

For Mothers and Babies: Pregnancy and Antenatal Care – Low income women’s experiences during the 80’s, 90’s and early 2000’s.



University for the Common Good



This briefing highlights findings from a project carried out in partnership between the Centre for the Social History of Health and Healthcare (CSHHH), the Scottish Poverty and Inequality Research Unit (SPIRU) and the Poverty Alliance during March – November 2017 and funded by the Wellcome Trust. The evidence collected from women living on a low income who had given birth in Glasgow during the period of 1980’s – early 2000’s offers a historical snapshot of lived experiences. This briefing provides findings and reflections for policy makers and practitioners to consider with regards to the provision of antenatal care and the support offered to women.

Methodology

The research was conducted jointly by Dr Janet Greenlees, based at the Centre for the Social History of Health and Healthcare (CSHHH) and the Scottish Poverty Information Research Unit (SPIRU) and Fiona McHardy from Poverty Alliance. This partnership allowed for the sharing of expertise and to conduct the research with depth and care. Both organisations have expertise in conducting inclusive and sensitive research with low income groups. The research was approved by the Glasgow Caledonian University ethics committee.

The sampling criteria for the women involved in this study targeted those who had given birth in Glasgow during the time period of the 1980’s to the early 2000’s. After discussion with community based organisations, participants were recruited through information sheets. Nineteen women were involved across four discussions held in North and South Glasgow.

The data in this pilot project was collected through a twofold approach. Firstly, research participants were asked to complete a short survey with open and closed questions which detailed their main service engagement and antenatal care experiences. This survey also provided open space for participants to share other information they deemed appropriate. By adopting this approach prior to the focus group discussion, it provided a reflective tool for participants to draw upon as part of the focus group discussions. Discussions were jointly facilitated by the project team and focused on women’s prenatal experiences and the relationship with low income. Focus groups allowed the exploration of the commonalities and differences across women’s experiences and the group setting provided useful prompts for participant’s reflections. The project team placed an emphasis within the focus groups on creating a safe non-judgmental space and allowed time for participants to speak to the research team afterwards if required about available support and advice.

Introduction

Over the last 40 years there have been significant health improvement measures introduced to tackle health inequalities for women during pregnancy and beyond. Indeed, in the past decade a significant amount of policy attention has been given to early years and focusing on providing children the best start in life.¹ Despite this, there remain significant challenges with mothers on a low income being more likely to experience health inequalities due to their socio-economic status. The importance of supporting low income mothers during pregnancy is critical. Pregnancy is recognised as being a key trigger that increases the risk of women living in poverty.² This is the result of both greater outgoings to support children and a reduced capacity to participate in the labour market due to childcare responsibilities.³ Vulnerability can also be increased by household type; for example this risk increases further if a woman is a lone parent.⁴ The impact of poverty on women and their pregnancies can be significant. Evidence from the UK Millennium Cohort study reveals '*several adverse pregnancy outcomes including pre term birth and still birth are linked to lower socio-economic status.*'⁵

In Scotland antenatal care provision has undergone significant changes in terms of the delivery of support provided. Healthcare for women during pregnancy and beyond continues to be a key focus in tackling health inequalities.

Understanding the relationship between socio-economic inequality and pregnancy is a critical area of policy to allow effective targeting of support and advice for women. This briefing will go on to provide a snapshot into the experiences of women and will provide some recommendations drawing on the evidence collected.

Findings

Pregnancy: an Unexplored Time

Across this study, participants recognised the value and welcomed the opportunity of being able to share their views and experiences on being pregnant and the care and support

which they had received. Research participants recognised that pregnancy, labour and the early post-natal period were important periods in their lives for their health, for them as individuals and for their families. Women expressed there had been few opportunities prior to this research for them to share formally their views and experiences of this aspect of their lives and their wellbeing during their first and/or subsequent pregnancies. This study was viewed as an important opportunity to reflect and draw on their experiences for service providers and policy makers working on antenatal healthcare.

Participants recognised that since having their child, and more generally, there had been shifts and improvements in antenatal care and post-natal care time in terms of the approach and choice within service delivery. Each stage of a pregnancy both pre-and post-birth was viewed as having different challenges and women expressed in particular the value of feelings supported throughout this journey. Pregnancy brought a period of significant change in terms of how women lived their lives, concerning their identity, their relationships and wider life in their community, as well as both in terms of emotional and physiological development.

Hidden costs and Pregnancy

Finances were viewed as critical for women not only during pregnancy but also following their births. Low income had a critical role to play in terms of how women coped with pregnancy and the strategies they employed pre- and post-pregnancy to adjust to this transition in their lives. Low income affected the choices and decisions women were able to employ during their pregnancy and their day to day wellbeing.

The experience of being pregnant and living on a low income often placed pressures on women during their pregnancy, including increased stress due to worry about additional costs. This was heightened for those participants who were in more precarious financial circumstances during their pregnancy, for example due to the insecure or part-time employment status of

¹ *Early Years Framework (2009)*, <https://beta.gov.scot/publications/early-years-framework/>

² *Scottish Government (2013)*, *Scottish Government Equality Outcomes: Pregnancy and Maternity Evidence Review*.

³ *Tavistock Institute (2014)*, *Personal Relationships and Poverty an Evidence and Policy Review*.

⁴ *Ibid.*

⁵ *Annual Report of the Chief Medical Officer (2012)*, *Our Children Deserve Better: Prevention Pays*.

them or their partner, lack of clarity around maternity pay and other entitlements and security of housing. Pregnancy brought about new costs and some hidden costs which impacted on household budgets.

Low income constrained women from the earliest stage of their pregnancy, for example some women spoke of limited choices available for pregnancy testing because of the cost of getting a home pregnancy test kit. Women across the study reported going to the GP for a pregnancy test as opposed to home testing due to the cost. This meant women had to access a healthcare professional for a test.

“They [home testing kits] were expensive...”

Women in this study also reported costs when attending antenatal scans. Women discussed being expected to pay or provide a donation for pictures taken as prenatal ultrasounds. Medically, scan pictures provided important records of developmental stages during pregnancy, but they also provided a valuable way for a mother to connect with her unborn child. These fees were only removed from Scottish health boards in 2017.⁶

Some women in the study relied on their social networks to provide support in helping them adapt to their changing financial circumstances. Coping mechanisms included: when preparing for the birth of their child, getting clothing and other goods second hand from family and friends. Women also reported trying to save money through using charity shops and markets as places to buy goods for their children. Some participants discussed the recent Scottish Government provision of the baby box scheme as being a positive development for mothers based on their own experiences of preparing for a birth.⁷

Financial circumstances impacted negatively during pregnancy, due to the level of resources pregnancy took to manage and support. Women in this study were adaptive in their decision-making, however despite this it took energy, time and effort to

manage during pregnancy, which also brought about stress and anxiety because of the financial uncertainties.

Employment and Pregnancy

Many women in this study discussed employment and pregnancy. Low pay constrained women's experiences of working during pregnancy, with some women citing they opted to work very late on in their pregnancy to maintain an employment income to provide stability for the impending financial changes. Women also spoke about returning to work soon after having given birth, for example when their baby was only a few weeks old, simply because they needed the income. Childcare was provided by family members in this situation. Work patterns often remained as normal because income constraints meant that an ongoing loss of income was unsustainable.

“Okay but you have always got that kind of like, for six, maybe nine months o ‘the year it’s okay, but you’ve always got that kind of, the weather determines his wages, you know what I mean, so your kind of, have I got enough money to get milk or nappies, you know that kind of thing as well.”

(research participant)

Mixed experiences were reported around financial support and entitlements such as additional benefits. Some women reported they were unaware of entitlements to financial support and assistance available during pregnancy or post pregnancy. For others in this study, entitlement information came through peer networks, employers and through some healthcare sources such as midwives. Women reported they would have benefited from further advice, information and support around this.

Wider issues linked to their labour market experiences were also reported. Examples were given of women having to provide appointment cards to their employer in order to ensure that they were allowed time to attend antenatal checks.

⁶ *The Scotsman* (2017), ‘Call to Stop Charging Highland Mothers £5 for Baby Scan.’ http://www.heraldscotland.com/news/15416205.Call_to_stop_charging_highland_mothers__5_for_baby_scan_photo/

⁷ *Scottish Government* (2018), *Scotland’s Baby Boxes*, <https://www.mygov.scot/baby-box/>

Wider research published in Equal Opportunities Commission (2005) indicated that women in pregnancy faced a number of problems and estimated that almost half of the 440,000 pregnant women in Great Britain experienced some form of disadvantage at work. It also reported that their research found 1 in 10 surveyed women were discouraged from attending antenatal classes during work time.⁸

Maintenance of a steady income was considered important to participants. Employment provided a way of doing this for some women and this was a key priority. One participant in this study reported breastfeeding in their workplace during lunchbreaks to enable them to maintain their employment.

Physical and Emotional Wellbeing

Pregnancy was widely acknowledged as being a key milestone in women's lives and a situation where women experienced a significant period of physical and emotional change. Being supported with this change in their lives was considered important. Women discussed that different stages of pregnancy presented different concerns, such as changes in relationships, the impact on finances, changes in their body and so on and raised different support needs for different stages. One critical area was that of mental health. Mental health during pregnancy was seen as an often overlooked area by women across this study and participants discussed the reluctance around talking about emotional wellbeing. Feelings of shame and inadequacy and low confidence often prevented women from asking for help. Perceptions and ideas about being a good mother intensified women's feelings of isolation and were often a barrier to seeking support or advice.

“I didnae even know what post-natal depression was, it wasnae spoke about, it wasnae spoke about in family circles so I was totally isolated, and eh, I took a kind of breakdown.”

“I never went to the GP, or you know tried to find out what it was a, because it wasnae encouraged.”

“It was seen as if you were a failure.”

Vulnerability to post-natal depression should be considered in relation to deprivation and maternal mental health. Evidence from Growing Up in Scotland (2010) has illustrated how mental health difficulties have been associated with a mother's social circumstances. Those who experienced poverty and those living in areas of deprivation were more likely to experience brief and repeated mental health problems.⁹ Wider research from the NSPCC illustrates that in the early 2000's there were recognised gaps in the provision of postnatal mental healthcare.¹⁰

Women in our study viewed their healthcare choices as being limited by the situation they were in, whereby they were often facing competing issues and priorities. Poor mental health compounded the pressures women experienced. In addition to this, a theme emerged across this study on trauma and difficulties pre- and post-birth which had long-term impacts on mental health. Pregnancy was perceived by women across the study as a time that should be happy in women's lives. For those who had negative experiences of pregnancy and giving birth or other difficult life events around this time, such as bereavement, this had significant impacts on emotional wellbeing. Participants spoke around the need for empathetic care. Where women had negative experiences, for example in how they perceived they had been treated by healthcare providers, this had left them with distrust and unease over their health and wellbeing in subsequent pregnancies.

On a wider level, mental health was considered important in terms of preventative healthcare. Participants in this study spoke of having never been offered support with their experiences and this had contributed to long-term poor mental health. It was argued that more support was required, particularly for mothers who had suffered miscarriage and stillbirths and who were not provided with formal aftercare. These all had adverse impacts on their long-term wellbeing.

⁸ Equal Opportunities Commission (2005), *Greater Expectations: Final Report of the EOC's Investigation into Discrimination against New and Expectant Mothers in the Workplace*.

⁹ Growing up in Scotland (2010), *Growing Up In Scotland: Maternal Mental Health and its Impact on Child Behaviour and Development*, <http://www.gov.scot/Publications/2010/04/26102536/2>

¹⁰ NSPCC (2015), *Getting it Right for Mothers and Babies. Closing the Gaps in Community Mental Health Services*.

Accessing Support and Advice: Formal Support

Advice and support during pregnancy and during antenatal care appointments was discussed in detail throughout this study. Women described receiving advice and support from a number of different sources including healthcare professionals, partners and wider social networks. These sources of support were prioritised differently by women across the study. Factors that influenced support accessed included: individual understanding of pregnancy, confidence, relationships with service providers and living on a low income.

Engagement with formalised healthcare services varied across the participants in this study. The importance of healthcare professionals being supportive and non-judgmental was central to positive and respectful engagement. This was of particular importance to younger mothers but also to mothers with low confidence or when experiencing stressful circumstances.

Many women in this study spoke about only building a trusted relationship with healthcare staff when they had extensive engagement with them, for example when they had health difficulties while pregnant or if they had difficulties in conceiving. Limited appointment times at routine check-ups with midwives and other professionals prevented women from feeling that they 'knew' a professional well. Generally women perceived having been 'left alone' during pregnancy and the processes of antenatal care being minimal, unless there were difficulties in the pregnancy.

Where women in this study had opportunities to build more of a bond, for example due to more healthcare contact such as support with assisted conception, this connection was viewed as beneficial. Primary care staff, particularly GP's, were discussed most regularly across the study as where women could get advice and support. These were more often readily utilised than formal antenatal care appointments because the women had previously established relationships with their GP.

Health Messages

The women in this study felt they received mixed messages around pregnancy and women found it difficult to know what healthcare advice to follow. This was of greater importance for women during their first pregnancy. These women expressed confusion and anxiety about wanting to make the right choices for themselves and their baby.

Some women discussed advice changing between earlier and subsequent pregnancies, for example surrounding diet and nutrition. Generally women spoke about adhering to professional advice as much as possible, although some examples were provided of women choosing not to follow the health advice given, such as stopping smoking in pregnancy or reducing caffeine.

"I've tried to stop smoking so many times, but I wasnae a heavy smoker."

Women who had babies during the 80's and early 90's felt that the context for advice was very different for their pregnancy than for women now. People were more dependent on healthcare professionals for advice and there was a lack of readily available advice sources such as the internet or information pamphlets provided at antenatal appointments. Processing information provided by care providers could also be difficult. It often brought new fears or worries to women trying to adhere to all the advice provided. Some women preferred to not know what the different stages of pregnancy would incur. However, women acknowledged that pregnancies now benefitted from the growth of information and advice provided online. This was seen as a generally positive way to enable women to make sense of the pregnancy on their own and was viewed as empowering.

"Where was Google then?"

By the early 2000's, information and advice provision was changing and women discussed being given books by relatives or being provided with information booklets. Such information was considered useful; however women spoke more readily of the value of direct advice administered by a healthcare professional because questions or concerns could be discussed.

Accessing Support and Advice: Informal Support

In terms of wider support outside of formal routes, a particular emphasis was placed on advice from trusted peers such as other female relations, with the pregnant woman's mother often reported as being the main source of advice. This has been the case for centuries. Nevertheless, some women reported not wanting to bother people with questions if they deemed the individuals had other issues they felt were more important. Despite this, women expressed a need for greater support and advice during pregnancy than they had received.

Women reflected on their understandings of their body prior to getting pregnant. Social attitudes towards women and their sexuality both shaped and constrained women's lives. Women spoke about how subjects such as menstruation and sex education had often been socially taboo subjects and which also shaped reactions on learning about pregnancy. Some women discussed their lack of understanding about their bodies and how they worked and many spoke about not realising they were pregnant. This was a particular issue for those who were younger at the time of pregnancy.

Reactions to pregnancy announcements from wider social networks varied across this study. Societal expectations of women, the age of the mother and views about the partner all shaped reactions to pregnancy announcements. Negative reactions, for example if it was an unplanned pregnancy, often left women feeling upset and in some cases isolated. This sense of isolation also made women reluctant to engage in antenatal care provision. Participants discussed concerns about engaging healthcare professionals in anticipation of further potential negative reactions.

“You were scared to ask anything when you went.”

Partners were infrequently discussed as a source of pregnancy support across this study, with few women mentioning them as key sources of support. Partners provided more practical support such as assistance with traveling to appointments and also provided more visible support with the later stages of pregnancy such as labour. However, some women discussed their partners' distinct disinterest in the details of pregnancy.

Family and friends were one of the most common places where women had gained advice. Women spoke about how this was often provided, whether or not this had been requested, and occasionally how they received contradictory messages.

“People are really good at giving advice, you know, if you ask, whether you want it or no.”

Research participants recognised that there was more support available for women at present than there had been historically,

although there was an acknowledgment that multiple barriers such as fear, low confidence and knowing who could answer queries remain an issue for women today. Some women spoke of difficult circumstances when they were pregnant for example, being a young mum, living in insecure housing and difficult family circumstances around the pregnancy which limited their service engagement. For women who had been young mothers this was often challenging due to the stigma they perceived from healthcare professionals, wider family, friends and community. For some, this resulted in difficult relationships with their partner or their immediate family. This often left women feeling quite isolated and impacted their confidence. All of these factors combined to discourage women from asking for help and advice from healthcare professionals. Other studies have also reported young mothers feeling disempowered in terms of accessing support and advice.¹¹

Vulnerable circumstances

Women expressed dealing with complex emotions and situations and they reported having many fears about how they would be perceived or treated by health professionals, for example being judged or not respected, perhaps due to precarious circumstances such as insecure housing. In some situations, such as when a woman had experienced domestic abuse in pregnancy, women expressed fears about potential repercussions upon seeking support, for example further domestic abuse.

Within antenatal care provision, being asked specific questions about domestic abuse in pregnancy was seen as critical because it provided an opportunity where women could access support. Research has shown that pregnancy is often a trigger point for domestic abuse or can increase its intensity.¹²

“The night he found oot, he went mental. He was happy at the time, that night he smashed up the hoose, he smashed up everywhere, it was an absolute nightmare, he had me crying, everything, eh.”

¹¹ Royal College of Midwives (2009), *Teenagers Experiences of the Maternity Services*. <https://www.rcm.org.uk/learning-and-career/learning-and-research/ebm-articles/teenagers%E2%80%99-experiences-of-the-maternity>

¹² Royal College of Midwives (2012), *Interventions to Reduce Domestic Abuse in Pregnancy: A Qualitative Systematic Review*.

Figures show that around one in four women experiences domestic abuse at some point in their lives.¹³ This may be physical, sexual, emotional or psychological abuse. More than 30% of this abuse starts in pregnancy, while existing abuse may get worse during pregnancy or after giving birth.¹⁴ Exposure either in utero, or after birth, can impact on a child's wellbeing and its developmental outcomes.¹⁵

It was suggested that written questionnaires as part of routine antenatal care could provide a useful mechanism for women who found it difficult to speak about the issues. Women across this research had mixed experiences of being asked about domestic abuse during their pregnancies. Some had opportunities to disclose to a midwife, while others, who had been pregnant during 80's and early 90's, had not experienced this.

"I wish people had picked up what was wrong because I never told anybody."

"I think they could tell in the hospital, the way I was acting', and eh they ended up, they always kept asking 'to bring in a social worker to talk to, because they could see it and they could see how he was acting in the hospital or whatever, and did I have social workers."

Critical to women feeling that it was safe for them to disclose domestic violence was their level of trust in the healthcare professionals and their perceived safety from their abusive partner to do so. For some women, fear or worry about what might happen following a disclosure was also reported as a barrier preventing them from accessing support. Evidence has shown that pregnancy offers a unique window of opportunity to identify women who are experiencing domestic abuse and offer them support.¹⁶ Currently all pregnant women are given an opportunity to disclose Domestic Abuse through routine enquiry.¹⁷ Historically domestic abuse was not routinely asked about in the UK during pregnancy and often midwives faced challenges if they sought to enquire.¹⁸

Women in this research study welcomed the changes in antenatal care whereby they were routinely asked about domestic abuse as part of their antenatal care. This was seen as a critical change for an intervention point where support and advice could be offered to women.

"Before you didn't have an option..."

On a broader level, those in more precarious financial circumstances are particularly vulnerable to the intensification of their poverty or precariousness at time of pregnancy due to changing circumstances and requirements such as time off employment. Support with this is critical. Pregnancy and maternity are key transition periods for women to access advice to ensure that they are getting the pay and welfare benefits to which they are entitled.¹⁹

Stigma and pregnancy

Specific forms of support such as antenatal classes were also discussed. Some women reported that they did not feel comfortable attending these due to perceptions of stigma they would experience from other people attending. Women spoke of the classes being 'not for them' or not feeling they required the advice that was offered if they felt comfortable about dealing with a child. Groups reported feeling they wouldn't 'find people like me'. Indeed, evidence collected through Growing up in Scotland (2007) reported that in a study across different income cohorts, women on a lower income were less likely to report attendance at antenatal classes.²⁰ Women also reported being less likely to attend post-natal or mother and baby groups after the baby was born, with confidence being a key reason for non-attendance.

Participants reported differences across pregnancies with their personal requirements for support and advice. It was argued that there was an assumption by healthcare professionals that you needed less advice with subsequent pregnancies. You were expected to "get on with it." This belief was considered misplaced because women faced different challenges with subsequent pregnancies and were often in different social circumstances.

¹³ Refuge (nd), *What is Domestic Abuse*, <http://www.1in4women.com/what-is-domestic-violence.php>

¹⁴ NHS Choices (2015), *Your Pregnancy and Baby Guide*, <https://www.nhs.uk/conditions/pregnancy-and-baby/domestic-abuse-pregnant/>

¹⁵ World Health Organisation (2011), *Intimate Partner Violence during Pregnancy*, whqlibdoc.who.int/hq/2011/WHO_RHR_11.35_eng.pdf

¹⁶ O'Reilly R, Beale B, Gillies D. (2010), 'Screening and Intervention for Domestic Violence during Pregnancy Care: A Systematic Review.' *Trauma, Violence & Abuse* 11(4): 190-201 cited in S. Leneghan, M. Sinclair and P. Gillen, 'Domestic Abuse in Pregnancy: "I'm more used to unhealthy relationships than healthy relationships,"' *Evidence Based Midwifery* 13(4): 120-125.

¹⁷ NHS Choices (2015), *Your Pregnancy and Baby Guide Domestic Abuse*. <https://www.nhs.uk/conditions/pregnancy-and-baby/domestic-abuse-pregnant/>

¹⁸ *Domestic Violence in Pregnancy: Opening Pandora's Box: Report of a Meeting of the Forum on Maternity and the Newborn of the Royal Society of Medicine, held on Thursday 13 November 2003.* <https://www.rcm.org.uk/news-views-and-analysis/analysis/domestic-violence-in-pregnancy-opening-%20pandora%E2%80%99s-box>, 12 June, 2008.

¹⁹ Scottish Government (2013), *Scottish Government Equality Outcomes: Pregnancy and Maternity Evidence Review*.

²⁰ *Growing Up in Scotland (2007), Pregnancy and Birth*, www.gov.scot/Resource/Doc/163083/0044329.pdf

Conclusions and Recommendations

This pilot project provided some important insights into the experiences of women living on a low income and pregnancy from the 1980's to the early 2000's. This pilot research provided an important opportunity to research what has been historically an often overlooked issue in anti-poverty work.

A number of key messages emerged from this study surrounding the barriers that poverty presented and the need for service provision to embed an anti-poverty approach around antenatal care. It was generally perceived by participants that healthcare provision had improved for women with greater access to medical knowledge and more understanding of women's needs. This was viewed positively for improved health and wellbeing during pregnancy. In particular, this study revealed how women's experiences across pregnancies were shaped by multiple factors including health prior to and after conception, income, and knowledge of pregnancy and available support.

There are a number of recommendations for policy and practice:

- **Participation:**

It is important that the experiences of low income women in relation to pregnancy are included in the development of both local and national child poverty policies, for example through the development of local Child Poverty Action Plans as part of the Child Poverty Act. It is critical that service providers reach out to women to ensure that they are able to participate in the development of services that will impact upon them.

- **Income:**

Women's care in pregnancy across all stages of pregnancy, including the first six weeks, should be poverty proofed to remove hidden costs and barriers that women face and in terms

of the service provision they receive. Antenatal experiences must also be considered as part of the Scottish Government's analysis of all available options open to it in order to realise its commitment to the introduction of a new income supplement aimed at low income families. The delivery of the Best Start Grant, due to be introduced by summer 2019, should be monitored to ensure maximum impact for low income families.

- **Employment:**

Wider research is required on low income women's experiences of employment post pregnancy

- **Mental Health:**

A greater focus is required on emotional wellbeing at all stage of pregnancy including post-pregnancy. Particular focus needs to be paid to women who have experienced some form of trauma such as bereavement.

- **Complex circumstances:**

Greater focus is required around exploring complex circumstances that women may be facing, such as domestic abuse and support routes and the health and welfare referrals available to women. The implementation of the Scottish Government's Equally Safe delivery plan should reflect and consider the experiences of women facing complex circumstances in pregnancy.

- **Isolation:**

A greater focus is required on antenatal isolation and how this may impact on women's ability to engage in antenatal care provision. The Scottish Government's upcoming social isolation and loneliness strategy offers an opportunity to provide this focus and should include action to further understand and overcome the barriers faced during pregnancy.

This briefing has been written by Fiona McHardy, Research and Information Manager at the Poverty Alliance. May 2018.
We would like to thank all the research participants who took part in this study for their time and openness.

Opinions expressed in this report do not necessarily reflect the views of Poverty Alliance or its members.
