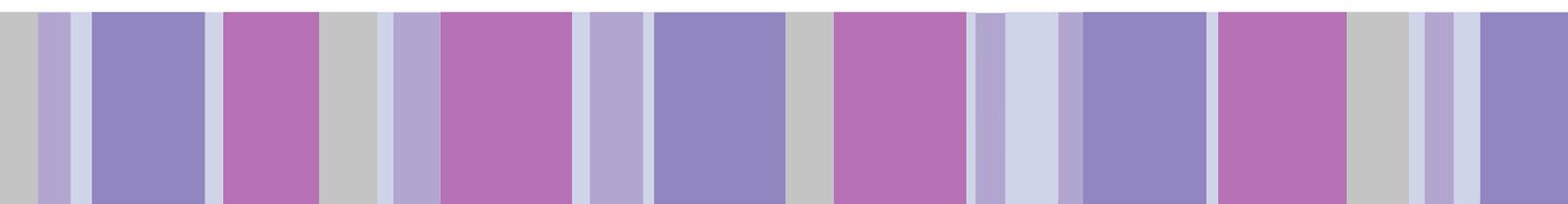


Working Paper Series
No. 10

Multiple identity and access to health

**The experience of black and
minority ethnic women**



Heidi Safia Mirza

Ann-Marie Sheridan

Centre for Racial Equality Studies

Middlesex University



Women. Men. Different. Equal.
Equal Opportunities Commission



Women. Men. Different. Equal.
Equal Opportunities Commission

**Multiple identity and access to health:
the experience of black and
minority ethnic women**

Heidi Safia Mirza and Ann-Marie Sheridan
Centre for Racial Equality Studies
Middlesex University



© Equal Opportunities Commission 2003

First published 2003

ISBN 1 84206 088 0

EOC RESEARCH DISCUSSION SERIES & WORKING PAPER SERIES

The EOC Research Discussion Series and the Working Paper Series provide a channel for the dissemination of research carried out by externally commissioned researchers.

The views expressed in this report are those of the authors and do not necessarily represent the views of the Commission or other participating organisations. The Commission is publishing the report as a contribution to discussion and debate.

Please contact the Research and Resources Unit for further information about other EOC research reports, or visit our webpage:

*Research and Resources Unit
Equal Opportunities Commission
Arndale House
Arndale Centre
Manchester
M4 3EQ*

E-mail: research@eoc.org.uk
Telephone: 0161 838 8340
Webpage: www.eoc.org.uk/research

This report can be obtained in electronic format from the EOC website or in paper format from the EOC's Helpline as follows:

Website: www.eoc.org.uk

E-mail: info@eoc.org.uk

Fax: 0161 838 8312

Helpline: 0845 601 5901

Post: EOC
Arndale House
Arndale Centre
Manchester
M4 3EQ

Interpreting service available for callers to the Helpline

Typetalk service available – Tel: 18001 0845 601 5901

CONTENTS

	Page
ACKNOWLEDGMENTS	ii
EXECUTIVE SUMMARY	iii
1 INTRODUCTION	1
2 POVERTY, HEALTH AND EXCLUSION	6
3 RACIALISATION OF HEALTH	11
4 WOMEN'S 'OTHER WAYS OF KNOWING'	17
5 INSTITUTIONAL RACISM AND STRUCTURAL INEQUALITIES	22
6 CONCLUSIONS	28
APPENDICES	
A1 Summary of the interviews	32
A2 Guiding questions for interviews	34
BIBLIOGRAPHY	35
ENDNOTES	44
TABLES	
1 Percentage of black and minority ethnic female population in each ethnic group, England and Wales, 2001	2

ACKNOWLEDGEMENTS

This project would not have been possible without Katherine Zappone, the Equality Authority in Ireland, the Equality Commission for Northern Ireland, and the Joint Equality and Human Rights Forum, whose radical vision of a new equalities agenda led to this unique commission on multiple identities. We would like to thank the EOC for their support, in particular Liz Speed who guided and encouraged us patiently and kindly with her exceptional research insights and editorial skills. Thanks also to David Darton whose challenging input was invaluable in helping us shape our arguments. We are most grateful to the research team at the Centre for Racial Equality Studies, especially Jeanne Gregory who has been a fount of knowledge from the outset, and Joella Hazel and Maria Hussain whose input and commitment to the project kept us flowing. Most of all we must thank the women we interviewed, who welcomed us most warmly into their lives. We hope we have done justice to their stories.

EXECUTIVE SUMMARY

The primary focus of this study was to consider how black and minority ethnic women understand and perceive their identity, and to assess the validity and helpfulness of looking at equality and human rights issues from a multiple identity perspective. It was carried out as part of a wider study in which the equality and human rights agencies in the United Kingdom and Ireland participated.

The research provides us with a snap-shot of the issues encountered by black and minority ethnic women of different ages, social classes and from a variety of cultural and religious groups, when accessing services in relation to their health and well-being. Three focus groups were held with black and minority ethnic women; in addition, three case-studies with women and three interviews with health professionals were conducted. Sensitive and innovative research methods were used, based on an adaptation of an 'oral narrative' and 'life history' approach.

Poverty, health and exclusion

The link between socio-economic position and inequality in health play an important role in explaining the health experiences of minority ethnic groups. Many of the women in this study talked about becoming ill through feelings of disempowerment and lack of control – these feelings were increased through isolation and experiences of racial harassment. The women were also affected by the wider social expectations on them to be 'good wives and mothers'. Pride in the home is crucial to who they are, thus living in cramped, unhygienic and unsatisfactory conditions over which they had no control became a constant source of stress. Rigid and inflexible health care delivery resulted in services excluding the very women they were aimed at helping.

Racialisation of health

The racialisation of health refers to the way in which health data and facts are actually informed by conscious and unconscious racial presumptions. When a black or minority ethnic woman enters a doctor's surgery she is often not seen as an individual, but classified immediately according to a racial category. The professionals in this study were well aware of how widely stereotypical assumptions were held within the health service. Many women experienced gendered racialisation; they were dismissed by professionals as a nuisance and hard to please. Often the women's cultural practices, and in particular their diet, were deemed inferior and believed to be the root cause of poor health.

Women's other ways of knowing

The black and minority ethnic women had developed active strategies and practices which helped them in their struggle to survive. They had a strong cultural identity and avoided statutory and mainstream services and officials where possible. Social

networks, whether local or transnational, were extremely important in helping individuals to overcome obstacles within the health system.

The women did not recognise that they were building their own bridges to achieve equality and access, and viewed the support they gave each other and their exchange of information as 'women's business'. They saw 'equality' as something that you obtained from a more structured organisation.

Institutional racism and structural inequalities

Many health authorities have produced local multi agency strategy plans and good practice guides for work with black and minority ethnic communities. Unfortunately, such a progressive institutional identity sits unhappily with the current language of objectives and targets. There are inherent contradictions in being able to deliver equalities in a climate of profit and business within an increasingly privatised health service.

The introduction of equal opportunities policies in the health service have been significant at one level, but there is little evidence to suggest that they have had much impact in breaking the cycle of discrimination and disadvantage experienced by many non-white staff. Despite the inclusive language of 'valuing diversity and recognising difference', equality did not appear to translate into practice.

Conclusions

The women in this study did not describe themselves in terms of being a woman, or black, or a refugee, or being young or old. Instead, they expressed experiences of poverty, neglect and discrimination as holistic individuals. The way in which the equalities terminology divided and cut across their natural multiple identities artificially separated the different aspects of who they were and how they really experienced inequalities.

The language of inclusion within the health service is ill at ease with a contradictory practice of targets and audits. Cultural assumptions and preconceived attitudes about the women obscured their right to be seen as individuals. The women's difference, in terms of cultural practices, language and diet, framed how they were seen in the health care system – as a problem. Positive change in the women's lives came from their ways of working around the system. The women did not recognise or use equality bodies or services as a means of leveraging access.

This study illustrates the value of taking a multiple identity approach in the context of the new and expanding equalities agenda. The experiences of the women suggest that there remains a real gap between policy and legislation on one hand, and delivery of services on the other.

1 INTRODUCTION

This small scale, exploratory study seeks to sketch out a picture of black and minority ethnic women's¹ diverse experiences in relation to equality and access to health. In particular, the study focuses on the complex ways in which a range of black and minority ethnic women, with different life experiences, draw on their specific cultural knowledge and social resources² when encountering the health service. Focusing on the women's multiple identities in the context of their strategies to maintain health and well being enables us to explore the ways in which the specific situations and experiences they encounter, challenge or support the core value of 'equality of access' within the health service in particular, and the equality agenda in general.

Background

This research arose as a result of a joint initiative by the Equality Authority in Ireland and the Equality Commission for Northern Ireland which carried out a study into multiple identities in order to develop a conceptual framework for equality strategies in Ireland (Zappone, 2001). The Chief Executives representing the member organisations of the Joint Equality and Human Rights Forum³ agreed that they should work together to develop further the concept of multiple identities, so enabling them to utilise the thinking and experiences of a wide range of equality and human rights institutions. The overall project was co-ordinated by the Equality Authority and each equality agency was tasked with conducting research into a specified multiple identity group. In the Equal Opportunity Commission's (EOC) case, this was black and minority ethnic women. A report of the entire project containing chapters on each of the individual studies is available (Zappone, 2003); this report is a longer version of the EOC chapter which appears in that publication.

Multiple identity and black and minority ethnic women

Although there are 2.3 million black and minority ethnic women in Britain making up 8 per cent of the female population (Office for National Statistics, 2003; General Register Office for Scotland, 2003) there are few statistical and research studies that explore their social and cultural positioning (Mirza, 1997a). Table 1 (on p.2) presents data from the 2001 Census showing the proportion of the black and minority ethnic female population from each ethnic group in England and Wales. Almost half are Asian or Asian British, a little over a quarter are Black or Black British and around 1 in 7 are in the 'mixed' ethnic group.

The distinctive demographic characteristics of black and minority ethnic women are often hidden within the broad brush of the Census classifications, which masks the diverse economic, social, cultural and religious differences between and among women living in the UK.⁴ Important differences are overlooked if they are subsumed

under the homogeneous term ‘black and minority ethnic women’. This overarching collective term can incorporate recent refugees fleeing war and famine, to third generation Afro-Caribbean settled migrants, who have established work and cultural patterns in the UK.

Table 1 Percentage of black and minority ethnic female population in each ethnic group, England and Wales, 2001

Ethnic Group	%	Ethnic Group	%
Mixed	14.6	Asian or Asian British	48.8
White and Black Caribbean	5.3	Indian	22.7
White and Black African	1.7	Pakistani	15.3
White and Asian	4.1	Bangladeshi	6.1
Other Mixed	3.5	Other Asian	4.7
Black or Black British	26.2	Chinese or other ethnic group	10.4
Black Caribbean	13.2	Chinese	5.1
Black African	10.8	Other ethnic group	5.3
Other Black	2.2		

Source: Office for National Statistics (2003) Census 2001: National Report for England and Wales. Table S101.⁵

The issues become even more complex when we look further within, to reveal the multiple identities of the various black and minority ethnic women. The women have multiple experiences in terms of age, sexuality, disability, religious and cultural differences. For example, an older Asian widowed woman who has worked in the family business will have a very different identity and face different equality issues compared with a younger professional Somali woman refugee doctor unable to secure employment. Each woman therefore, has a different ‘story’ to tell. Just as their experiences are different so too multiple definitions of themselves have evolved in terms of everyday lived experience of gendered and racialised social relations (Brah, 1996; Mirza, 1997a).

Black and minority ethnic women are often invisible occupying a ‘blind spot’ in mainstream policy and research studies, which talk about women on one hand or ethnic minorities on the other (Mirza, 1997a: 4). While ‘intersectionality’ informs policy in terms of perceiving people as being either black or female (Crenshaw, 1993; UN, 2000), it is unhelpful to disaggregate the women’s narratives and fragment their life experiences in terms of either being gendered or ‘raced’. In order to sketch a profile of black and minority ethnic women’s multiple identities as a lived reality it is important that the women are seen as ‘holistic individuals’ and not ‘objectified’ in terms of preconceived political and social categories which often underpin social policy and equalities thinking.

Universalistic generalisations concerning the majority (white) female population do not hold true for different black and minority ethnic women. For example all minority ethnic groups contain more children and fewer elderly than the white population. Thus, while child dependency ratios for Bangladeshi women are more than double that of the white population, elderly dependency ratios are three times lower for black groups than for white (CRE, 2002; Dench et al., 2002). Similarly Pakistani and Bangladeshi women are more likely to have children in their early 20s, be married and not working than white women (Bhavnani, 1994; Bhopal, 1998; Dale et al., 2002). In contrast African Caribbean women are more likely to be employed in skilled manual work and are three times more likely to be lone parents than any other group (Owen, 1994; Berthoud, 2001; Dench et al., 2002).

Thus the issues faced by different groups of women in terms of caring, working, health and service needs are substantively different and therefore have implications for equality of access. Clearly there is a 'gap' in health and welfare services, which have failed to understand the multiple identities of black and minority ethnic women with regard to their specific needs. The aim of this project is to explore the nature of this gap, at the intersection of policy and practice.

The study

The overall purpose of the study has been to explore the experience and identity of black and minority ethnic women in Britain and their access to the National Health Service (NHS). The research provides us with a 'snap-shot' of the issues encountered by black and minority ethnic women of different ages, social classes, and from a variety of cultural and religious groups, when accessing services in relation to their health and well being. We held three focus groups with black and minority ethnic women and conducted three case studies with individual women. To contextualise their experience we also explored the response of health agencies to the different cultural and social positionings and multiple identities of the women, by interviewing three professionals working in the NHS. However, as two of the three professionals were also black and minority ethnic women, their narratives mirror and illuminate the issues experienced by the women in the study more widely.

This was a six month, small scale exploratory study and thus any conclusions are necessarily limited and cannot be said to be representative. To gain access to the women within the given time we 'piggy-backed' pre-existing networks and contacts within the Sure Start health programme and associated community organisations in a London inner city borough. It is a large multicultural area, where over 52 per cent of the female population are from black and minority ethnic communities and over 193 languages are spoken.

The researcher had strong connections with the Sure Start programme having worked there on previous occasions. This enabled access to the women themselves, health professionals and translators.

The three focus groups took place at established community centres and health education meetings. These settings were culturally appropriate spaces, where the women felt comfortable and have existing connections. The focus groups comprised of eight to fifteen women per session. The thirty-five women interviewed came from a range of ages, cultures, religions and occupations.

- The three case studies of women gave in-depth narratives from a British born African professional mother, to a middle-aged Afghani mother and unemployed doctor, to a younger African Caribbean single mother and community worker. The interviews took place in either the women's place of work or home.
- The three interviews with health professionals enabled us to explore the issues raised by the women, and to examine their understanding of the equality agenda in the Health Service. These included a white woman health trust manager, an African Caribbean midwife and an African Caribbean health visitor.

The respondents did not advertently describe their own identities using conventional labels to identify themselves, such as country of birth, age, occupation etc. However, we do use these labels to identify the women in the text. We acknowledge that the women's identities were much more complex and textured than such labels allow, as indeed the women's narratives revealed.

To achieve some measure of integrity and accountability in the research process we used sensitive and innovative methods based on an adaptation of an 'oral narrative' and 'life history' approach (Vaz, 1997; Rassool, 1997). 'Storytelling' about 'life experiences' was accessible and appeared to be culturally more naturalistic, enabling holistic reflections on identity, illness and wellbeing as experienced by the women. Given the restrictions on time and resources this approach invited the women to share and talk about private and personal health issues.

A range of broad and flexible research questions informed and shaped the direction of the focus groups, discussions and case studies (Appendix 2). These guiding questions allowed the women to 'tell their stories' in relation to who they are (identity) and what they experience (access to health and well being). Each interview took about one hour and the discussions were taped unless the respondent declined.

Gaining access, building trust and overcoming language difficulties are all research issues we have encountered in the process. Anonymity and confidentiality have been maintained throughout the research – all names, including the places, have been changed.

2 POVERTY, HEALTH AND EXCLUSION

Zena is a 34 year old asylum seeker from Afghanistan. She is a mother to two young children, living with her husband in a one bedroom flat with no front door and drug users in the hall. In Afghanistan she was a practising gynaecologist at a large hospital. She had to leave Afghanistan in 1998 as the Taliban had raided her house and accused her of teaching children about sex. After being attacked and badly injured she fled her country for England. Zena still suffers from headaches and acute pain from the injury, but admits it is aggravated by issues compounding her frustration in this country. As a mother she wishes for safety and space for her children, as a gynaecologist she wishes to practice in this country, as an asylum seeker she wishes to be treated as equal, as a woman she wishes to have freedom.

Poverty and ill-health

The link between socio-economic position and inequality in health plays an important role in explaining the health experiences of minority ethnic groups, including women (Karlsen and Nazroo, 2000). Patterns of ill health related to social disadvantage for black and minority ethnic communities in Britain are well established (Acheson, 1998). We know for example, that babies born to Pakistani women are twice as likely to die in their first week as those to British born mothers (Kings Fund, 2001).

Stark statistical evidence such as this raises important issues for human rights and equality strategies in an advanced industrialised democracy like Britain where we find still more than half of all Pakistani and Bangladeshi households living in the 10 per cent most deprived wards in England (Cabinet Office, 2002b). Such areas are characterised by more neglected housing, vandalism, and high crime rates, which isolate women who live in fear and suffer disproportionate mental and physical illness, which in turn affects their ability to go out and work. The connection between ill-health and living in insecure situations with regards to housing and safety can have a negative impact on health. Nettleton and Burrows (1998) argue that it is not only the physical effects of material deprivation which affect health but also the psycho-social processes associated with the experience of such deprivation.

The narratives of the women in this study reveal the personal consequence of such interlocking structures of exclusion. Many of the women tell their 'stories' of becoming ill through feelings of lack of control and disempowerment in relation to faceless bureaucratic public services which, because of the women's economic dislocation and loss of community and support networks, they have no choice but to rely on. The emotional cost of living in unsuitable and unstable living conditions is amplified by isolation and experiences of racial harassment (Chahal and Julienne, 1999).

This is expressed through profound feelings of fear which are manifested as worry, headaches and stress related illness. Yet the women do not see themselves as victims and talk about the exclusionary processes⁶ they encounter in terms of unsafe places and a notion of 'them' (the big faceless council) in relation to 'us' (the small silenced tenant). As Munzia, Zena and Hilda explain:

I am afraid the council will throw me out if I tell them about the problems in the flats... I don't say anything... I am scared to tell them anything... I get headaches and pains in my neck because I worry so much... there's no one to talk to.

Muniza, Bangladeshi mother, 30, in U.K. 10 years

There is no lock on the front door to the house – boys come in drinking smoking – at night I am terrified that something will happen – I don't sleep – I worry that they will drop a cigarette and the place will go up in flames or that they will come up and attack us – they (the council) won't let us fix it and they won't fix it themselves – my husband has to go down in the night and move the people who sleep in the corridor – nobody cares about us.

Zena, Afghani mother, 34, refugee and doctor, in U.K. 5 years

We were living on an estate before – there were nasty teenagers who were rude and we didn't feel safe – I didn't even want to leave the flat – it was an awful time – we were up on the top floor and the boys would shout at me when I was out and about .

Hilda, Polish mother, 28, in U.K. 7 years

Identity and social exclusion

Not only are black and minority ethnic women's experiences shaped by their immediate living conditions, they are also influenced by the wider social expectations of them as 'good wives' and 'good mothers.'⁷ A recent study of immigrant women's health in Canada suggests women from Asia, Africa, central and south America and the Middle East define their personal physical health in relation to their ability to function as resources for their families' well-being (Meadows et al., 2001). It would appear that gendered social and cultural conventions which link women to the private domestic sphere clearly operate to tie working class, black and minority ethnic women to their role in the home (Mohanty, 1997). However, Carby (1982) argues that in oppressive situations, for example under racist conditions of slavery or forced migration, the family can become a strategic site for resistance. For many women the family and institutions such as the mosque and church can provide a means of cultural survival through self-actualisation, conscientization, organisation and empowerment. In a sense, the private domestic sphere for black women can become the public political arena of struggle (Hill Collins, 1998).

As keepers of the family honour, many women are anchored in the patriarchal discourse of 'honour and shame' (Westwood and Bhachu, 1988). Pride in the home,

as good home-makers is crucial to 'who they are' as wives, mothers daughters. Therefore, living in cramped, unhygienic unsuitable conditions over which they have no control means an essential part of who they are as 'women' is negated. This results in constant stress:

(There are) too much problems in my home - it's so dirty – I worry all the time about it – it affects my health I can't sleep – for real I can't sleep – I worry all the time.

Ilham, Turkish mother, 32, in U.K. 3 years

I am in a hotel for one year and five months – there's one room for me and my daughter – it's bad carpet and very small – I get headaches and its always cold.

Tula, Algerian mother and refugee, 26, in U.K. 1 year

My brother has a house that is no good – it smells – there is an infection in the house – it's got coackroaches - plenty of them – and bugs – he gets sick all the time – so do his children.

Shafar, Kosovan mother and refugee, 23, in U.K. 6 months

It is through Zena's identity as a mother that she expresses her anguish with her home. She is concerned about the children and feels responsible for the safety of the family and the situation they are in. She explains:

Yesterday when I was depressed I kept thinking – how can I get out of this area – I was crying for many hours – my children were seeing me and that makes it even worse – I can't find a solution.

Zena, Afghani mother, refugee and doctor, 34, in U.K. 5 years

Ironically it is not her material conditions, but her role as a mother which historically brought women like Zena, that is black and migrant women, to the attention of health and social services (Lewis, 2000). Their visibility was not about equality of access or help but because they were seen to pose a problem. In Britain in the 1970s and 1980s many working class and black and minority ethnic women had children removed from their care and underwent non-consensual sterilisation. They were deemed to be 'bad mothers' as they had to work or leave their children with others (CCCS, 1982; Bryan et al., 1985).

Margaret is a 38 year old professional woman of African heritage who has lived in the UK for most of her life. She understands the poverty and economic context of women's lives that often ends up in the pathological cultural construction of 'bad' black mothers.

The property affects people – it brings on depression – it makes people smack their children if you're living in a confined area.

Margaret, African born in UK, mother and advocacy professional, 38

Professionals in the health service like Hazel, a 40 year old African Caribbean woman, also acknowledge the relationship between socio-economic conditions, mental health and mothering in her daily working experience. As a black female health professional Hazel is what Hill Collins calls an 'outsider within' (Hill Collins, 1998). She is a black woman with her own 'cultural knowledge', who also works in a mainstream, mainly white-run public health service. In this sense Hazel is able to draw on her experience and social positioning to understand the social issues she observes in a different way to that established and embedded within the health organisation. She thus grounds her analysis of black women's familial relationships, not in terms of the usual explanation of negative familial pathology, but in a way that appreciates the women's struggle and motivation. Hazel talks about control over visible outward appearance as a strategy among black women to maintain self esteem in the context of material deprivation:

In my experience I see housing as a major issue...this impacts on their mental health – their self esteem – the way they relate to their children – even in terms of the way they look after themselves – they feel what's the point – or they over compensate when they are over dressed and concerned about their physical appearance but not what's going on up here (points to head)... You know mentally or internally...

Hazel, African Caribbean mid-wife and mother, 40

Furthermore she acknowledges the political context and consequence of the 'maternal control':

A lot of black people will say they are concerned about their children's education – its not an accident that our children are doing badly at school – although it's a real concern you feel kind of paralysed – if the mum's mental state is such that she's not functioning, she's not going to have the resources to deal with it or other issues that may arise.

Hazel, African Caribbean mid-wife and mother, 40

While black and minority ethnic women often defined themselves and others through 'acts of mothering' (Reay, 1998), the lack of childcare generally and child-friendly facilities in the health services in particular, is quite spectacular. Rigid delivery structures and insensitive planning often ensured GP's clinics aimed, in theory, at women as service users actually actively excluded them. Hazel, a midwife, explains how exclusionary practices operate in relation to post-natal checks:

Talking about women's health is often around childcare – I can't tell you the amount of times I referred women to GPs for their 6 week post natal check up and they won't go because they have to bring the baby – they weren't able to leave the baby anywhere – the GP refuses to do a physical examination (with the baby present)... look at the position the woman has to get on to on the couch – she can't take the buggy into the surgery

because she's not allowed – she ends up not having her check up... they don't care – the onus is on the woman to provide her own childcare – I don't think they (the GP) give a second thought to it.

Hazel, African Caribbean mid-wife and mother, 40

Whatever the needs or identity of the women, the doctors' surgeries had an identity of their own in which women as users were at 'the bottom of the food chain'. As far as the GPs were concerned they delivered a service at a time and for a purpose as they defined it – it was *their* service - and quite simply up to the women to 'fit in'. Lack of consideration shown by GPs to women was borne out by Hazel, who said:

The times are ridiculous – it (the surgery) doesn't take into account what's going on for women – the surgeries happen right at the time when the woman is dropping the children off (at school) and she ends up having to take them with her (to the surgery) – (there's) no space to get a buggy in the door – there's no food on site – usually no water – awful receptionists – dirty furniture – it really is ridiculous.

Hazel, African Caribbean mid-wife and mother, 40

3 RACIALISATION OF HEALTH

The ‘racialisation of health issues’ refers to the way in which so called ‘objective’ health data and ‘facts’ are actually informed by acknowledged and unacknowledged background racial presumptions (Ahmad, 1996). The consequence of such ‘racialisation’ is that differential treatment for different ethnic (and class) groups is pre-judged on the basis of spurious racialised ‘scientific’ knowledge. One such way in which the racialisation of health plays out is in the assumption that populations can only be meaningfully understood if divided into ‘ethnic’ or ‘racial’ groups. These groups are then taken as primary categories and used for explanatory purposes. Stratification by class, income, and other determinants of health care and health status such as individual and institutional discrimination, are thus deemed at best irrelevant or at worse, political (Ahmad, 1996). Nazroo (1998) explains that the dominant assumption that ethnic differences found in epidemiological data must be due to genetic or cultural risks among these populations evolved when research could not easily link socio-economic conditions to variations in mortality. Such variations in the health status of different ethnic communities are all too often “rooted in over simplistic culturalist explanations, which trace differences in health variations to behaviour, which in turn are linked to cultural differences” (Mason, 2000: 92).

The process of stereotyping

The construction of black and minority ethnic communities as ‘other’ has proved significant in understanding the women’s access to health. When a woman enters a doctor’s surgery she is often not seen as an individual - she is constructed first and foremost in a racial category: as a ‘subservient Muslim woman’ (Brah, 1996); a ‘single black woman’ (Reynolds, 1997); an ‘undeserving refugee woman’ (Crawley, 2001). The health professionals were aware of how pervasive this way of thinking is in the health service as Valerie and Jacinta explain:

I think there are very unsympathetic doctors out there – I think if you come in as the stereotypical image of being single and having children by more than one father and have limited English I think that the service is probably diabolical.

Valerie, white NHS Trust Manager, 40

We see some black and ethnic minority families having so many children – maybe they have 3 under the age of 5 – we perceive it as a problem... but maybe they don’t – it’s more natural for them to have larger families... we make assumptions of what is right and wrong.

Jacinta, African Caribbean health visitor, 42

Stereotypical, racialised, cultural assumptions about black and minority ethnic women are widely held (Law, 2002). Media images of undeserving refugee women,

aggressive Romany mothers or docile hapless female Muslim victims in Afghanistan pervade our daily screens and newspapers (Mirza, 1998; Mirza, 2003). These pictures and stories reflect and reinforce pervasive common-sense public views about black and minority ethnic women. Unlike white middle-class British women whose media identity revolves around individual and family choice and work-life balance, black and minority ethnic women are presented devoid of difference, diversity or individuality. The disempowered, those that do not have the power to 'write back' or 'speak back', are reduced to a social imagery informed by simple categories or types which in the end becomes the 'truth' about them. This normative authoritative 'gaze' or pervasive knowledge about the 'other' (black) woman is informed by a silent but powerful position of (white) privilege which the media rarely reflect on (Dyer, 2000). However as a black woman, Cynthia is acutely aware of the impact of pervasive stereotypical views:

If a young girl comes in pregnant they say 'here comes another one' we know what she's been up to...if you see a black man in a suit with nice shoes and a briefcase they think – there's a business man – if they see a black man in black jacket and trousers and a dark hat – they think oh, here's a man who's going to mug us... I believe that these stereotypes must exist in the health service too.

Cynthia, African Caribbean mother and community outreach worker, 30

Professional knowledge and cultural assumptions

A dimension of the racialisation of health issues is the construction of professional knowledge about black and minority ethnic women. The treatment of many women from different cultural and social backgrounds has often been predetermined by existing 'professional' knowledge about their bodies and minds. It has been argued that 19th century medical and scientific knowledge was grounded in anthropological thinking about Asian and African 'black female others' who were perceived as 'strange and exotic' bodies who simultaneously embodied desire and disease (Simmonds, 1997). Today the powerful 'gaze' or authoritative views held by the medical profession are less overt but still informed by sexualised and racialised cultural assumptions of the female 'alien other'. Blanket professional knowledge underpins assumptions such as the hyper sexuality of black women who contracts Aids, or the sexually oppressed Asian women who attempts suicide (Mirza, 2003). While there are social and economic conditions that are likely to affect some cultural groups more than others, these presumptions limit the fair and individual treatment of black and minority ethnic women who are denied the complexity of their situation and are treated dissimilarly to others (Fredman, 2002).

In a recent study, Box (1998) demonstrates the way in which power and professionalism operate in the context of gendered and racialised women. The South Asian women attending for cervical smear testing did not find the experience

welcoming. When they overcame their discomfort, embarrassment and fear they were often treated with coldness “like a piece of meat”. They were seen as difficult, little eye contact was made, and they were spoken to offensively, one being told “if you can open your legs for your boyfriend you can open them for me” (Box, 1998: 11). Box suggests health advocates which facilitate the women’s own knowledge, confidence and ‘voice’ are essential to developing a more sensitive and appropriate service.

In our findings most women experienced this gendered racialisation through the professional construction of them as ‘difficult’ or ‘hard to please’. It was a widespread acceptable and legitimate professional practice to talk of black and minority ethnic women as ‘a nuisance’. In GPs surgeries, hospitals or clinics professionals treated the women’s ‘stories’ about illness, poverty and stress with intolerance and disbelief. At the core of this professional construction about the women is the imbalance of power between the professional and the patient. The doctor had the advantage of being in control of how the woman is viewed and hence of ‘knowing black and minority ethnic women better than they know themselves’ (Mirza, 1997a). Valerie as a health care manager, exemplifies this unconscious way of thinking and treating Black and minority ethnic women:

I think it's their (GPs) impatience and prioritisation and how they see things – especially when they (the women) are coming back quite often for social reasons you know – presenting symptoms of headaches and pains when actually it's stress and the difficulties of life.

Valerie, white NHS Trust Manager, 40

A study looking at barriers to health among minority ethnic women in the Wakefield area suggests GPs find the women difficult and demanding, with high expectations, and in need of constant reassurance. They complain that the women’s concept of illness is to be ‘cured by a tablet’ and that they seem to be looking for the ‘magic pill’ (Ashrafi and Brian, 1997). However as Jan and Zena articulate, the women had developed an oppositional discourse in which they knew they were being perceived as ‘a nuisance’:

The real problem is that they will not examine you properly – they just want to get rid of you when you come in...they just give antibiotics – all the time – it's not good – I am a doctor too – I understand these things – you need to understand why the child is sick – not just give medicines all the time.

Zena, Afghani mother, refugee and doctor, 34, in U.K. 5 years

You wait so long and then they (the GPs) say ‘what’s wrong with you’ – they just give you antibiotics – they just give them to you – but I know

about antibiotics – I know they are not good for you – the doctor just sees it as an easy way to get rid of you.

Jan, African born Goan, mother and church worker, 54, in U.K. 30 years

In hierarchical power relations that underpin social interactions in public health service, the women's narratives reveal the complexities of class, gender and racialisation. It was interesting that GPs who were themselves women and/or ethnic minorities did not necessarily share any deep rooted emotional (essential) empathy with women :

The first doctor I went to was very rude – she didn't have an idea of ethics – she was Indian – she told me to find another doctor – I asked her to help me because I was bleeding – she said go and find someone who can speak your language.

Zena, Afghani mother, refugee and doctor, 34, in U.K. 5 years

When I talk to the doctor he says I talk too much and he's shouted at me... he's Bengali... I said I've had these problems for a long time and he said I can't help you and told me to go.

Khadija, Bangladeshi mother and grandmother, 60, in UK 30 years

It is hardly surprising that women speak of avoiding such negative interactions and attempt to seek help elsewhere. Research has shown that though ethnic minorities are as likely as white people to consult with their GP, they are less likely than whites to leave the surgery with a follow up appointment (Gilliam et al., 1989).

'Cultural imperialism': diet, language and information

One of the manifestations of the racialisation of health is the belief that 'other cultural practices' are inferior to those which are practised here 'in the West', and thus these practices are seen as the root cause of poor health (Nazroo, 2002). This attitude can be seen around diet and eating habits as Jacinta explains:

There is an assumption that 'your food is inferior to ours'... we make the women conform to British foods. As a health visitor we are not told to suggest foods that the women would be familiar with. We say 'have cereals like weetabix'... we don't say why not use this root vegetable – which they are familiar with and which has the same health values as the processed cereals – or may have more.

Jacinta, African Caribbean health visitor, 42

It is clear that food is a crucial cultural identifier among ethnic communities. 'Ethnic' food markets characterise inner-city areas, where the women and their families live and work. During the research gifts of food (and clothes) were given, recipes were revealed, and meals were cooked and shared with the researcher in the homes of the women and in the community centres where they gathered. Food and female

cultural identity are strongly intertwined. Hazel talks of "people like me ...who eat this food", yet as a health worker both she and Jacinta are trained against the grain with an ethnocentric model of good nutritional value. As she acknowledges, this means that she misses an opportunity for engagement with the women:

There's a lack of information given that is appropriate to our diet – its no use saying to us use low salt foods and no sugar – tell me which food that's in that's relevant to me... I wasn't aware that plantain was a high carbohydrate food and in particular quite a poor type of carbohydrate – that's important information for people like me who eat this kind of food – so it's irrelevant showing me bog standard food and fruit – show me food that I eat and recognise.

Hazel, African Caribbean mid-wife and mother, 40

Just as food is a terrain of struggle for recognition and empowerment, so too is language. Issues of 'immigrants and asylum seekers not speaking English' is fundamental to the ongoing debate on 'British citizenship and the right to 'belong'' (The Guardian, September 2002). Thus it is hardly surprising that language and literacy issues frame the public health services discourse on 'otherness'. High on the agenda for health professions are issues of communication in terms of language information and culture when dealing with black and minority ethnic women (Ashrafi and Brian, 1997). Achieving equality for the health service was often articulated in official health service equality documentation in terms of the tangible and obvious language and communication issues, especially the need to facilitate the women's ability to understand.

However, despite the rhetoric, basic access to information and simple translations were still hard to find as Margaret explains with regard to the automated phone services used by her local hospital.

When you make an appointment for instance you can't speak to anybody- you just have to do everything on your phone- you have to use buttons on the phone and leave your number...it would be so much easier to have someone on the phone-it's a difficult thing to do – you have to understand English to leave that message- what if you can't speak English- you haven't got a chance- not everyone is as self-sufficient as me – I can read and write - if you haven't got that then you're nothing in the system.

Margaret, African born in the UK, mother and advocacy professional, 38

Even though language differences and the need to access information was the dominant discourse in the health service for achieving equality, the most simple oversights remain characteristic as Jacinta and Zena explain:

Years ago I remember sending out appointment cards for routine medical appointments when I worked as a school nurse... no one turned up... I

couldn't understand why – but I found out – the parents couldn't speak or read English... this still happens – women are missing out because they don't understand the language... also on leaflets there are no directions – if you don't know the area you won't know where to go... or who to ask to get there.

Jacinta, African Caribbean health visitor, 42

There are so many leaflets – all with important information but they are never in any other languages – so how can women understand about contraception if they don't understand what they are saying.

Zena, Afghani mother, refugee and doctor, 34, in U.K. 5 years

There was a huge assumption about the efficacy of literature as the main vehicle to disseminate information in the health service. In Hazel's experience, simple solutions based on 'insider' community knowledge and tapping into local entertainment and local 'ethnic media' were logical:

We can't make the assumption that everybody can read or has the time to read... it's often the last priority – reading might not be the best form of passing on information...community TV or radio – they should be tapping into these sources – it strikes me that if I want to hear any news about my community I turn on my local radio – not the mainstream one – the one appropriate to my cultural group.

Hazel, African Caribbean mid-wife and mother, 40

On the surface, English language and literacy issues appear simply to be about access. However, speaking 'your' language also signifies deeper identity issues for the women in terms of being accepted for what they are, who they are, and what they have to offer. Hazel felt that if she or her community was not 'mirrored' by an organisation she had difficulties in connecting with it:

One thing for me as a black woman - I don't show interest in something unless it is something that mirrors myself – so even as a health professional with all my awareness if I don't feel comfortable in an environment I won't go – if it's in the wrong place – the wrong side of the borough – or delivered by someone I can't identify with, I won't go – so we need to address this – and recognise that mirroring is a real issue.

Hazel, African Caribbean mid-wife and mother, 40

4 WOMEN'S 'OTHER WAYS OF KNOWING'

Though the black and minority ethnic women in the study were diverse and different in terms of culture, religion, age, length of time and type of entry to the UK, they nevertheless shared a similar social positioning - that is "marginalized from the loci of power" (Thorogood, 1989: 331). However in the context of their marginalisation, black and minority ethnic communities have active strategies to support and empower themselves by developing a strong cultural identity and spirituality and avoiding statutory and mainstream voluntary family services and officials (Joseph Rowntree Foundation, 1997).

The strategies the women employed were not simply 'coping strategies', but were grounded in self actualisation and 'real knowledge' derived from their lived realities of racial and gender exclusion (Mirza and Reay, 2000). Such 'real knowledge', or 'other ways of knowing', was grounded in acts of resistance in which the women had evolved identities of refusal. They did not accept the dominant discourse but redefined their world with their own codes, values, and understandings (Mirza, 1997b). As Phoenix (2001) points out, women living in a racist society develop practices which allow them to co-exist with different world-views, while keeping their alternative identity and spirituality intact.

Cultural strategies and 'other' knowledge

The women's narratives tell about being strong, brave, clever and dignified in the face of others' perceptions of them as strange, stupid, manipulative or voiceless victims. In opposition to these popular constructions many women tell stories of the creative and inventive strategies they use to preserve cultural dignity.

One African Caribbean woman reveals that her elderly mother, who has mobility problems after a stroke, gets up at 5.00 a.m. to clean the house very slowly if she is expecting a visit from the health visitor or social worker. Being clean and being seen to be coping is part of who she is - as a proud African Caribbean elder (Patel, 1996). However as Joy (1996) shows, cultural values about greeting visitors among the African Caribbean community can work against the women receiving the benefits they are entitled to. The black and disabled women in her study who struggled to put on their best clothes and get the house clean were not seen in the real context of their lives. Their efforts were interpreted as a sign of their mobility and their benefits were cut accordingly.

In the context of limited access to rights, many women talk of cultural strategies they have evolved to 'fight for their rights'. They construct proud and brave identities as 'natural survivors' and 'challengers of injustice'. Ultimately they know this means they

are seen as problematic in the 'system', but they have little choice as Cynthia reveals. Her son had meningitis and was hospitalised for some weeks. It took several trips to the hospital's Accident and Emergency Department to have him diagnosed and she really had to fight to get the doctors to take his condition seriously :

To be honest with you the response of the health service to him and us was bad... if I had gone on their opinions I wouldn't have a son today... it upsets me and makes me angry – like about Dwaine and his meningitis – sure I'm angry but I don't moan and groan about things like others do..I guess the reason I'm like this is because I challenge things when they happen and try and get an answer – I speak my mind – maybe that's why black women don't succeed so much – we say how we feel – white people tip toe around it – but we say how it is - I had a problem with a manager once – I told her and to be honest it didn't do me any favours – maybe it offends people – we've had to stand up for ourselves – we've had to fight our corner – so now we just do it naturally.

Cynthia, African Caribbean mother and community outreach worker, 30

Other women, those who were refugees or non-English speaking had different, less obvious strategies, but they were equally effective for their needs. Many brought friends or husbands to hospital or doctors' appointments, not always because this was culturally desirable or due to oppressive social positioning in which men or chaperones must be present, but to help them negotiate the intolerant and dismissive doctors.

I'm also scared to go on my own because I think the doctors are horrible..... with my husband I feel more comfortable.

Fatma, Afghani mother and refugee, 32, in U.K. 1 year –
speaking through a translator

Many women also strategically drew on family members as 'fixers' as the main mechanism for bypassing an incomprehensible health advice system:

When I have a problem my children fix it for me.

Khadija, Bangladeshi mother and grandmother, 60, in U.K. 30 years –
speaking through a translator

I went to the Citizens Advice Bureau, but it takes a long time to help – so now I go to my nephew.

Mariam, Bangladeshi mother and grandmother, 64, in U.K. 2 years –
speaking through a translator

Social networks and resources

Some women, when pushed to the limit, frustrated at being reduced and 'silenced' in the system, sought to find a voice by proactively negotiating help by drawing on other resources including global and transnational networks. In contrast to the black British women who have developed identities based on 'survival through challenging injustice', refugee and migrant women drew on their cultural capital to find solutions and develop unique strategies based on 'survival through transcendence', as Hilda explains:

My son... kept getting flu last year – I'd go to the doctor – he'd give antibiotics – which gave my son diarrhoea – then he lost more weight – he was really very ill. We went back to Poland on a holiday with him and he got sick there, so we brought him to a Paediatrician who helped and found out the real problem by examining my son and taking tests – we found out that my son had a bad chest infection – bordering on pneumonia – not flu like the doctor here said – the Polish doctor gave the correct medicine and also gave me advice on how to look after him – he's been fine since.

Hilda, Polish mother, 28, in U.K. 7 years

In a similar bid to by pass an obstructive system, one refugee woman explained how she had used her social networks abroad to overcome the system. Following considerable efforts on her part to make her doctor see that she was having many problems sleeping at night and that she needed medication, she finally sent a message to a friend back in her homeland to post her the sedatives she required.

Some women used their transnational networks in other ways. In response to the lack of support and help within the health service and no means of childcare to release her to re-qualify in the UK, Zena, an Afghani doctor, explains how she has been active in starting up and working in an Afghani community medical centre. It is run by lecturers, doctors, and postgraduates, mostly now unemployed. She explains:

The organisation has helped me a lot – I feel I can do something for myself - I am here 4 and a half years – at first I didn't know what to do – there was no one to show me the way - it has taken a long time to get here.

Zena, Afghani mother, refugee and doctor, 34, in U.K. 5 years

Alternative health and community support

Holistic and home remedies, folk knowledge and alternative health cures, were other ways the women rationalised their health and well being and took control over their lives. Speaking at the older women's forum, the women felt that it was a satisfactory way around the unsatisfactory system.

We've learnt from our mothers how to treat our colds and flu – we take ginger and cumin and whatever else we know we should – it is much better than going to the doctor.

Rhona, African born Goan, mother, librarian and community worker, 44,
in U.K. 32 years

While many of the older generation of women talked about these alternative methods to conventional medicine, they also spoke of being penalised by the health service as a result of not attending their doctor regularly. Two women said they had been taken off the doctor's register for not having attended in some time. They found this quite humorous, as they saw themselves being punished by the system for not being sick.

Though hidden from view, black and minority ethnic women do organise collectively and effectively. As Sudbury (1998), Mirza and Reay (2000) and Davis and Cooke (2002) demonstrate, black and minority ethnic women's organisations are grassroots, organic and built on women's ability to develop affective relationships with each other, with friends and with neighbours. Such emotional and social capital demonstrates women's collective agency through invisible undervalued acts of caring, 'giving back' and personal accountability.

Most of the women interviewed in this study were engaged in structured support groups, set up by Sure Start and also by voluntary organisations. By engaging with other women, and having a space to talk, the women used these 'safe' spaces as places to develop their social capital within the system. They often used the connections they made there to enable them to find solutions to their problems. The organic nature of the support the women received at these meetings was demonstrated during a focus group (see box on p.21).

Collective problem solving was also used by the older group of women. One of the women, Dora, spoke about violence in her neighbourhood and fear of going out. She drew the connection between feeling trapped in her home and her health. The group were actively seeking a solution to the problem, and had decided to hire a vehicle to collect her so that she could attend evening functions.

At this focus group these older women also referred to their dissatisfaction with going to the GP for general check-ups of their blood-pressure. They had recently bought a blood-pressure machine, and during the interview they realised that one of their group members was a nurse and would be able to check their pressure, thus bypassing the health service.

Muniza is a Bangladeshi mother who has lived in the UK for 10 years. Her two year old child has a pronounced problem with his feet, which are turned in and which give him many problems in walking. During the focus group, Zena, an Afghani doctor, notices the problem with the boy's feet. She interrupts the interview to ask Muniza if she has been to the doctor about it. Muniza says she has, and that the doctor has said it is not a problem, that 'slowly it will get better'. Zena disagrees. An older Asian grandmother supports Zena, and they both diagnose the child with rickets. Together they explain to Muniza how to help her son, in a non-judgemental, and gentle manner. They put her mind at ease and say he needs massage and sunlight. Zena demonstrates to Muniza how to massage her son's feet appropriately, and repeats the importance of this to heal the boy, who will not, as the GP said, "just grow out of it". The support has given her peace of mind and practical advice with regards to his condition, while it has allowed Zena to use her experience as a doctor and given her a feeling of satisfaction, as she is unable to practice as a doctor in this country, due to her status.

Ironically, when asked where they went to seek help in terms of equality advice and help with access to the health service, none of the women consciously recognised that they were building their own bridges to equality and access. The support and information they shared was seen as 'women's business' - organic and natural. 'Seeking help' and 'getting fair and equal treatment' was articulated in terms of the dominant discourse of going to a more structured organisation like the Citizens Advice Bureau (CAB). However, they rarely visited these places:

I went there once (CAB) – but they were no help – so I went to another group who run a drop-in – they helped me.

Zara, Kosovan mother and refugee, 25, in U.K. 2 years

5 INSTITUTIONAL RACISM AND STRUCTURAL INEQUALITIES

Much has been written on the excluding and inequitable practices within the health service, from recruitment and promotion of doctors and nurses and staff (Coker, 2001; Carter, 1999) to user perspectives on access to services, treatment and illnesses, and attitudes (Smaje, 1995; Ahmad, 1996; Johnson, 1996; Nazroo, 1997). In recent years the impulse towards modernisation in the public sector has led to the conscious adoption of a liberal democratic discourse on equality and anti-discrimination in the health service.

Mapping the 'language of equalities'

This study included a limited investigation into the institutions that structured the women's experiences of health care. We found that when equality was raised in the health service, it was clearly centred on the notion of social inclusion through 'meeting needs and facilitating access'. Health care organisations employed 'the language of inclusion' which as Valerie demonstrates, is characterised by being flexible, embracing difference, and working in partnership:

I totally agree that different people have different needs – but I don't feel we are in a particularly good position to say what those specific needs are ...there's a greater need to do a more concerted piece of work and then again not identify people through their personal characteristics – therefore you are African and a single mother you must need this – it's hitting a happy medium – being flexible – having a better needs assessment or partnership working group with women about what they need and how they can access it.

Valerie, white NHS Trust Manager, 40

In response to recent 'race' equality legislation such as the Race Relations Amendment Act 2000 and EU Race and Employment Directives 2000, many local Health Authorities have produced local multi agency strategy plans and good practice guides for dealing with black and minority ethnic communities.⁸ Valerie explained her Trust's approach:

Again the trust has just started to do 'Respecting Diversity Training' – that's certainly a positive step in the right direction - that's for everyone – managers and practitioners and all staff.

Valerie, white NHS Trust Manager, 40

Such a progressive institutional identity, which embodied 'all the right things' was however at odds with the language of 'objectives and targets'. This 'politicised' mechanism – which is measured by results, is used to drive the agenda forward as Valerie explained:

The whole health service is very target led and when you have targets it can actually reduce your capacity to meet diversity because you have to put a lot of effort into one specific area – and there are bad ways of doing that where a waiting time for one service can be reduced by increasing it in another service – but the other service isn't being monitored so you know you look like you're doing well.

Valerie, white NHS Trust Manager, 40

However, there is a lot of resistance to improving equalities in the health service. She suggests the language of change in the NHS is the language of enforcement:

I think that whatever the policies say unless they're enforced and audited and checked they're useless – maybe that's an area of weakness - I think the LA (Local Authority) do better – They're more focused on checking how recruitment is done and feeding back.

Valerie, white NHS Trust Manager, 40

This emphasis on targeting and auditing to meet the legislative requirements of the Race Relations Amendment Act (2000) highlights the contradictions of delivering equalities in a climate of profit and business within an increasingly privatised health service. Under these reductive conditions black and minority ethnic women slip through the cracks of a crude equalities accounting system which fails to recognise the complexities of implementing gender-blind 'race' targeting on one hand and colour-blind gender targeting on the other. Black and minority ethnic women become invisible in an equalities agenda that focuses on either ethnic minorities or women at any one time, but rarely both at the same time (UN, 2000; Mirza, 2003).

Generally there is a greater awareness (of black and minority ethnic women) but how high up the priority list it is, is questionable.

Valerie, white NHS Trust Manager, 40

Hazel commented that though there was now a greater awareness of the issues surrounding black and minority ethnic women, a lot more work needed to be done:

In my experience as a midwife things like specific medical problems related to ethnic groups like sickle cell or thelassaemia... there is a lot more awareness... but in practice... well it's not put into practice... there's a lot of information and training and whatever but when it gets down to the nitty gritty of providing there is a way to go... the translation of information has to be developed.

Hazel, African Caribbean mid-wife and mother, 40

Tracking equal opportunities

Equal opportunities is an equalities strategy that aims to achieve a fair and equal society by addressing ongoing discrimination through facilitating access and removing barriers to participation (Fredman, 2002). However, the daily experiences

of black and minority ethnic women health care workers in the health service highlighted the persistent inequalities they experienced, despite the rhetoric of equal opportunities. As Jacinta explains:

They have an equal opps. policy – or at least they say they have... but opportunities are not equal here for workers or service users...promotion is never fair in terms of black women... black women don't seem to get beyond a certain level... there is a token gesture but they don't go beyond that.

Jacinta, African Caribbean health visitor, 42

While the introduction of equal opportunity policies in the health service has been significant at a symbolic level, there is little evidence to suggest that the policies have had a marked impact on breaking the cycle of discrimination and disadvantage experienced by non-white workers in the health service. As Carter explains, minority ethnic nurses “are located in the least desirable types of nursing and on the least desirable shifts...and few reach management positions” (1999: 58). Valerie gives us a clue as to why:

It (the equal opportunity policy) is as effective as the manager makes it – there's no pressure from above about equality targets – not about equality.
Valerie, white NHS Trust Manager, 40

The reality of this racialised and gendered expectation of low status work among black and minority ethnic nurses hits home when Hazel tells a story of mistaken identity:

There is an automatic assumption that when we walk into a room the black person is more than likely the lower grade... it's happened to me ... when I was a staff nurse way back when a doctor came in the ward... I had the white staff nurse dress on and a student nurse had the blue student dress on – but the doctor went straight to the student nurse... and you could only assume this was because she was white.. people get the ideas...

Hazel, African Caribbean mid-wife and mother, 40

Valerie, a health service manager, cited the fact that the Trust is currently involved in collecting ethnic monitoring data on the staff to obtain a better picture the local community it served. This, she felt, was important in addressing the issue of under-representation. Hazel, a mid-wife, is not normally included at a management level meetings but was deputised as a higher ranking colleague was ill. She observed:

I looked in that room and I was the only black woman there - there was one other Asian guy – I just thought 'I think you need to look in your own back yard first before you start looking at the lower grades'...

Hazel, African Caribbean mid-wife, mother, age 40

Unpacking institutional racism

In the study, the black women working within the health service were being subjected to institutional constraints which they experienced at a personal level. Hill Collins (1998) explains that black women are now ‘controlled’ in new ways, in ‘unraced desegregated work places’. She argues that isolated and visible professional black women have to account for themselves more than others and this amounts to covert forms of surveillance in the public sphere. She calls this process of everyday racism the ‘politics of and containment’. Cynthia reveals how she experiences this process of racial exclusion as part of her lived reality:

We always have to prove ourselves as better – there is a feeling that black women can only succeed if they’re hairdressers or hanging around dance halls – so we have to strive higher – we have to have higher standards – we have to be competitive – we have to be better than the white counterparts – you will be put down for your colour otherwise... like in my last job, from the first day I wasn’t spoken to, I was looked up and down, I was misinformed... and this was in a school setting – they made it clear that ‘you’re here because we need an ethnic person to make it look good’... and so I left... I didn’t care if I didn’t get another job – I couldn’t stay there any longer.

Cynthia, African Caribbean mother and community outreach worker, 30

Jacinta experienced a form of ‘cultural containment’ when she applied for study leave and felt she could go no further in her career, and thus could not fulfil her potential. The official criteria of ‘no precedent, no special treatment’ failed to acknowledge her identity and duties as a breadwinner and mother:

They (the employers) give options of unpaid leave – but how can I study without a salary – and run my family home with no money... we don’t get rewarded for our desire to improve ourselves – I wanted to do a course that would really help my work – but I wasn’t allowed – I was told it would set up a precedent – and that was the end of that .

Jacinta, African Caribbean health visitor, 42

Hazel, a midwife for 20 years, explains that this process of needing more grades and qualifications has cemented the process of racial exclusion for black nurses in the last 10 years. Whereas there were more black nurses in senior positions as sisters when she first worked in the NHS, she argues that this process is now reversed with black health workers becoming increasingly invisible in management positions.

The combination of official obstacles, hoops and ‘insider knowledge and networks’ on one hand and cultural and gendered insensitivity on the other, amounts to what the Stephen Lawrence Inquiry Report describes as ‘Institutional Racism’. In this process a person is denied their right to equal opportunity because of their ‘race’ or ethnicity.

Unwitting processes, attitudes and behaviours underpin discrimination and prejudice within an organisation (Macpherson, 1999: 28).

Jacinta was clearly caught in an institutionally racist 'trap'. Her cultural commitment to her family as an African Caribbean woman, was at odds with the individualism of achievement and success which defined the masculine career structure of the organisation she was working for. Rather than the organisation taking responsibility for this structural lacking, *she* is pathologised as unambitious:

We don't have extended families – so if there is a sick child we have to stay at home to look after them – we are penalised for staying with our families. We are not seen as power hungry – but that's because we have so many other commitments – it doesn't mean we don't want to succeed. We don't have the time to network or get inside information on jobs etc because we have so many other commitments... so how can we move up if we're not in the right environment... it's a catch 22 situation.

Jacinta, African Caribbean health visitor, 42

Understanding 'equality' versus 'difference'

From the evidence presented here we can see there are many problematic equalities issues within the health service. Despite having adopted the inclusive language of 'valuing diversity and recognising difference', equality did not appear to translate into practice. In their daily experiences black female health workers still experience a distinct lack of equal opportunities through embedded racist institutional practices.

To move the equalities debate forward in the health service the issue of black women's 'difference' within the system has to be addressed. As Jacinta pointed out above, dealing with her difference is a 'catch 22 situation' within the health system. Are people treated equally by treating them all the same, or by recognising their differences? Cynthia highlights this conundrum when she expresses the dual need for belonging (sameness) on one hand and the need for recognition (difference) on the other:

We (African Caribbean black women) don't feel we're different to anyone else and so we should be treated the same...

But on the other hand she says:

If you've got someone coming from a troubled country or a third world country they will have special needs – and it's important not to lump all those together – you know Africa is a big place with lots of different religions, foods, cultures – so is Turkey even – you need to know about the cultures of these places – like some women might find it difficult to be examined by a doctor – some women might not be comfortable with that –

I guess we need to understand more about cultures – every client has needs really – and you just can't make generalisations – you need to take each client on their merits – not as a whole population.

Cynthia, African Caribbean mother and community outreach worker, 30

Getting the balance right between 'equality' and 'difference' means being sensitive and reflexive. As the Commission on the Future of Multi-Ethnic Britain concludes in its report (Runnymede, 2000), this will be *the* equality challenge for the health service in the 21st century.

6 CONCLUSIONS

This study has focused on black and minority ethnic women's multiple identities in the context of their strategies to maintain health and well being as users and employees of the health service in Britain. It explored the ways in which the specific situations and lived realities of the women's lives impinged on their right to appropriate care and equal treatment in the health service. Using an adaptation of the culturally sensitive method of 'oral narratives' and 'life histories', a total of 40 black and minority ethnic women of different ages, social classes, and from a variety of cultural and religious groups told their 'stories' of hardship and transcendence when attempting to access the service.

This was a short six-month study, thus any findings are necessarily tentative and exploratory. The core aim of the research was to map out the key issues for establishing an integrated equality agenda. Such an agenda calls for:

A need to create a common equality consciousness and conceptualise equality strategies to include an understanding of diverse traditions and backgrounds.

(Zappone, 2001:103)

Zappone argues that a comprehensive integrated equality agenda will, by necessity, be underpinned by an understanding of inclusivity and affirmation of diversity. She explains further that an essential pre-requisite to operationalising measurable equality of outcome and developing an inclusive model of equality, is recognising the differences between social groups, and in particular the needs of the most vulnerable and marginal in our society.

In the light of this integrated equalities agenda the primary purpose of the study was to ask the question:

- is multiple identity a useful tool for understanding inequalities to access with particular regard to health?

A second, but associated aim was to ask:

- to what extent can a multiple identity approach illuminate and advance our theory and practice of equalities more generally?

Thirdly, in the light of the women's experiences we ask:

- how meaningful is the core value of 'equality of access' within the health service in particular, and the equality agenda in general, when we evaluate the outcomes for black and minority ethnic women?

Multiple identity versus intersectionality

In relation to the first aim, to explore multiple identity as a means of understanding the process of social exclusion and inequality, our findings were revealing. The women's narratives through which they expressed experiences of poverty, neglect, marginalisation and discrimination were not expressed in terms of an overt equalities discourse where identity was expressed in terms of either 'being women' or being 'black' or being a 'refugee', or being 'young' or 'old' or 'disabled' or 'gay'. Such 'intersectionality' (Crenshaw, 1993; UN 2000) which characterises the official equalities debate artificially separates out our combined racial, gendered and other identities. The official equalities constructions thus divide us up and cut across our natural multiple identities as experienced in daily life. In reality we experience our gendered, racial and other identities in a continuous flow of one through the other (Brah, 1996). Maynard explains:

... racism and sexism are interlocking systems of domination that uphold each other. It does not make sense to analyse 'race' and gender as if they constitute discrete systems of power.
(Maynard, 1994: 21)

In the women's daily, lived experiences they expressed their personal identity in the collective gendered terms of familial roles and responsibilities as mothers, workers, and wives. They talked about duty to the family, protecting their children, and surviving poor conditions, caring for others and organising for change. They expressed themselves as 'holistic feminised beings', who were active and self-motivated, but also spoke of their frustration at the services and treatment they received.

Many Asian and refugee women knew they were being pathologised as complainers and that the doctors neglected and dismissed them as a nuisance. It was the stress of their gendered and racialised social positioning that made them feel unwell and sent them into spirals of depression. Similarly, the black African Caribbean women, who were positioned differently than the Asian and refugee women as workers in the health service, experienced a comparable underlying process of racism and construction of their difference. At work, the processes of institutional racism within the organisations positioned them as unambitious or difficult or just invisible because of their identities as survivors or their maternal duty as breadwinners. As a consequence they were often not promoted or were excluded.

Multiple identity and the equality agenda

The second purpose of the research was to explore the possibility of using a multiple identity approach to illuminate the 'gap' between the theory and practice of 'equalities'. Much is said about the process of exclusion (Social Exclusion Unit, 1998)

and the need to address persistent inequalities with anti-discrimination and equalities legislation (Fredman, 2002; Department of Trade and Industry, 2002a, b), and to re-organise the existing equality commissions (Hepple et al., 2000; O’Cinneide, 2002). The multiple identity approach enabled us to explore the covert nature of the process of exclusion as it was experienced by the women in the context of these legal and institutional mechanisms for redressing inequalities.

In the study, we found that cultural assumptions and preconceived attitudes about the women obscured their right to be seen as individuals. In the doctor's surgery they were defined through childcare or inability to speak English - thus they were seen as ‘black single mothers’ or ‘demanding Asian women’ before they were seen as a person. Despite progressive equality legislation, it has been demonstrated that black and minority ethnic women are still categorised in ways which do not relate directly to the application of the equality legislation. As a consequence they have been found to suffer cumulative multiple discrimination (Fredman, 2002; UN, 2000), double (Bradley, 2001) or triple jeopardy (Gregory, 2002). This means black and minority ethnic women often fall between the scope of the separate legislative provision for race, sex and disability discrimination and are very rarely able to make multiple discrimination claims.

In the health service, the discourse on social inclusion through ‘respecting diversity and achieving equality’ had at its core the concept of the ‘recognition of difference’. However, understanding the way in which this particular social construction of ‘difference’ manifested itself in the women’s lives is the key to understanding the process of exclusion in the health service. The women’s ‘difference’ in terms of language, diets, and ways of childcare framed how they were perceived in the health care system. In the study they were universally seen as a ‘problem’. There was a crude cultural reductionism that underpinned this way of thinking. The women’s health issues were a consequence of either cultural practices or ethnic ‘predispositions’ to certain illnesses or conditions. Ironically, in the discourse on ‘respecting diversity’ in the health service the cultural problem was also seen as the solution – access to language and changing the women’s diets were the focus of ‘good practice’.

Thus, because the women’s difference was the object of scrutiny, the commonalities of class and social positioning across all ethnic groups (including white groups) and the impact of shared socio-economic and material conditions was lost. The women’s narratives of poverty and family and ill health, though expressed in a cultural context, could be universal to all women who shared their social positioning.

Multiple identities and equal access

The third issue we address in this study is the reality of 'equality of access' within the health service. If there is equality then what are the 'real' outcomes for black and minority ethnic women? The women did not recognise or use equality bodies or services as a means of levering access. The lower income and refugee women saw the health, housing and welfare services as obstacles to happiness and well being. The women who worked in the health service experienced equal opportunities as rhetoric, not practice.

Positive change, in the women's lives, was expressed through their own narratives of positive self-determination and ways of working around the systems of exclusion. Their strategies, which included self-esteem and embodied pride, served to mirror that which was lacking in the services. Their cultural ways were not problems but strengths. Such creativity and self-help was however, neither valued nor developed in the health service, which operates a top down approach to equalities. The language of inclusion, with its discourse on difference and flexibility and community partnership, was juxtaposed with a contradictory practice of targets, audits and enforcement.

A multiple identity approach

This study illuminates the value of taking a multiple identity approach in the context of a new, far reaching and expanding equalities agenda. It demonstrates the need to understand the social and cultural dynamics of the people that most require legal protection. Recently, the Race Relations Amendment Act (2000), the 1998 Human Rights Act and the EU Race and Employment Directive (2000) have widened anti-discrimination, equal treatment and positive provision. Protection now can cover direct and indirect discrimination based on sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth, racial or ethnic origin, religion or belief, disability age and sexual orientation.

Such extensive protection needs to be accessible to the most marginal and excluded if it is to be credible. The findings of this study indicate that a gap remains between policy and legislation on one hand and practice, and delivery on the other. At the heart of this gap is the lived experience of black and minority ethnic women. It is their stories that light the way through the maze of what has become the 'equalities agenda'.

APPENDIX 1

Summary of the interviews

(Names and places have all been changed)

Focus Groups

1. Here We Grow, mother and child group

White Garden School Annex

Thursday 5 July 2002

The group runs through the school year by Sure Start and A.L.S. (Adult Learning Services). The philosophy behind the group is to provide a space for parents and their children, who are a year before starting school. The parent's set the agenda for each term, highlighting issues that they are interested in, related to their children. The team also organises educational trips for the mothers to places of interest in the area.

There were eight women present on the day of the interview, from Polish, Afghani, Turkish and Asian backgrounds. The interview was taped.

2. Holi Centre, women's group

Steep Road, White Garden

Thursday 11 September 2002

The Holi Centre was set up as a Bangladeshi Women's Centre. They run classes in English, sewing and other skills. They provide a support network to Bangladeshi women living in the area, but are also open to members from all parts of the community.

The interview took place following an English Language lesson, with a group of 15 women. The women came from Bangladesh, Somalia, Kosova, and Algeria. Several of the informants had difficulties with conversing fluently in English, and relied on each other for translations. The interview was taped.

3. Pensioners Group

Welcome Community Centre

Brighton Road

Thursday 26 September 2002

The Welcome Community Group was set up by people from the Goan Community. They have a centre where they run courses and social events for

members of their and other communities. The pensioners group meet once a week, and have active sessions where they do keep fit, cook and socialise. They also welcome in guest speakers to talk about issues affecting their health and well-being. The 12 women who attended on this occasion came from Goa, Kenya and Malaysia. The interview was taped.

Case Studies

1. **Zena** (age 34), Afghanistani mother, doctor and asylum seeker.
Saturday 31 August 2002
The interview took place in Zena's home in White Garden, on Saturday afternoon. Her children (age 7 and 2) were present as her husband was sleeping (he works nights). The interview was taped.
2. **Margaret** (age 40), African professional and mother, working as an advice officer for a refugee charity.
Thursday 26 September 2002
The interview was taped and took place at Margaret's place of work in White Garden.
3. **Cynthia** (age 30), African Caribbean single mother, working as a community outreach worker for Sure Start.
Thursday 7 November 2002.
The interview took place over the phone and was not taped.

Professional Interviews

1. **Jacinta** (age 42), health visitor with Sure Start team.
Tuesday 10 September 2002
The interview took place in Sweetview Lane Health Clinic and was not taped.
2. **Hazel** (age 40), mid-wife with Sure Start team
Tuesday 10 September 2002
The interview took place at Sweetview Lane Health Clinic and was taped.
3. **Valerie** (age 40), Health Trust Manager.
Monday 14 October 2002
Valerie has been in this position for 4 months. The interview was taped and took place at her office at St. David's Hospital.

APPENDIX 2

Guiding questions for interviews

Focus groups and case studies

- What is your cultural and religious and family background? (Tell me about your selves?)
- Where do you go if you have a problem or an issue with your health? (How do you find out information; what is the first place/ people you go to?)
- What barriers are there to accessing services? (Do you face any problems getting help i.e. language; times; environment; travel; childcare?)
- What other issues in your life affect your health and well-being? (Does where you live and what you do affect your health i.e. housing; jobs; family; money; worry?)
- What do you think of equal opportunities policies in health service? (Do you think the health service is fair and understanding of your needs?)

Key professionals

- What is your role and remit in the health service? (What is your job and do you meet black and minority ethnic women in your daily practice?)
- What specific needs do black and minority ethnic women have in relation to their health and well-being? (What do you see as the major issues for black and minority ethnic women?)
- How sensitive is your job and the health service in general towards helping black and minority ethnic women? (Does the health service facilitate women's access to the services they are entitled to and /or need?)
- What equal opportunity policies exist within the health service? Are they applied effectively? (How effectively are the policies of equality applied in practice?)

BIBLIOGRAPHY

Acheson, D. (1998) *Independent inquiry into inequalities in health report*. London: The Stationery Office.

Afshar, H. (1994) 'Muslim women in West Yorkshire: growing up with real and imaginary values amidst conflicting views of self and society' in Afshar, H. and Maynard, M. (eds.) *The dynamics of race and gender: some feminist interventions*. London: Taylor and Francis Ltd.

Ahmad, W. I. U. (1996) 'Making black people sick: 'race', ideology and health research', in Ahmad, W. (ed.) *'Race' and health in contemporary Britain*. Buckingham: Open University Press.

Alexander, J. and Mohanty, C. T. (eds.) (1997) *Feminist genealogies, colonial legacies, democratic futures*. London: Routledge.

Allen, S. (1994) 'Race, ethnicity and nationality: some questions of identity' in Afshar, H. and Maynard M. (eds.) *The dynamics of race and gender: some feminist interventions*. London: Taylor and Francis Ltd.

Ashrafi , K. H. and Brian, A. (1997) *Report of ethnic minority women's health project to identify the barriers experienced by ethnic minority women in accessing primary and secondary health care services in the Wakefield area*. Wakefield: Wakefield Health Authority.

Berthoud, R. (2001) 'Teenage births to ethnic minority women', in *Population Trends* 104 (Summer): 12–17.

Bhavnani, R. (1994) *Black women in the labour market: a research review*. Manchester: Equal Opportunities Commission.

Bhopal, K. (1998) 'How gender and ethnicity intersect: the significance of education, employment and marital status', in *Sociological Research Online* 3 (3), available at: <http://www.socreasonline.org.uk/socreasonline/3/3/6.html>

Bivand, P. (2002) *Ethnic minorities and the labour market*. Centre for Economic and Social Inclusion. Available at: www.cesi.org.uk/_newsite2002/publications/wb/w132/html/ethnic_minorities.htm (accessed 31/10/2002).

Blackwell, L. (2001) 'Fragmented life courses: the changing profile of Britain's ethnic populations', in *Population Trends* 101 (Autumn): 6-10.

Blunkett, D. (2002) 'What does citizenship mean today?' *The Observer*, September 15.

Bourdieu, P. (1986) 'Forms of capital', in Richardson, J. (ed.) *Handbook of theory and research for the sociology of education*. New York: Greenwood Press.

Box, V. (1998) 'Cervical screening: the knowledge and opinions of black and minority ethnic women and of health advocates in East London', in *Health Education* 57, 3-15 March.

Bradley, H. (2001) 'Handling double disadvantage: minority ethnic women and trade unions', available at: <http://www.leeds.ac.uk/esrcfutureofwork/projects/details.html>

Brah, A. (1994) 'Race' and 'culture' in the gendering of labour markets: South Asian young Muslim women and the labour market' in Afshar, H. and Maynard, M. (eds.) *The dynamics of race and gender: some feminist interventions*. London: Taylor and Francis Ltd.

Brah, A. (1996) *Cartographies of diaspora: contesting identities*. London: Routledge.

Bryan, B., Dadzie, S. and Scafe, S. (1985) *Heart of the race: black women's lives in Britain*. London: Virago.

Cabinet Office (2001) *Women and work: challenges and opportunities*. Available at: <http://www.cabinet-office.gov.uk> (accessed 3 June 2002).

Cabinet Office (2002a) *Improving labour market achievements for ethnic minorities in British society: scoping note*. Performance and Innovation Unit, available at: <http://www.cabinet-office.gov.uk/innovation/home> (accessed 29 April 2002).

Cabinet Office (2002b) *Ethnic minorities and labour markets: interim analysis report*. Performance and Innovation Unit, available at: <http://www.cabinet-office.gov.uk/innovation/home> (accessed 24 April 2002).

Carby, H. (1982) 'White women listen! Black feminism and the boundaries of sisterhood', in CCCS (ed.) *The empire strikes back: race and racism in 1970s Britain*. Centre for Contemporary Cultural Studies. London: Hutchinson Press

Carter, J. (1999) 'Ethnicity, gender and equality', in Barot, R., Bradley, H. and Fenton, S. (eds.) *Ethnicity, gender and social change*. London: Macmillan Press.

CCCS (1982) *The empire strikes back: race and racism in 1970s Britain*. Centre for Contemporary Cultural Studies. London: Hutchinson Press.

Chahal, K. and Julienne, L. (1999) *"We can't all be white!" Racist victimisation in the UK*. Joseph Rowntree. London: Routledge.

Coker, N. (ed.) (2001) *Racism in medicine - an agenda for change*. London: King's Fund.

Commission for Racial Equality (2002) *Ethnic minority women: Fact Sheet - 1997*, Commission for Racial Equality, available at: <http://www.cre.gov.uk/facts> (accessed 20 June 2002).

Cornell, S. and Hartmann, D. (1998) *Ethnicity and race: making identities in a changing world*. London: Sage.

Crawley, H. (2001) *Refugees and gender: law and process*. Bristol: Jordon Publishing.

Crenshaw, K. (1993) 'Whose story is it anyway? Feminist and anti-racist appropriations of Anita Hill', in Morrison, T. (ed.) *Race-ing, justice en-gendering power*. London: Chatto and Windus.

Crenshaw, K. (2000) 'Race reform and retrenchment; transformation and legitimation in anti-discrimination law', in Back, L. and Solomos, J. (ed.) *Theories of race and racism*. London: Routledge.

Dale, A., Fieldhouse, F., Shaheen, N. and Kalra, V. (2002) 'Routes into education and employment for young Pakistani and Bangladeshi women in the UK', in *Work, Employment and Society* 16(1): 5-27.

Davis, S. and Cooke, V. (2002) *Why do black women organise: a comparative analysis of black women's voluntary sector organisations in Britain and their relationship to the state*. London: Joseph Rowntree and Policy Studies Institute.

Dench, S., Aston, J., Evans, C., Meager, N., Williams, M. and Willison, R. (2002) *Key indicators of women's position in Britain*. London: Women and Equality Unit, Department of Trade and Industry Publications 6309/1.8/11/02/NP, available at: www.womenandequalityunit.gov.uk

Department of Health (2000a) *Health survey for England 1999: health of ethnic minority groups*, available at: <http://www.doh.gov.uk/public/hs99ethnicpress.htm> (accessed 30 November 2002).

Department of Health (2000b) *Ethnicity: collection of ethnic data in DH central statistical collections: a 'position statement' update*, available at: <http://www.doh.gov.uk/ethdevlist3.htm> (accessed 15 April 2002).

Department of Trade and Industry (2002a) *Equality and diversity: the way ahead*. London: HMSO, available at: <http://www.dti.gov.uk> DTI Pub.6351/30k/10/02/NP.

Department of Trade and Industry (2002b) *Equality and diversity: making it happen*. London: HMSO, available at: <http://www.dti.gov.uk> DTI Pub.6354/30k/10/02/NP.

Dyer, R. (2000) 'The matter of whiteness', in Back, L. and Solomos, J. (eds.) *Theories of race and racism*. London: Routledge.

Evandrou, M. (2000) 'Social inequalities in later life: the socio-economic position of older people from ethnic minority groups in Britain', in *Population Trends* 101 (Autumn): 11- 18.

Fredman, S. (2002) *The future of equality in Britain*. Manchester: Equal Opportunities Commission.

General Register Office for Scotland (2003) *Scotland's Census 2001 – Reference Volume*, available at: <http://www.gro-scotland.gov.uk/grosweb/grosweb.nsf/pages/scotcen6>

Gregory, J. (2002) 'Discrimination, equality and human rights: dilemmas and contradictions'. Middlesex Research Seminar, May, Middlesex University.

Gilliam, S., Jarman, B., White, P. and Law, R. (1989) 'Ethnic differences in consultation rates in urban general practice', in *British Medical Journal* 299: 953-957.

Hepple, B., Coussey, M. and Choudhury, T. (2000) *Equality a new framework: report of the Independent Review of the Enforcement of U.K. Anti-Discrimination Legislation*. Oxford: Hart Publishing.

Hill Collins, P. (1998) *Fighting words: black women and the search for justice*. Minneapolis: University of Minnesota Press.

HMSO (1999) *The 2001 Census of Population*. Cmnd 4253. London: The Stationery Office.

Holdsworth, C. and Dale, A. (2000) 'Ethnic variation in the impact of childbirth on women's employment and occupational attainment'. CCSR Occasional Paper 13. University of Manchester: CCSR Faculty of Economic and Social Studies.

Johnson, M. (1996) 'Equal opportunities in service delivery: responses to a changing population?' in Ahmad, W. (ed.) *'Race' and health in contemporary Britain*. Buckingham: Open University Press.

Joseph Rowntree Foundation (1997) *Black families' survival strategies: ways of coping in UK society*. Report for the Black Families Talking Project. Joseph Rowntree Findings, Social Policy Research 135, November.

Joy, F. (1996) 'Fight on all sides: black disabled women', in *Community Care* 1135 (29 August): 12-13.

Karlsen, S. and Nazroo, J. (2000) 'Identity and structure: rethinking ethnic inequalities in health', in Graham, H. (ed.) *Understanding health inequalities*. Buckingham: Open University Press.

King's Fund (2001) 'General election 2001 briefing no.13: inequalities in health', May. Available at: <http://www.kingsfund.org.uk> (accessed 3 December 2001)

Law, I. (2002) *Race in the news*. Basingstoke: Palgrave Press.

Lewis, G. (2000) *Race, gender, social welfare: encounters in a postcolonial society*. London: Polity Press.

Macpherson, W. et al., (1999) *The Stephen Lawrence inquiry: report of an inquiry by Sir William Macpherson of Cluny*. London: Stationery Office.

Mason, D. (2000) *Race and ethnicity in modern Britain*. Oxford: Oxford University Press.

Maynard, M. (1994) 'Race', gender and the concept of difference', in Afshar, H. and Maynard, M. (eds.) *The dynamics of race and gender: some feminist interventions*. London: Taylor and Francis Ltd.

Meadows, L., Thurston, W. and Melton, C. (2001) 'Immigrant women's health', in *Social Science and Medicine* 52: 1451-1458.

Mirza, H. (1992) *Young female and black*. London: Routledge

Mirza, H. (1997a) 'Mapping a genealogy of black British feminism', in Mirza, H. (ed.) *Black British Feminism*. London: Routledge.

Mirza, H. (1997b) 'Black women in education: a collective movement for social change', in Mirza, H. (ed.) *Black British Feminism*. London: Routledge.

Mirza, H. S., (1998) 'Race, gender and IQ: the social consequences of a social scientific discourse', in *Race Education and Ethnicity* 1 (1): 109-126.

Mirza, H. (2001) 'Research review on black and minority ethnic women'. Rowntree Research Seminar, *Reviewing research on black and minority ethnic communities*. July, York.

Mirza, H. (2003) "'All the women are white, all the blacks are men: but some of us are brave" - mapping the consequences of invisibility for black and minority ethnic women', in Mason, D. (ed.) *Explaining ethnic inequalities*. Bristol: Policy Press.

Mirza, H. and Reay, D. (2000) 'Redefining citizenship: black women educators and the third space', in Arnot, M. and Dillabough, J. (eds.) *Challenging democracy: international perspectives on gender, education and citizenship*. London: Routledge Falmer.

Modood, T., Beishon, S. and Virdee, S. (1994) *Changing ethnic identities*. London: Policy Studies Institute.

Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S. and Beishon, S. (1997) *Ethnic minorities in Britain: diversity and disadvantage*. London: Policy Studies Institute.

Modood, T., Berthoud, R. and Nazroo, J. (2002) 'Race', racism and ethnicity: a response to Ken Smith', in *Sociology* 36 (2): 419-429.

Mohanty, C. T. (1997) 'Women workers and capitalist scripts: ideologies of domination, common interests, and the politics of solidarity', in Alexander, M. J. and Mohanty, C. T. (eds.) *Feminist genealogies, colonial legacies, democratic features*. London: Routledge.

Nazroo, J. (1997) *The health of Britain's ethnic minorities*. London: Policy Studies Institute.

Nazroo, J. (1998) 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', in Bartley, M., Blane, D. and Smith, G. D. (eds.) *The sociology of health inequalities*. Oxford: Blackwell.

Nazroo, J. (2002) 'The racialisation of ethnic inequalities in health', in Dorling, D. and Simpson, L. (eds.) *Statistics in society*. London: Arnold.

Nettleton, S. and Burrows, R. (1998) 'Mortgage debt, insecure home ownership and health: an exploratory analysis', in Bartley, M., Blane, D. and Smith, G. D. (eds.) *The sociology of health inequalities*. Oxford: Blackwell Publishers.

O'Connell, C. (2002) *A single equality body: lessons from abroad*. Manchester: Equal Opportunities Commission.

Office for National Statistics (2003) *Census 2003. National Report for England and Wales*. London: HMSO, available at: <http://www.statistics.gov.uk/census2001>

Owen, D. (1994) *Ethnic minority women and the labour market: analysis of the 1991 Census*. Manchester: Equal Opportunities Commission.

Parmar, P. (1982) 'Gender, race and class: Asian women in resistance', in CCCS (ed.) *The empire strikes back: race and racism in 1970s Britain*. Centre for Contemporary Cultural Studies. London: Hutchinson Press.

Patel, N. (1996) 'Healthy margins: black elders' care: model, policies and prospects', in Ahmad, W. (ed.) *'Race' and health in contemporary Britain*. Buckingham: Open University Press.

Phoenix, A. (1996) 'Social constructions of lone motherhood: a case of competing discourses', in Bortolia Silva, E. (ed.) *Good enough mothering?* London: Routledge.

Phoenix, A. (2001) 'Research review: children, families and young people'. Rowntree Research Seminar, *Reviewing research on black and minority ethnic communities*. July, York.

Price, J. and Shildrick, M. (1999) (eds.) *Feminist theory and the body*. Edinburgh: Edinburgh University Press.

Rassool, N. (1997) 'Fractured or flexible identities? Life histories of 'black' diasporic women in Britain', in Mirza, H. (ed.) *Black British Feminism*. London: Routledge.

Reay, D. (1998) *Class work: mothers' involvement in their children's primary schooling*. London: University College Press.

Reynolds, T. (1997) '(Mis)representing the black (super)woman', in Mirza, H. (ed.) *Black British Feminism*. London: Routledge.

Runnymede Trust (2000) *The Parekh report: Commission on the Future of Multi-Ethnic Britain*. London: Profile Books.

Scott, A., Pearce, D. and Goldblatt, P. (2001) 'The sizes and characteristics of the minority populations of Great Britain - latest estimates', in *Population Trends* 105 (Autumn): 6-15.

Simmonds, F. (1997) 'My body myself: how does a black woman do sociology', in Mirza, H. (ed.) *Black British Feminism*. London: Routledge.

Smaje, C. (1995) *Health race and ethnicity: making sense of the evidence*. London: King's Fund.

Social Exclusion Unit (1998) *Bringing Britain together: a national strategy for neighbourhood renewal*. Cmnd 4045. London: HMSO.

Sudbury, J. (1998) *'Other kinds of dreams': black women's organisations and the politics of transformation*. London: Routledge.

The 1990 Trust (2002) *Black information link*. Available at: <http://www.blink.org.uk/> (accessed 30 April 2002).

Thorogood, N. (1989) 'Afro-Caribbean women's experience of the Health Service', in *New Community* 15 (3): 319-34.

UN (2000) 'Gender and racial discrimination'. Report of the expert group meeting, *UN Division for the Advancement of Women*, 21-24 November: Zagreb, Croatia (Submission by K. Crenshaw).

Vaz, K. (1997) *Oral narrative research with black women*. London: Sage.

Westwood, S. and Bhachu, P. (eds.) (1988) *Enterprising women: ethnicity, economy and gender relations*. London: Routledge.

Woodward, K. (ed.) (1997) *Identity and difference*. London: Sage and OUP.

Yuval Davis, N. (1993) 'Gender and nation', in *Ethnic and Racial Studies* 16 (4): 621-632.

Zappone, K. E. (2001) *Charting the equality agenda: a coherent framework for equality strategies in Ireland North and South*. Ireland: Equality Commission for Northern Ireland and the Equality Authority.

Zappone, K. E. (ed.) (2003) *Re-thinking identity. The challenge of diversity*. Dublin: The Equality Authority.

ENDNOTES

¹ In this study we use the popular and 'official' term 'black' and minority ethnic women. This is not a term women tend to use themselves, and there is much controversy about what it really signifies and to whom (Modood et al., 2002). It has evolved due the complex and political nature of racial definitions. In the social construction of identity it is argued that there is no scientific or biological foundation for racial difference . Thus 'Black' is not a 'race'/racial category, but a politically contested homogeneous term which has come to mean those who are visibly and politically racialised as 'other'. It has been appropriated positively by some groups, such as 'black' African Caribbean women and politicised British non-white women to identify themselves (Brah, 1996; Mirza, 1997a). Ethnicity on the other hand includes self-defining religious and cultural groups, who can be similarly racialised as culturally defined groups, but because of differential power among and between ethnic groups inherent differences in worth may not necessarily apply in the same way as with 'black' groups (Cornell and Hartmann, 1998; Runnymede, 2000). However, while those defined as 'ethnic' make up majority populations globally, they find themselves defined as small 'minority' migrant communities in the UK - hence the term 'minority ethnic.'

² The women draw on 'social capital' (networks) and cultural capital (education) both of which are socially and economically determined. The material and symbolic significance of different types of social, cultural, physical and economic capital explain the production and reproduction of social class (Bourdieu, 1986). Access to different forms of capital (or not) is determined by the women's social location. The women develop social capital such as friendships, community contacts, family and neighbours which provide access to valued resources which help compensate for lack of state provision in terms their access to cultural capital (i.e. education and wealth). They work to create affective ties to help enhance their communities stock of social and cultural capital (Mirza and Reay, 2000).

³ These are the Commission for Racial Equality, Disability Rights Commission and Equal Opportunities Commission in Britain, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission, the Equality Authority and Irish Human Rights Commission.

⁴ However, the statistical categories do not necessarily give us a clear picture of women in Multiethnic Britain. 'White' ethnic groups such as Irish, Southern and Eastern European are often subsumed under 'White'. Turkish and Middle Eastern communities are classified as 'Asian Other', while significant new migrant and refugee communities, such as Somali are categorised under 'Black Other'. Similarly new and growing diverse identities that reflect social change and complex multiplicity among minorities in the UK are defined as 'Mixed' in relation to the white majority or simply as 'Other Mixed' in the 2001 Census (HMSO, 1999).

⁵ Census data are Crown Copyright. Crown Copyright material is reproduced with the permission of the Controller of HMSO and the Queen's printer for Scotland.

⁶ In the social construction of identity women are active agents in the constant construction and reproduction of their identity. This evolves in relation to exclusionary practices and is lived out through embodied experiences (Woodward, 1997; Price and Shildrick, 1999).

⁷ There are 'ideologies of femininity' which circulate in art, media, schools, law, science and medicine and popular culture which permeate our common-sense everyday thinking about what a 'woman' should be (Woodward, 1997). However there are different ideological constructions of black and white femininity (Mirza, 1997a; Alexandra and Mohanty, 1997). The ideological regulation of third world women who do not fulfil the expectation of an idealised western model of femininity is just one way in which black and minority ethnic

women have been constructed. As Alexandra and Mohanty (1997) argue third world women's bodies are 'disciplined', that is brought into line with gendered ideology in many different ways. In nationalist representations women are expected to be 'guardians of culture' and idealised as 'bearers of the races'. In state constructions of the nuclear family they are represented as compliant 'wives and mothers'. In contrast to the western image of the 'bad working mother', armies of third world mothers are deemed 'good' workers when their legendary 'docility' maximises globalised capital investment and profit.

⁸ An example of a multi-agency good practice guide unrelated to this research is *Achieving Equality, Respecting Diversity: A partnership approach to promoting the health of black and minority ethnic communities: A three year strategy 1998-2001* (Enfield and Haringey Health Authority).