household during the pregnancy: in these instances, it was the impending or actual arrival of an infant which prompted the institution of the household.

The ideology of the man:woman relationship lay in an ethos of personal commitment of two individuals:

"We are not actually married as such, we are as good as married, we have been together for about four years and the baby is 4½ months" [32.1]

These central relationships could be reformed, and this mother was describing a second partnership; in this way grandparents and siblings become peripheral to the relationship between the two parents.

During the analysis and writing up of this data, this ethos of 'romantic love' was portrayed in some of the mass media as under threat, with the break-up of the marriage of the Prince and Princess of Wales, and its emergence as an

'arranged marriage'. I do not pursue this theme here, but it suggests another avenue for research on the nature of romantic love: for the Welsh and English women it was personal commitment which lay at the basis of their household; for the Bangladeshi women with whom I was able to raise this subject, their perspective took the form of "He is my husband, so I love him".

Welsh and English women often contrasted their roles as mothers, wives, and workers outside the home. Many commented on the need to spend time with their husbands, and made regular arrangements to have time out together. For the first woman quoted here, a former chef living with another chef, this both met her own need to get out of the house but at the same time contributed to a feeling of "meeting everyone else's needs",

"...that's what went wrong with my last relationship, she [her first daughter, 8 years old when the second daughter was born] took up a lot of my time, she was very poorly, and it caused a lot of stress and a lot of worry, and like I sort of totally looked after her and he was away a lot in the Army and that, and we never got out together, we just grew apart, and I... Mistakes like that are made, you tend not to let the same mistakes arise again. And I enjoy getting out, I need the break from them you know, cos like being a chef. He works nights, split shifts, so I have the two of them mostly all day, somedays I think I don't want them today, it's terrible." [57.13]

My notes following this interview comment in particular on the issues encountered in negotiating the needs of her daughter by her first partner, and her baby with her current partner:

"she found it very hard to be meeting everybody's demands. Her older child, who is 8, was wanting to go to Brownies in the evening, and she didn't want her to feel that because there was now a new baby she couldn't do some of the things she had got used to doing ... she felt she was rushing round looking after everybody else's needs." [M57.1]

These extracts too show the ability to make explicit contrasts between relationships, and some of the tensions inherent in successive relationships. Insights such as these did not emerge from my interviews with Bangladeshi women, but that is of course not to say that contrasts between partners are not made in more informal circumstances.

Some women commented that they had chosen to become pregnant and to have children, and accepted that their social lives would change. This woman had first been a teacher and had subsequently run her own business, but had stopped working outside the home during her pregnancy:

"I think we are a family now, and he is part of us, and I don't believe in this business of going out without him, I mean we wouldn't have had him if we still wanted to socialise." [53.14]

In contrast to the integral place of Bangladeshi infants in households, for Welsh or English parents children were regarded as additional. Parents saw naming the infants as their choice, and responsibility for their care lay with them, with help where necessary from family, friends or paid carers. This took the form of informal reciprocal childcare, one or more regular paid babysitters, or a creche. One mother, returning to her post as a social

worker for two days a week, saw in the creche advantages over a childminder: not only was the creche more public than a childminder, but it avoided the possibility of the baby becoming particularly attached to one other person:

"I didn't want a childminder, I was really unhappy about that already. I mean there are good childminders around, but at the end of the day you don't know what goes on behind closed doors - I think that comes from the job as well - and I thought, the thought of him going somewhere and seeing one other person, I just couldn't have handled that." [46.17]

This mother commented too on the boredom of full-time motherhood:

"If I wasn't working, I don't know what I would do with myself, I really don't" [46.16].

In contrast to the Bangladeshi mothers who would ask me "Aren't you bored without children?" the idea that caring for infants was potentially boring was a view expressed frequently by Welsh and English mothers.

Over the longer term, various different patterns of relationships and families emerged. Several mothers had children from a previous marriage or partnership. The children had stayed with their mothers, the fathers being more or less regular 'visitors' to mothers' households. Where a father had children by a previous partner, they sometimes visited the new household of which he was a part at weekends. One slightly unexpected result of this was that men having children by two (or more) women ended up with relatively large numbers of children. This statistic did not appear in the Cardiff birth survey, which recorded the number of children one woman had had. This reflects

a more general pattern in official statistics, including the Census, which records how many children a woman has had, but does not do so for men.

Talking about motherhood often centred around interest in my status as a non-mother. Middle-class mothers were more likely to be older, and to have come to motherhood in their 30s. Most asked me about whether I had children. When I told them that I did not, reactions varied from "I went through it, you might as well too, come back and see me if you do" to "it's great, I'm sorry I waited so long". The most heartfelt reaction was from a woman commenting on how much work was involved in looking after a baby: she asked simply "Has this job put you off having babies?". Even when the status of motherhood was low, it was nonetheless used as a way of establishing authenticity: "when I had my kids..." was a common opening phrase.

Unlike Bangladeshi women, age of motherhood was a constant feature of English and Welsh mothers talking, reflecting a heavily medicalised view of pregnancy in terms of risk. As a middle-class woman in my late thirties, this was the perspective with which I was most familiar. Two people in particular spoke of their concern about their age:

"I mean it was the case of time is running out, and do you know, you get to the point and think 31, and [my husband] was going to be 35, and it was like, there aren't that many years there, and you think maybe we should do something about it, and that was why we got married in 1989, you know, I was pregnant by April last year, so it was all planned. It was incredibly lucky really." [46.2]

This Civil Servant was on maternity leave following the birth of her second child:

"I was nearly 29, but we were, I mean [my husband] was doing a fair bit of travelling at the time, and I feel resentful now that I could have gone travelling with him, and it was my hormones basically screaming out to me, you must have a baby ... I was also worried because two of my sisters have had problems with their fertility and I was, even though I knew theoretically there should be no reason why you shouldn't because your sisters do, but I was convinced that I would have problems, and therefore I shouldn't leave it until my 30s, 'cos otherwise do what my elder sister did which was spent all of her 30s worrying about having children, and then finally give birth when she was 40." [54: 13]

For middle-class mothers who had joined local National Childbirth Trust groups, to be in their early 30s was to be a relatively young mother. The combination of late motherhood (in the eyes of the health professionals) and a career break, whether temporary or permanent, was described as particularly hard:

"I think it is when you have had a career and independence, that's when it hits you really hard" [13.15]

The majority of Welsh and English mothers had some way of describing themselves, of claiming an identity, that was beyond motherhood. If Bangladeshi women achieved status through motherhood, Welsh and English women valued it in relationship to the other roles available to them.

Some women slipped easily into motherhood. One, a seamstress (working part time from home, with the baby being cared for by a childminder) had just had her fifth child, the first with her second partner, a bricklayer.

She enjoyed motherhood to the extent that she had just been sterilised to ensure that she would have no more children:

"My mum did always say I would be the first to have kids, I mean I always have been a motherly type ... you would have to be with five kids" [32.2]

"To tell you the truth, this was why I was sterilised, because I am beginning to doubt myself. I thought, crikey, by the time he is toddling I will be wanting another one, and it's got to end somewhere you know, it's got to end somewhere." [32.19]

Giving birth was a relatively rare experience for most women and for first-time mothers their primary concern was the birth itself. Women who had had two or more children became much more confident about both birth and infant care:

"You are more laid back, like on my first one you are checking her every two minutes in the cot, and you put them down, if they are breathing like, and you tend to sort of fuss over them, whereas, 'cos I had the next one so quick you know, he settled down quicker because he had to wait." [55:3]

"It's very nice having a second child because all the kind of worries about the practicalities, you just don't have ... you really enjoy them, a lot more because you are not worried 'Oh, God, What do I do? I'm going to break her arm putting the babygro on or something." [54.21]

The processes of pregnancy, childbirth and motherhood themselves created new social networks through new acquaintances at ante-natal and parentcraft classes, in hospital, and afterwards at mother-and-baby or well-baby clinics. Some of these friendships lasted, some did not; they reflected however the shift of social patterns which took place with pregnancy, and the way in which new friendships emerged with motherhood, and some existing friendships with childfree people withered. The problem in



meeting other women through ante-natal classes, childbirth and motherhood seemed to be that these processes were the only thing they had in common. Pregnancy and childbirth also activated new networks for the exchange or long-term loan of clothing (for both mother and child) and child-care equipment (prams, cots, pushchairs).

Some working-class mothers drew on help and advice from their mothers, and - for those in employment - from colleagues. Grandmothers in this category were more likely to live close by, but were also often working full time. It was among the working-class mothers who had previously been in work, but who had not returned, that I found real isolation. One, a chef whose experience of post-natal depression I cite below (page 243, interview 57), described how her Health Visitor would come and "just sit" with her sometimes. Middle-class mothers were more likely to be returning to work, to be able to afford paid helpers either for housework or childcare, and at the least expected that any isolation would be relatively short lived.

English mothers, particularly in the middle-class category, were more likely to have moved to Cardiff following either their own or their husband's career paths. They drew support and help from networks of friends, colleagues and neighbours, rather than through family links.

In one area of the city from which I recruited both Bangladeshi and Welsh middle-class mothers, the National Childbirth Trust was actively involved in promoting breast feeding, and running various activities for mothers with babies and toddlers. They organised separate activities for people with babies and with toddlers: 'bumps and babies' was a special group run to meet the needs of pregnant women (with 'bumps') and mothers with babies, who were "put off by having toddlers running around".

The following extract is taken from an interview with a woman who was actively involved with National Childbirth Trust. She had previously worked for a theatre production company, was married to an architect, and was a full-time mother. It illustrates a number of issues: a middle-class English woman moving to a new city, having little social contact with women who had grown up in the area, the narrowing of mother's social circles when they have babies, the concentration of such families in particular local areas, and the abilities within the group which allow the organisation of help and support for each other:

Q Do you have friends you can talk to?

A This street is amazing, and I mean the NCT [National Childbirth Trust] are an incredible sort of group, so yes, I mean, I don't feel lonely or anything.

Q Is that mainly how you have met other mums?

A Yes, that has been an absolute lifeline... It was just a friend told me about it and at the time we did not have any friends with children. I mean I do not go so much now as I sort of tend to have made a lot of friends who were in it and aren't any more, and we have got our own little sort of group, but it is just

- and it is all women from away. I don't think there is any local woman in it, and it becomes like we have a babysitting circle and people do swaps, you know like when I had Jane everybody was taking Kate off for me, and was very supportive. It tends to be incredibly middle class, but I mean that is what I am I suppose." [13.9]

One example of networking within the group was described to me: a mother with post-natal depression had been introduced to a psychiatrist who was also a member of the local NCT group:

"..they are very supportive, I mean if anybody is having a problem, I mean, there is a woman in the next street, you know, has been diagnosed as having post-natal depression, and one of the women in the NCT is a psychiatrist, so like she has been seeing her. You know if you had any problems there is always somebody who has had the same problem and it is amazing." [13.10]

This experience of post natal depression was very different from that described to me when I asked the former chef - referred to earlier - if she took her baby out sometimes:

"Well, I've suffered a little bit with post-natal depression, so I've had difficulty taking her out, well not just, it's just I find it hard to go out so I try not to, I do take her out when I have to, but unless I have to take her out I won't go out."

"Did you get depression last time?"

"I did, but I didn't know, I didn't realise, but I thought it was my circumstances then, because I was splitting up with my husband, and I lived in a foreign country. I just assumed it was that, but that's why I said to my Health Visitor and my Doctor, this time I don't understand why it has happened, and they said, maybe I'm just one of those people that are prone to it because I had it before and I thought because my circumstances were so different this time, it wouldn't happen. But it did happen and there was nothing I could do about it to stop it, however I tried I could feel it coming, but I couldn't do anything about it... Some days are better than others, like the Doctor has given me anti-depressants to take, but he just said it will just take time for the body to get back to normal, and some days are better than others." [57.19-20]

Whilst in some instances social networks came into operation, for many people motherhood was a lonely experience

"you see so many women going there [to the ante-natal clinic] especially with your first one, desperately smiling at people, and you know like my Mum said in her day there was a tea urn and a load of biscuits".  
[13.10]

One woman described her feeling of being alone with a young baby all day, as being "Faced with five days a week to fill"; another saw it as sacrificing the present in order to achieve an aim: "giving up a few years to have babies".

Some of the women who took part in the research combined motherhood with work outside the home. They were spread across middle and working class. With both, it was difficult to arrange interviews when the baby was around six months old, as by this stage they were fully occupied meeting the combined demands of work inside and outside the home.

For middle-class women following a particular career path the decision to return to work was based on both career prospects and income. In addition, there was a feeling of returning to being themselves: commenting on the benefits of going out, of getting dressed-up and made-up, one mother said succinctly, "it'll be me again". On the other hand, one working-class woman, recognising the sheer volume of tasks involved, said:

"the thought of having to give her breakfast as well as getting her ready and myself ready is a bit daunting" [3.5]

At the same time as recognising the benefits of working outside the home, some mothers commented that they had not realised how tied they would be with a child, both physically and mentally. For some it had been unexpectedly hard to leave the infant in order to go back to work because they simply missed the baby. Another problem which emerged was the difficulty of seeing their baby become more attached to somebody else. One mother in this position put it this way: "I like to think I would be the most important person to her".

One of the questions I asked was "could you imagine not having had babies?" This line of research followed my thinking that more may be made of motherhood when it was one of a number of different roles. Where it was the only role for women, and one that brought status, as with the Bangladeshi women, it was only in its absence that it attracted comment. In this context my own non-motherhood was a source of comment and interest, particularly in the light of the job I was doing, for Bangladeshi, Welsh and English women.

Responding to my question concerning the possibility of non-motherhood was relatively easy for the Welsh and English women, some of whom had always assumed that they would have children, some being surprised at finding

themselves as mothers. Others commented that if they had not had children, they would have had both more money and more time with their husbands, reinforcing the notion of the preeminence of the 'couple', with children as an addition. For the Bangladeshi women the question was irrelevant: there was no choice. Motherhood, as described in the previous chapter, is not only expected, but the way of consolidating the marriage, and achieving status in the household.

One woman whose baby had been born by caesarian section identified a paradox: she spoke of "not feeling like a mother" because there had been "no birth", and no "birth pain", particularly when the infant had gone straight into the special care baby unit:

"It was hard going, we were back up in the hospital every day, the week before we came home. Then obviously they told us he was coming home that week, but we could see that he was taking the bottle and doing quite well so my husband went in for 2 o'clock feed, that was three nights. The night before I stayed - bit of an anti-climax I think for women who have their babies in Special Care because first of all you are in the ante-natal ward, everyone is in the same boat, eventually you are all going to have a baby and then post-natal ward. At first I was in a big ward of eight of us, and at one stage they all seven had their babies with them, but I did get moved around then, cos I was there such a long time I had quite a few little wards, then after he was born I was in there for a week. You have all the cards, the flowers, but you still haven't got your baby with you, and then you - to be honest I felt as if I never had a baby." [37.16]

This emphasis on what it is that makes women "feel like a mother", prompted me to ask a further question concerning

the source of ideas about motherhood. I have already commented on the contrast between the extended Bangladeshi family and the nuclear Welsh and English family unit, and the relative familiarity and unfamiliarity of infants. Welsh and English mothers tended to refer to their own childhood for their own ideas about motherhood, rather than to contemporaries, be they relatives or friends. On the other hand, in the view of one health visitor, many mothers expected their lives to resemble "television commercials", with everything under control, clean and smiling infants, and perfect meals served at normal times. This idea reinforces the separateness of 'mother-and-infant' as a unit, a notion mentioned above in noting that virtually all the interviews with Welsh or English women were with mothers with - or occasionally without - their infants, but rarely was anyone else present.

Just as motherhood was one of a woman's many roles, so too fatherhood and grandparenthood took many forms. Whether in or out of work, fathers contributed in different ways. One woman commented of her husband, "he's rubbish"; another that the father's principal contribution had been in the decision to have a baby. Other fathers put their children to bed or gave them breakfast, or both; some fed infants, with food prepared by the child's mother. In some cases the father's role was playing with the children. Some parents took turns in getting the baby up and some shared all the chores (which resulted in them spending less

time together, which they hadn't anticipated): "he's great, he's a real worker, but he doesn't see much of the kids". Some fathers were very child oriented - "he can't resist picking him up" - whilst others, in their wives' view, felt left out if "it's all baby". One unemployed father (a former docker who had lost his job when Cardiff's docks gradually lost their importance) clearly devoted all his time to caring for his two daughters: "we do everything as a family". He took an active part in the interview.

The role of the baby's grandparents was in general peripheral to the household. Amongst mothers who lived in the area in which they had grown up, the baby's grandmother (Nan) and on one occasion greatgrandmother (Nana) were involved in "minding" the baby when the mother was doing short-term cleaning work. In general, working-class women were more likely to have younger parents living close by, but they (the grandparents) were also more likely to be in full-time employment. The infant's contact with its grandparents was described as "visits" which were organised in advance. In a few cases grandmothers were involved in the day-to-day care of infants, and were present at the interviews. This kind of picture is very similar to that described by Cotterill in North Staffordshire, who found that paternal grandmothers

"are unwilling to undertake full-time childcare and are prepared to do so only with reluctance and in extreme circumstances" (1992: 615)



For the middle-class women, who were more likely to have moved to Cardiff, grandparents were living some distance away and would visit occasionally. Living at a distance did not mean that they did not express their opinions. The birth of an infant seemed to be a time at which mothers "reclaimed" their daughters, and sometimes their expertise: mothers often described receiving different advice from their own mothers, mothers-in-law and Health Visitors. Sometimes grandmothers came down on the side of the "in my day..." ; on other occasions they tended towards current practice - "everything's changed nowadays".

The birth of a grandchild was a period during which grandparents acted as "historians" of the family, providing information on how the new parents had been as infants, and expressing forceful views about infant care (most commonly "don't pick him up all the time - you're making a rod for your own back" and "you did that too (screaming), and you survived". Sometimes mothers used their own mothers as the final arbiter in a situation where they had received conflicting advice: "after all she brought me up". The distinction between parents and grandparents was much clearer in these households than in the Bangladeshi ones, where women had more children over a longer period of time and it would quite unremarkable for a woman to be mother of a young infant, and grandmother, simultaneously.

In summary, these households were smaller than those into which Bangladeshi infants were born. They centred around the infant's mother and father, both of whom had a range of other possible roles and commitments with which they negotiated their roles as parents. This separation of adult roles also involved the separation of infant care from the immediate family, and the involvement of childminders or nannies, nurseries or creches. This separation was made explicit in perceptions of space and time within the house. This is an instance in which carrying out parallel series of interviews threw contrasts into sharp relief. It was the recognition of the ways in which Bangladeshi households were organised that prompted my interest in similar concepts within Welsh and English households.

The previous chapter described how the Bangladeshi population in Cardiff lived in fairly well defined areas. I invited Welsh and English mothers living in these or similar areas to take part in the research, but these areas were less easily identified than those occupied by the Bangladeshis. Particularly for the middle-class participants, the housing varied from "gentrified" versions of the Victorian and Edwardian terraced houses to the occasional detached Victorian or more modern detached villa. Specific areas, particularly those in which National Childbirth Trust was active, were characterised as "having a lot to offer" for people with young children.

Interviews in Welsh and English households tended to be simply with the infant's mother, whilst those in Bangladeshi households involved a larger number of people. This difference between infancy as the domain of the nuclear or the extended family was clear in the organisation of the property in which people live. Regardless of the type of accommodation, whether houses or flats, households comprised smaller, two-generational, family units with their own front doors. Whilst Bangladeshi households (sometimes of 12-14 people) had one front door bell, often not working (people simply knocked on the window and walked in), a terraced house occupied by three Welsh nuclear families had three front door bells.

The Welsh or English household in Cardiff was not just small, but it was also private and self-contained. I was always met at the front door, and escorted in and out of the house; sometimes whole Bangladeshi families accompanied us to the door, but it was quite ordinary to leave (particularly in houses in which I was familiar) without being "seen out". I found this uncomfortable at first, my own practice being to let people in, and afterwards to see them out, as a matter of courtesy. In the Welsh and English households, I came to feel that this emphasized the feeling of privacy of the household. It may be that among English and Welsh people not seeing visitors out of the house signals intimacy, possibly between close friends or neighbours; it may also be that

these practices vary with class, region and type of accommodation. My experience in Cardiff, however, was that - for whatever reason - Welsh or English households attached more importance than did Bangladeshi households to escorting me to their front door of their flat or house.

Having discussed the households into which Welsh or English infants were born, I now move on to look at concepts of time, space and privacy. Interviews generally took place in the front room, with an initial visit to the kitchen to make tea, often with me carrying the infant. Where a mother was working in the kitchen, or feeding a child, I simply carried on the interview as unobtrusively as possible. On a couple of occasions I arrived to find a very fraught atmosphere, and arranged another date.

The importance of privacy for the mother, either from her child but with her partner, or without her partner, is discussed below in relation to time. Time, however, was often expressed in terms of 'space' - be it physical separation from the infant or other people, or 'space for me' in a more personal, symbolic sense. Again, the notion of 'time for a bath' referred to below expresses both physical solitude and time to oneself. Here, too, contrasting desires for solitude in both time and space became explicit through drawing parallels with practice in Bangladesh - where bathing was a social, shared activity.

In similar vein, in Bangladesh, sleeping, like bathing, was a social rather than a private activity, that is to say that it was undertaken in the company of other people. Amongst the Welsh and English parents it was clear that they wanted their children to have their own rooms and that they should have quiet separate space in which to sleep, if not immediately at least in the future. The mother cited below had worked as a Civil Servant, and had completed a doctorate in child health. My fieldnotes, however, refer to her as a National Childbirth Trust mother - here I fell into the pattern of categorising mothers as 'NCT', much as Health Visitors and paediatricians did. She talked at some length about her infant's sleep patterns:

Q "Where does she sleep at night"

A "She sleeps with me in our bedroom in the carry cot next to the bed. My husband doesn't sleep in our bedroom at the moment, he is sleeping - all good fun - he is sleeping with my daughter because when she [the baby] was having colic she [her older daughter] would be disturbed and she would try and come ... He sleeps with her basically to stop her coming in and being awake in the night, so we have got to deal with that sometime, getting him out of her room, but it just seemed practical basically."

Q "Did [your older daughter] cope with going into her own room quite easily?"

A "When she was a baby...she went in - I kept a diary - just a day less than 8 weeks. She moved into her own room and I wrote at the time 'we all sleep better for it' because she used to make lots of noises, well she still does, and it was less disturbance for us and presumably for her."

Q "And do you find it intrusive having the baby in the same room?"

A "No she is very quiet actually, I mean we will move her out as soon as the colic has gone - that's the only reason."

Q "Some people say they don't like to have sex with babies in the same room as them"

A "I'm not bothered." [54.10]

The link between sex and privacy was one I explored when I felt the relationship within the interview was well established. I was interested for a number of reasons. As I mention above, it became clear that there were a number of activities which in Bangladesh are either shared or performed with other people - bathing and sleeping - which in Britain would be regarded as private, or at least generally performed alone. Blanchet (personal communication) had described working in Sylhet and sleeping in shared space within a big household, and how it was sometimes obvious that sexual activity was taking place. It was also suggested at one conference of health professionals that within the context of a piece of research associated with the reduction of SIDS, the practical implications of a recommendation that Welsh or English babies should sleep in the same room as their parents might be seen as being too intrusive. For these reasons, I was interested, where possible, in asking about sexual activity with a baby in the same room. This elicited a range of responses:

- "I don't even like having the cat around" [40.11]
- "that never bothered me, she was so young anyway ... I mean the dog sometimes was in here [59.18]
- "To be honest we've done it with the baby in bed with us, and with the baby awake in the cot" [M32.2]
- "that's gone out the window" [50.3]

These comments both suggested a range of responses to the notion of the presence of an infant in the same room as parents, but also opened up another area, that of the parallels between an infant and a domestic pet. This is an area to which I return later in the present chapter, and in the final chapter of the thesis.

There was also another idea which emerged, which I refer to as 'body privacy', and which was expressed in a reluctance to carry an infant too much:

"Everytime when my other daughter, the faintest cry we picked her up and that was actually, that resulted in her wanting to be picked up and therefore why shouldn't we? But on the other hand, it did present problems like she wanted to be carried round for ages and really there was no reason why she should be carried that much." [54.7]

Given the Bangladeshi mothers' constant contact with their infants, and the idea of nominating somebody within the household to carry the infant, this idea of the infant intruding on the mother's body was another element that contributed to my view of Welsh and English parents encouraging the separateness and independence of the infant.

In discussing the family unit, I described the primacy of the couple, and the way in which infants intruded in the adult world, and were expected to adapt to it. Mothers regarded infants as being "in the way" during interviews:

"my husband is off this afternoon, he's taken her to the clinic to be weighed, I thought we would have a bit more peace if she was out of the way" [M4.1]

Similarly, mothers described feeling that they were "intruding" if they took their infants to a gathering not specifically organised for people with children.

The second part of this chapter focusses in more detail on the infant world, and on perceptions of holding or carrying the infant. At this stage, however, the important point is that perceptions of space were expressed in two ways: the first was the desire for privacy on the part of the parents, and the second the need to encourage the child to become accustomed to being on their own. The particular case of the introduction of a 'bedtime' is discussed later, offering as it does the focal point at which time and space meet. In some households babies had their own rooms, often prepared before birth. In one instance the parents had put up a partition wall, in order that the new baby would have its own room. The mother described how the wall was so thin that she could "hear every breath"; nonetheless she had ensured that she had a special baby listening device!

To complete the current section, however, I discuss the way in which time structured the household's activities. The timetable of the household was dictated by the work and other commitments of both parents. The arrival of a new infant was an event for which preparations were made, including for instance the decorating of a room, buying furniture and clothes.



For some people, babies were seen as "disrupting" this timetable or as creating a new one, at least for the mother. It sometimes seemed as if the mother's role was to meet the baby's needs, but in addition to protect the father's routine. In other cases there was a feeling that parenthood was a choice, and that having made it you should "devote all your energies to it".

On one occasion when I asked about preparations before the baby's birth, it was understood in terms of "was the baby planned?" which it had not been. In this case the baby's birth was the point at which the parents started living together.

The concept of "routine" was important, either in trying to impose one, or of allowing the baby to establish its own routine, or a definite decision not to follow a rigid timetable. One mother described how she could "set the clock" by her children, although she hadn't particularly tried to impose a routine. Others, particularly those returning to work, emphasised the importance of knowing the child's routine, in order that the person taking over the care of the child could maintain continuity with meal times. One mother, about to return to work, had actually kept a diary for this purpose, since the creche to which the child would be going would "adapt" to the routine of each baby. She found that keeping a diary for several months had made her realise how similar the days were on

paper, much more so than in the way she remembered and experienced them.

Interviews with Welsh and English mothers were easier because they shared my assumption of linear time, which was built into asking mothers to talk about "a day in the life" of their babies. Activities, and even time itself, were divided up and labelled. For the Bangladeshi mothers, clock and calendar time was unimportant within the household, but became an issue when they came into contact with people beyond it, such as English for Pregnancy tutors or health professionals concerned about appointments or length of pregnancy.

As I became more aware of the different ways in which time was conceived and described, I asked "what would you do with some spare time?" This was the question with which I generally ended the interview, since it brought the conversation back to focus on the woman herself. Whilst this was a particular emphasis of mine, I felt happier at moving away from the infant for a while, to move back to the woman as a person rather than in her capacity as a mother (and often reflecting some of the issues that had arisen during our conversation). It generally raised a smile, and often a physical relaxation in posture. I discuss spare time further below, and later in the chapter show how time was discussed both in terms of quantity (to

measure and mark the day), and quality (to give meaning to particular periods of time).

Spare time for parents, separately or together, was recognised as important, mostly in its absence. In contrast to the Bangladeshi mothers who referred to spending time with their infants if they had spare time (although perceptions of time were so different that to classify it as 'spare' is very much my perspective rather than theirs), Welsh and English mothers often talked about the idea of having a bath in peace. The following extract shows the different roles this woman felt she was fulfilling, the way in which she organised some time to herself, and her choice to spend the time in the comfort and solitude of the bath:

"Trying to juggle everything like looking after yourself, you know make sure you have got time for yourself or whatever, looking after them you know. John [her husband] obviously needs some time from me. I just feel it just drains off you, that's hard."

Q "How do you make time for yourself?"

A "The answer to that really is you don't."

Q "What would you most like to do if you did have the time, if somebody gave you..?"

A "..John did this not long ago. He took them both off."

Q "I just want to be in the house and to have time to have a bath and like read a magazine. You know I don't want to do anything sort of that needs brain power, just to be able to relax without one of them running round your feet you know." [13.12-13]

Other mothers talked about reading a book, simply wanting time away from the baby, an evening out, or missing 'lie-ins' and freedom. In one instance time stopped being

'spare':

"I kind of think what I ought to be doing next, you know I don't feel as if it's spare time any more really" [22.14]

One of the other ways in which time was important was in the recording of age. In describing how Welsh and English women spoke about motherhood earlier in the chapter, I mentioned their concern at the age at which they became mothers. Here I continue this interest, showing how mothers conceptualised their infants' ages as well as their own. As a way of initiating interviews with a few questions designed simply to encourage an informal conversation, I asked mothers their own ages and when their babies had been born. They replied with both their date of birth, and their own age at the time (the sentence frequently took the form of "I'm 24, I was born in 1967"). Infancy emerged as a period during which time, and the marking of time, was particularly important both for women conscious of their own age, and aware of their growing and changing infant. The younger babies were, the shorter were the time intervals identified in describing their age: one week, one month, six months, a year, eighteen months.

It was relatively straightforward on these occasions, in contrast with interviews in Bangladeshi households, to obtain information on dates of birth or ages. Similarly, asking about numbers of siblings, and age difference between them, was easy: the answers were usually given by

year of birth, and there were generally only one or two siblings. In terms of research, this is an instance in which adopting a comparative approach makes certain contrasts explicit. Despite the often quoted urge to make "the familiar strange" (Clifford 1986: 2), I doubt if I would have thought about this difference in the perception of age had I not also been interviewing Bangladeshi women.

Welsh and English infants were born into households shaped by both the demands of work and other commitments outside the home, and the broader cultural values of independence. They were expected, to a greater or lesser extent, to develop a particular pattern of behaviour. The latter part of this chapter goes on to outline some of the values attributed to infants and their care, in particular the importance attached to their gradually increasing independence. In contrast to Bangladeshi perceptions of time, it was more important in Welsh and English homes for an infant to have a predictable series of activities which allowed either or both parents to pursue independent interests, and sowed the seeds for the infant to do the same.

This discussion of time and space within the household completes the first part of this chapter. The second section now turns to look more specifically at infants within these households.

**The Infant World: Unfamiliar Infants**

In this second part of the chapter I explore the social context of infant care, in particular the unfamiliarity of infants in the small nuclear Welsh and English family units, the value attached to the emergent independence of the infant, and the negotiation of the needs of the infant with those of its parents. I describe how separate 'babyworld' was created in the home, how parallels emerged between infants and domestic animals, the steps that marked the transition between infancy and childhood, and finally the more medicalised concept of vulnerability which emerged from mothers' increasing awareness of the possibility of Sudden Infant Death Syndrome. These contrasts became clear in the light of my parallel fieldwork in the larger Bangladeshi households where infant care was shared by mother, siblings, aunts and grandmother, and infants were an essential part of the extended family rather than an unfamiliar addition to a household comprising one woman and one man.

Having recognised how unfamiliar infants were to many new parents who had had little experience in a previously 'childfree' adult world, I attempted to explore just what mothers did expect of their infants. To this end I asked if they had been surprised at anything about their infants.

This elicited a range of replies, from amazement at being pregnant to a series of "horror stories" (about labour,

sleepless nights or the amount of washing involved). Some women emphasized the positive elements of the experience: "I couldn't imagine it...I just loved her"; "It was easier than I'd expected". First babies brought changes to the organisation of the household, and the loss of the ability to act on the spur of the moment: in one woman's words, "everything has to be planned". I return to the importance of the infant developing a predictable routine later in this chapter, but for now show how mothers talked about their first contacts with their infants. The following reactions capture some of the elements that contributed to my describing infants in these households as unfamiliar:

- "What do I do with it?"
- "It's so tiny"
- "I couldn't even put her clothes on"
- "I had never touched one in my life".

One woman, a musician, commented particularly memorably:

"I was completely un-child-trained before I had the baby. I don't think I'd ever held a small child or a baby before. I had hardly even seen one." [M22.1]

This idea of the lack of experience of infant care was emphasized in the ways in which help was provided to new parents in, for instance, "babycraft" classes. The terms "craft" and "class" both emphasize that these were skills which could be taught and learned, by expert health professionals and amateur parents respectively. If Bangladeshi mothers were being taught language skills (and, in my view, implicitly learning about the processes of

medicalised birth and infant care), the Welsh and English women were offered tuition in their parenting roles.

Within the small households responsibility for the care of infants lay with the male:female couple, the biological parents. Whilst the care could be undertaken by a range of people, it was the parents - primarily the mother - who retained responsibility for organising care in a variety of different ways. These included reciprocal arrangements with family, friends or neighbours, informal paid 'babysitters' or more organised 'babysitting' circles, and the increasingly commercial and professional care provided by baby-minders, nurseries, creches and professional nannies. Health professionals (health visitors, general practitioners, paediatricians) all provided a secondary increasingly medicalised system of 'back-up' care to which parents could turn.

In order to facilitate the care of the infant by a range of people, babies were encouraged to develop a routine (following their own pattern or that introduced by their parents), and to become used to sleeping, playing and so on, on their own.

In talking about "a day in the life" of their babies, mothers used the concept of time both to mark the order of the day and to characterise particular parts of the day: they spoke, for instance, of infant feeding times, bathtime



or bedtime. The previous chapter has shown both the fluid perceptions of time in Bangladeshi households, and the surprise of Bangladeshi women who were aware of western practices at the use of bedtime as a sanction. It was not however simply a sanction for older children, for Welsh and English infants bedtime was a way of establishing a routine which would in turn provide some private time for the parents. Here I show two examples of mothers describing their infants' days, one developing a sophisticated categorisation of types of time, the other showing how her day was a more continual process of care, centred around breastfeeding. In each instance, the needs of the infant are counterposed to those of the mother individually, and the parents together.

This mother was also a musician, and we arranged to meet in the afternoon which, as became clear in her comments, she regarded as "baby" time:

"I try to devote some time after, in the afternoons to her 'cos the mornings are generally my time. I do what I want to do, and she has to just be there, so in the afternoons like now I generally devote some time to her." [59.11]

Our arrangement to meet in the afternoon reflected the general practice of Welsh and English mothers. They tended to suggest that we met either mid-morning or mid-afternoon, and offered me tea or coffee when I first arrived. In Bangladeshi homes, we had tea after the 'work' of the interview or the English lesson, which suggested to me a different view of the interview. For

the Welsh and English mothers it was a social occasion, a time to produce tea and sometimes biscuits or cakes and to talk informally about their lives; in Bangladeshi homes, this came afterwards in the period of exchange of news with the interpreter, which tended to take place after we had completed our three-way interview. For the English musician quoted above, her time was divided and characterised in the following way:

- "work": time when she was working, either in the home or outside it (paid work, rather than housework);
- "leisure": organised activities outside the home;
- "my": time spent on her own
- "our": spent with the baby's father, but without the baby;
- "baby": devoted to caring for the baby
- "play": with the baby, for specific activities, involving specially designed and purchased equipment.

In contrast to the schema of activities cited above, the woman talking below was breastfeeding. Her account shows a very different picture of her baby's day, and her perception of it, and in particular the differences between her own needs and those of her infant.

"it was awful when she was awake all day. What I do now to try and get her to sleep, I swaddle her...I use a sheet, yes just an ordinary sheet, then I put a blanket around that. Before we had a lot of problems

in getting her off to sleep but this is the only thing that really works, and it actually helps with the wind problem as well.

Q "Did somebody suggest that to you?"

A "Yes, my mother-in-law [who was Jordanian]. But my mother also used to carry her round in a shawl, sort of Welsh style, and that's the same idea. That did the trick as well, it always gets her off to sleep, so I keep her tight with her arms down like that, warm, then she wakes up for a feed every 1½ hours and it goes on like that through the day really. She wakes up in the afternoon and stays awake until about 7.30 and then she goes off to sleep again, but it is on and off through the day because I think with breastfeeding it is like that, you can't feed them every five hours and they drop off. In the hospital they were having four- or five-hourly feeds but of course that is bottle-fed babies." [27:5-6]

For both these women, one still working part-time as a musician, the other having given up employment as a legal executive since the birth of her child, their infants' needs were constantly recognised and negotiated in terms of their own needs and those of the babies' fathers. Earlier in this chapter I cited a former chef's experience of a previous relationship having "gone wrong" at the time of her first child's birth. In her view this had been a result of her not spending enough time with her then husband.

The importance of encouraging infant independence, and meeting an infant's needs at the same time as those of its carers, is a thread that runs through this chapter, made particularly evident in the light of the Bangladeshi emphasis on the vulnerability of infants and their constant sharing of both time and space with other household members.

As well as reflecting on the way in which an infant's arrival had altered the timetable of the household, and the roles of the people within the household, infants were also allocated specific spaces and commodities. Again this is a contrast which became explicit in observing both Bangladeshi and Welsh and English households.

Welsh or English parents provided separate rooms for their infants, often prepared before their births and decorated in colours and materials thought suitable for infants. A range of furniture, including cots, cribs, carry-cots, high chairs, free-standing seats, and occasionally play pens was available. All the houses I visited had some of these special pieces of furniture, older or newer, but all specifically there to meet the perceived needs of the infant. In addition to furniture, toys, clothes (romper suits, bibs, nappies) and accessories (baby bottles, feeding dishes, rattles, the brightly-coloured and multi-textured babymat, and the babygym) were tailored to the infant. In the previous chapter I mentioned that only one Bangladeshi mother had suggested that her husband would be buying a babywalker in the future. For the Welsh and English infants these were familiar, and seemed to me to crystallise the desire of the parents to encourage the baby to develop - or to appear to develop - a measure of independence. All these contributed to what I term the separate 'babyworld' within these households.

Earlier in this chapter I referred to the reservations some Welsh or English mothers expressed about the frequency with which an infant should be picked up, by whom, and for how long. I now continue this discussion, using the idea of 'body privacy', to draw attention to the balance mothers were negotiating between infant and parental needs.

If Bangladeshi babies were generally on someone's lap, Welsh and English babies were encouraged either to "go to anyone" or to become accustomed to being on their own. I was often handed the baby, accompanied by comments like "oh she'll go to anyone", or "she's got to get used to new people". In this way, parental needs that the baby should become adaptable to various environments, and should not rely wholly on the parents, were expressed much more explicitly than in Bangladeshi households.

For many mothers, and particularly grandmothers when they were commenting as we talked, there was a feeling that it was possible to pick a baby up too much. This was most often accompanied by disapproval, a fear of establishing a pattern that would be difficult to break, typified by "you're making a rod for your own back". Babies who wanted to be picked up were described as "clingy", "like a leech", "on me all the time". Implicit in these terms was a notion of the infant as animal-like, an idea to which I return later; further, however, the infant was in some way intruding on the boundaries of the mother's body in an

unacceptable way, threatening her own sense of bodily integrity or 'body privacy'.

This was not always the case, however. One woman in particular, herself a health professional, identified contact as important for the baby:

"I think the most important thing is contact and I like her to be with us, I never put her upstairs on her own. She's a sociable baby, she likes to be here. She has got a few little cousins around, she loves it when they're here." [1.3]

This same mother, however, also described how she took her baby "up to bed", and arranged for her husband to take the baby to the clinic in order that we might have "some peace". Whilst she saw contact as important for the baby, it was also equally important that we should have time and space for our conversation, and that the infant should have its own time and space for night-time sleep.

Some mothers recognised the pleasure they experienced in having the baby close to them. One described how she brought him into bed with her when he was "unsettled": "I like it, cuddly, yeah" [34.8] For others, it was the mother who wanted to hold the baby more than the baby wanted to be held:

"He likes a cuddle now and again, mainly just picked up on the shoulder. Cuddled in the arms he doesn't like that at all." [37.16]

The contrast with Bangladeshi infants here was that they were constantly with other people, and frequently in close contact with mother, siblings, aunts or grandmother. For

the Welsh and English infants "cuddles" were occasional, remarked upon, and indicated either affection or concern at the infant's possible ill health.

It was in the context of contact with infants that I came across the use of the Welsh shawl. This was a way of carrying the infants with no specific concern to offer affection or particular care such as those suggested by the women above. The shawl was a large square of woven wool, the colour and weave originally indicating the part of Wales in which it originated. It was folded into a triangle and wrapped around the mother's shoulders with the ends tucked under the baby. In effect the infant was tucked under one arm, leaving the other arm and both hands free. None of the mothers used the shawl, but in one instance the baby's grandmother always carried him in a shawl. The mother pointed out an ordinary blanket hanging over a radiator in the front room, and described how her mother would put the baby in it every week when she came to visit.

"Well, my mother uses this actually, I didn't really know how it worked but she has tried to explain it to me, but it is very complicated, you put the baby there and then it sort of ...

Q "She puts the baby in the shawl?"

A "Yeah, and then wraps all round the body and just her little head sticking out, the baby is completely enclosed. It's like the system they use in Africa and Thailand and these places, but it works." [27.8]

Several people described how the shawl was sometimes used in the house, but not outside in the street. I was told

I would see people standing on doorsteps "up the valleys" with their babies in shawls. This use by grandmothers, and on the boundaries of Cardiff in the valleys, provided an instance of a specifically Welsh infant care practice.

That it might be used inside the house, but not outside, suggested it was in some way less valued than the alternatives. The woman quoted here was enthusiastic about the use of the shawl both in Cardiff and in distant parts of the world, but despite her own mother using it, she found its use difficult and complicated.

The shawl was associated with the past, with grandmothers, and with what I term a "reservoir" of Welshness to which people could refer. It was not seen as particularly desirable, more as a vestige of old practice, picturesque but not particularly relevant. In contrast to the range of other ways of transporting infants (prams, pushchairs, or backpacks, papooses and so on) or of seating them (highchairs, bouncing chairs, for instance) the shawl appears to restrict the mothers, both in the movement of their arms and in threatening their sense of the integrity of their own bodies.

The use of the shawl was one focal point around which the contrasting and sometimes competing needs of both infant and child were articulated. Quietness was another value attributed to infancy by this mother who commented:

"I tend to sing nursery rhymes to her quite a lot, she likes that. She is quiet if I sing to her." [1.2]



This mother's association of a happy baby with quietness again reflects the needs of both not only for separate time and space, but also lack of intrusion of the noise of an infant. I go on now to show how it was in addressing parental needs for privacy, already identified in the first part of this chapter, that the parallel between infants and domestic animals first appeared. Here women were talking about how they felt about sexual activity with the baby in the same room:

"We don't when he is awake, anyway I wouldn't" [34.9]

"I asked her about having sex while the baby was in the room, and she replied 'well, you know, we do, and to be honest we have done it with the baby in the bed with us, and with the baby awake in the cot'. She said the point at which she would move the child out was when he might become aware of what was going on, and think that Dad was hurting Mum - that was how she put it. I asked if she could put an age on that: she replied 'yes, about 10 months or so' - she was quite specific about it." [M32.2]

"Well, we found that doesn't work either because he does wake up and it is inhibiting, I mean, so we escape round that one and sort of find an alternative. No, we don't really do anything like that when he is in bed. I think I would find it very disconcerting if I woke up and he was - I'm not really sure what they can see, and what they can understand even at this stage. Aesthetically, from our point of view, I don't even like it if the cat is in the room." [40.11]

The final extract suggested a parallel between infants and animals. Comparing the presence of the cat to that of an infant suggested that both were capable of intruding on private adult space and activity.

The parallel between infants and domestic animals is one that has emerged indirectly - but persistently - through talking to Welsh and English mothers. In the same way that Bangladeshi mothers only rarely spoke of their infants as spirits, or vulnerable to the spirit world, Welsh and English mothers only sometimes drew this parallel. One reason for this may have been a certain discomfort at seeing their infants, and indeed themselves, as animals.

As well as seeing similarities in the ways in which infants or domestic animals could intrude in adult space, some women referred directly to the 'animal dimensions' of their roles as mothers, particularly in relation to breastfeeding. For some this was a natural and easy part of motherhood; for others, it symbolised aspects of their bodies and their selves with which they were unfamiliar and perhaps uneasy. One of the most explicit accounts of drawing easy parallels between women breastfeeding, and cows feeding their calves, came from a midwife:

"She was breastfeeding the baby at home, and one of her little nieces came up and asked 'what are you doing?'

Claire said she was trying to make it as simple and as ordinary as possible and the way she explained it was 'you know that cows produce milk for their calves, calves suck the milk from the udders, well this is exactly how [the baby] is taking her milk from me'. The little girl had wanted some breast shields [small pads] to take home with her, so Claire had given her a couple, but apparently her mother immediately wanted to hide them, to put them in a little bag so that nobody would see them." [M38.11]

This parallel was echoed by several mothers, but instead their focus was on the unease or embarrassment they felt at

breast feeding. Two colleagues, not participating in the research, but following its progress closely, commented separately:

"It's not very nice being a cow"

and

"I feel like an udder on legs"

As well as the processes of infant care bringing mothers face-to-face with their own animality, and seeing parallels between the infants and domestic animals, a third dimension in comparing infants and animals emerged. Asking mothers if they could identify how infants became children revealed a movement away from qualities that would be associated with animals but not humans, and were acceptable in infants but not in children.

The first of the two extracts that follow identifies the importance of walking rather than crawling, and the wearing of specific clothes associated with childhood rather than infancy. The second focusses more on the meaning of being able to move independently, to recognise parental disapproval, and if necessary the child's ability to initiate movement away from the mother:

"[My older daughter] didn't walk until she was 15 months you know, I'm sure she wasn't a baby then, she crawled when she was 11 months, so she seemed like a baby then, somewhere between 1 year and 15 months she stopped being a baby I think. I mean I can visualise - we've got photographs of her, we were on holiday in Portugal when she learned to walk... - she actually looked like a child, she was wearing children's clothes as opposed to baby clothes." [54.11]

"Well, when they are running around and they know what they are doing, I mean all children are naughty I think when they, they are running around and they do something you tell them not to. There is a bit of a child now, rather than 'oh, they are a baby ... I mean it is a toddler stage, but once they know exactly what they are doing ... I'd say 12 or 18 months, say about that, giving them a bit of leeway. I mean obviously there is some things they don't understand, but I think by that age they know what naughty is, and [what] 'don't touch' means, and when they do it you think 'oh, that's just children, they do it don't they?' you know, you won't stop them." [55.6]

The emphasis on increasing mobility underlines the importance attached to the appearance, if not the actuality, of independence in infants. I mentioned above the widespread use of babywalkers. In thinking about parallels with animals, walkers give infants both an upright stature as opposed to the 'four-legged' movement of crawling, and an increased range of mobility. A friend whose child was in a walker commented shortly, "It's just like having a dog". She was discovering both the increased reach of the infant:walker combination, and the need to close doors to limit accessible and safe space.

Finally, recognising the liminal status of infancy to which I return in chapter 8, one mother emphasized the temporal elements of infant care:

"they are only babies for such a short space of time, once they go to school really you are never going to have that sort of constant thing at home again"  
[13.24]

Rosaldo (1993) uses the example of contrasts between dogs and children to illustrate different theoretical approaches

to studying culture. This is discussed further in the final chapter of the thesis.

To complete the present section of this chapter I turn to the notion of vulnerability of infants. Whilst Welsh and English parents encouraged independence in their infants, they saw too that they were vulnerable. If Bangladeshi infants were perceived to be open to the threats of a potentially harmful spirit world, it was cot death that seemed to pose the greatest concern for Welsh and English parents. This was principally because of the timing of the fieldwork, which coincided with enormous media publicity surrounding the death of the infant son of a famous television personality. In turn this resulted in both the Foundation for the Study of Infant Deaths and the Department of Health changing their advice about the sleeping position of young infants. I cite the example here because it reveals contrasting perceptions of vulnerability among the Bangladeshi and Welsh or English parents.

"Are you happier with him close to you

"Yes, I think we are much happier, especially I mean the cot death. I'm not paranoid about it, but I like to see him and like to know that he is still breathing, and you've only got to look and you can still see him." [34.9]

The mother quoted below contrasts her experience of caring for her fifth baby, born during a period of great public concern about SIDS, with that of her previous four

children, born in the 1970s. For her, the worry about SIDS was tied in with her own age:

"...because I am a lot older now, and you are aware of things like cot deaths, and all the things that can go wrong, I mean you don't give a lot of thought when you have your first baby at 18 which I did. You don't think about, you are still young yourself you know, but as you get older and you learn more about these things, you definitely feel more protective towards your baby, I mean I am a nervous wreck with this one.

Q "You worry more about this one?"

A "Definitely, yes, it's not him, I've got no reason to worry. It's my age, and I know that it's not only that - my age - you know because when I had the last four, cot deaths, I mean I didn't give it a thought."  
[32.16]

These extracts show not only very different notions of infant vulnerability, but also how the concept of vulnerability has itself been medicalised, in this woman's concern about both her age at motherhood and her fear of SIDS. They mark the midpoint of the theme of medicalisation which runs throughout the thesis, while the following chapter shows one extreme of this theme. Before moving on to the next chapter, which shows how this data was presented to audiences of health professionals, I return briefly to the broader context of the themes that link the various elements within the thesis.

### **Towards Medicalisation and Independence in Infancy**

This chapter places Welsh and English infants and their care around the centre of a continuum which runs at one end from the Bangladeshi women experiencing their first

contacts with medicalised infant care, to health professionals making explicit recommendations concerning infant care which derive from research into Sudden Infant Death Syndrome. It has shown how infant care was primarily the responsibility of the nuclear family, co-ordinated by the mother, and shared by a range of professional and lay carers, on either a commercial or reciprocal basis.

Talking to mothers about their infants revealed the importance of encouraging independence in the infant, in order to allow the parents time and space to themselves. The parenting role was only one of many, and had to be adapted to other priorities associated with work outside the home, or leisure activities. The independence of infants and parents emerged too in the ways in which mothers drew parallels between infants and domestic animals, particularly the way in which each could be seen to be intruding on adult privacy. There emerged too an idea that infants could intrude on the boundaries of the mother's body. If the Bangladeshi infant was constantly close to other people in the household, being held or sleeping in a pile of cushions close to other people, the Welsh or English infant was encouraged to adapt to lone quiet sleep, or to playing independently with a range of specially acquired and designed infant accessories. The symbolic power of infancy is discussed further in the final chapter of the thesis.

The following chapter now turns to look at how the fieldwork presented in earlier chapters was shaped for introduction to health professionals with a specific interest in Sudden Infant Death Syndrome.



## CHAPTER 7

## HEALTH PROFESSIONALS AND INFANT CARE

This chapter is the third in a set of three describing cultural constructions of infancy. The previous two chapters have shown how Bangladeshi, Welsh and English mothers conceptualised their infants. I now move on to show how this data was presented to audiences of health professionals with a specific interest in the Sudden Infant Death Syndrome. This chapter is therefore at the most medicalised, or 'medicalising', pole of the three themes that run throughout the thesis: for the health professionals their knowledge about infancy was expressed in terms of explicit recommendations reflecting epidemiologically-derived risk factors associated with Sudden Infant Death Syndrome.

Using the idea of health professionals as a 'culture', or in Cohen's terms a 'community of meaning' (1985), in this chapter I show how the data on infancy were tailored to fit both the form (the 'slide show') and the perspectives of an audience whose prime interest was in the cause and prevention of Sudden Infant Death Syndrome.

In looking at how I shaped the social anthropological data in order to present it to health professionals, I recognise

what Lock calls "the social and cultural construction of biomedicine" (1988: 7). I presented this fieldwork to audiences which, at various times, included health visitors, midwives, pathologists, physiologists, epidemiologists, and developmental psychologists. Whilst they had different perspectives and emphases, here my interest is in their shared knowledge and beliefs about the causes of infant death and their professional investment in infant wellbeing.

The second half of this chapter examines in more depth the some of the elements of the process of medicalisation which emerged during the preparation and 'construction' of this presentation. These include what I term 'visual reductionism', reflected in the essential place of slides in presentations to audiences of health professionals. Second, I discuss the explanatory power of epidemiology in a context, such as that of Sudden Infant Death Syndrome, where other explanatory frameworks do not produce satisfactory answers. Third, I suggest that the fall in the incidence of Sudden Infant Death Syndrome has resulted in a mutual reinforcement of the power of epidemiology and changing individual risk factors, and a marginalisation of other possible explanations.

The second part of the Chapter draws both on the three articles considered at some length in Chapter 2, and on Wright and Treacher's discussion of "The Problem of Medical

Knowledge". They suggest that "medical knowledge is a child of social forces" (1982: 2), but further that:

"modern medicine ... serves as a set of categories that we use both to filter and construct our experience" (1982: 6).

The evidence presented here shows in particular the introduction of the term "risk", which derives from statistical epidemiological analyses associating particular caring practices with the incidence of SIDS, in connection with infancy. The first step in this discussion, however, is my description of the presentation made to audience of health professionals.

#### **The SIDS Slide Show**

The presentation that I describe here was made to one of the annual scientific meetings of the Foundation for the Study of Infant Deaths. On these occasions epidemiologists, pathologists, physiologists and biochemists, all funded by the Foundation for the Study of Infant deaths, presented their latest research findings to the Foundation's Scientific Committee and to each other. I also gave papers of this kind at the annual conferences of the British and Welsh Paediatric Associations, and various specialist seminars on SIDS and infant care.

The first immediate contrast to presenting papers at social science conferences was the essential place of slides. Two incidents early in the fieldwork made this explicit.

Scene I: An evening post-graduate seminar in the school of social sciences in Cardiff, a group of students and tutors chat after the formal business of the seminar has been completed:

"If you're presenting to doctors, make sure you use slides. They like something to look at. If you are talking about methodology, put up a slide which simply says 'Ethnography'."

Scene II: A postgraduate seminar in the medical school in Cardiff. Early evening, tea and biscuits have been provided with funds from a baby food manufacturer, which has also allowed the meeting to be widely publicised using glossy posters. A paediatrician from another Welsh city is visiting, and we are waiting for a slide projector to arrive:

"I'm sorry I can't start without them. My relationship with my slides is like that between the drunk and the lamppost. I rely on them more for support than illumination".

I heard this familiar joke, or variations on it, many times in the 18-month period during which I was based at the College of Medicine. I attended as many relevant seminars, post-graduate meetings and lectures as possible. It was very rare for speakers not to use either a slide or overhead projector, or even a combination of a laptop computer and an overhead projector. The production of slides within all medical schools is highly organised, through heavily-used specialist departments. Speakers at medical conferences are given clear instructions about letter size, and number of words per slide. At these conferences the detail and complexity of slide production

(both in the individual slides themselves, and in their packaging - from specially produced plastic sheets, books, boxes to slide cabinets) was a matter of pride and institutional, departmental and individual competition.

In the section that follows I use ten of the slides I used most frequently in talking to audiences of health professionals. In this sense the 'SIDS slide show' provides an outline both for the way in which these presentations were structured, but also for this part of the thesis.

This first slide acted as a short introduction, to summarise the research question, and to introduce the idea that quantitative data may reveal paradoxes which could be investigated through qualitative research. I used this slide for both the FSID Annual Scientific Meetings to which I presented. At the second, my paper followed an epidemiological analysis of SIDS by ethnic origin in East London (Hilder: unpublished). This data had shown that

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THE PARADOX

SIDS IS RARER IN ASIAN BABIES  
DESPITE POORER SOCIO-ECONOMIC  
CONDITIONS

---

slide 1

whilst SIDS remained low among Bangladeshi infants, the rate among Pakistani infants was increasing (although the size of the Pakistani population was too small for this to be statistically significant). It also allowed me to suggest that terms like "Asian" and indeed "Caucasian" should be defined more clearly, and that collecting information about ethnicity on both birth and death certificates would be valuable.

In discussing the concept of ethnicity in this context, I had my own agenda, prompted in some ways by an early meeting with the Race Equality Council in Cardiff. Their approach built on the idea that "we are all ethnic", that ethnicity (and, in this context, 'culture') was not simply an attribute of non-white peoples. The Race Equality Council in Cardiff undertook racism awareness training. They described to me how participants in a short course would be asked to imagine that they had three time capsules which would be buried for future generations to find. Each capsule was to be filled with three items to represent a particular culture: in Cardiff the cultures chosen were Asian, Afro-Caribbean and White. The point of the exercise was the ease with which the Asian and Afro-Caribbean capsules would be filled by white participants, but the difficulty these same white participants had in finding objects which represented their own 'white' culture. The exercise aimed to demonstrate the ease with which we characterise 'other' cultures, and

the difficulty with which we recognise our own. It was this approach which led me often to talk about ethnic minorities and the ethnic majority. I hoped in this way to encourage audiences to reflect on their own practice, and to recognise that there was a range of possibilities in how infants and their needs were perceived.

I deliberately chose with medical audiences to use language appropriate to them (and to dress more formally than I would for other meetings) in order not to antagonise those people who felt sociological or anthropological approaches had little to offer. Terms like 'investigation' were used far more in this context than 'exploration', which is the word I would use for a social science audience.

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#### METHODOLOGY

QUALITATIVE/QUANTITATIVE

THEORETICAL BACKGROUND

ETHNOGRAPHIC INTERVIEWING

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Slide 2

Having introduced the contrasting roles of qualitative and quantitative research methods, I used this second slide to recognise the broader methodological question of appropriate research methods. It was also important to locate the method chosen within a particular academic discipline, and for this reason at this point I addressed

both the theoretical background drawn from physical anthropology, and the specific method of ethnographic interviewing drawn from social anthropology.

The first step in discussing this slide was to establish the value of both qualitative and quantitative research, and to recognise their complementary roles at different stages of a research process (at this stage I cited Janes and Stall [1986] on "Anthropology and Epidemiology"). In commenting on the first slide I had already shown that epidemiological analyses could produce apparent paradoxes. Here I suggested that by adopting an open-ended qualitative approach it would be possible both to offer explanations for the paradox of the low incidence of SIDS in Asian families in Britain, and to identify new categories for inclusion in future epidemiological analyses.

The second step was to provide a theoretical background for the research, which would relate to the health professionals' interest in infant physiology. In this context, placing infant care in an evolutionary context made sense. Ethnic minority populations in Britain were being cited as providing examples of 'natural' infant care, little influenced by western practices. This was part of a more general practice within the wider medical press, using populations in non-industrialised cultures as examples of 'natural' behaviour (for instance crying patterns among !Kung San infants in the Kalahari desert:



Barr et al 1991). A paper on the contrasting incidence of SIDS in ethnic minority groups in the UK, published during the fieldwork period, suggested:

"...cultural factors may be protective. One of the striking features of the Asian community in Birmingham is the strength and endurance of the extended family." (Kyle et al 1990: 833)

This quotation implies that 'Asian' populations in Britain may represent an idealistic notion of the 'natural' family, the family as it used to be in Britain, and continues to be in other cultures, the epitome of the desirable way to care for infants. I met a belief among some members of audiences of health professionals, sometimes implicit and sometimes explicit, that in some ways western parenting practices had "come too far", become "over-civilised", and that ethnic minority populations provided a way of looking at how things had been in an idealised past. These were not views I shared, but they were the basis for a shared interest and understanding, and I attempted to use them as such.

The original research application (at Appendix II) submitted to the Foundation for the Study of Infant Deaths had cited the work of the physical anthropologist, James McKenna (1986). He adopts an evolutionary approach to SIDS, focussing his interest on two features of SIDS: it is species specific, and the majority of deaths occur within a relatively narrow time band. His argument has developed from his observation that sudden infant death does not occur in other primate infants. He suggests that

Unlike other primate infants, human infants are unique in developing first intentional crying and later language. For this reason the immature respiratory systems of infants are put under pressure in a way that those of other primates are not. In his thesis, it is quite ordinary for infants to pause in their breathing (an 'apnoea' in the language of health professionals), as respiration shifts from what he terms 'involuntary' to 'voluntary' control. It is at this time of respiratory vulnerability that infants "expect" - or are adapted to - the sensory environment provided by being close to other people, as human infants have been through millions of years of human evolution. In his presentations, McKenna uses a wide range of slides showing examples of infants being carried - in a variety of different historical and cultural settings, and with or without carriers or binding cloths - close to adults or older children.

From this base, McKenna has turned to exploring the physiological mechanisms of arousal: these include touch, hearing, smell, and control of the thermal and chemical microenvironment, all of which, in his analysis, may contribute to the regulation of infant breathing when infant and adult are in close proximity. Through looking at the sleep patterns of mother:infant pairs sleeping both separately and together, McKenna has shown that infants sleeping close to an adult experience more arousals, sleep for shorter periods of time, and experience fewer periods

of deep sleep. In his view, all of these contribute to protecting infants from Sudden Infant Death Syndrome. Further, research into for instance infant sleep patterns, which places infants to sleep on their own, reflects a very limited historical and geographical range of infant caring practices.

In order to make explicit the contrasts between physical and social anthropology, I described how my approach differed from that of McKenna, and that it drew on the methods of social anthropology to look at the belief systems or 'cultural ideologies' of different groups. For the purposes of presenting to audiences of health professionals, these different groups were the Bangladeshi and Welsh or English households; it is only for the purpose of writing these data up for a PhD thesis I refer to a third group reflecting the 'culture of biomedicine'.

In discussing the methods adopted, I described ethnographic interviewing as an informal and unstructured 'guided conversation' (quoting Lofland 1971), which uses a check list of areas which the interviewer wishes to cover and is undertaken against a background of research about, consultation with and observation of the various groups concerned. I outlined my use of a broad question to initiate the interview, in this case requesting a description of "a day in the life" of each infant. I hoped to encourage the audience to reflect on their own

priorities, and areas of interest and concern, if they had been asked that question. I discussed my use of periods of observation, as an English for Pregnancy tutor, in mother and baby clinics, and during interviews themselves, and my recording these as detailed fieldnotes for later analysis. Similarly, I described working with an interpreter, tape-recording and transcribing interviews, the idea of 'grounded theory' developed by Glaser and Strauss, of hypotheses developing from data, rather than data being collected in order to test specific hypotheses.

My experience of presenting this work was that one questioner would always ask for quantitative data. At this point in a presentation I therefore tended to repeat my emphasis on the complementary contributions of qualitative and quantitative data, to present a small amount of quantitative data "as context" for the qualitative data, and to emphasize that the people interviewed were not a "representative sample" of the population, but were recruited to reflect as wide a range of beliefs and practices as possible. The quantitative data I presented comprised numbers of interviews (60), spread over working-class (20 Welsh or English and 20 Bangladeshi) and middle-class (a total of 20 made up of Welsh, English and Bangladeshi); total population of Cardiff (277,182) and Bangladeshi population (0.6% or 1,663 according to 1991 census figures); total number of births per year in South Glamorgan (c6,000 in Cardiff), and

average number of Bangladeshi births (c35); number of SIDS deaths (9 pa) and in the last 9 years (the period for which local data was available) 93 deaths. I also described how local statistics revealed a strong link between SIDS, low social class and poor housing conditions, in an area with an aging population rather than one with a high proportion of young families. It was clear that any epidemiologist would immediately say that these figures were too small to be statistically meaningful, but it was also clear that they needed to have them, to be assured that the data had been collected.

This second slide provided broad background, setting the specific method used in the context of broader methodological debates about qualitative and quantitative approaches, but offering too a relatively full explanation of an unfamiliar approach. This 'educational' function continued in the next slide, which used the term 'emerging differences' to introduce the initial results.

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EMERGING DIFFERENCES

HOUSEHOLD STRUCTURES

SLEEPING PRACTICES

BELIEFS ABOUT INFANTS

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Slide 3

Referring to 'emerging differences' reinforced the idea

that results emerged from the data, rather than being shaped by a research design which tested particular variables against specific outcomes. This slide also provided a 'signpost' for the outline of the remainder of the presentation. This was in fact an early slide, and I presented it as such, explaining that early themes had been refined, and new ones identified, as the research progressed.

The idea of results emerging from - or being grounded in - data was clearly unfamiliar to most audiences. As one physiologist put it to me at breakfast, the day after I had given my presentation, "once you've found out something new, we can do some proper research". I challenged the idea that qualitative research was not 'proper', but agreed with her general conclusion that qualitative research could generate new categories of analysis for quantitative work. The idea of qualitative research as somehow not as rigorous as quantitative also emerged in comments that such research was 'anecdotal', rather than relying on systematic observation and analysis. The category of 'anecdotal' was used to describe observations which were widespread, interesting, but on which neither consistent qualitative research nor large scale epidemiological data was available. The rarity of SIDS in Asia - and here I use Asia to include the Indian sub-continent and the Middle and Far East - was sometimes described in this way.

A nice example of qualitative research generating new categories of analysis for quantitative work emerged at the conference when one researcher commented to me that they had assembled a large number of diaries of infant sleeping place and position, as part of a project recording temperature over 24-hour periods. These data could allow them to look at periods of high and low sensory input (this is a term referred to in a later slide). He felt that as parents had been told, and could see, that the principal interest had been the temperature in which the infant was sleeping, the record of the place and position of infant sleep would be little affected by parental views being influenced by their perception of researcher approval or disapproval.

Having discussed the background, I then turned to some of the initial 'results':

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**HOUSEHOLDS**

<u>BANGLADESHI</u>	<u>WELSH/ENGLISH</u>
3 Generations	2 generations
c12 people	2-3 people
house	house/flat
babies "common"	babies "rare"

---

**Slide 4**

This slide was introduced as the first of three which would

set the context for a description of infant care practices. They were all laid out as oppositions, partly to make the contrasts explicit, and partly to present a large amount of information in a small space.

The oppositions were important in recognising how the data were adapted for presentation to health professionals. The emphasis was on contrast between two groups, reflecting first the idea that it was possible to identify groups that were either Bangladeshi or Welsh/English (but with Welsh infants), and that such definitions were simple. Chapter 4 has discussed the issue of ethnicity at some length, but in the context of presenting to health professionals it was regarded as simply one 'variable'. Second, the use of two groups implicitly (or - for some of those attending the conference - explicitly) accepted the idea of one group being the 'control' group. For me, such terminology was inappropriate: both groups were equally new and strange to me. In fact quite which group could be viewed as the 'control' was not clear. Each was in some way being regarded as a 'control': the Welsh/English being the group which was familiar, whose infant care practices would follow particular familiar and predictable patterns; on the other hand, the Bangladeshi group, as an ethnic minority group, was regarded as having had their infant care practices little influenced by western advice, and in this way offered a 'control' or example of 'non-intervention' by health professionals.



I used slides as a way of focusing attention, accompanied each time by a warning that they were summaries and that whilst they were abbreviated to opposites they should be thought of more as continuum. This proviso was always worth making to maintain my own integrity (and to satisfy any other social scientists in the audience), and often useful to refer to in dealing with questions.

In talking about this slide I did not simply recapitulate its contents. Some speakers did this, which was both boring for the audience and a poor use of speaker time. I elected to talk more fully, adopting a deliberately anthropological language in describing how Bangladeshi households in Britain adapted a pattern of extended family living, based on male lineages, to the accommodation available in Cardiff. At this point I used a slide of a typical small terraced house, describing how up to 12 people may live in a Bangladeshi household, while the same accommodation may be adapted to two or three Welsh nuclear units. I explained the custom of arranged marriages, with women always moving into their husbands' households, and the prestige associated with parenthood for both women and men. In this way a picture of big households in which parents themselves had many siblings and cousins, and in which young infants were common, was allowed to emerge as a direct contrast to the smaller nuclear family units into which Welsh and English infants are born, and with which health professionals would be familiar. I also suggested

that in such families the practices of caring for infants were handed on from the other women in the household, mother-in-law or sister-in-law, so that the low maternal educational status often associated with poor infant mortality may not be a useful indicator for Bangladeshi mothers.

In this context too I mentioned that many women would not have an accurate record of their own birth dates, as this was not seen as important information, and that many would be recorded in their hospital notes under the "wrong" name. The usual form of address would be, for instance, Fateha (first name) Begum (title accorded to a married woman), which led to many references to "Mrs Begum" and even "Baby Begum". All these inaccuracies may pose questions concerning the validity of official statistics.

The second of the three slides providing the background against which infant care could be understood related to the contrasting perceptions of time within households. Rather than an abstract discussion of time, however, I focussed on the contrasting timetables which operated within the households:

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**TIMETABLES**

<u>BANGLADESHI</u>	<u>WELSH/ENGLISH</u>
Restaurant work (men)	9-5 or shift work (women and men)
Infant care in extended family	Infant care in/ beyond nuclear family
"spare time" with infant	"spare time" away from infant

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**Slide 5**

Restaurant work was an easy starting point, as I quickly became aware that it was when eating in so-called 'Indian' restaurants that many of my medical colleagues had their only contact with Bangladeshi people (they may or may not have made the distinctions between Bangladeshi, Pakistani and Indian). One of the Sylheti linkworkers, for example, estimated that 90% of Bangladeshi men in Cardiff worked in restaurants.

Having established with the audience that the day had a very different pattern, with men being out of the house from late afternoon to the early hours of the morning, I could then go on to make the point that infants in Bangladeshi households were cared for within an extended family whilst Welsh and English infants were more likely to have parents who worked outside the home, and therefore more likely to receive care from other carers and in other places. This in turn allowed me to describe how the

return of Bangladeshi men to the house in the early hours of the morning sometimes coincided with a young infant's feeding time, and it was quite ordinary for the household to stir at this time. Welsh and English households in contrast expected longer periods of uninterrupted sleep, and introduced bedtimes for children, a practice which was unfamiliar to the Bangladeshi households.

The overall picture I was trying to create here was one in which the structural constraints of time were more varied in Welsh and English households than in Bangladeshi ones. This resulted in different ways of defining time, of identifying "spare time" away from the infant for either work or leisure, while for Bangladeshi mothers time itself - either as an organising axis for the day, or as a way of characterising different activities - was simply not very important.

I used this contrast between relative and chronological time to comment too on the status of older people in Bangladeshi households. Most of the Bangladeshi women I interviewed did not know their own ages or those of their siblings: they did know the approximate difference in age between them, and it was relative age which was accorded status. Elders were valued members of households, both because of their age status and because of their knowledge and experience (although in the few households with British-educated women living with parents who had little

English the power axes were clearly in flux). These were points I made very briefly: their importance was more to set the context for later contrasts between independence and interdependence of generations, and to recognise that some members of an audience of health professionals may have encountered ethnic minority families with older people in positions of relative power in the household. Karseras (1987) for instance comments on the importance of recognising the influence of "mother-in-law" on infant care.

The third of the background slides on household organisation related to use of space. In presenting data of this kind to social science audiences I would have used a term such as "cultural constructions of space", but in the context of a presentation on SIDS I chose to focus on the familiar notion of privacy, without pausing to make explicit some of our own cultural norms associated with such a concept.

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**SPACE**

BANGLADESHI

Shared

Bedrooms shared  
parents+infants

WELSH/ENGLISH

Private

Own bedrooms

For audiences of health professionals I related ideas about privacy to the use of space within a house. In this way I hoped to make the point that it was not simply lack of availability of space that led Bangladeshi parents to share rooms with their children, but a belief system which held central the absolute unacceptability of infants being left on their own, and indeed the rarity of anyone sleeping or wishing to spend time on their own.

In early presentations, questioners had asked about sleeping patterns in middle-class Bangladeshi families, assuming that smaller families in larger houses might change their practices. For this reason I made explicit that, in both middle-class and working-class British-educated Bangladeshi families, although there was a recognition that encouraging infants to sleep on their own was "more modern, more western", they nevertheless saw this as at best extraordinary and unacceptable, and at worst cruel. I presented this as an exception to the more general Bangladeshi view of things "more modern, more western", as "better, more hygienic". This latter argument was widely used to describe childbirth and infant care in Britain, and was frequently cited in favour of bottle feeding.

To illustrate very different notions of privacy, I described how rare it was for me to interview a Bangladeshi mother on her own. It was quite unexceptional for a

mother-in-law, sisters-in-law, husband or brothers-in-law, or even neighbours, to be around, and to comment and contribute to our conversation. With Welsh mothers, the vast majority of interviews were with the mother and the infant. In this sense I characterised childrearing as more public in Bangladeshi households than in the extreme privacy of Welsh and English nuclear families. One question I was often asked - by doctors, social workers or psychologists with a specific interest - was about sexual abuse. This was based not on an assumption that abuse was more or less likely in specific households, but on general concern among health professionals at that time. Whilst I had no data directly relevant to this, I generally commented on the public:private contrast, on the numbers of people involved in a Bangladeshi infant's world, and on the rarity of anyone in the extended Bangladeshi household being on their own.

I concluded this section by talking briefly about the importance that some Welsh and English interviewees attributed to privacy for sexual activity. This built on the early discussion of differing values attached to privacy and use of space, and on questions often asked (usually in informal conference breaks rather than in the formal question time immediately after a presentation) by health professional colleagues about "how Bangladeshis procreate?". The question was not so much "how?" as "where?", and I generally explained that whilst this was a

difficult and sensitive area to research, evidence from Blanchard (personal communication) suggests that in Bangladesh couples simply have intercourse during the night whilst other people in the household, sleeping in the same space, would be expected to be asleep. I contrasted an attitude to sex for 're-creation', with a more explicit view among some Welsh and English mothers as sex for recreation, as an activity worthy of time and attention and, in most cases, privacy.

I spoke about sex partly because I knew it would attract interest (which it always did - much as in teaching medical students), and it played on a theme I heard several times that "anthropologists always talk about sex" (possibly associated with a view of anthropology emanating from Malinowski and Mead). Second, I recognised the apparent reticence of the Foundation for the Study of Infant Deaths in talking about the potential protective factors that could be associated with infants sleeping in the same room as their parents. During informal conversations over coffee and lunch various meeting participants described informally the "English public school attitudes" which made it appropriate to issue guidance about infant sleeping position or maternal smoking, but inappropriate to recommend that infants should sleep in the same room as their parents - which could be seen as an infringement of parental privacy, and no part of the Foundation's role. Interestingly, by the end of the research period, when our



paper about this research was published in the British Medical Journal (Gantley et al 1993), the Foundation was commenting that it may be better for infants to sleep in the same room as their parents for the first six months of life (FSID 1993). This is not, however, a recommendation that they make in their leaflet on reducing the risks of cot death. It raises of course the question of the potential advantages or disadvantages of parents and infants sharing either beds or rooms, which lies outside the scope of this thesis.

Having completed discussion of the three background slides encapsulated under the headings of 'households,' 'timetables' and 'space', I then shifted the focus to contrasting perceptions of infants. The title of slide 7 (overpage) "Beliefs about infants" was intended to recognise that all infants needed protection, but that they were perceived as vulnerable in different ways, and therefore protection would be achieved through different means.

Specifically, Bangladeshi infants were thought to be at risk from evil spirits, whilst Welsh and English were thought to be more at risk from infection. The use of amulets tended to be interpreted by non-anthropologists as "exotic", the stuff of anthropology, but that at least had the advantage of attracting interest and attention. This then allowed the more medical perspective of some health

professionals to conclude that Bangladeshi infants in Britain were receiving the protection of immunisation, as well as that of the constant care of the extended family.

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**BELIEFS ABOUT INFANTS**

<u>BANGLADESHI</u>	<u>WELSH/ENGLISH</u>
Vulnerable to spirits protection by amulets/company	Vulnerable to germs protection by immunisation
Generations interdependent	Independence

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**Slide 7**

For the Welsh and English infants protection was achieved through immunisation, and specific attention to domestic hygiene. In writing this description, I realise that one element I did not include in my discussion of the ways in which Welsh and English infants were protected was that of baptism. A minority of babies had been baptised, although its importance varied from family to family. This too may be regarded as seeking the protection of a particular church, and a parallel to seeking protection against evil spirits.

This slide also allowed me to build on the idea of encouraging infant independence, describing how Welsh and English infants would often be placed on the floor to play, in a specially-created environment which I characterised as a "babyworld". Bangladeshi infants were more likely to be on somebody's lap, or asleep either next to or in the same

room as other people. This also provided me with the opportunity to comment that, in evolutionary terms such as those argued by McKenna (1990a,b), humans "carry" rather than "cache" infants. In using this sort of terminology I recognise that I was feeding into positivistic linear models of evolution, in which ethnic minority populations may be cited as adopting 'natural' infant care practices. I justified this on the grounds of creating a coherent argument for a particular audience in a particular context.

Contrasting the notions of independence and interdependence allowed me to refer again to the value of older people in a Bangladeshi household, and their contribution to infant care in both practical terms, and as a source of expertise. I suggested that in Welsh and English households there was more emphasis on maintaining the independence of each member of a household, and for this reason grandparents' involvement in infant care was on an occasional, pre-arranged basis.

This discussion of beliefs about infants laid the foundation for me to talk about sleeping practices generally, and infant sleeping in particular. Slide 8 consolidated a number of themes introduced earlier, the differing views of privacy and use of space which resulted in infants and young children sleeping with parents in Bangladeshi households, whilst those in Welsh households were encouraged to sleep on their own, and to allow their

parents to do so too. I emphasized that the social:private distinction could also be drawn during the day, with Bangladeshi infants often being asleep on sofas or in chairs immediately next to, often touching, mother or grandmother or older sibling; Welsh infants in contrast were more likely to be placed to sleep during the day in a separate, quieter room partly because this was thought to be conducive to sleep, and partly because it allowed private space and time to parents.

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**SLEEPING PRACTICES**

<u>BANGLADESHI</u>	<u>WELSH/ENGLISH</u>
Social	Private
Night sleep interrupted	Sleep through night encouraged
Backs/sides	Front->backs/sides

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**Slide 8**

It was often assumed by questioners that middle-class families would be more likely to put infants in their own rooms, and for this reason I made explicit first that there were a small number of middle-class Bangladeshi homes, and second that the belief that infants should remain in the same room as their parents was stronger than any "modern" advice that they should sleep separately. My interest in making clear that there were middle-class Bangladeshi homes arose from a comment made by a referee on the original project proposal submitted to the Foundation, which seemed

to me to suggest that all middle-class mothers in Cardiff would be white.

Amongst Welsh and English middle-class families, I described two very different attitudes, identified for me early in the research by a consultant neonatologist as "earth-mother or high-tech". The former wanted to know everything about Asian mothers, had "natural birth" plans ("which, incidentally," she commented "they never follow"), slept with their babies, and breastfed. The latter had high-intervention births, bottlefed, and put their babies into their own rooms immediately. While this was an early and brief stereotype, it was very much borne out during fieldwork. For working-class Welsh or English mothers it was more likely that the infant would not have its own room, simply because of space limitations, but there was nonetheless a desire to establish sleeping in a quieter part of the flat or house during the day, and to accustom the infant to being alone, to sleeping alone and to developing a routine which would allow care to be provided outside the home.

An earlier slide had drawn contrasts between different working patterns, and this slide made the implications explicit in terms of sleeping practices: for Bangladeshi infants their night-time sleep was often interrupted, while in Welsh and English households the emphasis was more likely to be on encouraging infants to 'sleep through the

night'. Health professionals commenting on this tended to draw on their own experience, prefacing their remarks with 'as a parent' or 'when my children were young'; in so doing they were drawing on the social demands on them as both parents and workers, rather than the influence of some health professionals in encouraging specific infant sleeping periods. In this way they were placing themselves at a cultural boundary, looking to both their own embodied experience as parents and the apparently objective knowledge of epidemiology. This is an idea to which I return in the final chapter of the thesis.

Finally, I used this section to discuss sleeping position. This was partly to preempt inevitable questions about sleeping position (a topic of great interest at the time), and partly to make the point that during the research period advice about sleeping position had changed. My description showed how Bangladeshi babies had always been placed to sleep on their backs. I learned the term "culturally-valued" from health worker colleagues who used it to describe practices - usually among ethnic minority populations - that were unfamiliar to them. In this instance I identified the "culturally-valued rounded head" of Bangladeshi infants. This was achieved by back sleeping, and occasionally side sleeping, placing the infant on a soft white cloth, often an old sari or towel. In contrast, at the beginning of the research period Welsh infants been placed on their fronts or sides; advice had

changed however to either side or back sleeping (through leaflets produced by the Foundation for the Study of Infant Deaths: see appendix X). This comment was, in turn, a 'signpost' for the final slide which presented some of the issues which arose following this change in advice.

To complete the presentation on infants and their needs, I used one slide to summarise the data presented previously, introduced an infant perspective, and coined a new term "infant sensory environment".

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**INFANT SENSORY ENVIRONMENT**

<u>BANGLADESHI</u>	<u>WELSH/ENGLISH</u>
Larger households	Smaller households
Social (day/night)	Quiet periods
Tactile	Lone/play sleep
Smoke-free	Smoking more common
Cool	Warm

---

**Slide 9**

The term "Infant sensory environment" was designed to refer the audience back to the theoretical background for the research, and McKenna's hypothesis that arousal via a series of physiological interactions may contribute to the regulation of both parental and infant breathing. Adopting an infant perspective allowed a contrast to be drawn between the consistent stimulation of a Bangladeshi environment, and the alternating high- and low-potential

arousal environments of Welsh infants. I suggested that the epidemiological evidence which indicates that SIDS infants are most frequently found after long periods of lone sleep (cited in Golding 1985) would be consistent with the hypothesis that arousal levels may contribute to the regulation of infant breathing.

In discussing sleeping practices, I mentioned that I presented data on sleeping position partly in order to preempt questions. For this reason this slide also included information on smoking and on room temperature, although in very general terms. Both these 'variables' were included in the new epidemiological evidence of risk factors for Sudden Infant Death Syndrome. If asked further about smoking, I added that there were clear class distinctions in smoking behaviours along the lines indicated by Graham (1987), but at the same time among the working-class mothers who took part in this research there was an attempt not to smoke near their babies. This slide also mentioned the tactile environment of the Bangladeshi infants, and here I explained how grandmothers would regularly massage babies with oil.

Finally, as indicated in discussing sleeping practices, I concluded by reflecting how the women I had interviewed were responding to the fact that advice concerning SIDS had changed, and that it was being passed on through a wide range of channels. There was also an implicit suggestion



that this was an area which merited further research: our application for funding to explore some of the issues associated with changing health advice, however, was not successful.

In raising a discussion of changing health advice, my intention was to encourage a recognition of the fact that the transition from 'knowledge', in this case new epidemiological data concerning links between infant care practices and SIDS, to changes in practices, was by no means simple, for either those caring for infants or for their professional advisors. In order to initiate such a discussion, however, I drew attention to the broader social context of SIDS at the time.

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#### CHANGING HEALTH ADVICE

Effect of media coverage of SIDS

Fear

Scepticism

"They're always changing their minds"

"My other babies slept on their fronts and they're fine"

"The doctor in the hospital put the baby on its front"

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#### Slide 10

In the early stages of the fieldwork it had been possible to complete interviews without the subject of SIDS being raised. As the climate of concern changed, this became increasingly rare. Interest increased noticeably when the

death of the infant son of a 'daytime' television presenter, Anne Diamond, was attributed to Sudden Infant Death Syndrome. She subsequently launched a national appeal, and made a television documentary, critical of both the British Department of Health (DoH) and the Foundation for the Study of Infant Deaths (FSID) for being slow to recognise the implications of research in both New Zealand (Mitchell et al 1992) and Avon (Fleming et al 1990) about the association of specific infant care practices with SIDS.

The effect of this massive increase in publicity was a great deal of concern, sometimes even fear, with mothers talking about constant checking of infants, listening to their breathing and so on. At the same time there was a scepticism of risk reduction advice, sometimes accompanied by a fatalism which assumed 'if it's going to happen it's going to happen, and there's nothing we can do about it'.

In opening this chapter I commented on how the new advice about SIDS was presented in terms of risk. Here women were responding to the concept of risk with either a sense of fatalism, or contrasting it with their own earlier experience: "my other babies slept on their fronts and they're fine". As Davison (1991) observes in discussing lay explanations of coronary heart disease,

"In the absence of an adequate aetiological hypothesis (the mechanism of misfortune is not understood), the answer to the more personal explanatory question (why this person and not that one?) is found in another rich field of British cultural life, that of chance."(1991:14)

I return in the second half of the chapter to discuss the importance of the search for explanation, in particular the importance of epidemiology where postmortem fails to reveal a cause, as with SIDS.

To return to my discussion of changing advice, however, once both FSID and DoH had issued new guidelines for both public and health professionals, the problems involved in health professionals' changing practice became clearer. To illustrate the problems one health professional had in responding to new guidelines, and to show how mothers received a range of different advice from a number of sources, I drew on the following illustration. I had been invited to attend a meeting at the College of Medicine at which senior community and hospital health professionals were discussing how best to implement the newly-issued Department of Health guidelines on SIDS prevention. These included backsleeping in cool temperatures and in smoke-free environments, and reporting any minor symptoms to general practitioners (Department of Health 1993). During the discussion of sleeping position, I was able to feed back that mothers contributing to our research had already commented that "the doctors in the hospital are still putting babies on their fronts". One consultant

neonatologist looked at me thoughtfully, and said "You're right Madeleine, it's natural for me to put babies down on their fronts". As he spoke he moved his hands, as if picking up an infant, and then replacing it in a cot, on its front.

For health professionals with both professional and personal experience of infant care, changing advice often posed conflicts. One of the ways in which both health professionals, and indeed social scientists, resolved these conflicts was by prefixing their remarks with "as a parent"; this seemed to offer an element of authentication, demonstrating their own personal experience and expertise, as well as their professional knowledge. Some Health Visitors had adopted an approach based on "We learn something new every day". Health Visitors in particular, in regular contact with mothers through clinics, faced the question of the actual advice they should be giving. For a short period, the new evidence was being reported in the media, but DoH advice to Health Visitors remained that infants should sleep on their fronts. It was only when a new DoH circular was published (issued as "professional letters" to doctors and nursing officers under a heading of "Professional Advice from the Chief Medical Officers and Chief Nursing Officers of United Kingdom Health Departments"; reprinted in Department of Health 1993) recommending back or side sleeping that Health Visitors had guidance legitimated by the Department of

Health. For many, however, as I have indicated above, the new guidelines were uncomfortable: as one Health Visitor commented to me, "I don't like to see babies on their backs."

My own particular interest here was in the fact that advice had changed, and that mothers were saying to me "they're always changing their minds", or "My other babies slept on their fronts and they're fine". It seemed to me that the implication here was that many of the SIDS deaths in recent years (since the advice to sleep babies on their fronts was issued deriving apparently from premature babies around 20 years ago) were not simply preventable, but the result of incorrect advice having been issued. I wondered whether such advice would prompt people to say "you were wrong before", and whether this in turn would reduce the impact of other health education campaigns. Interestingly, I found most people grateful for the new 'knowledge', which was seen as progress particularly as SIDS deaths started to drop dramatically in 1991 and 1992. The idea of progress in medical knowledge is one to which I return later in this chapter.

As I commented in introducing this final slide, part of my intention in drawing attention to the question of changing health advice was to suggest that this was an area worthy of further research. That it was not funded suggests a very different perception of the question of changing

health advice: for those people assessing the research proposal the issue was simply one of transmitting knowledge, whilst for me the interesting dimension was in how such messages were perceived and understood by those caring for infants.

This contrast between the apparently simple messages of epidemiology, and the ways in which medical knowledge is culturally constructed, forms the bridge to the next part of the present chapter which discusses some of the elements in the process of 'constructing' the slides that were presented to conferences of health professionals. In discussing this process, however, I am doing more than showing how the data were tailored to a particular format. In the following section I attempt to draw out some of the ways in which the data was shaped to the "culture of biomedicine", and in particular the construction of medical knowledge which lies at the heart of that culture.

#### **The Cultural Construction of the Slide Show**

Wright suggests that a constructionist approach starts from

"the recognition that all knowledge - medicine and science not excepted - is the product of human social activity and is used by human beings to bring into existence their own lives and experience" (1988: 300).

Earlier in the thesis I described the distinction I have drawn between cultural and social construction. This echoes Wright's point that all human knowledge is necessarily social, and concentrates on the cultural

dimensions of contrasts in beliefs. At this point, however, the question is not the distinction between social and cultural constructions. My emphasis is on the process of construction - be it social or cultural - of medical knowledge in relation to AIDS.

In looking at this process, I draw on the questions posed by Wright and Treacher (1982) in their discussion of "The Problem of Medical Knowledge". They suggest that there are four traditional assumptions made about medical knowledge: that it is based on science; that it is effective; that diseases are natural objects simply waiting to be identified; and that social forces are assumed to be distinct from medicine. They then identify three criticisms of these assumptions, and suggest that they be questioned in particular ways. Their criticisms suggest first that the power of the processes of professionalisation should be recognised: that is to say that one of the ways in which apparently objective, technical knowledge acquires status is through the power of its practitioners. Second, they suggest that medical knowledge itself should be conceptualised as a symbolic system. Third, they point to the approach adopted by Armstrong - a Foucault-based analysis of modern medicine - as a language which "creates its own objects of analysis" (1982:7).

Wright and Treacher suggest that a constructionist approach should address three questions: how certain areas of human

life come to be seen as medical, how the medical:non-medical boundary is maintained, and why this sort of knowledge is so prestigious. The issues raised by these questions underpin the remainder of this chapter.

Initially, however, I focus on three specific aspects of "medicalisation".

In presenting the ethnographic data to an audience of health professionals, three aspects emerged particularly clearly. I describe these as visual reductionism, explanatory power, and the mutual reinforcement of epidemiology and behavioural change. By visual reductionism, I refer to the processes of the production of slides which reflect the reduction of the qualitative ethnographic data described earlier into apparently simple oppositions. In discussing the power of explanations, I suggest that the strength of epidemiological knowledge lay in its ability to allow health professionals to offer an explanation for the previously unexplainable phenomenon of Sudden Infant Death Syndrome. Finally, I use the term 'mutual reinforcement' to show how the cycle of the use of epidemiological data to generate behavioural change - which in turn apparently led to a reduction in the incidence of SIDS - resulted in the reinforcement of an epidemiological approach. This is perhaps more powerful in the short lifespan of infants than in the longer timescale involved in the epidemiological analysis of diseases appearing in older people.



Perhaps the most obvious initial difference in presenting these data to audiences of health professionals lay in the orientation towards Sudden Infant Death Syndrome. They were not simply about perceptions of infancy, but were explicitly linked to a problem, that of SIDS, and the possible contribution of infant care practices.

The presentation had to take account of the conceptual systems of the audiences of academic researchers and health professionals. Reducing the data to slides suitable for the social processes of the academic and practitioner conference, involved making it visible, presenting it as oppositions of apparently single variables.

The principal function of slides seemed to be in authenticating both presenters and data. Slides effectively reduced the data to a series of apparently visible and measurable factors. Rhodes (1990), in discussing social and medical imagery, cites Rapp's (1988) work on genetic counselling to suggest that the:

"visual aids used by counselors, such as charts and graphs, have an effect in 'shaping the perceptions of the client'".[Rhodes 1990: 162]

In the particular case of health professionals, this aspect of visibility - be it of parts of the body or of statistics - seemed particularly important. The dual elements of oral and visual presentation were always present. This echoes what Foucault refers to as "seeing and knowing":

"The clinical gaze has the paradoxical ability to hear a language as soon as it perceives a spectacle" (1973:108).

As well as their role in authenticating both speaker and data, slides necessitated presenting the data in a series of small chunks, summarising the contrasts between the two populations. This led to my dividing the data into headings of 'Bangladeshi' and 'Welsh/English'. In Chapter 4 I discussed how these terms encompassed a wide range of experience: rural and urban Bangladeshi women, working and middle-class Welsh women from both coal-mining valleys and from the city of Cardiff, English women whose careers had led them to Cardiff, and British-educated Bangladeshi women who were either finding themselves "between two cultures", or creating a new identity for themselves of "British Asian". Whilst I recognised that the categories described by these headings of 'Bangladeshi' and 'Welsh/English' were not homogeneous, I nonetheless used them. In doing so, and in drawing contrasts between the two categories, I recognise that I reinforced their apparent validity. It was not simply that they were categories that reflected a continuum rather than a separation, but that the simple reference to and apparent finding of variations acted - as Armstrong argues - to reinforce that validity of the categories themselves.

Within this visual framework, the content of the slides focussed on the search for explanation, a topic of interest from the perspectives of both the construction of medical knowledge, and of anthropology. In the instance of medical knowledge about SIDS, the possible explanatory frameworks were offered by pathological, physiological and

epidemiological analysis. Neither pathological nor physiological explanations was conclusive; however, a combination of epidemiological analyses and behavioural change programmes served to reify the explanatory power of epidemiology.

One of the prime methods of establishing a cause of death is the post-mortem. In the instance of SIDS, however, post-mortem was described as a 'diagnosis of exclusion' rather than a cause of death. The definition cited by the UK Department of Health Chief Medical Officer's Expert Group on The Sleeping Position of Infants emphasizes this lack of explanation:

"the sudden death of an infant or young child, which is unexpected by history, and in which a thorough post-mortem examination fails to demonstrate an adequate cause of death." [DoH 1993]

A slightly different explanation was offered by a paediatric pathologist speaking at the FSID's Annual Conference in 1992. He described SIDS as a "mode of death" (Prof J Berry, unpublished conference address) rather than a cause. Both definitions, however, emphasize the lack of illumination offered by post-mortem; this in turn reinforced the potential of epidemiological analyses to generate both possible explanations and possible ways of developing health education messages which could reduce the number of infants dying from sudden infant death syndrome.

Two major epidemiological studies of SIDS were published during the research period, and identified slightly

different "risk factors" which subsequently became the basis of national health education campaigns. In Avon, Fleming et al (1990) concluded that placing infants on their fronts, and overwrapping them, constitute risk factors for SIDS. These conclusions formed the basis for recommendations that infants should be placed to sleep on their backs, and should not be overwrapped; in addition, they advised that infants should be in a smoke-free environment,, and that minor symptoms should be referred to a General Practitioner. These guidelines formed the basis of "Reduce the Risk" campaigns run in the United Kingdom by the Foundation for the Study of Infant Deaths, and the Department of Health [the focus of these campaigns was the leaflet at Appendix X]. In New Zealand, Mitchell et al (1992) also concluded that infants should be placed to sleep on their backs, and should be in smoke-free environments; in contrast to the UK, however,, they also recommended that infants should be breastfed, and should not share the same bed as their parents.

This reference to bedsharing returns us to the work of James McKenna, referred to earlier in the chapter. His approach, informed by physical anthropology, reflected the interest of physiologists in infant arousal levels during periods of sleep. However, his argument that bedsharing may protect some infants against SIDS appeared in direct contradiction to Mitchell's early conclusion that bedsharing was an independent risk factor [a later analysis (Scragg et al 1993) concludes that bedsharing is a

significant risk factor particularly when associated with smoking]. I do not rehearse here the arguments concerning the cultural values associated with bedsharing, particularly among the Maori population in New Zealand. The point of interest at this stage is that physiological analyses of infant respiration and temperature control mechanisms [summarised in DoH 1993], whilst receiving considerable funding and research interest, did little to reduce the number of infant deaths. This again served to increase the significance of epidemiological analysis.

As I suggested above, the two major epidemiological analyses that were published during the research period identified two different sets of risk factors. This suggests that apparently objective statistical analysis of the same cause of death is in some measure influenced by the perspectives of the researchers. As Tudor-Hart says,

"The assumptions of epidemiologists about society and its history necessarily and inevitably affect their choice of questions for study, the way they are asked and the solutions they find credible, however much they conceal this from themselves and their readers by 'value-free' terminology." (1988:99)

These epidemiological analyses, however, did not only identify different risk factors. They focused too on the individual risk factors affecting infant care, rather than on those associated with income or educational levels, or social class. In both the United Kingdom and in New Zealand the analyses drew a distinction between the risks that were amenable to individual change, and those that

would require social intervention. In New Zealand the contrast was made explicit, with caring practices such as sleeping position being characterised as "modifiable".

"Population-attributable risk provides an indication of the impact that controlling a causal factor might have on the incidence of sudden infant death syndrome. The national cot death prevention programme is attempting to reduce the prevalence of four modifiable risk factors ..." (Mitchell et al 1993:15)

In this way the socio-economic factors became implicitly "non-modifiable". These authors too identify the importance of the search for causal factors, but further suggest that the effectiveness of a programme to change infant care practices would reinforce and legitimate those recommendations.

In focusing on the individual risk factors - those that are amenable to change by individual people caring for infants - epidemiologists, health professionals, and cot death activists continued both the process of the medicalisation of infant care, and the emphasis on individual change rather than social interventions. Southall, in an editorial for the British Medical Journal has drawn attention to the lower incidence of SIDS in countries with a specific policy aimed at reducing poverty and inequalities in health:

"In countries that seek to optimise the environment of babies and mothers before and after birth infant mortality from all causes (including the sudden infant death syndrome) is low. Infant mortality (both from all causes and from the sudden infant death syndrome) is high in socioeconomically deprived families. The implications of this are obvious, although the financial costs of reversing the effects of deprivation would be high." (1992: 266)

### **Expanding Medicalisation**

To return to the three questions posed by Wright and Treacher, examining the construction of these data on infancy and infant care for health professionals interested in SIDS suggests that: epidemiological analyses draw new areas of infant care - in this case the sleeping position of infants, their bedding and clothing - into the domain of professional expertise and surveillance; the medical:non-medical boundary is maintained through the epidemiologists themselves defining which factors should be regarded as modifiable and those which are therefore implicitly non-modifiable; the prestige of the knowledge is associated with both the shock of infant death, particularly the unexplained death of an apparently healthy infant, in an industrialised context, and the apparent effectiveness of the campaign in both changing infant care practices and in reducing SIDS. The symbolic power of infancy and infant death is a subject to which I return in the final chapter.

In terms of the themes running through the thesis, this chapter has shown the most medicalised and medicalising pole, constructing infancy in terms both of the Sudden Infant Death Syndrome and of recommendations about specific caring practices. I have suggested that specific aspects of this medicalising process - visual reductionism, the explanatory power of epidemiology, and the mutual reinforcement of epidemiologically derived risk factors and

change in practice served to legitimise this knowledge. Here I go a step further to suggest that the mothers' experience of infant care has been altered through the introduction of the statistical language of "risk factors" into the domain of infant care.

Drawing on an analysis such as that of Emily Martin (1989), in which childbirth is viewed as production, infant care has become 'risk management', and carers have become 'managers'. Chapter 6 described the fear of SIDS among some mothers, and in particular how this was a fear that they had simply not felt with previous infants. In this way health professionals, by introducing the concept of risk, maintain their own expertise in an expanding number of infant care practices, whilst placing the responsibility on the carer, usually the mother. More fundamentally, the medical model actually shapes the mother's experience of caring for her infant, introducing both notions of personal individual responsibility, and the concept of risk.

Thus far in the thesis, I have presented the data along a continuum from the Bangladeshi women's first experience of medicalised pregnancy and infant care, through the Welsh and English women's increasing knowledge and fear of SIDS, to the health professionals' focus on SIDS and risk reduction. The final chapter draws this data together by placing the focus on the symbolic dimensions of infancy, and on the place of anthropology.



**CHAPTER 8**  
**INFANCY AND ANTHROPOLOGY**

In chapter 1, I described how this particular thesis originated. This final chapter marks the point at which it ends. If my starting point was the opportunity to undertake research designed specifically to illuminate a particular aspect of the epidemiology of SIDS, informed by a particular theoretical perspective drawn from medical anthropology, my position at the end of the thesis is rather different. Not only have I developed a broader perspective on infancy, and on the influence of medical models of infancy and infant care within this broader context, but I find myself with a rather more practical orientation towards anthropology in western industrialised contexts. This chapter explores both this broader perspective on the symbolic power of infancy and infant death, and the way in which these came to light through placing anthropology at the juncture of different systems of meaning.

**Infancy: The Personal, The Professional and The Political**

Throughout this thesis I have used the idea of a continuum, with Bangladeshi perceptions of infancy at one end, Welsh and English in the centre, and health professionals at the other end. A number of contrasts have emerged along this

continuum, and here these are drawn together to illustrate the personal, the professional and the political dimensions of infancy. Emily Martin suggests in her analysis that she was interested in "what else" women were talking about when they discussed their own experiences:

"Even though I talk at length about biological and medical processes, my concern is not what is true or false about those processes nor am I competent to say. Instead I try to get at what else ordinary people or medical specialists are talking about when they describe hormones, the uterus, or menstrual flow. What cultural assumptions are they making about the nature of women, of men, of the purpose of existence?" (1989: 12-13).

It is this kind of perspective that I adopt here. I am however, not simply exploring what was implicit for those women who contributed to the research, I address too my own assumptions which became increasingly explicit as the fieldwork progressed. Later in the chapter I return to the notion of liminality, the transience of infancy which contributed to the symbolic power of both infancy and infant death. For now, however, I concentrate on the idea of "what else" was being discussed as we talked about infancy. In doing so, I divide the issues into personal, professional and political concerns about infants and their care.

Within the personal domain, when Bangladeshi women spoke about their infants they talked of their vulnerability. Indirectly, they talked of superstitions, and ghosts, and angels; that is to say they talked of the infant's closeness to the world of spirits, or the supernatural.

They spoke of sending to their spiritual home or desh for amulets to protect the infant, and of the unacceptability of leaving infants on their own. In describing how in Bangladesh a young woman would be allocated the task of carrying an infant, they drew attention to the rich tactile environment an infant would experience. Their fluid perceptions of time challenged my own preconception of the infant day being defined in terms of a series of activities, such as I had anticipated in asking about in "a day in the life" of the infant, and highlighted the contrast with the Welsh and English households.

Welsh and English women also spoke of vulnerability in their infants, but this was couched in terms of germs (about which they felt they could take precautions), and in terms of the risk of cot death (about which they felt increasing fear). They drew parallels, often tangentially rather than directly, between infants and domestic animals, in terms of both their role and their care. They talked of the ways in which infant independence, or at least hints of independence - such as through placing their infants in baby walkers - could be fostered. In doing so they emphasized their own need for privacy, for time and space to themselves, in a way that was both unlikely and apparently unimportant in Bangladeshi households.

In talking about this independence, Welsh and English women identified a number of features that marked the shift from

infancy to childhood. James and Prout (1990) suggest that transitions are particularly significant stages of life, and that in western industrialised societies they are likely to be fragmented rather than more overt 'rites of passage'. Here steps such as language use, walking upright, wearing clothes, all contributed to the transition from infant to child. This suggests that an important element in looking at transitions lies in the status that is left behind, as well as the status that is reached. Here, it seems that human infants are relinquishing the 'animal' aspects of infancy. It was not, of course, only the infants who were leaving behind these animal aspects: some mothers also drew parallels, through the language in which they spoke of breastfeeding, with the animal aspects of breastfeeding their infants.

In moving on to talk about "what else" health professionals were saying when they spoke of infants, I return to the concept of liminality. For mothers - be they Bangladeshi, Welsh or English - the infant stage of their child's life was essentially temporary. It was liminal in both time, and in categorisation of the child within the domain of either the spirit or the animal world. As Murcott puts it, in discussing parallels between the 'feeding' of young infants and of animals:

"babies - and pets - are marginal to the adult world"  
(1987: 366).

For the health professionals involved in infant care, however, the situation was rather different: infants were

very much the centre of their attention. They were a constant category, and their wellbeing - as Mein Smith argues - the site of their professional practice and prestige.

Health professionals working on Sudden Infant Death Syndrome devoted their attention - via epidemiological analysis or offering advice - to different stages of the process of identifying possible risk factors associated with Sudden Infant Death Syndrome and translating these changes into practice. These were concentrated at the boundaries of the infant body - the sleeping position, the clothing, the smoke-free environment. They narrowed the focus to the body, choosing to view broader structural issues as part of a set of "unmodifiable" factors, such as social class or mothers' educational level. In Chapter 2 of this thesis I cited Armstrong:

"With this new configuration in the relationship between disease and the body, medical practice had an important new effect: by investigating, diagnosing and managing pathological states the doctor was also mapping and defining the limits of the discrete individual body". (1986: 222)

In this way, health professionals with an interest in SIDS underlined the idea of the autonomous bounded body of the infant.

The health professional perception of the autonomous infant body suggests an alternative way of conceptualising these contrasting perceptions of individuality and independence is in terms of body boundaries. This reflects the

emphasis of both Douglas (1966) and Cohen (1985) on the boundaries of both bodies and conceptual systems. For Bangladeshi infants, their body boundaries were constantly blurred through being in a rich tactile environment. For the Welsh and English infants their body boundaries were alternately crossed through deliberate contact, and brought into sharp focus through their separation from other people in order to encourage lone sleep. Some Welsh and English mothers referred to their infants in ways which suggested that they interfered in some way with their own body boundaries. They used terms which suggested that there was a possibility of too much contact between infant and mother, such as a "leech" or a "growth". In the biomedical analyses each infant was seen as autonomous, and its care as a series of separable practices. In this way this research has added to the existing literature (for instance, Mead 1973, Oakley 1979 and 1986, Maher 1992) on the separateness, and separation, of mother and child associated with the medicalisation of childbirth and childrearing.

As I indicated in the previous chapter when discussing risk, I argue here that the medical model of the infant and infant care on which health professionals base their advice actually shapes women's perceptions of their infants. Martin's argument that medical metaphors of menstruation, birth and menopause echo those of industrial production may be continued to suggest that the metaphor of infant care is

that of infant body management, with the mother as the manager (with a specific focus on risk), and the healthy child as the product.

The metaphor of management is reinforced by the introduction of the concept of risk. The Foundation for the Study of Infant Deaths and the Department of Health behavioural change campaigns used the title of "Reducing the Risk". Like Martin, Crawford (1977) argues that an analysis of health must be placed in its political context. He argues that health education targeted at individuals creates a model of health as a long-term investment, with individuals responsible for their own well-being, or indeed their own illness. In the particular instance of SIDS, the short lifespan of infants who die, and the apparent effectiveness of campaigns to change sleeping practices of infants, has reinforced the notion of personal responsibility for individual health. In this case, changes have occurred in infant care practices, which could be conceptualised as successful risk management by those caring for infants.

For health professionals, and for some of the Welsh and English women, the practices of the Bangladeshi women were seen as an example of 'natural' infant care. This is one of the assumptions identified by Maher in her discussion of breastfeeding, in particular the acontextual approach of some medical experts which she characterises as

"accompanied by ethnocentric stereotypes about developing countries, defined as 'traditional societies', which are supposed to be close to Nature" (1992: 153)

Maher's comments on the closeness to 'Nature' of traditional societies are made in the context of a discussion on breastfeeding, in which apparently natural practices (breast feeding) are placed in opposition to apparently artificial ones (bottle feeding). This is a slightly different opposition to that described by Armstrong, who counterposes natural and social explanations of infant death. In this latter instance, the natural explanations are seen as beyond human understanding and intervention, whilst social explanations lie within the domain of human understanding and therefore intervention.

A further distinction also emerges in juxtaposing social and individual explanations: in the case of epidemiological analyses of SIDS, social explanations refer to social class and education levels of the mother, whilst individual explanations refer to specific infant care practices. These differences of interpretation of the 'natural' and the 'social' were contrasts that emerged from presenting the ethnographic data collected in this study to health professionals.

Within the professional domain, the power of infancy, and in particular infant death, translated into a way in which health professionals could demonstrate their effectiveness. The risk reduction campaigns, as described in the previous



chapter, were based on epidemiological evidence, and the apparent success of the campaigns served to reinforce the effectiveness and value of both medical research and its practitioners. However, just as Mein Smith argued that the professionalisation of infant care succeeded rather than preceded a fall in infant deaths in Australia, so too in the UK there is evidence that the SIDS rate was falling in some areas before the introduction of the risk reduction campaign (Gibson et al 1991). There is also evidence that the areas in which the early research was carried out had a particularly high initial incidence of SIDS (Southall 1992).

Southall also points out that in countries where efforts are made to improve the socio-economic factors that affect infant health, the incidence of SIDS is low. As I describe in chapter 7, with epidemiological studies characterising individual infant care practices as "modifiable", they both implicitly characterise socio-economic factors as non-modifiable, and make caring practices all important. In so doing, this places the responsibility on the parent to follow expert advice, on health professionals to deliver it, and on researchers to provide evidence which results in recommendations. Thus the 'success' of interventions, such as new advice, appears to add to the status of medical knowledge.

The question of just why the SIDS incidence should have

fallen because infants were placed on their backs or sides is one that remains to be answered. The more interesting question for me in this connection is the presentation of the fall in SIDS as a success for the medical profession. Precisely why advice to place all babies on their fronts (viewed as appropriate for premature babies) had been widely introduced is unclear (Morley, unpublished conference paper, FSID annual conference 1992). At the beginning of the research period health professionals were advising that infants should sleep on their fronts, and by the end of it they were arguing that new advice to place infants on their backs had resulted in a fall in deaths from SIDS. This would seem to suggest that a proportion of the mortality associated with SIDS may be attributable to the provision of incorrect guidance, associated directly with the medicalisation of infant care. Yet reversing the advice about infant sleeping position has been conceptualised as a success for medical research, rather than a reflection of the fact that previous professional advice had been incorrect.

At the political level, during the research period it became clear that the issue of preventable infant death mattered very much to national government. The event that prompted government involvement was the death of the infant son of a daytime TV presenter, Ann Diamond. Her role as a popular daytime television presenter is important, in that it gave her access to audiences of young mothers at

home, to teams of television researchers, to health professionals, and to politicians.

Ann Diamond's reaction to the death of her infant was to investigate the issue of cot death, and to make a television documentary (broadcast within the current affairs schedule, rather than as part of her daytime television programme) critical of both the Department of Health and the Foundation for the Study of Infant Deaths. In her view, both these organisations should have acted on the epidemiological evidence from both New Zealand and the Avon region of England that there were infant care practices that were, in principle, amenable to change. FSID subsequently produced a leaflet and lobbied DoH to fund a national advertising campaign: this resulted in the national "Reducing the Risk" campaign launched in 1991. The timescale was short: Ann Diamond's television programme was broadcast in September 1991 and the Chief Medical Officer's guidelines for health professionals were issued in November 1991.

As I write the final stage of this thesis the incidence of SIDS continues to fall, the FSID continues their research and education programmes. The question of why placing infants to sleep on their backs should actually result in a reduction in SIDS remains the subject of debate.

The particular questions associated with SIDS, however,

become a distraction at this stage. My aim has been to show that exploring the symbolic dimensions of infancy is a fruitful area for anthropological research, opening up debates about both the cultural construction of infancy itself - in particular the perception of the independence of the bounded infant body - and the ways in which biomedical constructions of infancy and infant death themselves reflect and influence broader perceptions of infancy and independence.

At this stage, therefore, I leave the debate on SIDS and infancy to return to anthropology.

#### **Anthropology at Cultural Boundaries**

In the opening chapter I described how two roots had met in this particular thesis, the first the opportunity to undertake empirical research on the apparently low incidence of SIDS among Bangladeshi populations in Britain, and the second my own theoretical background in medical anthropology. It is to the latter perspective that I return now, in an attempt to reflect on my own experience of shifting from an essentially theoretical perspective, to one informed by fieldwork in a contemporary western setting.

In chapter 1 I cited the work of Cohen (1985) on the symbolic construction of community, and drew on this

perspective to look at the symbol of infancy. In particular, chapter 4, which showed for the first time the ways in which the 'cultures' I identified here came into contact, reflected Cohen's argument that it is people at the boundary of different systems of meaning who are in a position to observe and experience difference. I recognise that these cultures are in no way homogeneous, and for this reason have suggested that they are best thought of as placed on a continuum with Bangladeshi views of infancy at one end, Welsh and English perceptions of infancy in the middle, and health professionals' perceptions at the other end.

I have also suggested that these different perceptions of infancy met through the processes of medicalised infant care. The diagram of overlapping circles in Chapter 4 shows, for instance, how medicalised infant care brought Bangladeshi women into contact with health professionals, and to a limited extent with Welsh and English women. It was these areas of overlap that provided the opportunity for those within them first to observe, and in some instances to reflect on, the difference in both the ways infants were cared for, and indeed how infants were conceptualised.

It was not simply Bangladeshi women meeting health professionals for the first time, however, who found themselves at boundaries of systems of meaning. Welsh

women living in Cardiff but seeing the Valleys as their home, the place where infant care still involved the use of the Welsh shawl; English women living in Cardiff and receiving conflicting advice from their mothers living at some distance, and from local health professionals; British-educated Bangladeshi women living in extended households which constantly referred back to Bangladesh; all of these people were in some senses on boundaries, 'looking two ways'. Health professionals whose personal and professional experience (of not placing infants on their backs) was at odds with the new advice, found themselves in an uncomfortable position in which their own experience was inconsistent with epidemiological analyses.

The emphasis on boundaries is one that is shared by Rosaldo (1993). Earlier in the thesis, I cited his observations on the parallel between domestic animals and children, in the context of my discussion of how Welsh and English mothers drew parallels between their own infants and the care of dogs and cats. He adopts the term 'cultural borderlands' to identify the areas of dissonance experienced by people living on the boundaries of two or more cultures. He uses the example of his Mexican-born father's amazement at a dog being referred to, in apparently human terms, as a 'patient' of a vet to illustrate the lack of 'fit' between apparently simple categories.

Rosaldo uses this example of human infant:domestic pet comparisons to illustrate two different analytical frameworks, and to argue the importance of developing a focus on the borderlands of culture. The first he characterises as:

"a classic concept of culture seeks out the 'Mexican' or the 'Anglo-American,' and grants little space to the mundane disturbances that so often erupt during border crossings." (1993: 28-29)

This kinds of analyses would have led me, in this thesis, to concentrate on the 'Bangladeshi' or the 'Welsh' perceptions of infancy.

On the other hand Rosaldo suggests that:

"cultural borderlands have moved from a marginal to a central place" (1993 :28).

It is adopting this sort of analytic framework to examine apparently simple categories that I have found valuable in approaching infancy. Juxtaposing the perspectives of Bangladeshi mothers, Welsh and English mothers, and health professionals, has revealed not only some of the ways in which the processes of professionalised infant care bring these groups into contact, but also the contrasts between the independent autonomous infant body of epidemiology, the fostered independence of the Welsh or English infant, and the protected vulnerability of the Bangladeshi infant.

In the introduction to the thesis I referred in particular to the work of Scheper-Hughes and Lock, and their suggestion that medical anthropology should take into

account the phenomenological, social and political bodies. I commented at that stage that the empirical data I would be able to collect would relate to the social symbolic domain, rather than to the phenomenological or political.

At this point, however, I suggest that my own focus, whilst clearly weighted towards the symbolic and structural domains, nonetheless incorporates elements of the phenomenological and political. Their suggestion that their analytical separation be integrated through the medium of emotions seems rather redundant, possibly a reflection of their theoretical purpose. I find myself adopting a rather more pragmatic and practical approach, which reflects the fact that all of the people who contributed to this research - be they health professionals, full or part-time mothers - each offered views and experiences which had elements of all the analytical perspectives identified by Scheper-Hughes and Lock.

Looking at cultural borderlands, or areas of overlap, also pushes the anthropologist to find a place for herself. In Chapter 1, I cited Clifford's comments on ethnography:

"Ethnography is actively situated between powerful systems of meaning. It poses its questions at the boundaries of civilisations, cultures, classes, races and genders." (in Clifford and Marcus 1986: 2)

This extract bears repetition at this stage in the context of a discussion of the place and role of anthropology. Whilst many people find themselves at such boundaries - be



they religious or medical missionaries, or tourists, or indeed the Bangladeshi women who had grown up in Britain - anthropologists deliberately position themselves at these borders.

Conceptualising each community of meaning, or culture, and placing myself as an observer at different points within it, encouraged me both to recognise my personal perspective, and how that changed over the research period. In describing the process of "leaving the field" I commented that the once foreign world of the hospital had become so familiar that I walked unconcernedly through various areas restricted to pharmacy staff. This particular incident stays in mind as marking the point at which I realised that I had shifted towards identifying myself as part of the community - with all its hierarchies and variety - of health workers who staffed the hospital. I subsequently took the decision - with the encouragement of my supervisor - to leave the field. At this distance, both spatial and temporal, I can place myself at the boundary of the circle encompassing Welsh and English mothers. As a non-mother, I am clearly not in that circle, but on the edge of it, looking both inwards towards that and the other circles, and outwards to realms beyond infancy.

Moving beyond this study of infancy, it is a theoretical perspective that encourages an understanding of cultures as

communities of meaning, and that explores the many cultural borderlands where implicit meanings may become explicit, that I will take with me. Adopting such a perspective entails placing myself as both observer and observed, an integral part of an albeit partial picture.

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## Sudden infant death syndrome: links with infant care practices

M Gantley, D P Davies, A Murcott

### Abstract

**Objectives**—To investigate infant care practices in a small ethnic minority population within Britain that might suggest possible factors contributing to the low incidence of the sudden infant death syndrome in Asian populations.

**Design**—Ethnographic interviewing, a qualitative comparative method drawn from social anthropology.

**Setting**—Central Cardiff.

**Subjects**—Non-random sample of 60 mothers of Bangladeshi or Welsh ethnic origin and working or middle class occupational status, who had infants under one year old. None of the families interviewed had experienced a sudden infant death.

**Results**—Broad cultural contrasts emerged as a series of themes from the interview data: living patterns, family networks, sleeping patterns, and concepts of time and dependence.

**Conclusion**—Bangladeshi infants were cared for in a consistently rich sensory environment; Welsh infants, in contrast, were more likely to experience alternating periods of high and low sensory input. Long periods of lone quiet sleep may be one factor that contributes to a higher rate of sudden deaths in white than in Asian infants.

### Introduction

Sudden infant death syndrome—the sudden, unexpected, and unexplained death of an apparently healthy baby—remains the single most important cause of death in the United Kingdom of children aged between 1 and 12 months.<sup>1</sup> Research on its aetiology has focused, at one end of the spectrum, on causal mechanisms—for example, inherited metabolic diseases<sup>2</sup>—and, at the other end, on infant care practices that may be potentially protective or harmful, such as sleeping position.<sup>3</sup>

There is now increasing evidence of both national and regional variation in incidence. The syndrome is, for example, very rare in Hong Kong.<sup>4</sup> Within Great Britain, data from the Office of Population Censuses and Surveys for the years 1982-5 (classified by mother's country of birth) indicate significantly lower rates among babies of mothers born in Africa or Asia (India, Pakistan, or Bangladesh) than in those of mothers born in the United Kingdom or the Republic of Ireland.<sup>5</sup> In Birmingham, for 1981-3, with ethnicity classified by mother's own report, incidence of deaths from the syndrome was found to be lowest among Asian babies and highest among Afro-Caribbeans, with white infants falling in between.<sup>6</sup> In east London between 1987 and 1990 the largest ethnic minority population, Bangla-

deshis, had rates approximately half those of the white majority (L Hilder, unpublished data). Among Asian populations in the United States (Asian in this case referring to Chinese, Japanese, Vietnamese, or Filipino, defined by mother's own report), the incidence of the sudden infant death syndrome increased with period of residence.<sup>8</sup>

British research also provides information on neonatal deaths for Asian and white infants. OPCS data show higher neonatal deaths among Bangladeshi babies in 1981-3, but comparable rates in 1984-8. In Birmingham the rate of sudden infant deaths was low in Asian infants but there were high rates of congenital malformations resulting in perinatal mortality. In east London neonatal mortality among white and Asian groups was broadly similar. This evidence is not sufficient to suggest that low rates of sudden deaths in Bangladeshi infants are achieved at the expense of high neonatal mortality. It does reinforce the need for detailed local statistics, with ethnicity recorded by personal report rather than by country of birth.

The relatively low incidence of the sudden infant death syndrome among Bangladeshi babies in Britain represents something of a paradox, since many of these babies grow up in conditions that would predict a relatively higher incidence of the syndrome.<sup>9,10</sup> These include poorer socioeconomic conditions, apparently crowded housing, and young mothers often with many children. This paradox has prompted research on the potential contribution of varying infant care practices to the prevention of deaths from this syndrome. Rather than retrospective studies of infants who have died or epidemiological analyses of the sudden infant death syndrome in specific population groups, our research offers a complementary perspective. Recognising that the apparently low incidence of the sudden infant death syndrome was difficult to explain wholly in terms of currently recognised risk factors, we sought to identify other differences in infant care practices that may contribute to the lower incidence of such deaths in Bangladeshi babies. For this reason we did not work with families who had lost an infant: instead we investigated the ordinary patterns of beliefs about infants and their care in two different populations, mothers of Welsh and Bangladeshi infants in Cardiff.

### THEORETICAL BACKGROUND: AN ANTHROPOLOGICAL PERSPECTIVE

In 1991 the *Lancet* carried a series of articles on medical anthropology arguing that "medical anthropology has now emerged as a potential focus for those interested in explaining disease in terms of the patient's cultural context."<sup>11</sup> This paper is part of the emergent contribution of medical anthropology, and presents an

Department of Child Health, University of Wales College of Medicine, Cardiff CF4 4XN  
M Gantley, research officer  
D P Davies, professor

Health Promotion Sciences Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London WC1E 7HT  
A Murcott, senior lecturer

Correspondence to:  
Ms M Gantley, Health Promotion Sciences Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT

account of the theoretical background (drawn from biological anthropology) and the method (drawn from social anthropology) of a study of culturally varying infant care practices.

Medical anthropology occupies a middle ground between biological and social anthropology, biological anthropology specialising in human adaptation to specific environments and social anthropology in the associated cultural systems of belief (ideologies). Anthropology adopts a broad comparative perspective, drawing on both historical and cross cultural evidence: parts of medical anthropology narrow the focus to beliefs about the nature, cause, and treatment of illness within specific cultures.

Biological anthropology in the present context considers infants and their care within an evolutionary perspective, arguing that over the millions of years it has taken for humans to evolve, infant-parent contact was likely to have been virtually constant for at least the first year of life. McKenna, recognising the species specific nature of the sudden infant death syndrome and the relatively narrow time range of the majority of deaths, drew attention to both the relatively long period of physical dependence of the human infant and the ways in which caring practices vary with historical and cultural contexts.<sup>12</sup> He described human infants as being likely to experience problems in the regulation of breathing, such as those associated with the sudden infant death syndrome, because their anatomical and neurological immaturity coincides with a period of change that is specific to humans, that of the acquisition and use of language. Thus development of intentional crying and later of speech requiring sophisticated, learned control of breathing—characterised as “speech breathing”—poses a challenge that is unique to human infants.

The second part of McKenna's thesis posits that during this period of respiratory instability the infant's “evolutionary past” should not be forgotten.<sup>13</sup> In other words, the practice of placing infants to sleep on their own, for relatively long periods of time, which is widespread in Western industrialised societies, is not only historically and culturally unique but also evolutionarily recent. McKenna suggests that infants sleeping alone lose the external sensory stimulation that may stabilise breathing. The mechanisms through which this stimulation occurs include rocking, chest movement, touch, and noise, all of which are concomitants of close proximity to other people and affect levels of arousal; mothers sleeping close to infants also contribute to the monitoring and control of temperature and chemical microenvironment (particularly carbon dioxide levels). Current experimental work with mothers and infants sleeping together in sleep laboratories is tracing the interaction of their patterns of breathing, and has found that in such conditions infants spend less time in deep stages of sleep.<sup>14</sup>

We understand an important pathophysiological mechanism underlying the sudden infant death syndrome to be a failure of respiratory control at a vulnerable stage of development. Disturbance to this delicate equilibrium by a number of different risk factors coinciding in a particular vulnerable baby may upset the regulation of breathing, leading sometimes to death. Epidemiological risk factors are somehow linked with destabilising influences on breathing, and it is through their avoidance or modulation—for instance through a change in the sensory environment of sleep<sup>15</sup>—that risk of death can be reduced.

#### Method

As Janes and Stall have explained: “qualitative and quantitative measurement may inform the other at different stages of the research process.”<sup>16</sup> We used a

qualitative social anthropological approach to explore the quantitative, epidemiological evidence of international and intranational variations in the incidence of sudden infant deaths. Social anthropology addresses cultural ideologies by using a variety of methods, including community observation and ethnographic interviewing. Ethnography—literally, textual description of particular cultures—also describes the techniques used to achieve an understanding of the beliefs and practices of specific groups, be they medical students<sup>17</sup> or ethnic groups within Britain. Thus ethnographic interviewing describes an open ended unstructured approach designed to encourage informants not only to describe individual infant care practices but also to locate them within a broader ideology. The interviewer sets the framework for the interview—in this case mothers were asked to describe “a day in the life” of their infant—but allows the informant to determine the pace and order of the conversation, to select topics considered important. The interviewer uses a checklist to ensure that specific areas are covered, requesting explanations or introducing new topics as necessary.

Sixty such interviews have been completed—with an interpreter where necessary—with mothers of babies under 1 year old and living in Cardiff, south Wales (population 279 055<sup>18</sup>). Each interview lasted about an hour and was audiotaped and transcribed. The sample comprised 20 Bangladeshi and 20 Welsh working class mothers and 20 middle class mothers (although we recognise Alam's argument<sup>19</sup> that urban versus rural origin is a more appropriate distinction within the Bangladeshi population in Britain). A middle class group of 13 Welsh and seven Bangladeshi mothers was included to reflect class based variations in infant care practices. Four of the Bangladeshi mothers had been educated in Britain; all continued to live in extended households. Bangladeshi identity remained strong, only one mother preferring to describe herself as “British Asian.” In terms of both household size and number of children per family ethnicity seemed more important than class, with 3.6 and 3.7 people in Welsh working class and middle class households respectively, and 6.7 and 7.1 in Bangladeshi working class and middle class households respectively; Welsh middle and working class families had 1.5 children on average, while Bangladeshi working class averaged 3.4 and middle class 2.1. Such figures do not of course reflect variation in household constitution: Bangladeshi households were typically extended either longitudinally (over three generations) or laterally (two or more brothers living with their wives and children).

These groups should not be regarded as representative of the Cardiff population: the 1991 census data records a Bangladeshi population of 1663, some 0.6% of the total.<sup>20</sup> Our sample was non-random, Bangladeshi mothers being recruited first in view of their relatively small numbers. Mothers of Welsh infants of similar age were then recruited from the same areas of the city; they were thus living in similar accommodation and served by the same health professionals.

Bangladeshi mothers were chosen as a relatively recently arrived group of suitable demographic structure who had had comparatively little exposure to the infant care practices of the city in which they now live. The definition “Bangladeshi” refers to infants whose mothers were born in Bangladesh, and the few mothers who were born or grew up in Britain. “Welsh” is used to describe the ethnic origin of babies of parents who described themselves as either Welsh or English, but their infants as Welsh.

#### ETHNIC MONITORING

It should be noted that data on the ethnic origin of babies who died of the sudden infant death syndrome



Bangladeshi babies benefit from constant social stimulation

are collected only in certain areas, and the definitions used are inconsistent, being based either on mother's country of birth or her own report of her ethnicity. Classifying by mother's country of birth results in babies of, for instance, Pakistani mothers born in Britain appearing as British rather than Pakistani. Although such an attribution is important in terms of nationality, it loses information where health beliefs or possible variations in cultural practices are concerned. Consistent ethnic monitoring of both births and deaths is needed to provide accurate information on the local variations in the incidence of sudden infant deaths. This in turn will allow the recognition of high and low risk groups, and so the possibility of identifying high and low risk practices. If British born people of minority ethnic extraction are invisible in statistics on sudden infant deaths (or any other areas) we lose the chance to identify accurately both health trends and the health practices that may be associated with specific morbidity or mortality. The availability of the 1991 census data on local populations by ethnic origin offers a timely opportunity for ethnicity—like occupational class—to be systematically recorded.

### Results

This paper reports broad cultural contrasts between Bangladeshi and Welsh mothers' beliefs and infant care practices. The evidence is presented as a series of themes which emerged from the interview data. The analytical procedure is to use each theme as an axis around which different elements of empirical data are grouped.<sup>3</sup> They provide a context within which to understand the beliefs and practices of the Bangladeshi and Welsh mothers: this in turn allows practices—potential risk factors or protective factors—to be identified.

### LIVING PATTERNS

Bangladeshis in Cardiff live in relatively large groups in small unheated Victorian terraced houses, adapting the pattern of extended family living to the accommodation available. A typical pattern is two or three brothers living together, each with a wife and several children. It presents a sharp contrast to similar houses occupied by their Welsh or English neighbours, divided into flats for nuclear units of mother-father-child or mother-child. The pattern of extended family living persists with the few Bangladeshis who have grown up in Cardiff or elsewhere in Britain. Bangladeshi infants are constantly in a busy social and tactile environment, whereas Welsh babies grow up in smaller households

in which independence is encouraged. It is rare to leave a Bangladeshi baby to cry, or to play alone. Childcare is relatively public in Bangladeshi households, involving all the members of the extended family. In Welsh families, childcare is the prime responsibility of one or both parents, with occasional help from family, friends, and health professionals. Welsh parents attach considerable importance to privacy and to time away from the work of child care, for either work outside the home or leisure activities.

### FAMILY NETWORKS

Adult Bangladeshis in Cardiff are children of large families and thus have extensive networks of cousins. Each of these is regarded as part of the family, as are people who originated in the same village. Family membership is highly valued, and new arrivals will be incorporated into groups resident in Britain, receiving practical and financial help if necessary. Bangladeshi grandparents in Cardiff live as part of the extended family, either sharing a house or living close by, and are closely involved in childrearing. The involvement of Welsh grandparents takes a different form: contact may be less frequent and based on invitations to visit or regular arrangements for contributing to childcare one day or one evening a week.

Bangladeshis in Cardiff continue to have large numbers of children, compared with Welsh and English families. The relatively large number of babies provides the opportunity for a more general familiarity with infants, and the arrival of a baby involves fairly small changes to family life. Thus very few preparations are made before birth. For the Welsh mothers, in contrast, the arrival of a baby often marks a series of dramatic changes associated with loss of income and employment, and the relatively low status, and often isolation, of motherhood.<sup>2</sup>

Most Bangladeshi mothers breastfed their babies for the first few weeks, switching to either combination or bottle feeding after this period. Bottle feeding was regarded as both more "Western" and "modern" and had the advantage that other family members could deal with feeding the infant. It is very rare for Bangladeshi women to smoke; some men do so. Smoking was more common among Welsh parents, accompanied by an attempt not to smoke while close to the baby. Oil is used to massage Bangladeshi babies after bathing, increasing their tactile stimulation; this task is often undertaken by grandmothers. Welsh mothers, in contrast, were more likely to use talcum powder.

### TIMES AND DATES

Most Welsh households included husbands working outside the home during the day. Most of the Bangladeshi men worked in restaurants, so their working hours were more variable. They left the home between 4 pm and 5 pm and returned in the early hours of the morning, often coinciding with the feeding time for a young baby. The household timetable revolves around restaurant work, with children often being late for school, and visitors being least welcome (and this is a very hospitable culture) early in the morning. The notion of a routine, of a particular time for meals, baths, bed for young children—to fit in with the other interests and commitments of parents working outside the home—is not especially important. If Bangladeshi mothers' idea of time emphasises fluidity and flexibility, then Welsh mothers' notions emphasise regularity and routine.

### SLEEPING PATTERNS

Bangladeshi babies are thought to be vulnerable, and they sleep close to other people both day and night;

at night they are either in the mother's bed or in a cot next to it, a practice also reported by Farooqi *et al.*<sup>22</sup> They are put to sleep on their backs, being turned at times on to their sides in the belief that this will promote a culturally valued "rounded" head. Older children also sleep in their parents' room, a pattern which continued in the middle class Bangladeshi families in this sample and those in which the parents had grown up in Britain. It is not simply a question of availability of space, but of a belief that, as one mother put it, "I like to wake up in the night and see all my family around me."

The babies born to Welsh and English parents were, in contrast, sometimes placed in cots in their parents' rooms for a period of two to three months, and then encouraged (close to the peak age for the sudden infant death syndrome) to "get used" to sleeping alone, where possible in their own rooms. For daytime sleep Welsh babies were consistently said to need quiet, and to be placed in as peaceful a spot as possible, sometimes in another room, sometimes upstairs. In contrast, Bangladeshi babies sleeping during the day were always in the same room as other family members, in a relatively noisy, busy environment. There is less pressure in Bangladeshi families for babies to "sleep through the night." For Welsh parents, the demands of either or both working outside the home resulted in considerable emphasis on the infant's sleeping time.

Bangladeshi mothers expressed concern at the possibility of infant overheating, and this was one of the explanations given for the practice of shaving babies' heads. Welsh mothers were in general more concerned to keep an infant warm, although during the research period the publicity concerning the link between sudden infant death and temperature increased awareness of temperature, some mothers using room thermometers.

#### INTERDEPENDENCE OR INDEPENDENCE

All the mothers interviewed recognised that babies need looking after. In contrast to the notion of vulnerability in infants expressed by Bangladeshi families, there was among Welsh and English mothers a clearer push towards encouraging babies to be independent. This was motivated by the need for the mother to return to work or the wish for the parents to have time to themselves.

Among the Bangladeshis, the notion of interdependence of family members—both within and between generations—was clearer, underpinning the practices of parents and children sleeping in the same room and the extended family living together. Where Bangladeshi belief systems emphasise group membership and close informal proximity, Welsh belief systems emphasise individuality, independence, and self reliance.

#### Discussion

In the context of a varying incidence of the sudden infant death syndrome in different ethnic groups, and the possible contribution of infant care practices to this variation, this paper has described the beliefs and practices concerning infant care among two groups of carers in populations that have been shown to have significant differences in the likelihood of the syndrome.<sup>27</sup>

The themes presented describe the broad socio-cultural context of the specific practices we identified. Some may protect against sudden infant deaths; others may add to risk. Some relate to factors that are already recognised (sleeping position, environmental temperature, smoking) and others offer new avenues for research.

During the fieldwork period, sudden infant deaths

received enormous publicity in the national media. Both the Department of Health and the Foundation for the Study of Infant Deaths published leaflets describing the new advice that babies should be placed to sleep on their backs or sides rather than on their fronts. We considered the practical implications of our findings, and the potential contradictions faced by both parents and health professionals. The research process highlighted the difficulty of going from research to recommendations, and the effect of changing health advice on both health professionals providing advice and on mothers receiving it.

Inherent in this type of research is the potential to generate new categories or variables and to reconsider existing analytic categories in a fashion that also addresses their validity. An example arising from this study is the notion of infants being alone. Asking mothers to discuss whether or not their babies notice being on their own generated unfamiliar varieties of parental attitudes to children being left alone (for instance, to sleep in the day) or a report of the amount of time infants are likely to spend alone. One mother commented, while the baby was upstairs asleep, "she's never alone, someone's always here." Closer scrutiny of the precise meaning of "alone," as well as verification of the length of time infants would spend alone in a day, is needed if drawing conclusions that sudden infant deaths are not more common in babies whose periods of sleep are taken "on their own."

Reflecting on the rarity of the sudden infant death syndrome in crowded Hong Kong in 1985, Davies commented that "there might be some benefit to such high-density living. Babies are left alone much less. Sleep patterns might be different, effecting subtle modulations to physiological responses concerned with ventilatory control. The question 'When can I put baby into his own room?' is virtually never raised. Might closer overall contact with the sleeping baby somehow lessen the risks of sudden death?"<sup>24</sup> The environment in which Bangladeshi babies in Cardiff are brought up has similarities with that of Hong Kong, both being richer in sensory experiences<sup>13,14</sup> than that experienced by Welsh babies. We are not suggesting that to adopt all the practices evident among Bangladeshis in Cardiff, or Hong Kong residents, will prevent sudden infant deaths. In the words of Bergman, however, the sudden infant death syndrome "is like a nuclear explosion where a critical mass must be obtained before the event is to occur."<sup>23</sup> This type of research represents a midpoint between the epidemiological linking of incidence in particular populations with particular infant care practices and the investigation of possible physiological mechanisms. It stands alone as a study of infant care practices, but we hope that it contributes to a discussion of those factors which form Bergman's "critical mass."

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## Investigation of inheritance of chronic inflammatory bowel diseases by complex segregation analysis

Marianne Orholm, Lennart Iselius, Thorkild I A Sørensen, Pia Munkholm, Ebbe Langholz, Vibeke Binder

### Abstract

**Objective**—To investigate the mode of inheritance of ulcerative colitis and Crohn's disease by complex segregation analysis.

**Design**—Cross sectional population based survey of familial occurrence of chronic inflammatory bowel disease.

**Setting**—Population of the Copenhagen county in 1987.

**Subjects**—662 patients in whom inflammatory bowel disease had been diagnosed before 1979, of whom 637 (96%) provided adequate information. Of 504 patients with ulcerative colitis, 54 had 77 relatives with ulcerative colitis and of 133 patients with Crohn's disease, five had seven relatives with Crohn's disease.

**Main outcome measures**—Patterns of segregation of either disease as assessed by complex segregation analysis performed with the computer program POINTER.

**Results**—The analysis suggested that a major dominant gene with a penetrance of 0.20–0.26 is present in 9–13% of adult patients with ulcerative colitis. The analysis did not allow for other components in the familial aggregation. For Crohn's disease the best fitting model included a major recessive gene with complete penetrance, for which 7% of the patients are homozygous. However, this model was not significantly different from a multifactorial model.

**Conclusions**—The segregation pattern indicates that a major dominant gene has a role in ulcerative colitis, and suggests that a major recessive gene has a role in Crohn's disease.

### Introduction

Familial occurrence of chronic inflammatory bowel disease has been reported in several studies during the past decades.<sup>1-3</sup> The prevalence reported among first degree relatives seems to be much higher than expected from the prevalence in the background populations. Familial aggregation may be due to shared genes as well as to shared environments—for example common customs, dietary habits, or exposures to viruses, toxins, or chemicals.

In a regional study including about 10% of the Danish population we found the population relative risk of ulcerative colitis and Crohn's disease among first degree relatives of patients with either disease to be about 10, which strongly suggests that these disorders have a genetic cause.<sup>4</sup> To explore the mode of

inheritance further we performed a complex segregation analysis.<sup>5</sup> This allows testing of hypotheses of inheritance of a major dominant, additive, or recessive gene and multifactorial genetic or environmental inheritance.

### Patients and methods

The county of Copenhagen has about 500 000 inhabitants, about 10% of the total Danish population. The annual incidence of ulcerative colitis and Crohn's disease in this region was estimated for the years 1962 to 1978 and the prevalences on 31 December 1978 were calculated.<sup>6</sup> Of the 694 patients with prevalent disease in 1978, 662 were alive on 1 January 1987. These patients served as probands in the present study.

The diagnostic criteria for ulcerative colitis and Crohn's disease in the probands have been described.<sup>6,7</sup> Briefly, the diagnosis of ulcerative colitis was based on the presence of at least three of the following four criteria: a typical history of diarrhoea; stools containing blood and pus, or both, for more than one week or in repeated episodes; a typical sigmoidoscopic appearance, with granulated friable mucosa or ulcerations, or both; histological or cytological signs of inflammation; and radiological or colonoscopic signs of ulcerations with or without spiculation or granulation of the inner surface of the colon proximal to the rectum. The diagnosis of Crohn's disease was based on the presence of at least two of the following four criteria: a history of diarrhoea lasting more than three months; radiological findings of typical stenoses and prestenotic dilatation in the small bowel or segments with a cobblestone appearance in the large bowel; histological findings of transmural lymphocytic infiltration or occurrence of epithelial granulomas with giant cells of Langhans' type, or both; and the occurrence of fistulas or abscesses, or both, in a region of intestinal disease. Before either ulcerative colitis or Crohn's disease was diagnosed infectious and neoplastic diseases had to be ruled out.

In 10 patients who had met the criteria for ulcerative colitis in 1978 the diagnosis was later changed to Crohn's disease; the diagnosis was changed to ulcerative colitis in three patients who had originally had Crohn's disease diagnosed. The diagnoses presented in this study were those made in 1987—that is, the conclusion reached after a median 15 (9–49) years of observation.

We sent a questionnaire requesting complete family history to each patient. Adequate information was

Medical  
Gastroenterological  
Department C, Herlev  
Hospital, University of  
Copenhagen, Copenhagen,  
Denmark  
Marianne Orholm, senior  
registrar  
Pia Munkholm, registrar  
Ebbe Langholz, research  
fellow  
Vibeke Binder, chief  
physician

Department of Surgery,  
Karolinska Hospital,  
Stockholm, Sweden  
Lennart Iselius, registrar

Institute of Preventive  
Medicine, Copenhagen  
Health Services,  
Copenhagen Municipal  
Hospital, Copenhagen  
Thorkild I A Sørensen,  
professor

Correspondence to:  
Dr M Orholm, Department  
of Infectious Diseases 7721,  
Rigshospitalet,  
Tagensvej 20, DK-2200  
Copenhagen N, Denmark



**PARENTAL ATTITUDES TOWARD INFANT CARE: A POSSIBLE SOCIO/CULTURAL LINK WITH THE SUDDEN INFANT DEATH SYNDROME (SIDS)**

---

**Project Proposal**

Ethnic and geographic variations in the incidence of the Sudden Infant Death Syndrome (SIDS), where some of its lowest incidences have been found in populations with increased socio-economic adversity, suggest to us that socio-cultural factors in the caring environment of young infants might provide an important link to its aetiology. In many western countries babies are brought up in environments very different from those in the developing world, often having to endure long periods of solitude. Current anthropological opinion proposes that during the first six months or so after birth (a time of special vulnerability to SIDS) cues provided by close contact with a caregiver might be needed to help establish the required control of respiration. Prolonged periods of separation might heighten risks of respiratory instability and contribute to early unexpected death. They might also blunt parental awareness of minor illness that undetected might lead to demise. A severe dearth of evidence on cultural diversity of infant caregiving practices makes it difficult to pursue this hypothesis. Using data collected via the standard anthropological technique of intensive, unstructured audio recorded interview we intend to make a detailed investigation of infant care practices and associated parental attitudes in two culturally diverse groups in Cardiff, indigenous British and Bangladeshi (a choice derived from our establishment that, in Cardiff, a sizeable and discrete population of Bangladeshi people are available for study) who have been shown to have contrasting incidences, higher and lower respectively, of SIDS.

**Purpose of Proposed Investigation**

Occasioned by ethnic and geographical variations in the incidence of the Sudden Infant Death Syndrome (SIDS) we propose to investigate socio-cultural factors in the caring environments of infants in the first six months of life in two population groups in South Wales, British indigenous and Bangladeshi: two groups who have been shown to have comparatively higher and lower incidences respectively of SIDS. This is a first stage towards exploring the hypothesis that culturally identifiable infant care practices might provide a link to the aetiology of SIDS.

**Background**

After extreme prematurity and congenital lethal malformations, the Sudden Infant Death Syndrome (SIDS) continues the leading cause of infant death beyond the neonatal period in developed countries with an approximate worldwide incidence between 2 and 4 per 1000 live births. In its epidemiology SIDS has a characteristic age distribution with an almost total immunity in the first few weeks after birth followed by

a maximum incidence between two and five months: 90% of all deaths occur under six months. More deaths take place during sleep with boys usually succumbing more than girls and the incidence higher in winter months. Poor housing, social underprivilege, inadequate antenatal care, low birth weight and young parents have often, but not invariably, been shown as high risk factors.

Yet the aetiology of SIDS remains obscure. It is likely to represent a heterogenous group of conditions and of the many theories and hypotheses advanced over the years most have explored medical biological models of illness or physiological incompetence to explain the SIDS phenomenon. Examples include surfactant defects, faulty maturation of immunoglobulins, environmental temperature, fatty-acid oxidation defects, fatal child abuse, suffocation.

### Ethnic associations

One factor that has received comparatively little attention in the search for an explanation is the considerable ethnic and geographic variations in its incidence. For example, in Chicago from 1975 to 1980 there was a much higher incidence in Blacks (5.1/1000 live births) than in Whites (1.2) and Hispanics (1.3). The South Island of New Zealand currently has one of the highest incidences of SIDS in the developed world (7.6/1000): yet in another part of the Western world, Finland, a rate of only 0.41/1000 was described in 1969-1980. In Hong Kong an extremely low incidence of 0.29/1000 was described in 1987/89 corroborating unpublished clinical impressions of the rarity of SIDS amongst the Chinese and other ethnic groups in South East Asia. In the United States the incidence has also been reported lowest among the Oriental Americans (0.51/1000). In England and Wales the only report of infant deaths related to ethnic factors has shown that during 1982-85 death occurred significantly less often among infants whose mothers came from the Indian subcontinent and Africa than among those whose mothers were born in Britain.

Some ethnic variations in the reported incidence of SIDS are paradoxical. Mothers born in Pakistan and Bangladesh and who now live in Britain are reported poorer, have more children and shorter intervals between pregnancies and live in less satisfactory housing than indigenous mothers, factors that might be expected to increase the likelihood of SIDS. In the Chicago study Hispanics shared many adverse social environment factors with black families, yet their incidence was four times less. In Hong Kong living conditions for many people are much less than adequate by Western standards and respiratory infections are very common. The possibility that there exist influences that somehow protect against death, even in the presence of potential risk factors, has, therefore, to be raised. Those that come particularly to mind are infant care practices.

One lead has been provided by McKenna and others in the United States who offer an anthropological perspective on SIDS. They remind us how contemporary urban Western industrialised society has evolved very different patterns of parent/infant care-giving interactions from those in which primate evolution has developed, most notable being that young babies have often to expect to endure especially long periods of

solitude by day and night. Between about two and six months there is an instability in the regulation of breathing which possibly has part of its expression even in healthy infants' episodes of physiological apnoea. Over this period there also appears to take place a functional shift in the regulation of breathing as cortical brain mechanisms begin to dominate over earlier brain stem systems. In this way a primitive and relatively inflexible system is replaced by one far more labile in which some learning is needed for its evolution. McKenna postulates that during this period of respiratory vulnerability, tactile, auditory, thermal, chemical (changes in concentrations of respiratory gases in the infants immediate environment) and vestibular sensory stimuli derived from the infant's micro-environment and entering the brain stem reticular formation could have a function in helping to regulate respiration. These cues are optimally provided in the natural care-giving environment in which the human species (along with other mammalian orders) has evolved, with the young co-sleeping in close contact with its mother - an environment of adaptiveness - to help stabilise breathing.

But our current urban western norm provides a very different micro-environment for the young infant as many babies are typically placed for long periods in their own rooms and out of contact with anyone. In so doing, their solitary existence during sleep inevitably deprives them of much environmental sensory experiences. During deep sleep respiratory drive and rhythm are especially dependent on sensory input and chemical stimuli to override biological deviations in breathing control. If now, and for whatever reason, such a baby happens to have a lapse in breathing there might be less opportunity for self correction. Lipsit has described SIDS babies as though they had simply "forgotten to breathe", unable to arouse themselves to take the next breath and so continue the respiratory cycle. Infants at greater risk, (for example through respiratory infection, premature birth, previous nervous system damage), might be expected to be particularly vulnerable to these lapses. This anthropological perspective views SIDS more as a developmental anomaly, an ultimate expression of sensory deprivation. Might the widespread Western habit of putting young infants to sleep alone for artificially conditioned lengthy periods be potentially harmful? Apnoea and respiratory control have been major foci of attention in seeking the aetiology of cot death. But as well as focusing on reasons for apnoea itself, we should also be asking whether some infants might fail to reinstate breathing after "physiological" episodes of apnoea that are now well recognised to take place in early infancy. Another level at which the close contact theory might operate, other than that related to the regulation of breathing, is that being left along for long periods might lead to a worsening of a minor clinical ailment - such as colds, snuffles, development of high body temperatures - that if detected early could be appropriately dealt with. An enhanced physical presence might make the mother (or other care-giver) sensitive to small changes of behaviour that would lead to her seeking help. We therefore see infant care-giving practices occupying an important role in this socio cultural model that might provide an important link with SIDS. In babies in high risk groups do there exist deviations in care that might lend support for a socio-cultural model of aetiology? In ethnic groups whose social circumstances appear to constitute a risk factor, yet who have a lower than expected incidence of SIDS, are there care-giving practices that lessen vulnerability? It is with this issue that this research proposal is concerned.

This speculation cannot currently be adequately addressed due to a severe dearth of evidence on the cultural diversity of infant-rearing practices. Worldwide, anthropological work has concentrated on children in older age groups and much is now

very dated or has considered more specific public health problems, notably infant feeding. In Britain work has similarly dealt with either infant feeding or with older age groups often focusing on learning difficulties and handicap or on schooling. The sole exception here is the Newsons' work in 1963 which significantly reports that by a year old only 26% of infants in their sample were sleeping in room alone, of which 54% were in social classes I and II and 3% in classes V. Their study, however, is now 27 years old and moreover, groups recently immigrant to Britain were specifically excluded from the investigation. Reviews of medical literature reveals that in Hong Kong, in keeping with other parts of South East Asia and many parts of the developing world, babies are rarely left alone for long periods. In Britain many Asian households exist in extended family groups possibly leading to babies rarely left alone. In contrast, current western practices tend to encourage babies to be left alone in their own rooms from a very early age. But very little has been written on this and nothing on what determines and influences parental attitudes towards infant-rearing practices. Interest is currently being shown in countries as diverse as Holland, Hong Kong and New Zealand in the prone sleeping posture as a risk factor for sudden death.

Studies of cultural diversity in Britain have attended to various topics, eg problems of assimilation and rejection, the extent and nature of cultural differences and problems in defining and identifying ethnic groups but deals not at all with infant care. The dominant theme of the small literature on health and ethnicity generally in Britain is a lament over the insufficiency of evidence and its over-emphasis on diseases specific to distinct groups.

A little evidence is available on pregnancy and aspects of motherhood in the very early period, eg food use and attitudes to mental health. Attention to health promoting behaviour of all kinds is insignificant and to wider cultural practices that may be health-protective totally absent. This applies also to SIDS.

### Plan of Investigation, Research Strategy and Study Design

The most suitable research approach in the absence of existing relevant evidence is qualitative, in order to identify relevant phenomena in the first place, rather than quantitative, which addresses the question of the frequency and distribution of phenomena already identified. Accordingly, standardised questionnaires and the statistical representativeness of a sample are inappropriate. A three stage comparative anthropological project is envisaged, the first stage of which is that of the present application for funds.

**Stage 1.** A detailed investigation of mothers' reports of infant rearing and handling practices and of associated attitudes. Data will be collected via the standard anthropological technique of intensive unstructured audio-recorded interviews. Two culturally diverse groups will be included. Indigenous British and Bangladeshi. The latter choice derives from our establishment that in Cardiff a sizeable and discrete population of Bangladeshi people are available for study.

**Stage 2.** A standard anthropological participant observation study of infant rearing and handling practices in two or more culturally diverse groups.

**Stage 3.** A standard minute-by-minute observational study recording the infant's micro-environment for the groups included in Stage 2.

Our own preliminary groundwork locally is establishing that, in addition to appropriate sensitive negotiation with community leaders and other members of the culturally diverse groups concerned, consultations will be essential with other health and social service agencies devoted to the care of special groups. Moreover, diplomacy demands that these negotiations and consultations cannot be once-and-for-all, but will necessarily be a continuous feature of the conduct of the research. Furthermore it is already established locally that the demographic structure of each group is suitable and that, subject to the exercise of diplomacy, locating respondents via health clinics is likely to meet with agreement by all concerned.

Interviews of an average of 60 minutes (achieved on one or more occasion) are to be conducted in their own homes with 20 Bangladeshi and 20 British mothers of infants up to 6 months old in South Glamorgan attending well-baby clinics matched, as far as possible, for socio-economic circumstances. Earlier work by one of us has established that interviewing about aspects of infant care is readily acceptable to respondents and that good and usable data result. The main criterion for the selection of respondents will be a high degree of allegiance to Bangladeshi/British culture. A locally relevant screening instrument will be developed. The research is planned for two years.

**PARENTAL ATTITUDES TOWARD INFANT CARE: A POSSIBLE SOCIO/CULTURAL LINK WITH THE SUDDEN INFANT DEATH SYNDROME (SIDS)**

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**Referee's comments**

The proposed study addresses a very interesting, difficult area. The authors have presented a considered and well researched argument backing up the need for the study. The study itself will be qualitative rather than quantitative. Whereas I accept that the qualitative approach does not require standardisation of questionnaires or sampling techniques, it does not entirely preclude the need for care in dealing with these aspects of the study. The authors implicitly accept this as they have already decided to match the indigenous British mothers in their sample according to socio-economic group with the Bangladeshi mothers. If it is accepted that some matching and sampling is required then I am of the opinion that three groups will be necessary.

1. Bangladeshi mothers
2. British mothers matched with Bangladeshi mothers for socio-economic circumstances (these are likely to be in social classes four and five)
3. Group of British mothers from more privileged backgrounds ie social classes one and two.

On the basis of my own observations and impressions I would expect the babies in more privileged British homes to be separated earlier and more frequently from their parents than those in the less privileged British families. It is also known that the children from more privileged British households are far less likely to suffer sudden infant death syndrome. There is a danger that false assumptions will be made about the importance of child separation if the two proposed groups are looked at as opposed to the three suggested above.

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Coleg Meddygaeth Prifysgol Cymru  
University of Wales College of Medicine

Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
Dr. K. Verrier-Jones, M.B., B.Ch., F.R.C.P.  
Dr. P. H. T. Cartledge, D.M., M.R.C.P.  
Dr. M. Alfaham, M.B., Ch.B., M.R.C.P.  
Dr. G. E. Butler, M.B., B.S., M.R.C.P.

University Department of Child Health,  
Heath Park, Cardiff CF4 4XN  
Tel: 0222 755944 Exts: 3375/3374/2273/2274  
3444/3123/3410  
Fax: 0222 762208

October 1991

Dear General Practitioner

This letter is to let you know that as part of an on-going social research project in your area we may be approaching some mothers whose names appear on your list. Mothers are being recruited through a number of different channels including the Cardiff Birth Survey, and are being asked to agree to a confidential interview about "A day in the life of your baby". The research has received the approval of the Ethics Committee of the South Glamorgan Health Authority, and respondents are asked to sign a letter of consent.

The research is being conducted under the auspices of the Department of Child Health of the University of Wales College of Medicine and the London School of Hygiene and Tropical Medicine. Funding has been provided by the Foundation for the Study of Infant Death.

We hope that this letter, together with the enclosed Information Sheet, will be sufficient to keep you in the picture. If, however, you have any questions, Madeleine Gantley would be happy to provide further details.

Yours sincerely

Madeleine Gantley MSc  
Research Officer

David P Davies  
Professor of Child Health





Coleg Meddygaeth Prifysgol Cymru  
University of Wales College of Medicine

Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
Dr. K. Verner-Jones, M.B., B.Ch., F.R.C.P.  
Dr. P. H. T. Cartledge, D.M., M.R.C.P.  
Dr. M. Alfaham, M.B., Ch.B., M.R.C.P.  
Dr. G. E. Butler, M.B., B.S., M.R.C.P.

University Department of Child Health,  
Heath Park, Cardiff CF4 4XN  
Tel: 0222 755944 Exts: 3375/3374/2273/2274  
3444/3123/3410  
Fax: 0222 762208

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INFORMATION SHEET FOR MOTHERS

A Day In The Life Of You And Your Baby

We are carrying out a study of how a very young baby spends the day. For instance, how long does your baby sleep? How often does he or she feed?

We are talking to mothers when their babies are around 12-16 weeks old, and would like to come and see you at home, for 45 minutes or so at a time to suit you. All information provided is in strictest confidence.

I hope you will be prepared to take part in this study. Please complete the attached form to indicate your agreement.

Yours sincerely

Madeleine Gantley  
Research Officer



Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
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Dr. M. Alfaham, M.B., Ch.B., M.R.C.P.  
Dr. G. E. Butler, M.B., B.S., M.R.C.P.

University Department of Child Health,  
Heath Park, Cardiff CF4 4XN  
Tel: 0222 755944 Exts: 3375/3374/2273/2274  
3444/3123/3410  
Fax: 0222 762208

MG/CC

CONSENT FORM

A Day In The Life Of You And Your Baby

I have read Madeleine Gantley's letter asking me to participate in a study on how very young babies spend the day, and agree that she may come and talk to me, at a time to be arranged, when my baby is 12-16 weeks old.

Name: .....

Address: .....  
.....  
.....

Baby's Name And Date Of Birth: .....

Signature: .....

Date: .....



Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
 Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
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 Dr. G. E. Butler, M.B., B.S., M.R.C.P.

University Department of Child Health,  
 Heath Park, Cardiff CF4 4XN  
 Tel: 0222 755944 Exts: 3375/3374/2273/2274  
 3444/3123/3410  
 Fax: 0222 762208

## মাদেৰ জন্ম সংবাদ।

### আপনি ও আপনাৰ মিশ্ৰ জীৱনেৰ একোটি দিন।

একোটি খুব ছোট মিশ্ৰ কি ভাবে সাৰাদিন কটায় তই নিয়ে আমবা গবেষণা কৰাছি। যেমন ধৰুন আপনাৰ মিশ্ৰ সাৰাদিন কতটুকু সময় ধুমায়ে? বা আপনাৰ মিশ্ৰ কতখন পৰ মাওয়া দাওয়া কৰে?

মিশ্ৰৰ কয়ম যখন ১২ মেকে ১৬ সপ্তাহ সেই সময়ে আমবা মাদেৰ সাথে আলাপ কৰাছি। আমবা আপনাৰ বড়ীত এসে আপনাৰ সাথে আলাপ কৰব। আপনাৰ সুবিধা অনুযায়ী সময়ে এসে আমবা অনুমান ৪৫ মিনিট সময় আপনাৰ সাথে আলাপ কৰব।

যে সব ওখ সংগ্ৰহ কৰা হবে তা অতি ভালানে ৰাখা হবে।

আমা কৰি আপনি এই গবেষণায় অংশগ্ৰহন কৰবেন। আপনি যে এই গবেষণায় ৰাজি তৰ জন্ম দয়া কৰে এই চিঠিৰ সাথে দেওয়া সংগ্ৰহ পূৰন কৰুন।

বিনীত :

ম্যাডেলিন গ্যান্টলি।

বিনীত আশিকাব।



Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
 Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
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University Department of Child Health,  
 Heath Park, Cardiff CF4 4XN  
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 3444/3123/3410  
 Fax: 0222 762208

## অনুমতিপত্র

### আনানি ও আননার মিশ্র জীবনের একটা দিন

মুৱ ছোট মিশ্ৰৱা কি ডাৰ একটা দিন অতিবাহিত কৰে তাত  
 অংগগ্ৰহন কৰাৰ জন্য ম্যুচাৰিন ন্যুট্ৰিচনৰ চিঠি আশি পড়দি  
 এব; আশি অনুমতি দিছি যে আমাৰ মিশ্ৰৱ বয়স যখন  
 ২২ মেক ২৬ সপ্তাহ ২ৰে তখন আমাদেৰ ডেডেলৰ সুবিধা  
 অনুসৰে একটা সময় ঠিক কৰে কেউ এম আমাৰ মাথ  
 এ স্থানত আনান কৰতে নাব।

নাম: .....

ঠিকানা: .....

মিশ্ৰৱ নাম ও জন্মৰ তাৰিখ .....

স্বাক্ষৰ .....

তাৰিখ .....

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University of Wales College of Medicine



Professor D. P. Davies, B.Sc., M.D., D.Obst., D.C.H., F.R.C.P.  
 Dr. E. N. Thompson, M.D., D.C.H., F.R.C.P.  
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University Department of Child Health,  
 Heath Park, Cardiff CF4 4XN  
 Tel: 0222 755944 Exts: 3375/3374/2273/2274  
 3444 3123/3410  
 Fax: 0222 762208

## INFANT CARE STUDY

### "A Day In the Life of Your Baby"

The UWCM Department of Child Health has recently received funding from the Foundation for the Study of Infant Death for a two-year research project to explore the ways in which very young children are looked after in different cultures. This initiative reflects both the growing awareness that specific caring practices may protect young children against certain causes of ill-health, and a wish to recognise and draw on the best practices within different cultures.

This project is the first phase of a potentially larger initiative, and at this stage the number of people involved is small. We are hoping initially to talk to mothers from two different ethnic groups in Cardiff, the first from an ethnic minority, and the second from the ethnic majority. Mothers from Bangladesh will be the first group to be approached, since they represent a relatively large percentage of ethnic minority mothers in Cardiff. We would hope to be able to talk to approximately 25 mothers in each group during the relatively short time available.

The information will be collected through informal interviews carried out, with the help of an interpreter where necessary, by the project's research officer, Madeleine Gantley (who is a social researcher, rather than a health professional). Mothers will be asked to describe "a day in the life" of their baby when he or she is around 8 weeks old. If they agree to do so, transcripts of the interviews will be prepared, and anonymous extracts will be used to provide the basis of a report to the funding organisation. We hope that interviews will start in February and will be completed by late 1991.

This information sheet can only provide brief information about the project and how we hope to carry it out: if you would like to know more, please contact Madeleine Gantley at the Department of Child Health on Cardiff 743371.



SOURCE: THE ADIVASIS OF BANGLADESH 1991 MINORITY RIGHTS GROUP

# UNIT 1

**Contents**                      **First Booking – Part 1**  
**Conversation with receptionist and/or nurse**

**Teaching Objectives**                      To elicit personal details relevant to pregnancy,  
i.e. names, addresses, telephone numbers, relationships, dates, etc.

**Core dialogue**  
**Questions asked by receptionist and/or nurse**

- What's your name/surname/other name(s)?
- What's your address?
- What's your telephone number?
- Age?/How old are you?
- Date of birth?/When were you born?
- Marital status?/Are you married?
- How long have you been married?
- Who's your next of kin?
- What's his name/address?
- What's your husband's occupation/job?
- Where does he work?
- Is that in (Leeds)?
- What's his telephone number at work?
- What's your occupation/job?
- What's your national insurance number?
- What's your religion?
- What's the name and address of your G.P./family doctor?
- Have you got a medical card?

**Teaching Aids and Notes**

The core dialogue questions have been split up and re-arranged on the worksheets to facilitate teaching, so they do not appear in the same order as above.

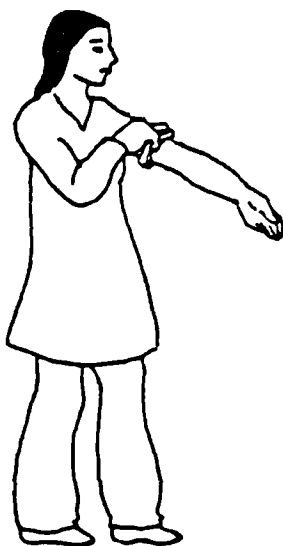
- WS. 1.1    Simple form and medical card.
- WS. 1.2    Telephone numbers.
- WS. 1.3    Calendar page.
- WS. 1.4    Date of birth.
- WS. 1.5    Family relationships.
- WS. 1.6    Husband's occupation.

**Things to be prepared**

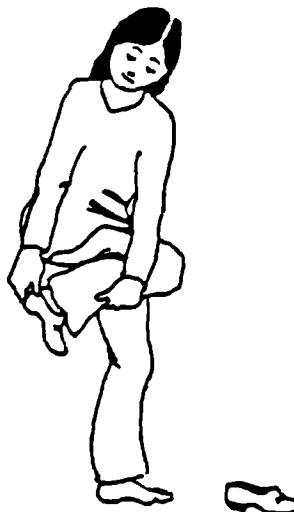
- Tape of core dialogue – with a different voice giving appropriate responses.
- Number cards – for teaching students to count.
- Telephone numbers – if there are a different number of digits in your area, adapt WS. 1.2.
- Medical card – ask students to bring them to the class.
- A current calendar – showing clearly the division into months and weeks
- A list of years – going back from the current year to the oldest student's date of birth.

Instructions prior to examination

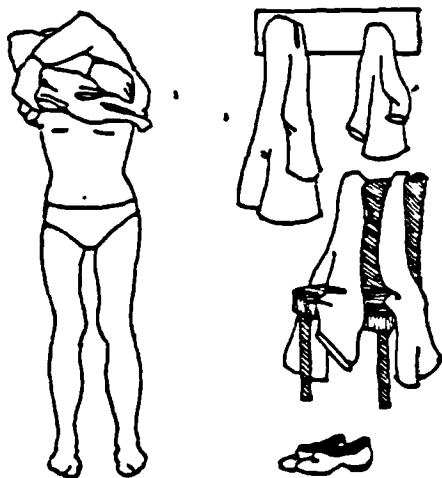
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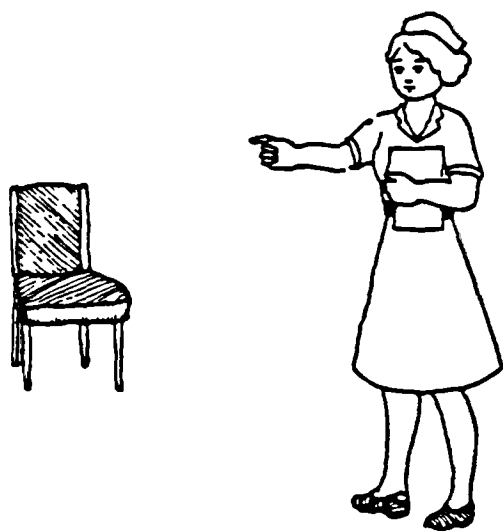
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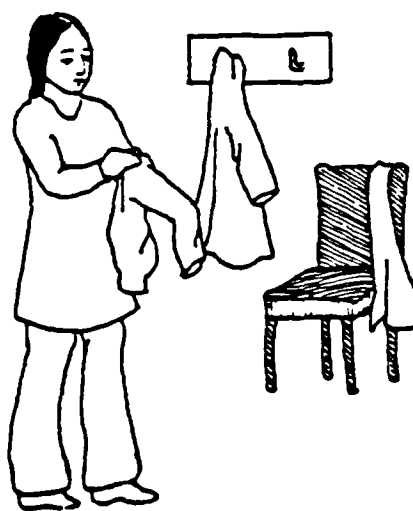
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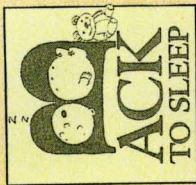
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6







## ● Smoke-free

Create a smoke-free zone for your baby. Do not smoke anywhere near the baby. Better still do not smoke at all.

## ● If your baby seems unwell seek medical advice early and quickly.

**Research continues into the causes of Cot Death. Remember it is comparatively rare, so do not let the fear of Cot Death spoil the first months with your baby.**

Further copies of this leaflet are available by writing to:

Reducing the Risk of Cot Death  
Health Publications Unit  
No. 2 Site  
Heywood Stores  
Manchester Road  
Heywood  
Lancashire  
OL10 2PZ

## ● Temperature

Babies should be kept warm, but they must not be allowed to get too warm. Keep the temperature in your baby's room so that you feel comfortable in it.

Use lightweight blankets which you can add to or take away according to the room temperature. Do not use a duvet or baby nest which can be too warm and can easily cover a baby's head.



# REDUCING THE RISK OF COT DEATH

THE DEPARTMENT OF HEALTH

BTS1/E

**Cot Death, also known as Sudden Infant Death Syndrome, usually affects babies between one and five months. It happens while they're asleep and is always sudden and unexpected. Thankfully, it is comparatively rare.**

**Because no-one yet knows why Cot Death happens, there's no sure way to prevent it. Studies have shown that by taking a few simple precautions, you can reduce the risk.**

**The information in this leaflet is for everyone who looks after a baby...not just parents but other members of the family and other carers such as childminders and babysitters.**

**Why not keep this leaflet next to where your baby sleeps so everyone knows what to do.**

## ● Sleeping Position

Recent research shows that Cot Death is more common in babies who go to sleep on their tummies. By making sure your baby goes to sleep in the right position you can reduce the risk of Cot Death.

Babies should be laid down to sleep:

**A)** on their backs or,



**B)** on their sides, with the lower arm forward to stop them rolling over.



Don't be worried that babies might be sick and choke if laid on their backs. There is no evidence that this happens.

Some babies who require special care or who have particular medical problems need to be nursed on their tummies. Your doctor, nurse or midwife will explain why. If in doubt talk it over with them.

For babies who have been sleeping on their tummies, try them on their backs or sides. But they may not like the change and find it difficult to settle. If this happens then it is probably wise not to upset them by insisting on the new position. If you are at all worried then speak to your health visitor or doctor.

The right sleeping position is only important until babies are able to roll themselves over in their sleep. Once they can do this it is safe to let them take whichever position they prefer.